

Developing workplace and medical benefits policies to support staff with HIV

**In collaboration with partners in
Cambodia, Burkina Faso and Senegal**



The International HIV/AIDS Alliance (the Alliance) is an international non-governmental organisation (NGO) that supports communities in developing countries to make a significant contribution to HIV prevention, AIDS care and to the provision of support to children affected by the epidemic. Since its establishment in 1993, the Alliance has provided financial and technical support to NGOs and community-based organisations (CBOs) from more than 40 countries.

The Alliance Emerging Practice Series consists of reports and papers which are currently in draft form, which we feel may contain useful information for people working on HIV/AIDS policy and programming, and people providing support to NGOs and CBOs in developing countries. The series is intended to provide updates on issues in areas where practice is being developed, and where debate and learning about good practice is still largely emerging.

This series of draft reports and papers is available in electronic form for people to download and print if they wish. The text of these reports and papers will be subject to change as additional information becomes available, and we would appreciate your feedback.

Once good practice begins to be agreed and consolidated, our intention is to use these drafts to form the basis of practical tools and technical support resources for use by NGOs and CBOs working on HIV/AIDS in developing countries, and for use by people who provide support to these organisations.

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International HIV/AIDS Alliance
Queensberry House
104-106 Queens Road
Brighton BN1 3XF
United Kingdom

Tel: +44 1273 718 900
Fax: +44 1273 718 901
www.aidsalliance.org
mail@aidsalliance.org

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANCS	Alliance Nationale Contre le SIDA
ARV	Antiretroviral
ED	Executive Director
HIV	Human Immunodeficiency Virus
IAS	International AIDS Society
ILO	International Labour Organisation
IPC-SIDA	Initiative Privée et Communautaire de lutte contre le VIH/SIDA
LO	Linking Organisation
NGO	Non-Governmental Organisation
PEP	Post Exposure Prophylaxis
PLHA	People Living with HIV/AIDS
STI	Sexually Transmitted Infection
TS	Technical Support
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary HIV Counselling and Testing
WHO	World Health Organisation

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1. Introduction

This draft report shows the process of developing HIV/AIDS in the workplace and medical benefits policies with linking organisations of the International HIV/AIDS Alliance (the Alliance) in Cambodia, Senegal and Burkina Faso during 2002. It is intended to inform NGOs and other organisations who may wish to develop their own similar policies¹. Information from this draft report will be integrated into a document detailing further lessons learned by the Alliance and partners during 2003. We anticipate this will include challenges encountered during implementation and strategies used to address these challenges.

For further information, please contact: Tilly Sellers, Co-ordinator: Civil Society Development at the International HIV/AIDS Alliance.
tsellers@aidsalliance.org
Mandeep Dhaliwal, Co-ordinator: Care and impact mitigation. mdhaliwal@aidsalliance.org

1.1 Background information: increasing access to medical treatment for HIV-positive staff in AIDS non-governmental organisations in developing countries

Since 1996, generally effective treatments for HIV/AIDS have been available in developed countries, and are increasingly available in developing countries and countries in transition. Costs in most contexts remain high, however, and in the absence of government health insurance plans, which include combination antiretroviral therapies, many people living with HIV/AIDS employed in the formal sector will look to their employers for assistance with health coverage.

Employers have an interest in maintaining the health of their employees, including employees living with HIV/AIDS. Until 1996, mostly in developed countries, any employer assistance was largely limited to support for the treatment of opportunistic infections, providing psychosocial care and support, and accommodating the needs of HIV-positive staff

through job reassignment, flexible working hours, and extended leave during long periods of illness. The outcome in most cases was early retirement or death and employees living with HIV were understandably reluctant to reveal their HIV status at work because of the stigma and discrimination likely to follow. Employees who did disclose were often viewed as a liability at best and were frequently denied opportunities for training, travel and career advancement.

In developed countries, the advent of effective antiretroviral treatment has radically changed the way persons living with HIV/AIDS are viewed in the workplace. These employees are now often fit enough to continue working without specific accommodation for their HIV status, and consequently have no need to disclose their status to their employer or co-workers. At least, the popular belief, that antiretroviral therapies have transformed HIV infection into a chronic, manageable condition, means that when/if a person's HIV status does become known, employment and even career advancement need not be threatened. HIV-related stigma and discrimination have been reduced, although remain far from eliminated.

Most national governments have undertaken by international treaty to ensure the progressive implementation of the right to the highest attainable standard of physical and mental health. However, resource limitations in many developing countries mean that combination antiretroviral therapies and associated medical monitoring are beyond the scope of most national health plans (Brazil and other South American countries are a notable exception). Because the vast majority of people living with HIV employed in the formal sector cannot afford private medical care, employer-sponsored health care is the only option.

The International Labour Organisation (ILO) has developed a code of practice in consultation with its tripartite constituents (governments, employers, labour). The 'Code of Practice on HIV/AIDS and the World of Work'² contains fundamental principles for

¹ Please note that any costs mentioned in this report refer to the time when policies were developed in each country and may have changed since.

² ILO Code of Practice on HIV/AIDS and the world of work, ILOAIDS, 2001; www.ilo.org/public/english/protection/trav/aids/download/pdf/hiv_a4_e.pdf

1. Introduction

policy development and practical guidelines from which concrete responses can be developed at enterprise, community and national levels in the following key areas:

- prevention of HIV/AIDS
- management and mitigation of the impact of HIV/AIDS on the world of work
- care and support of workers infected and affected by HIV/AIDS
- elimination of stigma and discrimination on the basis of real or perceived HIV status.

The Code meets two needs. It is an instrument for advocacy, in particular for strengthening private sector involvement, in action against HIV/AIDS. It is also a guide to the development and implementation of policies and programs at the national level and in the workplace and the community. The Code notes:

'Some employers may be in a position to assist their workers with access to antiretroviral drugs. Where health services exist at the workplace these should offer, in co-operation with government and all other stakeholders, the broadest range of health services possible to prevent and manage HIV/AIDS and assist workers living with HIV/AIDS. These services could include the provision of antiretroviral drugs, treatment for the relief of HIV-related symptoms, nutritional counselling and supplements, stress reduction and treatment for the more common opportunistic infections including STIs and tuberculosis.' (9.3 of the ILO Code of Practice)

The Code also notes the importance of addressing stigma and discrimination. In particular, employers should 'ensure that work is performed free of discrimination or stigmatisation based on perceived or real HIV status' (5.2 of the ILO Code of Practice). The Code is not a legally binding document, however, and national laws do not require employers to provide treatments for HIV infection. However there are general obligations on employers to address discrimination in many jurisdictions. It is essential that stigma be addressed if workplace health care programs are to be successful.

The UN policy is to treat HIV/AIDS the same way as other serious medical conditions. HIV infection itself is not a barrier to recruitment or career advancement, and the same conditions apply regarding health insurance as apply to other chronic illnesses. The experience, over recent years, of United Nations agencies working in many high HIV prevalence developing countries is that stigma is a strong deterrent to national staff access to medical treatment. Evidence shows that as long as HIV infection remains a highly stigmatised condition, national staff living with HIV/AIDS will not seek medical treatment for HIV infection even where it is provided for staff and dependants through agency health plans. Anecdotal evidence indicates that the fear of job loss or workplace discrimination keep staff with HIV isolated and silent. The clear message from the UN experience is that health plans, which include treatment for HIV infection, will not be accessed, or treatment will be unnecessarily delayed, if workplace stigma and discrimination are not simultaneously addressed.

AIDS service organisations, because of the nature of their work, have a specific interest in recruiting and retaining staff living with HIV and will often have a greater number of HIV positive staff than organisations of a comparable size working in other areas. This fact, and the interest in recruiting HIV positive staff itself, may weigh in favour of a more generous consideration of HIV infection than of other medical conditions. For example, the workplace health insurance policy may waive the usual waiting period before coverage becomes available so that staff with HIV can access treatment upon recruitment.

Such positive discrimination, and other measures such as extended sick leave, reassignment to lighter duties, and part-time employment during periods of recovery, should be seen in the broader context of the institutional, national and international response to the HIV/AIDS epidemic. Beyond the legal duties imposed by national legislation (often limited in the developing country context) and the institutional interest in recruiting, retaining and keeping healthy trained and experienced staff, there is a moral and ethical imperative. The latter relies on management

1. Introduction

and co-workers to support such workplace policies, and their HIV-positive colleagues, arising from universal principles based on respect for life and human dignity and found in every religious and moral code. Particularly in countries severely affected, it is essential that such ethical and moral principles be constantly and visibly reaffirmed, as they must continue to provide guidance for individual and community action if and when formal state institutions and the rule of law begin to fail.

1.2 Alliance and partners' experience in developing HIV/AIDS in the workplace and medical benefits policies

In 2001 the Alliance developed policies on HIV/AIDS in the workplace and on staff medical benefits. The reasons for providing medical benefits for staff living with HIV/AIDS included:

- The basic need for access to treatment for People Living with HIV/AIDS (PLHA)
- The importance of recruiting, retaining and keeping healthy PLHA as staff working for an NGO responding to the epidemic
- The particular role of the Alliance as an HIV/AIDS NGO

The issue of medical benefits was treated separately from the general policy on HIV/AIDS in the workplace because of the urgency of putting in place a medical benefits policy for staff in the expanding Alliance offices in India, the Ukraine and Zambia. The Alliance Trustees decided that all Alliance staff, including locally recruited staff in developing countries and countries in transition, should have, as a minimum, the equivalent of the medical benefits available to the staff in Alliance headquarters in the UK.

The Alliance received technical assistance from the Canadian HIV/AIDS Legal Network in the development of the policies. The Alliance HIV/AIDS workplace policy was adapted from the International Labour Organisation (ILO) Code of Practice on HIV/AIDS and the World of Work (2001).

In April 2001, the Trustees also instructed the Executive Director to develop a project of support to Alliance Linking Organisations (LOs)³ to help them:

- Explore if and how to provide medical treatment for staff living with HIV/AIDS; and
- Address broader issues of stigma and discrimination in the workplace.

Some of the guiding principles adopted by the Alliance Board of Trustees for this project were the following:

- The Alliance should recognise the legal autonomy of its partners, and approach these issues in a proactive way while avoiding compulsion.
- The Alliance should avoid offering pre-packaged answers, but rather generate discussion and innovation.
- The programme should seek to develop practical short-term strategies to address access to treatment and discrimination issues, but should also lay ground for longer term more innovative thinking.

Of the 17 Linking Organisations initially contacted to develop their own policies on HIV/AIDS in the workplace and staff medical benefits, almost all indicated an interest in receiving technical support. It was decided to initiate a pilot project in a limited number of countries in 2002. The countries where Alliance LOs received technical assistance on these issues were Cambodia (June), Senegal (October) and Burkina Faso (November).

This report presents the methodology used for the technical support process led by the Alliance in the three countries as well as a comparative analysis of the outcomes of the process, i.e. the policies developed by Alliance LOs – Khana in Cambodia, ANCS in Senegal and IPC-SIDA in Burkina Faso. It may also be useful to read the paper prepared by the Canadian HIV/AIDS Legal Network and the AIDS Alliance for the Barcelona Global AIDS Conference in 2002.

<http://www.aidslaw.ca/barcelona2002/alliancemedicaltreatmentpaper.pdf>

³ Linking Organisations are NGO support organisations in developing countries who partner with the AIDS Alliance to access technical support and resources

2. The process of developing HIV/AIDS in the workplace and medical benefits policies

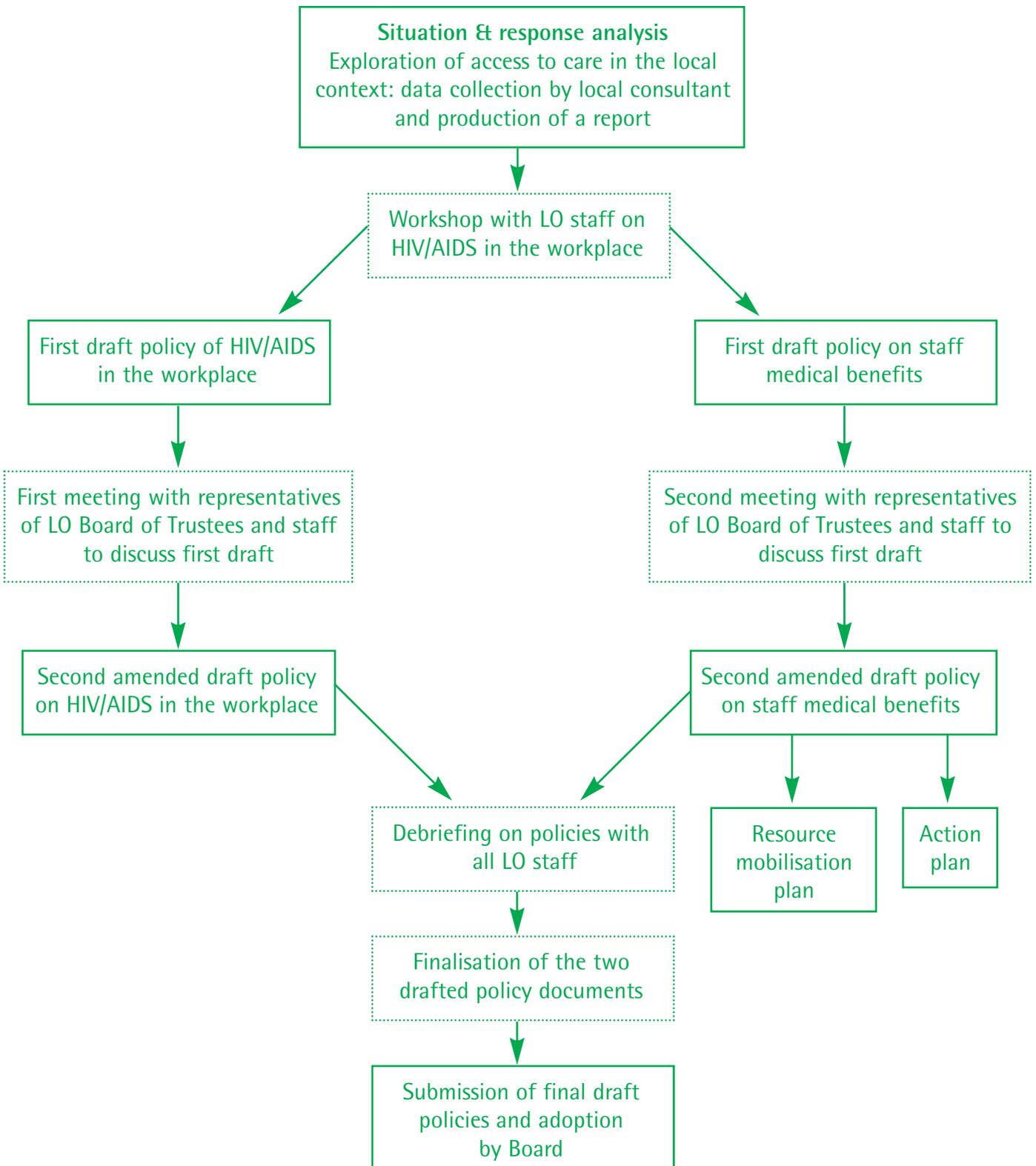
In the three countries where the Technical Support (TS) programme was implemented in 2002, the steps were very similar, with only some slight variation depending on the countries. The following diagram shows these steps. The table presented in Annex 1 gives a more detailed description of the steps followed and also indicates who, from the Linking Organisations and the Alliance, was involved in each of them.

Visits to each one of the three countries by international Alliance staff or consultants took no more than a couple of weeks (see schedule of the TS programme in Cambodia - Annex 2).

Reports on access to care in the local context were prepared by local consultants before the visits.

2. The process of developing HIV/AIDS in the workplace and medical benefits policies

Methodology used to help Alliance Linking Organisations develop their own HIV/AIDS in the workplace and medical benefits policies



2. The process of developing HIV/AIDS in the workplace and medical benefits policies

2.1 Situation & response analysis

In each one of the three countries local consultants employed by the Alliance undertook research and provided a written report on access to care in the local context. The reports included the following sections:

- Access to Voluntary HIV Counselling and Testing (VCT)
- Access to Post Exposure Prophylaxis (PEP)
- Access to medical treatment for Sexually Transmitted Infections (STI)
- Management of HIV infection – clinical aspects
- Management of HIV infection – psychosocial aspects
- Health insurance system
- In Burkina Faso it was agreed to add a section on Prevention of Mother to Child Transmission.

A draft version of a terms of reference for the situation and response analysis is detailed in Annex 4.

In Cambodia the local consultant also included, in the same report, an analysis of the current and likely future needs of the LO to provide HIV treatment to staff as well as a summary of options for providing medical treatment for HIV/AIDS.

In Senegal and Burkina Faso, besides the report presenting the findings of the situation analysis, a separate document has been produced, listing recommendations for improving access to care for LO staff in all the areas researched (see above), including medical treatment for HIV/AIDS.

Copies of the draft documents were usually made available to LO staff and their Trustees, who were involved in the early development of the policies, before or at the beginning of the meeting aimed at discussing the policy on staff medical benefits.

In Burkina Faso and Senegal, several sections of the situation analysis report were designed to be used as practical guides for LO staff, including contact details of service providers and factual information about the services (office hours, criteria for eligibility, etc.).

A fact sheet on VCT services was even disseminated during the workshops attended by all LO staff.



- The situation analysis must be rigorous in costing all components of treatment.
- The response analysis must be rigorous in presenting options for the medical benefits policy, including the pros and cons of each option, and in costing the options.
- The LOs in Senegal and Burkina Faso saw the situation analysis report as a useful document that they could use not only for the development of policies but also with their partner organisations in the future, since no information specific to the LOs is included in this report.
- It seems therefore preferable to produce two documents: (a) a general situation analysis that can be widely disseminated, and (b) a separate analysis of the LO response and options available, which is disseminated only internally.

2.2 Workshop on HIV/AIDS in the workplace

'It is the first time we talk about our HIV and not someone else's HIV',
Programme Officer, LO, Burkina Faso

'This is a good start to create a supportive environment for PLHA in our organisation',
Executive Director, LO, Burkina Faso

In each country a workshop was held with LO staff at the beginning of the TS process. It was made clear that the presence of all levels of staff was mandatory. Board participation was optional.

The main objectives of the workshop were as follows:

- Sensitisation: Sensitise staff around issues related to HIV/AIDS in the workplace, e.g. stigma and discrimination, confidentiality, etc.

2. The process of developing HIV/AIDS in the workplace and medical benefits policies

- Consultation: Discuss essential and desirable components of policies on HIV in the workplace and staff medical benefits in order to use feedback for the development of the policies.

The methodology used was participatory. Many activities carried out during the workshops with the Cambodian LO had been tested with Alliance staff in the United Kingdom. In Senegal, activities on VCT were included in the workshop at the LO's request. Staff gave very positive feedback on these activities and it was decided to include them as well in the workshop in Burkina Faso.

The workshop lasted one day in Cambodia and a day and a half in Burkina Faso and Senegal (see Annex 3 - Detailed agenda of the workshop held in Cambodia).

A summary of the workshop agenda

Main workshop activities in Cambodia	Main workshop activities in Burkina Faso and Senegal
Introduction	Introduction
HIV/AIDS - Clarifications and queries	HIV/AIDS - Clarifications and queries (Let's speak the same language!)
Stigma and Discrimination issues	VCT Issues - HIV status: To know or not to know?
Confidentiality and disclosure	Confidentiality and disclosure - HIV status: To tell or not to tell?
Understanding what information is confidential	Understanding what information is confidential
HIV/AIDS in the workplace - Issues and concerns	Stigma and Discrimination issues
	HIV/AIDS in the workplace - Issues and concerns



- It is important to make clear that the workshop is one of the first steps of a participatory and consultative process aimed at developing policies on HIV/AIDS in the workplace and staff medical benefits in the organisation.
- However, staff must know that final decisions will be made by senior staff and ultimately the Board of Trustees.
- Feedback on both the methodology and contents of the workshop was positive in each country. Positive feedback included the following comments:
 - It is an opportunity to learn about HIV/AIDS (technical information, terminology, etc.)
 - It is an opportunity to understand issues related to HIV/AIDS in the workplace and also to care for PLHA
 - It is an opportunity to discover new participatory activities (for programmatic staff)
- The workshop also became a team-building exercise for the LOs, as it was the first time all staff, including auxiliary staff, could spend some time together to discuss individual and organisational issues.
- Auxiliary staff, and to some extent administrative staff who were not used to workshops, felt particularly motivated by the fact their participation was valued by their organisation. Challenges for their meaningful participation included language (in spite of translation). It may be useful to have an additional discussion with the auxiliary staff to gain their further input.
- The workshop proved a useful exercise to assess the level of knowledge of staff on HIV/AIDS in a non-threatening way. It also showed to LO management how important it is to update the knowledge of all their staff on a regular basis.

2. The process of developing HIV/AIDS in the workplace and medical benefits policies

2.3 The development of policies

2.3.1 Development of the policy on HIV/AIDS in the workplace

In Cambodia, the LO used the policy on HIV/AIDS in the workplace developed by the Alliance as a template for the development of its own policy. In Senegal, documents produced by both the LO in Cambodia and the Alliance were used to produce a new template and in Burkina Faso the Senegalese draft was the basis for a new document.

In each country suggestions and recommendations made by the LO staff during the workshop on HIV/AIDS in the workplace were included in the template.

The resulting policy document was discussed during a one-day meeting with the LO management team and some Board members, as well as representatives of staff chosen by the management team in Burkina Faso and Senegal. The document discussed during the meeting was amended based on the changes requested by the LO representatives, in order to produce a second draft policy document ready to be submitted to the Board for final approval.

2.3.2 Development of the medical benefits policy

The process for the development of the policy on staff medical benefits was very similar to the process described above for the development of the HIV/AIDS in the workplace policy. However, the main documents used for discussion were the following:

- In Cambodia, the report on access to treatment in the local context, including the analysis of the LO's response and a list of options for medical benefits
- In Burkina Faso and Senegal, a summary of the findings on access to care in the local context together with the analysis of the response and recommendations to optimise access to care for LO staff⁴.

During the second meeting dedicated to the discussion of the best options for staff medical benefits, participants also developed a resource mobilisation plan and a policy implementation plan including who would be responsible.



- It was very important for LO staff to see that the suggestions they had made during the workshop were included in the draft policy documents.
- LOs liked the speed of the policy development process, made possible by the Alliance technical support. They felt that there was a good balance between the time invested by LO staff and Trustees and the outputs of the process. There was a great sense of achievement within each LO at the end of the technical support process.
- The participatory nature of the policy development process, with the early involvement of staff in the process through the workshop, increased the credibility of the policies with the Trustees.

⁴ A full report on access to care in the local context was available but LO staff and Trustees did not have time to read it before the meetings and therefore used the summary of findings with the corresponding recommendations.

3. The outcomes

3.1 Policies on HIV/AIDS in the workplace

When the TS programme was launched in each country, there was no existing policy on HIV/AIDS in the workplace in any of the LOs involved in the programme. They therefore started from the same level.

As mentioned in the introduction, one of the guiding principles of the TS programme was to 'avoid offering pre-packaged answers' to the LOs. Each organisation was absolutely free to develop its own policies. Having said that they took into account the international good practice that the Alliance itself had already included in its policy by adapting the International Labour Organisation (ILO) Code of Practice on HIV/AIDS and the World of Work (2001). As a result policies developed by the Cambodian LO and the Alliance have a lot in common.

The policy on HIV/AIDS in the workplace includes more or less the same sections in all the countries where it was developed:

Sections of the HIV/AIDS workplace policies

- Statement of duty and a list of commitments (included at the beginning of the policy in Cambodia, Burkina and Senegal)
- Objectives
- Definitions
- Responsibility for implementation
- HIV screening, recruitment and employment
- Confidentiality
- Duty travel and vaccination
- HIV prevention
- Occupational or other exposure
- Information and training
- Stigma and discrimination
- Reasonable accommodation
- Termination of employment
- Gender dimensions
- Counselling and psycho-social support
- Grievance and disciplinary procedures
- Revision
- Commencement

- Annex 1 - Commitment to confidentiality or confidentiality agreement

Although policies developed by the Alliance and its three LOs are very similar, there are also some differences. Some of them were influenced by the cultural and socio-economic context of each country, others were the result of the polishing of the text by an increasing number of people with various backgrounds and levels of analysis. A list of the major differences follows:

• Commitment to a healthy lifestyle

In Cambodia the LO linked the rights for its employees described in its workplace policy, to their commitment not to put themselves at risk and live a healthy lifestyle.

'In subscribing to these policies, we are also committing ourselves to living a healthy lifestyle, which includes good health practices and good health-seeking behaviour. The HIV/AIDS in the workplace and medical benefits policies are developed on the premise that we do not knowingly put ourselves at risk.' (Statement of Duty)

• Understanding the meaning and the scope of confidentiality

The LOs in Senegal and Burkina Faso included in their policy the commitment to develop a code of good practice regarding confidentiality, and they stressed the importance of disseminating this code to all employees and other people working with the organisation. This decision was based on discussions about confidentiality during the workshop on HIV/AIDS in the workplace and the difficulty in understanding what is confidential or not.

The LOs in Senegal and Burkina Faso also included a clause reminding that the respect of confidentiality should also apply to information regarding employees who no longer work for the organisation.

• Beyond HIV/AIDS: other illnesses and disabilities

In Burkina Faso and Senegal, there is mention of other chronic illnesses and disabilities in the workplace

3. The outcomes

policies (for example under the section on 'Reasonable Accommodation'), although the policies still focus mostly on HIV. This arose from a concern among staff that there would be some form of discrimination between people who live with HIV and those who live with other serious illnesses or disabilities. The same concern was expressed in Cambodia and is reflected in the medical benefits policy.

- **Beyond the organisation and its employees**

In Burkina Faso, staff felt that information on HIV transmission and prevention should be disseminated to dependants of employees. As a result the LO states in its policy that it will facilitate this dissemination and encourage its employees to act as resource persons in their community.

- **The importance of mother-to-child transmission in Africa**

In Burkina Faso and Senegal, the LOs felt that it was important to mention specifically mother-to-child transmission under the sections on 'HIV prevention' and 'Gender dimensions'.

- **Filling the gaps of the national health system: insurance for work-related accidents**

In Cambodia, the LO decided to state that insurance cover for work-related accidents and injuries would be provided for all staff. This was not mentioned in other countries where it is already part of the national health system that covers employees in the formal sector.



- The main lesson learned is that in spite of huge cultural differences between the countries where HIV/AIDS workplace policies were developed, there is a universality of rights for employees affected by HIV or other illnesses and disabilities.
- At the same time, many LO staff acknowledged that working with the ILO Code of Practice, the Alliance policy, and in some cases other LOs' policies was an eye-opener on many workplace issues they had never considered before.
- LO management teams saw the HIV/AIDS workplace policy as something innovative and useful for their organisation.
- Trustees representing other NGOs in the Board of the LOs felt that they also learned information useful for their own organisations.

3. The outcomes

3.2 Policies on staff medical benefits

The cost of HIV treatment varied enormously from country to country (see table below).

Country	Services	Estimate of annual cost of HIV treatment for the patient (2002)
Burkina Faso	ARVs, treatment of opportunistic infections, consultations, tests (including CD4 and viral load)	\$1,745 (ARVs = \$1,520)
Cambodia	ARVs, treatment of opportunistic infections, consultations, tests	\$ 500
Senegal	Treatment of opportunistic infections, consultations, tests (including CD4) - ARVs are provided free of charge by the State for most patients	\$ 185

All LOs had already some form of medical benefits for their employees, although packages were extremely different depending on the organisations. In Burkina they had a health insurance scheme for employees, in Senegal a percentage of staff salary was added for health benefits and in Cambodia a maximum amount was stipulated for all staff. The table below shows existing packages before the TS process on medical benefits as well as the new options chosen during the process. **In all countries policies were developed with the recognition that the cost of treatment was falling and was likely to continue doing so for some time.**

3. The outcomes

Country	Medical benefits packages existing before the TS process	Medical benefits packages proposed after the TS process
Burkina Faso	<ul style="list-style-type: none"> • Private insurance for employees, spouses and their children. Maximum/person/year = \$4,630 • The insurance covers HIV-related treatment up to \$2,315 on top of the standard cover (total = \$6,945) 	<ul style="list-style-type: none"> • Same private insurance. • Negotiations with insurance company to improve management of confidentiality and to include some medical services such as VCT. • Emergency fund for employees who do not have enough money to pay costs of medical services in advance. • Extension of the insurance to children who are legal dependants of employees (other than their own children). • Extension of insurance during three months after termination of employment.

Country	Medical benefits packages existing before the TS process	Medical benefits packages proposed after the TS process
Cambodia	<ul style="list-style-type: none"> • Medical benefits allowance = \$300/person/year. • Unspent medical benefits allowance returned to the Alliance at the end of the financial year. 	<ul style="list-style-type: none"> • Medical benefits allowance = \$400/person/year. • Reimbursement of 90% of medical, optical and dental treatment when provided by approved service providers. • Possible additional medical expenses for serious chronic illness or accident, up to \$200. • Unspent medical benefits allowance kept by the LO in an account dedicated to medical benefits.

3. The outcomes

Country	Medical benefits packages existing before the TS process	Medical benefits packages proposed after the TS process
Senegal	7.5% of gross salary on top of the salary for medical expenses but the employee is free to use this allowance as s/he wants.	<ul style="list-style-type: none"> • Mutual Health fund or private insurance for employees and their dependants, including children legally fostered by employees, father and mother of employees. • Additional allowance for medical expenses related to VCT and HIV treatment (\$245/person/year) • Specific allowance on top of severance pay if the termination of employment is due to illness.

3.3 Main issues in policy development

• Who are the beneficiaries: what is the definition of dependants?

One of the most discussed issues during the development of the policies in all countries was the definition of the dependants of the employees who would have access to the medical benefits, because of its implications for the cost of the policy. Including too many people could affect negatively the sustainability of the policy, but employees saw excluding certain categories of 'dependants' as unfair. All LOs tried to reach a balance between sustainability and social justice.

The definition of dependants was also the component of the policies most influenced by the social and cultural context and this is therefore where there are the major differences between countries.

In Burkina Faso there was also a debate on whether some form of support should be provided to Trustees who are HIV positive and do not have access to HIV treatment through the organisation where they work. The question was left without response and left to the Board of Trustees for further discussion.

In all countries, there was some confusion about the beneficiaries of the medical benefits policy and other

categories of persons who were directly affected by the HIV/AIDS in the workplace policy but would not have access to medical benefits. For example in Burkina Faso, the LO wanted to make clear that all relatives of employees should be protected by the policy on confidentiality. However only some of these relatives would be covered by the insurance, hence the use of detailed definitions and very specific terminology in both policies.

• Insurance schemes and stigma

Some LOs already had a health insurance scheme or were willing to take one with a private company or a mutual fund. Nevertheless they had to deal with the issue of stigma, as these institutions still have problems managing the confidentiality of medical information regarding people living with HIV or suspected of living with HIV. In Burkina Faso it was good to discover that the company already providing health insurance to the LO did not exclude PLHA. The LO also found out that the annual amount authorised for the treatment of HIV was reasonable and could cover a full treatment for a PLHA, including ARVs.

• What to do on termination of employment of an employee living with AIDS?

In this first policy formulation in Cambodia, the medical benefits policy makes clear that 'on termination of employment for whatever reason, the

3. The outcomes

LO is under no obligation to continue medical benefits'. In the other two countries, LOs tried to find systems that would avoid an interruption of treatment for PLHA on termination of employment, as the interruption of a combination therapy can have disastrous consequences on the health of the patient and contribute to drug resistance.



- There was general consensus that the medical benefits for HIV/AIDS should be part of a general, comprehensive medical benefits policy, as it would be seen as unfair to treat in different ways PLHA and people affected by other serious illnesses.
- A major concern was the financial implications and financial sustainability of a policy that would try to address all the needs of employees and their dependants living with HIV or other chronic illnesses.

4. Conclusions

4.1 An overall success

The TS programme was well received by the three LOs in spite of some initial scepticism. The main reasons why the process was successful were the following:

- LO staff felt that the process fully took into account their opinions and suggestions because of a truly participatory methodology.
 - The process was not time consuming for LO staff, including management teams, as all documents were prepared and amended by Alliance consultants or staff. Most workshops and meetings were also prepared and facilitated by the Alliance.
 - There was only a short period of time (less than one month) between the beginning of the programme in each country and the production of the final outputs (policies, implementation plan, resource mobilisation plan)
 - LO Trustees were also involved in the process at an early stage. Most of them became enthusiastic advocates for the TS programme itself and the implementation of the policies.
- All LOs expressed interest in replicating the process, particularly the workshop on stigma and discrimination, with other organisations in their respective countries including their own partner organisations.
 - They felt that it was important for them to start advocating for positive policies and practices on HIV/AIDS in the workplace and medical benefits with other intermediary NGOs, or even with the private sector and organisations providing health insurance.
 - In Burkina Faso, the LO found that their new expertise on how to manage confidentiality and stigma issues could be used to improve their programming strategies on HIV and micro-insurance.

4.2 Some concerns about funding

LOs understood the need for a resource mobilisation plan but there was also an expectation that the Alliance would support financially the implementation of the policies, at least at the beginning, as the development of these policies had been initiated by the Alliance. In Cambodia there were serious concerns about whether any other donor besides the Alliance would fund the policies.

4.3 Long term perspectives: a potential new role for Alliance LOs

Beyond the development of policies and practical short-term strategies to address access to treatment and discrimination issues, the programme has laid ground for long-term innovative thinking and work. This was one of the wishes of Alliance Trustees when they requested the implementation of the programme (see introduction).

5. Useful resources

The following resources address HIV/AIDS in the workplace and HIV/AIDS treatment access in resource-poor contexts as of March 2003. While there has been substantial interest in private sector programs, there is yet little published information about HIV/AIDS workplace policies of development NGOs or their country partners.

Resource	Description
<ul style="list-style-type: none"> • ILO Code of Practice on HIV/AIDS and the world of work (code of practice, 2002) • Education and Training Manual (manual, 2002) 	<p>The Code contains fundamental principles for policy development and practical guidelines from which concrete responses can be developed at enterprise, community and national levels in the following key areas:</p> <ul style="list-style-type: none"> • prevention of HIV/AIDS • management and mitigation of the impact of HIV/AIDS on the world of work • care and support of workers infected and affected by HIV/AIDS • elimination of stigma and discrimination on the basis of real or perceived HIV status. <p>The Education and Training Manual contains many useful resources to assist organisations develop their own policies, including examples of policies, workshop activities, and further resources.</p>
<p>Web: www.ilo.org/public/english/protection/trav/aids/index.htm</p>	
<ul style="list-style-type: none"> • Increasing access to medical treatment for HIV-positive staff of AIDS non-governmental organisations in developing countries (conference paper, 2002) 	<p>Sets out the issues and describes the Alliance response to June 2002. Includes the principles adopted by the Trustees, steps taken by the Alliance in developing the project, and proposals for technical support to Alliance partners. (Paper presented at 14th International AIDS Conference, July 2002).</p>
<p>Web: www.aidslaw.ca/barcelona2002/alliancemedicaltreatmentpaper.pdf</p>	
<ul style="list-style-type: none"> • International Treatment Access Coalition (website) 	<p>Contains useful information and links to a variety of government and NGO materials.</p>
<p>Web: www.itacoalition.org</p>	
<ul style="list-style-type: none"> • Mainstreaming HIV/AIDS matters: an account of Oxfam International's Satellite Session at AIDS 2002 in Barcelona (meeting report, 2002) 	<p>Brief summary of discussion with references to experiences of Oxfam, ActionAID, and Dfid.</p>
<p>Web: www.oxfam.org/eng/campaigns_deve_aids.htm</p>	

5. Useful resources

Resource	Description
<ul style="list-style-type: none"> Scaling up antiretroviral therapy in resource limited settings: guidelines for a public health approach (WHO, 2002) 	Details treatment options and includes recommended first and second line therapies in resource limited settings.
<p>Web: www.who.int/hiv/pub/prev_care/pub18/en/</p>	
<ul style="list-style-type: none"> Untangling the web of price reductions: a pricing guide for the purchase of ARVs in developing countries (MSF, 2002) 	Gives recent price discounts on ARVs by country, including those available to non-government organisations.
<p>Web: www.accessmed-msf.org/index.asp</p>	
<ul style="list-style-type: none"> Workplace HIV/AIDS programs: an action guide for managers (Family Health International, 2002) 	Although aimed at the private sector this comprehensive guide gives much useful information, with case studies from developing countries.
<p>Web: www.fhi.org/en/aids/naids.html</p>	

6. Annex 1 – Technical support steps

Technical support steps and outputs

1. Situation & Response Analysis :

Exploration of access to care for PLHA in the local context and LO response in terms of existing staff medical benefits

including existing workplace policies, medical insurance plans and other arrangements for staff

- ⇒ Summary of current situation and recommendations for alternative options produced in consultation with senior staff

2. Workshop with LO staff on issues related to HIV/AIDS in the workplace

E.g. stigma and discrimination, management of confidentiality, etc.

- ⇒ Workshop report

Useful tools:

ILO Code of Practice on HIV/AIDS in the world of work
Experience from the Alliance and other LOs, e.g. pilot project in Cambodia

3. Preparation of draft policy documents

on HIV/AIDS in the workplace and staff medical benefits.

- ⇒ First draft of policies

Useful tools:

ILO Code of Practice on HIV/AIDS in the world of work
Experience from the Alliance and other LOs, e.g. pilot project in Cambodia

4. Policy development meeting No1 – HIV/AIDS in the workplace

One-day meeting with representatives of the LO staff and Board of Trustees to discuss and amend the draft policy document.

- ⇒ Amendments to draft of HIV/AIDS in the workplace policy

5. Preparation of a second policy document on HIV/AIDS in the workplace

including the amendments proposed by LO staff and Trustees during the meeting

- ⇒ Second draft of HIV/AIDS in the workplace policy

6. Policy development meeting No2 – Medical Benefits

One-day meeting with representatives of the LO staff and Board of Trustees to discuss and amend the draft policy document, and to develop plans for the implementation of the policies and the mobilisation of financial resources to fund them.

- ⇒ Amendments to draft of medical benefits policy

7. Preparation of a second policy document on staff medical benefits

Including the amendments proposed by LO staff and Trustees during the meeting.

- ⇒ Formatting of the implementation plan and resource mobilisation plan.

8. De-briefing on policies with LO staff

9. Submission of final draft policies to LO Board of Trustees and adoption by Board

7. Annex 2 – Technical support programme – example of schedule

Time	Activity	People involved
2 hours	Briefing with the LO <ul style="list-style-type: none"> to discuss and gain input about the process & expected outcomes to address comments, queries etc. 	<ul style="list-style-type: none"> LO ED International Alliance staff
1/2 day	Update of local context of access to treatment <ul style="list-style-type: none"> to discuss research findings of local context of access to treatment 	<ul style="list-style-type: none"> Local Alliance Consultant International Alliance staff
1 day	Prepare for stigma and discrimination in the workplace workshop <ul style="list-style-type: none"> to work with 2 local facilitators (drawn from LO staff) to plan the content and process of the stigma and discrimination in the workplace workshop 	<ul style="list-style-type: none"> 2 facilitators drawn from LO staff International Alliance staff
1 day	Stigma and discrimination in the workplace workshop <ul style="list-style-type: none"> implement workshop outputs would be process documentation & recommendations for what should be included in the workplace & medical benefits policies 	<ul style="list-style-type: none"> All LO staff including auxiliary staff 2 facilitators drawn from LO staff International Alliance staff
1 day	Prepare for medical benefits policy development workshop <ul style="list-style-type: none"> to work with local consultant to plan the content and process of the medical benefits policy development workshop - this would include providing relevant feedback from the stigma and discrimination in the workplace workshop 	<ul style="list-style-type: none"> Local Alliance Consultant International Alliance staff
	Prepare for HIV/AIDS in the workplace policy development workshop <ul style="list-style-type: none"> to prepare 'draft' workplace policy for discussion during the HIV/AIDS in the workplace policy development workshop to plan the content and process of the HIV/AIDS in the workplace policy development workshop 	<ul style="list-style-type: none"> International Alliance staff
3/4 day	HIV/AIDS in the workplace policy development workshop <ul style="list-style-type: none"> implement workshop including senior staff members providing feedback to Board members about the stigma & discrimination in the workplace workshop outputs include process documentation, agreed HIV/AIDS in the workplace policy document and implementation plan 	<ul style="list-style-type: none"> Senior LO staff Board members International Alliance staff

7. Annex 2 – Technical support programme – example of schedule

Time	Activity	People involved
	<p>HIV/AIDS in the workplace policy</p> <ul style="list-style-type: none"> to finalise HIV/AIDS in the workplace policy document - output final HIV/AIDS in the workplace policy document <p>Prepare for medical benefits policy development workshop</p> <ul style="list-style-type: none"> to continue to work with local consultant to plan the content and process of the medical benefits policy development workshop - this would include providing relevant feedback from the stigma and discrimination in the workplace workshop and HIV/AIDS in the workplace workshop, developing options for the medical benefits policy to develop a 'draft' medical benefits policy (outlining different options) for discussion during the workshop 	<ul style="list-style-type: none"> International Alliance staff Local Alliance Consultant
	<p>Prepare for medical benefits policy development workshop</p> <ul style="list-style-type: none"> to continue to work with local consultant to plan the content and process of the medical benefits policy development workshop - this would include providing relevant feedback from the stigma and discrimination in the workplace workshop and HIV/AIDS in the workplace workshop, developing options for the medical benefits policy to develop a 'draft' medical benefits policy (outlining different options) for discussion during the workshop 	<ul style="list-style-type: none"> Local Alliance Consultant International Alliance staff
1 day	<p>Medical benefits policy development workshop</p> <ul style="list-style-type: none"> implement workshop - 1/2 day for policy options and 1/2 day for planning implementation including resource mobilisation outputs include process documentation, agreed medical benefits policy document, resource mobilisation plan and implementation plan that would include monitoring and further TS needs. 	<ul style="list-style-type: none"> Senior LO staff Board members Local Alliance Consultant International Alliance staff
2 days	<p>Medical benefits policy</p> <ul style="list-style-type: none"> to finalise medical benefits policy document, resource mobilisation plan and implementation plan - output final medical policy document and documentation of resource mobilisation plan and implementation plan that would include monitoring and further TS needs 	<ul style="list-style-type: none"> Local Alliance Consultant

8. Annex 3 – Workshop on HIV/AIDS in the workplace – example session plans

Time	Activity description
1 hour	<p>Session 1. Introduction</p> <ul style="list-style-type: none"> • Why are we addressing issues of HIV/AIDS in the workplace? <ol style="list-style-type: none"> 1. Need for improving access to treatment for PLHA 2. Importance of recruiting, retaining and keeping healthy PLHA as staff working for NGOs responding to the epidemic 3. Need to do advocacy and demonstrate leadership in this area 4. What others are doing • What are some of the key issues? <ol style="list-style-type: none"> 1. Stigma, discrimination, confidentiality in workplace 2. Staff information needs 3. Safe working environment - responsibility of organisation and staff 4. Reasonable accommodation - making reasonable (to both the organisation and staff member) arrangements when a staff member is unable to carry out work duties - special needs of staff with chronic illness 5. Medical benefits - what is available and accessible? • Process of developing workplace and medical benefits policies - how the day's work fits in with the process of developing workplace and medical benefits policies • Fears and expectations • Objectives <p>HIV/AIDS – clarifications & queries</p> <ul style="list-style-type: none"> • The aim is to clarify information, questions that staff have about HIV/AIDS. • Use activity with a list of relevant statements about HIV/AIDS ~ agree, disagree, not sure.

8. Annex 3 – Workshop on HIV/AIDS in the workplace – example session plans

Time	Activity description
2.5 hours	<p>Session 2. Stigma & discrimination</p> <ul style="list-style-type: none"> • The aim is to develop understanding of concepts of stigma and discrimination. • Define <i>stigmatisation</i> - a process of devaluation - self & others; stigmatisation of self & others can lead to discrimination • Define <i>discrimination</i> - a distinction (based on the perception of some characteristic) that leads to a person being treated unfairly or unjustly • <i>Stigma, discrimination, the fear of stigma & discrimination</i> are the main reasons why people don't want to share/reveal their HIV/AIDS status. Stigma, discrimination, the fear of stigma & discrimination are barriers to a supportive and enabling workplace environment. • Even though we may not mean to, we can stigmatise or discriminate against someone to different degrees. <p>Activity:</p> <ol style="list-style-type: none"> 1. In small groups sit in circles with pens and pieces of paper, ask each person to think of something personal, that they wouldn't want anyone to know about them. 2. Each person writes/draws this on the piece of paper, folds it up so that no one can see it. 3. Each person passes their piece of paper to the person on their left who must not unfold the paper. 4. Each group discusses the following questions: <ul style="list-style-type: none"> ?? How does it make you feel that someone is holding this information? Why? ?? How would you feel if they opened up your piece of paper & came to know something about you that you don't want them to know? Why? ?? How would you feel if they stigmatised, discriminated against you as a result? ?? How do you feel holding someone else's piece of paper? Why? 5. Ask everyone to give the papers back unseen. 6. Share group discussions. Remind ourselves of how we would feel if personal information were disclosed. Appreciate this feeling to remind ourselves to be cautious with information that others share with us. 7. Plenary - stigma and discrimination - whether perceived or real - is one of the main reasons why confidentiality is important to individuals. Stigma and discrimination is not only one of the main obstacles limiting disclosure from people living with HIV/AIDS in the workplace but also a more general limitation for the development of an open and supportive workplace environment. Although we all aspire not to stigmatise and discriminate - it is possible to do so to different degrees without being aware. It can be useful to reflect on what we would rather that other people did not know about ourselves; to appreciate some of the less obvious things we might fear others would discriminate or stigmatise us about. Reminding ourselves of the feelings we might have if this information was disclosed to others helps us to appreciate the concerns others might have and remind ourselves to be cautious with the information that others share with us.

8. Annex 3 – Workshop on HIV/AIDS in the workplace – example session plans

Time	Activity description																									
1.5 - 2 hours	<p>Session 3. Confidentiality and disclosure</p> <ul style="list-style-type: none"> • The aim is to develop understanding of concepts of confidentiality and disclosure. • Define <i>confidentiality</i> - keeping personal information private • Define <i>disclosure</i> - to reveal/share private information. The onus of disclosure is on the person who owns the information. It is the individual's own choice. • In some situations in the workplace, disclosure by another may be necessary. The principle is that it should be limited to a 'need to know' basis and wherever possible, it should be the person whose information it is who controls the disclosure. • There are <i>different levels of disclosure</i> - none, partial, full • There are <i>different reasons for disclosure</i> - to claim medical expenses, to get support from a colleague • There are different end points for disclosure - what you let others do with your personal information - happy to have them tell some people but not others • Within partial disclosure there are different kinds (spheres) of disclosure: <ul style="list-style-type: none"> a) Disclosure for different reasons - for example, finance dept. to access to medical benefits, line manager for support and understanding at work, friends for support, as a public testimony at a conference but not tell your children etc. b) Disclosure with different end point - what you allow others to do with the information (happy for them to tell certain other people etc, need to know transfer of info. only, non transfer etc). <p>Activity:</p> <ol style="list-style-type: none"> 1. Work in the same groups as the previous activity. 2. Each group develops a flipchart answering the following question: ?? Imagine that the information in your neighbour's hand is your HIV positive test result. Within the LO office(s) - what do you think would be the general advantages and disadvantages for both you, and the LO for: <ul style="list-style-type: none"> • Not letting anyone look at that piece of paper? (no disclosure) • Letting some people see the piece of paper? (partial disclosure) • Letting everyone see the piece of paper? (full disclosure) <table border="1" data-bbox="316 1547 1497 1742"> <thead> <tr> <th></th> <th colspan="2">For Individuals</th> <th colspan="2">For KHANA</th> </tr> <tr> <th></th> <th>Adv.</th> <th>Disadv.</th> <th>Adv.</th> <th>Disadv.</th> </tr> </thead> <tbody> <tr> <td>None</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Partial</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Full</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <ol style="list-style-type: none"> 3. In plenary, share group work, draw attention to the disadvantages and how they might be overcome. Use the following questions to guide plenary discussion: Q: What does disclosure means to you? ?? What different levels of disclosure might there be? ?? Can we understand partial disclosure in different ways? ?? What does confidentiality mean to you? 		For Individuals		For KHANA			Adv.	Disadv.	Adv.	Disadv.	None					Partial					Full				
	For Individuals		For KHANA																							
	Adv.	Disadv.	Adv.	Disadv.																						
None																										
Partial																										
Full																										

8. Annex 3 – Workshop on HIV/AIDS in the workplace – example session plans

Time	Activity description
2 hours	<p>Session 4. Understanding what information is confidential</p> <ul style="list-style-type: none"> • The aim is to develop an understanding of what information (in the workplace setting) should be confidential. • Confidentiality as concept may be clear - but it is not always easy to understand what kind of information is confidential unless someone explicitly tells us. To some extent this relies on us using our common sense, respecting the privacy of others, treating others as we would want to be treated and when disclosing - doing so with the consent/participation of the person concerned and only on a 'need to know' basis. <p>Activity:</p> <ol style="list-style-type: none"> 1. Working in four groups ask each group to think of two or more situations which they as a group agree constitutes a breach of confidentiality. 2. Identify three areas of the room which can be labelled disagree, not sure, and agree. 3. Ask the groups to describe the situations that they identified with the whole group. Groups may also like to act out the situation. 4. Ask everyone to walk to the relevant area of the room to show whether they disagree, agree or are not sure whether the situation constitutes a breach in confidentiality. 5. Ask individuals standing in the different areas to explain why they made the choice that they had. 6. Ask others to share their situations. 7. This activity may result in a lack of clarity about what information should be confidential. It is impossible to predict all situations and attempt to outline what would or would not constitute a breach in confidentiality. We should all use our common sense and be cautious about sharing information that we have been told or discovered about others.

8. Annex 3 – Workshop on HIV/AIDS in the workplace – example session plans

Time	Activity description
2.5 hours	<p>Session 5. HIV/AIDS in the workplace – issues and concerns</p> <ul style="list-style-type: none"> • The aim is to discuss key issues and concerns around HIV/AIDS in the workplace. These issues and concerns will then be fed into the HIV/AIDS in the workplace & medical benefits policy development process. • HIV/AIDS gives rise to a number of issues in the workplace such as: <ol style="list-style-type: none"> 1. Information needs - information about HIV/AIDS evolves & changes - how do we keep all staff up to date 2. Safe working environment - what to do about accidents; availability of PEP; responsibility of employer & staff 3. Gender - burden on female staff members 4. Reasonable accommodation - finding reasonable (reasonable to both the employer and the staff) options to support the special needs of staff with chronic illness 5. Stigma, discrimination, confidentiality and disclosure - see three previous activities 6. Putting policies into practice - what will it mean?? <p>Activity:</p> <ol style="list-style-type: none"> 1. Present & discuss the issues listed above - provide relevant examples of each. 2. Ask group if there are any other issues besides the ones that have been identified above. 3. Work in three groups, ask each group to select two of the issues and to identify their concerns about the issues they have selected. They can also do this using drawings or a Venn diagram. 4. Ask each group to share their discussions with the larger group. 5. In the larger group, ask how concerns could be addressed. 6. Sum up discussions, listing issues & concerns that will guide the development of the HIV/AIDS in the workplace & medical benefits policies. 7. Ask staff to identify next steps - such as regular opportunities to address issues around stigma and discrimination in the workplace.
	<p>Session 6. Wrap up</p> <ul style="list-style-type: none"> • Evaluation of the day's work • Wrap up the day with a discussion about the day's work fits into the development of the HIV/AIDS in the workplace & medical benefits policies. • Agree next steps/follow up with staff

Draft terms of reference for situation & response analysis

The consultant will undertake research and provide a written report on access to treatment in the local context. The report will include the following sections:

1. Access to voluntary counselling and testing
2. Access to post exposure prophylaxis (PEP)
3. Access to medical treatment for sexually transmitted infections (STIs)
4. Management of HIV infection – clinical aspects
5. Management of HIV infection – psychosocial aspects
6. Health insurance
7. Organisational needs and recommendations

Questions to be addressed in the report include:

1. Access to voluntary counselling and testing (VCT)

- Is confidential VCT for HIV and other STIs available to staff and dependants?
- What kind of pre-and-post test counselling is available?
- Is the service provided gender sensitive and youth friendly (for child dependants)?
- What kind of testing is used (initial and confirmatory)? What safeguards are in place to assure the quality of testing?
- Is anonymous testing available? What other measures are taken to protect confidentiality?
- Is HIV infection a reportable medical condition? Is nominal data reported?
- Is VCT provided free of charge, are costs subsidised, or does the patient or his/her insurer or employer contribute all or part of the VCT costs? Indicate likely costs where payment is required.
- If payment is required, is it payable in advance or can the patient (or his/her insurer/employer) be billed for payment at a later date?
- Identify any significant barriers to staff and dependent access to VCT.
- Make recommendations for necessary improvements in VCT services for staff and dependants.

2. Access to post-exposure prophylaxis (PEP)

- Is PEP available and under what circumstances?
- Is post-exposure contraception also provided (e.g. in cases of sexual assault)?
- What counselling is provided to accompany PEP?
- Is the service provided gender sensitive and youth friendly (for child dependants)?
- If payment is required, is it payable in advance or can the patient (insurer/employer) be billed for payment at a later date?
- Identify any significant barriers to staff and dependant access to PEP.
- Make recommendations for necessary improvements in PEP for staff and dependants.

3. Access to medical treatment for STIs (non-HIV)

- What kind of STI (non-HIV) treatment services are locally available? (refer to standard guidelines for treatment in resource-poor settings e.g. WHO guidelines – see below)
- Is STI treatment provided in a confidential, gender sensitive and youth friendly manner?
- Is significant travel to a regional centre required for treatment of any conditions? If so, indicate likely time and cost of travel involved, as well as number of visits to complete treatment.
- Is STI treatment provided free of charge, are costs subsidised, or does the patient or his/her insurer or employer contribute all or part of the treatment costs? Indicate likely costs where payment is required.
- If payment is required, is it payable in advance or can the patient (insurer/employer) be billed for payment at a later date?
- Identify any significant barriers to staff and dependent access to STI treatment.
- Make recommendations for necessary improvements in STI treatment services for staff and dependants.

4. Management of HIV infection – clinical aspects

- What HIV monitoring and treatment services are locally available?
Assess the quality of services, including:
 - the local expertise in HIV medicine,
 - availability of reliable laboratory monitoring services (including routine haematological and

biochemical tests for the detection of drug toxicity as well as facilities for monitoring the immunologic and virologic parameters of HIV infection),

- availability and quality of drugs for the treatment of opportunistic infections, and
- anti retroviral therapy (refer to standard guidelines for treatment in resource-poor settings e.g. WHO/UNAIDS/IAS guidelines - see below)
- What local and national initiatives are in place or planned to assure access to HIV medications, including anti retroviral medications? (e.g. the UNAIDS accelerated access initiative in some countries)
- Is HIV monitoring and treatment provided in a confidential, gender sensitive and youth friendly manner?
- Is significant travel to a regional centre required for monitoring or treatment of HIV infection? If so, indicate likely time and cost of travel involved, as well as the frequency of visits?
- Is HIV monitoring or treatment provided free of charge, are costs subsidised, or does the patient or his/her insurer or employer contribute all or part of the treatment costs? Indicate likely costs where payment is required. Include reference to anti retroviral treatment where available.
- If payment is required, is it payable in advance or can the patient (insurer/employer) be billed for payment at a later date?
- Identify any significant barriers to staff and dependent access to HIV monitoring and treatment.
- Make recommendations for necessary improvements in HIV monitoring and treatment services for staff and dependants.

5. Management of HIV infection – psychosocial aspects

- What kind of psychosocial support services are locally available? Include counselling, nutrition advice, legal advice and other services.
- Are psychosocial services provided in a confidential, gender sensitive and youth friendly manner?

- Is significant travel to a regional centre likely to be required for psychosocial services? If so, indicate likely time and cost of travel involved, as well as the likely frequency of visits required.
- Are psychosocial services provided free of charge, are costs subsidised, or does the patient or his/her insurer or employer contribute all or part of the treatment costs? Indicate likely costs where payment is required.
- If payment is required, is it payable in advance or can the patient (insurer/employer) be billed for payment at a later date?
- Identify any significant barriers to staff and dependant access to psychosocial services.
- Make recommendations for necessary improvements in psychosocial services for staff and dependants.

6. Funding options

- What health insurance schemes are available to cover all or part of medical costs (diagnosis, treatment, medications, counselling, related costs) for STIs, HIV infection, and other health conditions?
- What conditions are covered or excluded by these schemes, and under what circumstances? Will they accommodate employer coverage of otherwise excluded conditions (e.g. if HIV infection is excluded, can the employer simply pay this component and ensure a continuity of service from the health care provider for all the patient's medical needs)?
- What conditions apply to benefits payable (qualifying periods, pre-existing conditions, benefit capping, front-end deductibles, other conditions)?
- Are the benefits provided in a confidential, gender sensitive and youth friendly manner?
- Are services payable (in part or in full) in advance, or can the patient refer the invoice directly to the insurer?
- What other funding options are possible (e.g. the creation of a staff health fund to cover costs of treatment not addressed by health insurance).
- What has been the experience of other organisations providing such health care, including the creation of a staff health fund and/or obtaining health insurance for staff and

9. Annex 4 – Examples of TOR for situation & response analysis, and of draft policies

dependants? Identify other organisations (including contact person) which might be interested in future collaboration on the issue.

References

Safe and Effective Use of Anti-Retroviral Treatments in Adults with Particular Reference to Resource Limited Settings, UNAIDS, WHO, IAS, revised edition January 2001.

www.who.int/HIV_AIDS/WHO_HSI_2000.04_1.04/

Guidelines for the Management of Sexually Transmitted Infections, WHO, 2001.

www.who.int/HIV_AIDS/STIcasemanagement/STIManagementguidelines/who_hiv_aids_2001.01/index.htm

Example of an LO HIV/AIDS workplace policy

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Annex 1: Commitment to confidentiality

Annex 2: HIV/AIDS Workplace Team

Statement of duty

As an organisation working in the field of HIV/AIDS prevention and control, we often tend to be outward oriented. Duty bound to provide our services to others. To date, we have focused on the expertise and actions required by partners, those affected and infected.

However, we are reminded every day that HIV/AIDS is non-discriminating. We are not only service providers, but also directly and individually affected.

We are duty bound to practise compassion and tolerance towards all people with HIV/AIDS, including our colleagues. These workplace and medical policies aspire to provide a framework for recognising the existence of HIV/AIDS in our midst as well as for providing mechanisms for providing prevention, care and support to ourselves and our colleagues.

In subscribing to these policies, we are also committing ourselves to living a healthy lifestyle, which includes good health practices and good health-seeking behaviour. The HIV/AIDS in the workplace and medical benefits policies are developed on the premise that we do not knowingly put ourselves at risk, and that we seek appropriate care and support of acceptable quality.

Commitments

- The organisation shall be fully committed to providing a supportive working environment for dealing with HIV/AIDS in the workplace.
- The organisation shall not discriminate against staff on the basis of their HIV/AIDS status with specific regard to training, promotions and staff retention.
- The organisation shall have a zero tolerance approach towards verbal, physical, emotional or psychological abuse and discrimination of HIV positive persons by or from co-staff and management.
- The organisation shall ensure and foster a high sense of team spirit and support for HIV/AIDS infected and affected persons.
- The organisation views confidentiality as imperative when dealing with HIV/AIDS and shall therefore ensure that confidentiality about HIV/AIDS status is not infringed upon. Mechanisms shall therefore be put in place to ensure that:
 - All medical and other HIV/AIDS-related information is kept confidential.
 - Shared confidentiality is respected.
 - Any other relevant personal information is not revealed without the consent of the HIV infected or affected person.
 - The organisation shall not endorse / require mandatory HIV testing for whatever purposes from staff or would-be staff.
 - The organisation shall undertake to treat HIV infection and AIDS as any other chronic illness.
 - The organisation is fully committed to offering a broad range of prevention, care and support measures and interventions to all its staff.

9. Annex 4 – Examples of TOR for situation & response analysis, and of draft policies

- The organisation is committed and obliged to reasonably accommodate HIV-positive staff to enable them to continue working.
- The organisation shall demand and expect reasonable levels of responsibility and commitment from all staff towards living a safe & healthy lifestyle.
- The organisation shall provide support in the event of demise of a staff member and immediate family members.
- The organisation, through the HIV/AIDS Workplace Team, will ensure effective implementation of all activities and interventions hereto.

1. Objectives

The organisation HIV/AIDS workplace policy has the following objectives:

- to prevent HIV infection in the organisation's staff and their dependants.
- to assure a supportive work environment for staff infected and affected by HIV/AIDS.
- to manage and mitigate the impact of HIV/AIDS on the work of the organisation.
- to eliminate stigma and discrimination in the workplace on the basis of real or perceived HIV status, or vulnerability to HIV infection.

Should any of the policies outlined in this document be in conflict with national law, then in every instance national law will take precedence.

2. Definitions

'Staff' includes full-time and part-time staff with contracts of employment with the organisation.

'Dependant' includes both adult & child dependants meaning:

- 'Adult' is a person aged 18 years or older.
- 'Adult dependant' includes a person who is either a staff member's spouse, staff member's parent or spouse's parent who lives with the staff member and is dependent

'Child dependant' includes both

- staff member's child under the age of 16
- staff member's child under the age of 20 if still in school

'HIV-related information' includes information that someone:

- may have HIV
- has chosen to have an HIV test or has been counselled about having a test for HIV
- is receiving or has received treatment or counselling which suggests he or she may have HIV
- may have had experiences which put him or her at risk of contracting HIV or
- has a close association or relationship with someone with HIV/AIDS or with someone from a stigmatised group.

'HIV screening' means any measurement of potential or actual HIV infection, whether direct (HIV testing), indirect (assessment of risk-taking behaviour) or asking questions about tests already taken or about medication.

'Reasonable accommodation' means any modification or adjustment to a job or to the workplace that is reasonably practicable to both the employer and the staff and will enable a person living with HIV or AIDS to have access to or participate or advance in employment.

3. Responsibility for implementation

3.1. The Executive Director, through the HIV/AIDS Workplace Team (see Annex 2), has responsibility for the implementation of this policy.

4. HIV screening, recruitment and employment

- 4.1. The only medical criterion for recruitment is fitness to work. HIV infection does not, in itself, constitute a lack of fitness to work.
- 4.2. There is no obligation on applicants or staff to inform the organisation of their HIV status.
- 4.3. HIV screening will not be required either as a condition of recruitment or for continuation of employment, unless required by law (e.g. for duty travel).

5. Confidentiality

5.1. The organisation encourages a supportive work environment in which staff can discuss HIV/AIDS openly, including their own experience of living with HIV/AIDS. Where staff disclose that they or

their dependents are living with HIV/AIDS, the confidence will be respected with regard to the circumstances in which the information was shared. If there is any doubt, the person living with HIV/AIDS should be consulted before further disclosure takes place.

- 5.2. HIV-related information relating to applicants for employment, staff or dependants will be kept strictly confidential, and be kept only on medical files.
- 5.3. Staff and volunteers working for the organisation shall sign a commitment to confidentiality (see Annex 1), and shall be informed that the unauthorised disclosure of HIV-related information is a disciplinary offence, that may result in a grievance procedure as per the organisation's personnel policies. Depending on the situation, it may also lead to legal proceedings against the person who disclosed the information, and the organisation.
- 5.4. With the voluntary and informed consent of the person concerned, HIV-related information may be disclosed strictly as necessary for the purposes of recruitment or assignment of staff living with HIV where the job description or task identifies this qualification.

6. Duty travel and vaccination

- 6.1. For duty travel to a country which requires HIV screening for entry or residence, this requirement will be made known to staff in advance of duty travel. In such cases, the staff member with HIV may choose not to travel to the country concerned.
- 6.2. Where HIV screening is chosen, the organisation will make available pre- and post-test counselling, if it is not otherwise available free of charge.
- 6.3. If a staff member is unable to take up an assignment in a particular country because of that country's HIV-related requirements, depending on the situation, the organisation will take reasonable steps to find an alternative assignment.
- 6.4. Proof of vaccination (e.g. yellow fever) may be required for travel to some countries. In such

cases the organisation will advise staff and ensure that they have the opportunity to seek confidential medical advice on the advisability of vaccination according to their health status and to seek an exemption from vaccination.

7. HIV prevention

- 7.1. The organisation will provide staff with sensitive, accurate and up-to-date information to enable them to protect themselves from HIV and other sexually transmitted or blood-borne infections.
- 7.2. The organisation will provide information to staff as to where safe blood can be obtained.
- 7.3. The organisation will also provide information on where sterile needles and syringes can be obtained.
- 7.4. The organisation will ensure all the organisation vehicles are fully fitted with seat belts. Where available, seat belts must be worn by all staff when travelling on duty. The organisation will also ensure that all the organisation vehicles are regularly and properly serviced and maintained.
- 7.5. Helmets must be worn by the organisation staff when travelling on duty by motorcycle. Helmets shall be made available for staff travelling on duty by motorcycle.
- 7.6. Access to good quality condoms (male and female) shall be made available to staff. Access will be free, simple and discreet.
- 7.7. Access to free, voluntary and confidential HIV testing and counselling shall be made available to staff and costs reimbursed as per the medical benefits policy.
- 7.8. Access to free, STI diagnosis and treatment shall be made available to staff and costs reimbursed as per the medical benefits policy.

8. Occupational or other exposure

- 8.1. In the case of accidents involving the risk of exposure to human blood, universal precautions shall be used to ensure there is no risk of transmission of HIV or other blood-borne infections.

- 8.2. The organisation shall develop procedures for the immediate referral for counselling, assessment and medical treatment (with post-exposure prophylaxis, where appropriate) of staff exposed to the risk of HIV infection (e.g. through accident or sexual assault), whether in the workplace or elsewhere.
- 8.3. Reasonable paid time off will be provided for counselling following occupational or other exposure.
- 8.4. The organisation shall provide insurance cover for work-related accidents and injuries for all staff.

9. Information and training

- 9.1. The organisation will provide information and training on the workplace issues raised by the epidemic, on appropriate responses, and on the general needs of people living with HIV/AIDS and their carers.
- 9.2. Such information and training will be gender sensitive, as well as sensitive to disability, and sexual orientation.
- 9.3. Information will include the availability of local support organisations for people living with HIV/AIDS, and other affected communities.
- 9.4. Staff training on HIV/AIDS will take place during paid working hours and attendance by all staff including senior staff shall be considered as part of work obligations.

10. Stigma and discrimination

- 10.1. The organisation will not discriminate on the basis of actual or perceived HIV status, or membership of a group at increased risk of HIV infection, in the conditions of work, including opportunities for advancement.
- 10.2. Staff living with HIV/AIDS, shall be treated no less favourably than staff with other serious illnesses.
- 10.3. The organisation will undertake activities to address HIV and related stigma in the workplace, including through staff training and the promotion of an open, accepting and supportive work environment for staff who choose to disclose their HIV status.

11. Reasonable accommodation

- 11.1. The organisation may reasonably accommodate the special needs of staff living with, or directly affected by, HIV/AIDS on a case-by-case basis, subject to the overall requirements of the organisation.
- 11.2. Depending on the situation, reasonable accommodation may include flexible working hours and time off for counselling and medical appointments, extended sick leave, transfer to lighter duties, part-time work, and return-to-work arrangements.

12. Termination of employment

- 12.1. HIV infection is not a cause for termination of employment. Staff with HIV-related illness will continue in employment as long as they are otherwise fit for available, appropriate work.
- 12.2. In the case of termination of employment due to extended illness, staff with HIV/AIDS will be accorded the same benefits and conditions as apply to termination due to other serious illnesses.

13. Gender dimensions

- 13.1. The organisation acknowledges that HIV/AIDS impacts on male and female staff differently. This includes the recognition that women normally undertake the major part of caring for those with AIDS-related illnesses, and that pregnant woman with HIV have additional special needs.
- 13.2. Any staff and family assistance arrangements will be designed to accommodate these differing impacts, and as appropriate to redress gender inequalities, for example by encouraging and supporting men as carers.

14. Counselling, grievance and disciplinary procedures

- 14.1. The organisation will identify a qualified counsellor from whom staff can seek confidential advice, counselling and referral on HIV-related matters. Information will also be provided on where such advice, counselling and referral can be found.

9. Annex 4 – Examples of TOR for situation & response analysis, and of draft policies

14.2. Staff can use grievance procedures from the organisation's personnel policies for work-related grievances, including failure by the organisation to implement any aspect of this policy.

14.3. Disciplinary proceedings, as per the organisation's personnel policy, may be commenced against any staff member who violates this policy.

15. Revision

15.1. The Executive Director, with the support of the HIV/AIDS Workplace Team, shall review this policy periodically, and revise it as necessary in consultation with the Board.

16. Commencement

This policy applies from the date that the Board formally adopts the policy.

Annex 1: Commitment to confidentiality

1. I have read and understand the organisation's HIV/AIDS workplace policy and medical benefits policy.
2. I recognise that through my employment or association with the organisation I may learn information of a highly personal and confidential nature.
3. I understand that such information includes information that someone
 - may have HIV;
 - has been asked to have an HIV test or been counselled about having a test for HIV;
 - is receiving or has received treatment or counselling which suggests he or she may have HIV;
 - may have had experiences which put him or her at risk of contracting HIV; or
 - has a close association or relationship with someone with HIV/AIDS.
4. I will only disclose such information when authorised by my supervisor, or with the consent of the subject of the information.
5. I understand that breach of this agreement may result in disciplinary action, and depending on the law, possible legal proceedings against myself or the organisation.

Signed: _____

Executive Director: _____

Date: _____

Annex 2: HIV/AIDS workplace team

The HIV/AIDS Workplace Team (herein referred to as the 'Team') shall be responsible for the following:

- Development of the workplace & medical benefits policies and its subsequent review on a regular basis.
- Provide information and other requisites for the smooth implementation of the policies.
- Planning, implementation and overall monitoring of policies & their implementation.
- Advocacy and information.
- Serve as mechanism for handling relevant grievances.

The Team shall comprise the following:

- Executive Director
- A representative of programme staff
- A representative of finance and admin staff
- A representative of auxiliary staff

The workplace programme, implemented by the Team, shall provide:

1) Awareness/information

- Staff educational sessions
- Positive Living
- Confidentiality
- Addresses/contacts and other related information
- Rights of a client

2) Counselling

- Approved list of counsellors
- Referrals

3) Health care

- Approved list of providers & suppliers⁵
- Referrals

⁵ Where not available start with the UN approved provider list in each country

9. Annex 4 – Examples of TOR for situation & response analysis, and of draft policies

- First aid kit for office and staff who are travelling including training on first aid & universal precautions

4) Provision of condoms

- Access to male and female condoms will be readily available at all times
- Focal point person for condom supplies
- Instruction and demonstration

5) Accommodations

- Working hours (Flexi-time)
- Job descriptions as appropriate
- Compassionate leave
- Extended sick leave
- Part-time work; lighter duties
- Return to work arrangements

6) Compensation

- Workmen's compensation for work related accidents & injuries

7) Death benefits

- Paid compassionate leave in the event of the death of spouse or immediate family member
- Payment of funeral expenses

8) Process/mechanism for handling HIV/AIDS related grievances

Example of an LO medical benefits policy

Contents

1. Background and objectives
2. Commencement
3. Definitions
4. Register of dependants
5. Medical information
6. Responsibility for implementation
7. Medical benefits
8. Revision

Annex 1: Medical, optical and dental expenses for staff and/or dependants.

Annex 2: List of Approved Medical Providers, Laboratories and Suppliers

1. Background and objectives

- 1.1 The organisation provides staff with a range of benefits in addition to salary as part of its remuneration package. The remuneration package as a whole is intended to attract and retain skilled, motivated and experienced staff to support the organisation in the pursuit of its mission. This medical benefits policy;
 - contributes to the overall objective of attracting and retaining healthy staff, and additionally has a key role to play in attracting, retaining and facilitating the contribution of staff with chronic illness including staff living with HIV/AIDS;
 - contributes to the organisation's HIV in the workplace policy in creating a supportive and non-discriminatory workplace environment
 - contributes to an outcome whereby staff with HIV or chronic illnesses can access health care on an equal basis compared to staff with other health care needs.
- 1.2 The organisation seeks to ensure that staff receive appropriate medical care in the case of illness or accident. The organisation provides insurance coverage for medical care for work-related injury or accident for staff members only. In addition, the organisation provides

medical benefits for staff and/or dependants up to a maximum of \$400 per staff member per year, as outlined in section 7 of this policy document.

- 1.3 Should any of the policies outlined in this document be in conflict with national law, then in every instance national law will take precedence.

2. Commencement

This policy applies from the date that the Board formally adopts the policy.

3 Definitions

'Staff' includes full-time staff and part-time staff with contracts of employment with the organisation.

'Adult' is a person aged 18 years or older.

'Adult dependant' includes a person who is either

- the staff member's spouse, unless employed by another organisation and receiving comparable medical benefits
 - the staff member's parent or spouse's parent who lives with the staff member and is dependent
- 'Child dependant' includes both
- staff member's child under the age of 16
 - staff member's child under the age of 20 if still in school

'HIV-related information' has the same meaning as described in the HIV in the workplace policy, namely that someone:

- may have HIV
- may be considering having an HIV test, or been counselled about having a test for HIV
- is receiving, or has received treatment or counselling which suggests s/he may have HIV
- may have had experiences that put him/her at risk of contracting HIV, or
- has a close association or relationship with someone with HIV/AIDS

4. Register of dependants

- 4.1 A confidential register of staff dependants eligible for medical benefits is to be kept at the organisation, based on the Family Book or other documentation deemed acceptable to the organisation. Staff are individually responsible

for ensuring that the register of their dependants is up-to-date.

- 4.2 Only those dependants listed in the register of dependants are entitled to medical benefits under this policy.
- 4.3 In exceptional cases, the Executive Director may approve the inclusion of an additional adult or child dependants in the register of dependants beyond those defined by this policy.

5. Medical information

- 5.1 The organisation shall keep confidential all medical information, including HIV-related information, acquired about a staff member or a dependant.
- 5.2 The organisation shall remove from its records such information when it is no longer required.

6. Responsibility for implementation

- 6.1 The Executive Director, through the work place team, has responsibility for the implementation of this policy.

7. Medical benefits

7.1 General principles

7.1.1. Medical benefits, including medical treatment for chronic illnesses (including HIV infection and AIDS) are offered in order to recruit qualified staff (including people with HIV), retain them and keep them healthy.

7.1.2. Chronic illnesses (including HIV infection & AIDS) are specifically excluded from most medical insurance policies. The organisation recognises that chronic illnesses (including HIV infection & AIDS) have a negative impact on maintaining healthy staff, and seeks to address the special needs that arise from chronic illnesses (including HIV infection & AIDS).

7.1.3. The organisation will address HIV infection and AIDS in the context of chronic medical conditions generally.

7.1.4. On confirmation of employment (following satisfactory completion of a

probationary period), medical expenses may be claimed retrospectively and pro-rata from the date of employment.

7.1.5. On termination of employment for whatever reason, the organisation is under no obligation to continue medical benefits. This shall be made clear to staff on recruitment.

7.1.6. A qualifying period of three months' employment (viz. the probationary period) applies for access to the medical benefits set out in this policy.

7.2. Medical, optical and dental expenses after three months of employment

7.2.1. Within the guidelines set out in this policy, the organisation will pay for 90% of medical, optical and dental treatment for each staff member and their dependants, up to \$400 per staff member per year. This threshold is effective from the date of approval by the Board of this policy, and may be subject to change.

7.2.2. The entitlement for each year begins on the first of January. Any employee joining the organisation during the course of the year will be entitled to medical benefits for that year on a pro rata basis.

7.2.3. Benefits will only be paid for medical, optical or dental consultations, tests and supplies from approved clinics and laboratories, and for supplies of ARVs from approved suppliers. A list of Approved Providers and Suppliers are given in Annex 2.

7.2.4. Only reasonable and necessary medical, optical and dental treatments, tests and supplies will be covered by this policy, which does not include elective treatment.

7.2.5. There will be no payment made to the employee for unused medical allowance at the end of the year. However, any unspent allowance

9. Annex 4 – Examples of TOR for situation & response analysis, and of draft policies

will be credited to an accumulating fund for the organisation to be held in a dedicated account in Cambodia. This fund may be used, at the discretion of the Executive Director, when any staff member, or one of their eligible dependants, needs treatment which exceeds the annual medical benefit allowance.

7.2.6. Additional medical expenses related to a staff member's serious, chronic illness or accident (above and beyond \$400 per year) may be approved at the discretion of the Executive Director, up to \$200 per year. Coverage of extraordinary expenses over \$200 per year is subject to approval by the Board.

7.2.7. In the case of a chronic illness (including HIV infection & AIDS), where the costs of treatment exceed the limits provided elsewhere in this policy, the organisation undertakes to obtain additional funding to pay these additional costs.

7.2.8. A staff member (or spouse) who is entitled to paid maternity leave will also be granted a one-off payment of \$200 toward the cost of medical care related to childbirth.

7.2.9. Staff wishing to claim such expenses shall follow the procedures set out in Annex 1.

8. Revision

8.1 This policy will be revised and updated regularly to ensure the objectives of the policy are attained - especially given the rapidly evolving context of ARVs in Cambodia.

Annex 1 – Claiming medical, optical and dental expenses after three months of employment

Claims

The procedure for medical claims is as follows:

- Complete an Admission Letter (provided by the organisation) prior to attendance at an Approved Provider, Laboratory and/or Supplier

- Following treatment, submit to the Finance Department a copy of the Admission Letter, together with the doctor's prescription, receipts & other appropriate documentation from the Approved Provider, Laboratory and/or Supplier
- Once attendance at the Approved Provider, Laboratory or Supplier has been confirmed, 90% of the costs of medical, optical or dental care will be reimbursed, up to the agreed maximum amount as specified in this policy.
- In the case of emergency, staff may obtain the Admission Letter following treatment, but within 72 hours of treatment.

Annex 2 – List of approved medical providers, laboratories and suppliers (to be attached)

The list of approved providers, laboratories and suppliers will be reviewed and updated regularly to ensure the objectives of policy are being met – especially given the rapidly evolving context of ARVs in Cambodia.

Example of draft TOR for situation & response analysis

The consultant will undertake research and provide a written report on access to treatment in the local context. The report will include the following sections:

1. Access to voluntary counselling and testing
2. Access to post-exposure prophylaxis (PEP)
3. Access to medical treatment for sexually transmitted infections (STIs)
4. Management of HIV infection - clinical aspects
5. Management of HIV infection - psychosocial aspects
6. Funding options

Questions to be addressed in the report include:

1. Access to voluntary counselling and testing (VCT)

- Is confidential VCT for HIV and other STIs available to staff and dependants?
- What kind of pre- and post-test counselling is available?
- Is the service provided gender sensitive and youth friendly (for child dependants)?
- What kind of testing is used (initial and confirmatory)? What safeguards are in place to assure the quality of testing?
- Is anonymous testing available? What other measures are taken to protect confidentiality?
- Is HIV infection a reportable medical condition? Is nominal data reported?
- Is VCT provided free of charge, are costs subsidised, or does the patient or his/her insurer or employer contribute all or part of the VCT costs? Indicate likely costs where payment is required.
- If payment is required, is it payable in advance or can the patient (or his/her insurer/employer) be billed for payment at a later date?
- Identify any significant barriers to staff and dependant access to VCT.
- Make recommendations for necessary improvements in VCT services for staff and dependants.

2. Access to post-exposure prophylaxis (PEP)

- Is PEP available and under what circumstances?
- Is post-exposure contraception also provided (e.g. in cases of sexual assault)?
- What counselling is provided to accompany PEP?
- Is the service provided gender sensitive and youth friendly (for child dependants)?
- If payment is required, is it payable in advance or can the patient (insurer/employer) be billed for payment at a later date?
- Identify any significant barriers to staff and dependant access to PEP.
- Make recommendations for necessary improvements in PEP for staff and dependants.

3. Access to medical treatment for STIs (non-HIV)

- What kind of STI (non-HIV) treatment services are locally available? (refer to standard guidelines for treatment in resource-poor settings e.g. WHO guidelines – see below)
- Is STI treatment provided in a confidential, gender sensitive and youth friendly manner?
- Is significant travel to a regional centre required for treatment of any conditions? If so, indicate likely time and cost of travel involved, as well as number of visits to complete treatment.
- Is STI treatment provided free of charge, are costs subsidised, or does the patient or his/her insurer or employer contribute all or part of the treatment costs? Indicate likely costs where payment is required.
- If payment is required, is it payable in advance or can the patient (insurer/employer) be billed for payment at a later date?
- Identify any significant barriers to staff and dependant access to STI treatment
- Make recommendations for necessary improvements in STI treatment services for staff and dependants.

4. Management of HIV infection – clinical aspects

- What HIV monitoring and treatment services are locally available?
Assess the quality of services, including:
 - the local expertise in HIV medicine,

9. Annex 4 – Examples of TOR for situation & response analysis, and of draft policies

- availability of reliable laboratory monitoring services (including routine haematological and biochemical tests for the detection of drug toxicity as well as facilities for monitoring the immunologic and virologic parameters of HIV infection),
- availability and quality of drugs for the treatment of opportunistic infections, and
- antiretroviral therapy (refer to standard guidelines for treatment in resource-poor settings e.g. WHO/UNAIDS/IAS guidelines – see below)
- What local and national initiatives are in place or planned to assure access to HIV medications, including antiretroviral medications (e.g. the UNAIDS accelerated access initiative in some countries)?
- Is HIV monitoring and treatment provided in a confidential, gender sensitive and youth friendly manner?
- Is significant travel to a regional centre required for monitoring or treatment of HIV infection? If so, indicate likely time and cost of travel involved, as well as the frequency of visits.
- Is HIV monitoring or treatment provided free of charge, are costs subsidised, or does the patient or his/her insurer or employer contribute all or part of the treatment costs? Indicate likely costs where payment is required. Include reference to antiretroviral treatment where available.
- If payment is required, is it payable in advance or can the patient (insurer/employer) be billed for payment at a later date?
- Identify any significant barriers to staff and dependant access to HIV monitoring and treatment.
- Make recommendations for necessary improvements in HIV monitoring and treatment services for staff and dependants.
- Are psychosocial services provided in a confidential, gender sensitive and youth friendly manner?
- Is significant travel to a regional centre likely to be required for psychosocial services? If so, indicate likely time and cost of travel involved, as well as the likely frequency of visits required.
- Are psychosocial services provided free of charge, are costs subsidised, or does the patient or his/her insurer or employer contribute all or part of the treatment costs? Indicate likely costs where payment is required.
- If payment is required, is it payable in advance or can the patient (insurer/employer) be billed for payment at a later date?
- Identify any significant barriers to staff and dependent access to psychosocial services.
- Make recommendations for necessary improvements in psychosocial services for staff and dependants.

5. Management of HIV infection – psychosocial aspects

- What kind of psychosocial support services are locally available? Include counselling, nutrition advice, legal advice and other services.

6. Funding options

- What health insurance schemes are available to cover all or part of medical costs (diagnosis, treatment, medications, counselling, related costs) for STIs, HIV infection, and other health conditions?
- What conditions are covered or excluded by these schemes, and under what circumstances? Will they accommodate employer coverage of otherwise excluded conditions (e.g. if HIV infection is excluded, can the employer simply pay this component and ensure a continuity of service from the health care provider for all the patient's medical needs)?
- What conditions apply to benefits payable (qualifying periods, pre-existing conditions, benefit capping, front-end deductibles, other conditions)?
- Are the benefits provided in a confidential, gender sensitive and youth friendly manner?
- Are services payable (in part or in full) in advance, or can the patient refer the invoice directly to the insurer?
- What other funding options are possible (e.g. the creation of a staff health fund to cover costs of treatment not addressed by health insurance)?

9. Annex 4 – Examples of TOR for situation & response analysis, and of draft policies

- What has been the experience of other organisations providing such health care, including the creation of a staff health fund and/or obtaining health insurance for staff and dependants? Identify other organisations (including contact person) which might be interested in future collaboration on the issue.

References

Safe and Effective Use of Anti-Retroviral Treatments in Adults with Particular Reference to Resource Limited Settings, UNAIDS, WHO, IAS, revised edition January 2001.
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WHO, 2001.
www.who.int/HIV_AIDS/STIcasemanagement/STIManagementguidelines/who_hiv_aids_2001.01/index.htm