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UN System HIV Workplace Programmes

HIV Prevention, Treatment and Care for UN System Employees and Their Families

UNAIDS BEST PRACTICE COLLECTION

Cover photo: Wall hanging
made for the Ethiopia workplace programme.

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Foreword

In light of the devastating impact that the AIDS epidemic is having on UN staff and the organization itself, in September 2002, the Secretary-General appealed to all UN agencies to take responsibility for providing their staff with adequate information and access to medical care and counselling.

By 2002, many UN country teams had already taken steps to institute HIV workplace programmes. Since then, many more have joined their ranks. In 2002 and 2003, the *Access, Care, Treatment and Interorganizational Needs Pilot Project* (A.C.T.I.O.N.) sought to discover those elements of workplace programmes that would improve access to care and support, including voluntary testing and antiretroviral therapy in selected pilot countries. As a follow-up to that report, the present study was commissioned.

Among the many good practices observed in the Cambodia, Ethiopia, Kenya and Rwanda interagency efforts, three findings are paramount.

Reliable access to treatment: can provide an incentive to find out one's HIV status. Knowing one's HIV-positive status is key to living positively and productively with HIV infection. Facilitating access to treatment and care is an indispensable element of workplace programming.

The power of leadership: without leadership and support from senior management, workplace programmes would not get past the starting point. Where workplace programmes are addressing difficult issues most effectively managers are making bold policy decisions without waiting for direction from the top. This is significant. In the face of an epidemic that is both devastating and complex, the UN community needs to challenge the status quo and 'push the envelope' systemically.

Interagency multidisciplinary responses: interagency approaches encourage agencies to put the greater good of the UN system above individual agency needs. System-wide applications allow staff from all agencies, funds and programmes—no matter how small—to benefit from workplace programmes.

This report will assist UN staff members and partners responsible for HIV in the workplace to design, evaluate and fine-tune workplace programmes to have the greatest possible impact on mitigating the effects of HIV. I hope it also serves as a wake-up call for those agencies and those country teams for whom HIV in the workplace has not been a priority.

Dr. Peter Piot
Executive Director
UNAIDS

Abbreviations, acronyms and terms

A.C.T.I.O.N. Project	Access, Care, Treatment and Inter-Organizational Needs Pilot Project
AIDS	Acquired Immunodeficiency Syndrome
FAIRPACK Policy (Kenya)	Guaranteed Fair Employment Package
FAO	United Nations Food and Agriculture Organization
FHI	Family Health International
GIPA Project	Greater Involvement of People Living with and Affected by HIV and AIDS Project
HABITAT	United Nations Human Settlements Programme
HIV	Human Immunodeficiency Virus
ICTR	International War Crimes Tribunal for Rwanda
IEC	Information, education and communication
ILO	International Labour Organization
ISP	Joint UN Implementation Support Plan to coordinate and guide interagency efforts to support national HIV and AIDS efforts
KPA (Kenya)	Kenya Ports Authority
MIP	Medical Insurance Plan
NCHADS (Cambodia)	National Centre for HIV/AIDS, Dermatology and STD
NGO	Nongovernmental organization
PEP	Post-exposure Prophylaxis
STI/STD	Sexually Transmitted Infection/Sexually Transmitted Disease
'3Cs' conditions for HIV testing	Confidentiality, Counselling and Informed Consent
Three Cs Policy (Kenya)	Confidentiality, Counselling and Care Policy
UNAIDS	Joint UN Programme on HIV/AIDS
UNCT	UN Country Team
UNDP	United Nations Development Programme
UNECA	United Nations Economic Commission for Africa
UNEP	United Nations Environment Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCC (Ethiopia)	United Nations Health Care Clinic
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Programme for Women
UNJMS (Kenya)	United Nations Joint Medical Service
UNON (Kenya)	United Nations Office at Nairobi (a division of the UN Secretariat)
UNSECOOR	United Nations Security Coordinator
UNV	United Nations Volunteer Programme
UNWECP (Ethiopia)	United Nations Workplace Education and Care Programme
VCT	Voluntary counselling and testing
WB	World Bank
WFP	United Nations World Food Programme
WHO	World Health Organization

I. BACKGROUND

Today, more than 20 years since the first cases of HIV infection were recognized, the epidemic continues to expand relentlessly. Despite early and ongoing efforts to contain its spread and to find a cure, 20 million people have died and an estimated 40.3 million people worldwide are living with HIV[1]. In the latter half of 2004, the number of people on antiretroviral therapy in low-income and transitional countries increased dramatically, but still only about 12% of the 5.8 million people in developing and transitional countries who need treatment are getting treatment[2].

The far-reaching social and economic consequences of the epidemic are having an impact on individuals, communities and the workplace. The UN, like many employers all over the world, is faced with major challenges related to the direct and indirect costs of the epidemic: increasing medical costs, absenteeism related to illness, high staff turnover, increasing recruitment and training costs, strained labour relations and the ever-increasing erosion of human capital.

Many UN staff come from and/or work in countries with high HIV prevalence and perform duties that may put them at increased risk of exposure to the virus. The UN recognizes its duty as a socially responsible employer and has thus committed to protecting the rights of its staff by making HIV in the UN workplace a priority.

UN Policy Framework[3]

Personnel Policy

In 1991, the United Nations system adopted the *UN System Personnel Policy on HIV/AIDS*[4]. Still in place, it applies to all agencies and programmes in the United Nations system and covers all employees and their families. The UN policy asserts that UN staff and their family members should be provided with:

- information, education and other preventive measures;
- voluntary confidential HIV testing and counselling, with pre- and post-test counselling and assured confidentiality;
- non-discriminatory terms of employment and service; and
- health insurance regardless of HIV status.

Declaration of Commitment

With the adoption of the *Declaration of Commitment* at the June 2001 United Nations General Assembly Special Session on HIV/AIDS (UNGASS)[5], the UN called for an integrated, system-wide approach to HIV and AIDS in the UN workplace based on the ILO *Code of*

[1] UNAIDS (2005). *AIDS epidemic update*, p. 1. Geneva.

[2] UNAIDS & World Health Organization (2004). *Treat 3 Million by 2005*. "3 by 5" Progress Report. Dec. 2004.

[3] Documents referred to in this section may be located on UNAIDS' Internet site at http://www.unaids.org/. Those not posted on the site can be made available upon request to hrm@unaids.org.

[4] United Nations HIV/AIDS Personnel Policy, ACC Decision 1991/10.

[5] *Declaration of Commitment on HIV/AIDS: United Nations General Assembly, Special Session on HIV/AIDS, 25-27 June 2001*. New York, United Nations Department of Public Information and UNAIDS, New York, 2001.

Practice on HIV/AIDS and the World of Work[6]. The *Declaration of Commitment* calls for action in the workplace, including strengthening the response to HIV in the world of work by establishing and implementing prevention and care programmes in public, private and informal work sectors, and by taking measures to provide a supportive workplace environment for people living with HIV.

To help countries meet that commitment, the International Labour Organization (ILO) published the ILO *Code of Practice on HIV/AIDS and the World of Work*. The ILO *Code* is now recognized as an essential companion to the *UN System Personnel Policy on HIV/AIDS*. The *Code* gives new emphasis to the protection of human rights related to HIV and to AIDS. It underscores the right to non-discrimination on the basis of real or perceived HIV status, and the centrality of non-discrimination in effectively promoting prevention, treatment, care and support.

UN Learning Strategy on HIV/AIDS

In 2002, UNAIDS coordinated a learning needs survey involving 8000 UN system employees in 82 countries. The survey found that much work needed to be done in order to institutionalize AIDS awareness, policies and practices within the organization. Thus, the United Nations *Learning Strategy on HIV/AIDS* was developed[7]. It provides a guide to building the capacity of all UN system employees to respond to AIDS at levels appropriate to their responsibilities. The *Learning Strategy* establishes expected outcomes to be achieved through minimum standards for HIV in the UN Workplace. To date, 198 AIDS learning facilitators from 105 countries, representing 19 UN agencies and programmes, have been trained to work with country teams to find ways to institutionalize HIV prevention and AIDS treatment programmes throughout their UN system workplaces.

Living in a world with HIV and AIDS

In 2004, UNAIDS published a revised edition of its information booklet for employees of the UN system and their families, entitled *Living in a World with HIV and AIDS*[8]. This booklet is designed to provide staff and family members with important information about HIV and about AIDS and to make them aware of the resources and services available to them—the essential message being that with the right information, the UN family can collectively fight and eliminate HIV.

Post-exposure prophylaxis (PEP) starter kits have been supplied by the UN medical services to all countries with a UN presence and are available to UN employees and their families through the UN dispensary physician and/or the UN security officer. Post-exposure prophylaxis is an emergency medical treatment that, according to UN policy, will be provided to UN staff and family members following an accidental exposure to HIV, either as a result of an occupational accident or following sexual assault. Every UN country team must establish a country-specific UN system protocol as to how post-exposure prophylaxis kits may be accessed in the event of accidental exposure. This protocol should be widely disseminated and understood by all staff.

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[6] ILO *Code of Practice on HIV/AIDS and the World of Work*. Geneva, International Labour Organization, 2001.

[7] UNAIDS (2003). *United Nations Learning Strategy on HIV/AIDS: Building competence of the UN and its staff to respond to HIV/AIDS* Geneva.

[8] UNAIDS (2004). *Living in a World with HIV and AIDS: Information for employees of the UN system and their families.* Geneva.

UNAIDS/WHO Policy Statement on HIV Testing

In June 2004, UNAIDS and WHO issued the *UNAIDS/WHO Policy Statement on HIV Testing*, that re-asserts the '3Cs' of HIV testing. HIV testing must be:

- confidential;
- accompanied by counselling; and
- only conducted with informed consent, meaning that it must be both informed and voluntary.

Mandatory HIV screening is only recommended for blood that is destined for transfusion or for manufacture of blood products. UNAIDS/WHO do not support mandatory testing of individuals for public health reasons on the grounds that it is less likely to result in behaviour change to avoid transmitting HIV to other individuals. "The voluntariness of testing must remain at the heart of all HIV policies and programmes, both to comply with human rights principles and to ensure sustained public health benefits.[9]"

Issues Related to Facilitation of Treatment and Care in the UN System Workplace

A solid policy framework is the most important step in the process of institutionalising sound HIV and AIDS practices within the UN workplace. But it is only the first step. Since the establishment of the *UN System Personnel Policy on HIV/AIDS* in 1991, UN system organizations, including individual agencies and programmes all over the world, have discovered that putting AIDS policies into practice is a challenge. Indeed, as one senior UN staff member candidly points out, "HIV and AIDS have served to illustrate the weaknesses in our human resource systems". Challenges include the myriad of contract types, the varieties of and gaps in insurance coverage, and how to reconcile in-house treatment and care facilities for staff in contexts where such facilities are inaccessible to the communities served by the UN.

Contract types

As eligibility for medical insurance coverage is related to contract status, the ever-increasing number of different types of contracts used by the various agencies and programmes of the UN system, and the well-recognized problem of temporary contracts for long-term needs are issues that have direct bearing on staff affected by HIV[10]. As a result of HIV- and AIDS-related concerns, many UN organizations have initiated changes to their contractual instruments. In an effort to harmonize such changes, at its 57th session (summer 2003) the International Civil Service Commission reviewed proposals for the establishment of a general framework for contractual arrangements outlining three categories of appointments that would serve as policy guidelines for the organizations of the common system.

Insurance coverage

There are no fewer than 19 health insurance schemes in the UN system, with significant differences between them regarding benefits, contributions and administration. There are good reasons for the existence of several schemes—to accommodate different organizational

[9] UNAIDS & WHO (2004). *UNAIDS/WHO Policy Statement on HIV Testing.* Geneva.

[10] The number of contract types is at least partially a result of the changing relationship between regular and voluntary funding. Precarious funding arrangements lead to precarious employment conditions. If the UN is to tackle this problem, regular and predictable funding from donors and/or member states will have to be part of the solution. This point is equally applicable to insurance coverage, in the section below.

needs and medical and legal environments—but variations in insurance schemes and medical coverage place many staff members (particularly nationals) in precarious positions. For example, in most UN agencies, staff members on short-term contracts (or on a series of short-term contracts) are not eligible for medical insurance coverage. Even where agencies (such as WFP) have taken measures to insure their contingency workforce members, coverage includes a "pre-existing condition" exclusion, meaning that if the staff member has a medical condition upon entrance into the organization, s/he is not eligible for insurance coverage for medical expenses related to that condition. In addition, using the WFP example, where coverage for other medical conditions has a ceiling of US$ 10 000 per year, medical insurance coverage for HIV- and AIDS-related medical expenses is US$ 4000. Family members may not be covered[11], and interruption of treatment at the end of each short-term contract is an issue. Another problem is that in the case of most UN staff insurance schemes (national and international alike), the staff member is responsible for paying 20% of his/her health-related expenses. This ceiling on reimbursements and the payment of medical expenses up-front, especially where more than one family member may be claiming, are seen as obstacles to long-term care.

In recognition of these issues, a number of agencies are taking steps to streamline contractual arrangements and insurance ceilings that are the source of perceived discrimination, but as with the issue of contractual arrangements above, the UN is endeavouring to harmonize coverage across the system. At its spring 2000 session, the Consultative Committee on Administrative Questions requested that a sub-committee present proposals for improving and harmonizing medical insurance coverage for national staff within the United Nations system. This was to ensure that *all* schemes provide staff members and their dependants with a comparable level of protection—regardless of their category, level and duty station—and based upon the understanding that "the establishment of a single world-wide health insurance scheme for all UN staff is not a desirable or practical option[12]". In March 2003, the Secretariat of the Chief Executives Board for Coordination proposed that the HR Network create an interagency task force on insurance to analyze the main discrepancies between the various schemes and to propose strategies and practical measures that might achieve a more coherent approach. This work is still ongoing. It is hoped that such efforts will lead to a set of minimum standards in health insurance coverage.

Providing In-House Facilities versus Strengthening National Response

In countries where medical facilities are inadequate and where there are sufficient numbers of UN staff members and dependents at the duty station, the UN establishes a UN Dispensary to provide basic health-related services to all internationally and nationally recruited personnel of the UN system and their recognized dependents. Based on outlined criteria, the UN has established 44 such Dispensaries around the world, each headed by a UN Dispensary Physician. These dispensaries are not intended to replace, but rather to act in liaison with, local facilities.

The HIV epidemic has served to heighten awareness of the fact that the UN provides better levels of care to its international and local staff than are accessible to the surrounding communities in many low income countries. This is a sensitive issue, but through its efforts to strengthen national responses to HIV and AIDS, the UN is seeking to narrow this gap by pushing for access throughout countries and communities.

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[11] WFP is currently working on a policy to cover recognized dependents.

[12] United Nations System (2002). *Health Insurance Schemes (HIS) in the United Nations System*. Chief Executives Board for Co-ordination, Meeting of CEB HR Network, UN, Geneva, 3–5 April 2002.

In keeping with the adoption of the *Declaration of Commitment* at the June 2001 United Nations General Assembly Special Session on HIV/AIDS, each country team has a UN Theme Group on HIV/AIDS, made up of Heads of UNAIDS Cosponsors and other interested agencies. The UN Theme Group is the key mechanism for joint UN action and coordination of AIDS-related activities. In addition, each team has a UN Technical Working Group on HIV/AIDS, made up of focal points within UNAIDS Cosponsoring agencies. In most countries, these groups have been very largely focused on strengthening the national response.

Building on earlier initiatives by the UN, WHO and UNAIDS set an ambitious target that three million people living with HIV (in developing and transitional countries) would be receiving antiretroviral therapy by 2005—the "3 by 5" Initiative. Since then, a strong international movement has gathered behind the Initiative. In conjunction with the Global Fund to Fight AIDS, Tuberculosis and Malaria, the United States President's Emergency Plan for AIDS Relief, and the World Bank, scale-up and advocacy for stronger national responses have progressed markedly. The "3 by 5" Initiative has made gains in several key building blocks of antiretroviral therapy, including:

- expanding access to HIV testing and counselling;
- integrating antiretroviral therapy and tuberculosis programmes;
- improving access and integrating care and support services;
- preventing mother-to-child HIV transmission;
- providing medicines and diagnostics;
- training professionals, community members and people living with HIV;
- developing systems for tracking and monitoring people receiving treatment; and
- institutionalizing operational research into evidence-based programme design adapted to local conditions[13].

If managed wisely, the scaling up of antiretroviral therapy can lead to the strengthening of both HIV prevention programmes and broader health systems.

Thus, parallel to efforts to protect and treat its staff and their families, the UN is investing in the world-wide response to HIV, with special emphasis on improving the infrastructure for delivery of treatment and care in developing and transitional countries.

The A.C.T.I.O.N. Project

Framed and guided by the policies and resources being developed at central levels, UN country teams began to align their own policies and procedures and to develop programmes that aimed to reduce the transmission of HIV and to mitigate the impact of AIDS on their staff and families. In 2002 and 2003, the *Access, Care, Treatment and Inter-Organizational Needs Pilot Project* (A.C.T.I.O.N.) sought to discover those elements of workplace programmes that would improve access to care and support, including voluntary HIV testing and counselling and antiretroviral therapy in selected pilot countries[14]. Ten countries were chosen, the selection criteria being the availability of antiretroviral medicines, large numbers of UN system staff and depen-

[13] UNAIDS and World Health Organization (2004). *Treat 3 Million by 2005*. "3 by 5" Progress Report. December 2004.

[14] The A.C.T.I.O.N. Project has since produced *Guidelines for providing access to treatment and care for HIV/AIDS to UN system employees and their families*. WHO, 2004.

dents and, in most cases, high prevalence of HIV infection. The ten countries were Cambodia, Ethiopia, India, Nigeria, Rwanda, Senegal, Tanzania, Uganda, Zambia and Zimbabwe.

A.C.T.I.O.N. found examples of good practice in all ten countries, but the team was particularly impressed by the approaches being taken in Cambodia, Ethiopia and Rwanda. These three countries were thus selected for case studies to showcase the approaches they had taken to prevention, treatment and care for their staff. In addition, because 'out-of-the-box' thinking was leading to innovation, empowerment and development of local solutions in Kenya, it was added as the fourth country to be presented.

UNAIDS Best Practice on Prevention, Treatment and Care for UN System Employees and their Families

The present study is the result of research undertaken in Cambodia, Ethiopia, Kenya and Rwanda between September and November 2004. Its purpose is to capture lessons learned, keys to success, and challenges that must be met if there is to be optimal access to HIV-related prevention, treatment and care for UN staff and their dependents.

The programmes examined as part of this study cater to the prevention and treatment needs of both national and international staff.

II. ETHIOPIA: Solid Groundwork

The Ethiopia case study examines the UN's systematic laying of the groundwork for an effective workplace programme in Ethiopia. Before antiretroviral medications were available on the market in Ethiopia, the UN Health Care Clinic imported them through its regular procurement system. Through effective interagency collaboration, the UN *Workplace Education and Care Programme* has gathered the data, trained peer educators and established mechanisms to ensure that its HIV in the workplace programme is effectively implemented and monitored.

National Response to the AIDS Epidemic

Ethiopia is one of the heavily HIV-affected countries in sub-Saharan Africa. As of 2004, approximately 1.5 million people were living with HIV. The virus is transmitted primarily through unprotected heterosexual sex, and has spread very quickly to all parts of the country and all segments of the population. Average adult prevalence is estimated to be 4.4%[15]. There is a wide disparity between urban and rural areas, with Bihar Dar, Jijiga, Nazareth and Addis Ababa having the highest urban prevalence[16].

The Government of Ethiopia's response to the epidemic began in 1985. A National Task Force was established, followed in 1987 by a National AIDS Programme, both under the Ministry of Health. A comprehensive AIDS policy (1998) and a five-year multisectoral National Strategic Framework and Plan (1999) subsequently updated for the period 2001–2005 were developed. A multisectoral HIV/AIDS Prevention and Control Council was established in 2000. The impact of the national efforts has been an increase in awareness about HIV.

Despite its framework and mechanisms, and despite a mushrooming in the level of services related to HIV in the country (183 identified actors at last count[17]), Ethiopia has lagged behind other countries in the area of treatment and care because until recently, antiretroviral medicines were not available officially. Free treatment (or very cheap treatment) via government channels are now available, given the large amounts of funding recently received from the US President's Emergency Plan for AIDS Relief and from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

The UN Response to HIV in the Workplace

The UN Country Team in Ethiopia is one of the UN's largest missions, bringing together the full range of UN agencies, the Bretton Woods Institutions, the UN Economic Commission for Africa (UNECA) and UN Liaison Offices to the African Union and UNECA. Altogether, the UN has just under 5000 staff and family members resident in Ethiopia, with UNECA accounting for a little over half of these. Given the presence of UNECA, the UN also plays host to a steady stream of high-level delegations, diplomatic missions and other visitors.

Joint UN HIV-related activities in Ethiopia have been coordinated by the UN Theme Group on HIV/AIDS under the UN Resident Coordinator, with technical and secretarial support from the UNAIDS Secretariat. In 1999, with the realization that HIV was posing a serious

[15] UNAIDS (2005). *AIDS epidemic update,* p. 28. Geneva.

[16] UN Theme Group on HIV and AIDS on HIV/AIDS/Ethiopia (2004). *UN Implementation Support Plan on HIV/AIDS,* June 2004–December 2005.

[17] Ibid.

threat to its staff, the UN system in Ethiopia established the UN Workplace Education and Care Programme. With donations of US$ 10 000 from the A.C.T.I.O.N project and US$ 28 000 from the UNAIDS Programme Acceleration Fund, the UN Workplace Education and Care Programme Task Force has supported a wide range of initiatives.

The Task Force has established and followed an annual work plan every year since 2001. Actions have included the following.

- Peer educators were trained and helped to formulate plans of action for their respective agencies. Since then, the Task Force has organized refresher training sessions for the peer educators, and peer educators have organized awareness-raising sessions including testimonials by persons living with HIV in their respective agencies. Information sessions for senior managers have advocated for support for the peer education and workplace programme in general.
- Condoms have been promoted and distributed in most of the agencies since 2002.
- A UN Staff HIV and AIDS Benevolent Fund was initiated by the UN Workplace Education and Care Programme, and endorsed by the UN Theme Group on HIV and AIDS (see below).
- A survey of private medical services at clinics and hospitals in Addis Ababa was undertaken and distributed to all UN staff.
- A study of the obstacles affecting the implementation of the UN Policy on HIV was undertaken as an initial step in identifying the measures the UN could take to support UN staff infected and affected by HIV.
- An International Labour Organization rapid assessment to establish baseline data on workplace interventions was distributed to 16 agencies (responses from 12 agencies revealed useful findings for workplace programme planning, implementation and monitoring).
- The objectives of the UN Learning Strategy have been clearly incorporated into the Task Force's current work plan.
- In collaboration with the UN Health Care Clinic and the UN Women's Association, awareness raising and education sessions have been conducted in a number of high schools, and regular adolescent forums for family members of UN staff are organized.
- The UN Workplace Education and Care Programme Task Force has facilitated capacity building of UN Health Care Clinic staff in counselling, treatment and care. Visits to counselling and testing centres, a survey of peer educators' needs, and a retreat for peer educators are also planned.

Comprehensive Care at the UN Health Care Clinic

Exceptionally large for a 'UN Dispensary', the UN Health Care Clinic in Ethiopia is a 24-hour outpatient and admission facility (including an intensive care unit) providing health promotion as well as preventive and curative services for staff and dependants. It has 22 medical staff (including two full-time general practitioners) and 19 paramedical staff[18], 11 nurses and a wide range of specialists who rotate in and out on a regular basis. Between 20 000 and 23 000 consultations per year take place.

[18] One of these two positions is currently vacant.

The Clinic was set up in 1966 in response to the fact that the UN employed or was host to thousands of staff, dependants and visitors in a context where healthcare services were inadequate or non-existent. Although the healthcare context has improved since then, the UN Staff Physician still describes the UN Health Care Clinic as "an island in a precarious health environment"[19].

Until 1999, HIV testing and counselling were available at the UN Health Care Clinic, but testing was done at a referral lab where results took as long as 15 days to come back, and antiretroviral treatment was not available. With the ever-increasing number of people coming to the clinic with advanced HIV disease, and in the absence of any other HIV treatment facilities in Ethiopia, in 1999 a comprehensive HIV clinic was established within the UN Health Care Clinic. Headed by a Task Force chaired by the Chief Medical Officer, the clinic is responsible for the UN's comprehensive care programme for UN staff and family members living with HIV.

In 2001, following the Chief Medical Officer's visit to the *Cipla Laboratories* in India, the UN Health Care Clinic began to import antiretroviral medicines, tax-free, through its regular procurement mechanisms.

Today, the UN Health Care Clinic offers a comprehensive range of HIV services, including HIV testing and counselling, post-exposure prophylaxis, prevention of mother-to-child transmission therapy, health education (including a newsletter published every two months), antiretroviral therapy and treatment for opportunistic infections. In the eight-year period from 1991 to 1999, the Clinic counselled and tested 321 patients for HIV; in the four-year period from 2000 to 2004, it tested almost the same number (319), effectively doubling the rate, with a steady increase year-on-year.

Nurse Menbere Teklu (also a peer educator), Dr. Azeb Tamrat and Dr. Eyesusawit Shewangizaw. The UN Health Care Centre used to be called the UNECA Clinic, but the name was changed to emphasize its UN system-wide mandate.

Although the UN Health Care Clinic is subsidized by each UN agency based on its total number of full-time staff, it operates on a partial cost recovery basis. Its current estimation of annual HIV-related costs per patient is just under US$ 2100 (not including treatment for opportunistic infections). In the past, to make it easier for staff members to budget for and cover the costs of their treatment, the clinic amortized this annual amount over twelve months and charged a fixed fee of US$ 35.29 per month. Currently, the UN Health Care Clinic has requested that this amount be deducted directly from staff salaries, providing it does not exceed 40% of the staff member's

[19] Interview, Dr. Azeb Tamrat, UN Health Care Clinic, October 18, 2004.

net salary. This covers all counselling and consultation, routine and miscellaneous laboratory tests, and antiretroviral treatment. The agencies withdraw the fee directly from their respective staff members' salaries. In some cases, such as when a staff member also has dependents on treatment, the amount is amortized over a longer period. These exceptional administrative mechanisms are good examples of 'special accommodations' to meet the needs of HIV-positive staff.

The clinic has worked out credit agreements with a number of hospitals, such that the hospitals treat the staff members for free, and bill the UN Health Care Clinic directly. The UNECA settles the bills, and the UN Health Care Clinic invoices La Garantie Médicale et Chirurgicale (GMC Services)[20] directly for 80% for UNDP and UNDP-administered staff members. As is the case throughout the UN system, in Ethiopia, the mechanisms for recovering the remaining 20% from the staff member, and how confidentiality is assured via systems in the workplace, vary from agency to agency.

A big issue facing the clinic is that high levels of stigma, fear of disclosure and denial prevent staff from coming forward at the point when symptoms first appear. As a result, patients usually present themselves at the clinic in the advanced stages—often when they are already in urgent need of hospitalization and aggressive treatment for opportunistic infections, both of which are very costly. Because staff members fear stigma and discrimination, they typically wait a long time before seeking medical assistance; as a result, in the early stages, nearly 25% of the clinic's HIV-positive patients died—a rate which could have been prevented if staff living with HIV had sought treatment at earlier stages of illness.

Given the recent improvements in access to affordable antiretroviral drugs, the clinic emphasizes that finding out one's status and being treated early can make the difference between life and death. This is perhaps the single most important message for the UN to emphasize in its awareness-raising campaigns. Indeed, there has been a steady increase in the number of staff and family members being tested since 2001, and both the percentage of patients on antiretroviral treatment and the percentage of staff that have died from AIDS have declined steadily. For the staff physician, this is an indication that with increased awareness, staff members are beginning to seek treatment at earlier signs of the illness.

Notwithstanding the progressive increase in the number of people being tested at the UN Health Care Clinic, and notwithstanding the praise for the UN Health Care Clinic by HIV-positive staff members who are currently being treated, there will always be a number of staff members that simply do not wish to be treated at their place of work. In Ethiopia, as in many other countries, this is largely owing to the climate of fear surrounding HIV. In response to these concerns, the UN Health Care Clinic has strengthened confidentiality systems that cover pre-test counselling, testing, post-test counselling, provision of antiretroviral therapy and insurance claims. For example, in response to the expressed fear that being seen in the office of the HIV Specialist could result in involuntary disclosure, the UN Health Care Clinic provided all medical staff with training so that patients can now be seen by any one of a number of physicians who work at the clinic.

[20] GMC Services is a Paris-based insurance company that the UNDP has contracted to administer UNDP and UNDP-administered Medical Insurance Plan claims worldwide.

"[My doctor] even goes to the pharmacy to collect the medicine to protect my confidentiality…"

A male HIV-positive patient being treated at the UN Health Care Clinic

"Before she told me about AIDS, the doctor told me about the policy. It's completely confidential. The medical treatment is very proper."

A female HIV-positive patient being treated at the UN Health Care Clinic

The clinic has also identified other treatment and care facilities in Addis to which it may refer reluctant staff members.

UN Learning Strategy a Priority

In July 2003 the Regional Directors for Africa committed themselves to developing country-level joint UN Implementation Support Plans to coordinate and guide inter-agency efforts to support national HIV and AIDS efforts. The preparation of the Ethiopia Implementation Support Plan for 2004-2005, initiated by heads of agencies in the UN Theme Group on HIV/AIDS and guided and facilitated by the UNAIDS Secretariat, was both participatory and consultative. It involved an extensive document review by members of the UN Theme Group on HIV/AIDS, participation of UN designated focal points in retreats where the methodology was established, and a Heads of Agency Retreat where the collaborative programme was discussed and enriched. Planning culminated in a workshop (March 2004) where the draft Implementation Support Plan was worked out. This participatory and consultative process itself has been identified as a best practice in workplace programme planning—because experience shows that strategic planning is only as effective as the various stakeholders' involvement in the planning and ownership of the outcome.

The Ethiopia Implementation Support Plan identified three strategic priorities:

(i) national-level advocacy;
(ii) *Woreda* (district)-level capacity building; and
(iii) mainstreaming of the UN Learning Strategy (half of which is devoted to workplace programming).

Each priority area is led by a technical working group headed by an individual member of the UN system (not by an institution).

The objectives of the Learning Strategy priority area are to:

- reorganize the UN Workplace Education and Care Programme to play a more proactive and motivational role;
- create a venue for staff to build a supportive working environment; and
- create a working environment that is safe and supportive for staff members living with or affected by HIV.

For purposes of implementation, a Coordination Committee comprised of the chair and the co-chair of the UN Theme Group on HIV and AIDS and chairs of the technical working groups, has been formed. The Implementation Support Plan clearly articulates the roles and responsibilities of the UN Theme Group, the Coordination Committee, the UN Technical Working Group on HIV/AIDS, and the UNAIDS Secretariat. Responsibility for implementing the unified Implementation Support Plan rests with the UN Theme Group, as does responsibility for monitoring and evaluation, with technical assistance from the UNAIDS Secretariat. The

Theme Group updates the plan annually and reports bi-annually to the UN Country Team about progress in the implementation of the collaborative programme. In this way, the Implementation Support Plan serves as a management tool for the Theme Group.

The UN Country Team has thus invested time and resources into the establishment of structures and mechanisms for planning, implementing and monitoring its HIV-related work, with the workplace programme figuring large in its priorities. This investment in structures and systems is a clear example of best practice that helps ensure that decisions about workplace activities are consultative and well informed, that impact is monitored, and that lapses are detected and corrected in a timely manner.

To some extent, the UN Workplace Education and Care Programme's focus on the Learning Strategy may underscore the team's emphasis on awareness raising and education—at the risk of neglecting treatment and care. The UN Workplace Education and Care Programme's 'Work plan for the Implementation of the UN Learning Strategy 2004' is largely focused on raising knowledge and understanding, with no specific treatment and care objectives and only a couple of activities and outcomes related to services, entitlements and uptake of HIV testing and counselling. If the UN Workplace Education and Care Programme is to play a meaningful role in guiding or supporting the UN Health Care Clinic comprehensive care programme, it needs to have treatment and care objectives. The Staff Physician is one of the two UN Learning Facilitators and is a member of the UN Workplace Education and Care Programme Task Force, but the absence of treatment and care objectives in the work plan raises the question of whether the UN Workplace Education and Care Programme has inappropriately delegated entire responsibility for treatment and care to the UN Health Care Clinic.

Setting Standards for Best Practice

Through concerted interagency efforts, the UN system in Ethiopia is setting standards for best practice in workplace programming.

To effectively tackle the complexities of workplace programming, the UN Workplace Education and Care Programme has found it needs to persevere in spite of the odds and find creative solutions to constraints. A good example of this was its decision to import antiretroviral medicines before they became available on the open market. Another example is that even though sub-contractors and part-time staff are not covered by insurance schemes, they are encouraged to use the clinic on a fee-for-service basis. The UN Health Care Clinic also assists staff in applying for waivers of the 20% out-of-pocket expense, on the basis of catastrophic illness.

The UN Workplace Education and Care Programme, including a three-agency secretariat (ILO, UNDP, UNAIDS), technical and human resources focal points, peer educators, the Staff Association and Medical Services, is an ideal structure for ensuring that the workplace programme has participation from the various divisions of the organization whose role it is to deal with HIV in the workplace issues.

A very important initiative of the UN Workplace Education and Care Programme has been the establishment of an interagency benevolent fund. The UN Staff HIV and AIDS Benevolent Fund is meant to support eligible HIV-positive staff and family members on antiretroviral treatment. It was initially capitalized with seed funding from the A.C.T.I.O.N. programme, UNICEF and the ILO. A drive is ongoing to raise funds from the other UN agencies in Ethiopia, with the objective of generating a rolling three-year reserve. A Benevolent Fund Constitution

that provides the organizational structure and terms of reference for operation of the Fund has recently been drafted. It provides for management by a board that reports to the UN Workplace Education and Care Programme Task Force. Once eligibility criteria have been worked out, the fund will become operational.

In general, the Ethiopia workplace programme demonstrates a level of responsiveness that is a best practice characteristic of the most effective Workplace programmes. When peer educators reported little progress in their work due to lack of support from their managers, the UN Workplace Education and Care Programme Task Force responded by preparing a document designed to guide agency representatives and senior managers in addressing the threats posed by HIV in a more serious manner. Managers were asked to rigorously enforce the UN Policy on HIV and AIDS in the Workplace; and in consultation with peer educators and staff associations, to establish operational work plans of actions to be undertaken to implement the Policy. The UN Workplace Education and Care Programme also organized an event to give thanks and to show recognition for the work of the peer educators. Demonstrating responsiveness, when ILO staff expressed concern about the amount of time they spent in workshops, the ILO peer educators decided to break up their awareness raising activities into smaller bites (one-hour or half-hour sessions here and there).

The various staff associations in Ethiopia, through the Union of Staff Associations, have been integrally involved in the set up of the Voluntary Fund, and are currently involved in soliciting donations to it. The Ethiopia case also presents best practice in its extensive collaboration with the UN Women's Association in the proactive involvement of family members, especially youth, in workplace programming. Youth Forums and a recent gala event to raise money for the Benevolent Fund are good examples of activities that can be effectively initiated by UN women's associations.

UNICEF and ILO focal points have workplace responsibilities reflected in their job descriptions. This is one of the best possible ways to ensure that focal points are allowed the time to devote to workplace programming, and that their work is recognized as important.

WFP's attempts to promote testing are exemplary. It has put aside US$ 10 000 to cover 100% of the cost of testing for any staff member who undergo testing. UNDP's inclusiveness is also a best practice. It recently invited all UN staff to take part in visits it was organizing to orphanages and voluntary counselling and testing centres.

The Ethiopia workplace programme provides examples of best practice that can be replicated anytime and anywhere; but above all, it should be emphasized that in the Ethiopia case, good practices evolved as a result of the workplace programme being consultative, inter-agency and solution-oriented.

III. KENYA: Groundbreaking solutions

The UN System in Kenya has made radical and groundbreaking policy changes in order to put into effect a workplace programme that truly meets the needs of its workforce. In the face of considerable debate at the HQ level, and in spite of not having all of the answers worked out, senior managers decided to forge ahead because it was the right thing to do. In the words of the UNAIDS Country Coordinator, "if we don't push the envelope systemically, we're never going to get there."

National Estimates of HIV in Kenya, 2003

The HIV epidemic has had and continues to have a devastating impact on Kenya. According to the National AIDS and STD Control Programme, estimated HIV prevalence in adults (15 to 49 years) in 2003 was about 7% (6.1% to 7.5%)[21]. Of the estimated 1.1 million adults living with HIV, just under two thirds are women. The urban rate (10%) is almost twice as high as the rural rate (5-6%), with Nairobi, Mombasa, Kisumu and Kakamega being the worst affected cities. Nyanza Province in western Kenya, at 14%, has the highest provincial prevalence. The trends are alarming: most new infections occur among youth and women aged 15 to 24; the annual number of AIDS deaths is still rising steeply; and of the 1.7 million orphans under the age of 18, half have been orphaned by AIDS.

Impact on the UN System Workplace

The UN System in Nairobi is the largest established duty station in Africa. It is home to approximately 75 agencies, programmes and funds, including global headquarters of the UN Environment Programme (UNEP) and the UN Human Settlements Programme (UN-HABITAT), United Nations Office at Nairobi (UNON, a division of the UN Secretariat), regional bureaux, Kenya Country Offices and the South Sudan and Somalia secretariats.

In Kenya 120 staff members are known to be living with HIV and are on antiretroviral treatment. It is estimated that a further 331 staff members and their dependents are infected[22]. According to the UNON-managed UN Joint Medical Service (UNJMS) records, there have been 32 AIDS deaths among UN staff members since 1997. Compounded by widespread denial, persistent myths and lack of information, the epidemic is contributing to fundamental changes in social and work relations, and to widespread fear and stigma.

In addition to the personal suffering that HIV has caused, such statistics have had a profound impact on the UN workplace. The annual cost to the UN in Kenya, including cost of health care, productivity losses and death benefits, is estimated to be in the range of US$ 815 000[23].

[21] UNAIDS (2004). *Understanding the latest estimates of the global AIDS epidemic—July 2004*.

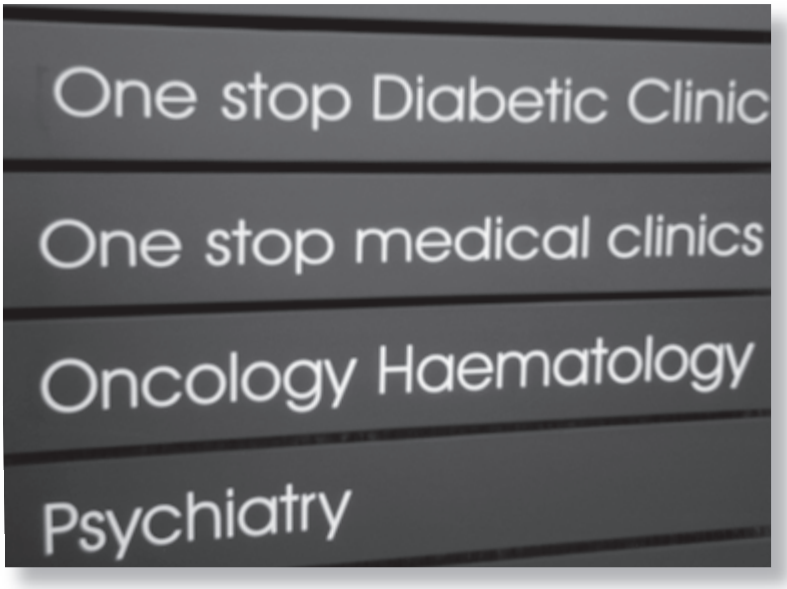
[22] Terms of Reference, UN System Workplace HIV/AIDS Coordinator. September 2004.

[23] UN Kenya Learning Team, Power Point Presentation on the Three C's Policy, presented to the UN Heads of Agencies, undated.

Treatment and Care Policies

The Three Cs Policy

The UN System in Kenya benefits from, and has taken full advantage of, access to first-rate healthcare services. When it came to the attention of the Staff Physician that the Aga Khan Hospital in Nairobi had developed a One-stop Clinic for HIV[24], UNON took steps to negotiate a treatment and care agreement with the hospital. Under the terms of this agreement, HIV-positive staff members (or those presenting symptoms that are consistent with HIV infection) are issued nameless identity cards and referred to the One-stop Clinic for HIV-related services ranging from testing and counselling to nutrition advice, treatment and psychosocial support. The Aga Khan Foundation subsidizes the One-stop Clinic so the UN in Kenya is fortunate indeed to have access to world-class AIDS treatment at a subsidized rate[25].



What makes the One-stop Clinic so effective is its completely integrated service (incorporating counselling, testing, care and access to medicines); standardized messages; the multidisciplinary team approach (availing access to the full range of specialist services available at the Hospital); the credit facility; and its confidentiality mechanisms.

The Aga Khan Hospital had already worked out credit and nameless card systems that effectively protect patients' identities from their employers. Upon referral from an employer that has made a deposit with the Aga Khan Hospital, the One-stop Clinic treats patients and invoices the employer on a monthly basis. The deposit acts as a line of credit, and every month, upon invoicing, the employer 'tops up' the line of credit.

Although not a UN system best practice per se (even if the UN is commended for accessing it), the One-stop Clinic is certainly an industry best practice that UN duty stations should encourage and assist their local service providers to replicate[26].

In order to avail staff members of One-stop Clinic services, the UN had to come up with a sizable deposit—the equivalent of US$ 15 000, or approximately two months' billings. So as not to lose valuable time, UNON put up the deposit and agreed to work out the mechanisms for cross-charging later. The Aga Khan Hospital sends the UNJMS the monthly invoice with a listing of code numbers for each patient. It is important to note that the invoice is not sent to the respective agency, but to the UNJMS, thereby protecting confidentiality. The UNJMS advises UNON about the individual agencies' liabilities, UNON invoices each agency, and the

[24] "One-stop" refers to the integrated nature of the Aga Khan Hospital Clinic. At one clinical location, patients can access the full range of testing, medical and psychological services required for comprehensive treatment of HIV.

[25] The first consultation costs about US$ 15, including tests; follow-up consultations cost about US$ 9. According to the Aga Khan Hospital, approximately 50% of the costs of patient care are for testing.

[26] This may be easier said than done. The UN Dispensary in Nairobi has been trying to encourage the Nairobi Hospital, which is also a reputable medical facility, to establish a One-stop Clinic, but owing to its decentralized management structure, progress has been painstakingly slow.

agencies claim back 80%[27] from the Medical Insurance Plan (MIP) (or other relevant insurance carriers). Thus, 80% of UNON's credit line involves no risk.

In the planning phase, the stumbling block was how to recover the other 20%. After extensive deliberation, the UN community concluded that it would not be possible to collect the 20% from each staff member *and* to insure 100% confidentiality. So in the interest of insuring confidentiality and thereby optimising uptake, the UN community proposed in the short-term that agencies cover the remaining 20% themselves from operational budget lines of their choosing. It is envisaged that in the medium term, a proposal will be made to ask all agencies to contribute a set annual fee per staff member (note: *not* per HIV-positive patient) to capitalize a 'Three Cs Fund' that would be used to repay UNON for the remaining 20% in each case. Based on actuarial figures, the annual cost to the UN in Kenya (i.e., the uninsured portion) would be in the range of US$ 125 000. If this had been applied in 2004, the annual per capita fee to be charged to each agency would have been US$ 50.

To date, 11 agencies representing 70% of the workforce have signed up even though it is not yet clear where the individual agencies will charge the expenditure.

Thus, the Three Cs Policy was born. Only one C of the Kenyan Three Cs Policy is different from the UNAIDS/WHO Position Statement on HIV testing (see http://www.unaids.org/html/pub/una-docs/hivtestingpolicy_en_pdf.pdf) which underlines the '3Cs' conditions for HIV testing: confidentiality, counselling and consent. In Kenya, the '3Cs' refer to confidentiality, counselling and care. The stated goal of the policy is 'to provide free quality health care to all eligible UN staff with HIV/AIDS'[28]. The major implications of this policy decision and subsequent buy-in on the part of 11 agencies are that:

(i) 120 staff and dependents are receiving antiretroviral treatment for free;
(ii) confidentiality is absolutely assured; and as a result;
(iii) more and more staff are coming forward for treatment.

So it is the policy framework developed and approved by the UN community under the leadership of the Director-General of UNON and the UN Resident Co-ordinator for Kenya in order to take advantage of the One-stop Clinic that makes this particular case so noteworthy.

When asked whether the cost of antiretroviral medication is a strain for a female staff member whose husband is being treated for AIDS at the One-Stop-Clinic, she replied that it was hard at first, but that the treatment had made him feel so well that he is able to work again.

"It is not so hard to pay for the pills anymore because my husband can work now. It is okay."

Major challenges for the UN Learning Team on HIV/AIDS in Kenya (established in January 2004) include:

- increasing awareness of the 'Three Cs' Policy among staff members;
- encouraging the other 24 agencies to subscribe;
- covering non-eligible staff (e.g. Special Service Contract holders);
- dealing with continuation of care on work separation; and

[27] Depending on the agency, insurance coverage may be as high as 96%.

[28] Eligibility is determined by type of contract, enrolment in MIP being the criterion. Internationals and other contract holders may also use the One-stop Clinic, but they pay up front and process their own claims.

- increasing understanding of the Kenyan and African situations by Headquarters and other UN Funds, Programmes and Agencies.

Concerning the last point, having the global headquarters of UNEP and HABITAT and a division of the UN Secretariat (UNON) on the ground has been an absolute asset for the Kenya duty station. Because they experience first hand the realities of AIDS in Africa, Kenya-based senior managers understand the magnitude of the problem and the need for ground-breaking solutions.

A presentation on Kenya's 'Three Cs' Policy would not be complete without reference to a reservation that has been raised about it. There is the concern that 100% reimbursement for HIV- related medical expenses reinforces the stigma of HIV by dealing with it in an extraordinary way. The question is raised as to whether a woman with breast cancer or a dependent with diabetes shouldn't also get their treatment for free[29]. UNAIDS takes the very strong position that HIV *is* truly exceptional, and applauds the extraordinary measures that the UN in Kenya has taken.

The FAIRPACK Policy

In 2002, the Global AIDS Alliance, a not-for-profit advocacy group, published a critical article about the working conditions for employees of sub-contractors at the UN Complex in Nairobi—the issue being that outsourcing for services (cleaning, gardening, travel, etc.) meant that close to 400 workers (employed by 17 subcontractors) who spent more than half of their working week at the UN complex did not enjoy even a modicum of health insurance benefits. In the words of one UN staff member, "we had people cleaning our toilets who weren't even entitled to maternity leave".

Ironically, at the point when the Global AIDS Alliance article was published, the UN Ad Hoc Committee on HIV and AIDS was already working on a policy that would address this issue. The article triggered a shift into high gear, however, and since July 2003, tough new conditions contained in the *Guaranteed Fair Employment Package* (better known as the *FAIRPACK Policy*) apply to all contracts signed between UNON as the manager of the UN complex, and companies providing such services.

Under the FAIRPACK policy, all contractors are required to make provisions for health care including treatment for HIV-related disease, maternity leave, a minimum guaranteed wage, a nutritious lunch and transport for employees working at the UN. The provision for medical treatment for HIV-related disease applies to both the employee, his/her recognized spouse and a maximum of five children below 21 years of age. At the request of the Director General of UNON, a FAIRPACK II for short-term contract holders is now being developed.

The implementation of this policy will have significant cost implications for the UN. Since July 2003, as contracts expire or come up for renewal, contractors are asked to submit bids that comply with the conditions of the FAIRPACK Policy. As a result of the new policy, there has been a marked increase (up to 100% in some cases) in contract costs[30]. However, it should be noted that increased costs are not exclusively attributable to FAIRPACK. The increased attention to sub-contracting in general has forced the UN to look at its sub-contracting

[29] An alternative to the '3Cs' Policy is UNDP's "Stoploss" clause. Independent of the nature of the sickness, UNDP reimburses, at 100%, recognized professional medical services and medications once a participant along with his/her family members have collectively incurred in a calendar year out-of-pocket expenses equivalent to one month of his/her net base salary.

[30] Interview, Barnaby Jones, Chief, Facilities Management and Transportation Section, UNON, and Co-Convenor, UNLT, October 22, 2004.

policies—which had been to select the lowest bidder regardless of quality—so some correction upward was probably warranted even in the absence of FAIRPACK.

The FAIRPACK Policy, which is believed to be a first of its kind for the UN, is ground breaking best practice. The policy even includes terms of reference for a monitoring committee that will act as a focal point for queries, complaints and recommendations related to the FAIRPACK policy. Although the terms of reference do not include responsibility for monitoring the impact of the policy, there is already a distinct impression that morale and productivity on the part of sub-contracted staff have improved tangibly.

It is interesting to note that the UN developed this policy when other employers were not willing to take such measures on the grounds that they did not want to interfere with local labour law, and when the financial implications were not yet known. The UN went ahead because it was the right thing to do.

The UN Learning Team and Confident Leadership from the Top

In January 2004, following a training of HIV and AIDS Learning Strategy Facilitators in Namibia, the Kenya UN Learning Team on HIV/AIDS was formed. The UN Learning Team actually took over from the ad hoc Committee on HIV and AIDS and incorporated responsibility for the management and supervision of the 'Three Cs' Policy. The UN Learning Team includes representatives from all UN offices and staff unions in the duty station, and people living with HIV. It reports directly to the Director General of UNON. The UN Learning Team's focus is implementation of the UN *Learning Strategy on HIV/AIDS* in the Workplace, a comprehensive strategy for building capacity of the UN and its staff to respond to HIV and AIDS.

The high level of representation on the UN Learning Team has been key to its success as an effective decision-making body for interagency planning and coordination of a workplace programme. In Kenya, the membership includes the UNAIDS Country Coordinator, UNDP Assistant and Deputy Resident Representatives, the Secretary to the Interagency Administrative Coordination Committee, Chief of the Facilities Management and Transportation Section (responsible for common services), Chief of the UNJMS, HIV technical officers, human resource, finance and administrative officers, the Staff Counsellor, a communications officer and representatives of staff associations.

The Kenya Interagency Administrative Coordination Committee is equivalent to an Operations Management Team. Discussions about HIV in the workplace by this interagency team benefit from the collective wisdom of an inter-disciplinary team.

The fact that senior staff members were selected as Learning Strategy Facilitators, and

that the two Learning Facilitators co-chair the UN Learning Team are identified as definite elements of best practice. When it was suggested that UNAIDS chair the UN Learning Team, the UNAIDS Country Coordinator took the position that in order for workplace mechanisms to be sustainable, it would be important *not* to create structural dependence on UNAIDS; hence, the Learning Facilitators were selected to co-chair the group. Another success factor is the insistence that every member have an alternate—a highly strategic move in a world as mobile as the UN.

The way UN Learning Team meetings are run is another success factor. Meetings are very well attended (even after eleven months of meeting every two weeks) because they are so effectively run: they are held to one hour, starting and finishing on time; an agenda, with items for decision-making at the top of the list is circulated in advance; minutes are taken, circulated and approved, with the effect that decisions are made and acted upon. Busy people do not have time for meetings that waste their time, so a definite best practice for maintaining interest is efficient management of processes.

Personal commitment and team chemistry have also been identified as determinants of success in this case. The UN Physician and the Chief of the Facilities Management and Transportation Section (one of the UN Learning Facilitators) have been outspoken and dynamic champions of the workplace programme, without whom, things may have turned out quite differently. But the UN Physician insists that the chemistry between senior and mid-level managers has been almost more decisive than the power of individual managers. "A couple of us are pretty pushy people with strong characters. If the senior managers had been threatened instead of challenged by us, there's no way we'd be where we are today.[31]" Strong and confident leadership from the top is unquestionably a success factor, as is the commitment to putting the greater good of the UN above individual and agency needs in addressing important issues facing the UN.

The first major activity undertaken by the UN Learning Team was a needs assessment of all UN staff on HIV. The survey recorded the highest staff participation of all UN duty stations, with 59% (more than 1500 responses) of the workforce participating. This success was achieved through the support of heads of agencies, staff association heads and staff association representatives who served as survey focal points. The survey results indicated that much work remains if UN staff members are to develop the knowledge and ability to cope with HIV in the workplace, so the UN Learning Team's next goal is to develop a training programme for the UN system.

To this end, the UN Learning Team has recruited a UN System Workplace HIV/AIDS Coordinator, whose role will be to prepare a detailed budget and work plan, to plan and organize training for focal points and peer educators, to disseminate UN policies, to conduct an education and information campaign, and to organize annual awareness events on HIV. The heads of agencies endorsed the proposal for this position at a Heads of Agencies Retreat in July 2004, and budgetary allocation for an initial nine-month position was approved at an Interagency Administrative Coordination Committee meeting in August. Justification for the appointment of the coordinator is related to the size of the UN mission in Kenya, the need to move quickly, and the reality that no staff member within the UN could possibly devote the time required to undertake the work needed.

[31] Conversation, Dr. Ling Kituyi, Chief Joint Medical Service, Nairobi, October 25, 2004.

Implementation of the education and information campaign will necessitate sharing of costs among all UN offices in Kenya, on a per capita basis. The budget for this campaign, including the costs of the coordinator, is estimated in the range of US$ 160 000, or approximately US$ 50 per staff member. The fact that the UN Learning Team has found ways to cover this expenditure is another example of how the team in Kenya makes bold decisions in the interest of doing the right thing. On the grounds that "if we wait until all of the ducks are in order, we'll never do it", the UN leadership in Kenya has simply taken the position that "it has to be done, so let's do it"[32]. For this reason, it has been suggested that the 'Three Cs' should refer to "care, courage and capacity"!

Other country teams may find inspiration in the decisive leadership that has characterized the Kenya workplace programme.

From Strength to Strength

Workplace programmes traditionally focused on raising awareness about HIV and on preventing transmission; facilitating access to AIDS treatment and care came later, with the advent of antiretroviral medicines. (In many cases, this sequencing can be counter-productive given that awareness raising generates demand for testing and treatment, but in the absence of facilities or referrals to such services, the incentive for coming forward to be tested may be diminished.[33])

Exceptionally, the interagency effort in Kenya has concentrated on getting its treatment and care policies and mechanisms right before it launches a wide-scale interagency communications strategy. This is not to say that UN agencies in Kenya have done nothing related to awareness raising and prevention, because for years, individual agencies have offered various HIV- and AIDS-related workshops and other activities; and several interagency activities, such as the Country Needs Assessment, briefings for senior managers, and World AIDS Day events, have been very much focused on information. The point is that the UN Learning Strategy on HIV and AIDS has been perfectly timed for Kenya. Having put in place its '3Cs' Policy and FAIRPACK policies, a system-wide education and information campaign will reinforce messages about prevention widely disseminating information about the One-stop Clinic, confidentiality mechanisms, the need to know one's status and the importance of initiating treatment as early as possible. It is anticipated that given such carefully designed access mechanisms, the UN's information campaign will lead to unprecedented levels of uptake—effectively going from strength to strength.

[32] Conversation with Kirstan Schoultz, UNAIDS Country Coordinator, wherein she paraphrased the position taken by Paul Andre de la Porte, Resident Coordinator and Resident Representative, October 21, 2004.

[33] Taken from various conversations with Tobias RinkedeWit, Director, PharmAccess, based on evidence his organization has gleaned from the monitoring of workplace programmes for the private sector in several African countries.

IV. RWANDA: an enabling environment and extraordinary initiative

The Rwanda case study is the story of the extraordinary efforts of a UN Dispensary to tackle HIV in the UN workplace. With support from the UN Country Team, the Dispensary staff systematically 'worked the system' to remove obstacles and to create the trust and other conditions necessary for increasing uptake of HIV testing and access to treatment.

An Enabling Environment

In 1998, when the then Dispensary Physician first started work at the UN Dispensary in Kigali, "every week there was a death"[34]. This may have been an exaggeration, but on a walk through the cemetery with the then Resident Representative, the UN Physician commented that unless something was done about AIDS, the two of them would be spending a lot of time at the cemetery. The Resident Representative pledged his full support, which is all the Dispensary Physician needed to hear.

At the time when the UN Physician was first discovering the magnitude of the problem in the UN Rwanda workplace, the national context was very different from what it is today. Antiretroviral medicines were not available on the market, laboratories were not equipped to test for HIV infection and local physicians had not had training in HIV testing and AIDS treatment.

In 1999, the *Programme national de lutte contre le sida* within the Rwandan Ministry of Health launched an aggressive strategy to deal with the problem. The Treatment and Research AIDS Centre within the Rwandan Ministry of Health was set up to establish the national protocol and to train and accredit medical professionals in counselling, testing and treatment; and the National AIDS Council was established to undertake country-wide awareness raising. The Government began to import and market antiretroviral medicines via a national pharmaceutical provider—albeit at a price that only those with means could afford—and the National HIV and AIDS Reference Laboratory (in Kigali) was equipped to perform HIV testing.

The Dispensary team took full advantage of the enabling environment provided by the Government of Rwanda, with tremendous results for the well-being of UN staff and their families. Five years later, HIV prevalence among adults in the 15–49-year-old range is estimated to be 5.1% (low estimate 3.4%; high estimate 7.4%)[35]. Antiretroviral medicines are available from government-run facilities and cost approximately US$ 60 per month for people with jobs in the formal economy, and are free for the unemployed or destitute[36].

Resourcefulness and Creative Solutions

In 1999, when CD4 testing and antiretroviral medicines first became available in Rwanda, the Dispensary moved quickly to facilitate UN staff access. Its initiative was supported at all levels of the organization. The UN Physician says that the encouragement and support she

[34] Interview, Dr. Maria Epee-Hernandez, Kigali, 14/09/04

[35] UNAIDS (2004). Report on the global AIDS epidemic: 4th global report. Geneva, 2004.

[36] US$ 60 per month is approximately 24% of the net monthly income of a UN staff member at the lowest grade on the salary scale.

received from the Resident Coordinator, the Heads of Agencies and from the UNJMS in Geneva was essential. "Without their support and encouragement, nothing would have happened."[37]

The Dispensary Physician did not use interagency mechanisms so much as she personally visited and appealed to each and every Head of Agency. Starting with the Resident Coordinator, she made the rounds. Arguing that the cost of laboratory tests was an impediment to HIV testing, she appealed for funds to equip the Dispensary laboratory, and she got them. She petitioned the individual agencies for buffer stocks of antiretroviral medicines. All of the relevant agencies agreed to pre-finance their own staff members' medicines. Although formal financing mechanisms for such things did not exist, somehow the agencies found creative ways to identify sources of funds, and the Physician set up a system for the Dispensary to settle claims directly with the insurance company. Some of these mechanisms are explored in detail below, but the point here is that the Dispensary staff did not allow the usual obstacles to treatment and care stop them. The staff members sought creative solutions for each, and through relentless advocacy, they won the individual and collective support of each member of the Country Team—with very good results.

Dr. Maria Epee-Hernandez knew that she could not afford to wait for direction from New York or Geneva – but more importantly, she discovered that *she did not need to wait*. Her supervisors applauded and supported her initiative at every step of the way.

The Dispensary Physician called all-staff meetings to personally present information about HIV. She appealed to the Staff Association to mobilize staff members to visit the Dispensary and to meet with her. She actively sought out staff with symptoms or risk factors and encouraged them to get tested. She did not let her own lack of HIV specialization stop her, nor did she wait for the UN to provide training for her. She asked the Ministry of Health for training, and got it. She was tireless.

The UN Physician nurtured her relationships with other doctors and medical professionals in the community. Regular contact and technical consultations paved the way for responsive service and consistent supplies. Her networking even led to other organizations adopting workplace programmes. The physician at the National Bank reports that as a result of the Dispensary Physician's influence, the Bank now has a workplace programme that is very closely modelled after the UN example. External networking was mutually beneficial. The UN Physician benefited from the technical support and consultations provided by her counterparts, and they benefited from their association with the UN.

But although the UN Dispensary Physician is the star of this particular case, she refuses to take all of the credit and emphasizes the importance of developing and retaining local staff. The Physician insists that national staff (particularly the nurse) were and still are indispensable to the workplace programme success. "She [the nurse] is a nurse, but she's not a nurse. She's everything. She *is* the Dispensary. "[38]

The Rwandan Government's proactive approach to HIV created an enabling environment within which a UN workplace programme *could* facilitate access. But without the

[37] Interview, Dr. Maria Epee-Hernandez, Kigali, 14/09/04.

[38] Ibid.

personal initiative of a few individuals, and the recognition of and support for that initiative on the part of the Country Team leadership, the enabling environment alone would certainly not have had such a positive impact on UN staff well being.

Buffer Stocks and Confidential Mechanisms

Very early on, the Dispensary Physician recognized that two of the biggest constraints to effective treatment were the cost of antiretroviral medicines—even for those on UN salaries—and ruptures in the supply line. So she designed a system whereby agency pre-financing of antiretroviral medicines ensured that staff would not have to be out of pocket, and whereby the Dispensary would have a reliable buffer stock at all times. This buffer stock system is an excellent practice in contexts where the supply of antiretroviral medicines is unreliable. Since 1999, most of the UN agencies in Rwanda have provided pre-financing for this buffer stock. The Dispensary tells each agency how many of its staff members are on antiretroviral treatment (without identifying staff members by name), each agency puts up the funds to buy a one-to-three-month stock for a given number of staff, and the Dispensary procures and dispenses the medicines.

Three-month buffer stocks of antiretroviral medications are supplied by UN agencies and stored in a locked cabinet in the UN Dispensary.

The fact that insurance coverage is not harmonized across UN agencies complicates the processing of claims to some extent, but the Rwanda Dispensary has worked out a system with which staff members are comfortable. When staff members pick up their antiretroviral medicines at the Dispensary, depending on which agency they work for, they either pay nothing on the spot or they pay 20% of the monthly cost of their treatment.

Until 2003, the Dispensary cleared the 80% portion of medical refund claims directly with the respective insurance companies on behalf of staff members. For those who had not paid 20% upon receipt of their antiretroviral medicines, the Dispensary certified the claims and sent them to the appointed "certifying officer" within each agency, who then arranged to withhold the 20% from staff members' salaries. (In some cases, the Dispensary even nominated the "certifying officer" within the agency in the interest of selecting certifying officers that HIV-positive staff members could trust.)

With the exception of UNDP and the smaller agencies that rely on UNDP for personnel administration, the buffer stock system is still in operation with only minor variations in the way the different agencies handle the processing of claims. Under this system, because the certifying officer within each agency is party to confidential medical information, confidentiality is less assured. But the buffer stocks and pre-financing are extremely effective means to mitigating against ruptures in supply and to support continuity in adherence to treatment.

In 2003, UNDP contracted GMC (La Garantie Médicale et Chirurgicale) Services to administer UNDP and UNDP-administered Medical Insurance Plan (MIP) claims for national staff globally. Under this new scheme, the Dispensary still procures and dispenses the medicines; staff members (from UNDP, UNESCO, UNFPA, UNAIDS, UNV, UNSECOOR, UNIFEM, FAO, WHO and the UN Dispensary) pay the Dispensary for their antiretroviral medicines, and then claim their refunds directly from GMC Services. Under this new system, confidentiality is

better assured, as no one within the agencies has anything to do with the claims. With the loss of advance-positioned stocks from UNDP and the smaller agencies, however, the workload for the Dispensary has increased considerably. It still stocks in advance, but cannot do so on a three-month agency-wide basis. Because staff members pick up and pay for their medicines on different schedules, the cash flow is more like a constant trickle, the Dispensary needs to do more trips to the national pharmaceutical provider, and the administrative workload has increased.

In addition to the extra workload for the Dispensary staff, there is a bigger issue. The kinks have not yet been worked out of the new claims procedure, and some HIV-positive staff members report that they are struggling to pre-finance the cost of their medicines. There is thus a potential threat to treatment adherence.

WFP, the WB, UNHCR, the IWCTR and UNICEF still provide for buffer stocks, and have developed a variety of mechanisms for recovering 20% from staff members' salaries and for processing refunds from Van Breda and other insurance carriers—all with reasonably good levels of confidentiality and no complaints from staff members. FAO and WHO do not provide buffer stocks. Their staff members pay directly to the UN Dispensary and process their own claims.

WFP's approach to buffer stocks is particularly effective. It provides the initial three-month supply of antiretroviral medicines for free. Staff members are not required to pay for their first three months' supply of antiretroviral medicines, yet first-time patients are issued receipts from the Dispensary when they pick up their medicines so that they may submit them to Van Breda and use the refunds to pre-finance their subsequent prescriptions. In other words, WFP has made it possible for its staff members to be permanently 'ahead' of their medical costs. In terms of best practice, WFP's solution is exemplary.

UN Day: An Opportunity to Promote HIV Awareness

In 2000 on UN Day (24 October), the Dispensary, with widespread assistance from most of the agencies, organized a health awareness day for all staff. The Dispensary's primary intention was to increase uptake of HIV testing so in addition to awareness raising videos, a theatre performance, publications and information flyers, the Dispensary Physician arranged for free and confidential HIV testing facilities to be available on the grounds of the UN compound. Out of the entire UN body (including family members), 93 people voluntarily tested. Other than the heads of agencies, who volunteered to be tested in order to set a good example, the majority of those tested were cleaners and guards employed by maintenance and security sub-contractors. Out of the 93 people tested, 12% were seropositive. Since that time, sub-contracted staff members in need of treatment pay 100% for the medicines they buy from the Dispensary, and the Dispensary provides all other services for free[39]. Using such events as opportunities to motivate more people to learn more about HIV is another best practice, as is the flexible treatment of UN subcontractors.

Stigmatization and Discrimination Reduced

In 1999, Anti-AIDS Clubs (*Les Clubs Anti-SIDA)* were springing up around Rwanda, and the Dispensary staff seized the opportunity to promote Anti-AIDS Clubs at the UN. In

[39] These sub-contractors are not counted in the 40 UN staff currently being treated by the Dispensary.

the initial stages, these voluntary clubs were effective at raising awareness about HIV prevention, testing and treatment. Anti-AIDS Clubs even raised voluntary contributions to assist staff members to meet the costs of their antiretroviral medicines. These clubs have been credited with reducing stigmatization and discrimination in Kigali (if not yet in rural areas) as well as within the UN workplace.

"There is no discrimination in UNDP because the managers understand…Still,
I do not want to disclose… It is enough that I can work now…
I can encourage others without telling them about my sickness."

Female staff member being treated at the UN Dispensary.

Like other initiatives that were so enthusiastically taken up in the early stages of the programme, Anti-AIDS Clubs have since become less active, both inside and outside of the UN. In any case, Anti-AIDS Clubs cannot take all of the credit for reducing stigmatization and discrimination. Sadly, in Rwanda, as elsewhere in sub-Saharan Africa, HIV and AIDS have become household words. Virtually everyone has lost family members, friends, colleagues and neighbours. In other words, no one has been unaffected, and having been so personally affected, few people feel inclined to shun or persecute others. In the case of the Rwandan workplace, this tragic situation has served a purpose. With time, more staff members are disclosing their status and the more they "come out", the less stigma is attached to the illness.

Trust in the UN Dispensary

Although access to treatment and care in Kigali has improved since the late 90s, conditions are not yet ideal—even in the capital. There are lengthy queues at national treatment facilities and little to no counselling is provided. In addition, because "everyone knows everyone in Kigali", staff members are more inclined to seek services at the UN Dispensary where confidentiality is better assured.

It is estimated that HIV-related work takes approximately 50% of Dispensary staff time. With one physician (on a UNV contract), one nurse, a lab technician, a paramedic and a driver, the Dispensary is currently following 54 HIV-positive staff members, 40 of whom are on antiretroviral medicines. Dispensary staff members are aware that many UN employees have not been tested, and that some individuals opt to be treated elsewhere, so these figures do not account for all infected staff members[40].

Although treatment is free for the poor and destitute and affordable for most Rwandans on a steady income, the UN team in Rwanda maintains that it is not yet time to phase out Dispensary HIV-related services. Providing services in-house is more conducive to increasing uptake and to facilitating consistent adherence to treatment, and therefore deemed to be appropriate in the context. The National Reference Laboratory meets WHO guidelines for HIV testing so all tests are processed there on a fee-for-service basis. Otherwise all HIV consultations, pre- and post-test counselling and treatment for opportunistic infections are done at the Dispensary for free. Staff on antiretroviral treatment buy their medications at the Dispensary on a monthly basis and are monitored by the Dispensary physician. If the patient is not able to pay for the viral load test, the UN Physician negotiates with the respective UN agency to obtain an advance payment for the patient so that the test can be done when indicated.

[40] Interview, UN Staff Physician Dr. Alpha Ousmane Diallo, 14/09/04.

As is the case throughout the UN system, insurance coverage expires when contracts end and/or when staff members leave employment with the UN. In Rwanda, vulnerability is made worse by the fact that ex-UN staff members are discriminated against by national health care workers on the grounds that they *were* employed by the UN and are therefore assumed to have means. The Dispensary facilitates the transition of these former patients by (i) making referrals and introductions to national or other programmes, and (ii) monitoring the initial stages of their care. This is an especially important best practice, given that treatment interruption is a leading cause of resistance to first-line regimes. This is also a good example of how the UN Dispensary in Rwanda goes beyond the call of duty.

When asked what has made the Rwanda workplace programme so successful, staff members (including those currently being treated for AIDS) list trust in the Dispensary staff, confidential systems, insurance coverage and the fact that the Dispensary is located off-site as success factors. Clearly, the compassion and commitment of the UN Dispensary staff, both past and present, have been key to the success of this case.

It bears emphasizing that while UN doctors and other international staff come and go, national staff members remain and provide the continuity between one administration and the next. Without their commitment, and without investment in them, workplace programmes would fall far short of their objective of making the UN workplace a safe and supportive place for staff affected or infected by HIV.

The Way Forward: Interagency Collaboration

The UN Development Assistance Framework prescribes structures and mechanisms for HIV and AIDS in the Workplace programme analysis, planning and implementation. The *HIV/AIDS and Reproductive Health/Health Theme Group (UN Theme Group on HIV/AIDS)*, made up of Heads of Agencies, is responsible for leadership and oversight of Workplace Programmes. The *HIV/AIDS and Reproductive Health/Health Task Force*, made up of the HIV/AIDS and RH/H focal points, is technically responsible for implementation of Workplace Programmes.

Although HIV and AIDS in the workplace are mentioned in the work plan of the UN Theme Group on HIV/AIDS, in Rwanda, both of these groups are largely focused on strengthening the national response. Perhaps because the Dispensary so single-handedly tackled workplace issues, the impression is that this is the UN Dispensary's responsibility—which it is, but not wholly. While HIV-positive staff members who know that they are seropositive may be seeking and receiving appropriate treatment at the Dispensary, the UN agencies in Rwanda must not lose sight of the countless others who do not know their status. Indeed, the danger of a programme's success being so largely a function of one team's initiative is that systemic mainstreaming can end up being neglected. In order to reach all staff with consistent and compelling messages about HIV prevention and the value of HIV testing and counselling, a concerted interagency effort is required.

V. CAMBODIA: a prevention-to-care continuum linked to sustainable local services

The Cambodia UN System workplace programme works on a prevention-to-care continuum linked to sustainable local services. This case study is a good example of best practice in prevention through interagency collaboration and systematic investment in a peer education programme. It highlights the need to understand the national context and to consider the various options available to meet the HIV-related needs of employees and their families and then to adapt the workplace programme in response to the environment and these needs.

Changing National Trends in the Epidemic

Responding to high HIV prevalence

Cambodia has the highest HIV prevalence in the Asia-Pacific region. The first HIV case was detected in 1991, and the first AIDS case was diagnosed in 1993.[41] By 1998, prevalence among sex workers had reached 42.6%,[42] and new HIV infections among Cambodian men were rapidly accelerating. Private labs were doing testing and specimen analysis without counselling, and only a few hospitals in Phnom Penh were reliable sources for antiretroviral treatment.

Since then, the Cambodian Government has taken an aggressive approach to AIDS through its *Continuum of Care* framework. The National Centre for HIV/AIDS, Dermatology and STD (the National Centre) is its implementation body, and the National AIDS Authority its policy maker and coordinating body.

Examples of developments are:

- the National Centre is training medical workers;
- ever-increasing numbers of nongovernmental organizations are becoming involved in the sector;
- reasonably good HIV testing and counselling services are in place;
- medicines bought by the National Centre comply with WHO protocol, and cost in the range of US$ 30 a month[43];
- condoms are available and cheap on the market; and
- a number of nongovernmental organizations and hospitals also provide free services[44].

Impact of condom campaigns

Nationwide, a 100% *Condom Use Programme* was implemented, along with massive information campaigns and peer education with select client groups. These have been successful in increasing condom use and in decreasing the number of men visiting sex workers. These

[41] Government of Cambodia (2002).*Report on HIV Sentinel Surveillance in Cambodia 2002* Ministry of Health, National Centre for HIV/AIDS, Dermatology and STD.

[42] Ibid.

[43] US$ 30 is about 23% of the net monthly income of the lowest paid staff member on the UN Cambodia salary scale.

[44] However, hospitals that offer free treatment use a lottery system and accept only 10 new patients a day.

behavioural changes have had the effect of driving down the rate of new HIV infections for men and sex workers.

For other women, unfortunately, the situation is quite different. The number of new HIV infections in women has not declined as rapidly as the number of new infections in men. This is because:

- Cambodian women are primarily infected by husbands who may be current or past clients of sex workers;
- condom use between husbands and wives is relatively rare; and
- there is usually a time gap in husband-to-wife transmission between the time the husband becomes infected and infection is actually transmitted.

A context of stigma, discrimination, poverty and low literacy

Although the Cambodian epidemic is clearly not only 'sex worker'-focused, public perceptions often make this link. As a result, stigma and discrimination are very high.

As in other countries, cultural factors contribute to high stigma and discrimination. In Cambodian society, talking about sex or other private issues, especially among colleagues, is not seen as appropriate.

Stigma and discrimination around HIV continue to be high against background high levels of poverty and low levels of literacy. Responses to the epidemic need to be conscious of the Cambodian national context and demonstrate creativity in meeting changing needs within this environment.

Adapting the UN Workplace Programme to the National Context

The report from the Access, Care, Treatment and Inter-Organizational Needs (A.C.T.I.O.N) mission in June 2002 describes serious shortcomings in the existing UN workplace programme:

- lack of interagency collaboration;
- reactive rather than proactive decision-making;
- inconsistent awareness about the health care rights and benefits due to staff;
- lack of technical depth at the UN Dispensary; and
- allegations about lack of confidentiality and transparency.

When the current Dispensary Physician arrived in 2003, it was not yet clear what role the UN Dispensary should play in responding to HIV. The Dispensary Physician conducted a needs assessment with all the UN agencies. Responses pointed to a need for more health education, with a priority focus on HIV.

Early information and education steps

Following the assessment, information sessions and other activities were planned, but participation was poor. The only consistent access to staff was through one-on-one medical consultations. The Dispensary Physician approached the UNAIDS Secretariat for support and together they agreed that the UN Technical Working Group on HIV and AIDS (the Technical Working Group) needed to be involved[45].

In July 2003, at a meeting of the UN Theme Group on HIV and AIDS (the Theme Group)[46], a set of activities was proposed, including lunch hour information sessions and a question-and-answer box at the UN Dispensary. A representative of the United Nations Population Fund (UNFPA) made a presentation on HIV and the UN workplace. Heads of UN agencies agreed that peer educators could spend two hours every month on work related to HIV in the UN workplace.

Towards a more effective workplace programme

Based on these initiatives and the A.C.T.I.O.N concept paper, the Technical Working Group drafted a plan to be presented to the Theme Group. In September 2003, the *Interagency Initiative: HIV/AIDS in the UN Workplace in Cambodia* was approved.

The plan aimed to achieve the following.

- Ensure that all UN staff and family members would be able to make informed decisions to protect themselves from HIV.
- Ensure that if UN staff and family were living with or affected by HIV they would know where to access care and treatment, and how to protect themselves from discrimination.
- Emphasize the need to develop a clear set of guidelines for handling HIV in the UN workplace.
- Emphasize the need to review existing rights, benefits, policies and procedures.

The Technical Working Group asked for recommendations from people involved in the *Greater Involvement of People Living with and Affected by HIV and AIDS (GIPA) Project*[47] in compiling and validating an inventory of care and treatment resources, and then arranged for WHO to review the list.

Referring staff to services outside the UN

The Theme Group decided that it would be in the long-term interests of UN staff to be referred to services outside the UN. At the same time, the UN would build partnerships and work out contractual arrangements so that staff would have reliable access to treatment. If their contracts ended, the external health care facility would continue to provide comprehensive treatment at no or little cost.

The thinking was that the approach to refer staff would:

- ensure confidentiality and privacy;
- provide access to a wider range of service providers;
- provide access to comprehensive care and not just antiretrovirals;
- provide access to comprehensive treatment after the contractual period;
- strengthen partnerships; and
- strengthen the health-care system.

[45] The UN Technical Working Group on HIV and AIDS is made up of focal points within UNAIDS co-sponsoring agencies.

[46] The UN Theme Group on HIV and AIDS is the key mechanism for joint UN action and coordination of HIV/AIDS-related activities, and is made up of Heads of UNAIDS co-sponsors and other interested agencies.

[47] The *Greater Involvement of People Living with and Affected by HIV and AIDS Project* is funded by UNV, UNAIDS and UNDP. The GIPA Project aims to promote the GIPA Principle – the leadership and greater involvement of people living with and affected by HIV and AIDS in HIV/AIDS policies, programmes and practices.

Deciding not to build the treatment capacity of the UN's Dispensary

When the Dispensary Physician made a case for training dispensary staff in HIV counselling, care and treatment, this sparked a discussion about whether the UN should build its capacity to provide the full range of HIV-related services. The Theme Group decided that it would not be appropriate to build the treatment capacity of the UN Dispensary.

There were several reasons for this decision.

- The number of patients would not support the development of a comprehensive HIV care system by the UN.
- The UN Dispensary was positioned to deliver comprehensive care that would include appropriate counselling, confidential testing, systematic buying of medicines, monitoring of patients, providing psychosocial support through access to support groups, and providing links to other related facilities.
- Without investment in comprehensive care, the UN Dispensary would, at best, have only been able to hand out antiretrovirals—this would not have been in line with national treatment guidelines.
- At the time, the UN Dispensary's physical layout was not conducive to a confidential care system.
- The contracting system in the UN in Cambodia has large numbers of staff on short-term contracts—they are thus not entitled to health care benefits or may not be entitled to benefits when their contracts end. An examination of the possibility of long-term care for staff that serve for a year or less showed that no agency was prepared to take on providing long-term treatment for ex-staff and their families.
- A range of affordable or free HIV testing, counselling and treatment services was emerging in Phnom Penh.

The UN Dispensary stopped buying and administering antiretroviral therapy. However, the Dispensary Physician continued to provide pre-test counselling and to encourage and support staff wishing to find out their HIV status. A part-time laboratory technician takes blood tests and brings specimens to the Pasteur Institute for analysis. The physician receives the results, and in reviewing them with staff members, provides post-test counselling and referrals for people who test HIV positive.

Ensuring the continuation of care

In integrating and utilizing existing health services, the UN in Cambodia hopes to strengthen accessibility, acceptability and quality of health services, and to assure that there is a continuation of care even when staff members are no longer UN employees.

At the same time, staff and ex-staff, who were previously receiving only antiretrovirals from the UN Dispensary, are now being enrolled in comprehensive care programmes. These include psychosocial support, access to in-patient care and social support services.

Peer education to lessen fear and stigma

People within the UN system recognized that continuing fear and stigma were contributing to:

- staff members being unwilling to openly discuss HIV;

- staff members being hesitant to share information with the UN Dispensary or with UN employing agencies; and
- information about HIV and prevention not being made available to UN staff members.

To address these issues, the UN introduced an intensive peer education-based approach, led by peer educators and based on information needs identified by staff.

Dr Tin Tin Saw, Nurse Ottie Bleakly, Mr Suthy, the UN Dispensary driver and peer educator, and Ms Srey Tuth, receptionist, standing outside the UN Dispensary with a World AIDS Day poster, on 1 December 2004.

Interagency Collaboration

Interagency structures and links

The UN Theme Group is the key structure responsible for joint UN action and coordination of HIV-related activities.

The UN Technical Working Group reports to the Theme Group and is responsible for technical assistance to AIDS programmes. Members of the Technical Working Group come from:

- Medical services
- Human resources
- Programme staff
- Staff associations
- Peer educators.

In Cambodia, the terms of reference for the Theme Group and the Technical Working Group do not specifically mention responsibility for HIV in the workplace, but the two groups are united and coordinated in their efforts to lead and support action in the UN system workplace. The Interagency Initiative is a standing item on the regular agendas of the Technical Working Group and the Interagency Administrative Working Group[48], where decisions are recorded and action items followed up.

Efforts are now system-wide and collaborative. The Interagency Administrative Working Group meets regularly and feeds human resource, financial and administrative issues to the Technical Working Group. Using interagency channels, the UN Dispensary, peer educators, focal points, human resource officers and staff associations discuss issues and present recommendations to the Theme Group for decisions.

Making collaboration work

The high level of commitment and the strategic and formal use of interagency structures are widely considered as success factors and an element of best practice in the Cambodian workplace programme experience. A valuable side effect of the interagency collaboration on the HIV workplace programme has been the stimulation of interagency work on other issues.

[48] The Interagency Administrative Working Group is a forum regularly attended by finance, human resource and administrative officers.

Within these interagency efforts, the UNAIDS Secretariat has carved out a relevant and widely appreciated role for itself. As both advocate and implementer, UNAIDS has settled into an effective role as catalyst, technical adviser and facilitator. For example, UNAIDS:

- makes sure that issues are tabled and discussed;
- identifies technical resources within and outside of the UN; and
- generally marshals the workplace flow of events.

Staff associations have also been playing a strategic role. They are regularly represented at interagency meetings, and have encouraged staff to take part in surveys developed by peer educators. While peer educators play a role in bringing concerns to the attention of HIV and AIDS focal points, the staff associations' role is to bring these concerns to the attention of management.

Capacity-building of Peer Educators

Developing peer educators across agencies

The Technical Working Group established criteria for the selection of peer educators, and began to select peer educators from within each agency. A Training of Trainers team was identified, materials selected, and a capacity-building plan was developed.

From then on, the workplace programme has systematically and effectively invested in the capacity of its peer educators and other stakeholders in the programme.

This capacity-building programme provides excellent examples of best practice, as highlighted in Table 1.

Geeta Sethi, UNAIDS Country Coordinator, and Shizuka Nakamura, Associate Professional Officer, have established a key role for UNAIDS within the UN workplace programme in Cambodia.

Table 1: Best practice in workplace capacity-building in Cambodian UN workplace programme

Date	Best practice
March 2004	After the training of peer educators, constant follow-up and clarification are essential aspects of successful peer education. An on-line network link among peer educators and with the training team was established. Informal and regular communications with each other and with specialists allow peer educators to obtain needed information and to be responsive to their colleagues.
April 2004	The National Centre for HIV/AIDS, Dermatology and STD delivered an update on HIV and AIDS in Cambodia for the Theme Group, the Technical Working Group and peer educators. Keeping management informed and up-to-date is an excellent way to ensure continued support.
May 2004	An orientation on HIV testing and counselling was organized for peer educators, followed by a field visit to testing sites. Over 20 people from 13 agencies participated. A facilitated discussion about the experience allowed stakeholders to process what they had learnt. Field visits effectively reinforce traditional training methodologies.
June 2004	UNICEF/UNESCO provided all peer educators with information, education and communication materials about HIV testing and counselling. One agency's resources can easily be used to benefit all in this kind of interagency initiative.
July 2004	At their request, a meeting was held to familiarize peer educators with home-based care. Two experts from nongovernmental organizations talked about home-based care and how to make referrals. A person living with HIV spoke about peer support systems. Home-based care and peer support are frequently neglected in workplace programmes, but have been valuable elements of peer educator capacity-building in Cambodia.
Sept 2004	In collaboration with the Interagency Administrative Working Group, the WHO Representative and a UNICEF human resources officer facilitated training on confidentiality for human resource managers and peer educators. The aim of the training was more informed decision-making and more collaborative solutions for HIV-related administrative issues.
Oct 2004	Peer educators conducted training on the basics of HIV in selected provinces for UN staff members and their families. Bringing the workplace programme to provinces helps to address the needs of staff in remote places.
Nov 2004	The Theme Group plans to provide support to the National AIDS Authority to launch a similar peer education project with its member ministries. The UN workplace programme thus acts as a model, a technical resource and an advocate for workplace programmes outside of the UN.

Source - Update: Action against HIV/AIDS in the UN Workplace

Commitment to making a deeper impact

The UN team in Cambodia recognizes that the value of its workplace programme is directly related to the investment it makes in the training and continuing education of peer educators and members of its Theme Group and Technical Working Group. This systematic approach to developing capacity produces benefits including the following.

- Strengthening peer educators' ability to disseminate accurate and effective messages about HIV.
- Deepening the commitment of peer educators and management to the programme.
- In time, developing creative ways of overcoming challenges such as achieving the increased involvement of people living with and affected by HIV from within the UN workplace.

Significantly, the UN's peer educator model is being adapted and used by Cambodia's National AIDS Authority.

Creative Initiatives

Facilitating access for ex-staff members

In consultation with the Dispensary Physician, the UN Theme Group decided that, although it was unsustainable to continue to treat ex-staff members, they should be assisted in every way possible in their transition to external service providers. The Technical Working Group is actively involved in negotiations to ensure that ex-staff members continue to receive treatment when they are no longer with the UN.

With one nongovernmental partner, UN staff members are registered under the *payment for services* category, because they are not considered 'poor' by Cambodian standards. The agreement is that the staff member will be absorbed into the *free drugs and non-payment* scheme:

- after one year, or
- when the staff member is no longer a UN employee.

The UN is also discussing the idea of negotiating concessionary insurance premiums with local insurance companies for staff members who leave the UN. These initiatives are good examples of creative attempts to solve insurance coverage issues.

An interagency workplace programme fund

Early on in the workplace planning process, the Theme Group proposed that each agency contribute to a workplace fund that would cover expenses related to workplace programming, such as workshops or producing materials. All but one agency agreed to contribute.

In the end, this joint fund has not had to be tapped, as in-kind contributions (for example, of specialists or transport) have been made available by agencies or partners, and because the team has not yet exhausted a small fund provided by the A.C.T.I.O.N project. In principle, however, agencies have agreed to find the money to contribute to this fund when the need arises.

Information, education and communication strategies

When the Cambodia Country Team had the UNAIDS booklet, *Living in a World with HIV and AIDS* translated, they took advantage of the opportunity to adapt it to the Cambodian context. This included inserting information about locally available services and the UN Cambodia Post-exposure Prophylaxis Treatment (PEP) protocol. Disseminating country-specific information while promoting the UN booklet as a valuable source of information is an excellent interagency initiative. The Theme Group is planning to do the same with the new edition.

Creative and far-reaching communication methods include the following.

- Disseminating the UN booklet and other materials through agency-led trainings, as well as on request from UNAIDS.
- Distributing taped messages and music produced by UNICEF to UN drivers for playing while travelling.
- Providing peer educators with regular, in-depth materials on new developments, and handouts for presentations.
- Ensuring heads of agencies receive all materials, as well as briefings on activities and issues.

Information and education activities are wide-ranging and varied, such as:

- discussions around medical ethics and the principle of confidentiality;
- seminars on new epidemiological data and their implications for HIV programmes;
- field visits; and
- sexuality communication trainings.

These activities ensure that different levels of staff are exposed to information that is interesting and relevant to them. Peer educator training and materials in Khmer ensure maximum participation of local service staff.

In summary, the Cambodian workplace programme successfully uses a variety of different distribution channels and networks for different materials, depending on content and the audience.

Sharing initiatives and responsibility

UNDP peer educators plan to hold awareness-raising workshops in the provinces for UNDP staff and the staff of other agencies, including cleaners, drivers and other sub-contracted service providers. UNICEF was implementing its *Caring for Us Programme* before the inter-agency efforts began in Cambodia, but has since agreed to participate in interagency events. Likewise, WFP and UNFPA had begun their own workplace programmes, but have decided to collaborate with interagency efforts.

UNESCO has effectively taken responsibility for developing information, education and communication materials for the whole family of agencies, and the UNAIDS Secretariat is responsible for disseminating materials.

These examples of collaboration are the kind of integrated system-wide approach called for by the 2001 United Nations General Assembly Special Session on HIV/AIDS (UNGASS).

Challenges

Access to treatment and care in remote places

The UN has projects in 23 of the 24 provinces in Cambodia. Their mobility and distance from home make these project staff members particularly vulnerable. They are less aware about the availability of HIV services, and programmes that promote prevention may fall short of those offered in the capital city. The UN Technical Working Group on HIV/AIDS has not yet compiled an inventory of service providers outside of Phnom Penh, but plans to do so, with help from persons associated with the *Greater Involvement of People Living With and Affected by HIV and AIDS Project*.

Monitoring and evaluation

The Cambodian workplace programme is known for its interagency planning, decision-making and record keeping, and for its strategic investment in its peer educators. But it is less clear how this planning and capacity-building is consistently being translated into action within or across UN agencies.

For example, although some peer educators have begun to disseminate information in their workplaces, it is not clear whether or how peer education activities are being monitored. It is still too early to say whether the initiative is having an impact on increasing testing and treatment, or on sustainable behaviour change.

VI. Experience in other sectors

As part of the research for this study, the author interviewed private sector organizations in Rwanda, Cambodia and Kenya. The approaches and results of four organizations' HIV programmes, as well as the conclusions of a recent UNAIDS study on best practices in the private sector and a recent WFP study on lessons learned in transport sector HIV programmes, demonstrate that the UN can learn from its partners, and vice versa. Salient features of each of these programmes or studies are thus summarized below.

Bralirwa Brewery in Rwanda

Bralirwa Brewery, a subsidiary of Heineken with 3000 workers in Rwanda, was selected by Heineken to pilot an HIV programme for its workplace. Carefully designed and monitored by PharmAccess, a Netherlands-based nongovernmental organization, the programme has established some important good practices.

- The staff physician reports that leadership and support from the senior management at Heineken Netherlands and Bralirwa Rwanda have been absolutely crucial to the success of the programme.
- In the interest of ensuring confidentiality and generating confidence in the programme, all medical staff members sign agreements that stipulate that breaches of confidentiality may constitute grounds for dismissal.
- The staff physician takes part in bi-monthly conference calls with staff physicians in other countries. They help each other to identify solutions to unusual or difficult cases. This form of technical support for staff physicians has proved invaluable. (The UN Staff Physician would be welcome to join the Heineken conference network.)
- Anonymous voluntary saliva testing at a "Family Day Picnic" yielded very useful information about levels of infection amongst different categories of staff and family members, which the physician is now using to sustain management support for the programme, and to target affected categories with messages about testing.

A cost-effectiveness analysis comparing absenteeism, hospitalization costs and mortality rates before and after the introduction of the programme has demonstrated that a workplace programme is "…absolutely cheaper than just letting people die and treating opportunistic infections" [49].

ILO and UNAIDS Support the Private Sector in Cambodia

ILO and UNAIDS are playing important roles in promoting and supporting workplace programmes in the private sector in Cambodia. With US Department of Labour funding, the ILO is assisting the development of workplace policies within the brewery and hotel industries.

In partnership with a local nongovernmental organization, one Cambodian brewery[50] is implementing a truly dynamic programme for its workers. In addition to awareness raising and referrals, the brewery has also initiated vocational training and a savings scheme for its 'beer promotion girls'.

[49] Interview, Dr. Ngendahimana Gerard, Bralirwa Brewery, Kigali, 15/09/04.

[50] This brewery asked not to be identified.

During an interview at the brewery, the Managing Director pointed to one of his bartenders, who had been trained in tailoring as part of the vocational training programme. The Managing Director said:
"Look at her. Since her training in tailoring, she has been making clothing for all of the girls. See the gold on her arm? Now that she has skills, she won't need to prostitute herself."

The promising thing about this partnership, however, is the multiplier effect. Having successfully launched his own programme, the Managing Director is now encouraging other companies to adopt workplace programmes by hosting groups of 20 companies at a time and promoting the concept of 'socially responsible employment'. His dream is to become the first company in Cambodia that proactively hires HIV-positive people.

Barclays Bank in Kenya

The Global Business Council has recently voted the Barclays-Africa Workplace HIV/AIDS Policy among the 10 best HIV workplace programmes. A couple of features make the Barclays policy exceptional. One is the requirement that before launching the Africa policy in each country, the policy has to be tailored to the local context. The Staff Welfare Officer at each national headquarters researches the parameters of the epidemic, and the labour legislation and other country-specific factors that will have implications for a workplace programme. She or he then tailors the policy to fit the context.

The Barclays Kenya policy provides for monitoring of adherence to treatment: the Staff Welfare Officer receives periodic reports from the service provider that include the staff member's code number, the treatment protocol, the treatment cost, the entry date, the initial CD4 and viral load counts, the latest CD4 and viral load counts, plus comments about compliance. In this way, Barclays can monitor the quality and responsiveness of its service providers. Barclays is also monitoring the human resource, administrative and financial implications of its HIV policy.

Finally, Barclays' policy is explicit about entering into consortiums with other employers and supporting other agencies to counter HIVAIDS by sharing information and best practice.

The Kenya Ports Authority

The Kenya Ports Authority is a parastatal in which the Kenyan Government owns the majority of shares. Kenya Ports Authority is expected to make a profit for the Government as well as for its other shareholders, so when it became apparent that AIDS was having a negative impact on the organization's profits, the Chief Medical Officer at the Kenya Ports Authority took measures to change the situation. In the initial stages, it was hard to get her superiors to understand that investment in an HIV programme would save the company money, so she carefully documented the impacts, and in 1999, managed to convince senior management to support the programme. She says that winning the support of senior management was the major breakthrough.

Since then, through careful monitoring and tracking of indicators, the Kenya Ports Authority workplace programme has recorded impressive outcomes: decreases in absenteeism, sick leave and compassionate leave; reduced morbidity and mortality; increased productivity;

reduction in medical bills and terminal benefits; low rates of opportunistic infections and subsequent hospital admissions; improved workforce morale; a better corporate image; and importantly, "almost no staff declining VCT"[51].

Barclays' policy goes considerably beyond the UN personnel policy on HIV in the workplace, including provision for standards that may be instructive for the UN. The UN could learn from the monitoring and evaluation frameworks established by Bralirwa and the Kenya Ports Authority, to gather the data with which to sustain management support for HIV workplace programming.

Best Practices in the Transport Sector

Because members of mobile populations, specifically long-haul truck drivers and sex workers, have been identified as highly vulnerable to HIV infection, and because WFP is in a unique organizational position to reach truck drivers, porters and dock workers with comprehensive HIV-related information, WFP recently commissioned a study to identify best practices in the transport and port sectors[52]. While WFP contract workers technically are not WFP employees, their well-being is of concern to WFP. Having examined examples of current transport interventions in southern Africa, the study makes a number of recommendations. Many are very specific to the transport sector, but others are equally relevant to UN workplace programmes.

Comprehensive training: HIV awareness-raising must be comprehensive; that is, it must include prevention and HIV-related treatment, care and support information, including information on sexually-transmitted infections as well as on tuberculosis and other opportunistic infections, and emphasis on personal risk of HIV infection. "Emphasizing the 'wellness' approach commonly being used regarding health insurance, care and prevention is a very positive overarching umbrella under which to position HIV-related topics."

Rights-based approach: Emphasizing each person's human right to health information and health care will foster individual health-seeking behaviour and community norms of care and support. Involving a person living with HIV in the programme helps to sensitize participants to the realities of living with HIV.

Gender Sensitivity: Focusing on gender, sexual abuse and sexual exploitation in regard to HIV will help men and women to affect social evolution, decrease transmission of HIV, and better understand the needs for HIV prevention, care and support.

Family Focus: Particularly with staff members who are posted away from home, prevention messages should take a family focus, emphasizing the importance of keeping one's family in mind when travelling away from home.

This WFP study of best practices in the transport sector is the first step in a process to create Guidance Notes for WFP transport-sector HIV projects.

[51] KPA Power Point Presentation, October 25, 2004.

[52] O'Grady M. (2004) *HIV/AIDS Transmission and the Transport and Port Sectors in Sub-Saharan Africa*. Second Draft submitted to WFP on 27/08/04.

UNAIDS Case Study on Best Practices in the Private Sector

UNAIDS has recently published *Access to treatment in the private sector workplace* a case study on best practices in the private sector. Some of the lessons learned are well worth noting. It is especially interesting to note that all three of the companies surveyed[53] conclude that leadership from the top is vital if major initiatives for change are to be successful. According to the Chief Executive Officer of BHP Billiton, HIV has to be one of business leader's five or six key priorities.

Another finding is that the investment in workplace programmes is money well spent. "The issue is the business case. I never forget we're running a business… The provision of antiretroviral therapy and other care and support … nearly doubles the capacity of (people living with HIV and AIDS) to continue working. So there is no debate about costs/benefits"[54].

Prevention is still essential, but as the past 15 or more years have shown, it is not enough to change behaviour. A core concept of Anglo American's HIV strategy is that "treatment is the single short-term intervention that will make a difference to the way the epidemic unfolds, both in the workplace and in the communities within which we operate"[55].

"Access to (antiretroviral treatment) may be the best prevention tool available, and a significant way of eliminating stigma and discrimination. Increased access to treatment is one of the most powerful incentives to find out one's HIV status, as well as a concrete demonstration that a company cares about its workforce and (is against) stigmatising people…"

UNAIDS Access to Treatment in the private sector workplace quoting Brian Brink at Anglo American (Senior Vice President, Medical Services)

Conversely, treatment is not an alternative to prevention programmes. "However high the prevalence rate, the majority of workers are still negative and need to be supported to stay that way. Treatment must always be part of a comprehensive HIV/AIDS workplace programme"[56].

Other key findings include the following.

- Workers fear stigma from their colleagues more than discrimination by their employers in the workplace.
- Partnership is essential, with government (national and local), with civil society organizations, with other corporations and with unions. Partnership prevents having to re-invent the wheel.
- Monitoring has to be ongoing and intense.
- One cannot start early enough on HIV but it is never too late to start.

[53] Anglo American, one of the world's largest mining and natural resources groups; BHP Billiton, the largest metal and mining conglomerate in the world; and Eskom, a public company wholly owned by the South African government, that generates, transmits and distributes electricity.

[54] Vanderberg A. BHP Billiton, UNAIDS Access to treatment in the private sector workplace.

[55] UNAIDS *Access to Treatment in the private sector workplace*, Geneva.

[56] Ibid.

VII. Key elements of best practice

This study identified numerous elements of good practice that are discussed in the four case studies. We highlight these eight key elements of best practice:

- The power of leadership.
- Trust, confidentiality and respect.
- Bold and precedent-setting policy reform.
- Structured multidisciplinary mechanisms and system-wide applications.
- Adapting to the context.
- Strategic use of resources.
- Investing in key role players.
- Providing condoms in the workplace.

The Power of Leadership

When asked about the most important determinant of success in workplace programmes, the response from people involved in these case studies and in the private sector was that, without leadership and support from senior management, workplace programmes would not get past the starting point.

Central to the success of each of these four case studies has been the support and encouragement from headquarters, resident coordinators, heads of agencies, UN Dispensary physicians and committed individuals at the middle management level.

Personal charisma, volunteerism and systems are important elements, but without strong, confident leadership, workplace programmes cannot take the bold steps required to challenge existing conditions. This message was so loud and so clear — workplace programmes that are failing to thrive almost certainly have a lack of leadership at the top.

Trust, Confidentiality and Respect

Developing confidentiality in the face of stigma

Because AIDS is often related to sexuality, illness and death – private and sensitive topics in any culture – the HIV epidemic has led to stigma and discrimination. Although this is the very opposite of UN personnel policy, people fear that if they disclose their HIV status, they will be ridiculed or marginalized by co-workers, or their contracts will not be renewed. If staff do not trust that confidentiality is absolute, they are unlikely to seek HIV testing or access to treatment.

Where trust and confidentiality are at their best, such as in Rwanda and Kenya, they have been hard-won through policy and procedural reform, and consistent professional integrity.

- In Rwanda, storing medical records in locked cabinets and designating one trustworthy individual to handle claims within each agency help staff to trust that their HIV status will not become public knowledge.
- In Kenya, direct billing mechanisms, nameless identity cards and 100% coverage of treatment mean that agencies do not have to withhold the out-of-pocket 20% of the cost of treatment from staff members' salaries. In other words, outside of the UNJMS, no one in the agencies has any reason to see medical claims.

Overcoming the cycle of fear and cultural barriers

Fear persists even where workplace programmes have taken measures to protect confidentiality and where staff living with HIV, who are using the UN Dispensary, are confident and satisfied with the service, such as in Ethiopia. Extreme measures, creative solutions and consistent information about confidentiality systems are critical to engendering the kind of trust that is needed to break the cycle of fear.

Culture and HIV prevalence rates were also found to be influential factors. In Cambodia, where talking about sex and illness are especially taboo, no staff member is living openly with HIV and thus there was no one available to be interviewed by the research team. Where the culture or context so strongly discourages disclosure, it is an especially good practice to involve people living with HIV as resource people. This was done in Cambodia and Ethiopia in keeping with the GIPA Principle (the greater involvement of people living with HIV and AIDS).

In all of these case studies, there is an overwhelming sense that the staff members integrally involved in pushing for workplace programmes have genuine respect for their colleagues and care what happens to them. Respect and caring are thus fundamental attributes of workplace programmes that should be very actively encouraged.

Bold and Precedent-setting Policy Reform

The programmes that seem to be having the most dramatic impact on the uptake of treatment are those that do not wait for direction or approval from above. The Kenyan duty station has access to sophisticated medical services, but it is policy reform that has enabled it to take advantage of the resources that makes the Kenyan case study so extraordinary. Kenya's *Three Cs* and *FAIRPACK* policies are examples of best practice. The leaders simply took the position that, if they waited for headquarters to make decisions, they would wait forever. Where others were reluctant to take risks, the Kenyan team went forward because they were confident that they were doing the right thing.

Likewise, the UN Dispensary Physician in Rwanda did not wait until the interagency mechanisms were in place. Instead, she used relentless advocacy to convince the heads of agencies, one at a time, to pre-finance buffer stocks of antiretrovirals, and thus secure the programme against shortcomings in the system.

Identifying and responding to resource weaknesses

HIV and AIDS have served to expose many weaknesses in the UN's human resource systems. When the lack of medical benefits for Kenya's sub-contracted workers was exposed publicly, the team quickly resolved the weaknesses in its sub-contracting provisions. Kenya's old sub-contracting practices were not unique to Kenya, so its experience could serve as a wake-up call for other duty stations.

Workplace programmes are in a unique position to identify gaps in human resource policies and to advocate for political and procedural reform. In WFP's workplace strategy paper, the point is made that advocacy strategies need to:

"…influence decision-making about policy creation or reform [and] effective implementation and enforcement …[without being] belligerent or confrontational, but rather [by seeking] to build consensus by educating senior management about how sound policies can effectively mitigate the impacts of HIV on staff and on the workplace"[57].

Structured Multidisciplinary Mechanisms and System-wide Applications

Including high-level and multidisciplinary people

Ensuring that HIV competence and workplace programmes are institutionalised is both a key element and a challenge. Workplace programme committees should include high-level and multidisciplinary members. While the responsibility for workplace policy is best placed within human resource offices with the close involvement of medical services, HIV is not strictly a personnel or medical issue.

A multidisciplinary approach ensures that the full range of issues get tabled and discussed, and that relevant divisions of the organization are involved in their solutions. A strong workplace programme can thus, for example, involve:

- communications people;
- HIV technical officers;
- counsellors;
- finance officers;
- staff associations.; and
- women's associations.

In Ethiopia, the UN Workplace Education and Care Programme Task Force, with a designated secretariat and clear roles, has been highly effective in:

- planning for and building the capacity of peer educators;
- establishing a Benevolent Fund for UN staff;
- fundraising; and
- influencing the priorities of the Country Team's Implementation Support Plan to coordinate and guide interagency efforts to support national HIV efforts.

Investing in structures and systems for planning and monitoring

It is a worthwhile investment to take the time to put structures and systems in place for workplace programme planning and monitoring. In Cambodia, preliminary efforts stalled until the UN Theme Group on HIV and AIDS, the UN Technical Working Group on HIV and AIDS and the Interagency Administrative Working Group got involved.

Today, the Cambodian programme is dynamic, the workplace is a standing item on all groups' agendas, roles are clear, and all are united and coordinated in their efforts to lead

[57] Rand, J. (2004) *Agents of change: Conceptual Framework for Programme Design and Implementation*. WFP HIV/AIDS in the Workplace Strategy Paper (Long Version) WFP, October 2004, p18.

and support an interagency programme. As a result, decisions about workplace activities are consultative and well informed. A welcome side effect of the Cambodian programme is that, as a result of the interagency mechanisms, human resources, administration and finance officers report that they are also starting to meet and collaborate more effectively on issues that are not linked to HIV.

Interagency and *system-wide* are the key terms.

Interagency approaches engender commitment to putting the greater good of the UN system above individual and agency needs in addressing important issues.

System-wide applications:

- allow all agencies, funds and programmes to benefit from communication campaigns;
- ensure consistency in methodologies and information; and
- are more cost-effective.

Adapting to the Context

Being flexible within the limits of the national environment

Differences in culture, national policy frameworks, HIV prevalence and the availability of resources between countries mean that there can be no 'one-size-fits-all' programme. In some countries in sub-Saharan Africa, where HIV prevalence is high, where HIV is primarily heterosexually transmitted, and where virtually no one has been unaffected, more and more people are living openly with HIV.

In these contexts, certain methodologies, such as facilitated discussions about sexuality and in-house support groups, are more possible than they are in Cambodia, for example. There, the average person has had little or no experience with people living openly with HIV, and talking about sex in a work context has traditionally been taboo. The universal best practice of involving people living with HIV in workplace programmes becomes an even bigger priority in places such as Cambodia, where interacting with people living positively with HIV can help greatly to break down fear and stigma.

Wall hanging made for the Ethiopia workplace programme. It is very important that communication methods and materials are culturally sensitive and translated into local languages.

Planners of workplace programmes must thus be closely tuned in to the national context, including up-to-date awareness of government policy changes and lessons being learnt by other organizations. They must also be responsive to new developments in the scientific field.

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Programme managers must be aware of constant changes in the WHO treatment protocol and in the availability of antiretrovirals.

Adapting best practices

The best practices identified in these case studies can be adapted in all contexts, for example:

- Rwanda's and Kenya's administrative and human resource systems that protect confidentiality;
- Ethiopia's carefully mapped out capacity-building programme for peer educators; and
- Cambodia's involvement of persons living with HIV in compiling a resource inventory.

Kenya's *FAIRPACK* policy, that makes medical insurance coverage a requirement for all sub-contractors, may need adapting to local labour law, but would certainly be appropriate wherever the UN works.

Kenya's *Three Cs* policy depends on the availability of an integrated one-stop-clinic and direct billing mechanisms. This may not be possible in contexts where medical resources are less sophisticated. So, just as development programmers must adapt their project designs to local contexts, so must workplace programme planners.

Strategic Use of Resources

The strategic use of internal and external resources was identified as a success factor in all four case studies.

Drawing on the range of UN resources

The breadth and depth of experience across the family of UN agencies means an available stream of internal experts in medicine, human resource policy, programme planning, monitoring and evaluation, communications, facilitation, training, and community development.

While not always possible, much of the programme planning and monitoring can be done by interagency and multidisciplinary teams as in these examples.

- Kenya's resource inventory sub-committee drew on the assistance of in-house experts in counselling, home-based care, medicine, child welfare and many others to compile and vet the list of care and treatment resources.
- Cambodia asked the WHO to validate and approve its inventory listings.
- The UN Women's Association has been integrally involved in extending the Ethiopian programme's outreach to family members, with a particular emphasis on youth. Various staff associations have been instrumental in developing a Benevolent Fund for staff on antiretroviral treatment.

Wisely turning to external resources

Recognizing when it would be wiser to use external resources is also part of this best practice. When antiretrovirals and reliable testing and treatment facilities became available in Cambodia, the management decided that referring externally would be better than investing in

in-house capacity. When the Kenyan team realized that quickly rolling out a communications programme would be beyond its resources, the agencies agreed to cost-share a full-time coordinator for that pivotal nine-month period in the programme's history.

Networking and professional consultation with counterparts outside of the UN has also proved to be mutually beneficial. In Rwanda, maintaining strong networking with service providers outside of the UN provided the staff physician with much-needed technical consultation and support. It also allowed the UN workplace model to influence the establishment of a similar model in the private sector.

Investing in Key Role Players

Investing in peer education and other initiatives

Committees, peer educators, medical personnel, HIV and AIDS focal points, human resource officers and staff associations need to be equipped for their roles in workplace programmes. They need to be educated about HIV, and helped to carry out their roles in protecting and promoting workers' rights.

The team found excellent evidence that this is happening. For example, the Cambodian team realizes that its peer education programme will only be effective if its peer educators are comprehensively prepared to participate. Elements of the programme that can easily be copied elsewhere are its schedule of creative training events, including site visits and informal communication methods.

Peer educators at a training session in Cambodia. The Cambodian team realizes that its peer education programme will only be effective if its peer educators are very well trained.

Ethiopia has also invested soundly in its peer educators, including organizing an event to showcase the work they do and thank them for their contribution.

The Rwanda case study demonstrated that, without the commitment of and continuity provided by national staff, and without appropriate investment in them, workplace programmes would fall far short of their objectives.

Investing in human resource and other training

The 2005 work plan of the UN *Learning Strategy* includes identifying approaches to and developing materials for training of human resource and other managers. Managers are expected to have abilities related to key issues such as information technology and gender sensitivity — in other words, in areas outside of their technical specialization.

Similarly, to have the capacity to cope with HIV in the workplace, UN managers need to keep up with and be aware of factors such as:

- recent advances in HIV research;
- the financial implications of HIV on their organization;
- HIV workplace issues and the cost-benefits of workplace programming; and
- UN policies and practices on HIV.

It is especially important to sensitize managers to the need for 'zero tolerance' if workplace programmes hope to eliminate stigma and discrimination in the workplace.[58]

Both male and female condoms are available in all washrooms in UN offices in Kigali, Rwanda

Providing Condoms in the Workplace

One of the minimum standards agreed in the UN's *Learning Strategy* is to ensure that there are condom demonstrations for both male and female condoms. All four case studies have emphasized condom demonstrations in their training programmes and have made condoms available in toilets, in medical services offices and in other places where staff feel comfortable to confidentially help themselves.

It is important that *both* male and female condoms are introduced, and that access to female condoms is facilitated. Female condoms are generally harder to find, and in some contexts less acceptable culturally. However, because they empower women, it is vital that UN agencies break down these barriers to their accessibility and use.

[58] See Barnett, T. & A. Whiteside (2002) *AIDS in the Twenty-first Century: Disease and Globalization;* Palgrave Macmillan, UK; and UNAIDS (2002). *The private sector responds to the epidemic; Debswana—a global benchmark*, UNAIDS Best Practice Collection, September 2002, for more details about institutional audits and managers' competencies.

VIII. The challenges

We focus on four key challenges cutting across the four case studies.

- Promoting HIV testing and counselling.
- Preventing the development of drug resistance.
- Facilitating access in remote places.
- Monitoring and evaluating for impact, and understanding the cost-benefits of investment in workplace programmes.

Promoting HIV Testing and Counselling

Prioritizing access to testing and treatment

Increasing the number of people who come forward for HIV counselling and testing and who obtain access to treatment should be a primary objective of all workplace programmes. Yet with only one exception, the UN workplace programmes reviewed in the four case studies are not promoting testing. All of the UN medical professionals interviewed encourage and promote testing in one-on-one consultations. Knowledge of serostatus has formed part of some training and awareness-raising events.

What is needed as a priority strategy in all workplace programmes is:

- regular campaigning to promote the advantages of knowledge of HIV serostatus, and
- clear communications about the commitment of employers.

In promoting HIV counselling and testing, the private sector is ahead of the UN. Previously, because of concerns about stigma, discrimination and lack of access to treatment, testing was not universally recommended. Today, the private sector is adopting a more aggressive testing strategy that shifts from *voluntary testing to routine offers of testing with an opt-out possibility*. Where workplace policies used to stress "the right *not* to know", they are now emphasizing "the right to know"[59]. This is particularly important in contexts such as those of our four case studies, marked by high levels of poverty and low levels of literacy.

UNAIDS/WHO policy directives

The *UNAIDS/WHO Policy Statement on HIV Testing* asserts that:

"Among the interventions which play a pivotal role both in treatment and in prevention, HIV testing and counselling stands out as paramount"[60].

Unfortunately, fear of stigma and discrimination is preventing millions of people, who are probably HIV positive, from being tested. Thus, the *Policy Statement* goes on to say:

"The cornerstones of HIV testing scale-up must include improved protection from stigma and discrimination as well as assured access to integrated prevention, treatment and care services"[61].

[59] Email correspondence, Dirk van Hove, UNAIDS Country Coordinator, 15/11/04.

[60] UNAIDS (2004) *UNAIDS/WHO Policy Statement on HIV Testing*.

[61] Ibid.

The impact of affordable antiretrovirals

People also fear knowing their status because a positive diagnosis has traditionally been seen as a death sentence. Today, with the increase in affordable antiretroviral medicines, a key message of all workplace programmes should be that knowing your HIV status early could mean the difference between life and death.

Information campaigns focusing on basic facts and prevention messages have had a notable impact on general awareness about HIV. But now information campaigns need to go into more specific detail on key issues such as:

- facts about the stages and progression of HIV infection;
- antiretroviral treatment;
- the advantages of knowing your HIV status before 'rescue therapy' is needed;
- the importance of treatment adherence; and
- the implications of treatment failure.

The *UNAIDS/WHO Policy Statement on HIV Testing* emphasizes that mandatory testing is counterproductive and is therefore not advised. The *Policy Statement* does highlight *provider-initiated* approaches in clinical settings. While the primary model for HIV testing has been providing *client-initiated* counselling and testing, more and more health care providers are routinely initiating an offer of HIV testing in a setting that guarantees providing effective prevention and treatment services, or at least referring people to these services. Routine offers of testing must include the '3Cs' of informed consent, confidentiality and counselling. It should include referral to medical and psychosocial care for those found to be HIV-positive. It should always include the explicit right to refuse or defer testing without consequences for other medical treatment or employment.

Preventing the Development of Drug Resistance

Predictions suggest that the cost of providing HIV-related treatment in the workplace will increase hugely in the years ahead because:

- many people who are currently living with HIV, but not yet clinically in need of treatment, will progress to AIDS; and
- a variety of conditions are contributing to the development of drug resistance and treatment failure.

Trends in drug resistance

In developed countries, the rate of drug resistance is relatively stable at around 15%. In low- and middle-income countries, possible increases in the development of drug resistance to higher rates are expected. The following points are major concerns.

- Without consistent and affordable health care, patients may self-prescribe, share medicines with others, self-medicate, or start and stop treatment.
- With discontinuation of treatment, there is an increased chance for developing resistance, and thus negatively affecting the effectiveness of antiretrovirals when resuming treatment.
- Resistance to antiretrovirals will develop during multiple cycles of starting and stopping therapy.

As a result of these concerns, people are strongly advised to use antiretrovirals as prescribed, and not to interrupt or stop their treatment.

Cost implications of drug resistance and treatment failure

Drug resistance and treatment failure has large cost implications:

- first-line regimens have come down in price and are more affordable in many countries;
- second- and third-line regimens are still very expensive; and
- the more staff experience treatment failure (e.g. because they start and stop treatment repeatedly), the more staff and family members will need to progress to second- and third-line regimens—this will result in much higher costs of health care for the organization.

The monthly cost of the first-line regimen in the four countries studied ranges from 22% to 27% of net income for a staff member in the lowest grade on the UN salary scale. Even with insurance coverage for 80% of the cost, affordability can be a very real deterrent to treatment adherence. This is especially true for staff members who support more than one family member on treatment.

As these case studies have shown, workplace programmes need to explore creative and sometimes exceptional means to ease the financial burden. Good examples are:

- the UN Kenya *Three Cs* policy of 100% reimbursement for HIV-related medical expenses; and
- the Ethiopia Health Care Clinic's assistance to staff to apply for waivers of the 20% out-of-pocket expense on the basis of 'catastrophic illness'.

MONTHLY COST OF ANTIRETROVIRALS AS PERCENTAGE OF INCOME

Country	Monthly US$ cost of antiretrovirals	Net monthly income (US$) of lowest salary grade (GS1)	Monthly cost of antiretrovirals as % of monthly income
	30	133	23%
Ethiopia	61	231	27%
Kenya	60	269	22%
Rwanda	49	204	24%

Key policy issues

Among the more challenging policy issues that may play a role in contributing to drug resistance are:

- non-coverage of family members;
- inappropriate use of short-term contracts;
- the 20% out-of-pocket expense (especially for those with dependents on treatment);
- lack of access in remote places; and
- lack of a 'continuum-of-care' after leaving the UN.

Drug resistance is a complicated issue; organizational policy-makers need to understand the medical complexities of antiretroviral treatment. They have to ensure that organizational policy and practice minimizes the consequences of drug resistance. For example:

- staff associations need to be proactive in tabling policy issues;
- senior policy-makers need to understand the uniqueness of HIV, and the need for exceptional steps to maximize access to care and treatment; and
- UN clinics and peer educators have a key role to play in providing adherence support and counselling.

Facilitating Access in Remote Places

Responding to high mobility of UN staff

The high mobility of some UN workers may increase their likelihood of exposure to HIV.

"Being away from home, or for some being more or less permanently on the move, tends to provoke high-risk sexual behaviours, including high rates of sex partner change… Freed from the strictures of their home communities, they may engage in risk behaviours they would not practice at home…The spouses of members of…highly mobile population groups have been known for 15 years or more to be at much higher risk of HIV infection than the norm, despite the monogamy many of them practice themselves.[62] "

UN staff members have special needs in emergency contexts and in remote sub-offices where treatment and care facilities are non-existent or very basic. Entry medicals for staff being posted to remote places are performed at the UN Dispensary or Clinic, but afterwards their medical needs are less consistently attended to by UN medical facilities. For members of staff who are able to access rest and recuperation, transport and leave, attending to medical needs on a regular basis is possible. For others, treatment and care options are often limited.

Opportunities for action

The challenges are to:

- build capacity (e.g. through peer educators or workplace focal points) in remote places at the same time as the programme is launched at country headquarters;
- establish inventories of care and treatment resources in remote places, or alternative access solutions, as early as possible in workplace programme cycles; and
- identify and build the capacity of medical professionals in the vicinity of each remote office.

[62] O'Grady, Mary (2004) *HIV/AIDS Transmission and the Transport and Port Sectors in Sub-Saharan Africa*, Second Draft Submitted to WFP, 27/08/04.

Monitoring and Evaluating for Impact, and Understanding the Cost-Benefits of Investment in Workplace Programmes

Over the past 10 years or so, the development community has been coming to grips with the need to monitor and evaluate its programmes for impact. HIV in the workplace programmes are no different. Without consistent monitoring and regular evaluation, it is impossible to know what works and what doesn't, and whether continued expenditure is justified or being well directed.

ILO indicators

The ILO has recently completed its publication *Indicators to monitor the implementation and impact of HIV/AIDS workplace policies and programmes*. This covers a range of indicators to assess whether the organization has a programme, and whether that programme has appropriate features. For example, it includes indicators on:

- the development and implementation of appropriate policy;
- increased availability and use of prevention, care and support services;
- improved knowledge and attitudes to reduce risk behaviour which increases risk of HIV exposure; and
- reduced stigma and discrimination.

However, to date the UN is not systematically or routinely tracking trends such as:

- decreases in absenteeism, sick leave and compassionate leave;
- reduced morbidity and mortality;
- increased productivity;
- reduction in medical bills and terminal benefits;
- rates of opportunistic infections and subsequent hospital admissions;
- improved workforce morale;
- a better corporate social image; and
- increases in HIV testing and access to treatment.

These are the kinds of results that can be used to convince managers to invest or to continue to invest in these programmes.

Pointers from the private sector

In some ways, the private sector is ahead of the UN in HIV workplace policy and workplace programme monitoring and evaluation. People tend to dismiss this as related to the fact that the private sector is profit-oriented and can afford it. However, aggressive private sector programming in the workplace is a clue that spending on workplace programming is cheaper in the long-run than ignoring the challenges posed by HIV.

Workplace programme managers need to compile data and to develop a well-documented advocacy platform for workplace expenditure on HIV programming. This can be used to persuade senior management and to advocate for donors to allow allocating programme funds to HIV workplace programmes as a legitimate expenditure.

Annex

The UN System HIV-positive Staff Group

In 2005, some UN staff members living with HIV formed an informal group to give voice to issues affecting those living with HIV and working within the UN system. The group has received support and encouragement from the UNAIDS Executive Director and senior colleagues working in Human Resources and other departments who can help improve working conditions for those living with HIV.

More formally the goals of the group include:

- contributing to the development or improvement of policies relating to HIV within the UN system;
- helping to create an enabling environment in the workplace for all HIV-positive members of staff regardless of their disclosure of HIV status; and
- being an organized and effective voice for people living with HIV that may especially challenge stigmatization and discrimination.

The group has set up a UNAIDS-based e-workspace to provide a platform for communication and discussion of issues, based upon the personal experiences of people living with HIV within UN system organizations. Issues to be covered will be determined by the interests and contributions of group members. Current topics include: workplace policy issues; mobility and travel restrictions; staff rules and regulations (including health insurance); recruitment processes; and general experiences of living with HIV and being a member of UN staff. The group is exploring different ways to ask for inputs while respecting individual boundaries around status disclosure. The Group recognizes the important contributions that affected individuals (for example staff members with partners or other family members living with HIV) can make. They too have support needs and other issues which they may wish to raise. The HIV-positive Staff Group therefore encourages contributions from the widest possible circle of concerned or affected individuals, their friends and colleagues. The views of the group will be summarized regularly and opinions and decisions will be communicated to the Human Resources department of UNAIDS and other agencies as appropriate.

Links to join the e-workspace and contact addresses of Group members may be found on the UNAIDS website **www.unaids.org** .

The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together ten UN agencies in a common effort to fight the epidemic: the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children's Fund (UNICEF), the World Food Programme (WFP), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Office on Drugs and Crime (UNODC), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO), and the World Bank.

UNAIDS, as a cosponsored programme, unites the responses to the epidemic of its ten cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV/AIDS on all fronts. UNAIDS works with a broad range of partners – governmental and nongovernmental, business, scientific and lay – to share knowledge, skills and best practices across boundaries.

Produced with environment-friendly materials

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- is a series of information materials from UNAIDS that promote learning, share experience and empower people and partners (people living with HIV/AIDS, affected communities, civil society, governments, the private sector and international organizations) engaged in an expanded response to the HIV/AIDS epidemic and its impact;
- provides a voice to those working to combat the epidemic and mitigate its effects;
- provides information about what has worked in specific settings, for the benefit of others facing similar challenges;
- fills a gap in key policy and programmatic areas by providing technical and strategic guidance as well as state-of-the-art knowledge on prevention, care and impact- alleviation in multiple settings;
- aims at stimulating new initiatives in the interest of scaling up the country-level response to the HIV/AIDS epidemic; and
- is a UNAIDS interagency effort in partnership with other organizations and parties.

Find out more about the Best Practice Collection and other UNAIDS publications from www.unaids.org. Readers are encouraged to send their comments and suggestions to the UNAIDS Secretariat in care of the Best Practice Manager, UNAIDS, 20 avenue Appia, 1211 Geneva 27, Switzerland.

Prevention, Treatment and Care for UN Employees and their Families

Facilitating access to HIV-related treatment and care may be the single-most effective tool available to workplace programmes. Awareness raising and prevention continue to be essential; but reliable access to treatment provides the incentive to find out one's HIV status, and knowing one's status is the key to living positively and productively with HIV.

This Best Practice Case Study captures lessons learned, keys to success, and challenges that must be met if there is to be optimal access to treatment and care for UN staff and their dependents. It describes UN workplace programmes in Cambodia, Ethiopia, Kenya and Rwanda where multi-disciplinary teams are discovering the power of leadership and the value of multi-disciplinary interagency approaches.

These cases show that where trust and confidentiality are at their best, they have been hard-won through policy and procedural reform and consistent professional integrity. Workplace programmes are in a unique position to identify gaps in human resource policies and to advocate for political and procedural reform. The more successful programmes make bold decisions in the interest of doing the right thing. Strategic use of internal resources is a success factor—but so is recognizing when it would be wiser to use external resources. Finally, these cases illustrate that the UN has to invest in and equip staff members for their roles vis-à-vis workplace programmes.

This report is aimed at senior managers, policy makers, medical personnel, human resources officers, technical working groups, peer educators, HIV and AIDS focal points and staff associations—in short, at anyone (within or outside of the UN) who is responsible for designing or implementing HIV and AIDS in the workplace programmes.

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