FINAL REPORT

Cross-Country Study of the ILO/USDOL HIV/AIDS Workplace Education Program Strategic HIV/AIDS Responses in Enterprises (SHARE)

Prepared for the U.S. Department of Labor

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EXECUTIVE SUMMARY

I. Scope and Purpose of the Study

This study of SHARE, Strategic HIV/AIDS Responses in Enterprises, was jointly conceived by the International Labour Organization (ILO) and the United States Department of Labor (USDOL) to gather insights into the project and to inform future programming. The following target countries were selected based on availability of sufficient data, global geographic dispersion, and prevalence (both low and high) in the target countries: Barbados, Benin, Botswana, Cambodia, and India. Except for Botswana and India, and to some extent Cambodia, most companies participating in this multi-country study had very little actual experience with workers who had AIDS, but all of the governments involved rightly perceive the vulnerabilities of segments of their population to HIV infection.

The two-person study team used a combination of methods to ensure a thorough and well-rounded understanding of how each country's experiences, with nuances and modifications, could be carried out. The team worked in India, Cambodia, and Thailand; and in Barbados, Benin, Botswana, Geneva, the Caribbean, and Washington, DC. The approach involved document review, background interviews, and field visits, which included in-depth interviews, individual and small group discussions, and observation. The types of stakeholders interviewed included current and former project staff, government and NGO personnel at the national and provincial/state levels, workers' organizations and individual enterprises, as well as networks of people living with HIV (PLHIV). The purpose was to study the project linkages to existing national policies and frameworks, as well as the effectiveness and degree of implementation of project materials.

II. Main Findings and Conclusions

The outcome of the ILO/USDOL SHARE project demonstrates that an effective government response to HIV in the world of work should be characterized by a tripartite structure (involving ministries of Labor, and employer and worker organizations) with an ability to reach workers and mobilize enterprises for the prevention of HIV. Effectiveness is further enhanced by the multiplier effect of this approach, with the positive impact filtering through to families and communities.

This study finds that SHARE is a project well worth the investment, as it provides examples and strategies useful to address HIV in workplaces. Its design responds to the complexity of the AIDS phenomena with a set of sequential interventions to address stigma and discrimination, build capacities at several levels, and alter risky practices. A methodical approach was matched by excellent personnel who took full advantage of opportunities to enlarge the scope of action and increase impact. HIV is not merely a health problem, but also a social and labor problem, which naturally makes it a workplace issue, and in turn, a development issue. The project was able to address the problems and achieve its objectives using creative and innovative approaches. SHARE identified effective ways to address the problems and reach objectives within the budget allocated.

The project tapped into a broad range of ways to integrate HIV-awareness into the workplace: many of which, at least in the target countries, had not been utilized before. The project benefitted from the flexibility offered by not being tied to a rigid logical framework. There was no evidence of superfluous and inefficient spending or resources. There was also no evidence that saving money resulted in shabby materials. Behavior Change Communication (BCC) materials were durable and usually appropriate for the audience. The tools of the project are numerous and valuable. These strategies and tools are entirely appropriate for replication; either as is, or with appropriate modifications. In fact, the project—exactly as it was implemented—has much to lend to the world of development practice, and it would be a shame to

see other projects start from scratch when components such as the BCC Toolkit and some of the graphic materials have already shown to be effective.

Key Strengths of the Project

Positioning the project in the workplaces; building on the ILO's particular strengths and position; supporting the ILO's tripartite constituency, and extending the activities to a body of supporting players. The SHARE Model components, including the results-oriented Project Advisory Board and its role in national-level policy advocacy; the specially-designed and well-received Behavior Change Communication methodology, the creation of Workplace Policies, and HIV committees added to the list of valuable interventions. Other features of the program that were done well were most aspects of monitoring and evaluation, and the enterprise-based data collection. It is also worth acknowledging the efforts and achievements of the project in the informal economy. Finally, the project strategy utilized human capital and built capacity among various levels of stakeholders. The capacity of enterprises was strengthened through the education gleaned, the services made available, and the increased solidarity and understanding between management and workers. Focal Points and Peer Educators gained new skills and knowledge. The tripartite constituency was strengthened in many ways as well.

Workplaces

The strategy of locating the project in the workplaces, both formal and informal, is highly appropriate. The effectiveness of developing committees including managers and representatives from different staff categories and AIDS policies does much to advance the understanding and involvement of personnel around AIDS issues. Further, it promotes a more productive workplace because of the inherent aspects of building multi-level understanding, communication styles, and respect in general, which potentially creates a more open environment.

The capstone of the project was the strength that emerged in workplaces. Enterprises, through managers and workers, recognized the responsibility that they had to address HIV and AIDS in the locus of economic productivity in their society. The workplace is a central meeting place for a majority of the adult population and provides a perfect place to educate and serve society. As the primary employers in rural communities, safari resorts, and urban centers, the enterprises represent a gathering of community members. They are often leaders in their communities.

The establishment of committees, and open discussion and development of guidelines and policies, plus activities designed to address specific workplaces, empowered workers at all levels. In the beginning, many workplaces lacked guidelines and committees, but by the end of the project nearly every participating workplace had a policy, a committee, focal points, and peer educators.

ILO's Professional Approach

As the international agency dedicated to the World of Work, the ILO brings a presence to the project that local or international NGOs do not have. The relationship with governments and the credibility that it has with its tripartite constituents is significant and for the most part unfailing. For some employers and workers, it was the first time they had been involved in an ILO technical cooperation project, but the technical assistance and support that was made available through the National Project Coordinators (NPC) caused them to become aware of the agency and appreciate its strengths.

The Program Management Team (PMT), based in Geneva, is small enough to not lose focus. It is evident that there is a lot of information sharing, and a desire to improve the project. The division of country responsibility is in question as some staffers have a greater load than others. More field visits, brief and

with careful agendas, would probably enhance the project for many reasons, although the autonomy of NPCs should remain at its current level. Clearly the PMT holds the field staff in deservedly high regard, and does not interfere in routine administrative issues.[1] That autonomy builds the presence of the NPC in the country and further strengthens the project.

Project leadership must also be acknowledged as a key factor of the success of the project. The time taken for project design, with the aid of competent and thoughtful individuals from ILO and other consulting organizations, was essential to creating a strong base. The professional approach to recruiting and hiring resulted in "Champions" running the project, and high administrative standards.[2] In less populated countries, those implicated in the project were important movers and shakers, and that in and of itself was an accomplishment. Typically, leaders are stretched and must set priorities. For SHARE, people gave time and energy, and lent their well-known names to be associated publicly with the project in Cambodia, Barbados, Benin, and Botswana. This helped the tripartite constituency movement and the ILO. In India, the immense size of the country means every task may be lost and seem insignificant. That the project was noticed and garnered respect is noteworthy, and is due for the most part to the in-country leadership and the ILO's credibility.

The project staff commitment clearly extends from a dedication to better working conditions and fighting HIV and AIDS, to ensuring that the programs are competently run from a management perspective. There was no evidence of superfluous and inefficient spending or resources. There was no apparent evidence of underlying management problems or personnel issues in offices. The NPCs could use additional support administratively, particularly from the point of view of resources needed to function: Sitting in a darkened office in Benin without the benefit of a supplementary generator taxes even the most resourceful NPC.

The ILO Code of Practice on HIV in the World of Work was cited for its influence in keeping a strong project focus by employers, human resource staff, focal points, peer educators, as well as by national-level AIDS commission staff, international and national NGOs leaders, AIDS practitioners, in addition to tripartite constituents. The Code provides a set of guidelines to address the HIV epidemic in the world of work and within the framework of the promotion of decent work. The guidelines cover HIV prevention; management and mitigation of the impact of HIV on the world of work; care and support of workers infected and affected by HIV; and elimination of stigma and discrimination on the basis of real or perceived HIV status. The Code was used by nearly every workplace as a guide to either formulate workplace policies or revise existing ones. According to those interviewed in the tripartite constituency, the ILO's visibility and support has resulted in widespread credibility for the organization.

Tripartite Constituency

Again and again, project participants identified the tripartite constituency structure as one of the key elements of success for the project. For tripartite constituents of the ILO, this was taken for granted as a necessary component. However, most if not all of the tripartite constituents have never been engaged in a tripartite constituency project in which there was so much accord. Usually, explained one of the trade unionists in Benin, "…we are in opposition with one or the other of our tripartite constituents. In this case, we were in agreement on the problem and we were able to use the tools of the ILO to fight HIV."[3] For those involved who were outside the ILO's traditional tripartite constituency, the approach was considered extremely innovative. For those unfamiliar with the tripartite constituency, such as traditional

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[1] See pages 16-17.
[2] See Annex 3, The Champion Concept.
[3] Interview with representatives of Confédération Syndicale des Travailleurs du Bénin (CSTB) Tuesday, June 24th.

development NGOs; AIDS activists; and government officials in health, commerce, or tourism, it was welcomed as offering a solid framework within which to operate a project.

While activities of one form or another concerning HIV in the workplace were not unheard of in most of the countries studied when the project began, the Labor Ministries were often sidelined. By centering the project in the Ministry of Labor, creating the Project Advisory Board (PAB), and channeling all activities through the tripartite constituency system, the project invigorated ministry staff, including the higher-level authorities. The project did not bring huge amounts of financial or capital resources to the Ministries, but the training for labor inspectors and the enrichment to authorities helped build their capabilities.

Ministries of Labor are often empowered through their relationship with the ILO. Technological and material resources, assistance in advocating for policies, and training and capacity building are not unusual activities that characterize the relationship between ILO and labor ministries. In this instance, these and other resources were available. Ministries of Labor are used to working with the ILO on national legislation, often basing it on international conventions. Here, the activity towards incorporating the key principles of the ILO Code of Practice into legislation or national policy and workplace structures reached out to a larger constituency. The harmonization of relations among the tripartite constituency, as mentioned, contributed to achieving a broader agreement.

Enterprises, through their involvement with employer organizations as tripartite constituents, reported being empowered in ways not normally encountered. The benefits, if not immediately apparent at sign on, became evident later. Trade unions and workers' organizations were empowered because their memberships received upgrading and the workers profited. On the shop floor, the peer educators gained a tremendous amount in terms of knowledge, respect, and leadership experience. Some of the focal points and peer educators were more educated than others, but in this instance, the body of stakeholders at these two levels received information and skills that surpassed their normal routines. Even nurses and doctors who were focal points and peer educators learned more about an insidious infection and disease, and how to address it in the workplace. All of the stakeholders were exposed to complex concepts about human behavior and how it can be changed.

Addressing the National Policy and Legal Framework

The project included bolstering current law reform efforts and met with some success. Addressing National Policy and influencing and bringing about legislation are never easy, but the PABs were influential in affecting policy in some manner in every country included in the study. Each country was at a slightly different stage of addressing HIV and AIDS from a national policy standpoint. When the project began in Barbados, a declarative code on HIV had already been established by the social partners of workers and employers, and the Prime Minister had expressed support for workplaces to address PLHIV, a situation which helped open the door for more policy advocating on the part of the project. In Benin, the project was responsible for a Tripartite Declaration and clearly influenced the passage of the law, complete with a chapter on HIV in the workplace. Cambodia benefited from a labor ministerial decree to include requiring workplace HIV committees. In all of the countries studied (and reportedly in other SHARE countries as well), PAB members continue to be engaged, and remain among a growing group of national advocates.

Laws and policies, including ministerial decrees such as the prakas in Cambodia, can result in monumental change in countries where political transparency exists, or even where it purports to exist. As daunting as affecting national policy may be, and as lengthy a process as it may be, meaningful policies on HIV/ADIS in the workplace are important. The key players, such as PAB members and other tripartite

constituents, usually recognize this. In places where there is political will, this is an area where more time and money would effectively be used.

The SHARE Model

The model provides an effective overall approach to improving the situation with regard to HIV and AIDS in the world of work. Strict adherence to the model should not preclude opportunities to mainstream attention to HIV in a large range of settings. The India project is a good example of how such opportunities can be seized to reach more workers in all categories. In the Caribbean and Cambodia, the project also identified suitable openings to reach the informal economy.

The model is replicable. Although every country makes the case for how they can and must be flexible in the face of the model, accounting for cultural or political factors, the methodology is practical. For the time allotted, much has been accomplished. If the model is carried into other workplaces—the informal as well as the formal—each component of the model needs to be studied separately and its relevance to replication in each situation and country determined. The model is a template, with each step an opportunity to be adapted according to the norms, economic structure, and cultures of the society. Usually this adaptability meant creating woven tapestries as educational materials in one country and posting condom use reminder stickers on factory helmets in another. Elsewhere, it meant supporting the post of a state AIDS Commission worker. Both actions are justified by the objectives.

Several Components of the SHARE Model Had Particular Value

1. The **Project Advisory Board** worked unusually well in all of the countries studied. The representative Board was conspicuously involved in national level concerns, such as advocating for sound policies. Further, it offered expertise and position through individual members when needed; for example, on appropriate sectoral targets. It weighed in on smaller concerns as well, such as approving visual materials without becoming so involved in details as to lose focus or waste time. The activities were enough to maintain a highly motivated oversight body, visible enough to strengthen personal and professional credibility, and rich enough to build capabilities in the AIDS arena in particular.

2. The **Behavior Change Communication** methodology was the foundation of the workplace intervention, and it generally excited and inspired stakeholders. The strategy was effective in that it brought personnel together and identified aspects that are unique to each workplace. Staff was engaged in educating and being educated with their co-workers around a central and life-changing theme. The Behavior Change Communication process is an area where there has been a degree of willingness to experiment. Since the first workshop, the BCC Toolkit has been put forth as a 'work in progress'; before it existed, India was experimenting with ways to take traditional methods of Information, Education, and Communication (IEC) further along. The project has been adamant that the process is more than IEC, and this has confused some consultants, trainers, and practitioners, and made others ebullient.

   Also noteworthy of the workplace BCC project implementation were the design and creation of high-grade materials and appropriate events and workplace activities, which reached beyond workplaces into the community.

3. The **survey as part of** the BCC methodology was particularly successful in engaging workers. After ascertaining workers' knowledge, attitudes, behavioral practices, and the reasons underlying them in the formative assessment report, participants wanted to know more. **Baseline data** gathered helped to shape program emphasis. It was expected that workplace interventions would be tracked to ensure

effectiveness, measure steps towards achieving objectives, and finally, to assess their impact. Focal points routinely submitted data to the NPCs, who in turn recorded the information. Although final impact assessments were conducted, and in most cases, enterprises and workers learned the results, this area needs more development to deepen the level of learning, motivation, and action. The ILO and USDOL should want to continue to measure, document, and understand what makes people change. In some ways, it has not gone far enough to build on examination of gender roles or understanding more deeply the psychology of individual motivation and personal choices.

Conducted by local social scientists, the workers survey and formative assessment were well done and the outcome—BCC strategies to change behavior—was excellent. The notion of assessing impact (through data tracking or monitoring) to discover if the project is reaching its targets is flawed because, except in Benin, there is no evidence that targets are identified. The final assessments might depict change, but as there is no test of statistical significance, and no control group, it is hard to know if the impact has been important. Neither of these statistical components was included in the project design, and it was explained as being beyond the reach of the project.[4]

4. The project produced and relied on a structure of project coordination, planning, and monitoring instruments, such as the **Performance Monitoring Plan (PMP)** and the **Data Tracking Table (DTT)**.[5] Staff and the PABs in the field fully appreciated the value and efficacy of the PMP, and conscientiously filled them in and submitted them. They were less diligent in completing the DTTs, especially as they relate to policy indicators. It would be instructive to understand more thoroughly why this is so. Policy issues are perhaps more difficult to measure. Interviews did not reveal whether this was due to time limits, motivation, or misunderstanding. It appears that the indicators at the project level (development objectives) were mostly only measured at baseline and at the time of the impact assessment, even though Technical Progress Reports were submitted more often.

Midterm evaluations were taken seriously and, where possible, conditions were revised at the national program level. The brief time period of the project in the workplaces did not allow for mid-term assessments or major revisions to the enterprise programs.[6] At the end of the project, after final assessments were made, the enterprises are left with the results. Workplace committees, focal points and peer educators, workers and managers, all would benefit tremendously from a participatory midterm analysis. The final analysis should be conceived as a major point in the process of building program sustainability.

5. The project saw the development and successful implementation of **Workplace Policies** on HIV in most workplaces. The workplace policy component of the SHARE model is essential. It is distressing that developing such a policy continues to be a problem for even a minority of enterprises. The ILO Code of Practice is an excellent source of guidelines, and the existence of the workplace policy is seen as a major benchmark in project implementation by focal points. The workplace policy does much to build security for all workers, regardless of their HIV status. It takes about 2–3 years for a company to mainstream an HIV program and focus on adopting policies; even if not complete, it needs to be intensified. Additional clauses can be integrated once a company has internalized their usefulness to improve labor relations and economic ramifications.

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[4] "More rigorous evaluation methodology would have required more resources (not just financial) and thus was not practical for all the programs." Email from Fatemeh Entekhabi, Technical Specialist.
[5] For more on measurement tools, see pages 64–69.
[6] For example, India changed emphasis from the workplace to the national level after its first midterm evaluation.

6. An important component of the overall project was **Community Zero,** an interactive website. It was comprehensive, useful, and fairly easy to navigate as an organizing tool of the many reports and activities, although it could be much more interactive. It offered insight for NPCs worldwide.[7] It has the potential to communicate common goals and techniques across the world and merits expanded development.

III. Lessons Learned

Lessons that were learned in the course of the project account for some of the biggest successes.[8] These lessons included the following:

1. To advocate and inform the development of national policies and/or legislation, it is essential to create an environment of trust and mutual respect through a national mechanism in which many voices can be heard; in this case, it included all tripartite constituents, experts, and other stakeholders concerned with HIV in the workplace and in the national arena. The success of SHARE in doing this is largely attributed to the pre-existing framework of the tripartite constituency, the climate created in building the PAB, and the professional comportment and determination of the NPC.

2. Ensuring that the voices of people living with HIV be heard was part of the initial project design. But the value of that principle was not appreciated until it was put in practice. At each instance where PLHIV participated, the project objectives to dispel stigma and discrimination made more sense, and stakeholders better understood the need to enact national and enterprise policy and to draft national laws.

3. Worker Organizations need more capacity-building opportunities. Issues such as lack of clarity of purpose for trade unions and the effect of political affiliations were two of the challenges that these groups faced in the SHARE countries. While tripartite constituent employer groups also have some complexities, the worker groups lack resources and, more importantly, institutional development and technical assistance.

4. The selection of target sectors was sensible and, once made, led to good choices for participating enterprises.[9] Financial solvency was not articulated as a criterion, but economically sound enterprises were usually chosen. In a few cases, enterprises stayed with the program even though they were having economic difficulties.

5. The subject of AIDS makes people uncomfortable, and some aspects of HIV and AIDS are often overshadowed by obsession over the cause and transmission. This is unfortunate, and while education in the workplace certainly included transmission, the project also addressed those factors which can be resolved. This included examining risk behaviors (unprotected sex, drug use) and understanding how the risks can be avoided. A first look at how the behavior of an individual relates to contracting AIDS was the foundation of the BCC process. While this was, for the most part, completely innovative to the individuals involved, for others—the focal points, peer educators, Ministers, and management—sex remains almost taboo.

   While HIV is transmitted in several ways, in those countries in the cross-country study, the common denominator across the ILO project sites regarding HIV is that the disease is related to sexual

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[7] See pages 16–17.
[8] Comprehensive Lessons Learned and Recommendations begin on page 92.
[9] See pages 35–37.

behavior.[10] At first glance, one might suggest that sexual attitudes vary dramatically across the globe. It is true, for example, that with some Caribbean countries, music and common parlance more explicitly address sex than in other countries. In some cultures, people may be able to discuss sex more than others, but a delicate and fragile thread connects sex to relationships. As was said by one participant in the Caribbean interactive training session on Behavior Change Communication: "We talk and sing and dance and laugh about sex all the time in the Caribbean, but never with our wives and husbands."

Issues of morality and the judgment of another's behavior may not be appropriate for a project of this nature. The virtues of abstinence and fidelity may make good sense, but appealing to morality alone also implies judgment of others and invites discrimination in stigma. Practices within the community such as unprotected and indiscriminate sex, early pregnancies, casual relationships, and multiple partners, as well as issues related to mother and child rearing could be addressed as gender and cultural issues. In both Botswana and Barbados, research showed that even with increased condom use, the number of multiple partners did not decrease. In Botswana, the rate of multiple partners increased in a workplace dominated by women. Meanwhile, in Cambodia some young female workers were scolded by their families for bringing home IEC materials that were seen as 'pornographic' material. In a conservative country such as India, it is uncertain whether workers honestly report their sexual behavior to an interviewer. The results of the baseline indicate that at least some workers answer the question in a straightforward manner, but clearly not all do in light of sexual taboos. The idea that people must adhere to strict social norms (single partnerships, for example) that may or may not conform to a culture is beyond the purview of project designers and implementers. The project will have best results when decisionmaking concerning culturally-appropriate messages and activities is the responsibility of the local participants and stakeholders.

The SHARE project helped to place AIDS on a broader platform, moving it away from public health legislation, and looking instead at how it affects behavior in relation to sexual practices, other means of HIV transmission, discrimination, and stigma. HIV is more than just a medical term or an infectious virus, because it requires changes in sexual behavior and it concerns the regulation of human relationships. To change practices and behaviors in relation to sexuality is time consuming because there are many strong beliefs and taboos related to sex. Smoking is often used as an analogy: "How long have we been having campaigns to curb smoking? Many people still smoke so we have to be persistent."[11] With HIV, it may take even more time, staff, and effort than is currently possible. If we are to look at smoking—a dangerous addiction—as a habit to break, why not look at a habit that is easy to start; for example, using cell phones. The cell phone is ubiquitous and people have readily adapted to it worldwide. There may be some BCC issues from which to learn the motivations and key benefits of using mobile phones.

6. The project used the time wisely by investing in building foundation at startup. It is important to note that this project is about banking social capital through the establishment of collaborative bodies. Everyone traditionally involved with the world of work—the tripartite constituency—agrees that this has been a singularly unique experience in working together on a common theme without the competition, acrimony, or conflict that they sometimes experience. For the additional stakeholders, for example, those representing People Living with HIV/AIDS and NGOs, as well as other ministries

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[10] This is recognized as not being the case in other SHARE countries, such as Russia, and supports the case for ensuring that the project remains responsive to its context.
[11] From the Benin PMP Report, echoed by Paula Church, USDOL.

and AIDS Commissions, it has also been a novel experience and has the potential for future collaboration.

The time allotted to the projects was too short to accomplish major measurable behavior change. The objectives as set out are circumspect enough: "to reduce…" If objectives had stated the desire to actually eliminate discrimination, stigma, and risky behaviors, that would have been impossible in the time period. Thus, given the length of the project, and the obvious external forces such as increased media or pre-existing knowledge, the BCC outcomes cannot be considered a success or failure.

The information derived from these experiences is interesting but somewhat disappointing if dramatic change results were anticipated, but that should not be the main consideration. The data collection exercises alone added enormous value to the empowerment of the workplace stakeholders. The awareness raised among workplace participants and the development of materials and activities was unequivocally successful. The results of the BCC objectives—to change behavior among workers (including managers)—were less significant.

The project promises to have some long-term effect, if not become sustainable. Peer educators and focal points are members of communities. There is evidence that, as they have become empowered with knowledge and skills, they have extended the project by reaching out to families and local populations, as well as to those involved in the supply chain to the formal enterprises. In all of the countries studied, peer educators demonstrated a feeling of project ownership that they were interested in continuing in their roles as educators despite the end of the project. Managers and workers in both the enterprises and the informal sector workplaces indicated their commitment to continuing, encouraging, and arranging for meetings to take place and materials to be displayed, even if the project did not continue.

7. Replication of the model or its components depends on the financial resources of the tripartite constituency within a country. Also, much depends on the strength of the economy overall to determine whether companies are willing to develop and sustain HIV in the workplace programs over the long term. Governments have varying resources to replicate the model at central and local levels. Given the need to establish a strong start-up base of project components—national and workplace foci, building an advisory board, mapping, etc.—a minimum of 5 years project length (LOP) is necessary.

In addition, the project sharpened tangible project implementation skills that can be used in other ILO and USDOL projects. For example, best methods were discovered and established in inviting and involving the employers to be a part of the project, and in presenting a program to benefit workers to the senior management and owners of enterprises.[12] The most convincing way to gain entry into the workplace is to be able to demonstrate how the project can make the workplace more productive.

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[12] See pages 35–37.

IV.   RECOMMENDATIONS

There are several areas where more can be done to strengthen the ILO/USDOL interventions and to enhance any Workplace Education Program on HIV and AIDS.

1. Activities focused on improving the protection of workers in the AIDS arena can delve deeper into the consequences of unchanged behavior. Workers expressed interest in knowing more, despite the fact that sometimes issues were difficult. As long as they understood the key benefits, workers were interested and so were managers.

2. The BCC is an area where more can be done to raise awareness about vulnerabilities and strengths related to gender, and how HIV and AIDS are related. Some programs, particularly in the Caribbean, did work to further illuminate the connections between gender, violence, and financial dependency.

3. Research is sorely needed to document the payback to a company that has HIV workplace policies, committees, programs, and focal points, as compared to companies without such programs. Some managers are less visionary than others. Those with vision should be recognized, rewarded, and tapped as accessories to HIV and AIDS workplace education efforts.

4. Changing attitudes towards PLHIV were documented in the project through the Knowledge, Attitudes, and Practices (KAP) survey and through anecdotal accounts. In November 2004, a trade union activist who attended a general sensitization workshop in Benin reported it "taught us new ways to address HIV. Based on what we learned we elaborated a strategy that we now will implement in the company. Sensitization is a key element to inform people. Not all have changed their behaviors but they are more aware and there is no discrimination in our enterprise." Project objectives tried to address stigma and discrimination head-on, and according to impact assessments, there was definite improvement in how PLHIV will be perceived in target industries.

   Stigma and discrimination was addressed in the development of policies for workers, along with ensuring that PLHIV will not be cast out of the formal workplace. The policies need to be enforced, and there needs to be continued vigilance. This would be done by workers' organizations, which need more capacity-building opportunities. Issues of care and support of workers infected and affected by HIV needs to receive more attention in project design and implementation. Further, efforts to focus on analyzing the nature of discrimination can be connected to BCC strategies. The ILO's role in encouraging formalized, national, concentrated attacks on stigma and discrimination as workplace issues is an important one.

5. This report often prefers the term 'workplaces' to 'enterprises' to recognize that formal businesses and work arenas and the less organized, informal marketplaces are both represented. Some interesting outcomes of this project came not in formal enterprises, but in the **informal economic sector**. [13] Entry into the informal workplace for a project is difficult because there are few definitions common to the informal sector. For example, fisher folk and taxi drivers, two areas of employment reached in Barbados, require quite different skill sets, have different clients, and work in different environments. Some of the groupings have formal associations which bring them together, either for professional or fraternal reasons. It is in that venue where normally the NPCs were often able to gain entry, and ultimately make successful inroads. Some associations have bylaws and vending permits and licenses from operators in the informal sector, but the way in which the informal sector is treated is not

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[13] See pages 56–62.

uniform from country to country. Although production and management processes may be unsophisticated, these small enterprises can be rather advanced.

Informal workers come from a variety of backgrounds, work in highly diverse settings, and may be self-employed or a daily-wage earner. Any monitoring and impact analysis of their actions can be very difficult. Many workers are highly mobile and can only be reached for a few hours at a time. Some, such as truck drivers and migrant agricultural workers, are transient. Finding them subsequent to training or other actions that help determine a behavior or attitude change can often be particularly difficult. One area of success for the project has been where the supply chain workers, such as truck drivers, wood suppliers, or caterers for formal enterprises, have been integrated into the program.[14]

Worldwide, the informal economy represents a huge sector of workers who would benefit from HIV education programs, especially linked to behavior change. The informal economy benefitted from SHARE inputs in each of the countries studied.[15] The activities were interesting and innovative, but sometimes demanded more time and effort to implement. The SHARE model must be adapted more precisely when used to reach the informal economy.

6. As has been mentioned, the project was ambitious for the time period. Realistically, the project was too short to become truly institutionalized.[16] The follow-up programs in Botswana and Guyana with PEPFAR (U.S. President's Emergency Plan for AIDS Relief) funding will help to keep the momentum going, even if the program changes slightly. With the two major thrusts—a national policy approach and the workplace education activities—the activities of the projects overall have been inserted into government multi-sectoral efforts. National AIDS Commissions appreciated the outcome, but many are too distracted by health responses, ARV availability, and funders' priorities, to put emphasis on the workplace. *The workplace as a locus for anti-AIDS activities is agreed upon as a rational, and even a perfect place to do preventive work.* It is recognized as an excellent site to reach adult populations, just as schools are for children.

It is striking and noteworthy that the ILO and USDOL decided to implement a consistent strategy in two-dozen countries with solid national and cultural identities. The factors needed to implement projects successfully in each site are quite naturally diverse. Even within regional sites, Asia for example, all countries obviously do not approach a problem exactly the same. Further, the level of HIV and AIDS differed from country to country. Prevalence in some of the target countries was exorbitant (Botswana, 32% at the beginning), while in others, the rate was so low as to cause officials to question why they should exert any effort at all to fight the scourge of AIDS. As has been mentioned, the main modes of transmission of HIV differ from nation to nation. In those countries with more large industrial and entrepreneurial bases, the study found that workplaces were already beginning to address HIV and AIDS, partly because around the world, multinational businesses recognized the impact on productivity. Throughout, the model proved to be simultaneously consistent and adaptable.

As the project reaches new benchmarks in its international implementation, the ILO and USDOL should be better equipped through this study to capture the valuable elements that affected the success of the SHARE intervention. The project achieved results in fighting HIV and AIDS in the target countries because intelligent and committed country directors utilized the ILO special relationships; paid attention to outcomes through rigorous yet useful and fairly accurate monitoring and evaluation tools; and

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[14] Pages 61- 88
[15] For more on the informal economy, see pages 56-62
[16] See p. 7 for more on the Length of Project

introduced unique and credible strategies to promote people's behavior away from risky and hurtful action. The end goal—the unstated goal—was to contribute to a nation's economic development, support a productive work place, and eradicate AIDS. The well stated though seemingly modest objectives focused on the possible.

HIV and AIDS represent a pandemic of enormous proportions, in the context of which demographics change rapidly and continually. Even countries with a low prevalence are not protected from HIV and AIDS. Only prevention will make a difference, and the workplace is a logical site for them to gain the tools (BCC materials) and services that they need to be safe. Once infected, people are still productive and can continue to work, barring unwarranted discrimination and imposed stigma. Workplaces—the site of economic productivity—have to be accessible to those who are able to work, regardless of their status. The tripartite (Plus) structure, representing development and enforcement of laws and policy in the world of work, is a logical mechanism to ensure that will happen.

LIST OF ACRONYMS

General	
AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-Retroviral
ART	Anti Retroviral Therapy
BCC	Behavior Change Communication
CARE	Comfort, Assist, Reach-out, Educate Association
CBO	Community Based Organization
CDRC	Chronic Disease Research Centre
CSR	Corporate Social Responsibility
CZ	Community Zero
DFID	UK Department for International Development
DTT	Data Tracking Table
FA	Formative Assessment
FHI	Family Health International
HIV	Human Immunodeficiency Virus
IEC	Information, Education, and Communication
ILO	International Labour Organization
KABP	Knowledge, Attitude, Behavior, and Practices
KAP	Knowledge, Attitude, and Practices
M&E	Monitoring and Evaluation
MOC	Memorandum of Cooperation
MOU	Memorandum of Understanding
MSI	Management Systems International
NGO	Non-governmental organization
NPC	National Program Coordinator
NSP	National Strategic Plan
OSH	Occupational Safety and Health
PAB	Project Advisory Board
PE	Peer Educators
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV/AIDS
PMP	Performance Monitoring Plan
PMT	Program Management Team
PMTCT	Prevention of Mother to Child Transmission
RA	Rapid Assessment
SHARE	Strategic HIV/AIDS Responses in Enterprises
STI	Sexually Transmitted Infection
SWOT Analysis	Strengths, Weaknesses, Opportunities, and Threats Analysis
TB	Tuberculosis
TOR	Terms of Reference
TOT	Training of Trainers
TPR	Technical Progress Report
TSU	Technical Support Units
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNTG	U.N. Theme Group on HIV/AIDS
USAID	U.S. Agency for International Development
USDOL	U.S. Department of Labor
VCT	Voluntary Counseling and Testing

Barbados-Specific Acronyms	
BCCI	Barbados Chamber of Commerce and Industry
BEC	Barbados Employers' Confederation
CDRC	Chronic Disease Research Centre
OHS	Occupational Health & Safety Program
Benin-Specific Acronyms	
CAFEB	Centre for Action in Basic Education and Training
CCP	Conseil Consultatif Du Projet BIT/USDOL (Project Advisory Board)
CIM Benin	Cement manufacturer (enterprise)
CNLS	Comité National de lutte contre le SIDA (National AIDS Committee)
CPA	Centre de Promotion de l'Artisanat (Informal Sector Craftsmen)
CSA	Confédération des Syndicats autonomes du Bénin (Independent Unions)
CSTB	Confédération Syndicale des Travailleurs du Bénin
IBCG	Industries Béninoise des Corps Gras (Oil Industries)
FENAB	National Federation of Artisans
OHADA	Organisation pour l'Harmonisation en Afrique du Droit des Affaires-(Organization for Harmonization of Business Law in Africa; OHADA)
ORDH	Organisation de Recherche pour le Développement Humain (NGO) (Human Development Research)
PNLS	Programme National de Lutte contre le SIDA (National AIDS Programme)
PPLS	Programme Plurisectoriel de Lutte contre le Sida
SBEE	Benin Electricity Company (Enterprise)
SCB-LaFarge	Lafarge Benin Cement Company
SCB	Benin Cement Company
STEP	ILO Strategies and Tools against Social Exclusion and Poverty Programme
Botswana-Specific Acronyms	
BBCA	Botswana Business Coalition on HIV/AIDS
BOCCIM	Botswana Confederation of Commerce, Industry, and Manpower
BONELA	Botswana Network on Ethics, Law, and HIV/AIDS
BONEPWA	Botswana Network of People Living with HIV/AIDS
DIMSAC	District Multi-Sectoral AIDS Commission
DDS	Delta Desert and Safari
HATAB	Hotel and Tourism Association of Botswana
MLHA	Ministry of Labour and Home Affairs
NACA	National AIDS Coordinating Agency
NSF	National Strategic Framework
Cambodia-Specific Acronyms and Terms	
CAMFEBA	Cambodian Federation of Employers and Business Associations
CBCA	Cambodia Business Coalition on AIDS
CCTU	Cambodian Confederation of Trade Unions
CCTUF	Cambodian Construction Workers Trade Union Federation
CLC	Cambodian Labor Confederation
CPN+	Cambodian People Living with AIDS Network
FHI	Family Health International
GMAC	Garments Manufacturers' Association of Cambodia
MOLVT	Ministry of Labour and Vocational Training
NAA	National AIDS Authority
Prakas	Royal decree in Cambodia

India-Specific Acronyms	
CBWE	Central Board for Workers Education
GTZ	German Technical Cooperation
INP+	Indian Network for People Living with HIV/AIDS
MOLE	Ministry of Labour & Employment
NACO	National AIDS Control Organization
NACPIII	National AIDS Control Programme III
SACS	State AIDS Control Society
VVGNLI	V.V. Giri National Labour Institute

Focal Point: The person in a target enterprise or within a stakeholder structure who functions as the particular reference person vis-à-vis the ILO project.

ILO Tripartite Approach: "The ILO is based on the principle of tripartism—dialogue and cooperation between governments, employers, and workers—in the formulation of standards and policies dealing with labour matters."[17]

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[17] International Labour Organization. (2008). Tripartite Consultation. Accessed June 19, 2008, from .www2.ilo.org/global/What_we_do/InternationalLabourStandards/Subjects/Tripartiteconsultation/lang--en/index.htm.

MAPS

SOUTH ASIA
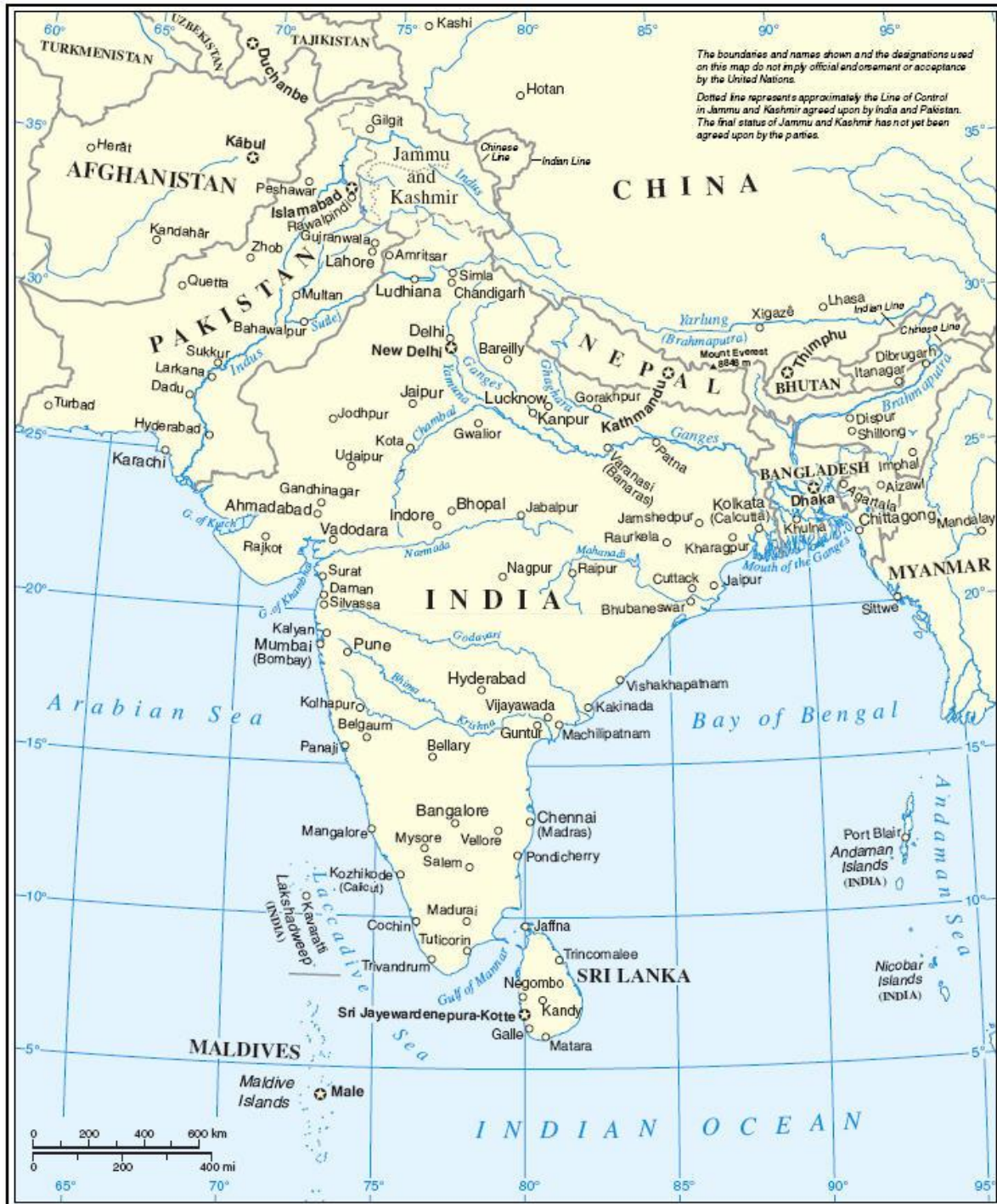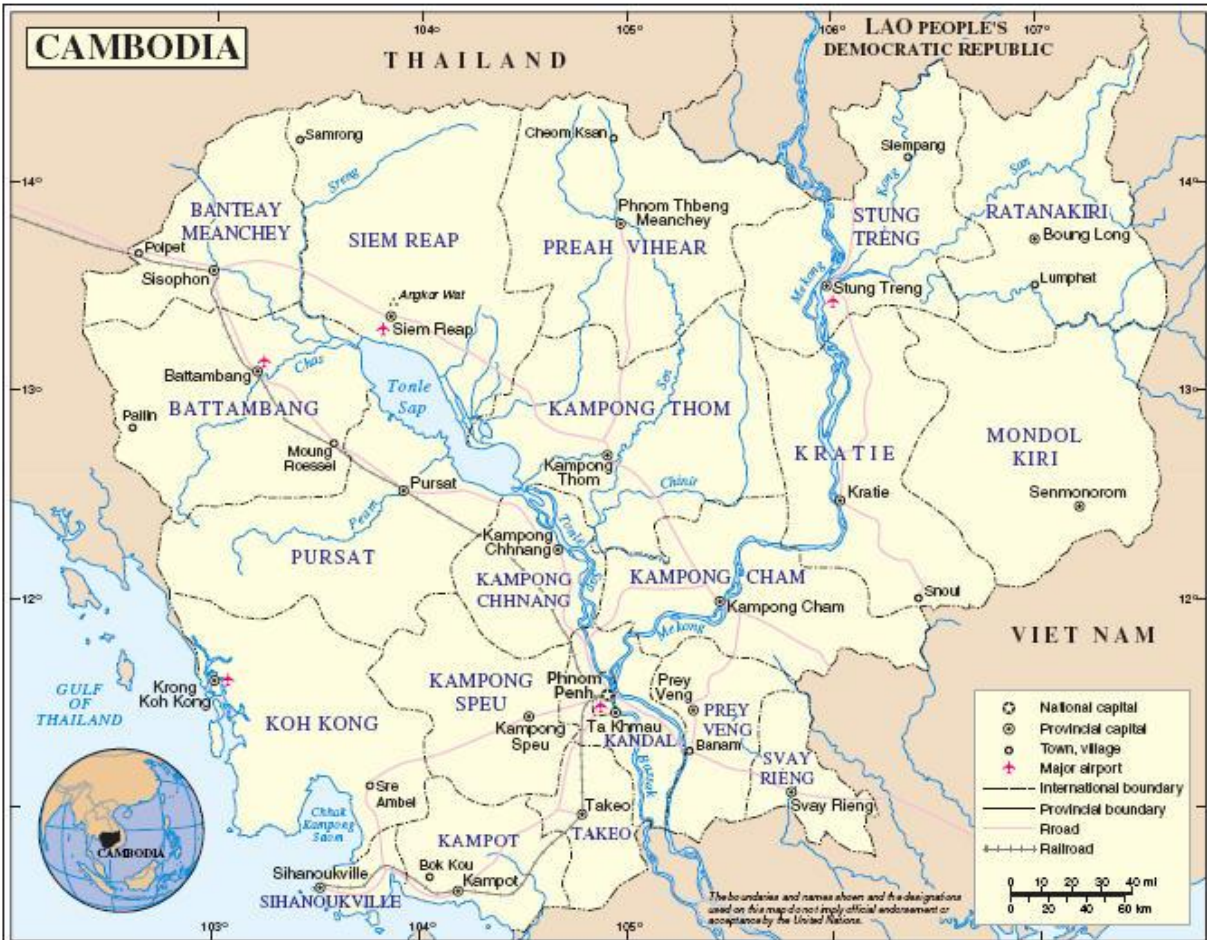
INTRODUCTION

Preventing HIV infection as well as addressing issues of stigma and discrimination against people living with HIV requires a comprehensive approach that targets people where they spend much of their time—the workplace. The workplace provides an opportunity to reach large numbers of people with prevention messages. At the same time, stigma and discrimination in the workplace present great challenges to people living with HIV since it threatens their very livelihood.

In 2000, the International Labour Organization (ILO), with funding from the U.S. Department of Labor (USDOL), began implementing Strategic HIV/AIDS Responses in Enterprises (SHARE), a program designed to protect workers from issues of discrimination and stigma related to HIV and AIDS, and to build an awareness of behaviors that place workers at risk to HIV. Starting with a pilot project in India, the program has now reached 24 countries. The USDOL and ILO selected five countries for an in-depth analysis of the SHARE model at the enterprise level, as well as with regard to the national and local enabling environment. The conclusions and recommendations are expected to assist USDOL and other government agencies, as well as the ILO and other international organizations, to improve workplace programs and to shape decisions about the design of future programs.

This report synthesizes experiences in the countries studied and explores how the model was conceptualized and rolled out, as well as what obstacles were confronted and what innovations were introduced. The countries studied were Benin, Botswana, India, Cambodia, and Barbados, with additional but more limited information collected through interviews on the experience of other countries in the Caribbean. While examples were drawn from the various countries studied, the report endeavors to first and foremost identify commonalities, and then highlight country-specific innovations. In other words, this synthesis should not be considered country-focused, but rather an analysis drawing lessons from the five countries.

The analysis of the projects on HIV and AIDS implemented in the world of work included:

- Reviewing the appropriateness and effectiveness of the strategy of the SHARE program

- Tracing and assessing the implementations steps

- Examining the national Tripartite (government, employers, and workers) guidance, support, ownership and leadership

- Analyzing the value of the key tools used

- Evaluating enterprise-level programs as well as those targeted at the informal economy

- Assessing the sustainability of the projects

- Highlighting the key findings from the impact surveys together with the lessons learned

- Determining the degree of transferability and potential for adaptation and utilization in other countries.

The quantity of information amassed and analyzed was voluminous, and every effort has been made to provide a readable report. The major themes which were articulated in the Scope of Work are covered in the main body of the report, which reflects the complexity and dimensions of the project and

explains the number of pages. However, the report is divided into four sections to direct the reader to areas of specify interest:

- Section I. Project Design and Context
- Section II. Project Implementation
- Section III. Lessons Learned and Recommendations
- Section IV. Annexes

I. Section I examines the relevance and success of the Project Design. This section introduces the project model and looks at how effectively the project design was integrated into national policies and laws. It also examines countries' strategies to deal with HIV in the context of the workplace. At a meeting in April 2008, the ILO Geneva-based personnel responsible for the SHARE program voiced an interest in reviewing the project step-by-step.

II. Section II, Project Implementation, reviews how the seven-step process was applied in the countries studied and draws evaluative conclusions. Besides the project startup issues, this section looks at the enabling environment at the national level and the participatory role of the tripartite constituency, as an important vehicle in the project. It also explores administrative issues, capacity building, and the implementation of programs in formal enterprises and the informal economic sector. The project focused on the workplace and the thrust of activities occurred within formal enterprises. However, despite challenges to project design and implementation, the informal sector was not ignored and Part Two of Section II describes the issues involved in and steps taken in dealing with HIV workplace education and behavior change in the informal economy.

III. Lessons Learned and Recommendations are found in Section III, with recommendations on how to further improve efforts in countries directly included in the study. Specifically, this means that the study determined what types of approaches and actions should be avoided, what can be improved, and what can be added so that HIV and AIDS can be addressed in the workplace using a tripartite constituency model. The extensive lessons analyzed and listed with recommendations include project management issues, general aspects of the SHARE Model, the tripartite constituency and other important stakeholders (including people living with HIV, non-governmental organizations [NGOs], community-based organizations [CBOs]), and the Policy Advisory Board. Policy advocacy; Behavior Change Communication implementation, activities and materials; trainers, focal points and peer educators are also listed. Lessons and recommendations pertaining to selling the idea to enterprises and sustaining management's involvement; workplace policy; corporate social responsibility; are reviewed, as is the informal economy; research; project monitoring, baseline, impact assessment; and sustainability.

IV. The Annexes in Section IV include additional information, charts and photographs, as well as the Terms of Reference (TOR) to illuminate and clarify the text. Each Annex is also identified in the Table of Contents.

In anticipation of the study, the two organizations, ILO and USDOL, approved specific questions that might be asked of the various stakeholders to illuminate the study. Indeed, these questions were asked of nearly every interviewee according to their situation, and the synthesis of responses is found throughout

the report. These questions are captured in footnotes under the heading, "TOR Questions."[18] There is also a cross-referencing chart of the questions in Annex 11.

Study Methodology

The two-person study team, hereafter called researcher, evaluator, or assessor, used a combination of methods to ensure a thorough and well-rounded understanding of how each country's experiences, with nuances and modifications, could be carried out. The team worked in India, Cambodia, and Thailand; and Barbados, Benin, Botswana, Geneva, Washington, D.C., and the Caribbean. The approach involved—

- Document review, including project-related documents and supplementary materials to provide relevant context of the studied countries, with respect to HIV and AIDS prevalence in different categories of the population, existing national policies and frameworks, and other potential issues of importance.

- Background interviews with ILO Headquarters, ILO Bangkok regional office representatives, and pertinent personnel at the U.S. Department of Labor.

- Study of the project linkages to the existing national policies and frameworks (and decentralized at State level in the case of India).

- Study and assessment of effectiveness and degree of implementation, to date, of the ILO SHARE guidelines, Behavior Change Communication toolkit, Performance Monitoring Plan, Data Tracking Table, and other materials developed by the project .

- Study of the results of baseline and post-project surveys to determine their validity and relevance.

- Field visits to Barbados, Benin, Botswana, Cambodia, and India.

  o   In-depth interviews with broadest range of stakeholders, especially key stakeholders, individually or in focus groups carried out within the timeframe (see Annex 9).

  o   Individual and small group discussions with project staff in the central office and elsewhere as relevant to the country situation.

  o   Observation of the stakeholders and their work in different settings as well as their networking actions.

  o   Visits to participating enterprises, and observation of nonparticipating enterprises.

  o   Individual discussions with other donors and agencies working on HIV and AIDS, particularly those also addressing HIV in the different work settings or providing coordination support.

  o   Observation and limited participation in a 5-day Interactive Learning Event on HIV/AIDS Behavior Change Communication for the Workplace in Barbados.

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[18] See Annex 12, Terms of Reference.

- o Individual in-depth interviews with representatives of the tripartite constituency from Belize, Guyana, Jamaica, Trinidad, and Malawi who attended the workshop.

- Follow-up discussions with project staff in the target countries to validate some findings, and to verify and clarify information obtained during the field visit.

- Follow-up contact with project and/or ILO headquarters-based staff.

- Modifications of a first draft, followed by collection of responses from stakeholders.

Types of stakeholder interviewed during the study included the following:

- Project staff (Barbados, Benin, Botswana, India, Belize, Guyana, Jamaica, Trinidad, and Malawi) and former project staff (Cambodia, Benin, and Belize)

- Ministries of Labor personnel

- National AIDS Organization (government) personnel

- Employers' organizations (federations at national and/or provincial/state level) personnel

- Workers' organizations (federations at national and/or provincial/state level)

- NGOs

- District and State AIDS Commissions (India, Botswana)

- Individual enterprises including employees in management, Focal Points and peer educators

- Informal economy representatives

- Isolated informants, such as university provost, other UN agencies staff

- Networks of People Living with HIV/AIDS (PLHIV)

Upon arriving in each country, the researchers first met with the National Project Coordinator (NPC), senior project staff members, and/or former project staff members to finalize the issues under examination and to obtain their input on the study. Meetings were held with relevant stakeholders in the capital and other parts of the country.[19] Individual and focus group interviews with stakeholder representatives covered a wide range of subjects to ensure that all issues were discussed.

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[19] See Annexes 9 and 10 for lists of programs and of persons met.

Project staff members facilitated the scheduling and researchers' transportation. This included drafting the list of interviewees, modifying the list after consultation with the researcher, and scheduling to ensure that all relevant stakeholders were included. The short timeframe did not allow the assessor to meet all of the many individuals who were involved with the project in various ways. However, the study team is convinced they interviewed all the key stakeholders at the national level and a good representation of partners at various other levels. The experience was filled with visits to factories, markets, banks, government and private offices, and other workplaces.

SECTION I: PROJECT DESIGN AND CONTEXT

The SHARE program is an integral part of ILO/AIDS; it has been the mainstay of the ILO's technical cooperation program and a major factor in the promotion and implementation of the ILO Code of Practice on HIV/AIDS and the World of Work.[20] SHARE focuses on the workplace as a logical locus for activities and works with the ILO tripartite constituents, expanding the group of project stakeholders to include experts, NGOs, coordinating bodies, and other relevant stakeholders related to the fight against HIV and AIDS. The project endeavors to influence and have a meaningful impact on two areas, both related to the world of work: the national **policy** front, through advocacy and technical assistance to strengthen the policy and legal framework; and at the level of the **workplace**, through technical assistance for the development and implementation of HIV policies and programs at selected enterprises.

1.   Project Objectives

As the mapping exercises and subsequent baseline surveys indicate, the objectives were in-line with the realities of the workplaces, as well as the societies in general in the target countries (see PROJECT OBJECTIVES text box, below). The attitudes of workers and employers towards, and the fears and hopes of, people living with HIV, were consistent with the modest objectives the project hoped to address. It was more pragmatic to try to 'reduce' the problems, rather than to believe it would be possible to 'eliminate' them in the time allotted and with the financial resources initially available.

PROJECT OBJECTIVES

__Development Objectives:__
1.   Reduced HIV/AIDS risk behaviors among targeted workers.
2.   Reduced level of employment-related discrimination against persons living with HIV /AIDS.

__Immediate Objectives:__
3.   Improved knowledge, attitudes, and perception of norms related to HIV/AIDS risk behaviors.
4.   Increased use of available HIV/AIDS workplace programs.
5.   Reduced stigma against persons living with HIV/AIDS.
6.   Increased knowledge and understanding of HIV/AIDS workplace policies.

__Sub-Immediate Objectives:__
7.   Increased availability of HIV /AIDS-Workplace Programs.
8.   Improved Workplace Policies.
9.   Increased levels of workplace collaboration and commitment by labor and management.
10. Increased capacity of workplace to offer comprehensive HIV/AIDS policies and programs on a sustained basis.
11. Improved coordination and cooperation between Tripartite [constituents] and other partners at the National and Sub-Regional Levels.
12. Improved National Level Policy Framework related to HIV/AIDS at the workplace.
13. Increased capacity of Tripartite [constituents] to support development of workplace policy and programs.

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[20] SHARE PMT, August 18, 2008.

2. The SHARE Model

The project used a systematic approach to achieve its objectives with human resources and tools specially designed for collecting data at the workplace, monitoring and evaluation, and building strategies to change behavior. These tools included the project coordination and planning instruments, such as the Performance Monitoring Plan (PMP) and the Data Tracking Table (DTT). At the enterprise level, information was gathered through the quantitative Worker's Survey, also known as the KABP or KAP (Knowledge, Attitudes, Behavior, and Practice), and a Formative Assessment, which collected qualitative data. The Behavior Change Communications (BCC) strategy was designed at the sector or enterprise level. Focal point and peer educators submitted Monitoring and Evaluation (M&E) instruments as well. All of these tools were integrated into the design in an orderly manner.

The project strategy utilized human capital and built capacity among various levels of stakeholders. An overarching Project Advisory Board (PAB) provided advice and oversight, and workplace committees were an equally important feature in the design. From the onset, the project was designed to build understanding on the issues related to HIV /AIDS; and to propose methods to fight discrimination, stigma, and behaviors that place all workers, including management, at risk of contracting HIV. The planned inputs comprised training, sensitization sessions, committee formation, creating Focal Points and peer educators, and creating and implementing a wide range of focused activities based on outcomes from the two data collection tools. With the assistance of professional consultants, who brought expertise in marketing, graphics, and BCC, a complex and responsive strategy was designed for each workplace to address the key weaknesses that were raised as far as workers' awareness, discrimination and stigma issues, and risk behaviors.

Partners in the target countries considered the project design well thought out and presented. There were few, if any, areas of ambiguity; and while PAB board members in several countries considered it ambitious, they were ready to meet the challenge, calling it "completely doable."[21] NGOs in Benin, new to the tripartite structure and to the workplace, but not to the AIDS arena, described the project design as "original." Many PAB members in Africa and the Caribbean echoed the sentiment that the workplace was the logical place for the project, where one had a captive audience, and where people live most of their lives. The peer education model was approved because co-workers are among the most important people to the productive adult.[22] In India, important partners such as the National Aids Control Organisation (NACO) and the Council of Indian Employers reported that, in their opinion, the program design is good. Cambodian interviewees deemed the choice of working through enterprises useful, but had questions about the long-term added value of these efforts. Working through national tripartite constituents was considered more important by some interviewees in Cambodia. Interviewees noted that pilot approaches in the enterprises implemented through the project were useful to illustrate how to involve both management and workers through a concerted effort.

A local NGO in consultation with the project developed the BCC materials. Some interviewees noted, however, that there could be more involvement from additional NGOs to improve the development and implementation of the BCC efforts in enterprises. The ILO's strengths were identified as concentrating on promoting and developing the tripartite constituency commitment and national capacities. The design in Cambodia was well linked to government strategies. The project, in turn, was also successful in influencing increased attention to HIV through policies and strategies in the workplace.

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[21] Botswana.
[22] Botswana.

Tackling the AIDS crisis will require sustained effort for a long time. Certainly, one of the most important elements of the response to AIDS is the prevention of new HIV infections in those countries where the disease has been particularly predominant. Where prevalence is low, discrimination, stigma, and general ignorance about the infection present major challenges. Another main issue is how to provide treatment and care to those living with HIV, particularly through the availability of Anti-Retrovirals (ARVs), which can allow people living with HIV to live long and healthy lives. Therefore, the project objectives were relevant and pertinent. Briefly, the development objectives to *reduce risk behaviors of targeted workers and employment-related discrimination against persons living with HIV* are realistic, albeit lacking the strong aggressive approach that is desirable in the face of discrimination.

Besides the tripartite constituents, other key players were correctly identified and involved, or brought in as appropriate. People living with HIV were involved. An interviewee from the Indian Network for People Living with HIV/AIDS (INP+, or Indian Network for People Living with HIV/AIDS) offered an interesting comment. He said that at first, the India Project Advisory Board lacked anyone from INP+. The project invited an INP+ representative to become a member of the PAB and they were represented from the second meeting onwards. This proved to be very effective. As the INP+ representative noted, "My personal history woke everyone up."

This feature of adaptability, while not stated explicitly in the project framework, is characteristic to all the countries studied. In Benin, the project design and further enhancements were considered to be completely participatory. Representatives of the tripartite constituency participated in early conceptualization, even before staff was hired and the project was publicly launched.

A Cambodian NGO stakeholder noted that the ILO might have increased its impact if the project design had included the creation of more synergies with other ILO projects. The interviewee noted that not taking advantage of potential synergies is common and often the result of donor requirements. Donors promote synergies but in fact require interventions to be isolated so that impacts can be clearly traced to their funding. An important question the interviewee asked was, "How can we create synergy to help people to integrate actions so we can effectively reach workers in a holistic way?"

In several countries, interviewees raised the issue that the focus on HIV in the workplace is isolated from other efforts to improve the working conditions of workers. People in Cambodia suggested that, from the beginning, the design could have been more closely integrated with government occupational safety and health initiatives. That was not a problem noted elsewhere. In Botswana, HIV is being increasingly incorporated into wellness initiatives.

3. Project Implementation Period

It is indeed true that the time allotted to the projects—3 years—was too short to accomplish major measurable behavior change. The objectives as set out are circumspect enough—to reduce. If objectives had stated the desire to actually eliminate discrimination, stigma, and risky behaviors, that would have been impossible in the time period.

The 24 countries where SHARE is implemented are at varying stages of infrastructural, political, and economic development. Roads and communications are more highly developed in India than in Benin, for instance. It is possible to travel around Barbados more than once in a day, while it takes 2 days to travel by road from Northern to Southern Botswana. Each country has a different bureaucratic or hierarchical route that slows or hastens the progress of any activity.

The tripartite structures are efficient vehicles, but there are different levels of development in them as well. In some countries, unions are vocal, dependable and somewhat homogenous. In Botswana, the unions are in the process of gaining clarity of purpose and worker support. In Cambodia, the project was challenged because workers' organizations that were not aligned with political parties lacked ample resources to fully implement programs. Many of their activities ceased at the project's end.

Human resources vary, and finding capable consultants and trainers, experts in BCC, for example, is easier in some places than in others. The common methodology was an efficient model. Even with changes from country to country, there were enough consistencies within the model that the M&E tools and the BCC strategies could be compared, contrasted, and set up for replication, with adaptation.

Culturally, viewpoints of sex can also be differentiated, although it is in that arena where perhaps most of the countries are similar. Discussion about sex is taboo, more or less, in every country. HIV is all about sex. Even though transmission can be made by other means, there are too many aspects linked to sex to make government officials, families and children, factory workers and managers comfortable about talking about it without the implementers' first studying specific, existing, cultural constructs.

It takes time to get a project going and moderately established. The question of how long is the right length of time is difficult. Once the veracity of the model is proven, it becomes possible for the government to pay more attention to it. This project combines both policy climate (advocacy) and service orientation. In the case of SHARE, the tripartite constituency vehicle was understood and appreciated by the labor ministries; this, coupled with the reputation and independent strength of the ILO, sped up the process of early and timely acceptance by government participation (though not in the forms of resources and institutionalization).

The first year of a project is often used completely for start-up. Government conventions or protocol issues, offices and staff hiring, assembling stakeholders and building a constituency, doing planning exercises, implementing training workshops and conducting baseline data—all appropriate and necessary activities that must take place before actually implementing the activities. Simultaneously, a thoughtful project implementation would include early identification and development of sustainability plans. In Benin, it took a year before the NPC even came on board. If the SHARE staff from Geneva had not done a great deal of behind the scenes start-up measures, especially in creating a policy climate, the project would have suffered. Benin was able to receive an extension, which contributed greatly to its success. As it stands, all of the projects were able to have significant impact within the 3-year project period. In Cambodia, this was attributed to the existing government policies and strategies that already explicitly promoted addressing HIV in the world of work. As recognized by the government and major NGOs in the country, the project was able to demonstrate some effective approaches and provided added value through the tripartite constituency approach. Employer and worker organizations together joining the government was an effective approach, despite the highly political nature of the different partners.

4.   SHARE Generations

Project design and documents differed from country to country, due to the time frame in which countries were integrated. There were several generations, beginning with India.

Table of SHARE Generations

Year	Country of Implementation
2001-2009	India
2002–2006	Belize, Benin, Cambodia, Ghana, Guyana, Togo
2003–2007	Barbados, Jamaica, Botswana, Ethiopia, Lesotho, Nepal, Russian Federation, South Africa, Swaziland
2004–2008	Burkina Faso, Cameroon, China, Indonesia, Malawi, Sri Lanka, Trinidad and Tobago
2007-2009	Madagascar

5.   National Policy, the ILO, and Country Strategies to Combat HIV

The SHARE project is crafted to fit into the national strategies of the target countries. In working on HIV issues, most countries have neglected the workplace, focusing more on the health sector. The SHARE project invigorated efforts by Ministries of Labor to bring the topic to their constituencies, workers and employers. The project contributed to increased attention to HIV in the workplace in national policies and strategies.

The **ILO Code of Practice** proved to be one of the most important technical mechanisms brought to the project, as it provided terminology and the strength of the ILO to workers, employers, and labor ministries. The ILO developed the Code of Practice in response to many requests for guidance, through a widespread process of consultation with government, employer, and worker constituents in all regions. The Code represents the ILO's commitment to help secure conditions of decent work and social protection in the face of the epidemic; its implementation is at the core of the Program's strategic plan.[23] The Code contains fundamental principles for policy development and practical guidelines from which concrete responses can be developed at enterprise, community and national levels in the following key areas: (a) prevention of HIV; (b) management and mitigation of the impact of HIV on the world of work; (c) care and support of workers infected and affected by HIV; and (d) elimination of stigma and

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[23] Each country develops its own Decent Work Country Program. Recently this has been linked to initiatives to strengthen Local Economic Development. That means working at local level (provincial, district, communities) to ensure decent work. "Decent Work" is an organizing concept for the ILO in order to provide an overall framework for action in economic and social development. It includes the promotion of opportunities for women and men to obtain decent and productive work in conditions of freedom, equity, security, and human dignity. Decent work is the converging focus of the four strategic objectives; namely, rights at work, employment, social protection, and social dialogue. ILO, 2004. Policy Integration, Decent Work, Theme in Brief. Available at www.ilo.org/public/english/bureau/integration/decent/index.htm (Accessed 14-11-2007). A description of a national plan is as follows: "National Plan of Action for Decent Work (DWNPA)—The tripartite constituents (workers, employers, government) and the office of the ILO review national policies and ongoing activities, analyzing the deficits/gaps/challenges from a decent work point of view. The DWNPA explains how the Decent Work Agenda should be integrated in national policies and programs to be implemented by governments and social partners. It takes into consideration four strategic objectives (fundamental principles, rights at work and international labor standards; employment and income opportunities; social protection and social security; and social dialogue and tripartism) as a framework for identifying decent work deficits and prioritizing the issues to be addressed. ILO. 2001. Brief On DWCP and its Implementation Plan With The ILO Assistance. Available at www.pakistan.gov.pk/divisions/labour-division/media/BonDWCP.pdf (Accessed 14-11-2007).

discrimination on the basis of real or perceived HIV status. The ILO code is now recognized as an essential companion to the U.N. system personnel policy. [24] Throughout the course of this study, employer, government, and employee stakeholders mentioned the ILO Code of Practice as an important and valuable project input. According to those interviewed in the tripartite constituency, the ILO's visibility and support to the tripartite constituency has resulted in widespread credibility for the organization, which is why the Code has been so widely accepted. The code is now translated in 14 languages from project countries including: Amharic, Bahasa, Chinese, Ewe, Ga, Hausa, Hindi, Khmer, Nepali, Oromifa, Russian, Setswana, Siswati and Twi. Overall, the ILO Code of Practice is available in 54 languages.

Besides working with the national bodies charged with coordinating the struggle against HIV, the projects focused on Sub-immediate Objectives: (e) improved coordination and cooperation between tripartite constituents and other partners at the national and sub-regional levels, and (f) improved national level policy framework related to HIV/AIDS at the workplace to influence lawmakers on the rights of people affected by the virus and illness to operate in the society. This section addresses the progress made by the SHARE project in supporting new legislation or strengthening existing laws; and collaborative moves with the national AIDS strategies.

a.   National Policy and Laws

Laws and policies concerning HIV in general and specifically in the workplace have proved difficult to realize, despite agreement by leaders and policy makers that the infection poses many legal issues. In its efforts to have an impact on national policy and legislation, the project has had mixed success. Within the scope of the project, it was felt that if the tripartite constituency could publicly support National AIDS Policy with declarations, it would send a strong message to enterprises and workers. Tripartite Declarations on HIV/AIDS have been adopted in a number of the SHARE countries, including Burkina Faso, Cameroon, Indonesia, Madagascar, Swaziland, and Togo. These declarations are considered important benchmarks that promote rights-based approaches. From the beginning, SHARE was anchored in national policy. However, even with existing policies in nearly every country, the project's focus on the workplace required new policies, strategies, and regulations.

National Policy and Legal Framework

Country & Population[25]	Barbados 294,000	Benin 9,033,000	Botswana 1,882,000	Cambodia 14,444,000	India 1,137,931,600
Project Dates	2003–2007	2002–2006	2003–2007	2002–2006	2001–Present
Status of National HIV AIDS Laws and Policies; *national HIV/AIDS and employment policies*	1. Social Partners Code of Practice on HIV/AIDS and Other Life-Threatening Illnesses in the Workplace 2004 **SHARE PAB** recommended for a review; the Social Partners'	1. *National Tripartite Declaration* to fight HIV/AIDS in the world of Work, 2005 (developed with **PAB,** based on the ILO Code of Practice) 2. *Act 2005-31* on Prevention,	1. Public Service Code Of Conduct On HIV, 2003 2. Ministry Of Labour and Home Affairs Policy, HIV/AIDS in the Workplace, 2001	1. Law on Prevention and Control of HIV/AIDS, with HIV workplace issue, 2002 (**Tripartite constituents** worked with NAA to develop implementation guidelines for	1. **Project** facilitated the development of a *Joint Tripartite Statement of Commitment* on HIV/AIDS of Central Trade Unions, 2005 2. **SHARE India** contributed to

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[24] Available at http://unworkplace.unaids.org/UNAIDS/workplace/ilo_code.shtml.
25 Figures are based on the most recent estimate or projection by the national census authority where available and generally rounded off. Other figures are based on the July 1, 2007 estimate by the United Nations Department of Economic and Social Affairs—Population Division.

Country & Population[25]	Barbados 294,000	Benin 9,033,000	Botswana 1,882,000	Cambodia 14,444,000	India 1,137,931,600
Project Dates	2003–2007	2002–2006	2003–2007	2002–2006	2001–Present
	Code to include all 10 Key Principles of the ILO Code of Practice.	Treatment and Control of HIV/AIDS, 2006 Chapter 6 addresses World of Work issues.	3. *Draft Policy* (developed with **PAB** support and advocacy) The draft of National Policy on HIV/AIDS and Employment is under consideration in Ministry of Labour and Home Affairs (MLHA) office.	the HIV/AIDS law) 2. MOLVT Ministerial Decree (*Prakas*), mandated HIV workplace committees **(SHARE** played influential role) 3. Trade Union Policy on HIV/AIDS 2006.	the adoption of Employers' Statement of Commitment on HIV/AIDS 2006 3. **Project** helped MOLE and NACO to draft HIV/AIDS and workplace National Policy, (now under discussion).
World of Work now in **National HIV/AIDS Strategic Framework**	Yes	Yes	Yes	Yes	Yes

In **Benin**, the first major achievement of their Project Advisory Board was the National *Tripartite Declaration to Fight HIV/AIDS in the World of Work*, which was passed in July 2005. The substance and text of the declaration was developed during a project sensitization workshop one year earlier, attended by 125 tripartite constituents in July 2004. The declaration was adopted at the end of the workshop and presented to the Ministry of Labour for signature. The persistence of the project NPC and PAB members resulted in the Minister for Public Service, Labour and Administrative Reform signing and publicizing the Declaration. Powerfully written, it has been extremely well received and forms the basis for enterprise policies.

Project stakeholders are particularly proud of their participation in advocating for and providing advice on Benin's law concerning HIV and AIDS, especially since Benin is one of the few countries in Africa with the law. The Benin AIDS law project actually began in 2001 when the Vice President of Parliament started working on it. With technical assistance from the African Union's *Organisation pour l'Harmonisation en Afrique du Droit des Affaires* (OHADA), he tried to create legislation but received little support. Once public and vocal support came from the distinguished Project Advisory Board, combined with the muscle of the Tripartite Declaration, the law, *Act 2005-31 on Prevention, Treatment and Control of HIV/AIDS* was passed on April 5, 2006. The law contains a specific chapter especially focused on the workplace. It makes discrimination in the workplace illegal. However, while the law includes penalties for breaches of confidentiality of people who are HIV-positive, and negligent handling of blood, it lacks penalties for discrimination. It is evident that the project had a lot to do with mobilizing employers and workers, as well as the labor ministry personnel, to advocate successfully in getting the law passed.

Meanwhile in **Botswana**, a nation that has visibly matured through decades of HIV and AIDS, creating a meaningful legal framework has been slow. As of mid-2008, Botswana still has not adopted the National Policy on HIV/AIDS and Employment. The Project Advisory Board, in several consulting meetings, played a major role in designing the current national policy draft. The draft policy is in the office of the Minister of Labour and Home Affairs, who is to present it to Cabinet for the second time. Cabinet had

rejected the first draft on the basis that it was biased towards workers and advised on a more balanced document based on the principle of shared responsibilities. So for the present, the country has neither a policy on HIV/AIDS and Employment nor any comprehensive legislation that directly addresses HIV and employment. The PAB can take responsibility for keeping the process for development of policy on the table. Initiated by the Ministry of Labour and Home Affairs, and tripartite constituents with technical assistance from SHARE, the policy is close to being accepted. However, tripartite constituents and other PAB members are concerned at government's failure to give the policy a priority.

In **India**, the project contributed to the adoption of policies and strategies on HIV in the workplace. The ILO Code of Practice was one of the tools used to inspire and formulate a number of the policies. The ILO Code of Practice was officially endorsed by NACO in 2006. The Ministry of Labour and Employment (MOLE) and NACO have drafted a National Policy on HIV/AIDS and the world of work, which is in the process of finalization. NACO has repeatedly mentioned the importance of private sector involvement and addressing HIV in the workplace in official documents, guidelines, and their website.[26] One set of guidelines on working with migrants and truckers, for example, includes a section entitled "NACO guidelines on Strengthening HIV/AIDS interventions in the world of work in India.[27] The Indian Employers' Statement of Commitment on HIV/AIDS was facilitated by the ILO project, NACO and MOLE in 2005, and is published on the NACO website.[28] A Joint Statement of Commitment on HIV/AIDS of the Central Trade Unions of India endorsing the ILO Code of Practice on HIV/AIDS was adopted in 2007. The Indian Network of People Living with HIV/AIDS has also endorsed the ILO Code of Practice as the key instrument for reducing HIV-related stigma and discrimination and protecting rights of PLHIV at workplaces. The INP+ has over 100,000 members. The ILO project and project stakeholders have contributed to the development of strategies for the National Aids Control Program III.

A draft law on HIV has been submitted to NACO but adoption procedures are still in progress.[29] The law covers many issues, not only on HIV in the workplace. An important component, however, is the prohibition of discrimination in the workplace based on HIV status. A large amount of advocacy to support the draft law has already been undertaken. The Labour Minister is the convener of the Parliamentary Forum on HIV/AIDS set up in India. Although the ILO project has provided advocacy support in collaboration with its partners, ensuring passage of the law is no simple matter. Several interviewees noted that passing laws in India is a very long and bureaucratic process and that the draft law may cover too many separate issues to ensure relatively swift passage. As India is a very large democracy, successful deliberations and passage of the law first requires input from a range of sources. Another interviewee noted that a sense of urgency to pass the law is lacking; HIV is seen as an important issue but not a priority. A related issue is that there is no special legal court or specialists who can judge any cases that might be brought as a result of the new law. There has been some training for judges but according to some interviewees, most legal system officials do not yet really understand the issues.

The experience of the project stakeholders in working on legal framework issues was extremely powerful. Over the life of the projects, PAB members and beneficiaries in different countries became aware of policies, laws, codes, and ordinances related to HIV in either supporting workers or having negative effects. The project engaged lawyers and activists outside of the tripartite structure to become re-focused on the workplace as a site for legal protections. The project could be more active in promoting sound

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[26] National AIDS Control Organisation. 2008. National AIDS Control Organisation. 2007.
[27] National AIDS Control Organisation. 2007.
[28] Indian Employers Organisations of India. 2005. Indian Employers' Statement of Commitment on HIV/ADS. ILO. Geneva and New Delhi. Accessed 10-06-2008; available at www.nacoonline.org/Quick_Links/Publication/IEC_
Mainstreaming_and_Social_Marketing/Others/ILO_Indian_Employers_Statement_of_Commitment_on_HIVAIDS/.
[29] Ministry of Law and Justice. 2006.

national policies and laws with consequential penalties in countries worldwide. The extent of implementation of policies that have already been adopted has not been carefully monitored. A system for improved tracking of the implementation of policies adopted by the tripartite constituents and their NGO partners needs to be developed. The legal and policy frameworks have the potential of doing more for workers and enterprises. The consensus of lawmakers and AIDS activists is that more needs to be done to ensure the protection of people living with HIV/AIDS in the workplace, and that workers have the right to services, treatment, and testing.

b.   Country Strategies to Combat HIV

In response to the HIV epidemic, **Botswana** established the National AIDS Control Program in 1986 and developed National Plans to guide the national response to the scourge. Like most countries, initial attempts were limited in scope and were largely health sector based. As the epidemic evolved, more sectors became involved, including multinational and large companies, particularly mining companies. Botswana

> **The first priority in the national response is Prevention of HIV Infection.**
>
> *-Botswana NACA, 2003, National Strategic Framework, p. 9*

has national- and district-level structure that is mandated to coordinate responses to HIV. The present National Strategic Framework on HIV/AIDS 2003–2009 is the most comprehensive plan ever for the country. It outlines priority objectives and describes minimum implementation programs for various sectors. Although Botswana had been an important international locus for AIDS projects and activities at the beginning of the SHARE project, the country offered an opportunity for the ILO's fresh approach as it sought different and more successful strategies.[30] Today, Botswana is clearly a more mature country as far as handling the AIDS issue. The SHARE project has contributed much in integrating HIV/AIDS education in the workplace, and by helping to expand the focus beyond the medical/health arena. Each Ministry has an HIV/AIDS coordinator with a job description that now includes wellness coordination. The trend in the country is to recognize HIV as one of many health issues and mainstream it into employee welfare, health and safety, and other wellness areas. For many practitioners and AIDS activists, the concern is that AIDS be considered uniquely and recognized for how it contributes to the other wellness issues including diabetes, tuberculosis, and other diseases. All ministries have an HIV/AIDS Focal Point, and some are more active than others.

In **Barbados**, since 2000 the national response to HIV has been coordinated through the Prime Minister's Office. The Prime Minister of Barbados is recognized as a key advocate of AIDS education, both nationally and regionally, in the Caribbean. The Ministry of Labour and Social Security is the line Ministry within the multi-sectoral approach and is responsible for implementing programs on HIV and the world of work. The Barbados Policy on HIV in the Workplace was developed in consultation with key social partners and is addressed in Protocol IV. The protocol on HIV has been extracted and compiled into a booklet entitled, *"The Social Partners of Barbados' Code of Practice on HIV/AIDS and other Life-Threatening Illnesses in the Workplace."* Based on the principles of the ILO Code of Practice, it is promoted as Barbados' official workplace policy document. In Barbados, AIDS is not considered as much a disease of poverty as it is considered a consequence of "risky behaviors ranging from unprotected sexual contact, needle sharing, multiple partners, early start of sexual relations, migration and mobility."[31] Thus, the Barbados Government has focused on addressing those issues.

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[30] Interviews with NACA Consultant, Peter Stegman; Botswana UNAIDS Country Coordinator Evaristo Marowa.

[31] Barbados HIV/AIDS Prevention and Control Project. 2003. Cooperation is key to fighting HIV/AIDS. World Bank document.

In **Benin** the National AIDS Control Program (PNLS), established in 1987 within the Ministry of Health, coordinates the national response to HIV. In 2002, the Government reinforced its commitment to fight the epidemic by launching a multi-sector response with the involvement of civil society and the public and private sector. The National HIV/AIDS Committee (CNLS) was created under the leadership of the President of Benin, and a National Strategic Plan (NSP) is now entering its second phase. The NSP provides the national strategic orientations, which include the priority action areas as well as the framework for tripartite collaboration. The Government has a weak strategy of appointed focal points in all Ministries who are responsible for issues concerning HIV and AIDS. The project has strengthened the CNLS and the director is a member of the PAB.

The project in **Cambodia** was launched in 2003 in direct support of the law on "Prevention, Combat against the spread of HIV/AIDS" to further strengthen the HIV prevention and care efforts and to reduce stigma and discrimination.[32] Article 9 states: "All institutions, enterprises, and handicrafts, shall collaborate with the National AIDS Authority in organizing the education programs on HIV at the workplace by including the topics on the maintaining of confidentiality at the workplace, and attitude towards those persons who have HIV." In August 2002, the government developed a Strategic Plan for a Comprehensive Response to HIV/AIDS, 2002–2006. Strategy 5 of this Plan calls for "Enhancing workplace interventions in support of preventing workers from HIV infections and increasing their accessibility to services." The strategy provides a detailed list of objectives under Strategy 5 that closely match the project objectives. During the interviews, the Ministry of Labor representative recognized the usefulness of the ILO project in implementing the strategy. External donors include the Global Fund (accounting for 20% of funding), U.N. Agencies (funding 18%), while bilateral donors such as USAID and the UK Department for International Development (DFID) accounted for 42 percent of the budget in 2006 and 2007.[33] U.N. agencies work in their respective areas of expertise. Several national and international NGOs have worked on HIV in the workplace, including CARE (Comfort, Assist, Reach-out, and Educate Association; garment industry), FHI (Family Health International), several large companies, the Ministry of National Defense and the Ministry of Interior (to reach the military and police structure and systems), and Australian Red Cross with the Cambodian Red Cross (Cambodia/Vietnam border casinos).[34]

In **India**, the project was developed in support of the Indian Government's broad strategies to address HIV. The Government of India established the National AIDS Control Organisation in 1992. The project started implementation under the second National AIDS Control Program (NACP II), which began in 1999 and ended in 2006.[35] Under the second NACP, the focus was on targeted interventions for high-risk groups, *preventive interventions among the general population,* and involvement of NGOs and other sectors and line departments such as education, transport, and police. The country is currently implementing the NACP III. The project has contributed to improving government capacities to implement HIV in the workplace through technical support on linking strategies and mainstreaming. The project prepared drafts, for example, on how to link prevention strategies and inputs on HIV in the workplace for the current NACP-III. NACO states in its message of introduction to the Indian Employers' Statement of Commitment on HIV/AIDS that: "The ILO Code of Practice mirrors the vision and action statements in India's National AIDS Prevention and Control Policy."[36] Other major donors on HIV in

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[32] ILO & U.S. Department of Labor. 2003. Project Document, p. 9.
[33] National AIDS Authority. 2008. National Strategic Framework (NSF) Botswana.
[34] Red Cross Australia. 2008.
[35] World Bank. 2007.
[36] Indian Employers Organisations of India. 2005; Indian Employers' Statement of Commitment on HIV/AIDS. ILO. Geneva and New Delhi, p. 3, para. 2.

India include a variety of U.N. and bilateral donors.[37] The donors have mostly supported national initiatives that are driven by either government agencies or through NGOs in support of the national strategies. Prior to the project start-up in 2001, there were few focused initiatives on HIV in the workplace. A few other agencies had undertaken efforts that did affect workers in various settings but these did not result in programs that were fully integrated into the workplace. The ILO project continues to take the lead on efforts to address HIV in the workplace. Donors and NGOs seek and receive technical input and support from the project.

According to the Project Management Team in all SHARE project countries, the National AIDS Strategic Frameworks now include a component on the world of work (except for Russia, where the National Strategic Framework (NSF) is still to be officially adopted).

c.   ILO Code of Practice on HIV/AIDS in the World of Work

The ILO Code of Practice on HIV/AIDS in the World of Work was very well received and found to be complete and precise by interviewees in every country studied. The ILO Code of Practice was used to inspire policies at all levels of the tripartite constituency and also for training materials. PAB members in Benin credit the Code for providing the background and "muscle" they needed to create their Tripartite Declaration.

In **Cambodia**, the ILO Code of Practice formed the foundation for the *prakas* Government policy guidelines on HIV in the workplace. Representatives of PLHIV were very appreciative of the Code overall, and noted that it is very appropriate for Cambodian workers. An important aspect for PLHIV is the fact that it clearly mentions stigma and discrimination of workers with HIV. The Cambodian Labor Confederation representative noted that the ILO Code of Practice is a very good tool to deal with HIV in the workplace, but that application is the key issue.

In **India**, project staff reflected that since the ILO Code of Practice is not a convention, and thus not an obligation, they actually had to encourage people to read it. After studying it, some people later actually wanted to know why it is a voluntary tool and not a convention. The project found no challenges with respect to any aspect of the ILO Code of Practice. Staff found that providing the Code directly in meetings is more effective than merely mailing it and expecting people to read it. The Indian National AIDS Control Organisation had no reservations with regard to the ILO Code of Practice and immediately endorsed it. Other donor partners, such as GTZ (German Technical Cooperation), also appreciated the content of the Code. The Council of Indian Employers indicated that the ILO Code of Practice is a good document but that the more important aspect is to "get companies to adopt it. That is a huge task." Employers and trade unionists, as well as government officials such as the District Multisectoral Commissioner in Maun, **Botswana**, cited the ILO Code of Practice as a really helpful guide to developing workplace policies. When the program began in Botswana, six enterprises had policies; some of them later refined their existing codes to conform to the ILO Code of Practice. In 2007, participating enterprise Delta and Desert Safaris refined their workplace policies to conform with the ILO Code.

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[37] World Bank. 2007.

SECTION II: PROJECT IMPLEMENTATION

During a meeting at the U.S. Department of Labor in April 2008, the Geneva-based SHARE Director Behrouz Shahandeh and USDOL representatives in attendance voiced an interest in reviewing the project step-by-step. Using the framework suggested in the Cross-Country Terms of Reference, this Section traces the seven major components followed in implementing the SHARE project in the five countries that were studied.

1.   Step-by-Step Implementation

a.   Setting Up the Infrastructure

1.   Technical and Administrative Support
ILO STAFF in Geneva work as a team, providing technical and administrative support to the 24 countries through a Program Management Team (PMT). This PMT consists of the Program Manager; Program and Operations Officer; Technical Specialist; Technical Officer, and two administrative staff. The program staff has divided up the countries so that each one has some responsibility for backstopping a few countries. Divisions are made according to language proficiency (e.g., francophone countries) and area of expertise. The level of interaction between country desk officer and NPC appears to be fairly regular, but there is some irregularity. The PMT has not visited all countries. For example, the Botswana NPC reports that most face-to-face interactions with Geneva have been at the South Africa project office. For the most part, this does not seem to have negatively affected project implementation. NPCs do not report feeling isolated. There were several visits to Benin. However, the Jamaica NPC had problems in organizing the Project Advisory Board—obfuscated by written, more positive reports, which might have been detected if a field visit had occurred. Determining the necessity of visits would seem to depend on the relationship and communication between NPCs and program officers; though generally, in any enterprise, visits from the 'home office' are appreciated once in a while. The key is ensuring that NPCs feel connected to and supported by the PMT, so that they can implement a project which is of the highest quality, while balancing the interaction so as not to appear detrimentally intrusive. The virtual community helped, as did regional meetings, but each country should be visited at least once during a project's lifetime.

The Program Management Team in Geneva was very competent, and extremely knowledgeable about those countries for which each was responsible. They were also well informed about other country programs as well, indicating a fair amount of staff information sharing; it is not known whether that is formally or informally done. It is a small office, manned by capable and organized people. They have handled the work well, considering the size of the project and the small staff size.[38]

2.   Community Zero
The Program Management Team set up Community Zero (CZ), an interactive web page that serves as a virtual community for all of the projects. All project documents, press releases, BCC materials, technical progress reports, and much more are found there. It is organized and easy to navigate, but the information is not always found where one expects. Both researchers for this study struggled to find Technical Progress Reports, only succeeding after intensive and somewhat counter-intuitive searches. It is

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[38] National Project Coordinators are of the professional level that they should be able to operate fairly independently. The bureaucratic nature of the ILO was not mentioned often enough to make it an issue, but all NPCs mentioned some irritating process required to, for example, obtain funds or reimbursement, or to modify the project. According to the International Labour Organization/U.S. Department of Labor (ILO-USDOL HIV/AIDS Workplace Education Project in Barbados 2004-2008, Final Evaluation, 25 February–5 March 2008): "…However, the ILO brings bureaucracy with its projects—permission was always needed from ILO Geneva for any changes in the Project."

somewhat difficult to gauge use and the question arises; do NPCs have the time to input, read, or communicate data, given their other tasks? There is a discussion area, with Sidewalk Café and options for IT tips. Friendly interactions took place sometimes, and the Cambodia NPC wrote a poignant farewell letter.

Particularly after earlier regional meetings, it seemed that the sharing of ideas took place among NPCs across borders, whether through Community Zero or by regular email. Despite power blackouts and faulty Internet connections, the **Benin** National Program Coordinator actively used Community Zero. He was committed to the *global nature* of the SHARE project and frequently used the example of CZ and the efforts of colleagues elsewhere as a motivating aspect when speaking with enterprise executive officers as well as peer educators. For him, it held great worth that the people involved in SHARE in Benin were not alone but part of a larger movement to support people in the workplace. The data input on Community Zero seems somewhat uneven when trying to compare and contrast country files, but despite its very minor flaws, it symbolizes and to a measured degree, supports the international aspect of the SHARE project.

3.   National Project Coordinator/Project Implementation Unit
In the countries studied, the National Project Coordinators were typically impressive. In interviews with stakeholders of the project, NPCs were frequently defined by their leadership skills, goodwill, and dynamism.[39] The project staff consists of an NPC, an administrative assistant, and a driver. In the **Caribbean**, several NPCs opted not to hire a driver, which saved money. In the case of **Barbados**, a much desired program assistant was not hired. NPCs hired capable staff; with limited financial resources and a short timeframe, efficient and flexible teamwork was needed in order to respond to the regular and ad hoc tasks that were called for during the implementation of the project. Drivers were knowledgeable about the project, knew key individuals and project sites, and had plenty of energy and enthusiasm for the project. They were trustworthy and intelligent, so that NPCs could depend on them to make necessary decisions in a pinch.

The caliber of these NPCs was noteworthy: In India, the project leaders earned the title of "Champion."[40] In **Botswana**, Marianyana Selelo, a nurse practitioner with experience working on AIDS programs among the military and private enterprise, was their first NPC. Using her strong skills in advocacy and personal relations, she visited individual employers as well as all the stakeholders and got them to agree on the TOR. By the time she had scheduled the first Program Advisory Board, she had most people already committed to the project. When she moved on, she was replaced by Jeffrey Makgolo, a well-known and respected NGO activist with proven leadership skills as head of the Botswana Business Coalition Against AIDS. **Barbados** NPC Arlene Husbands holds two master's degrees (Business and Public Administration from Baruch College, and Science in Health Education Management from Hunter College, City University of New York) and came to the position with more than 20 years experience working in the HIV and health field. When she took up her post in July 2004, she was already recognized throughout the country for the work she had done on HIV/AIDS in 1998. The former NPC of **Cambodia**, Chun Bora, was personally recruited to become part of the faculty team to share expertise for the first Social Work college degree program in HIV/AIDS at the Royal University of Phnom Penh (RUPP; in partnership with the University of Washington in Seattle, Washington).[41] In **India** at the project level, Project Director Asfar Mohamed and his team were commonly cited as effective champions for the cause of HIV in the workplace.

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[39] The head of the Barbados AIDS foundation was keen to hire the former NPC as an executive director.
[40] See Champions described in Annex 3.
[41] See http://depts.washington.edu/sswweb/rupp/ for further details and information about this partnership.

The Program Management Team acted prudently in hiring staff. Dr. Moucharafou Idohou, an MD specializing in work place health and safety in **Benin** at the time of the project. His integrity and ability were well known, and his colleagues urged him to apply. After panel interviews by Benin Government and U.N. officials with a number of candidates, 6 more months passed before the chosen NPC was contacted, delaying the project. During this time, the parties signed the Memorandum of Understanding (MOU) and took some preliminary steps, including elaboration of the project. Dr. Idohou swiftly took the prescribed steps to build solidarity and understanding among the stakeholders; implementing the necessary data collection, holding BCC workshops, and bringing the project up to speed.

In some countries, stakeholders easily praised the NPC. According to various stakeholders, including the Permanent Secretary of the Ministry of Labor in **Botswana** and the Director of the National Program to Fight AIDS in **Benin**, success was due to tireless advocacy and relationship building, enthusiasm for the work, and a professional approach. It is also impossible not to notice the high degree of professionalism and mutual respect that exists between and among the project staff in Botswana and Benin, and with the Labour Ministry, trade union, or ILO personnel housed in the same buildings.

4.   The Project Advisory Board
In every country, a PAB was formed to provide advice on the annual work plan of activities, review progress reports, and to advise on policy and implementation issues. Composed of representative constituents of the tripartite as well as NGOs and civil society groups (such as PLHIV), the Boards met regularly under the chairpersonship of a highly-placed labor ministry, such as the Permanent Secretary. Project Advisory Boards were routinely described as effective and having contributed to the implementation process.

It is not uncommon for structures such as the PAB—which are supposed to provide input and guidance for the functioning of a project—to be relatively ineffective. Individuals interviewed in the course of this multi-country study determined that this was simply not the case with the SHARE Project Advisory Boards. The PAB brought decisionmakers at the national level together to discuss issues directly related to the project, and even overall policies, strategies, and actions on HIV in the workplace. **Cambodia** is now creating a new structure based on the former PAB that will continue to address issues of particular importance in terms of implementation efforts. Regular progress reports were submitted and discussed within the PAB and work plans fine-tuned and finalized during meetings. In India the meetings are held every 3 to 4 months, while in Cambodia they were held every 6 months.

In **India**, PAB meetings are carefully planned and a report of the minutes of the meetings is sent to all participants and approved. Given the importance of democracy in government functioning in India, the PAB has been instrumental in direct advocacy with the Government because it is recognized as representing a range of important and large entities. The project staff noted that this was very useful, as opposed to advocacy being stimulated only by the ILO. One of the challenges, however, was that in some meetings organizations have sent consultants who do not have the institutional history in mind instead of senior decisionmakers. MOLE has sent a request to NACO, for example, that they need to send a more senior person. The role of MOLE as chair of the PAB has been efficient in terms of scheduling and approving the minutes of meetings.

In **Cambodia** and elsewhere, it happened that all members did not always agree on the best way to move forward. The chairperson plays a very important role in ensuring that consensus is developed. In Cambodia, consensus formation is an important method used in group decisionmaking. The relationship of the ILO National Project Coordinator with the PAB is critical and could have been improved if the MOLE chairperson's role had been better defined. Members need to fully understand the laws, prakas, and enforcement methods, and that there can be no discussion on the fact that they need to be

implemented. A balance needs to be found within the PAB to ensure participation, but members must also understand that 'laws are laws' and need to be implemented.

In **Botswana**, the Board was purposeful and functioned well. Each member had differing perceptions about the utility and effectiveness of PAB. The Permanent Secretary of the Labor Ministry was the Chair, who was rarely accessible and usually too busy to attend meetings. Consequently, he was vague about the process, but the Surrogate chair was an active participant who appreciated the PAB, the hard work that had been put into creating a national policy, and the effectiveness of the enterprise-based activities. Most members considered the PAB a serious player, even a leader; not just in the workplace but in the country's fight against HIV/AIDS. The National AIDS Coordinating Agency (NACA) representative, who had experience working on AIDS committees in Ghana, was impressed with the national respect that the PAB gained in a short amount of time, mostly due the efficiency of meetings and the focus. It was his impression that the PAB is a relevant structure in Botswana that offers great potential. As noted in the midterm evaluation, the representative of the Botswana Network on Ethics, Law, and HIV/AIDS (BONELA) left the PAB. The representative explained that the decision was because BONELA wanted more activism on the part of the board. Further, the group determined that their organization's input had been appreciated, but was no longer necessary for the rest of the project. In an interview, BONELA clarified that the experiences with PAB had been very positive, especially noting the work done in studying existing law and policy in the country while preparing a national policy draft. Further, it was the opinion of the BONELA Policy Advisory Board member that the board provided an important forum for lively discussions and the sharing of information that was lacking in the country.

Overall, the role of the Project Advisory Board was clearly defined. As a result, board members in the countries studied reported a high degree of satisfaction in their work. Members felt engaged, confident about the usefulness and effectiveness of the organization, and were pleased with the professional approach. Meetings were regular, well organized, and efficiently run. The PAB was the key body that served to associate the tripartite constituents at the national level. Tripartite constituents in all of the countries studied lauded the approach of joining efforts to address HIV in the workplace as an effective approach. Other NGOs, such as CARE, FHI, and local groups in Benin, India and Cambodia, noted the usefulness and added value of the tripartite constituency approach. CARE, a member of the Cambodia PAB, reported that the tripartite approach was new for them. They found the approach useful, because although they had worked with management in some companies, they were not familiar with working the unions.[42]

The apparent engagement of members and the changes and modifications made in other countries are sufficient to indicate that there was not rigidity about either the overall design or the implementation of the project, and that PAB members had an important role to play. As has been mentioned, the representative of the Indian Network for People with HIV/AIDS was welcomed on the board, and the input of that special constituency was seriously considered, causing project design modifications.[43]

In **Barbados**, the Project Advisory Board was considered to be a nurturing body. It offered the chance for key organizations and representatives to strengthen their relations and combine efforts where possible.

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[42] In only one instance did the impressive degree of engagement by PAB seem to be weak. The NPC for Jamaica reported that the Project Advisory Board was "non-functioning," and probably unnecessary. Because the ILO had a methodology and project design already, the PAB essentially "rubber-stamped" the activities, including the choice of sectors. Jamaica's AIDS activist community has sufficient coordinating bodies, and members of the PAB were stretched because they participated in other national HIV/AIDS activities.

[43] Celine D'Costa.

The Board was said to have developed "a healthy interdependence," which was noted during interactions amongst members.

In **Benin**, the Project Advisory Board (CCP; or the Conseil Consultatif Du Projet BIT/USDOL) was formed before the NPC was hired. Once on board, the President of the CCP and the NPC developed a rich collaborative approach and created an active body. The PAB consisted of 15 members and, like those in other countries, was presided over by a highly placed official of the Ministry of Labour, and included representatives from all of the tripartite constituency, UNAIDS, and the health sector. The head of the National AIDS Commission was also an active member. As in many other countries, the President of the country is the titular head of the National AIDS Commission, but it is presided over by the director, Dr. Valentine Medegan Fagla-Kiki, Secrétaire Permanent du Comité National de Lutte Contre le SIDA. She was not only available and accessible to the project advisory board, but was also an active participant; of which the NPC is also a member. Besides regular quarterly meetings, the PAB met several other times to discuss key milestones for the implementation of the project. These included: examination and adoption of the work plan; setting up a working committee to finalize the draft National Tripartite Declaration on HIV/AIDS; examination of the conclusions and recommendations of the national sensitization workshop; and adoption of the country-specific project monitoring tools.

b.   Getting Started

In most countries, the project began with preliminary consultations beginning with the ILO tripartite constituency. Up to 125 representatives met in workshops and meetings and there was wide-scale participation in project conception. In some cases, company representatives participated, but usually as members of an employer association. In the same way, union representatives were consulted on project conceptualization, but not individual workers. The original project document was revised using the input of the representatives and an analysis of the country needs and opportunities to address HIV in the workplace.

The Ministry of Labor of each country— in Cambodia, the Ministry of Labor and Vocational Training (MOLVT), the *Ministère de la Fonction Publique, du Travail et de la Réforme Administrative* in Benin, Ministry of Labour and Home Affairs in Botswana, Ministry of Labour and Social Security in Barbados, and in India, the Ministry of Labour and Employment—was the government partner that endorsed and launched the projects. As a pilot initiative on HIV in the workplace, India laid the groundwork for establishing the project elsewhere. Starting in 2001, preliminary consultations were conducted with ILO's constituents in India and other project partners prior to officially launching the first project. The design and work plan were adapted based on stakeholders' inputs. New phases were planned with stakeholders' inputs through the PAB.[44]

In some of the countries, activities were already happening in workplaces but the ILO used a different approach, including input from the traditional ILO tripartite constituency of government, employers, and workers. The project also aimed to influence policy on HIV in the workplace in government laws, regulations, and policies, as well as among employers and workers federations. Those involved in trying to implement workplace projects, such as CARE in Cambodia, mentioned that this combination of innovative coalition building in the workplace itself, as well as the focus on policy, garnered respect for the project. Also mentioned by interviewees in nearly every country, particularly among the tripartite constituency, was the efficient and systematic approach to implementation.

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[44] In India the PAB is called the Project Management Team (PMT).

1   Mapping Exercise

At the beginning of the project, National Program Coordinators oversaw a mapping exercise (often conducted by an independent consultant) to understand the actual situation and context regarding a wide range of issues related to HIV AIDS in the workplace. This included recognizing the prevalence and incidence of HIV AIDS in the country, reviewing national laws and government's policies, as well as workplace policies. The main purpose of this study was to prepare a status report on the existing or ongoing AIDS legislation, policies, workplace programs, research findings, and best practices related to the world of work in-country, and to provide an overview of existing material on Information, Education, and Communication (IEC) and Behavior Change Communication. This thorough study was conducted in accordance with the guidelines provided by the PMT to the National Program Coordinator and the consultants hired to do the mapping exercise.[45] As described by the consultant who did the mapping in **Barbados**, "The mapping exercise was the first activity undertaken in each of these countries before implementation of the project. The objective was to provide an overview on the impact of HIV in the country concerned, and of existing programs and activities relevant to the response in the world of work. The mapping exercise has three main pillars—

- A presentation of the current impact of HIV on the world of work;

- Information on existing policy and legislation, which may have implications for interventions on HIV in the world of work; and

- A collection of communication, training and resource materials that can support the world of work response."[46]

Before the ILO/USDOL project began in **Barbados**, the Chronic Disease Research Centre (CDRC)—connected with the University of West Indies—had conducted an HIV/AIDS Workforce Impact Study. The CDRC had also conducted sensitization sessions and needs assessment focus groups in 100 companies across all formal sectors. The project benefited greatly from this study and the group's experiences. Among other things, the study singled out useful issues, including the fact that while some national policy development had occurred and policies were in effect in some workplaces, most of the achievements were "fragmented."[47] Stigma and discrimination were considered serious problems, and effective approaches and policies to combat stigma were sought.

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[45] See CZ, Files and documents/Program Management Team/Guidelines.

[46] Sarah Adomakoh, Barbados HIV/AIDS and the World of Work: Mapping exercise report for Barbados (ILO/USDOL).

[47] Ibid.

The Government was anxious to support and promote broad public sector partnerships for prevention, advocacy, and action, especially in unions, NGOs, CBOs, civil society, and key populations at higher risk. The Barbados SHARE mapping exercise did much to confirm the CDRC study, but looked more deeply at national policy and specific workplaces; it found implementation of government policies across workplaces and other institutions "patchy, and in most cases, managers and sector planners do not have the necessary skills to implement, monitor, and sustain the sectoral implementation of AIDS policies."[48]

The CDRC worried that the public was becoming over-sensitized to the same information by various sources, and held that "novel methods are required to disseminate information including important research findings related to HIV and associated stigma." The Barbados SHARE project was designed to address exactly these concerns.

In **Benin**, an independent consultant compiled baseline data on the population generally, and specifically as it related to HIV; interventions that were in place in the fight against HIV and AIDS; identification of existing materials in-country and elsewhere that would be useful; and a general description of needs. The mapping exercise clearly identified a void in serving the workplace.

India's Mapping Exercise—a Rapid Assessment

Operating in uncharted territory, the India project carried out a Rapid Assessment (RA) in the three target states as the equivalent of the mapping exercise. The first RA was carried out in 2003 and repeated in 2006 as part of the midterm assessment, to enable the comparison of progress. The RA had both a qualitative and a quantitative component. The assessment's first phase consisted of collecting and analyzing secondary data on existing material and research already carried out. Phase II mapped locations of high concentrations of either formal and/or informal economy workers who may be vulnerable to HIV. Interviews with workers to improve understanding of their existing knowledge on HIV, their sexual practices, and media use comprised Phase III. The study identified common misperceptions across the three states, such as the idea that mosquitoes transmit HIV. Commonalities were used to develop the core messages. The RA concentrated on business sectors and included a cross-section of respondents. The study resulted in a swift development of core materials that could be adapted and replicated.

In the State of Jharkhand, the project partnered with NGO Synovate India, and conducted a mapping exercise to determine types and sizes of industries and types of informal economy workers. Studies were also carried out in Madhya Pradesh and West Bengal. Following the exercise, the researchers interviewed 703 informal economy workers and 1,405 formal sector workers on attitudes towards patients with HIV-related illness, condom usage, transmitted infections (STIs), treatment, media exposure, IEC intervention, and sexual behaviour. The survey's content was based on a list of questions they needed to answer in order to effectively implement the project. Quantitative and qualitative research and informal information collection was designed to have concrete questions answered, such as on condom use. The study appears scientifically and sufficiently planned, carried out, and reported; covering all of the issues satisfactorily, producing a good initial understanding of the situation so that actions on HIV in the workplace could start to be planned.

Employers and unions were concerned that virtually nothing had been done at the workplace level. Even among the multinational corporations in the country, of which there are few, health and safety issues did not address HIV-AIDS.

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[48] Ibid.

This was unusual, compared to multinationals in Botswana, India and elsewhere, where workplace projects existed already; particularly in the case of large international corporations. In Benin, the international corporations were identified as conservative and not particularly visionary. Some had policies for safety in the workplace, but none had policies addressing HIV and AIDS for their workers.

Sample selection was done using purposive selection methods. [49] Purposive sampling can mean that the sample of respondents is not truly representative of the larger pool of potential respondents. The report does not relate how individual respondents were selected within each sample unit. Although the study was primarily quantitative, there were stakeholder consultations, key informant interviews, and expert interviews, particularly in the initial mapping component. Additional discussions to deepen the understanding of the findings, particularly in focus group format, would have been beneficial.

In **Cambodia**, the mapping exercise contributed to the development of the indicators and the monitoring plan.[50] The exercise provided information that aided in selecting target sectors, described the work of other agencies, and signaled knowledge gaps of target groups. The mapping methodology consisted of interviewing key informants, assessing the existing legal framework in relation to HIV in the world of work, analyzing the research that relates to HIV and the workforce, and identifying research and programming gaps. The report is thorough and covers all the key information. An analysis of the strengths, weaknesses, opportunities, and threats (SWOT analysis) that the project would potentially face prior to and during implementation was included. The SWOT analysis was accurate and the project implemented many of the recommendations, but some of the good recommendations were not successfully implemented. Some of the recommendations that would have been useful to implement include the publication and dissemination of best practices in HIV workplace interventions in Cambodia and integrating IEC and/or BCC material development within one of the government units. A start has been made to implement several other recommendations. The short duration and limited human resources of the project impeded the full implementation.

As a first step in implementing the project, the mapping exercise provided staff, Labor Ministers and their staff, the Project Advisory Board, stakeholders, and other interested parties with a thorough understanding of the AIDS situation in the countries, as well as an in-depth view on the possibilities and needs for the project to succeed in the workplace.

2. Official Launch and Other Opportunities to Foster Effective Media Relations
The official launch of the **Barbados** ILO/USDOL HIV/AIDS Workplace Education Program called "Combating HIV/AIDS in the World of Work" took place October 12, 2004. The launch was combined with the debut of a booklet *HIV/AIDS Discrimination in the Workplace is Wrong*, published by the Barbados Employers' Confederation (BEC) in conjunction with the Barbados Chambers of Commerce and Industry (BCCI). The event was well attended by a wide cross-section of persons from government, the private sector, and NGOs. Coverage from both the print and electronic media was also good.

The description of the Barbados launch was typical of most of the other project launches worldwide and highlights the success that the project had in achieving necessary visibility. The events most often coincided with the signing of the Memorandum of Understanding by the country's Labor Minister and a representative from the ILO. The SHARE director signed the MOU in all countries. In Barbados and Botswana, for example, attention from the media did much to position the project as a national force. The signing of the MOU often represented the fruits of a long process involving sensitization, building loose

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[49] Purposive sample selection is the deliberate selection of sample units. Sample units are groups of respondents.
[50] International Labour Organisation, ILO/USDOL HIV/AIDS Workplace Education Program ITN/02/46M/USA (June 2004).

collaborative structures, and hammering out project concepts. It represented transparency that continued throughout the life of the project. Further, project coordinators felt any publicity furthered the cause of information and education about HIV and AIDS, especially in the context of the world of work. Most projects held public events and invited the media to a variety of activities, including the opening of training sessions, World Aids Day, and the HIV/AIDS Youth Conference.

Training events were frequently the subject of media attention. In **Botswana**, however, the opening ceremony of the northern Botswana BCC training started almost 2 hours late as a result of having to wait for the media. This partly contributed to the program running late the entire week. The media are paid or require travel expenses in some countries, particularly more impoverished ones such as Benin, and the trade-off needs to be considered as to the value of calling in the press.

The production of the film *Creating Change* and the new report-based book *Saving Lives, Protecting Jobs* are two examples of successful initiatives to increase public awareness of the project's accomplishments and to garner interest in HIV prevention. The film and book were launched in a number of project countries with good media coverage. The Caribbean Interactive Learning Event on Behaviour Change Communications marked the film premiere for the SHARE video and the media attended. The amount of media coverage was obvious, and the press in most of the participating nations also ran the story. The ILO offers Geneva-based press releases that are well written, timely, and pertinent. The ones produced for the film opening highlighted the work of SHARE in each individual country, plus contained updated general information about HIV and AIDS in the country and region.

3.   Sensitization Workshops
National sensitization workshops, which brought the traditional ILO tripartite constituents and the other relevant stakeholders into the process, formed a major step in the project implementation. These happened early on in the project and involved up to 125 participants.[51] Government officials and employer and worker organizations from all regions of the country were introduced to the mapping exercise and concepts of the potential effect of HIV in each of their individual bailiwicks. In some cases they created, or at least agreed, to adopt a plan of action. Sensitization workshops were extremely valuable for the tripartite constituents. The workshops brought together the concepts of the workplace as a logical place for HIV and AIDS programming. The results of the mapping exercises were always presented together with the ILO Code of Practice at the sensitization workshops. At first, meetings were complicated because of the variety of attending stakeholders. Once the tripartite constituency representatives began to work in separate groups, coming together to build consensus around the project, the project took off. Other resources included research organizations, UNAIDS, and NGOs, which added to the mix. This unusual grouping of tripartite constituents, in sensitization workshops, all working on a common theme was cited more than once as contributing to the success of the project in **Benin**, **Botswana**, and **Barbados**.[52] Although the trade union movement is not very strong in Botswana, the project offered the chance to open dialogue among all tripartite constituents. In the words of the Benin labor inspector responsible for norms, "Alone, these organizations could not have worked [on this project] but together they were able to face the issue."

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[51] Benin had 125 participants; in Cambodia 100 attended. In addition to earlier workshops held strictly for Botswana Labour ministry staff, one sensitization workshop was held for each of the tripartite constituents: employers in November 2004; worker organizations in December 2004; and another government workshop in April of 2005.
[52] India also organized sensitization workshops at the national level as well as in selected states. Initially organized by the tripartite constituents, the project later organized audience-specific workshops for constituents which proved to be very effective. Cambodia also held sensitization workshops, as consistent with the SHARE global methodology.

4.   Selection of Target Sectors

Beyond surveying the AIDS legal landscape, the mapping exercises provided necessary information that aided in the selection of target sectors. Sectors were identified according to some fairly common criteria worldwide. The program wished to address industries where there was thought to be high prevalence. For example, the economic sectors of tourism, commercial transport, factories, and mines are among those where large groups of workers are at more risk than others, and the mapping exercise identified those sectors in each country. After reviewing the results of the mapping exercise, the Project Advisory Boards participated in choosing the target sectors. It may be that NPCs and the influence of the ILO nudged the decision, but PAB members are satisfied with the choices that they made.

Botswana had one of the world's highest prevalence rates at the project's inception, so the choice of industries was critical. Any industry or enterprise might have qualified as having a great need, but the project wanted to create replicable models for targeted sectors. The relationship of industries to borders, migrant workers, transportation, and tourism were reviewed. The mining industry, closely linked to the same industry in South Africa, was determined to commit to, and run, well-organized HIV workplace programs. Significantly, the multinational mining firms have certification standards they impose on their supply chain enterprises. The PAB looked at those supply chain sectors, such as building construction. The PAB and National Program Coordinator decided to establish the program throughout the country in hopes of institutionalizing an activity in which ILO and the tripartite structure would be a reference point for those involved in the response to AIDS. According to Botswana's first NPC, "The program was interested in reaching people where they are, particularly those who work in isolated areas." While effective in a country the size of Botswana, this may not be operational in larger countries. Even in Benin, which is smaller geographically than Botswana, it was impossible to cover the nation because roads are inadequate. The importance of the informal sector in the country would have demanded coverage further north, but considering the resources available, it was more feasible to choose formal sector activities with greater economic clout.[53]

In **India**, selection was done through the PAB and was initially based more on geographic location as opposed to specific target sectors. NACO had suggested that little was being done in low prevalence states. The ILO was initially requested to concentrate on three states with low prevalence and less well-developed programs on HIV.[54] Within the states, however, other factors were considered in selecting industrial sector types that would be highly relevant, including in the informal sector. As time passed and the project acquired experience, more locations and sector types were added. Donors and national partners had already allocated priority states in India in accordance with their high prevalence of HIV. The argument for this allocation of states was to ensure greater coverage of programs across the country by different agencies working on HIV.

The selection of three relatively low-prevalence states hampered project implementation in several ways. The project had to overcome greater challenges to successfully advocate with their partners that HIV is an issue that deserves attention. Many companies and organizations were not easily convinced that they

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[53] According to the NPC, limited financial resources were the main reason for restraining the zones of action. Although Benin is a small country, compared to Botswana, for instance, geographical factors that affect the ability to run a completely country-wide project are also high cost factors. The extremely bad condition of the roads demands high maintenance costs for wear and tear of vehicles, which must have four wheel drive. It is possible to drive the entire north-south length of Botswana in a day. A shorter distance in Benin takes almost as long. Electricity and communication components also negatively affect 'pilot' project implementation. For the first phase, it was more efficient to work with partners closer to the maritime region, but the project resulted in many replicable practices and examples that would be worth pursuing throughout the country if resources were available.

[54] Madhya Pradesh, Jharkand, and West Bengal. In 2007 the prevalence in these three states was still less than 0.2% (UNAIDS & WHO, 2007). The Project Advisory Board together with the National AIDS Control Organisation determined the locations.

should invest time, effort, and financial resources into programs on HIV in the workplace. At the same time, the project was able to realize actions in the three states, thus demonstrating that even in low-prevalence states it is possible to implement preventive actions.

There was some discussion at project inception about the number of states in India to be covered. Efforts could have been more intensive if the project had worked in only one state. However, demonstrating a credible approach to HIV in the workplace necessitates a broader effort across several states.

The NPC of **Botswana** explained other target sector factors: "We were concerned about the textile industry where people are paid according to hourly wage and time is not provided for education. We wanted to advocate for stronger workplace policies. The strength of the program was not simply to try to introduce HIV and AIDS issues. It was also to strengthen the tripartite constituency in the workplace as well as at national level."

Safari-based tourism is a tightly controlled, high-end market that provides an important income source for Botswana. Tourism accounts for about 40 percent of the employment opportunities that have been created in the northern part of Botswana alone. The country has a policy of low-volume, high-cost tourism, intended to protect the fragile environment and stimulate sustainable tourism development. Those involved in safari programs are a special group of workers who have been determined to be at high-risk to contracting HIV. They spend 2 or 3 months at their workplace, isolated from their families. Despite the special nature of their jobs, they have a fair amount of idle time. There were found to be many elements of the work that put the safari staff at risk. Hotel and tourism enterprises had situations whereby, according to the workers' focus group participants, workers sold sex to the hotel customers. Safari Guides were noted for having a lot of disposable income from tips, and as a result, other workers targeted them for transactional sex, making them highly vulnerable to HIV. As in Botswana, the tourism sector in **Barbados** is also a high-risk sector. The mapping study showed that despite gains in developing pilot workplace responses to HIV, Barbados' efforts were in danger of stagnating due to lack of resources for a sustained response in private sector hotels and other outlets.[55]

The question on the selection of target sectors in **India** and **Cambodia** was a difficult one.[56] The projects worked with different types of businesses through a range of mechanisms. In both countries, aside from enterprises in specific types of sectors, a range of companies was also targeted through employer and worker federations and other partners. The federations usually include a wide assortment of types of companies in different sectors.

In India, the number of workers in different types of sectors is immense. The public sector alone employs over 18 million workers.[57] The government assesses that the number of people working in the informal economy is 340 million, while the formal economy employs approximately 55 million persons.[58] The agricultural sector is part of the informal economy in India. The number of informal economy workers in agriculture is 181 million, while the workers in other informal economy sectors number 159 million.

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[55] Findings from stigma and discrimination research under the Barbados HIV/AIDS Impact Project.

[56] The definition of what is meant by 'target sector' depends on the country and the interviewee. The consultant did not impose a definition of 'target sector,' preferring to allow interviewees to freely associate their responses so as to obtain a better idea of the actual groups concerned. In some countries the target sectors can simply be identified as formal and informal. In other cases businesses such as hotel and garment industries represent the target sectors. Other interviewees also interpreted sectors to include workers by type of worker, such as migrant workers, day wage workers, and contractual workers.

[57] Labour Bureau (2007).

[58] National Commission For Enterprises in The Unorganised Sector (May 2006).

Certain sectors, such as construction, are also included in the informal economy figures as most workers are casual laborers.

The India project unit implemented a rapid assessment that contributed to the selection of sectors to be covered within each state. In some cases, large international companies approached the project for assistance with setting up a program on HIV in the workplace. In other cases, the project identified potential companies to work with. Although the project correctly selected target sectors for the early stages of the project, interviewees noted that target sectors in need of more attention in the future include migrant workers, construction workers, and agricultural workers in plantations. Migrants, as in most countries, are vulnerable because they are mobile and away from traditional social control. Owing to their high level of mobility, they are simultaneously hard to reach. Some interviewees also noted that omitting agricultural areas in awareness raising and BCC programs is ill advised. Most migrants originate in rural areas and at least occasionally return home. As a representative of the Council of Indian Employers noted, "Women in rural areas do not have much voice and they should be addressed. Poverty is also a huge factor. They cannot ask their husband not to go to the city to work."

The target sectors in Cambodia were identified through a combined method of sectoral analysis of the key populations at higher risk and discussions with Project Advisory Board members. The Ministry of Labour and Vocational Training played an important role in the selection. The principal sectors selected were workers in the garment industry and in the hotel industry. The PAB considered these sectors to be of importance due to their size and their growth potential. Most workers in the garment industry are young migrants who are away from the social control of their home communities. Most workers are women who were found to lack knowledge of sexually transmitted infections (STIs) and condom use. In the hotel sector, there were more male workers found to use condoms infrequently when they sought sex services. The project concentrated on promoting behavior change by promoting the benefits of protecting oneself and one's family through consistent and correct condom use.

c.   Building National Capacity

Capacity building can be interpreted and administered in several ways; through human resource training and opportunities; in organizational development; with the elaboration of all management structures processes and procedures; and through institutional and legal framework development. Further, when programs focus on building these various capacities, one goal—whether stated or unstated—is to build sustainable structures. It can be said that the SHARE project addressed and succeeded in building capacity in ways related to the stated objectives.[59] Workplace policies specific to HIV, and in some cases, safety and wellness, were defined, developed, and/or improved, and they promise to remain in place in target enterprises. According to many representatives from the tripartite constituency, this project was unique in bringing together the traditional ILO tripartite constituents to develop workplace policies. Programs that met the needs (related to HIV/ AIDS issues) of the government, workers, and employers were designed and implemented. Materials developed for the workplaces were exchanged between sectors and enterprises (including informal sector workplaces), so capacity was enhanced in that area. In the context of the project, capacity building is mostly simply characterized by (1) training that increased knowledge and understanding, and (2) strengthening or building networks, coalitions.

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[59] To review, sub-immediate objectives included to improve workplace policies; increase labor and management workplace collaboration; increase workplace capacity to have sustained policies; improve the national level HIV/AIDS workplace policy framework; and increase the tripartite constituents' capacity in workplace policy development and programming.

1.   Working with the Ministry of Labor

Training and sensitization of staff, particularly of labor inspectors, were clearly activities that contributed to improving government capacities to implement HIV in the workplace through technical support on linking strategies and mainstreaming. In **Botswana**, the NPC worked with labor inspectors to understand how existing policies could be used to ascertain conditions regarding stigma, discrimination, services and referrals, and she accompanied some of them into the workplace in a spirit of experiential training. In **India**, the project prepared drafts, for example, on how to link prevention strategies and inputs on HIV in the workplace for the NACP-III. The project strengthened the capacities of the V.V. Giri National Labour Institute (VVGNLI) and the Central Board for Workers Education (CBWE). Both are training agencies under the responsibility of the MOLE.

In India, the project provided important support for institutional and informal training, including technical support and training to the VVGNLI. The VVGNLI conducts action-oriented research and provides training to grass root level workers in the trade union movement, including those in the informal economy. The Labour Institute also trains government labor officers who deal with industrial relations, personnel management and labor welfare. [60] The project implemented a pilot project in four locations through the Central Board for Workers' Education (CBWE). The CBWE provides training of workers in the techniques of trade unionism, and awareness raising among workers about their rights, duties, and responsibilities. [61] The CBWE trains 300,000 people every year across all sectors and in both the formal and informal economy. The CBWE works through "education officers" responsible for geographical administrative blocks. The project gave technical support for development of a communications package on HIV in the workplace that has been translated into 12 languages, and HIV has been mainstreamed into the syllabus.

While activities of one form or another concerning HIV in the workplace were not unheard of in most of the countries studied when the project began, the Labor Ministries were often sidelined. By centering the project in the Ministry of Labor, creating the PAB, and channeling all activities through the tripartite constituency system, the project invigorated ministry staff, including the higher-level authorities. The project did not bring huge amounts of financial or capital resources to the Ministries, but the training for labor inspectors and the enrichment to authorities helped build their capabilities.

2.   Working with the National AIDS Commissions

National AIDS Commissions function in all of the countries, but their effectiveness varies. In some cases, they are limited in their capabilities due to lack of funds, information, materials, or organizing and coordinating ability.[62] As the kingpin of the "Three Ones," they are responsible for coordination and keeping national activities on track.[63] It is noteworthy, therefore, that the NACA representative to the **Botswana** PAB frankly acknowledged that the ILO had contributed to keeping the NACA on track and raised their awareness of their duties and responsibilities. Without the project, the progress on a national AIDS policy would not have advanced as far as it has, according to him. In **Barbados**, the National AIDS Commissions and SHARE worked together. The NPC was considered technically strong and the NACA

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[60] Government of India. (2008). Both VVGNLI and CBWE are public sector organizations under the responsibility of the Ministry of Labour and Employment.

[61] Government of India. (2008).

[62] Country Coordinating Mechanism (CCM), case study documentation—BENIN; Report prepared for the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), financed by the French Ministry of Foreign Affairs April 2004.

[63] UNAIDS—The Three Ones: After consultations in 2003 among governments, multilateral and bilateral agencies, and a number of other stakeholders, the "Three Ones," were developed. These principles aim to strengthen coordination of national responses to HIV /AIDS by encouraging each country to have: 1.) One agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners; 2.) One national AIDS coordinating authority, with a broad-based multi-sectoral mandate; and 3). One agreed upon country-level monitoring and evaluation system.

board relied heavily on her managing and organizing skills. The world of work, or workplace issues, has been integrated into the HIV national strategic framework in all of the countries in the study.

One of the most important initiatives to strengthen national capacities happened in **India**, where a person specialized in HIV in the workplace was assigned through the project to the State AIDS Control Society (SACS) in Mumbai and Delhi as well as in the States of Jharkhand, Madhya Pradesh, and Goa. When the project started, India was in the second phase of the National AIDS Control Programme and there was not clear focus on workplace interventions. The project assessed two critical gaps; lack of a dedicated staff for SACS workplace interventions, and an absence of guidelines for SACS on workplace interventions. Including a person who specializes in HIV in the workplace was so successful, that it has been integrated into the National AIDS Control Programme III. The project improved government capacities to implement HIV awareness in the workplace through technical support on linking strategies and mainstreaming. The project prepared drafts, for example, on how to link prevention strategies and inputs on HIV in the workplace for the NACP-III. The project further participated in NACO's initiative to mainstream HIV into various ministries and departments. Experiences acquired by the project together with MOLE and the Ministry of Coal, Mines, and Steel were collated and provided to NACO for the purpose of developing work plans on mainstreaming HIV.

The project in **Botswana** was successful in building the capacity of district-level AIDS Commission government authorities in Maun (Northern Botswana) through relations established with participating enterprises, who participated on the local District Multi-Sectoral AIDS Commission (DIMSAC) through an umbrella tourism group. The highly developed system of routine transfer of civil servants by the Botswana government means each new DIMSAC Commissioner must re-learn what the former Commissioner understood. This has also occurred in the Charles Hill area, where there have been civil servant changes. The project could ask or offer to train all the civil servants, but in theory the government of Botswana is already engaged in highly focused workplace education programs.[64] International and private funds have poured into Botswana and the government is theoretically in the forefront.

3.   Working with the Workers' Organizations
Representatives from workers organizations were trained in all of the target countries. In **Barbados**, 40 representatives were trained, including 21 peer educators and 13 shop stewards. In **Benin**, 28 representatives from trade union federations were trained. More than 1,300 representatives from trade unions attended sensitization workshops in **India** and almost 500 trade union leaders were trained in their role to fight against HIV/AIDS.

In **Cambodia**, the project collaborated with three principal workers' organizations; the Cambodian Labor Confederation (CLC), the Cambodian Confederation of Trade Unions (CCTU), and the Cambodian Construction Workers Trade Unions Federation (CCTUF). The members of these trade unions cover a wide range of workers in various settings. Many members of the CCTUF are informal economy 'casual' workers. The Unions' capacity has likewise been strengthened through provision of technical support and training. The Unions, however, have limited resources and the extent of their being very active in assisting with the development of workplace programs remains uncertain unless further funding is provided. Unions work on a variety of labor issues, and integrating HIV components into their overall program is more likely to have an impact. This means that while Unions will not have intensive programs on HIV when they address labor issues, they are likely to ensure that it is included.

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[64] See, for example, the Ministry of Trade web page describing its HIV/AIDS workplace program. Unfortunately, the reality does not conform to the overall plan. As has been mentioned, some focal points are less aimless than others, and some government offices more aware than others.

Thirty representatives of the Trade Union Federation of **Botswana** were trained in the development of comprehensive HIV workplace programs. The trade union movement in Botswana continues to be very weak. There is a lack of clarity and understanding about trade unions; for example, a few entrepreneurial workers called themselves a union when they organized to collectively purchase mobile phones. One of the strongest trade unions, Botswana Mine Workers Union (BMWU) recently lost standing in an industrial court case in the face of withering criticism by the judge that their applications were flawed, saying "it was clear that someone who has no legal training prepared the application."[65] Capacity building in the strongest sense of the word is needed for the unions of Botswana.

4.   Working with the Employers' Organizations—Private Sector Response
The project's influence on the private sector should be considered important. A large proportion of the private sector was deemed somewhat sensitized to the impact of HIV at the onset of the project, especially in Botswana and Barbados. Despite this interest, however, activities were not targeted and usually involved small-scale workplace programs, charitable donations, or collaborative activities with the Ministry of Health. Once the project got off the ground, the response was still mixed, even within country. Although some companies expressed interest in tackling the epidemic through developing workplace policies and programs, and even had prevention education programs in the workplace, the companies lacked technical advice and assistance. They needed sensitization and training that was appropriate to their individual contexts. Companies were also reluctant to commit their funds, not sure of the effectiveness of interventions and the associated cost-benefit ratios before investing in a workplace response.

The **Barbados** Employers' Confederation received training in HIV issues, in conjunction with the Barbados Chambers of Commerce and Industry—an employers' organization committed to promoting and representing the interests of employers in Barbados. The group came into the project committed to the fight against HIV and had produced a booklet, Guidelines for Managers and Supervisors relating to HIV/AIDS, which the Ministry of Labour and Social Security had distributed from 2001 to September 2004. The group had voiced concerns, and by training 36 members, the project shored up their efforts.

Dr. Philippe Johnson of **Benin**'s National Employers Council *(Conseil National du Patronat du Bénin)* commented that the project "filled a worrisome vacuum." Noting that it is already a difficult task to build and maintain a healthy coalition of enterprise organizations, the project introduced a complicated issue and managed to bring the membership on board. Johnson is also a physician with experience as an MD in the workplace. He appreciated what he called the project's "innovative approaches." The project is much appreciated because (1) it is located in the workplace; and (2) medical professionals, enlightened employers, and trade unionists are concerned that because Benin had a low HIV prevalence, prevention efforts may be neglected until it's too late. Similarly, Serge Prince-Agbodjan, General Secretary for the private investors Council of Benin (Conseil des Investisseurs Privés du Bénin /CIPB), and a nationally respected law scholar, appreciated the richness of the information and facilitation that led to the PAB's important work on policy within the context of the project.

The **India** project signed memoranda of understanding with 11 corporate groups, most of which have multiple units in different locations. All the partner corporate groups are implementing AIDS interventions in all locations/plants, including with their contractual workers. This approach allowed the project to reach over 100,000 workers in the corporate groups. Fifty-seven executives of enterprises affiliated with employer organizations were trained in India.

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[65] Mmegi, *The Reporter*, July 8, 2008. Botswana: Court throws out BMWU case.

In **Cambodia**, the project worked directly with the main employer organization, the Cambodian Federation of Employers and Business Association (CAMFEBA). CAMFEBA represents over 700 companies in Cambodia, including small and medium enterprises as well as larger Cambodian companies and multinationals.[66] Seventy members received training through the project. The Garment Manufacturers' Association in Cambodia (GMAC), which is a member of CAMFEBA, benefited from some technical support from the project. CAMFEBA members represent a wide range of different types of business associations and companies, ranging from artisans to recruitment agencies for international Cambodian migrant workers and banks.

The establishment and achievement of the Cambodia Business Coalition on AIDS is an important step towards ensuring that the development of workplace policy and programs will continue. The CBCA has already started implementing actions, particularly to assist companies in establishing committees on HIV in the workplace. The project contributed to the capacity strengthening of the CBCA by providing technical support and/or training to individuals who later founded the CBCA. The CBCA has some internal funding sources, contributed from its membership, and is also in the process of raising funds from a range of sources. Volunteers are providing time to manage and support the activities of the CBCA. Consequently, the CBCA is able to independently continue its activities.

The **Botswana** Confederation of Commerce, Industry, and Manpower (BOCCIM) is an umbrella body of employers and is considered the main voice of the private sector. Thirty-six of its members received ILO project training, and the ILO Workplace Education Program provided training in capacity building for its subsidiary, the Botswana Business Coalition on AIDS (BBCA). Over 800 companies have been provided with information and education; of these, over 300 companies have been active in devising some workplace strategy. Still, the organization feels that there is much to do and ample room for the ILO Workplace Education Project, which it considers "a parent."

5.   Working with NGOs/CBOs
The project provided supplementary training for NGOs to ultimately become partners in the project. Depending on their needs and the specifics of the project in each country, the training for NGOs included 1) AIDS issues for those NGOs which had greater capacity as trainers or development practitioners, and 2) introduction to BCC and training to those NGOs with a high degree of HIV and AIDS experience. In more than one interview with NGOs, they expressed appreciation for the opportunities that they received from the ILO. Further, they benefited from the opportunity to network with other NGOs and the tripartite constituents with whom they were not normally involved. For example, by nature NGOs focus on civil society and sometimes find themselves in opposition to government programs. Often they are marginalized or, in contrast, they are deeply involved at a level that government is unable to penetrate. By bringing in the NGOs, the tripartite constituency became extended; referred to in India as "Tripartite Plus."

All of the NGOs involved in the program in **Benin** were enthusiastic about their experience. The NPC acknowledged that with little time to do a careful survey of potential consultants and NGO training groups, he collected references on the groups from other international projects and was certain he had selected the best Benin had to offer. Staffers from Racines and the Organisation de Recherche pour le Développement Humain (ORDH) received training in BCC methodology and worked onsite with the project workplaces, creating a strategy particular to each workplace after the KAP and Formative assessments were completed. The organizations have gone on to work with the British-American Tobacco Company, some NGOs, and the Université d'Abomey-Calavi in developing workplace HIV programs.

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[66] CAMFEBA website: www.camfeba.com/opencms/.

They worked separately in specific industries and enterprises. Racines worked in the informal sector. Another organization, the Action Center for Training and Basic Education (Centre d' Action de Formation et Education a La Base/CAFEB), received training from the project on HIV in the world of work and the BCC methodology. As a result of the training received and the work that the organization subsequently did for the project, they have received other contracts, and over the year have trained many more peer educators.

In **Botswana**, two NGO/CBOs that participated as members of the PAB likewise reported direct benefits to their organizations. The project expanded their networks and potential for greater collaboration on AIDS issues. These organizations operated independently with reasonable success before the project began, but the atmosphere of cooperation that emerged during PAB meetings created strong professional relationships. At the very least, PAB participants reported greater understanding of the constraints and challenges of different sectors of society—groups which had previously not worked closely, especially the tripartite constituents. The Botswana Network on Ethics, Law, and HIV/AIDS works to create an enabling and just environment for those infected and affected by HIV and AIDS, and in 2000, both they and the Botswana Network of People Living with HIV/AIDS (BONEPWA)—a national network formed by and for People Living with HIV/AIDS—benefitted from the training and sensitization.[67] Although both had been working in the HIV and AIDS arena for several years, they gained a different analysis of how change might occur while participating on the PA Board. BONEPWA, particularly, needs additional capacity building. Funding for capacity building has gone into capital assets such as computers, but institutionally the organization appears weak and fragmented. Its one major event is an innovative activity called Mr. Positive, a contest to encourage men's participation in AIDS issues. The 2008 *Mr. HIV Positive Living Pageant* theme was; "A new age of men involved, informed, in action against HIV." The annual Pageant could not be held in 2007 because of "financial constraints," which demonstrates the need for more capacity strengthening in the NGO. The group has a food production program for PLHIV, and has done some sensitization training of labor inspectors.

In **India**, the project prepared a list of NGOs and consulting agencies in the project areas that could work with corporate groups and other stakeholders as needed. NGOs and consulting agencies assisted with the implementation of the project baseline, company KAP studies, and several other studies carried out through the project. Staff from these NGOs and agencies were trained as master trainers, and their names supplied to the stakeholders. Corporate groups then worked directly with the NGOs and consulting agencies but with technical support from the project. Several corporate groups preferred to use their own staff and did not really associate any NGO to assist them in implementing their actions. One corporate group representative mentioned that they still need more information on potential NGOs with whom they can work to implement their corporate outreach program. An interviewee from PepsiCo indicated that having NGOs to contact when they need answers to specific questions that people ask is very useful. Interviewees from corporate groups consider that long term relationships with NGOs are essential in replacing the technical support provided through the project.

In **Cambodia**, the project worked with a local NGO to implement the KAP and develop the BCC materials. The potential of NGOs to provide a longer-term form of technical support when and where needed was not fully explored, partially due to financial drawbacks. Companies have not shown any interest in hiring or otherwise funding any activities through NGOs. HIV is still seen as an 'add on' issue that is not essential for the company.

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[67] This group uses the term PLWHA.

6.   Identifying and Creating a Panel of National Consultants and Trainers
National Consultants and trainers were widely used in the project. It was cost-efficient to use people and organizations with expertise for a specific task, such as data collection, research, graphic design, marketing, and training. In **Benin** and **Barbados**, those involved in the project crossed paths enough times to have now established a mutual support group. Barbados is small enough that the consultants and trainers formerly involved in the project talk regularly and share ideas and successes. Early in the project, Barbados sent three individuals to Caribbean regional training workshops on the ILO/FHI BCC Toolkit, strategic planning, and the use of the PMP. That core group and other talented individuals continue to work together. They are not an exclusionary circle of elite, however. The people involved are clearly hard working, earnest, and accessible activists who are respected by the stakeholders. Enterprise and workplace stakeholders as well as PAB members know that these people have become BCC and workplace specialists, and call on them regularly even though the project has ended.[68] In **Cambodia**, the project trained a group of master trainers, though a panel could not be contacted as they are not yet formally organized. A group of the best master trainers could form such a panel together with staff from other NGOs, NAA (National AIDS Authority), and other sources for training. Currently no new training is being organized by the existing master trainers due to lack of available funding. The former project staff is able to conduct such training and can be expected to provide their skills on master training in the future. The **Botswana** Business Coalition on AIDS received training and consulted for the project. The BBCA saw first-hand the impact of the BCC techniques and commented, "In working with the private sector programs [before], we should have been evidence-informed as the ILO project was." Thanks to the training that they received, the BBCA represents a strong league of experts. Though civil society in Botswana is weak, the University has consulting resources, and the team who conducted the Impact Assessment is competent.

Only in **India** was building a 'panel' of consultants done intentionally, with master trainers. Elsewhere, the establishment of a panel was not given priority in project implementation, and happened only serendipitously. The India project trained a series of master trainers who can train future master trainers. They form a panel of mostly NGO staff and consultants and can be contacted for training and capacity-strengthening efforts on HIV in the workplace. The project prepared a list of people that can be consulted by potential agencies, companies, and other organizations interested in accessing their skills.[69]

d.   Moving Into the Workplace

1.   Identifying Partner Enterprises and Entry to Enterprises
As mentioned, the PABs participated in the selection of economic sectors. National Program Coordinators had suggestions from the Program Management Team, but there is every indication that the sectors were locally selected after sensitization and careful thought. For the most part, it could be said that the choice of sectors and enterprises was rational; determined according to expressed or evident need for AIDS education, among other things. The geographical location of the businesses and their headquarters did not seem to be a major factor. In **Botswana** the NPC wanted a broad geographical coverage. In **Benin**, the NPC decided not to work with businesses in the far north due to costs involved traveling, but also because the enterprises in Central and Southern Benin offered a large worker base, with high prevalence factors, and a replication potential. In **Barbados**, the sectors and enterprises chosen were those that had

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[68] Interviews with Scotia Bank, AIDS Foundation, Arawak Cement Company in Barbados.
[69] According to the PMT, most of the projects were not in a position to hire a program or training officer because of budget limitations. It was obvious that many project activities would need to be implemented with the help of national experts to, among others things, conduct the baseline survey, facilitate training on behaviour change communication, design BCC materials, etc. Most if not all consultants/national experts used in project implementation were trained beforehand in performance monitoring or in BCC.

demonstrated interest and also offered the possibility to be models to other enterprises. The **India** project signed MOUs with 11 corporate groups, most of which have multiple units in different locations. All the partner corporate groups are implementing HIV interventions in all locations/plants, including with their contractual workers. This approach allowed the project to reach over 100,000 workers in the corporate groups.

Gaining acceptance to create workplace education programs presented challenges for all NPCs in all of the countries. Some enterprises were more attuned to the problem of HIV, whether existent or potential, but others were resistant. NPCs used various creative and professional approaches to get enterprises on board. NPCs related those techniques that they used successfully, signaling the need to choose an approach appropriate to the specific enterprise context.

NPCs discovered several reasons for resistance. Firstly, while many companies had expressed interest in tackling the epidemic through developing workplace policies and programs, and also through the delivery of prevention education in the workplace, the large majority require technical advice and assistance in the form of training and consulting on how to tackle HIV in the world of work. Such assistance ranges from program planning to implementation, execution, and evaluation. Secondly, companies are reluctant to commit funds to a task that has planning gaps; i.e., they need to understand the real benefit of interventions and the associated cost-benefits of investing in a workplace response. And thirdly, it is clear that despite individual and corporate interest, there still exists a degree of denial of the real threat of HIV. As a result, many employers need to see or feel the impact on their businesses before they take action.

In some cases, seminars of overarching employers' groups were held for a general recruitment of the enterprises with the target sectors, but NPCs and PAB members also approached workplaces individually. (This was particularly true for the recruitment of the informal sector).

Typically, a sensitization seminar was held with top and mid-level managers from enterprises working in the selected sectors. The workshop aimed to sensitize participants to the process the project should follow in developing BCC strategies and programs. National Program Coordinators with the assistance of the Geneva-based PMT and members of their Project Advisory Board created Power Point Presentations, speeches, flip charts, and other devices to build awareness among business and industry owners. Using graphics, the **Benin** NPC demonstrated how the possibility of just one worker contracting HIV affects productivity through absenteeism, recruitment, and training. He quickly moved from the general to the specific; from worldwide to Africa, to sub-Saharan, to neighboring Nigeria. "Nigeria has a 3.1 prevalence in a population of around 138 million, which results in more than 3 million people living with AIDS, and an estimated 2,600,000 people infected with HIV." [70] The NPC reminded leaders that Benin was on a major commercial route from Nigeria, and that Benin's rate, though low at the time, could rise. By using a

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[70] <u>UNAIDS 2008 Report on the global AIDS.</u> A brief explanation of prevalence rates: According to UNAIDS (and Dr. Idohou relying on that data), different sets of data are used to calculate estimates of HIV prevalence for *generalized* (highlevel) - where HIV is firmly established in the general population. In countries with *generalized* epidemics, estimates of HIV prevalence are primarily based on surveillance among pregnant women attending sentinel antenatal clinics (ANC). Such data are collected on an annual basis and are currently our primary basis for the assessment of trends. If available, population-based sample surveys that include testing for HIV infection (conducted much less frequently) are used to improve the antenatal clinic data-based estimates. For countries with low-level or *concentrated* epidemics, HIV estimates are based on studies
among key populations who are at higher risk of HIV exposure—such as injecting drug users,
sex workers, or men who have sex with men.

prevalence rate similar to Nigeria for Benin's population of only 6.6 million, he demonstrated that if measures were not taken Benin would potentially have around 110,000 people living with AIDS or infected with HIV. Even in a country with low prevalence for HIV, business leaders could understand that the situation of their neighbors had consequences on their economic productivity.

At C.B. LaFarge cement factory in Benin, the timing was propitious. The company operates in 76 countries worldwide. The global headquarters had been engaged in a process of recognizing HIV as a workplace issue through its participation in global business networks. The general manager of the Benin plant, which is located in a remote area close to the Nigeria border, received instructions from headquarters to create policies and programs around AIDS issues. Naturally, he was welcoming when the ILO program was offered.

> **Tips for engaging enterprises into the SHARE Program**
>
> - Create an enabling environment for management.
> - Sell the program with familiar marketing tools, videos, flip charts, or Power Point Presentations.
> - Overhead projectors trigger sleepiness.
> - Find the mechanism to entice management (special speaker, breakfast sessions, and luncheons).
> - Keep it short for the busy businesses.
> - Demonstrate logic and relevance.
> - Use the ILO as a way to target management.
> - Bring in the 'big guns'—American Ambassador or head of trade unions at a breakfast meeting.
> *-From Guyana Focus Group, BCC Workshop, 2008*

After acceptance, challenges for the NPC and the company management remained. The apparent complex methodology required of the project— creating committees, identifying focal points, education and training of peer educators, holding information caucuses, organizing activities, and taking time out for such activities during factory hours (which are 24/7)—at first seemed daunting. However, according to the Managing Director, since the strategy was logical and systematic, it was easily integrated into the schedule. With support from management, participants reported that the project was successful in changing attitudes, reducing stigma, increasing the use of condoms, and building relationships across management and worker levels.

In **Botswana**, business and industry had established methods of operation within the political environment that resulted in low motivation to become involved in the response to AIDS. Profit motivation stood in the way of introducing workplace changes that benefited workers. At various management and worker levels within businesses, individuals needed to be sensitized to the connection between economic development and productivity and a healthy workplace. The National Program Coordinator and the Ministry of Labor Focal Point (who was also a labor inspector) visited workplaces together. Although checking workplace activities and policies concerning HIV were not specifically factored into the routine work of labor inspectors, the presence of the two created a solid front in which employers started to understand more keenly the need to incorporate HIV into their policies.

An aspect that made some enterprises more open to the project in Botswana offers the possibility of replicability in a variety of sectors. There, many building construction, building supplies retailers, caterers, and other industries are linked to the diamond mining industry. DeBeers (the largest diamond mining company in the world) and Debswana Diamond Company (the world's leading producer of diamonds by value) require that companies interested in working for them meet certain standards. DeBeers demands tender-certified companies to have HIV workplace policies. This offered a strong incentive for companies to be a part of the SHARE program.

The project timing was also opportune for **Barbados** enterprise Scotiabank, one of North America's leading financial institutions. The bank is proud of its corporate culture: global reach, but energies

focused on individual customers, employees, and shareholders. As it considered its upcoming anniversary celebration of 50 years in Barbados, and 175th global anniversary in 2007, the bank wanted to extend their corporate culture of customer service, community support, and an interest in providing employees with secure and healthy workplaces, and therefore launched a national HIV/AIDS Pledge Campaign for a zero tolerance to stigma and discrimination in the workplace, home, and community. Corporate social responsibility (CSR) is an essential part of Scotiabank's organizational culture.

The 10 participating enterprises in **Benin** came from construction, mining and energy, vegetable oil production, and one group of informal handicraft workers. The choice of the Benin Electricity Company (SBEE) is relevant, as it belongs to the public sector (over 50% of formal jobs) and has a network of employees throughout the country. It was the first enterprise for the development of a BCC strategy in Benin, and started shortly after the FHI-run workshop. In Benin, the industry chosen to represent the informal sector was actually a handicraft association managed by the government of Benin's Ministry of Tourism as a state-run tourism and sports facility. The civil servants benefited and participated fully in the program as focal points within their departments.

Most of the enterprises associated with the **Cambodia** project had directly come forward to express their interest in the program. In 2004, the Cambodian Federation of Employers and Business Associations (CAMFEBA), held a workshop on HIV in the workplace for the general managers of some of CAMFEBA's members. Twelve enterprises came forward at the end of the workshop and committed to working with the project towards developing a company program on HIV. In some companies, particularly hotels, the project also approached managers and advocated their participation directly. The project staff needed to do a great deal of advocacy work to convince the management. Most companies also required extensive details about their potential roles and responsibilities and potential costs of developing an HIV in the workplace program.

2.   *Signing Memoranda of Cooperation/Understanding*
Memorandums of Cooperation were signed between participating enterprises and the ILO. For the most part, enterprises were used to having meaningful and binding contracts, and respected the elements of the letter. These Memoranda were set up with every single participating enterprise in the African and Caribbean countries included in the cross-country study. For at least one industry in **Benin**, the MOC was a contract taken so seriously that a framed copy was conspicuously visible to workers and management.

The project in **India** worked with government agencies and national employers and workers groups and had MOUs with 11 corporate groups. The corporate groups have a total of 150 factory units in different parts of the country. The total number of employees of these companies was 122,591, and 353 master trainers were trained to cover all the units.

3.   *Setting up Enterprise-level HIV /AIDS Committees*
As a part of the project's methodology, joint management-worker committees were established to work on AIDS issues. Not all of the enterprises or workplaces set up HIV-AIDS Committees. In some cases, particularly at larger, more established enterprises, the work of these committees were absorbed into the work of standing committees on health and safety or wellness, but usually a separate committee was formed. Besides the pre-existence of health and wellness committees, reasons given why some committees were never formed were that that the focal points and peer educators constituted a sort of committee, so that it did not seem necessary or appropriate to have an additional committee. In those instances, it appeared that such structures (peer educator and focal point together) worked well. In some businesses, the culture of the corporation did not lend itself to the establishment of a committee, but the lack of a committee did not seem to negatively affect the gains of the project. The committees built understanding and camaraderie among various levels of workers. However, it may have been a superfluous requirement, and perhaps should be considered as an option, rather than a requirement.

All the workplaces in **Benin** have committees on-site to deal with HIV/AIDS. In 9 of the 12 workplaces in Barbados, joint HIV workplace committees have been established. **India** reported 153 committees, and **Cambodia** reported 14. All workplaces in **Botswana** have committees onsite to deal with HIV/AIDS.

4.   Establishing and Training Enterprise Focal Points
Focal Points were named at the enterprises that were selected to participate in the project. Often, Focal Points were from management—Human Resource directors, or doctors or nurses from the health unit of a factory; but in other cases, management nominated interested and capable individuals regardless of rank. Like Focal Points in the ministries and at some of the PAB offices, they were expected to be the point person to interact with the project, coordinate activities at their particular place, and receive and disseminate information. However, they were also trained in monitoring and evaluating tools designed for the project, and expected to respond to requests from the project for information critical to understanding the impact of the SHARE efforts. Thus, **Focal Points** were identified and trained in each and every participating workplace. Thirteen focal points from 11 Barbados workplaces attended a 3-day training workshop. Ten Focal Points from Benin attended a workshop that lasted 5 days. By the end of the project, India reported 217 trained focal points, Botswana and Benin each had 10, Barbados had 8, and Cambodia had 15, one for each workplace.

One of the challenges faced by the project is that there was turn-over among the staff members assigned to be the focal point, thus affecting continuity. Either the focal point was promoted or they left the company for another position. This is an issue that affects sustainability, as in some locations, the focal point left after the project closed and no fully trained person had replaced him/her.

e. Implementing Workplace Programs

As the workplace education programs were implemented in enterprises and the informal sector, and BCC strategies developed, the project diverged in a few directions and became indigenous, and therefore, usually more appropriate. Contextual factors caused NPCs and their consultants to alter the prescribed steps, adapt the methodology, and react to in-country situations. That does not mean that the projects did not utilize the strengths of the methodology, but sometimes steps, particularly workshops, did not happen in the same order worldwide. The key elements—peer education, materials development, condom distribution, voluntary counseling and testing (VCT), prevention, and treatment referral— remained intact, but the order of implementation and substance of activities and materials differed from country to country.

For example, the **Benin** project suffered from delays in startup, but despite logistical hindrances so common to the developing world, the NPC implemented BCC strategies at an accelerated rate. All of the elements of the BCC were there, but some of the participatory approaches took place faster than in other countries. The sectoral strategy resulted in visual materials being made by a local artist, and reviewed by the PAB, which served as a valuable way to keep the board engaged.

The first workshop in Benin for the development of a Behavior Change Communication strategy was held for the publicly owned power company, Société Béninoises d'Énergie Électrique in Possotomè in November 2004. The ILO in collaboration with Family Health International (FHI) organized the 5-day workshop. Using the ILO/FHI BCC Toolkit, NGO and BCC consultants worked with the SBEE workers to develop their workplace-specific program. The SBEE workshop served somewhat like a pilot project for BCC applications. Later, the Benin project organized multi-sectoral workshops, separating the groups into work sectors where BCC strategies were planned.

The projects in **India**, **Botswana**, and **Barbados** were established in a context where some HIV workplace programs were already in place, although not following the BCC strategy. Company-based occupational safety and health (OSH) coordinators became Focal Points for the project, and embraced the BCC strategy. Delta and Desert Safaris in northern Botswana, for example, welcomed the discipline of the BCC strategy because their efforts, although worthy of national recognition and the Red Ribbon award, were not visibly affecting the behavior of their workers.[71]

Organizing HIV committees in the workplace, appointing and training Focal Points, collecting data through the Workers Survey and the Formative Assessment, and developing HIV-related workplace policies, are all activities that lead into the development of effective Behavior Change Communication strategies to curb risky and discriminatory behavior related to HIV and AIDS.

BCC is the cornerstone of the SHARE project, designed to support the tripartite structure and workplaces internationally as they face HIV and AIDS issues. Family Health International worked with the ILO to develop BCC especially for the SHARE program, creating a special strategy used in the SHARE project that applies information and data which reflects the target population and results in changes in their behavior. After 4 years, the approach has had several iterations and continues to be a 'work in progress.'[72] The BCC has been distinguished from regular information, education, and communication techniques (IEC) by SHARE's PMT and FHI. Although there continues to be some confusion even among expert

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[71] This annual competition is sponsored by the Botswana Business Coalition on AIDS to honor companies demonstrating good business practices concerning HIV/AIDS.

[72] Josée LaPorte, April 29, 2008. It is SHARE which has taken over the direction of the BCC and, through testing at seminars and in workshops, continues to create a distinctly responsive and fluid methodology.

practitioners, the distinction is useful. Simply, the SHARE project attempts to have a deep impact by examining behavior, hopes, expectations, aspirations, and motivating factors to induce people to understand more profoundly what it takes to change deeply ingrained behavior.

1.   Conducting Baseline Data Collection and Compilation (Workers' Survey and Formative Assessment)

In each SHARE country, important valid preliminary baseline data was collected using a consistent methodology outlined in the Performance Monitoring Plan. The Baseline Workers' Survey was done to provide a comparison for assessing program impact. Called the **KAP** Survey, it is a questionnaire administered to a random sample of at least 300 individual workers with approximately 50 (but no fewer than 30) workers from each enterprise chosen for the survey. Selection of the enterprises and workers to be surveyed sought to ensure a diversity of age groups, gender, and sectors of economic activity. Segmentations—staff categories, gender, were considered and the project ensured that all sectors were covered. The questionnaires were anonymous, and consultants administered the activity. The format required determinate baseline data, closely related to the program, as clearly indicated by the objectives of the program. Data collected from workers from the same enterprise for each survey were tabulated and analyzed by the consulting firm and reports were delivered to the NPCs.

> The interviewing atmosphere was warm and friendly and all interviews were conducted within the office of the respondents. Honest answers were encouraged within a relationship that promised confidentiality and openness.
> Interviews lasted between 45 minutes to 1 hour. All interviews were recorded with approval from the respondents, who were also encouraged to feel free to request that the recorder be turned off at any point and to seek a pass on a question. -*Guyana*

In **Cambodia**, data was collected to survey hotel and garment industry workers' understanding of their existing knowledge on HIV, their sexual practices, and media use.[73] While the purpose of the study was to establish a baseline, it is important not to extrapolate the results beyond the group that was studied. In the case of the hotel industry in particular, the companies selected were hotels of relatively high standing. The many small hotels that often employ less educated staff were not covered. The materials that were developed for the project were largely based on the outcome of this baseline and a formative assessment.[74] A total of 371 workers were interviewed in 11 workplaces. Selection of the sample respondents was well randomized. Only 131 of the respondents were in the garment industry. The researchers used a standard method for determining the sample size, although this could have been adapted to ensure a more sizable sample size for the garment industry. Extrapolating from such a small sample size in the sizable garment industry is somewhat questionable, particularly considering that most workers are migrants and come from socio-culturally different backgrounds. Eighty-two percent of the respondents in the garment industry were female, which is not unexpected because of the high number of women in the garment industry. In the hotel industry, 18 percent of the respondents were female, a figure also approximately representative of the gender balance in that industry. Seventy percent of the total sample interviewed was female. It is important to consider that women in Cambodia do not necessarily always have the power to insist on safe sexual practices. The survey form was well constructed but could have included more emphasis on this issue. The only questions alluding to women's power to influence safe sex were about attitudes towards women who carry condoms with them.

The baseline survey successfully administered in nine formal enterprises and in the informal sector (the Taxi Association) of **Barbados** produced conclusive results on the importance of stigma and

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[73] Vonthanak, Saphonn (2004).

[74] Brown, Eleanor (undated),

discrimination on the island at the time. Of the six enterprises in Benin surveyed in accordance with the PMP, the lack of basic facts about HIV and AIDS among workers was distressing.

In some of the **Indian** companies, management did not really see the need for implementing a KAP initially. With advocacy and capacity strengthening to implement the KAP with staff, all project partners agreed. Some interviewees reported how useful conducting an enterprise baseline was, while one interviewee noted that it was not very useful; "We only learned that our worker literacy rate is important for us to consider, so we can pass on such messages effectively."

The forms used for the KAP study in the enterprises were well worded and adequately covered the essential issues.[75] In a conservative country such as India, it is uncertain that workers will honestly report their sexual behavior to an interviewer. The results of the baseline do, however, indicate that at least some workers answer the question in a straightforward manner. Oddly, some companies and worker organizations in India had not yet implemented an impact survey, although they had already been working on HIV in the workplace for about 3 years.

2.   Formative Assessment
The Formative Assessment (FA) is an important component of the overall strategy because it forms an essential part of the BCC process. The end goal of the Formative

> **KAP Survey findings in Northern Botswana Industries**
>
> Respondents were mainly young people and men age 32 years—
>
>   Majority (71%) were single
>   Level of education—
> - 18% primary
> - 64% secondary
> - 18% tertiary
>
> Level of awareness/knowledge of HIV/AIDS/STIS—
>   97% of the respondents could correctly answer questions on basic information.
>
>   Risky sexual behaviors were found to be prevalent—
> - multiple sexual partnership
> - unprotected sex
> - inconsistent condom use
>
> Main Sources of information:
> - 28% mass media
>
> - 17% family and friends
> - 14% coworkers
>
> Workplace Policies:
>   13% had policies
>   Some companies without policies had programs
>
> Respondents had positive attitudes towards condoms:
>   85% reported using condoms
>   There were reports of incidences of stigma and discrimination either by coworkers and/or management.

Assessment was to ensure that the BCC intervention would be appropriate to meet the needs of the target population. As the baseline data collected in the workers' survey (KAP) is considered quantitative, the FA is designed to get an idea of the qualitative knowledge base.

As it was described in the Formative Assessment conducted in Botswana, "…It was not intended that these findings would be statistically representative of the total populations of the workplaces in question. Overall, it was the purpose of the research to include sufficient interviews to produce significant results for key population segments. To this end, key informant interviews and focus group discussions were

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[75] International Labour Organization, Project Prevention of HIV/AIDS in the World of Work: A Tripartite Response (Phase-II) India (2006).

designed to probe on specific issues emerging from the workers survey, and to achieve deeper understanding of respondents' answers."

Usually, an NGO or consultant with expertise in research methods conducted the Formative Assessment. Administered to a segment of the workplace population, it took forty-five minutes to several hours in a few cases, but enterprises, once signed on through the MOC, were willing to have the FA done, even if management did not fully understand why or what the results would mean. The reports took about 1 month to be prepared. In **Benin**, focal points and HIV/AIDS Committees conducted the Formative Assessments with the assistance of consultative NGOs. The activity involved all level of workers. Called a 'site inventory' in Guyana, the FA was used "to discover what…AIDS-related issues…stand out as opportunities and/or threats to inform the implementing of effective behavior change communication approaches within identified private enterprises.[76] The objective of the inventory was to collect, from knowledgeable workers, data in relation to the industries' geographic and social environments and opportunities for HIV behavior change communication programs. The workplace and the immediate community are perceived as possessing resource capabilities. However, these strengths would inform the gaps in implementing HIV behavior change communication programs."[77]

It is somewhat troublesome to find the disparateness of scale and intensity in the formative assessments as collected worldwide. In actual fact, it appears that the interviews were usually held with only a handful of people. For example, in **Guyana**, only four focal points provided information on three hospitality and manufacturing industries. Respondents answered 18 questions from 10 general areas. In **Botswana**, a 'purposeful sampling' approach was taken.[78] Key informant interviewees were drawn from workplace AIDS Coordinators (or AIDS focal persons), workers, local NGO's, or health facility staff. The focus group discussants comprised workers, excluding management[79]. Male and female discussions were held separately, and each session comprised not less than eight people.[80]

> **Staff Knowledge from Formative Assessment—Benin—**
>
> HIV transmission is by sexual relations, blood, and mother to child. **However:**
> - The erroneous belief that mosquitoes transmit the virus continues.
> - Doubts persist on the effective role of condoms in the prevention on HIV/AIDS. In their opinion, the promotion of condoms is part of a conspiracy to reduce African populations.
> *-The Société Béninoises d'Énergie Électrique (Benin Power Company)*
>
> In **Botswana**, on the question of whether abstinence could be a way to prevent HIV transmission, some respondents, especially men, were of the view that ***abstinence is impossible***.

In **Cambodia**, a formative assessment was done through a series of focus group discussions with hotel and garment industries workers. The total number of focus groups is not reported, nor the number of companies covered. The guidelines for the Cambodian focus groups had some questions that resulted in answers indicating women's ability to influence condom use in a relationship, and women did report

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[76] The PMT adds 'site inventory' is one of the data collection methods used to collect information for the formative assessment. Others include the KAP survey, focus group discussions, and key informant interviews.

[77] Guyana Formative Assessment, 2005.

[78] The logic and power of purposeful sampling, where research has a bias on whom to select, derive from the emphasis on in-depth understanding of issues, hence the selection of information-rich cases. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research.

[79] For purposes of this study, management included any person who held a supervisory role.

[80] Botswana Formative Assessment, 2005.

having low negotiation skills for encouraging the use of condoms.[81] It would have been advisable, however, to ensure that this issue is covered adequately by including at least one question *directly on the subject*. Also, the actual report on the formative assessment should have provided more details on both the methodology and characteristics of the actual focus group participants; even the total number by gender or age is not reported. A study that is qualitative still needs to be well described in terms of methodology and demographic data so that readers can have a good understanding of the quality and type of population included. Reviewing documents on Community Zero, it is difficult to conclude that the formative assessments were of a consistent quality across the community of SHARE projects. Nonetheless, the information gathered seemed to have been significant enough to sufficiently guide the project, get past managers who might have been concerned about staff time, and come out with data that enables artists and marketing experts to create BCC messages.

The Formative Assessments brought forward very interesting and useful information about attitudes and beliefs that could be integrated in the development of BCC materials. Once the results of the baseline data and the formative assessments were known, they were shared in some type of public forum in each enterprise. The information gathered between the Baseline Workers' Survey and the Formative Assessment was valid and useful. It identified the major areas of concern both quantitatively and qualitatively: discrimination and stigmatization at the workplace, prevention, and follow-up servicing needs. Most importantly, it underlined the obvious need to address HIV as a workplace issue. The consultants who were selected to conduct worker surveys as well as formative assessments in the countries studied were capable. Some were individuals while others came from local and national research organizations. Some came from university networks, but within the countries studied, no one actually utilized the national universities for the research. The baseline surveys were of a high quality that should be considered replicable. Likewise, the formative assessment, with some alterations, is worth using as a follow-up to the more quantitative survey. The combination of the two gives rich credibility to the project design and objectives, as well as to the utility of the results for the development of BCC strategies.

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[81]The garment focus group question guidelines includes questions such as; "What difficulties do you face protecting yourself from HIV/AIDS?" and "Generally, do people in these relationships use condoms? If not, why not?" If interviewees do not spontaneously answer that they find it difficult to ask for a condom to be used, there should be a question that can be asked to ensure that the issue is discussed.

3.   Developing Workplace Policies

The development of workplace policies was a fundamental aim of the project, and very successful. The project contributed to the adoption of policies and strategies on HIV in the workplace. The ILO Code of Practice was one of the tools used to inspire and formulate a number of the policies.[82] In all five countries included in this study, the ILO code of practice was used as the primary guide for the development of workplace policies on HIV and AIDS. In many cases, policies used exact wording copied from the ILO code of practice. However, interviewees were quick to point out that when this occurred, it was not because the document was simply copied, but that active dialogue, participation, and study by stakeholders had taken place.

During the midterm evaluator's visit to CIM-Benin (a cement manufacturer in **Benin**, one of the two workplaces engaged in the project at that point), the National Coordinator was given a copy of the "CIM-Benin SA policy on HIV/AIDS in the workplace," an enterprise-wide AIDS policy. The policy, signed on July 6, 2005, ratified point-by-point the fundamental principles of the ILO Guidelines and the "Tripartite Declaration on HIV/AIDS in the workplace." The Managing Director pledged to "… implement a strategy and annual programme on the prevention of HIV in collaboration with the ILO/USDOL programme in Benin, continuing the process beyond the life of the project." The example of CIM-Benin shows that elaborating an enterprise policy and signing up to a lasting commitment are feasible if management is convinced of its necessity and is supportive. The role of the project in encouraging this process and providing the tools needed to elaborate such a policy "is crucial," according to the midterm evaluation.

> **ILO Code of Practice**
> **HIV/AIDS and the World of Work**
>
> The 10 KEY PRINCIPLES of the Code:
> 14. Recognition of HIV/AIDS as a workplace issue
> 15. Non-discrimination
> 16. Gender equality
> 17. Healthy work environment
> 18. Social dialogue
> 19. No screening for purposes of exclusion from employment or work processes
> 20. Confidentiality
> 21. Continuation of employment relationship
> 22. Prevention
> 23. Care and support.
> *-Summary developed and used by SHARE enterprise Delta and Desert Safaris, Botswana to revise Workplace Policy*

By the end of the **Barbados** project, 7 out of 12 workplaces had established written AIDS policies. All of the participating enterprises and workplaces in **Benin** had written policies, as did those remaining participants in **Botswana**.[83] At Delta and Desert Safaris, the employees are participating in developing and annually updating the policy. Further, the enterprise has a standing steering committee on employee wellness. For those that were part of the 'supply chain' for the mining industry, for example, they needed to have a written policy to be certified.

Companies affiliated with multinationals tend to have written policies, but not all. Some corporations continue to feel that the 'Wellness Policy' suffices. In June 2007, **Barbados** partner enterprise Scotiabank released a revised Occupational Health & Safety (OHS) Program and provided an OHS training program. Employees in Barbados are represented by a health and safety representative, who along with the human

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[82] The key principles of the ILO Code of Practice were used to inform policy development at all levels. According to the PMT, for question[s] of ownership and national integration, if a policy is adopted at the enterprise level and there is an existing workplace policy at the national level in which the 10 ILO key principles are included (explicitly or re-drafted to be adapted to the national context) the enterprise will be referred to the national policy. Policy adoption has a trickling down effect and the ILO key principles as defined in the ILO Code are guiding all interventions directly or indirectly.

[83] Some of the businesses participating in Botswana had withdrawn from the program because of economic disabilities or left the country.

resources person served as project Focal Points. The Barbados bank profits from being part of a huge international corporate structure, which provides support through a combination of workplace health and safety policies, including HIV concerns. According to Scotiabank, they will accommodate the needs of employees without bias if they have AIDS. Medical benefits for current employees with HIV are provided in accordance with local legislation and practices, and there are other benefits, including income protection and Employee Assistance Program resources. Although Scotiabank states that the health, safety, and security of its workers is a priority which is addressed through policies and programs, human resource staff in Barbados expressed concern that Scotiabank had not finalized their draft workplace policy specifically addressing HIV, despite their copious community and workplace activities in the SHARE project.

4   Developing Sectoral BCC Strategies
Tripartite stakeholders, focal points, peer educators, HIV Committee members, NGO consultants, and affiliated NGOs all received BCC training at some time during the course of the projects worldwide. BCC workshops were designed to expose attendees to the impact of HIV at the workplace and build sustained understanding of Behavior Change and Behavior Change Communication (BC/BCC) objectives.

In the workshops, participants analyzed the results of the baseline data (KAP) and formative assessment, and with the help of trained consultants/NGO trainers, developed behavior change communication strategies. The quantitative and qualitative nature of the information collected enabled each sector to develop programs and messages that were individually focused on the needs of the workplaces. As a result, appropriate activities and message mediums were decided in this participatory manner. Trainers who had been trained in the methodology conducted the BCC workshops. The workshops are intensive, introducing somewhat complex concepts, but the BCC Toolkit and the facilitation skills of the trainers appear to have created a successful learning experience. Briefly, the structured learning process entails the following: *Stages of change, BCC messages; BC and BCC objectives; Message and Theme development; Key Benefits of adopting the desired behavior; Barriers to behavior change; and Planning, using SMART objectives.* Key Benefits that reflected the hopes and aspirations of workers were identified; for example, a healthier lifestyle can be linked to promotions, higher income, ability to attract the opposite sex, or other appealing options.

Understanding the behavior change process involved defining the behavior and behavior change. In multilingual countries, the definitions sometimes took on layers of meanings. Trainees learned that behavior is "the way one does things," while behavior change is "a process which individuals, groups, communities go through to accept, maintain behaviour/practice." A Behavior Change Model was introduced, delineating the five 'stages of change' of the Transactional Theory: (1) pre-contemplation (unaware); (2) contemplation (aware and concerned); (3) preparation for action (knowledgeable and motivated to change); (4) action (modifying behavior); and (5) maintaining new behavior.[84]

There is no evidence that substantive discussions took place to examine motivation patterns of individuals within the routine training and later peer-education sessions. It was left up to workers to reflect and think what the messages meant personally. However, the in-depth discussions held with peer educators, once the activity moved to the workplace, were quite powerful for some respondents. The size of the workplaces required that the behavior objectives be specific enough for the organizational culture, but general enough for the target population. As a result, most materials and messages bypassed management and addressed the behaviors of the larger workforce. Most formal enterprises encountered during the

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[84] *From Northern Botswana Training.*

course of this study had peer educators at management level. It was mentioned—in the course of the study, on the shop floor, and in the manager's office—that management also had problems.

The presentation of the findings of both the KAP and Formative Assessment, from which are extrapolated risk factors and risky sexual behaviors, regarding the benefits of behavior change made the workshops pertinent and relevant. Issues related to incidents of stigma, self-stigmatization, policies and sexual harassment were discussed. Discussions studying the formative assessments led to identifying a corporate or workplace culture. Using that analysis, materials were designed. For example, an industry that is mostly male, and values virility, machismo, and brute strength is a workplace culture from which the marketing experts could determine what motivates the workers in that particular enterprise. A key piece of research-based information that guides the BCC is that the more facilitating factors, the higher the chances that behavior change would occur.

Using easy-to-understand, though complex, grids, stakeholders created their programs, identifying Behavior Change and Behavior Communication Objectives, based on targeted key benefits and barriers to behavior change. Using the BCC Toolkit guidelines, trainees created messages, examined workplace-appropriate communication channels, and chose themes in line with their BC objectives. For example; "An informed workforce is a productive healthy nation;" "A Healthy workforce—key to productivity;" or" Together We Can Make the Difference."[85]

One of the most important pieces of the strategy was the BCC work plan. The work plan is a monitoring and evaluation tool with activities focused on the achievement of the BCC objectives for each of their BC objectives; it clearly defines, among other things, the target population, time frame, and responsible implementer. Focal points, peer educators, and enterprise management understood that evaluation was done at planned intervals, while monitoring was done continuously throughout the implementation of the project/program. Examples of indicators were given as follows:

BCC Objectives	Indicator
Increase demand for services	No. of persons presenting for a given service
Position HIV/AIDS in a positive light to reduce stigma	Percentage of persons who are able to state correctly how HIV is spread

Participants worked in their groups to develop a series of evaluation indicators linked to their BCC objectives. Together, participants decided on meaningful monitoring indicators: for example, the number of posters developed and disseminated, the number of workshops held, or the number of condoms sold, are indicators that have appeared in workplace plans. People voiced appreciation for these tools.

A successful exercise related to the eventual production of materials was when a group of trainees evaluated locally produced materials (e.g., posters or brochures according to criteria in the BCC toolkit).[86] At the Caribbean Regional Interactive Workshop in May 2008, tripartite constituents and other project stakeholders benefited from being able to share materials that they were using or planned to use. It can be

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[85] Northern Botswana BCC Workshop.

[86] Barber's aprons, key chains, and coffee mugs were analyzed at the Caribbean Workshop. Since it was regional, more materials were available to analyze. It was a lively and informative discussion.

distressingly revealing to discover that the materials that seem perfect to the artist will not make any sense in a real factory.[87]

Workshops were often the site for rich, open-ended discussions including, for example, questions on the types of services that should be provided for the PLHIVs, or gender inequities in the home or between boss and worker.

In **Botswana** and elsewhere, training groups that lacked homogeneity—spanned across staff positions (such as management and worker) or education levels; or had different literacy and language ability—posed problems. If possible, trainers organized groups according to staffing pattern and language abilities, though this was not always possible. In **Benin**, however, participants mentioned how much they appreciated working with people who were different, and gaining a better understanding of the issues that they faced in the context of their work. The BCC workshops were extremely popular and appreciated by nearly everyone who attended. There was a high level of empowerment, because of the significant volume of new information and skills provided. For the most part, the skills acquired go beyond the confines of the HIV workplace programs.

Racines and ORDH—two Béninoise organizations that were trained in the ILO's BCC methodology and in turn provided training at work sites—extolled the BCC materials. One of the NGO participants enthusiastically gushed; "For me, the BCC Materials were like the Bible. If I did not know an answer, I could look it up." A participant at the Caribbean Interactive Training program also used this exact description.

In **India**, the training for Master Trainers and peer educators (working for employer and worker organizations) was directed in how to train others as well as on changing their own behavior. Similarly, MOLVT staff—including 108 labor inspectors—had training aimed at them directly as individuals and as potential educators. The training programs were generally very well received. Comments from employers were such as, "I have seen that the training program is easy to understand and enjoyable. It keeps the attention and interest of all the participants. We do a lot of role plays and those are effective."

The first version of the BCC Toolkit developed by FHI was not available when the India project began, and as a result their behavior change approach is different. Although the approach used in India is sometimes referred to as a 'hybrid' of IEC and BCC, it appears that the project has been through enough years of experience in the corporate, formal, and informal sector to have perfected its methodology for changing risky and discriminatory behaviors. The India project team notes that the SHARE BCC Toolkit is primarily oriented to HIV in the workplace and does not cover other types of stakeholders. Advocacy materials and training for decision makers in enterprises, government, employer and worker organizations, partner NGOs, and others need to be covered in the Toolkit. In enterprises, for example, behavior change at management decisionmaking level is also expected and can be measured in terms of attribution of resources through budget allocations, for example.

The Program Management Team was very pleased with the Toolkit that FHI produced, as it provided a methodical and logical approach; however, it is still considered a work in progress. At the workshop in **Barbados**, the third version was used and participants were asked at each step for suggestions to refine it.

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[87] One attendee at the Caribbean Workshop described having to repeatedly return pre-tested and rejected artwork before the artist understood that it was the target audience, not the beauty of his artwork, that mattered. It is more effective to contract with an illustrator who understands how graphics must be used to sell ideas.

Participants were very involved in the procedure, offering suggestions and more practical and contextual approaches.

5.   Developing Enterprise-Level BCC Programs
Projects routinely followed the BCC Toolkit model. After (1) implementing the Knowledge, Attitudes and Practices baseline assessment, and (2) formative assessments to gain additional input in developing the BCC materials, the results were disclosed through public forum or focus group discussions to deepen understanding of the issues and obtain qualitative input to further enrich the process. The project would next conduct a workshop to introduce the BCC concepts and strategies. These were workshops in the strictest sense, and a product emerged: a sectoral strategy or an enterprise work plan.

5.1   Materials Development
Core materials for all countries generally consist of booklets, guides, card games, video, pamphlets, posters, and flip charts with stories and images for the various levels of education, including semi-literate and non-literate, as well as other materials. In **India**, companies have replicated or adapted the materials at their own cost. The materials are commonly used during formal and informal sessions with workers.

Routinely, the development of communication materials occurred along the lines of what happened in **Cambodia**. After 35 representatives from among the stakeholders attended a workshop for BCC development, the project used the results and developed a series of materials that could be used by the enterprises to inspire their actions on HIV. Booklets, posters, a video and other materials were produced. In **Benin**, the project created visual aids for the educational activities (behavior change pamphlets, posters, T-shirts) specific to the BCC strategies of the eight enterprises and the informal sector. Using messages adopted at the workshop, the graphic designer created posters with the themes:

- "Worker, send your wife to have the test to prevent transmission of HIV/AIDS from mother to child."
- "HIV/AIDS positive worker, the clinic can help you to live better with HIV/AIDS."
- "Consult the health worker."

Pre-testing was done, and when the visual aids were finally produced, the PAB approved them before distribution to the project partners.

Although messages were decided through a participatory exercise, and then delivered to artists or other practitioners, all communication materials came back to the workplaces for pre-testing. In this way, posters with pictures of people wearing hard hats and uniforms, for example, were evaluated to ensure that viewers would receive them as appropriate. For example, efforts were made to be sure that the lab coats worn in oil companies in Benin were the same color as the coats at each company; e.g., blue for one and green for another. This level of specificity was low cost and apparently not particularly time-consuming. Peer educators indicated that it was well worth the time.

The **Botswana** program developed a flip chart on durable plastic-coated materials that contain the most necessary information about HIV. High praise came from all over—the less sophisticated informal sector, the government focal points, and the highly organized Delta and Desert Safari—that the flip chart was an outstanding tool. The project in India developed two stories, displayed on small flipcharts for participants who are semi-literate or non-literate. The stories are realistic and well targeted to some of the potential audiences. In one case, the story is told of a worker who returns home to his village from his time working in the city. This basic starting concept of the story is very familiar to many of the audiences. The graphics are well done and the story clear with content covering all the major issues. The Delhi State AIDS Control Society has replicated the flipchart, and after pre-testing it, found 90 percent of the contents to be relevant to their target groups. An interviewee from another State AIDS Control Society reported that they even use the card game with the unorganized sector: "Even if they cannot read or write, we ask

others to help them and use the flipchart. They like that because it is in a story form." The materials could be improved by inserting the text of the story on the back of each image, so that the facilitator can easily tell the story and not forget to cover all of the points.

Besides flipcharts; posters, bumper stickers, mouse pads, towels, coffee mugs, tote bags, and the ubiquitous T-shirts were produced in the context of the project. Products were created because they fell within the realm of the appropriate and feasible, based on the formative assessments.

One aspect of the development of messages is the Key Benefits. Based on the information garnered from the formative assessment, aspirations and hopes are turned into messages which connect to Key Benefits for the worker. For example, a healthier lifestyle increases productivity, increases the chances of promotion, and helps the worker climb the professional ladder. Messages on posters and other vehicles address the key benefits. The coffee mug in daily use by young professionals working in the banking industry in **Belize** carries the message: "Bank on condoms; it's in your best interest." (In other words, if you want keep your wealth—protect yourself from HIV; then you can forego paying hospital bills and other expenses related to HIV and AIDS). The key benefits, as one of the elements of the Behavior Change Communication strategy, were picked up by marketing consultants more in some countries than in others.

The **Cambodia** project produced two specialized booklets, one each for the garment and hotel sectors. The booklets contain a short story about HIV with accompanying messages that are generally interesting and include useful messages. The story line for the hotel workers contains a statement like; "After the party, Some returned home completely drunk. His wife took off his clothes and cleaned his body with a wet towel, and then she opened her husband's bag. She saw that a condom was missing from the bag, so she feels that her husband loves their family because he used a condom with other partners outside." In the Cambodian context, it is true that many a wife accepts her husband's partying behavior. According to Cambodian informants, however, it is questionable that wives would be very happy to see a missing condom, as some level of jealousy does usually exist. Turning a blind eye to a husband's behavior is not the same as accepting its proof. Usually, materials are tested with workers directly, while spouses are not included. It would have been useful to test the material and hold focus group discussions with spouses of male workers as well. Aside from the booklets, the project developed posters by sector; a soap opera in DVD format; and distributed a guidebook containing information on locations where VCT and other services can be found. The former National Project Coordinator noted that the materials were quite successful because many workers come from relatively isolated villages and were curious to see the materials the peer educators showed them.

With some exceptions, most peer educators and master trainers did not have enough booklets to hand out to their co-workers or others in their community. Given staff turnover in every company or group, having materials to hand out is vital. No system for reproducing the materials after the project ended was evident within the companies and organizations visited. Due to the lack of materials to give to workers, several companies/organizations were handing out the old folders developed earlier by NGOs. The folders were not at all appropriate for the purpose for which they were being used. Most of the folders were clearly intended for health workers so that they could recognize symptoms of STIs, and not for the average person. The folders included photographs of diseased genitals, which were very graphic and unpleasant to view. As one peer educator related, this posed problems for some young female workers who were scolded by their families for bringing home so-called "pornographic" material.

Most of the time, materials were designed by public relations experts, graphic artists, and marketing consultants. Despite the disparity of levels of economic and social development in the countries, the level of marketing consultants seemed appropriate. The final products varied. One concern is that although creativity and even project resources may not be limited, in some countries available resources for the

production of creative message vehicles are. As a result, vehicles for media campaigns such as T-shirts continue to be used, although they are time limited and not proven effective. An urban-based development 'expert' said; "Here in Benin, people are poor so they like to get T-shirts;" but in the rural palm oil factory, the AIDS committee related that while they did hand out T-shirts as a relatively low-cost, one-time only premium, they considered other activities and message tools, such as their company-wide billboards or stickers for the helmets of factory workers, more effective.

In creating materials, the involvement of PLHIV is key and very effective, particularly with respect to stigma and discrimination. The involvement of PLHIV is perceived as humanizing the HIV issue. Linkages of PLHIV can also be increased, so that they can provide direct ongoing technical support in the form of monitoring and follow-up to enterprises.

In **Cambodia**, besides problems of effectiveness and appropriateness of materials, there were also accessibility issues. Most agencies and companies visited in the course of this study could not produce the materials that they purportedly used regularly, and no full set of materials was available when the mission immediately started in the country. Several people said, "I keep them at home so they do not disappear." If materials are kept at home they may be protected but are also less accessible, should they suddenly want to use them to hold an informal session. Other interviewees could only provide one booklet or a poster. Some also showed very poor-quality folders that had been made by other NGOs a number of years before. Only the Cambodian Construction Workers Trade Union Federation in Siem Reap could proudly show several full sets of their informal economy workers' toolkit. Interestingly, they also had several copies of the accompanying card game, which looked worn and obviously used.[88]

In fact, for the countries where the project has terminated, the ongoing availability of materials promises to be a problem. Even for those committed to the prevention and anti-discrimination messages, the state of our 'global economy' is a common explanation for heads of businesses to suggest that they will not be able to reprint a poster which is starting to fade and tear. On the other hand, some enterprises clearly intend to continue with the paystub messages, and C.B. LaFarge Cement Company in Benin is building a market where new AIDS murals will be painted. Already, they have painted the outer walls of the latrines with graphic, anti-risky behavior paintings.

5.2 Peer Education—Peer Educators Identified and Trained

Research suggests that people are more likely to hear and personalize messages, and thus to change their attitudes and behaviors, if they believe the messenger is similar to them and faces the same concerns and pressures.[89] Therefore, the use of peer education as a method to promote healthy behaviors and understand concepts of discrimination and stigmatization was a reasonable and prudent approach. Seen as a BCC strategy, peer education was the mechanism by which the target population (workers and managers) would feel comfortable and thus be more receptive to new and different information designed to make them change risky behavior and discrimination and stigma in the workplace. It involved the selection of key people in the workplace who could and would effectively transmit messages; provide information and referral; and report to the project, via focal points, management, or directly to NPCs, on

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[88] The master trainer had actually laminated one of the sets to preserve its quality.

[89] Sloane, B.C., C.G. Zimmer. 1993. The power of Peer Health Education. *Journal of American College Health, 41*:241-245. Milburn, K. 1995. A critical review of peer education with young people with special reference to sexual health. *Health Education Research, 10*:407-420. Studies show that teenagers who believe their peers are using condoms are also more than twice as likely to use condoms compared to teens who do not believe their peers use condoms. From, Using peer promoters in reproductive health programs for youth. *In Focus,* December, 1997; available at www.pathfind.org/pf/pubs/focus/IN%20FOCUS/peerpromoters.html.

behavior change and other measures of success or problems at project sites. Peer educators (PE) received training that usually lasted from 3 to 5 days—an indicator of the enterprises' commitment.

Individuals were chosen to be peer educators according to sensible criteria, sometimes (but not always) through voting by the specific work unit or department. The peer education strategy draws on the credibility that workers automatically have with their peers, and leverages the power of role modeling.[90] The peer educator is not a professional—medical or otherwise—when it comes to BCC. Some enterprises had doctors and nurses attached. In at least one case, a nurse was a peer educator among his peer income bracket/management level; that he was a health professional was considered a plus. In contrast to most of the peer education programs of SHARE, the **Guyana** Power Company peer educators *were not* peers working shoulder-to-shoulder with their constituents. The workers preferred the PEs who came to see them at their isolated workplace areas, and were more willing to open to them because they trusted confidentiality over local coworkers. It is worth analyzing the culture, size, and internal friendliness of the workplaces before choosing PEs.

The PEs received training and participated to a relatively small degree in the collection of the formative assessment and analysis of the data and the development of materials, all activities that typically were designed and implemented by independent consultants or NGOs.

The role of peer educators was essential to effective behavior change. PEs necessarily needed to adapt their approach 'on the spot,' to take the particular type of person with whom they are discussing into account. During the peer education, training games and role-playing were used to help educators learn how to talk to different groups. **Benin** and **Botswana** are typical African nations, in that they have varying levels of language usage. Some speak local dialects, while others speak either English or French. It was necessary to have peer educators of both language abilities, and materials used for the program also needed to take that into account. Peer educators mentioned materials in local language as one area where the project could improve.

The peer education method was effective because it helped to reach all workers more easily. Many female peer educators were very shy initially and several did not even know anything about sex. As one interviewee noted; "Some girls will even get married and do not know about sex."[91] This issue is currently being addressed through the introduction of an HIV curriculum into schools that also includes information about sexuality.

In **India** and in other project countries, some peer educators reported that they are still not sufficiently confident to answer all of the questions that workers asked of them, particularly on the subject of STIs. Some participants ask questions about the usefulness of Ayurvedic traditional medicine, and state that they do not have answers. Another common question that consumes a great deal of time to discuss is regarding the origin of AIDS. The educators state that simply having additional detailed background information would be useful as a resource for them to consult.[92] Some peer educators reportedly had a bad experience during their first presentation and then are too shy to continue. The audience sometimes asks questions that they do not know how to answer and this makes them uncertain. In a focus group discussion for this study, it became apparent that some PEs know that they must not try to answer all

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[90] National Hemophilia Foundation. 1994. Peer-to-peer health education programs for youth: Their impact on comprehensive health education. New York: The Foundation.
[91] Cambodia.
[92] The project did develop a guide, but some considered that it did not cover all of the questions they are asked.

questions and that it is alright to promise to get an answer for later.[93] Peer educators at factories and processing plants in **Benin** are lucky to be able to turn to in-house doctors and nurses for updated information, but it is often the case that one peer educator emerges as a leader who will do research for the others. In all project countries, peer educators are hungry for additional materials, refresher training, and innovative activities. In **India**, interviewees indicated that training and awareness raising often needs to be repeated and participants quickly become bored when the materials are repetitive. Where companies have developed their own methods, they are not always equally good. Some companies elect to use overhead projectors to present a rather monotonous lecture. This is the choice of the company even if the ILO project recommends against it. Where such lectures are used they are fortunately followed by question and answer games with small gift rewards and other interactive methods.

"The role of the peer educator is in facilitating meetings and providing information and support."[94] In **Cambodia**, formal organized training for groups included interactive sessions, participative demonstrations, games, role-playing, and other methods. Informal training usually consisted of chats during workers' free time. In most cases, employees were trained during their free time as opposed to being given time from their regular working hours to attend group training. In the **Cambodia** hotel industry, group training can be difficult to organize because people work in shifts. Some workers are also on 'standby' and are suddenly called to work or the peer educator is not on duty when the trainees are free. In **Benin** and **Botswana** as well, training often took place during work time for the target group. This meant that the peer educator, if on another shift, stayed late or showed up early to do a presentation.

Obviously, scheduling presentations when a PE is normally not on shift is a problem. Ways this has been resolved have been to choose two PE's; provide organizational skills so that they can expand the PE networks; encourage or build national, citywide, and regional networks of PE; and hold events to bring them together. According to NPCs in the Caribbean and Africa, peer educators need and appreciate to be kept updated. With new exercises, new materials, kits, refresher courses, the outcome has been that they stay. In **Guyana** and elsewhere in the **Caribbean**, NPCs reported that enterprises recognize the value of peer educators and have given them staff awards, including making them Employee of the Year.

Peer educators benefited from the project in several ways. They have mastered extensive sex information relevant to their own lives, received special training about HIV and AIDS, learned how to make presentations, and participated in analyzing somewhat complex ideas—especially where they were involved in the BCC analysis of the formative assessment. Peer educators at the Benin Handicraft Village, the Arawak Cement Company, and the FLUDOR Cotton Seed Oil Company reported that they had changed, and were more committed to responsible sexual behavior. Further, their peers and their community recognize them as leaders. Peer educators often also train their families and their neighbors. In **Benin** and **Botswana**, the peer educators proudly described their role as communicators and facilitators in communities beyond the workplace.

Recognition, remuneration, and rewards for peer educators are topics of discussion in Benin, which was echoed by participants at the Behavior Change Communication workshop in the **Caribbean**. The general consensus seemed to be that payment of peer educators for services rendered was inappropriate and,

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[93] A peer educator took the opportunity of the visiting MD to pose the case of his comrade on the shop floor who is in love with a woman who is HIV+. They want children. He had factually and correctly explained the options to the man. The discussion among peer educators was lively as it turned to adoption of children. In Benin, even though it is common for families take on the children of other family members when a parent dies, and even to nurse an orphaned child, adoption is rare, and bearing one's own child is important. There are orphanages with children who are not adopted because the concept is not appealing. "This disease offers opportunities, "said one PE, "Because it makes society change and take on new responsibilities."

[94] Discussion at Interactive Training Session.

indeed, not expected. In frank and open dialogue with peer educators at more than one project enterprise, it was clear that they value their role as volunteers and as peers. However, they shared concerns that while there were benefits to being peer educators as far as garnering respect in the community and gaining knowledge, there were sacrifices as well. For example, peer educators missed coffee breaks and other leisure time pauses when they were involved in preparing for a presentation. Some out-of-pocket expenses might have also been made for various activities. Peer educators seemed convinced that, were they to receive any remuneration, their relationship as peers might be compromised. Recognition, such as Employee of the Week, a plaque, or a reference book, key chain, or another similar premium as a symbol of appreciation by the company were suggested. A peer educator's photograph and name is prominently displayed in some work places. Workers thus know who their departmental peer educator is, and the peer educator is recognized for his or her special knowledge. In the **Caribbean,** some peer educators are feted with a picnic or family cruise, either at the expense of the project or the workplace, depending on the situation. The NPCs who reported having success by doing this affirmed that it is worth it, even with a small budget. Although these activities may seem purely symbolic, the discussions which surrounded the topic demonstrate that this is an important element to building capacity and solidarity among peer educators. It is noteworthy that PEs in a country as poor as **Benin**, where the average income is less than $2 a day, were firm that payment was not an option if they were truly to be "peers."[95]

An issue cited in **India** and the **Caribbean** is turnover among peer educators. At the Arawak Cement Company in **Barbados**, the focal point and AIDS [Safety and Health] committee lamented losing a "wonderful" peer educator to migration to the U.S. Another company, also in Barbados, was losing a peer educator to the U.S. immigration lottery. Since the personality of a PE is that of a leader, someone who is amenable to change and betterment, it is understandable that they might move on. A system needs to be designed to ensure that new persons are trained to replace them, or that there is more than one peer educator per unit.

In **Cambodia**, the work of peer educators was not monitored intensively during the project implementation. During on-site visits and meetings, the project staff tried to assess how implementation was proceeding and how much they remembered from their own training. This was less of a problem in those enterprises where the human resource personnel or upper management were more involved, as at Delta and Desert Safaris or Cresta Lodges in Botswana, Arawak Cement in Barbados, or C.B. LaFarge Cement in Benin, where key personnel attended peer educator events. Also, the reports that were due to SHARE required monitoring. Some NPCs were in touch about such reports on a quarterly basis even though they were only due twice a year.

In **Benin**, peer educators in an isolated cottonseed oil factory wanted to expand their mandate to address other health-related issues. This was consistent with the experiences in **Botswana**, at other **Benin** project workplaces, and was reported to be true in **Guyana** as well.[96] As SOLVE, a project of ILO, consists of modules that consider the inter-relationship of HIV with alcohol, drugs, stress, tobacco, and violence, peer educators could conceivably expand their roles.[97] Peer educator could be trained using the SOLVE methodology to address other psycho-social issues. In addition, they will benefit from training in malaria and tuberculosis (TB), which may threaten lives of workers—especially those living with HIV. The three diseases targeted for a global response are addressed by the Global Fund to fight AIDS, TB, and Malaria, which has a presence in many SHARE countries.

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[95] Available at http://news.bbc.co.uk/2/hi/africa/country_profiles/1064527.stm.
[96] Interview with Sean Wilson, Guyana National Program Coordinator.
[97] SOLVE is an ILO/SAFEWORK strategy to integrate the psychosocial issues of stress, alcohol and drugs, violence, HIV/AIDS and tobacco into a comprehensive organizational policy and develop action based on the policy through a number of different educational programs

5.3   Enterprise Implementation and Activities
The one consistent activity found at every workplace was to have peer educators lead short presentations on HIV/AIDS themes lasting between 15 minutes to 2 hours, depending on the enterprise. The presentations were at the end or beginning of shifts, during meals in the cafeterias, or at the canteen during coffee breaks. Usually, but not always, presentations were on the premises of the workplace. Some enterprises, such as Fludor in Benin, devote a morning or afternoon periodically for staff development. Formal group sessions include presentations with discussions, role plays, participative demonstrations on condom use, games and question and answer sessions. Other activities included sports and drama. (For a more inclusive list of the creative vehicles used by stakeholders, see Annex 7, Creative Activities Organized to Educate and Serve in Workplaces and Surrounding Communities.)

5.4   Condom Distribution
Relative to the enormity of the AIDS epidemic in Africa, providing condoms is cheap and cost effective. Even when condoms are available, though, there are still a number of social, cultural, and practical factors that may prevent people from using them. In the context of stable partnerships where pregnancy is desired, or where it may be difficult for one partner to suddenly suggest condom use, this option may not be practical. Despite this, condoms abound in the workplaces. In the SHARE partner Cresta Hotels of Botswana, condom machines dispense them free of charge to workers and guests alike. Some of the workplaces charge a small stipend, articulating a belief that the condom must be valued or it will not be used. However, enough enterprises, industries, and businesses offer staff free condoms, so that this argument—giving something away for free diminishes the use somehow— seems lame at this stage of the epidemic.

Fifteen workplaces in **Cambodia** report making condoms available, but the number of companies actually distributing condoms was unclear at the time of the study. Some of the hotels distribute condoms through their medical service, while others distribute them on World AIDS Awareness Day. Some hotels also distribute condoms when they hold certain types of events, such as staff parties, as rewards for winning games. Six out of the 11 corporate groups in **India** have introduced condom vending machines or distribute them through the focal point or medical staff. Condom distribution is somewhat uneven across the partner corporate groups. During the first year of project implementation, most companies did not provide condoms. By the second year, they now sometimes place vending machines or refer workers to locations where they can obtain them. In the Mumbai Port Trust program, for example, condoms are offered free of charge at the end of any training or counseling session. The Mumbai Port Trust already provides condoms to individuals requesting them in their hospital, and they are also in the process of identifying locations for installing condom vending machines.

5.5   Establishing Referral Arrangements for VCT, Prevention of Mother to Child Transmission, and Treatment, Care, and Support Services Available For HIV AIDS
Generally, enterprises and workplaces do not offer VCT or treatment, nor are they equipped to do so. Further, there is consensus that issues of discrimination, stigma, and even confidentiality persist enough so that some of the workplace health facilities work best for providing information and referral, but not treatment and services. It is not unusual for the doctor or nurse affiliated with the enterprise to accompany workers or assist in some way. In countries where there is low prevalence, health workers affiliated with the enterprise reported accompanying workers for tests or providing counseling.

None of the visits to formal sector workplaces in conjunction with this study indicated any level of service support as depicted in the film Creating Change, where the Swaziland Super Spar Market AIDS

Committee visits staff members who are ill and brings him food and supplies.[98] However, **Botswana** was the only country in the study with nearly the same level of HIV prevalence. It can be said that the participating enterprises in Botswana, all of whom have workplace policies, are extremely proactive in promoting testing and voluntary counseling, knowing and declaring one's status, and providing referral service for treatment and ongoing care. Doctors and nurses affiliated with partner enterprises in **Barbados** and **Benin** report accompanying workers to be tested. Fully recognizing the confidentiality issues, no one reported any staffers with the infection in the course of this research; two companies in **Benin** reported knowing the number but not names of HIV+ workers as a result of testing which had taken place. Except for **Botswana** and **India**, most companies participating in this multi-country study had very little actual experience with workers who had AIDS.[99] Companies associated with the project provided information on locations where VCT treatment, care, support centers, and agencies are available. Although the corporate groups associated with the project usually offer some type of medical service, most do not have the required expertise and resources to provide full-scale services on HIV. An **India** employers' group representative interviewed indicated that diagnostic and anti-retroviral (ARV) can best be coordinated through government services as opposed to promoting care and support through companies. The Crompton Greaves representatives in India indicated that they couldn't offer all the required care and support. Only large companies would have the necessary medical skills to handle such issues sensitively and correctly.

Focal points and peer educators are quick to point out that peer educators are not counselors. Delta and Desert Safaris is one of the few participating enterprises with lay counselors. Lay counselors are being used more and more in **Botswana**, though mostly through NGOs, organizations of people living with AIDS, and health facilities. The safari company has a visiting pastor who received the behavior change communication training from the ILO, in addition to other pastoral counseling training. For a small stipend and expenses, he visits the camps on a regular basis and brings a level of professional counseling, facilitating, and referral that enhances the program in that company.

In **India**, locally available counseling is also very limited, so meeting counseling needs is a challenge. An employer organization representative reported that some companies are averse to working with government centers since they consider that there is too much "bureaucratic red tape." Some interviewees mentioned that they still need more and continually updated information on VCT, care, and support. Some type of system needs to be developed so that enterprises are kept informed of new services at their worksites. Such a system could be developed in cooperation with the SACS. Nine of the 11 corporate groups in India, three in **Barbados**, and all of **Cambodia**'s participating enterprises and workplaces offer referral services.

Access to ARVs are available free of charge in **Benin**, where all 10 of the participating workplaces offer referral services. In each of the enterprises, the project has provided several maps that are color-coded and clearly mark the full range of services offered throughout the country. A peer educator in one enterprise explained that the maps were helpful because sometimes workers might want to go to another region for

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[98] The SHARE video highlighting behavior change communication initiatives from around the globe was premiered on May 20, 2008 as the culmination of the Caribbean Interactive Learning Event on Behaviour Change Communications (15-20 May) in Bridgetown, Barbados. From Community Zero: "Entitled 'Creating Change,' the video was screened following a presentation of the HIV/AIDS policy and programme of Purity Bakeries, one of the SHARE partner enterprises in Barbados. The video is centered on four countries (Belize, Benin, Indonesia, and Swaziland) capturing contrasting and original approaches from various sectors to deliver key workplace messages as appropriate within different working environments. The film was followed by a discussion with representatives from the Ministries of Labor and employers' and workers' organizations from the region as well as a question and answer period with media representatives."
[99] Some companies in Botswana or India had experience.

testing or treatment, or that they might want to communicate where the testing and treatment centers are to relatives in another region. Some workers are more mobile than others, and some are more transient, so the maps with multiple information and referral centers were considered helpful.

The **Cambodia** project supported the development of a guide containing the contact information of VCT, Prevention of Mother to Child Transmission (PMTCT), and treatment, care, and support centers and agencies. These guides have been distributed to project stakeholders so that they can improve their referral for workers to access such services. Updating the guide will be necessary as additional services become available and some centers and agencies close down. This low-cost, simple tool, like the map in Benin, could easily be replicated elsewhere. **Barbados** is moving towards providing access to antiretroviral therapy (ART) to all those in need. This is a serious problem, which could be the focus of advocacy on the part of ILO. Eight of the Barbados enterprises offered referral services for voluntary counseling and testing.

Botswana, which once had the world's highest rate of HIV infection, has one of Africa's most-advanced treatment programs. The country pioneered the provision of ARVs in Africa, starting its national treatment program in January 2002. By 2007, World Health Organization figures 93,000 people were receiving treatment, including those using the private sector, resulting in a coverage rate of around eighty percent.8 Thousands of lives have been saved as a result of the national treatment program. Nearly everyone knows about it, as the final impact assessment demonstrated.

Several hundred kilometers from Gabarone in the border town of Charles Hill, the focal point for the informal economy in Botswana is a well-known and well-liked civil servant. As a local person, she is not in danger of being transferred to another district. She works as a messenger in the district administrative department and serves as focal point and peer educator for the district government staffers as well. She was concerned that she did not have the most current information about ARVs and treatment. The government complex houses public health officials and a fairly large health compound with clinic, mother-child health facilities, infirmary, and meeting rooms close by. The facility offers a full range of HIV and AIDS information, testing, and treatment. Obviously, the problem is not that the focal point does not have access to information, but rumors are sufficient concerning the efficacy of current ARV drugs to pose a challenge. She feels she would benefit if the ILO provided her with refresher courses and up-to-date information so that she could dispel the rumors. Health officials who are more likely to remain in their offices and not proactively meet with the local population seem unaware of the rumors. Within the higher levels of government civil service, the system of periodically transferring officials works against building confidence among the local citizenry.

Testing and voluntary counseling have become activities integrated into the project with a lot of success. SHARE Enterprises in many of the countries report on having "Know Your Status Day" where staff members wear badges ("I know my status"), or red or green ribbons to affirm that they have been tested.

2.   Working in the Informal Economy

The informal sector comprises small-scale enterprises engaged in a wide range of economic activities on the margins of the formal economy. These very diverse businesses usually lie outside the sphere of government regulation and assistance. Due to the disparate nature of activities, organizational forms, and institutional environments, the informal sector cannot usefully be treated as a homogeneous sector. People of widely differing ages, social backgrounds, genders, training, and work experiences operate informal enterprises. These activities are the lifeblood of the countries where SHARE is being implemented and represent a workplace in and of themselves. Some represent the cadre of vendors and suppliers, called the supply chain, to the enterprises. Others are day (or casual) laborers. Such enterprises often provide goods and services either not produced by formal businesses or supplied by the latter in forms or quantities

unsuitable for or unaffordable to local consumers. The mobility of the informal worker and lack of adequate and readily available health services (and condoms) places this sector at high risk to HIV and AIDS.

The SHARE model used with formal enterprises does not apply similarly in the informal economy. Actions in the formal economy can usually be channeled through enterprises and can be implemented in a more similar manner. Informal economy workers are frequently very different from each other and a different model may be needed for each. Informal economy workers may consist of self-employed workers or family members in an informal economy enterprise. Migrant workers may be formal economy employees but many work in the informal economy. Informal economy migrant workers may also be casual/daily wage workers or long term employees without formal contract. Migrant workers may also work for just a few days as casual labor when the family needs extra income, and may return home for long stretches of time. Other migrant workers spend most of their time as casual workers and return home for just a short time (e.g., once a year or less).

Reaching the informal economy worker proved challenging for most NPCs interviewed, but once pertinent groupings were identified, such as the Taxi Association in Barbados, the project made inroads. Still, establishing programs in the informal economy may require more resources. Many informal workers are highly mobile. Finding them subsequent to training or other actions to determine any behavior or attitude change can often be particularly difficult. Entry into the informal workplace is difficult because of the lack of definition common to the informal sector. Although production and management processes may be unsophisticated, these informal enterprises can be rather advanced. Despite the challenges, there is an overabundance of opportunities to make a real difference in the informal economy. The Program Management Team provided guidance to NPCs for interventions in the informal economy.[100] The experiences in **India**, **Benin**, **Cambodia**, and **Botswana** are described below as some of the approaches piloted in the project.

a.   India

An interviewee from MOLE stated; "The biggest challenge on HIV in the workplace in India is the informal economy." Approximately 340 million persons work in the informal economy in India.[101] Most of the project activities were implemented through government agencies, employer organizations, corporate social responsibility programs, unions, and partner NGOs. In Madhya Pradesh, the project cooperated with the SACS to implement a 1-year pilot action with women in 64 villages who were either agricultural workers or wives of agricultural workers. An assessment indicated misconceptions on HIV and condom use. Women self-help groups gained BCC on HIV issues with the aid of a master trainer and a woman doctor. Some men were trained as peer educators to reach out to men in the villages. After 1 year, an assessment determined that women and their spouses were more aware of STIs and had sought treatment.

SHARE partner Ambuja Cement Company sensitized their truckers who transport their materials and final products. The company uses a total of 16,000 trucks and each has two to three people on board. As the interviewee stated; "The car is not air conditioned. He is tired and he wants to relax. He will not care if the water is clean or the food is good but he must sleep with someone in the night to relax. They told us that we can't use a condom because it lessens our pleasure. So they were using the condom for any other purpose except this. They will use it to repair the leaking water tap. It took us a lot of effort to convince

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[100] See CZ; files and documents/Program Management Team/Guidelines.
[101] National Commission for Enterprises in the Unorganised Sector (May 2006).

them but we are happy to tell you that they are using them." The assessor was not able to determine how many truckers have yet been trained but the program is still underway.

PepsiCo implemented a program with potato farmers and caffeine and carton supplier groups. PepsiCo also trained truckers who provide transport for their raw materials and final products. The PepsiCo corporate outreach carried out a program with the spouses of workers and in the local community near two plants visited by the assessor.

The project-supported specialist within the Delhi Aids Control Society gives assistance to two trade unions that cover railway porters, construction workers, and embroidery workers. The unions have completed the KAP study and are starting to train peer educators. More information is needed on where other concentrations of vulnerable informal economy workers are located. In Hyderabad, most of the railway porters worked independently and there was

Porters in Hyderabad Railway Station

great competition between them. A union organizer determined that it was important for them to be organized so as to improve their working conditions. She gained official recognition for them at the station, as well as registration as porters, complete with uniforms and standard prices for their work. The organizer noted through her work to support them that some porters had died of HIV and determined that it was necessary to add an action on HIV. She sought out the ILO to assist her in implementing a program. The organizer was able to train 30 peer educators among young railway employees to train the porters.

A key element in the success of the initiative was that the porters had developed a personal bond with the organizer who had helped them with other labor issues. They were willing to discuss the sensitive issues on HIV because of their trust in her. She noted that continuous monitoring, following-up with action, and a personal commitment to making it succeed are vital to ensuring behavior change. Other lessons learned include the importance of integrating the actions on HIV with other forms of support to be able to gain the interest of the target group and obtain their cooperation. The porters were very positive about the training because it had addressed their fears about HIV and cleared up their misconceptions. They pointed out that they were now no longer worried—at all—about working with someone who is living with HIV, "no problem." The peer educators found that at the first training session only 40 porters attended, but at the next session all 400 were present. The porters added, "When we have lunch or take a rest we just sit in some groups and we have our discussions in an informal way." The porters pointed out that the program should be continued on a permanent basis, as there is constant turnover among the porters.

The Hind Mazdoor Sabha Union works primarily with construction workers, who are mostly migrant casual/day laborers in the informal economy. Over 40,000 workers have already been trained through the action, mostly at locations where contractors come to select workers in the morning. Because the workers only spend a short amount of time standing waiting for possible work, new methods need to be adapted. Usually, union workers rely on a special flipbook developed through the project that illustrates a short story that contains all the key elements. The flipbook is especially conceived for the semi and non-literate person and has been well received. Only about 50 percent of waiting workers are truly interested in the session, since many feel they already know sufficiently about HIV through the media, even though they still have misconceptions. Condoms are handed out to the workers after the sessions, but they also have

access to vending machines in the area. We find that; "People's behavior has really changed. They do practice safe sex. Acceptability of people with HIV has improved although it is not yet complete. Workers also know they can approach the local HIV committee for any information." No formal impact analysis has been done, although a baseline analysis was carried out at the time of inception of the action three years ago. Official data to prove the assertion of behavior change is still lacking. Hind Mazdoor Sabha Union representatives felt that the model was too focused on training and insufficiently on care and support of workers found to be HIV positive. Casual female laborers sometimes also engage in sex work if they do not find work. The contractors are both clients and pimps for the workers. This issue is not yet sufficiently addressed in the materials being used.

The Central Board for Workers Education implemented a pilot action on HIV, mostly with informal workers, in four blocks (neighborhoods). Peer educators supported volunteers who effectively gained the trust of the local workers. The volunteers surpassed their targets and more than doubled the number of persons covered to over 6,000 persons. These CBWE trainers and peer educators hold informal sessions with workers in their roadside shops, workshops, and small building sites. Small brochures containing the core messages are handed out and posters are placed in prominent sites. Condoms are made available in earthenware pots hung in trees near roadside shops. One CBWE education officer reported that, while the action was successful, he faced challenges from his own agency. These challenges put into question the efficacy of fully up-scaling the efforts using similar methodologies. He felt that his supervisors had allotted too little time to properly implement the action, and that he faced bureaucratic hurdles. Official permission was sought for every step he undertook and for every hour he spent on the office computer to analyze data and write reports, for example. He insisted that, unless an education officer is truly motivated to spend extra time and effort on such an action, it will be difficult to achieve effective behavior change. He continued; "Reaching the informal economy worker is vital and the actual model used is potentially very effective. Human and financial resources to effectively reach informal economy workers need to be up-scaled substantially to implement the action throughout the city of Delhi and the rest of the country." There was no office space to meet with the volunteers and peer educators in the block where the pilot action was implemented, but the office of a local NGO was used. It may not always be possible to make such arrangements when upscaling such efforts.

One of the main challenges of reaching the informal economy worker is the enormous geographic dispersion and the wide diversity in ways of living and culture. The interviewees from MOLE indicated that, although a start is being made through its training institutes, "We are not really targeting this informal economy sector sufficiently."

b.   Cambodia

In Cambodia, the project focused its informal economy work on the development of a toolkit on HIV to be used with informal economy workers. The project worked in synergy with the staff of the ILO

Informal Economy project to develop a toolkit and pilot-test the action.[102] The action was implemented in collaboration with the Cambodian Construction Workers Trade Union Federation in Siem Reap and was also pilot-tested with some other groups. These included members of a handicrafts production association in Phnom Penh (Rajana Association), members of the Cambodian Association for Informal Economy Development,[103] and agricultural workers being supported by an NGO in Siem Reap. The construction industry in the tourist city of Siem Reap, site of the Angkor Wat temple complex, has currently taken on a large number of workers to build hotels and restoration of the temples. Most workers involved in the construction industry are casual daily wage workers. As an interviewee from the CCTUF indicated, "Many workers come from their village for a week or so to earn just enough money to go back home." Sometimes they manage to involve them for just one session because "when we return for the next session they have already returned to their village."

The Informal Economy Toolkit was developed in 2005 using a participatory approach through focus group discussions, pilot testing, and feedback workshops with informal economy workers and their communities in Phnom Penh and Siem Reap.[104] Technical support, including for the graphics, was provided through the ILO office in Bangkok. The Toolkit is to be used by organizations, unions, and associations within their membership or with other workers they wish to include in the training. The Toolkit consists of a detailed manual describing how to conduct interactive sessions, games, and demonstrations on HIV issues. A set of cards showing the key images representing the core messages is also included and used for playing games. Messages covered in the Toolkit include—

- Basic information on HIV/AIDS
- Roles of men and women in relation to HIV
- Behavioral change and prevention
- Rights and voice vs. Stigma and discrimination
- How to reach needed services.

While the Toolkit is generally well written and has good graphics, it could be improved. The section on stigma and discrimination is not very developed and the issue could have received more attention. The Toolkit is designed for use in a single training without a long-term strategy. Given the frequent mobility of many informal economy workers this is understandable, but strategies to conduct monitoring and follow up could be developed. As was the case with other materials, copies of the Toolkit were not readily available among potential partners. CARE, for example, does not have a copy although they also work with the informal economy.[105] The Informal Economy Toolkit on HIV is currently being replicated and adapted to be used in Mongolia.

The Ministry of Labour and Vocational Training representative stated that it is difficult for the MOLVT to intervene in the informal economy. The number of workers in the informal economy and their diversity makes reaching them effectively a challenge. He noted that it is most effective to work through existing workers organizations and local NGOs, though they often lack sufficient resources for in-depth actions.

The Cambodian Labor Confederation interviewees reported that they have two associate member associations that work with informal "tuk tuk" (three wheeled motorized vehicle) drivers, market sellers,

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[102] The ILO Informal Economy project ended in March 2006.
[103] Membership of this association consists of truck transport workers, motor and tri motor taxi drivers, street vendors, fishermen, and farmers.
[104] The title of the toolkit is, "Know More about HIV/AIDS: A Toolkit for Workers in the Informal Economy," International Labour Office (2006).
[105] The ILO does not distribute the toolkit. However, it is available to all who request it.

waitresses, and gas station workers. A farmers association has also recently applied for membership in their Confederation. The CLC is very interested in developing a program to work with such groups on the HIV issue. The potential to upscale the efforts on HIV with informal economy workers exists if the resources are provided.

The Cambodian People Living with AIDS Network (CPN+) interviewee indicated that the ILO should also link their efforts on HIV to assisting PLHIV to improve access to employment and/or work in the informal economy. [106] Because many PLHIV have fewer skills, they have problems accessing decent employment options. More efforts need to be undertaken to link the HIV in the workplace program to other programs on employment creation being implemented by the ILO and other agencies.

c. Botswana

The Informal sector was represented in the form of a women's tailoring collective located in a border town with extremely high HIV prevalence. The Focal Point who organized the workplace education program is also focal point for the HIV/AIDS Workplace Education project in the district office of the government. Her actions were as significant in the government workplace as they were among the dressmakers.

The group is housed in a public workshop and has received sewing machines and other supplies from various grants. The project input and impact at first glance appears to be low. However, the importance and visibility of the focal point as a local leader cannot be denied. She has taken on a leadership role that places her in the middle of the town, assuming a sort of "Champion," as is found in India.[107] She has reached out to 10 villages, and counts 25 peer educators. Her approach to BCC was completely unique, using cultural norms and attitudes to achieve objectives. At the same time, she followed the program systematically and as scrupulously as she could. Surveys and formative assessment were done on the smallest of scales—15 women. She also counsels women, which is not considered the role of a focal point, and in some instances can be counter-productive. In this case, she has gained local trust. She presents small dramas on her own, and enlists her peer educators to do the same. The materials used by the Informal Sector focal point are the same ones that she uses in her government office, but they seem to work in both arenas.

There is a significant group of local people, including health professionals, vendors, and the Peace Corps volunteer, who work together and have been able to organize activities such as soccer games and drama events to use as venue for AIDS education. However, they often feel very discouraged and isolated. Unemployment runs high, and in general the economy is skewed because of the particularities of the culture. People have animals and other signs of wealth, but are simultaneously impoverished and marginalized. At a meeting convened by the project focal point in Charles Hill, discussion centered on confusion and a sense of obligation to international funders and the National Aids Commission that they needed to organize a 'support group' for people living with AIDS. The meeting was composed of people living with AIDS and those not, all of whom participated fully. Without clear guidelines or mandate, there seems to be a national thrust to organize support groups, possibly originating among donors. Those attending worried that they did not have time for support groups because they needed to be working (in the informal sector). More interesting to them would be organizing revolving funds and micro-enterprise groups. Further, this particular group of activists was, in fact, a 'support group' to one another, working

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[106] The PMT adds that ILO/AIDS has a conceptual approach to employment possibilities and income-generating activities for PLHIV which is being implemented in a number of countries such as Nepal and Sri Lanka.
[107] For more details, see Annex3, The Champion Concept.

on the issue, sharing strategies and ideas. It is disconcerting that the informal sector has not been a greater part of the Workplace Education project (SHARE) in Botswana. Clearly, the National Program Coordinators were interested in involving them but the challenge of a distinct lack of organization is too great. It should be noted that Botswana has a moderately high contextual, regulated national culture. In the face of such a highly organized, benevolent government and business, the results are a civil society, the informal sector, and trade unions being somewhat undeveloped and rather weak players.

The Botswana project has had some success in stretching its program to reach the informal economy through supply chain industries, and it is in this direction that the Benin project has also moved. This is particularly true at C.B. Lafarge Cement Company, where management is cleaning up the slum market that has grown up outside of the plant by creating new facilities.

d.   Benin

The Informal sector in Benin easily comprises 95 percent of the country's working population. The project worked with the Centre for the Promotion of Artisans (CPA). A handicraft village managed by the Ministry of Tourism, the CPA houses dozens of men and women engaged in creating and selling a wide variety of handicraft and art objects. Among enterprises and work sites in Benin, the CPA was the only enterprise that recorded a significant number of people already affected by the infection. According to a peer educator, one of more than 30, "We were already preoccupied with the fact that our workers were at risk. Some were dying and we were uncertain what to do. The project came along at this time for us." After attending the initial sensitization workshop, a baseline data survey and the formative assessments were conducted, and peer educators were chosen. Artists and vendors were highly motivated to understand the infection and learn how to prevent it, although many had a fatalistic attitude. With behavior change communication materials and peer educator-led training they learned preventive measures, and that treatment is available.

Although it is difficult for informal workers to take time for training, the elected peer educators took off for five days of training. Like the other Benin programs, they receive some funding from the government PPLS (program to fight HIV AIDS) and the World Bank. With the help of the NGO Racines, the peer educators crafted messages to create changed attitudes. Heart-shaped wooden key chains, woven tapestries (posters), and other objects were created by the artists for sale to tourists. The calendar of events was fully charged. Through the project, they were able to show films about HIV and AIDS, which are very popular among the workers. Some events lasted for as long as 2 hours. With support from the government, the Artisans Center has condoms available. Many participants confirm that the behavior change program at the artisan center was dynamic, well organized and effective. The Center provided space for the training so that workers could be in their shops at break time. Most participants had apprentices who remained at the shops. The NGO Racines has continued to take an interest in the project and has helped in monitoring. The group calculates that they reached 150 craftspeople and another 150 art sellers. The anti-AIDS message graphics are seen all over the village so that when tourists come, they are also exposed to important, life-changing information. The project has been able to measure the depth of understanding among the participants.

It could be said that this sector was not truly 'informal' because it is actually an association managed by the government of Benin's Ministry of Tourism at a state-run tourism and sports facility. Here again, as in Botswana, civil servants benefitted and participated fully in the program as focal points within their departments. The Memorandum of Cooperation was signed with the Ministry of Tourism, and the quality of the program was due in large part to the committed staff. The Center has been open for more than 20 years, and the staff has been there since the beginning. Although not artists themselves, they have built up a strong allegiance to the goals of the center and thus to the artists. The relationship with the Tourism Ministry has an economic benefit to those who have workshops and stalls provided by the government,

and the relationship also enabled them to be a part of SHARE. This benefitted many more artists who rent stalls or who have loose relationships with the Center, but have stalls elsewhere in Côtonou.

If it appears that the Benin informal sector was only touched through the one mechanism (the Artisan Village), it should be noted that the informal sector in Benin is well integrated into the two participating trade unions. The confederation of independent unions CSA (Confédération des Syndicats autonomes du Bénin) encompasses motor-taxi drivers, dressmakers, hairdressers, and vendors; while the CSTB (Confédération Syndicale des Travailleurs du Bénin) offers membership to taxi vehicle owners and the National Federation of Artisans (FENAB). Both unions are part of the tripartite constituency, and the latter union was extremely active in the program, while the CSA only somewhat less active. The ILO Strategies and Tools against Social Exclusion and Poverty (STEP) project, which has been working since 2003 with groups of female and male workers in the informal sector, coordinated to some extent with the project.[108]

3.   Monitoring, Reporting, and Evaluation

There are several components of the project that provide information on success and impact through monitoring and evaluation. The ILO staff in Geneva, USDOL representatives, and Management Systems International consultants developed the SHARE overall strategic framework. Embedded in the project are the Performance Monitoring Plan, Data Tracking and internal reporting, baseline data collection (including workers' survey and a mapping survey, and a final impact survey. Technical progress reports, and midterm and final evaluations were included in the program as routine expectations from USDOL. In addition, each country has work plans, and BCC strategies are essentially work plans for the workplaces.

A special section on Community Zero that lists numbered tasks, called simply, TASK LIST, is a very detailed work plan, requiring stipulated dates and percentage of tasks completed. Little attention seems to be given this list, in that it was not mentioned in the course of the study although NPCs are involved in completing the list of tasks. It appears to be a powerful tool that should be incorporated into the PMP, if it has not already been done.

The SHARE strategic framework was generic enough to be tailored for each country; a viewpoint that was not specified but was probably understood, considering the grandeur of the project and the differences across countries. The development objectives—to reduce HIV risk behaviors among targeted workers; and to reduce employment-related discrimination against workers living with HIV or affected by HIV—are measurable when implemented through the four immediate objectives and sub-immediate objectives—

- Increased availability of quality workplace HIV services

- Increased levels of workplace collaboration and commitment by labor and management

- Increased capacity of workplace to offer comprehensive AIDS policy and programs on a sustained basis

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[108] STEP is a global program of the ILO's Social Security Department which focuses on the poor and excluded populations in the informal economy and the rural sector. STEP works in two interconnected fields: the extension of social security in health, and integrated approaches to fight against social exclusion at the local level.

- Improved coordination and cooperation between Tripartite [constituents] and other partners at the national level

- Improved national level policy framework related to HIV at the workplace

- Increased capacity of Tripartite [constituents] to support development of workplace.

a.   Measurement Tools

Measurement is done through the surveys and impact assessment. Monitoring is based on the Performance Monitoring Plan which joins implementation tasks with objective indicators. Performance, thus, is measured against a number of indicators assigned to the objectives of the strategic framework. A workplace monitoring form is filled in by enterprises every 6 months. In some countries and with some enterprises, the form was sent to the enterprise focal point who filled it in. In other cases, the focal point simply reported the data over the telephone, or e-mailed it. In those instances where the informal sector participated in the M&E process (and not all did), lower levels of literacy is one explanation for how the forms were completed. It has been suggested that labor ministries, with newly trained labor inspectors, could be involved in continuing the process.[109] NPCs used the collected data in preparing the Technical Progress Reports (TPRs) sent to Geneva and USDOL, but there is not a lot of evidence to suggest that meetings were held in which shop-floor stakeholders, such as peer educators or even focal points, participated in analysis of the data. Regardless, in the course of the cross-country study, focal points and others involved in monitoring routinely confirmed that they had received sufficient guidance, were well aware of reporting requirements, and regularly submitted their forms. The evidence was clear: stakeholders were engaged in the M&E process, particularly the reporting angle. It was remarkable to find the consensus among interviewees on the ease and usefulness of the PMP. The management team in Geneva confirmed that reporting requirements were met punctually and reports were comprehensive.

The PMP indicators are most highly focused on workplace issues. National level capacity building, policy, and legal framework indicators are included, but data reporting is not very clear. In **Cambodia** and **India**, for example, national capacity is mostly reported in terms of the number of people trained and who has passed post-training tests. The capacity strengthening of stakeholders using less formal means— such as through technical support in their companies or agencies, through meetings, and e-mail exchanges—has been important at the level of decisionmakers. The capacity strengthening of such decisionmakers is not adequately covered in the PMP despite its importance for long term sustainability.

The Data Tracking Table includes data on capacity strengthening of tripartite constituents to support development of workplace policy and programs.[110] The number of individuals who demonstrated "increased knowledge of effective workplace policy and programmes" on pre- and post-training tests was used as a measure of increased capacity. However, the actual ability of tripartite constituents to influence and support development of policy and programs was not measured. A random look at other countries not part of the study reveals the same thing: Data tracking tables are not complete, and BCC strategies for enterprises are likewise incomplete. It may be that the PMP and the accompanying DTT is impractical outside of the workplace, or that training was lacking in this particular area.

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[109] From Caribbean Interactive BCC Training event.
[110] The data tracking table captures results of the baseline and impact survey [and has] a section for ongoing monitoring of activities at the workplace and national levels.

The PMP/DTT process is highly regarded by all interviewed, but it cannot be disputed that it and the BCC process are complex. Enterprises are run by profit-makers, not social scientists, and yet they and their staff handled the data well. The NGOs who implemented the training and consulting may have had some problems with the complexity. The PMP covers a lot of data, but as a monitoring tool it may overlook some points while digging too deeply in others. The workplace objectives are clearly understood, but 'policy adoption' is more difficult to track.

In **Cambodia**, the midterm and final evaluators determined that the project Performance Monitoring Plan was generally a good tool to monitor and track the project but could be improved. [111] The number of indicators and sub-indicators used in Cambodia was excessive, and needs to be reduced to a series of core indicators that accurately reflect the key objectives.[112] The core indicators can include some common indicators for cross-country comparison while others are adapted to individual project needs. The current system includes important measures but the level of detail does not necessarily encourage the transition of the monitoring system to a national body. A post-project monitoring plan should be included in any sustainability plan to ensure that national entities can appropriate and implement it beyond the life of a project. For this reason, a PMP needs to be clear and limited to core indicators that have been shown to be essential to success and straightforward to implement. Although it is ideal for the measures to be the same over the life of a project so as to allow for comparison, it should be sufficiently flexible to allow for some adjustments as the project acquires experience on the usefulness and complexity of tracking. Data tracking tables were designed using the type of information collected in the baseline and impact assessments. Such data is not necessarily very useful for ongoing monitoring throughout the life of a project because of its level of detail. Data tracking tables for **India** and **Cambodia** show that the indicators were, in fact, mostly only measured at baseline and at the time of the impact assessment.

The ILO and USDOL wanted baseline data and common indicators to be able to compare and contrast effectiveness. *The Performance Monitoring Plan lays out the work to be done and the way that objectives will be measured overall. The Data Tracking Table documents input from the PMP every 6 months.* All countries received training on the PMP during the Strategic Planning and Performance Monitoring Workshop, which culminated in the adaptation of each country's PMP. The tripartite constituents, the survey administrator, and the National AIDS Committee were present among others.

How these data and statistical tools have been used varies somewhat from country to country. The position put forth in **India**, for example, is that "it is better not to start beating companies over the head with [the PMP and DTT] from the beginning, except to say that it would be preferable and is a goal. If included as a measure, it should be looked at flexibly."[113] Variation on quality also seems to stem from the amount of training given to the National Program Coordinators on the materials, and how much time they had in which to fill them out. The **Benin** and **Togo** projects had the benefit of the Management Systems International (MSI) consultants early in their training. The Benin DTTs are possibly the most comprehensive and rigorous of the countries studied. In reviewing the PMPs, DTTs, and final impact assessment, where available, the conclusion is that while DTT reports and assessments were usually punctual, there is some unevenness in the substance.

Differences in sexual behavior will influence the types of results on any common indicators reflected in the data tracking tables. Major recent regional studies have shown that sexual behavior is markedly

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[111] International Labour Office/United States Department of Labor (April 2005), Ketel, Hermen & Kien, Serey Phal. (May 2007).
[112] Indicators that track information that is nice to know but not essential need to be eliminated.
[113] Mei Zegers, from interviews on cross-country study in India.

different in countries such as **India** and **Cambodia** as compared other parts of the world.[114] Wives and female partners in much of Asia, for example, tend to rarely have multiple sexual partners, even over their lifetime. This influences development of the epidemic since once a man has passed on the HIV virus to his wife/partner; she rarely continues to pass it on to other partners. The sample size for some of the indicators in low prevalence countries affects interpretation of the results. If in one company, for example, only 4 percent said they had casual sex, and this is reduced to 1 percent, the effect is quite small.[115] Other factors may also influence the types of answers respondents provide. Once workers—as a result of training—have overcome their shyness of talking about sexuality, they may be more willing to talk about having casual sex.[116] If numbers of people reporting casual sex do not go down or only go down marginally, it may actually be because more people are admitting to casual sex.

Performance Monitoring Plan

Each national project uses this system to adopt a set of country-specific indicators that help assess progress, and identify the impact of the project…strengths and weaknesses for necessary further planning. The PMP assesses the impact of the projects at individual (workers) level, workplace (enterprise) level, and national level.

At the individual level, the PMP measures the project's impact on HIV knowledge, attitudes, and practices of targeted workers. This is achieved by conducting a survey…[a] questionnaire, administered to a sample of at least 300 randomly-selected workers in at least six partner enterprises, at the beginning (baseline survey) and towards the end of the project (impact survey). At the outset, survey data provides key information that influences the focus and content of enterprise-level interventions.

At the workplace, once a program is up and running, its impact is assessed through the use of a monitoring form, administered every 6 months. The form monitors workplace policies and programs and the delivery of HIV services in all the project's partner enterprises.

At the national level, impact is assessed through the use of a Tripartite monitoring form, administered by the project NPC every 6 months. This captures the impact of the program on ILO Tripartite constituents and other associated partners within the national framework. Issues covered include the development of national policies on HIV, the training of government officials as well as members of employers' and workers' associations, and other related actions undertaken by the Tripartite constituents. The monitoring tools developed through the PMP are intended to be used by stakeholders beyond the completion of project activities. The world of work indicators used in the PMP is progressively integrated into national HIV/AIDS unified monitoring and evaluation systems.

From: "Saving lives, protecting jobs," SHARE Second Report, p. 62

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[114] Commission on AIDS in Asia (2008).

[115] The term 'casual sex' was used locally in some countries and generally means sexual encounters with strangers, or agreements that can stretch over a longer period of time between two people who have sex together. This is also called multiple partnerships in other countries.

[116] In both India and Cambodia, shyness and reticence to talk about sexuality was a major issue during training. Most peer educators reported that shyness was reduced over the course of the training period.

The substantial interviews held with focal points and other stakeholders in **Barbados**, **Benin**, and **Botswana** confirmed the findings of evaluators in **Guyana**, which was that focal points who were involved in monitoring had received adequate training and guidance; and, understanding the reporting requirements, submitted their reports regularly. Often, project participants in enterprises "…underlined the usefulness of the PMP as a tool to obtain relevant information on impact and progress and to guide implementation."[117] Internal monitoring systems for some of the stakeholders in **India** have been designed and adopted, notably in corporate groups, but the V.V. Giri National Labour Institute and others indicated that they did not have an internal monitoring system to track and inform their activities. The Institute indicated that they would like to have such monitoring systems, "to at least track how many people we have trained and who they have trained in turn and where."

Everyone involved understood the importance of monitoring, which was carried out effectively, accurately, and in a timely fashion. One reason the monitoring and forms may have been so successfully used was because the formal workplace is habituated to monitoring. In factories, retail, and industry, keeping track of inventory is key to making a profit. In the enterprises where doctors and nurses ran onsite health and safety clinics, doctors and nurses who are trained to rigorously follow procedures saw the forms as a normal part of their jobs. The necessity of monitoring was fully acknowledged, but some pointed out that the project had numerous benefits that are not easily captured by numbers. For example, it could be useful to include the activities of peer educators in monitoring to get a better idea of how activities differed between enterprises and what impact this had. Such a system might include activities of peer educators, how many training sessions, how many persons reached, length of the sessions, etc. Some enterprises, for example C.B. Lafarge, Fludor, Delta and Desert Safaris, Purity Bakeries, and Arawak Cement Company kept scrupulous track of formal peer education sessions, including sometimes how many people were reached, though there is little recorded about informal sessions.[118]

While the number of indicators might be reduced, additional qualitative monitoring, preferably based within the workplace, could be developed.[119] Qualitative monitoring would help in the monitoring of actual behavior change, a factor that is under-highlighted in the current PMP. Enterprise monitoring systems have been developed in **India**, and though they do include a qualitative component, they are still mostly intended for management to track their efforts on HIV issues. A system that includes input from workers using qualitative as well as quantitative input on core issues can be useful to improving the actions and sustaining the interest of workers.

The PMP did not include tracking of the informal economy actions in **India** and **Cambodia**, although they were of significant importance. The projects in both countries also implemented some activities that are not captured in the PMP. The neighborhood pilot interventions implemented with India's Central Board for Workers Education are not included, for example. The development of a toolkit to use with informal economy workers in Cambodia is likewise not reflected. The PMP needs to include some flexibility to allow for the introduction of actions designed as opportunities to try out innovative approaches as identified.

Assessing SHARE's Monitoring and Evaluation tools—the PMP and the DTT, essentially—is somewhat complicated because quantified targets are not provided. The level of improvement depends on the individual situation within a company or stakeholders' organization. Factors such as the baseline results are highly relevant to interpreting any level of improvement. Under usual circumstances, it would be ideal

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[117] Guyana Mid-Term Evaluation.
[118] See Annex 6.
[119] The India Midterm Internal Assessment also recommended more qualitative measures.

to conduct a baseline and set achievable and acceptable targets based on the baseline results. Unfortunately, there was not a tradition of using control groups established within the project. Nor was the use of tests of statistical significance deemed an integral part. Without targets, or tests of statistical significance, it is difficult to assess the extent to which any possible differences between the baseline and impact surveys are scientifically significant. A more practical and useful PMP could be developed in two parts: One part that could reflect the type of information collected at baseline and at impact assessment. A second, more reduced number of indicators could be developed that are key to tracking, accurately reflect progress, and are practical to monitor.

More rigorous evaluation methodology would have required more resources (not just financial) and thus was not deemed practical for all the programs. The project in **China** has more resources, so the project added a control by matching enterprises. According to Fatemeh Entekhabi, SHARE project Technical Specialist, "There were not outcome targets per se for multiple reasons. One being that for peer education type of evaluations, there are no gold standards as to what the outcomes are. There are so many variables that it is difficult to set the gold standards (e.g., number of exposure to peers and messages for example)." Gender issues will also be under more scrutiny in the coming generation of SHARE.[120]

It is interesting to see the changes that have occurred over a period of time (from start to finish, literally), but without targets, something is missing. It would have been nice to know what stakeholders might have dreamed possible. Their dreams might have been unrealistic, or they might have resulted in even greater impact. One can imagine competition across enterprises, or visuals showing how close they were to their goal, if the data was tracked all along. As is, it remains interesting.

Participating enterprises in **Benin** did set targets, and the outcome was not only more pertinent, it was more exciting. For example, the Behavior Change Communication strategy that was adopted by Fludor, and other members of the food oil sector included such targets as—

- Within 1 year, 50 percent of the workers in the oil sector will use condoms
  - o In 6 months, all of the workers will be informed on the importance of a means of prevention (condoms).

- Within 1 year, the number of men whose wives avail themselves of voluntary testing services when they are pregnant will be increased by 50 percent
  - o At the end of 6 months, all the workers will know the benefits of testing.

- In 1 year, all the workers of the oil sector will systematically use condoms for sexual relations with a person who is not their habitual partner
  - o At the end of 6 months, all workers will have knowledge of the benefits of using condoms for sexual relations with a person who is not their habitual partner.

At the end of the project, the AIDS committee, peer educators, focal points, and managers pointed with pride at condom usage, awareness factors, and other behaviors, including enlightened management, as the product of their own efforts. They met their targets, just as they met production and quality assurance targets for their cottonseed and palm oil production.

In the cement factory sector, workers and managers attending the workshop set similar targets—

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[120] E-mail from Fatemeh Entekhabi, Technical Specialist.

Issue: Attitude of Managers Towards Workers who are HIV Positive

Result of KAP	Explanation	BC Objective	BCC Objective	Advantage	Message
Only 37% of the workers in secondary and higher levels would accept to working with people living with AIDS	Faulty information	From now till December 2007, 50% of managers in the sectors will change their attitude towards workers who are HIV positive	Within 3 months, all managers are informed of the benefits and will change their attitudes towards people who are HIV positive	Workers who are HIV+ in the cement sector will be better attended to by managers	The fight against discrimination is to help the cause of our colleagues who are HIV+ to be able to live longer

Participants voiced their hopes and knew what they were hoping to achieve. The results of the Final Assessment had added significance because workers could see if the BCC efforts had brought the change that they had desired. This approach—to set feasible goals—added to the experience of the workers and management in Benin, but was for some reason omitted in other countries. The result of having clear targets is that at the end, the BCC process has a proven track record of turning results into improved program design, management, and quality service delivery to target populations.

The standardization of the SHARE M&E system, with its PMP and DTT, the baseline data collection, as well as the BCC methodology, all accompanied by training, is consistent enough to recognize the benefits. The system institutionalizes, with a definite and cost-effective advantage, the use and collection of qualitative and quantitative assessment methods; provides tools that can be used for replication and program design; and generates data to both measure project performance and program impact.

b. Technical Progress Reports, Midterm and Final Evaluations

National Project Coordinators prepared and submitted regular technical reports to Geneva that were also sent to USDOL. These narrative reports were appropriately concise, informative, and not terribly rigorous. The PMT in Geneva also submitted reports (Combined Technical Progress Report) that covered the project progress, mostly in narrative format. USDOL received the TPRs as submitted from the National Projects. In several countries, staff indicated that the level of detail and timeframes at which the reports needed to be submitted interfered with the established work plans. That may explain why the reports were, at best, cursory. For example, one USDOL program officer gave an example: "The office hosted an ILO AIDS gender consultant who was on mission to evaluate the extent to which gender issues have been integrated into HIV and AIDS interventions in the workplace."[121] It would be helpful to understand by one additional sentence something about the pertinence and outcome of the mission.

Midterm and final evaluations were timely, and of variable quality. Usually, they were extremely well organized and contained a lot of useful information. In the course of this study, it became clear that these evaluations were appreciated and the comments taken seriously by NPCs. The midterm assessment in **Cambodia** made several recommendations that were implemented, including the hiring of an additional staff member and more intensive sensitization with company managers. The final evaluation expressed concerns about sustainability.[122] The imminent appointment of an ILO national AIDS focal point to

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[121] ILO/USDOL International HIV/AIDS Workplace Education Programme In Botswana, TECHNICAL PROGRESS REPORT29 February 2008

[122] International Labour Office/United States Department of Labor (April 2005), Ketel, Hermen & Kien, Serey Phal. (May 2007).

provide technical support to ensure upscaling of project efforts, and address HIV in the world of work in Cambodia in general, will partially address this challenge. The specialist will particularly concentrate on providing technical support at national level to tripartite constituents individually and as a group. The MOLVT will chair a working group that will be patterned after the former Project Advisory Board to plan, track, and implement actions.

In **India**, the current phase of the project was evaluated through an internal midterm assessment in 2006.[123] The midterm assessment enabled the project to take a step back and assess their work together with the evaluator. The midterm review in India recommended the need to address stronger efforts more intensively, so as to strengthen national employer, worker, and government organizations working on HIV. The project was able to improve in these areas after the midterm although more needs to be achieved. Regardless, gaining experience by working directly in enterprises, as was done in Phase I and the first part of Phase II, was useful to acquiring practical experience and field-level credentials. The evaluation placed special emphasis on addressing national policy, along with other recommendations, which the staff tried to implement, integrating them into their work plan.[124] The assessor also noted that recommendations were constructive and within the framework of the project at the time of the internal midterm assessment.

c.   Impact Assessments

At the end of the project, a final impact assessment is conducted which collects data based on the baseline workers survey (KAP). Independent consultants compile the information. The Data Tracking Tables also include the collected statistics. The final reports are filed with Geneva and can be found on Community Zero. The first part of this section describes the process and some results of impact assessments in three of the countries studied. The second part compares the data using graphs.

1.   The Assessment of Behavior Change in Three Countries
1.1   Botswana
Some countries hired the same consultants for both surveys, but when the final impact study was conducted in Botswana, the consultants hired were different from those who implemented the original KAP. The consultant expressed frustration with the original form and some of the questions: "It should be noted that the questionnaire did not allow room for probing reasons for answers given. Where probing was done despite this limitation, respondents were giving interesting and valid reasons for their answers which otherwise would have led to the conclusion that they did not know some of the transmission modes of HIV. This was particularly true with questions on transmission of HIV through blood transfusion and from mother to child… [some respondents who said] one would not get HIV through blood transfusion [argued] that health facilities do not use HIV-infected blood for transfusion, and indeed in **Botswana** all blood used for transfusion is screened for HIV, making it an insignificant mode of HIV transmission compared to the sexual route… [Some respondents said] a mother would not pass HIV to their unborn babies [because of] the presence of the PMTCT program. While the risk is still there, even with a PMTCT program, one would appreciate the fact that a 'No' in this instance was not borne out of lack of awareness of MCT as a possible route of HIV transmission but was more influenced by awareness of HIV prevention programs available in the country."[125]

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[123] International Labour Organization/United States Department of Labor (ILO/USDOL); Final Report, published in 2007.
[124] The purpose of the current assessment is to study the model being implemented across countries, and not an in-depth verification of implementation of recommendations.
[125] Impact Assessment of the HIV/AIDS Workplace Education Program implemented by the International Labour Organization in collaboration with the BOTSWANA Ministry of Labour and Home Affairs and social partners, (June 2008).

Gender issues have an impact throughout the study, such as the discussion of condom use and multiple partnerships. Of the 89.9 percent of workers who reported being sexually active, 37.6 percent had a sexual partner other than their spouse—up from 33.4 percent in 2005. Despite this upward trend in multiple sexual relationships, substantial improvement was noted in the use of condoms—90.2 percent of the workers who reported having sex with sexual partners other than their spouse, in contrast to 64 percent during the baseline study. The slight increase in the proportion of workers with sexual partners other than their spouse compared to the 2005 baseline survey was attributed to the sample size from the female-dominated CARATEX textile factory, where the highest proportion of workers reported having multiple sexual partners. The researchers felt that although the situation on the proportion of workers with other sexual partners increased, the reported "consistent use of condoms within such sexual relations is welcomed in terms of HIV prevention. The other factor, which may be driving people to keep multiple sexual relationships, is economic hardships. The presence of a good ARV program in the country may also have inadvertently removed people's fear of HIV, making them more inclined to have more sexual partners as compared to the time of the baseline survey. This trend points to the need for strengthened and more interactive educational approaches and for deliberate programs for economic empowerment."

1.2. India

The most recent impact survey conducted in India was in 2006. Like the assessment in Botswana, questions of language and context may have skewed the results. Willingness to live in the same house with a person who is living with HIV has surprisingly decreased somewhat, from 77 percent to 60 percent. This may be, however, because 100 percent are willing to share a room with a person living with HIV and the question was not well understood by some within the context of India. Many workers share rooms where they reside, and which would be considered their homes. The impact study report frequently uses the term "significant difference," but no statistical analysis of significant probability is reported.[126] The baseline survey was conducted almost 1 year after the project began. The impact assessment used the same methodology as the baseline survey.[127] A total of 403 respondents were interviewed from garment companies and the hotel industry. The sample does not completely correspond to the baseline survey in terms of gender representation.[128] In most impact assessments worldwide, gender representation has significance. The number of individuals who reported having had sex with a non-regular partner during the last 3 months prior to the survey was only 68 in the baseline and 50 in the impact survey. Such a small sample size makes it difficult to interpret the importance and significance of the result regarding the percentage that used a condom the last time they had sex with a non-regular partner.[129] In both situations, a very high percentage—96.5 percent for the baseline and 98 percent for the impact survey—reported having used a condom, so it is difficult to show attribute impact to the project in any case. It is also difficult to show improvement in areas where interviewees already had a relatively good understanding of the issues at baseline. The percentage of respondents who reported at baseline that a person might get HIV by having unprotected sex with a person who looks healthy at baseline was 95 percent and at impact the result was 96 percent.

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[126] Vonthanak, Saphonn (2006).

[127] Ibid.

[128] As opposed to an average of 70% women in the baseline, the impact assessment included 54% women. Although the technique of random sampling was used it would have been advisable to ensure that the gender balance was more similar to the baseline. Other demographic differences were also noted, the percentage of respondents with only primary school education was 39% in the baseline and 20% in the impact survey. These differences could have had an impact on the results and the ways in which they can be interpreted.

[129] During the last 3 months.

Questions concerning knowledge of an HIV policy in the workplace also need to be interpreted in light of the number of workplaces that actually adopted a policy. In fact, six of the 15 companies participating in Cambodian had actually formally adopted a policy. The data tracking table indicates that 19 percent of workers of all respondents are aware that there is a policy in their workplace. The problem is that this percentage should have been calculated based on the number of workers where companies had actually adopted a policy. Workers cannot be expected to be aware of a policy that does not exist even if it is informal. Respondents should have been categorized by whether or not their company has adopted a policy. Subsequently, the question should have been asked only of those workers in companies that have adopted a policy. The way the results are currently represented probably underestimates the knowledge of workers about policies in their workplace.

> **India Impact Study 2006**
>
> Condom use with a person who is not their spouse (from 56% to 89%)
>
> Percentage of targeted workers who report a supportive attitude towards HIV+ coworkers (from 60% to 83%)
>
> Percent of workers who could identify all four modes of HIV transmission (from 70% to 82%)
>
> Percentage that can identify two symptoms of STIs (from 37% to 52%)
>
> Percentage of workers who report using HIV services in the past 6 months increased (from 0% to 80% for HIV education, and 48% for condom availability)
>
> Percentage of workplaces with a written HIV policy (from 0% to 75%)
>
> Increased availability of HIV/AIDS Workplace Services (approximately, from 0% to 75% and higher).

1.3   Benin

The project witnessed changes, and the impact assessment report carefully documented progress in the different enterprises. It may be worthwhile to applaud any improvement, but when there are small changes, it is difficult to concede that it was the project that made the difference, except when questions concerned the actual workplace. In Benin, the increase in the use of condoms for sexual relations with the occasional partner went from 76 percent to 84 percent, but the percentage of workers taking risks with occasional partners, called multiple partners elsewhere, has remained fairly constant. The improvement in the knowledge of three forms of transmission rose from 53 percent to 72 percent, which is welcome. Of this, 78.9 percent are men. There has been an increase from 87 percent to 93 percent for those who understand the risks of having sexual relations without using a condom. An understanding of the risks of getting HIV as related to alcohol or drugs has risen from 50 percent to 52.3 percent. In 2004, 18 percent of the workers believed that their businesses would fire an HIV-positive worker, as opposed to 14 percent now. However, more workers believe that their employers would not offer the same advantages to people living with AIDS; among the workers this has increased by 1.4 percent and remains less than one-quarter of the workers. The following table lists the percent increase shown by the impact assessment for the behaviors listed above:

Attitude/Behavior	Percent Increase
Condom use for relations with occasional partner	8%
Knowledge regarding the three forms of HIV transmission	19%
Understanding the risk of HIV as related to condom use	6%
Understanding the risk of HIV as related to alcohol/drugs	2.3%
Belief that employer would NOT fire an HIV+ worker	4%

The greatest progress is seen in the reduction of discrimination and stigmatizing of people living with AIDS. Forty-three percent of the workers are willing to accept and support people living with AIDS, as compared to 24 percent at the beginning of the project. Almost three-quarters of the workers have used available services related to HIV. As part of the activities within the project, in some factories testing

days have resulted in almost 100 percent participation. However, this is an area for questioning as the definition may have been confusing. Many of the workplaces offer general health services but do not do HIV testing or offer ARV treatment. They do offer condoms, which may be the nature of the services that these workers have received. Almost half of the workers know that their workplace has an HIV policy, and 45 percent of them can identify three principles of the policy.

The questions related to the reduction of stigma also need to be interpreted in light of HIV prevalence. In countries where the number of known cases of people living with HIV in the respective companies was fairly low, as in **Barbados**, **Benin**, and **Cambodia**, a question remains; the number and percentage of targeted workers who report an incident of exclusion of an HIV+ worker by coworkers may not be very relevant as it depends on the number of people that coworkers actually know are living with HIV. Coworkers may not be aware of the HIV status of their colleagues, and prevalence may actually be relatively low in the company, so the question may be somewhat invalid. It is not totally unexpected that the number of known cases in the companies targeted may be small given that the national prevalence of HIV decreased to about 0.9 percent among adults aged 15 to 49 in 2006.[130] The prevalence of HIV is also still higher among most-at-risk populations, including female sex workers, their clients, and other sexual partners, men who have sex with men, and injecting drug users. Workers in the companies selected for the project are not primarily representative of these most at-risk populations.

2.   Impact Assessment Data
Data collected from the Workers' Survey and the Formative Assessment provided valid and verifiable information about the level and nature of knowledge, attitudes, behavior, and beliefs regarding HIV and AIDS that exist in the workplace. Much effort was put into engaging consultants, creating questionnaires, testing, and conducting the surveys. Collected by credible social scientists, the information was used to formulate BCC strategies, with the logical intention that change would happen once the behaviors were identified and understood. The impact assessments contributed a great deal of knowledge about the issues that were investigated. The disappointment comes in that there is not greater change. If there were great changes, then one might bring up the media, government policies, and other external forces to have contributed to change. Different numbers of people were interviewed, different people were interviewed, and the lack of a control group account for disparities that raise more questions than are answered. Surveyors in **Botswana** questioned some of the responses in the overall final assessment, citing problems with the original questions, but also noting that circumstances in the country (e.g., free, available ARVT) caused answers to be somewhat skewed.

Looking across SHARE countries, each country approached the data collection and data tracking in a way that the NPC and PAB apparently found most appropriate. Some countries focused on explicit questions dealing with discrimination and stigmatization, particularly **Botswana** and **Cambodia**, while others looked more generally at those questions. The **Barbados** and **Cambodia** Data Tracking Tables omit entries on national scale project objectives, such as tripartite collaboration and improved national level policy framework. These final impact assessments conducted at the end of each project were illuminating. What follows is a glimpse of the possible analysis of some of the key areas that were considered by the four countries which had consistent and usable information from the initial workers' surveys and the final impact assessments (and DTTs): **Barbados**, **Benin**, **Cambodia**, and **Botswana**. They are divided into areas of change at (1) the workplace level: (a) discrimination and stigmatization (b) organizations, policies, and change, (c) services; (2) individual level: (a) behavior change; and (3) national level.

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[130] National AIDS Authority, (2008)

2.1   Workplace Discrimination
The project set out to protect workers and put an end to discrimination by employers, perceived or real, and relieve workers of hurtful and dangerous stigmatization. Workers were surveyed according to beliefs concerning dismissal, hiring practices, exclusion, and attitudes.

% of targeted workers who report that they believe their employer would dismiss physically fit HIV+ worker
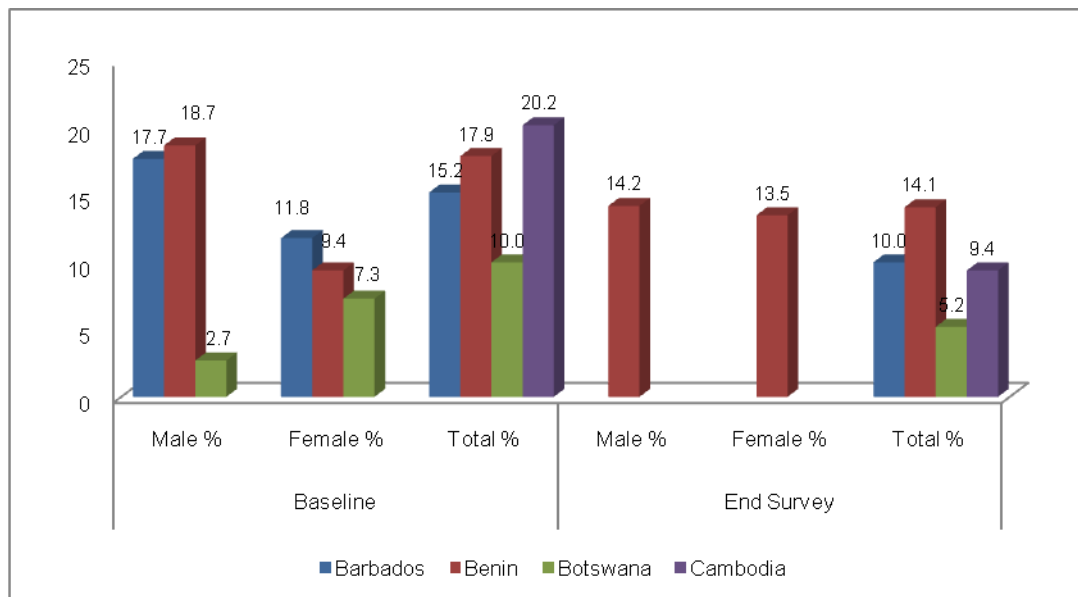
At the onset of the project, about one-fifth of the workers, except for **Botswana** where the AIDS crisis is more mature, believed that they were not protected from dismissal and would be denied opportunities in the workplace if they were HIV positive. After the project, some felt more secure, particularly in **Cambodia**. Between the baseline survey and the final assessment, results show workers now feel that their employer would be less likely to fire an HIV positive worker than they did in the earlier survey (if that person were physically fit and able to do his or her job). The number of workers interviewed differed from country to country (and from baseline to end survey in the same countries in some cases), but the percentages indicate an encouraging trend: confidence that discrimination is less likely to occur.

% of targeted workers who report that they believe physically fit HIV+ workers would be denied opportunities in the workplace
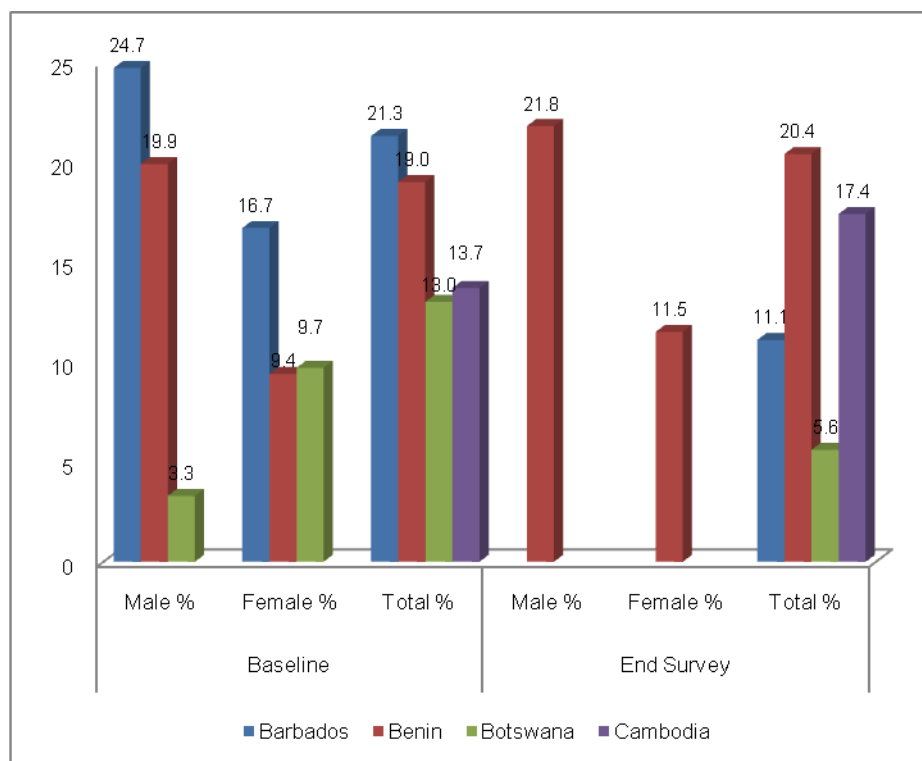

In **Barbados** and **Botswana**, there is an indication that fewer of the surveyed workers believe that physically fit HIV-positive workers would be denied opportunities in the workplace at the end of the project than at the beginning. In **Benin**, the tendency to believe that HIV-positive workers would be denied opportunities increased slightly. This increase is a little more pronounced in **Cambodia**. The greatest change was reported in **Barbados**, where—after the project ended—only 11 percent of workers believed HIV-positive workers would be denied work; a difference of about 10 percentage points. In **Botswana**, less than 6 percent of the workers believed work place discrimination could occur; a change of about 7 percentage points.

2.2   Stigmatization Issues
Over the life of the project, fewer employees reported experiencing or witnessing the exclusion of an HIV-positive worker by coworkers. **Barbados** reported a drop of nearly 20 percent in personal experience of exclusion. **Benin** reported the lowest rate of change, perhaps demonstrating acceptance of HIV in the workplace, or perhaps because Benin is a low-prevalence country where there may not be many HIV + workers. Indeed, in one of the Benin enterprises (IBCG, or Industries Béninoise des Corps Gras [Oil Industries]) visited in the course of the study, one section conducted confidential testing in which no one tested positive for HIV. **Botswana** shows a slight decrease of noticed exclusion towards people who are HIV positive.

% of targeted workers who report a personal experience of exclusion of an HIV+ worker by co-workers
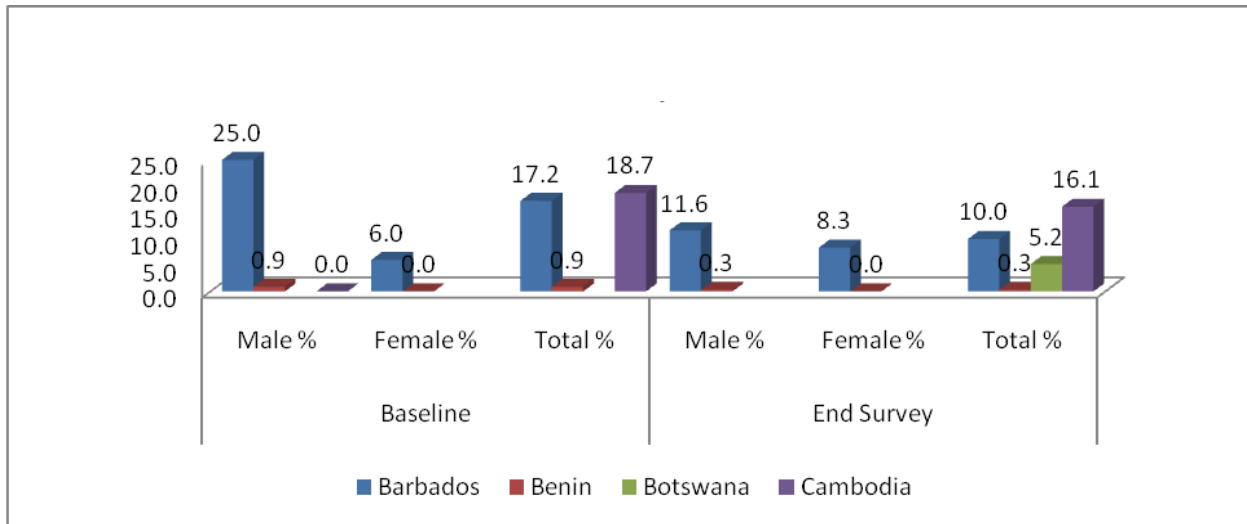

% of targeted workers who report an accepting or supportive attitude towards HIV+ co-workers
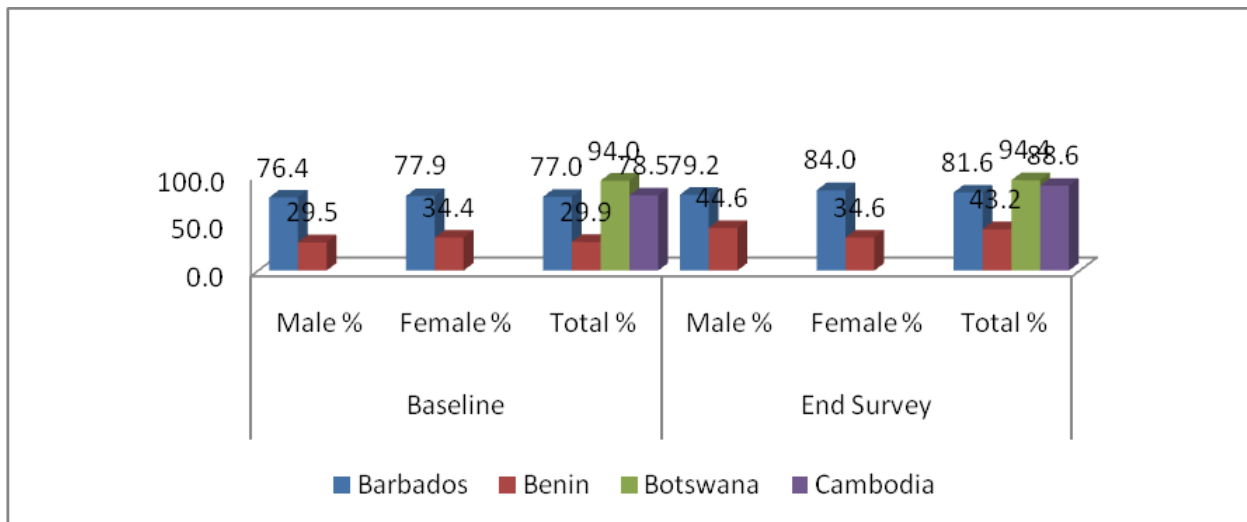
Most countries indicated an increased percentage of workers reporting supportive and accepting attitudes towards HIV positive coworkers in their workplace. The overall trend was positive, although there were only negligible increases in **Barbados** and **Botswana**. The largest increase was reported in **Benin**, where an increase of 14 percent of the workers indicated a more supportive attitude towards HIV positive coworkers since the beginning of the project.

% of targeted workers who report an acceptance or supportive attitude towards HIV+ person outside the workplace
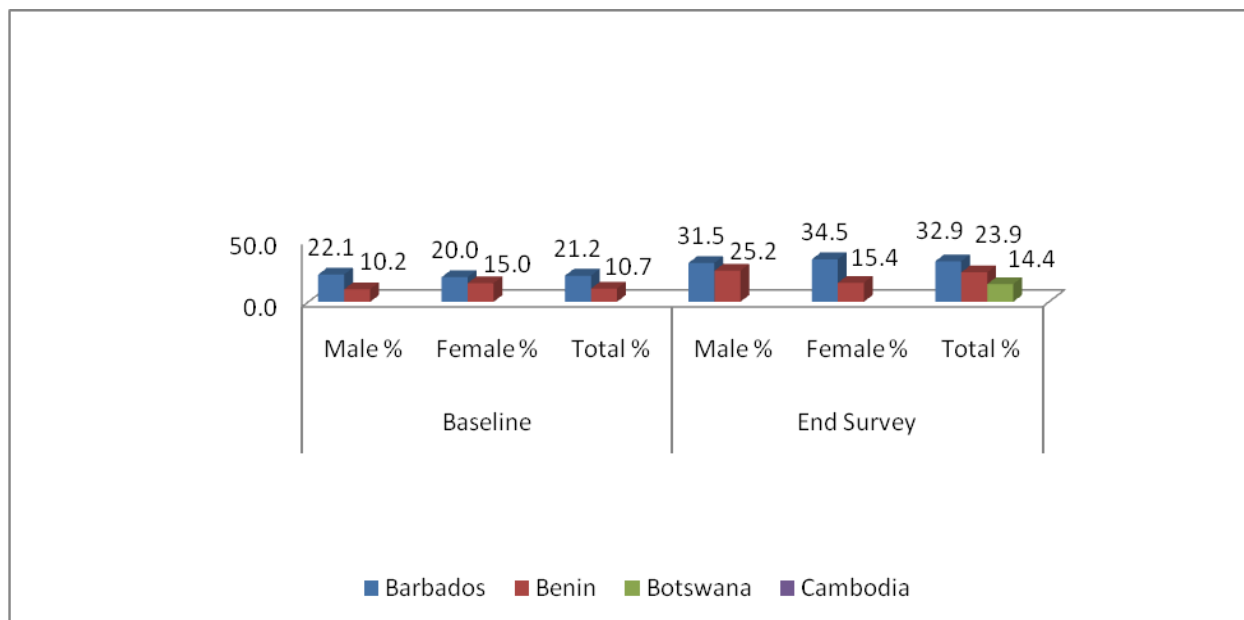

It is worrisome that the acceptance extends only to the limits of the workplace. Outside of the workplace, less than half of the workers report acceptance or support. Still, that the question is asked and answered opens the door to heightened awareness. The baseline workers survey and final impact assessments in **Cambodia** and **Botswana** focused on specific activities to identify behavior and attitudes regarding people with HIV and AIDS. For example, workers were surveyed as to their willingness do things with an HIV+ person, such as eat together, use the same toilet, hold hands, and buy food prepared by an HIV+ vendor. Overall, the results were encouraging.

2.3   Workplace Policies, Organization, Capacity, and Services
The capstone of the project was the strength that emerged in workplaces. Enterprises, through managers and workers, recognized the responsibility that they had to address HIV and AIDS in the locus of economic productivity in their society. The workplace is a central meeting place for a majority of the adult population and provides a perfect place to educate and serve society. The establishment of committees, open discussion, and development of guidelines and policies, plus activities designed to address specific workplaces, empowered workers at all levels. In the beginning, many workplaces lacked guidelines and committees, focal points and peer educators. A good place to start was to ascertain the workers' awareness.

% of targeted workers who report being aware that a written HIV/AIDS policy (or guidelines) exists at the workplace
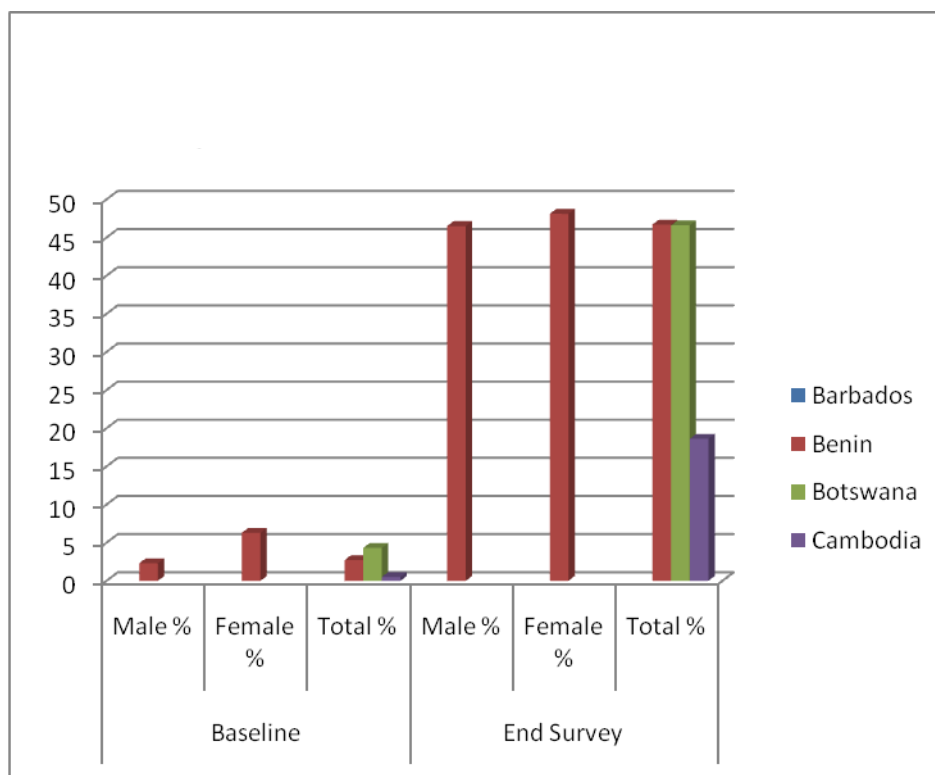
At the beginning of the project, workers reported very low levels of awareness about the existence of workplace policies or guidelines covering HIV in their workplace. At the end of the project, considerable progress has been made on the awareness, but it is still below one-half of those surveyed. Only 46 percent of the workers know of existing policies in **Benin** and **Botswana**. Less than 20 percent in **Cambodia** reported knowledge of the policies at the workplace.

One of the most important aspects of the SHARE project has been the strengthening of capacity of workplaces to address the issue of HIV in a sustained and ongoing manner. Indicators of the strengthened workplace include worker representation in designing and revising AIDS policy or guidelines in the workplace, participation of workers on HIV and wellness committees, and continued allocation of official working hours to education programs. The project developed guidelines and implemented the project activities based on the workplace-designed BCC strategies. The second SHARE Report and the outcome of the multi-country study revealed that **Cambodia** has a significant number of workplace policies (8/15) and HIV/AIDS Committees (14/5), as does **India**, but since these were not a feature of the final impact assessments available at the time of this report, they do not show up in this comparison.

2.4   Workplace Services
By the end of the project, participating enterprises in **Botswana** and **Benin** had built internal capacity and become better organized. They now have HIV/AIDS focal points and coordinators, and significantly underwrite the programs financially. Of the 10 workplaces surveyed in Benin, none had AIDS-related programs or services at the project's beginning. At the end of the program, all 10 workplaces surveyed provided services. No data was available from **Cambodia** or **Barbados** on this question at the time of this report. However, the second Share Report indicated that services were available in many of the

workplaces in the studied countries. All of the workplaces in **Benin**, **Botswana**, and **Cambodia** reported offering services, including condom distribution, referrals, VCT, and Sexually Transmitted Infection (STI) treatment information services. At the close of the program awareness of workplace services had increased measurably.

The Cambodiana Hotel relied on the Hotel nurse after the focal point had left the company. The nurse noted the ways in which the project had a positive impact. Discrimination against PLHIV on their staff had diminished, and she herself was more skilled in promoting condoms and handling opportunistic infections.[131] The HIV committee—established with support from the project—was still active and functioning at the time of the assessment, 1 year after the project ended. The 22 trained peer educators provide ongoing training, and the nurse distributes condoms as needed. The Hotel is pilot testing a condom dispenser, but this has been a mixed success. The nurse indicated that, "We fill in the box in the morning and in the evening it is already empty. We do not know if people are selling them. We cannot make out how many are needed and it is difficult to maintain the supply."
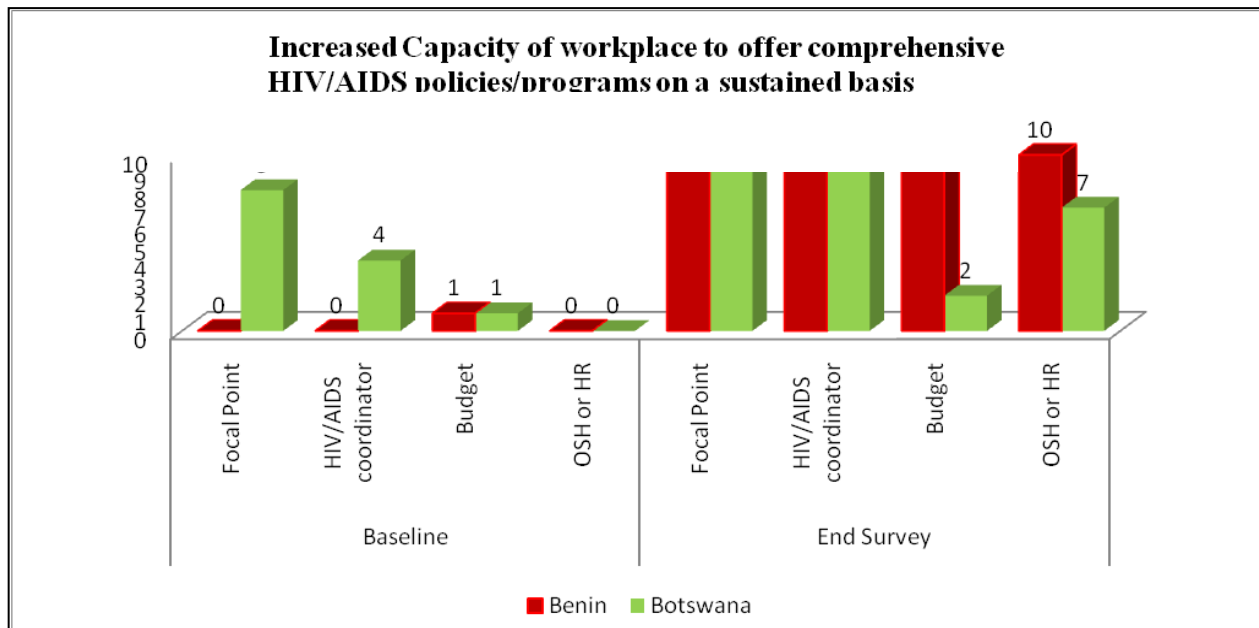
Increased Capacity of workplace to offer comprehensive HIV/AIDS policies/program on a sustained basis

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[131] Information was provided to her through linkages to health services.

# of Workplaces where worker representatives have been involved in the design of HIV/AIDS policy or guidelines in the workplace # of Workplaces with active Joint Committees addressing HIV/AIDS issues# of Workplaces that allocate official working hours
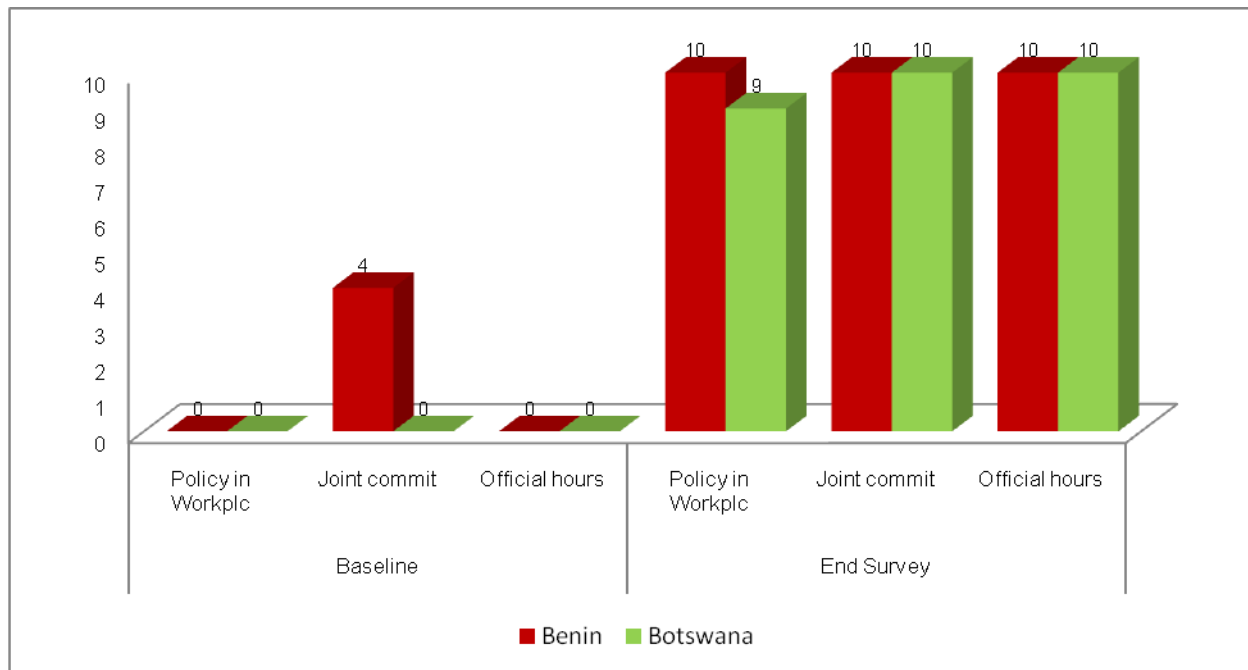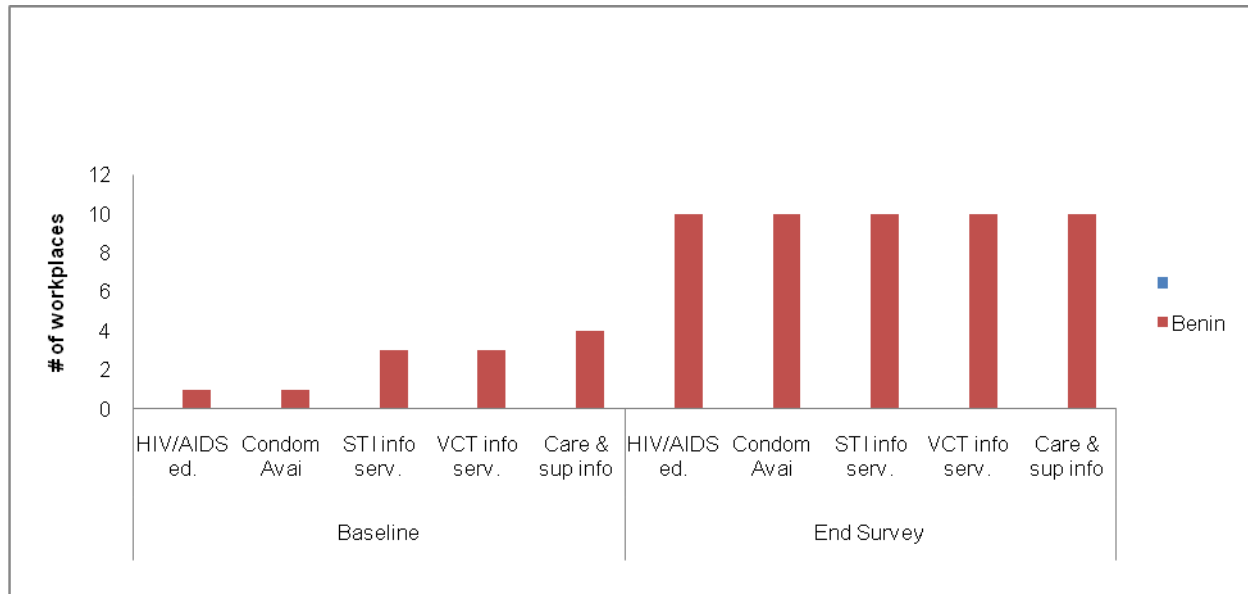

It is encouraging that more than half of the **Benin**, **Botswana**, and **Cambodia** workers are aware of services available at the workplace (below).

% of targeted workers who report being aware that HIV/AIDS services are available in their workplace
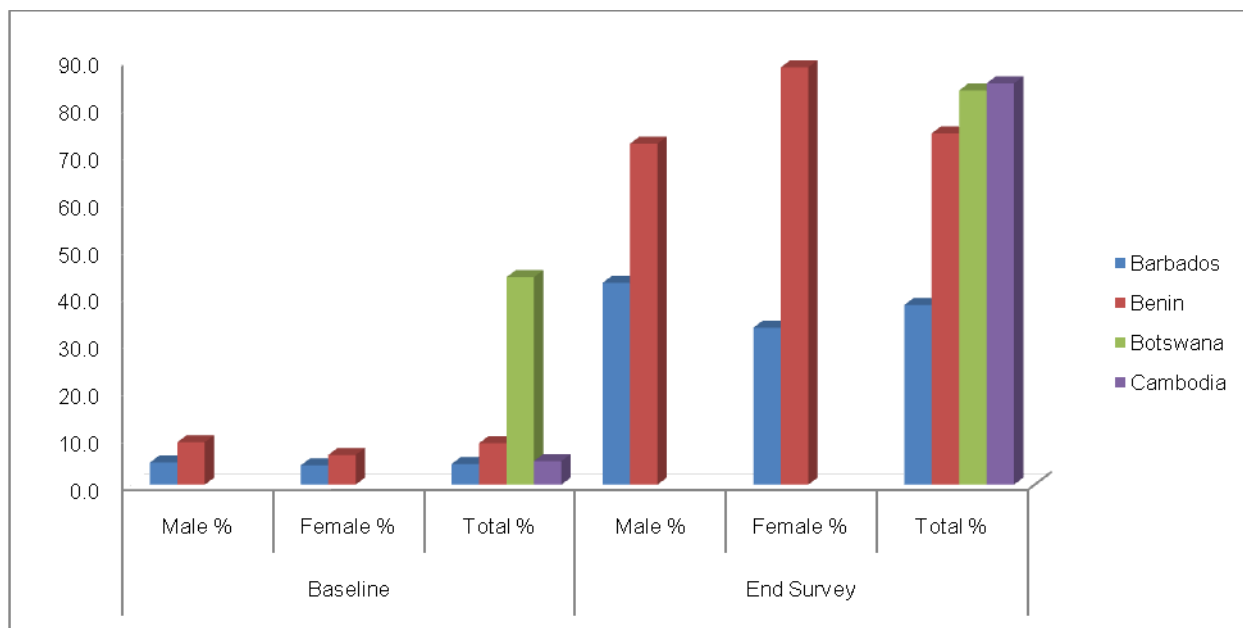
# of Workplaces with HIV/AIDS Services available in the Workplace, Disaggregated by Type of Service–*Benin Only*

In the graph below, workers describe services used, but not whether these are located at the workplace. **Barbados** shows a slight increase in the use of educational services provided in the workplace over the last months of the project. However, the Barbados workplaces also indicate a decrease for all other services, such as condom availability, VCT information and services, and care and support. Workers in **Benin** show an active and large degree of use of workplace services as a result of program activities. **Cambodia** shows dramatic increase in the use of HIV-related services by employees, especially in educational programs and condoms distribution. Since the project's beginning, STI and VCT services have been more widely used by Cambodian workers.

% of Targeted Workers Who Report Using HIV/AIDS Services in the Last 6 Months
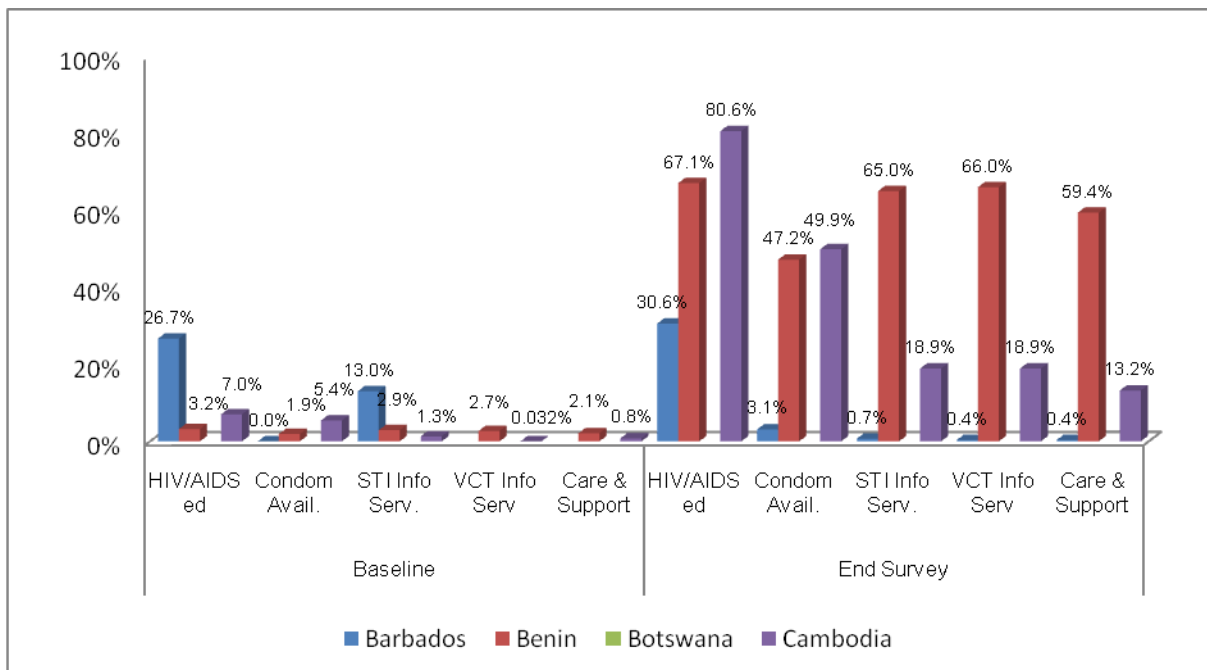
2.5   Individual Change

Knowledge about the Human Immunodeficiency Virus which causes AIDS continues to pose a major problem to prevention. At the beginning of the project, knowledge among workers of how the disease is transmitted and also means of protection was moderately high in some countries, and lacking in others.

% of Targeted Workers Who Correctly Identify Three Modes of HIV Transmission
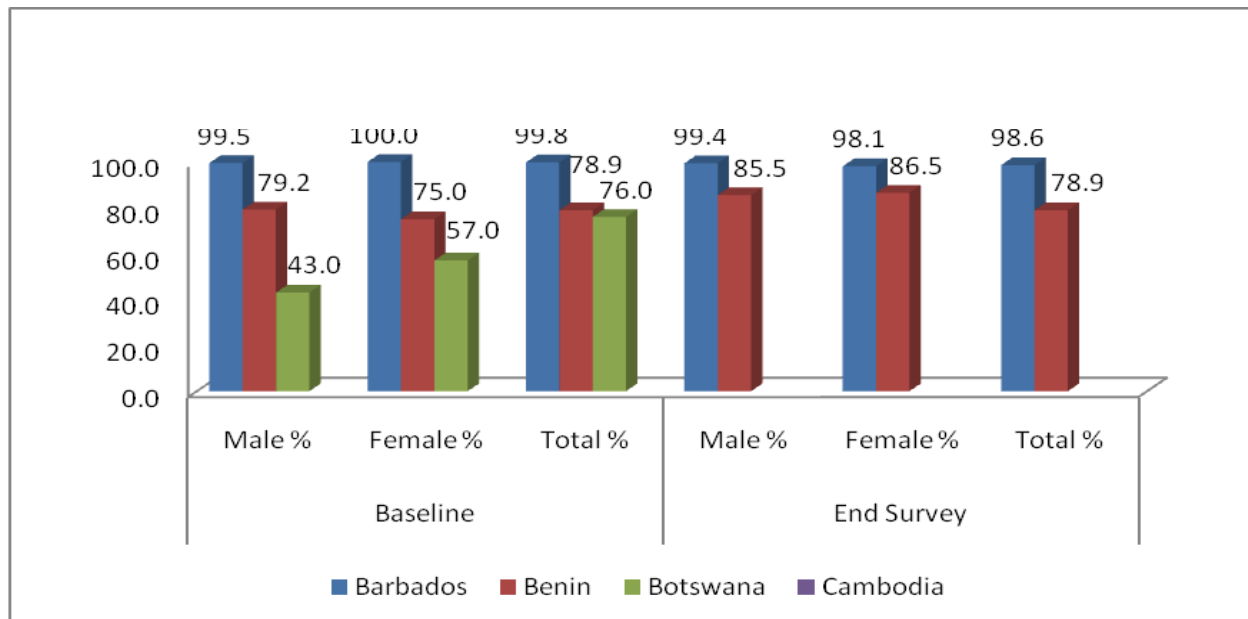
There was strong knowledge about HIV and AIDS transmission before the program in **Barbados**, and the drop in percentage points may be due to different workers surveyed at the beginning and end. Some of the industries in Barbados, including the informal sector, see high turnover of workers due to migration, and constant influx of young workers who were not exposed to the earlier program. Despite high percentages, the drop suggests the need for the program to continue. At the end of the project, a majority of workers in **Barbados** and **Benin** correctly identified the three modes of HIV transmission. This data is incomplete for **Botswana** and not available for **Cambodia**.

Barbados shows the strongest knowledge of means of protection to prevent transmission of HIV at both the beginning and the end of the project. The project also clearly made inroads in **Benin,** as seen in the table below.

% of Targeted Workers Who Correctly Identify 3 Means of Protection Against HIV Infection
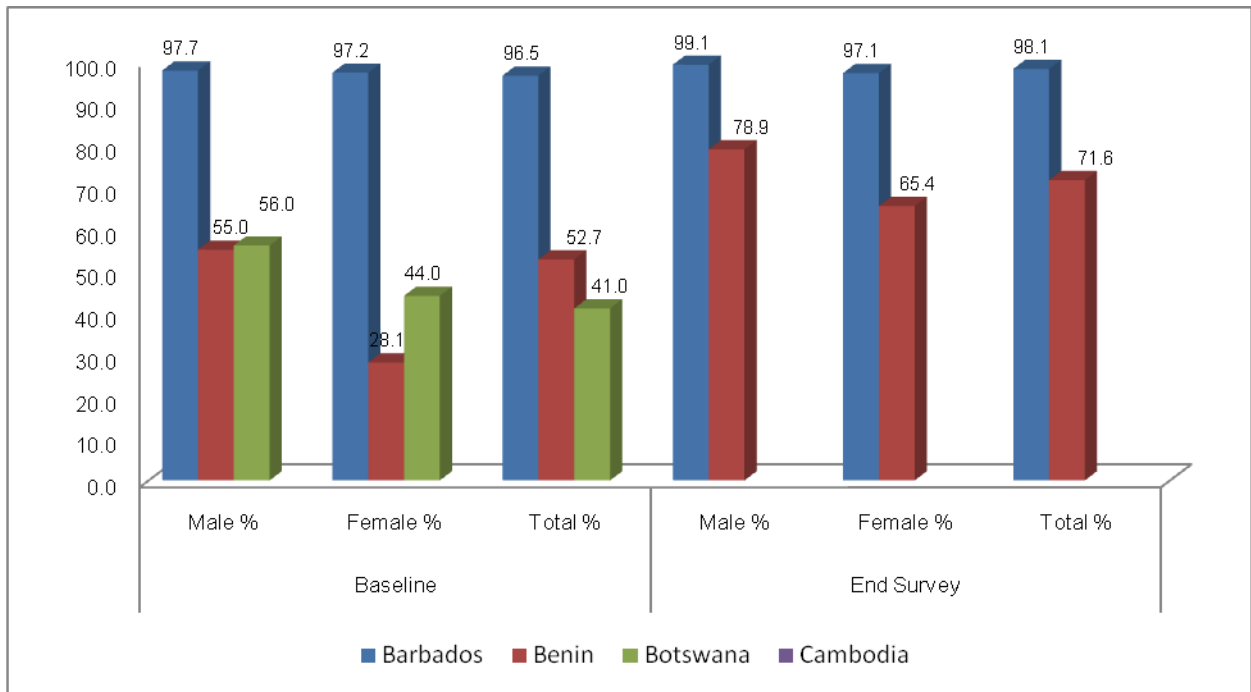
Variations in performance indicators between the baseline and the final assessments indicate that there has been a reduction of risky behavior leading to HIV infection among workers in the studied countries. While there has been notable increase of multiple partners in some countries, as seen in the table below, it does not indicate risky behavior if the individuals increase their use of condoms. This was seen among female textile workers in Botswana, for example, who reported greater condom use and doubled the amount of their sexual partners. In discussion at the preliminary final assessment report for Botswana, the researchers, labor ministry commissioner and NPC suggested the workers felt more confident dating a large field of potential husbands or financial supporters since they now carried condoms with them.

% of Targeted Workers reporting having sex in the last 3 months with a person other than their regular partner
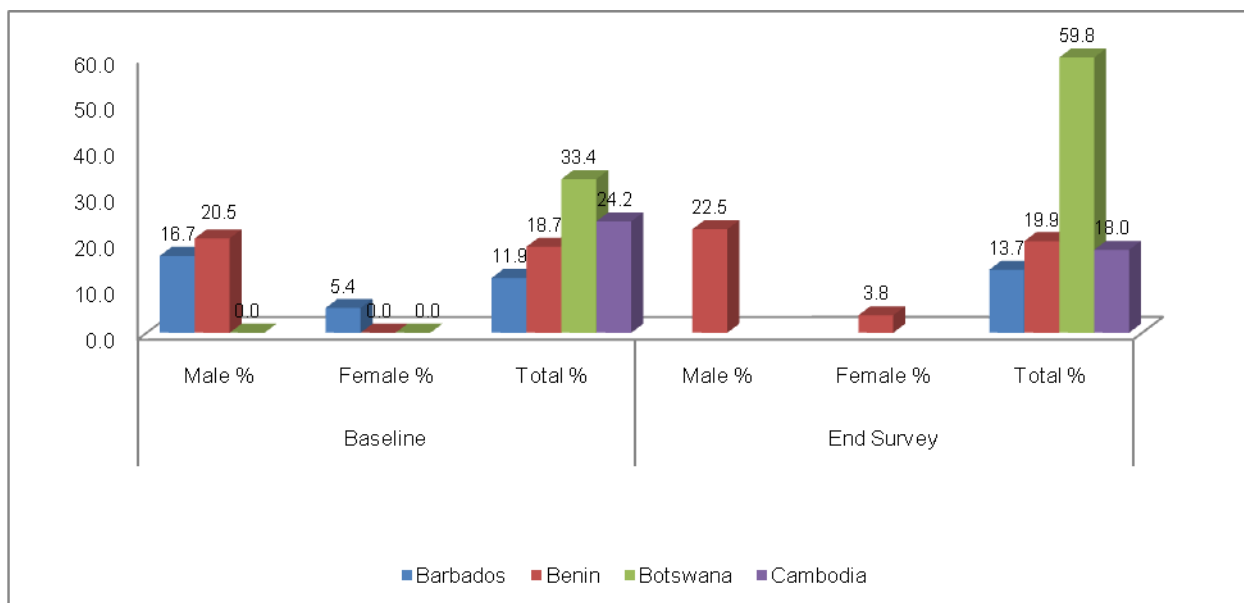
As seen in the table below, **Benin** has seen an increase in the use of condoms with occasional partners; from 76 to 84 percent. Workers risking sexual relations with occasional partners, however, remained virtually unchanged (18.7% to 19.9%). Workers in all represented countries reported using condoms within the last 2 months, when having sex with occasional or different partners. Condom use increased in all four countries, although **Cambodia** registered only a minimal increase of condom use. Questions about sexual relations are difficult to verify as workers might answer differently depending on the social taboos or the specific workplace culture. Less than 60 percent of the workers claimed to have sex outside of their regular partner, but a high percentage of those reporting used condoms.
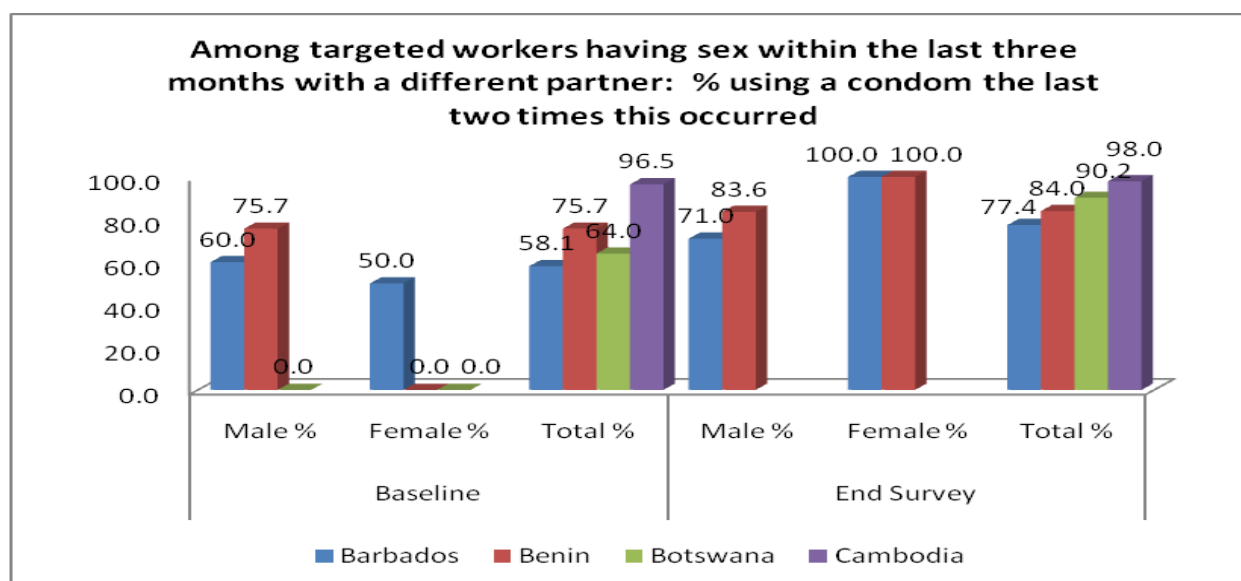
2.6   National Level and Collaboration of Tripartite Constituents
The project had development objectives to enhance the legal and policy framework and build tripartite constituency capacity. This was not included in the workers' surveys, of course, but the indicators are entered into Data Tracking Tables in **Benin** and **Botswana**, and thus can be seen as measured outcomes. The national-level efforts should be considered for their impact. Indeed, in the midterm evaluation for **India**, the project was encouraged to work more on national level policy, as the enterprises seemed to be forging ahead rather successfully.

Overall, the project had major success at the national level. The world of work was integrated into all HIV/AIDS National Strategies. Labor ministries were recognized as key players, even line ministries (**Barbados**), and employer and worker organizations worked together. The ILO Code of Practice was adopted in all enterprise workplace policies and tripartite declarations. Seminars were held to sensitize tripartite constituents and other PAB members in all countries. Additionally, tripartite constituents established focal points.

Improved Coordination/Cooperation between Tripartite Constituents and other Partners at the National Level
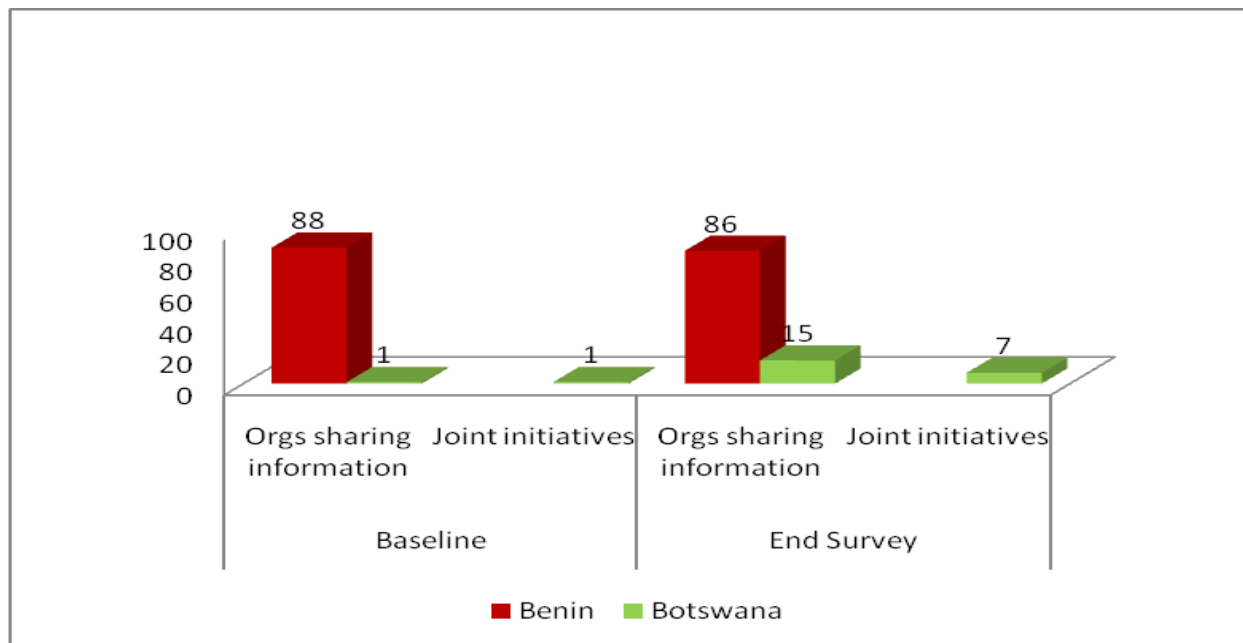
In **Benin** and **Botswana**, Data Tracking Tables identified trends towards collaboration between tripartite constituents and other important players at the national level. The two indicators were to ascertain shared information and joint initiatives among enterprises. In Benin, the number of organizations went from 88 to 86. In Botswana, information sharing among organization went from one at baseline to 15. In some countries, depending on internal conditions and geographic proximity, it was easier to share information and conduct joint activities. This table is included only as a representation that some indicators of national-level impact might be tracked better so that some indication of policy impact is possible.

d. Best Practices

Best Practice Workshops were held in several, if not all, countries, to identify and document case studies of good practice and to establish plans for sustainability. Although the experience was enriching, none of the countries studied pointed to the workshops as essential. Reports of best practices can be found on Community Zero.[132] Coincidentally, in the course of the cross-country study, UNAIDS released a document on best practices and mentioned an ILO program in Cambodia.[133] Good practices are being documented and collected by the various business coalitions on AIDS worldwide and regionally. Some of the SHARE enterprises are members but have not submitted their experiences. Enterprises with good management support and replicable programs should be recognized and encouraged to share their experiences. In addition, several papers by NPCs about their experiences have been accepted for the 17th International AIDS Conference to be held in Mexico City on August 3-8, 2008.

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[132] A sample is found in Annex 8.
[133] ILO and UNAIDS Support the Private Sector in Cambodia, 39. Les Programmes De Riposte Au VIH Sur Les Lieux De Travail Du Systèmes Des Nation Unies. Available at http://data.unaids.org/Publications/IRC-pub07/jc1066-unsystworkplace_en.pdf.

Actual best practices are embedded in this report as Lessons Learned and Recommendations.

4.   Sustainability and Replicability

The sponsors are concerned about the project's overall sustainability. Stakeholders queried were enthusiastic about how the project raised the awareness of government, employers, and unions regarding the necessity to address AIDS in the workplace. Representatives of the National AIDS Commissions in **Benin** and **Barbados** averred that before the project, there was virtually nothing similar in the workplace, or what was there was not as substantive as the SHARE project. Leaders of the tripartite constituency weighed in with similar appreciative statements.

Governments and other tripartite constituents, as well as enterprises at a national scale, can and will adopt the project activities if resources are available. The models developed are effective and have potential for upscaling, but a large amount of human and financial resources are needed for complete effectiveness. Realistically, the project was too short to become truly institutionalized. The follow-up programs in **India**, **Botswana** and **Guyana** with PEPFAR (the U.S. President's Emergency Plan for AIDS Relief) funding will help to keep the momentum going, even if the program changes slightly.

National- and workplace-level legal mechanisms that were accomplished to overcome discrimination were significant, and it is in that arena where the sustainability of the project has the greatest promise. The National Tripartite Declaration on HIV/AIDS and the workplace was an unequivocal product of the project in **Benin**. Signed in August 2004, after nearly a year of dogged advocacy among the tripartite constituents, the Declaration is framed and prominently hangs in the offices of project participants and tripartite leaders. There is clear evidence of ownership by the tripartite constituency. The project cannot claim the **Cambodian** Law on Prevention and Control of HIV/AIDS (2002), which identified HIV and AIDS as a workplace issue, but it did ensure integration of the Ministry of Labour and Vocational Training (MOLVT) Ministerial Decree ("prakas"), mandating the creation of HIV committees in the workplace.

The achievement of the Benin project to initiate the Declaration and to participate successfully in the enactment of the law cannot be ignored. Like the legislation in Cambodia, enforcement will continue to be a concern. The MOLVT in Cambodia organized an awareness-raising workshop for 40 companies on the implementation of the prakas two weeks prior to this multi-country study. Such initiatives indicate that there is some continued interest and effort from the MOLVT. Workshop participants were willing to start HIV committees but indicated that their company has no budget allocation to fund training on HIV. The MOLVT interviewees noted that one factor that impedes sustainability is that there is no budget to enforce the implementation of the prakas. In Benin, an important post-project event, led by the NPC, was a workshop for forty judges, magistrates, lawyers, and law assessors on the legislation. The law has some worrisome loopholes, and the workshop served to elucidate the areas of concern and provide guidance to the legal community on enforcement and next steps.

In all countries, the impact of the project on building or strengthening existing policies will not be diminished, even without continued funding. Strategies that are in place at the national level still need refinement, and they risk sliding into disuse. In **Cambodia**, the National AIDS Authority has established a working group to focus on policies and strategies, and the MOLVT is reviving the PAB in the format of a technical working group that will work towards the continued implementation and monitoring of new and improved programs on HIV. The ILO is appointing a technical specialist, called an ILO National HIV/AIDS Focal-Point, for a 1 year appointment to launch the working group.

The Cambodia Business Coalition on AIDS (CBCA) is intensifying its actions to ensure that all companies establish functional HIV committees. CBCA originated from within the business sector itself,

and received important technical support from the project. Its creation is an important sign of ownership and engagement by employer organizations.

In participating countries, ownership is visible among the workers' organizations and government, but technical support is still needed. Labor and Factory inspectors received training during the course of the project, and labor ministries plan more training. One of the roles of the inspectors is to visit workplaces on a regular basis to ensure compliance with labor laws and practices. In **Botswana**, the labor inspection checklist was also reviewed with a view to mainstream HIV and AIDS issues into it.

At the level of employer and worker organizations, training on HIV in the world of work has been mainstreamed but is implemented at a reduced level of intensity. Some informal AIDS awareness raising continues among workers, but formally organized sessions have substantially decreased.

The unusual nature of the tripartite collaboration, as seen in the project, will certainly be taxed as the government, unions, and employers face off due to economic and other challenges; but on the issue of discrimination pertaining to AIDS and other concepts within the project, the tripartite constituents in all of the countries is in complete agreement. There is evidence of lingering partnerships established between participating enterprises and other non-participating businesses, either those in the supply chain or businesses in trade organizations. Participating enterprises (Cresta Hotels, Delta Deserts and Safaris) from the tourism sector are members of the Hotel and Tourism Association of Botswana (HATAB), a private sector organization of the tourism sector. The Botswana government consults HATAB on policies, legislative issues, and governmental regulations that affect its members, and is also setting up a parastatal National Tourism Board. Those particular tourism enterprises are secure and rather successful; as a result, they carry a lot of weight in the HATAB organization and are clearly continuing to influence the memberships in the ways that they did while the project was in progress.

One thing that is absolutely clear is that the ILO continues to be a reference point on workplace issues for the tripartite members. The project has expanded the visibility of the ILO to National AIDS Commissions, private AIDS-related organizations, NGOs, and government entities beyond the labor ministries. The project reflected creativity and structure by bringing the tripartite constituents face-to-face to work on an issue together. Through the PAB, sensitization workshops, and other project activities, the tripartite constituents were clearly brought into the project in a way different from the normal way in which they are involved with the ILO or the local labor ministries, and they had the opportunity to expand their own constituency; becoming part of the NGO/CBO circle as well as the national programs to fight AIDS. It is up to them to continue the momentum and this is where it may be difficult. The training was effective, but more training needs to be done. Particularly where laws and policies are involved, civil servants, labor inspectors, magistrates and lawyers, journalists, employers and the informal sector need to understand how these policies are to be enforced. Labor inspectors have been trained but their work is limited in terms of time they can allocate and the number of companies they can cover.

The trade unions are keen to participate, but they are often stretched to the limit. The trade union movement needs financial support and further training. In **Benin**, one trade union federation is stronger and has a greater clarity of its mission than the other, both housed in the same building. In **Botswana**, the trade union federation needs to be able to provide assistance to its members, and workers need to better understand what the role of a union can be. The employer organizations in all of the countries are functioning well, but businesses are facing survival-level economic challenges in general, which threaten the implementation of policies. The employer organizations may be determined to keep the policies intact, but they would benefit from further technological assistance and advice.

The project activities, media coverage, materials, and training workshops, many of which were multi-sectoral, secured a place for the ILO in the anti-AIDS arena. However, the ILO needs to assert itself as a

major player in the response to AIDS, and needs to ensure the importance of the workplace as central to the fight. First of all, there is not enough evidence that the workplace as the logical locus for AIDS programs has been fully acknowledged by AIDS activists. Since HIV and AIDS are health issues, the emphasis on services, treatment, research and prevention continues to be contained within the health sector. The workplace as the logical site still seems to be fully recognized.

a. Sustainability Workshops

Most, if not all, projects held sustainability workshops as they neared the end of the project. Attended by the Project Advisory Board and interested stakeholders, the workshops, which were held a year or less before the project's end, were deemed useful and helped to maintain momentum in **Barbados** and **Botswana**. Everywhere, stakeholders regretted the end of the project because they felt there was so much more that could be done in terms of training and materials. In **Benin**, the end of the project was seen with foreboding. The project got off to a late start and, despite the gains, stakeholders wished they had more time to benefit from the advice, support, and presence of the ILO and its staff. Their own limited resources caused stakeholders to question what could realistically be their next steps. However, during the course of the study, representatives from trade unions and the two major employer organizations described ongoing steps that they will be taking to keep the programs going. These include continuing with focal points and peer educators. The main barrier for these groups to continue is a lack of resources. Enterprises in the country struggle with rising fuel costs and power outages, so that owners and managers do not realistically believe they can provide supplemental costs that might be associated with the project, aside from allowing it to continue minimally. Further, the response to AIDS is just beginning in some of these countries. Where there is low prevalence, it is shown that the population is in need of more education and information to understand the gravity of the illness.

> **The Sustainability Workshop in Botswana indicated positive progress at workplaces—**
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> Botswana enterprises have embraced HIV/AIDS as a workplace issue, and are plowing their own resources into training more peer educators, educating workers and management on HIV/AIDS related issues in the workplace, and promoting healthy lifestyles. Enterprises that cannot manage to financially support in-house activities are encouraged to make referral links with the service providers, especially government and NGOs within their proximity. Efforts are also underway to lure development partners into supporting the ILO to scale up its interventions. Through additional funding, the project can reach many more enterprises.
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> In addition, Delta Desert and Safari (DDS) extends its HIV/AIDS program out to its supply chain, partnering with those smaller companies which provide products and services to them (such as Ron's Produce and Game Trails). Other members of IHAB (the Botswana Hospitality Business Organization) receive advice and ideas from DDS. Okavango Delta Wilderness Group, with 700 employees, has reportedly started to model an HIV/AIDS workplace program after that of DDS.

At the time of this cross-country study, the project has been ended for 1 year, more or less, in **Benin**, **Botswana**, **Cambodia** and **Barbados**. **India** and **Botswana**, like Guyana, Lesotho, and Swaziland, are in the happy position of having qualified for PEPFAR funding, but the amounts are not excessive. [134] In

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[134] The project in Benin benefited from a 6-month extension financed by ILO/AIDS to facilitate the transition. As of this writing, the project has been ended for over a year in Benin and Cambodia. Barbados is set to resume activities. The NPC in Benin works on two HIV projects and ILO/AIDS funding, which forms part of his salary, helps significantly to continue providing technical support to the tripartite constituents and enterprises building on project achievements.

Benin, the National Program Coordinator continues to work for the ILO, fulfilling the needs of three projects, all related to HIV and AIDS. Despite formally ending, most of the programs on HIV in the workplace are still functioning, although at a lower level of intensity than during the project. Reporting requirements are no longer necessary, so few focal points record any monitoring. There is interest, particularly in Benin, to continue with the monitoring, as well as all aspects of the program. Although **Botswana** has PEPFAR funding, it is not used to continue the SHARE program. However, enterprises are still quite committed. Workplace committees continue, although many have become 'wellness committees.' A few companies have mainstreamed training on HIV in their pre-service orientation training.

At the least, informal information and sharing sessions continue by peer educators. In **Cambodia**, formal group training sessions had mostly ceased, although several companies had mainstreamed HIV in their pre-service training. In **Benin**, most participating companies continue to support activities, but few feel that they have adequate resources to pay for anything. A few companies also indicated that they raise the subject of HIV during staff parties and conduct 'question and answer' games with small rewards for those who answer well. Many Unions have integrated HIV in their regular workers' training, although sessions sometimes shortened.

Some NPCs interviewed identified the expectation of local resource mobilization as a

Just outside the fence of the C.B. Lafarge Cement Factory in **Benin** is a market where workers eat breakfast, lunch, or dinner, depending on their shifts. The present market is a hodgepodge of ramshackle stalls, many with beds for illicit sex, seen as a fertile ground for transmission of HIV and STDs. The company plans to relocate the market to a site a few yards away, deemed safer from the large cement truck traffic, but easy walking distance. They hope to make it a more interesting environment so that risky, recreational sex might decrease. The market will be reconstructed closer to the company-built sanitary latrines with large murals with unambiguous HIV/AIDS messages. LaFarge's investment in expanding the HIV/AIDS workplace education program outside of the confines of the factory will reach the vendors and other people in the supply chain. The manager confirms that the project's input was a major factor in their decision to extend Behavior Change Communication messages beyond the walls of the factory. The company is preparing more visual aids for the educational activities specific to the BCC strategies of the enterprise and the informal sector it intends to affect.

key concern for them as they began the project. In **Botswana** and **Barbados**, both NPCs brought experience generating financial support from donors and local fundraising to the job, and they were instrumental in helping local enterprises get support for their internal programs. This was not the case in **Benin**, but fortunately the national program to fight AIDS (PPLS) helped in that regard. Proposals to the Global Fund were made, and in **India**, they have received word that the proposal has been accepted for technical review. Continued resources and program sustainability remain a concern for those who have been affiliated with the project; including national program coordinators (present and former), PAB board members (such as the head of the AIDS Foundation of Barbados), and beneficiaries.

Many enterprises in all of the countries studied celebrate World AIDS Day. That those enterprises took part in the activities to commemorate the World AIDS Day, even after the project ended, is a meaningful testimony that some commitment lingers. Companies with corporate responsibility programs will continue to reach out to the communities, as with PepsiCo in India, Cresta in Botswana, and Scotia Bank

in Barbados. The tourism and banking businesses worldwide have also reached out to the community as a measure of corporate responsibility.

Despite the best intentions of business enterprises, the economic situation drives their efforts. At the Palm Oil factory in Benin, the murals on the walls need a new paint job. When the materials deteriorate, it is unknown if companies will reprint them. In the course of the cross-country study, the problem of bankrupt industries came up in **Botswana** and **Cambodia**, and the future of some of the participating businesses is severely threatened in **Benin**. At least one construction business relocated from **Botswana** to South Africa, where it will likely continue the workplace education program to some degree.

INDIA: Where SHARE began...

What Efforts have been made to sustain HIV/AIDS Workplace Education?

The India project planned for sustainability from project inception but, given the size and complexity of the country, expected success is not yet attained. Some ownership has been realized but more technical support is needed, according to tripartite constituents.

- Nationally, sustainability efforts focus on supporting policy and capacity strengthening of tripartite members and civil society partners. The V.V. Giri National Labour Institute has appointed an HIV in the Workplace training program coordinator, fully integrated into their budget. Technical support at the national level to the MOLE, trade unions, and NACO will likely be required for another 5 years for full sustainability. Technical support needs include providing input on HIV policy and program development.
- The National AIDS Control Organisation suggests more gradual post phasing-out activities to ensure complete sustainability. In the states, the project focused on capacity strengthening of the SACS to work effectively on the development of HIV in the world of work programs.
- Some companies are implementing sustainable programs independently. Mainstreaming HIV into existing training programs is less costly than a separate training course on HIV. Separate HIV training is more likely to have in-depth impact, but is less sustainable over the long term given the current relatively low prevalence levels. Updating the KAP surveys still need to be institutionalized in participating companies.
- The ILO-supported specialist at the Delhi AIDS Control Society confirmed that it takes about 2–3 years for a company to mainstream this, and it depends on the company.

Capacity strengthening of the tripartite and institutionalizing training into government centers help to ensure some level of sustainability. India is in the fortunate position of continuing workplace programs with PEPFAR funding. This recognizes that the project cannot be a short term effort, but must receive funding from external sources to implement all components.

Continued funding would be useful if project staff and constituents are able to implement actions effectively. More funding means reaching more people. Additional resources will be needed to cover the informal economy and to provide support to unions. Most unions do not have sufficient resources for large-scale actions on HIV. In assessing the sustainability of the project outcomes and their longer term impact, a close look should be taken at capacity building through the project, the structure that will be left behind by the project, and the commitment of stakeholders and target groups. Pilot activities (worker surveys and other research activities) took place, the results of which will go a long way to identifying relevant programs and activities in the workplace long beyond the project's lifespan. Partnerships have been established and functioning networks set up that will serve the project well in terms of sustainability.

b.   Replicability

The project has enormous potential for transferability. The approach to changing behavior must be seen as long term, and probably not easily measured, but the experiences of participants are enthusiastic and the empowerment factor from Ministries to shop floors is obvious. Replication of project actions has already started. In **India**, specialists with the State AIDS Control Societies that the project had provided, continue to replicate the actions. Though in Mumbai, the post of the specialist has been eliminated for the time being.

The Population Services International representative in India was very admiring of the input they had received. As a result, the NGO has replicated the project manuals and approach, and their staff have been trained. This is true of **Benin** and **Botswana** as well, in that both NGOs and enterprises affiliated with the project have replicated the materials (leaving the ILO emblem intact). Delta and Desert Safaris in Botswana had already been awarded a national prize for their efforts to stem HIV in the workplace when they became involved in the project, yet they could not have praised the training and materials that they received from ILO any more than they have. As a result, they have used their own resources to provide training and materials to their supply chains and their colleagues in the tourism business.

The experiences acquired in **India** are already being adopted and replicated in some other countries such as Nepal and Sri Lanka. A Pakistan employers' federation has developed a policy with some technical input from the project through UNAIDS support. The German Technical Cooperation representatives in India reported that they had tried HIV in the workplace programs before being in contact with the project, but learned how to improve their strategies from the project.[135] The project shared their corporate case studies and the ILO Code of Practice, which they noted were very useful.

The V.V.G. National Labour Institute has provided training to labor officers from 61 other countries in addition to India. HIV in the workplace has been mainstreamed into their national as well as international training programs. The National Highway Authority of India asked the Institute to assist them in implementing research on HIV with truck drivers. The VVGNLI also works with some national NGOs in Manipur and Nagaland to implement an HIV in the workplace program.

It is not always possible to predict whether a concept applied successfully in one place may also be successful (or not) in another. Similarity in terms of situations is not always a predictor of successful replication. A degree of willingness to experiment with new ideas and approaches needs to exist. It is common to engage in a type of cost-benefit analysis to determine whether trying something new will work. There are cases where the same approach worked very well in vastly different settings. For this reason it is important for donors to allow some leeway in terms of implementation of approaches. Donors often laud small innovations, but only if they work. Where innovations are less successful they are considered 'a waste of money.' As in any undertaking, a level of risk-taking is required and needs to be allowed.

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[135] GTZ also works on the issue of HIV, including a component on the workplace. They have used the ILO input in terms of material and technical advice from the **India** project staff. They have also informed the ILO and invited them to their own workshops.

A representative of the Delhi Network of People Living with HIV indicated that more efforts to replicate the actions directly in enterprises are needed. He correctly noted more time, effort, and financial resources are required. The representative stated, "Now is the time. More and more is required. It is like feeding the hungry. The more we do the more we realize how it is too little. We become aware about how much more needs to be done."

c.   Cost-effectiveness

Overall cost-effectiveness of the projects was very good. Budgets are never adequate for the actions planned, but the Conseil National du Patronat (CNPs; National Employers Council) prioritized their activities according to country needs. Actions were planned in coordination with tripartite constituents, often employing national strategies for inspiration. In all countries, more synergies with other existing ILO projects could have contributed to further extending resources and impact.

Barbados and **Cambodia** were initially understaffed given the amount of work that needed to be done. Following the midterm assessment recommendations, **Cambodia** was able to increase staffing. NPCs did not complain about having to cut costs, but a generator in **Benin** and an administrative assistant in **Barbados** were two areas where additional funds might have been used. Transportation costs will continue to rise, but mobility of key project personnel is one area where projects work efficiently. With excess capital assets, there is frequently politics involved and it is usually better if the project itself has few cars, computers, etc., that do not create political issues. At the same time, they need to be adequately equipped. Every project needs a project vehicle. Working out of MOL offices is efficient as long as autonomy is ensured, as it was in **Botswana** and **Benin**.

Although the budget for the **India** project is somewhat larger than for other countries, the sheer size of the country also far surpasses all other SHARE project countries except for China. The project staff considered that, although the budget was relatively small for the amount of work that needed to be done, it did force them to develop their approaches in the most efficient way possible. As one staff member stated, "One of the good things about this project is that every dollar is well spent. We have combined our missions to the field, for example, to handle different things at the same time so that we do not waste time and other resources." The project also advocated strongly with companies that they must finance all actions directly from the moment the MOU was signed. The project only provided technical support and materials in small quantities for actions. Corporate groups needed to pay for replication of materials themselves.

Additional funding can always be useful if project staff is able to implement actions effectively. Again, more funding means reaching more people. In all SHARE countries, additional resources to cover the informal economy and to provide support to unions are needed.

SECTION III: KEY LESSONS LEARNED AND RECOMMENDATIONS

The SHARE project introduced innovative activities into environments where little had been done, employing a body of practitioners unused to working together on the issue of HIV. The project produced key lessons, good practices, and recommendations combined here in this section for easy reference. Since recommendations are often based on lessons learned and good practices, it is not necessarily implied that an action was not implemented. Indeed, it is hoped that the lessons and practices reviewed here are seen as points of transferability and potential for adaptation and utilization in other countries, and suggestions on how the methodology can be applied in different and new settings.

1.   **Project Management Issues**

   1.1.   Some of the challenges that NPCs face include the following:

        1.1.1.   Enterprises which go bankrupt or suddenly move out of country (the impending World Cup drew construction companies out of Botswana to South Africa)

        1.1.2.   Multi-ethnic populations in the workplace demand sensitivity

        1.1.3.   Migration affects all attempts to create a consistent infrastructure, even with training excess peer educators

        1.1.4.   Lack of adequate support staff

        1.1.5.   Power outages for hours, even days on end. Both **Botswana** and **Benin** suffered from this. It is possible to spend an entire day looking for fuel only to have the electric gas pump go off when the power goes out. People drive from one end of town to another looking for fuel. They send e-mail messages and write reports in the dark, with mosquitoes buzzing around. Such draining infrastructural challenges may delay projects.

   1.2.   Choose national program staff carefully (as has been done in the countries studied). Recognize the necessity to stimulate staff to become 'champions' on the issue of HIV, as in **India** and **Barbados**. Continuous monitoring, active follow-up, and a personal commitment are what made the programs so successful in **Benin**, **Botswana**, and **Cambodia**.

   1.3.   The presence of the ILO sub-regional office in Trinidad and Tobago caused confusion for the project start-up, according to the NPC there. The very same office was considered beneficial for NPCs elsewhere in the Caribbean because the technical officers were on call with expertise and proximity. Clarity of roles and open communication are essential where there might be confusion within the ILO structure and for outside observers.

   1.4.   Project sites should be visited by an ILO PMT member once in the course of the project life. Similarly, USDOL staff should also visit once. This benefits both parties, as it strengthens the relationship and facilitates communication. The purpose is to build relationships, witness the actual situation, its obstacles and challenges, as well as its accomplishments, and help raise credibility. However, it should not be intrusive.

2.   **General Aspects of the SHARE Model**

   2.1.   The SHARE model provides a systematic guide, but should be considered flexible enough to be adapted to context. In some countries, particularly in **India**, **Barbados**, and **Botswana**, some enterprises needed to integrate HIV into the larger framework of the company's approach to general health or wellness. In **India**, this was because of a lack of awareness and interest in the infection, whereas in **Botswana**, HIV and AIDS has taken

its toll and is linked to new concerns such as tuberculosis and other widespread diseases, as well as diabetes and obesity.

2.2. Each component of the model needs to be studied together as well as separately, and its relevance to replication in other situations and countries determined.

2.3. The model needs to focus more on care and support while still maintaining its focus on BCC. It may be that the activities which are derived from the BCC process of workers surveys and formative assessments is more recognizant of the need for care in countries where there is a high prevalence of PLHIV. The project in **Swaziland**, for example, has much to tell about extending care and compassion to workers living with HIV. The Super Spar market allows staff time to visit workers, and supports time off for treatment. Such experiences should be highlighted and rewarded.[136]

2.4. Changes in the epidemic's demographics mean that the ILO and stakeholders can never think "OK we have done it, we have adopted the ILO guidelines and we are implementing the actions so now we are fine." It is important to raise awareness that there can and should be changes and that upgrading and adjustments need to be made. This includes major aspects of the model, but also details at the enterprise level; such as discoveries in the area of effective and environmentally safe disinfectants to be used in case of accidents in the workplace.

2.5. At project inception, consider subcommittees of the PAB for sustainability and national policy.

2.6. Create a Manual or **Handbook** at the PMT level for training and developing consistent terminology; and at the country levels to record lessons learned and best practices. Much can be learned from the experiences in the various participating countries. A broad range of tested interventions and methods should be combined into a handbook for reference by governments, tripartite constituents, and other agencies to use in-country, or to share with other countries embarking on workplace interventions. The handbook could be illustrated with case studies for easy understanding of practical implementation.

2.7. All of the countries developed innovative materials and had interesting experiences as well as challenges. Regional workshops like the one held in the Caribbean are extremely valuable. Community Zero also offers a mechanism for exchange and dialogue. A multi-country conference would be an excellent forum for sharing skills and knowledge. Potential stakeholders from other countries should come. One workshop could be, for example, "How can the model be replicated in Muslim countries?" or "How does the model work in countries with low prevalence vs. high prevalence?"

2.8. Programs that allow for differences in terms of HIV prevalence, population density, religion, caste, poverty levels, and many other sociocultural and economic factors challenge the model, despite its being flexible. Epidemiological, economic, and socio-cultural setting are in a constant state of change and need to be considered.

2.9. Involvement in **National Level policy advocacy** helps to make the linkages between the tripartite constituents and workplace programs stronger. The PAB has an important role to play in advocating new or stronger national policies and legislations. Sensitization needs to be ongoing on this, and local legal scholars, watchdog groups, and law schools can be involved. PAB members were energized, inspired, and motivated in the countries

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[136] The Spar initiative was highlighted in the film Creating Change, which has recently been released by the ILO/AIDS.

studied because they were involved in making change and rewarded through visibility and relevance.

2.9.1. Policy Advocacy can go beyond laws and anti-discrimination policies. Advocating for increased budget allocations to HIV in the workplace programs at national government level is necessary to improve long-term sustainability. Capacities alone are not sufficient to take the efforts to a next level of coverage in terms of diversity of sectors and geographic areas.

2.9.2. Participate in advocacy measures to ensure that lawyers and judges are adequately trained to enforce the legal framework to protect workers with respect to HIV.

2.9.3. The projects can support tripartite and other constituencies to advocate for capacity strengthening of health service providers to serve workers and address their needs.

2.9.4. Advocate for increased availability and better organization of VCT and other services.

2.9.5. Consider a stronger emphasis at the national level and greater involvement of local NGOs to implement workplace actions. High concentration of the limited staff on enterprise programs means that some opportunities to provide capacity strengthening at national level were missed.

3. Tripartite Constituency

3.1. The most important lesson learned regarding the Tripartite Constituency structure is that when the various members have a common concern, they can work harmoniously and achieve something important. Laying a foundation at the beginning of the project ensures that all participants understand the purpose and outcomes. The SHARE objectives, while well stated and measurable, should be preceded by the shared understanding of collective goals such as economic productivity, healthy population, national strengthening, and future healthy workers.

3.2. Be sure to fully introduce and use the ILO Code of Practice on HIV/AIDS in the World of Work. It has been widely accepted and very well received by employers and workplace committees as a guide for developing policies. It is comprehensive, specific, and succinct. It should be seen as a valuable tool.

3.3. For a program to have continuity after funding has ceased, more capacity strengthening of labor ministries staff in project management should be incorporated from the beginning; in this case, especially management of a program on HIV in the workplace. MOL staff and other stakeholders profited from the M&E aspects of this project, but more is needed. Capacity strengthening of MOL staff from the beginning of the project is recommended. It should focus on policy and strategy development *and* training of trainers, but also on the management of a program on HIV in the workplace.

3.4. Be prepared for personnel changes. The project in **Botswana** was successful in building the capacity of local and district level government authorities in Maun (Northern Botswana) through relations established with participating enterprises, who participated on the local District Multi-Sectoral AIDS Commission through an umbrella tourism group. The highly developed system of routine transfer of civil servants by the Botswana government means each new DIMSAC Commissioner must re-learn what the former Commissioner understood. This has also occurred in the Charles Hill area, where there have been civil servant changes. The project could ask or offer to train all the civil

servants, but in theory, the Government of Botswana is already engaged in highly focused workplace education programs.[137]

3.5. This is equally true of Focal Points and Peer Educators. They move, migrate, transfer, or otherwise leave the companies. Consider training pairs of PE and encourage or build national, citywide, regional networks of PE; hold events to bring them together. Also, rewards are good for everyone, from managers and CEOs (e.g., Arawak Cement Company in Barbados was recognized for its community outreach) to peer educators (Employee of the Year). One requirement is to be kept current regarding new developments through newsletter or other means.

3.6. Promote and implement a policy to avoid funding the actions of tripartite constituents. Concentrate instead on the provision of technical support, training, and training materials. Where this is not feasible, financing should be provided in a limited way and only to implement programs with sectors (such as in the informal economy).

3.7. The number of labor inspectors and office staff in most of the studied countries is still inadequate for full enforcement of the existing law. Transparency issues in the work of labor inspectors and how this clouds the work of some labor inspectors need to be addressed.

3.8. NGOs and civil society groups, particularly of people living with HIV, should be integrated in tripartite constituency planning and development of programs. If networks that have been created can be sustained, there is a good chance that workplace programs will continue and be introduced in other workplaces, especially the informal sector where NGOs work frequently.

3.9. National, state, and district capacities on developing flexible approaches to implementing a model on HIV in the workplace need to be strengthened.

3.10. Providing technical support on how to redress any disconnect between the central offices of trade unions and their local level offices ensures that HIV in the workplace is addressed at local levels.

3.11. Increased capacity strengthening of union workers at the local levels including on HIV is vital for continued success. Unions can integrate HIV in their regular workers training courses.

3.12. Pay particular attention to assist worker federations that are not affiliated with a specific political party, so as to identify resources to be used to develop HIV awareness in the workplace. If this is not possible, try to create the same welcoming conditions that the project had for the tripartite constituents. Put politics aside for the issue. Try to build an expanded tripartite constituency of all union and employer representatives. Where this was done, for example in **Benin**, it had positive results. [138]

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[137] See, for example, the Ministry of Trade web page describing its HIV/AIDS workplace program. Unfortunately, the reality does not conform to the overall plan. As has been mentioned, some focal points are less aimless than others, and some government offices more aware than others.

[138] An important challenge in Cambodia was the fact that worker organizations that are not aligned with political parties lack the resources to fully implement programs. While the project provided some financial support they were able to carry out activities, but now many of their activities have ceased.

3.13. Promote and provide technical support for the establishment or capacity strengthening of national Business Coalition on AIDS. Support the linking of the business coalitions to international business coalition networks.

3.14. Include measures in project designs that reduce bureaucratic hurdles within agencies and companies so that implementing actions at field level is efficient and effective.

3.15. National capacities of agencies providing diagnostics, care and support, as well as general non-discrimination in healthcare also need to be strengthened in some cases.

3.16. Systems for continuing the follow-up and monitoring of action on HIV in the workplace are needed.

4. Project Advisory Board

4.1. Ensure that all members of the Project Board understand laws, policies, and enforcement methods on HIV in the workplace.

4.2. Clearly define the role of the Project Advisory Board Chairperson taking national cultural styles of decisionmaking into account so he/she can improve the functioning of the decisionmaking process. Ensure that the chairperson is well briefed prior to all meetings.

4.3. Organizations representing People Living with HIV/AIDS should always be represented on the PAB.

5. Other Important Stakeholders, Including People Living With HIV, NGOs, and CBOs

5.1. As noted for the PAB, it is essential to involve People Living with HIV in as many steps of project implementation as possible. Organizations of PLHIV and individual people who are living with HIV and AIDS need to be included. They should be received as informants and resources, not as victims. They also need livelihood options, not simply time to complain. Support groups can be useful centers for the exchange of information about trends in the infection, AIDS, and treatment. Workplaces could offer time and space for that activity. Often, PLHIV have only been trained on advocacy and training others, though they believe they could also be trained on policy issues so they can play a greater role in promoting workplace policies.

   5.1.1. Linkages of PLHIV can also be increased so that they can provide direct ongoing technical support in the form of monitoring and follow-up to enterprises. Training of PLHIV to tell about their experiences has been very effective. In **India**, the association of representatives of PLHIV was highly effective in the entire project cycle and through all phases of the project. However, these groups are often fledgling and voluntary. The corresponding group in **Botswana** needs institutional development training.

   5.1.2. Perhaps the strongest ingredient to people gaining an understanding of the importance of the issue and how to address it was the involvement of a person living with HIV. The education officer stated, "All my trainees were meeting a positive person for the first time. Only then did they start thinking that they understood. It was a question of not just hearing about it. Unless you see someone with your own eyes you do not feel comfortable discussing this subject. This was one of the key things in getting the volunteers to understand."

5.2. Consider the legitimate concern of some workers regarding post-retirement care of PLHIV. This issue is not yet highlighted in most of the activities being implemented.

5.3. The ILO can also link efforts on HIV to assisting PLHIV to improve access to employment and/or work in the informal economy by creating synergies with livelihoods and other income- generating projects.

5.4. NGOs and CBOs enrich society, but are not always perceived that way by governments. The project offered opportunities for them to interact with sectors of government and society with which they sometimes otherwise have acrimonious relations. Furthermore, they benefited from the capacity building in the project.

5.5. Grassroots and community-based NGOs benefitted from replicable training; the tripartite constituents benefitted from working with groups who are sometimes more closely aligned with the disenfranchised and marginalized populations.

5.6. Linkages between ministries, such as between the Ministry of Health and the Ministry of Labour, could be improved. The same can be said for the relationships with the National AIDS Commissions, and other U.N. agencies.

5.7. Public private partnerships and provision of services could be more actively pursued and developed. Coalitions of Business on AIDS are emerging all over, and need the input of businesses, worker representatives, ministerial personnel, and other stakeholders to be able to focus correctly on the necessary issues.

5.8. Creating networks with other ILO and/or USDOL projects specializing in livelihoods and skills development can enhance the project by further helping workers who are living with HIV and AIDS.

6. Behavior Change Communication in the Workplace

6.1. Efforts should be made to focus on further analyzing the 'nature of discrimination.' Public communications programs and legislative action which addresses discrimination in the workplace should be promoted. Regional organizations should recommend interventions that have been introduced, measured, and proven to be successful in similar environments. The ILO must continue its role to encourage national, concentrated attacks on stigma and discrimination as workplace issues.

6.2. Selling the Idea to Enterprises and the Challenge of Sustaining Management's Involvement

6.2.1. A handbook/toolkit on how to approach and advocate with a company to have a program on HIV in the workplace is recommended for each country. Such a handbook also needs to include guidelines on how to develop a company program on HIV.

6.2.2. Case studies of companies who have successfully implemented a program on HIV in the workplace could be useful.[139] NPCs used various culturally and economically appropriate mechanisms to get buy-in from companies. These should be documented, and more importantly, shared. Thoroughly documenting the implementation of an HIV workplace program helps companies to understand the processes involved. A certain 'peer pressure' aspect is inherently evident in

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[139] The India project developed an "advocacy kit" for enterprises in 2002. It contained documentation of eight companies' work on HIV/AIDS; lessons; an advocacy film; and an operational manual providing step by step guidelines to companies. Later, in 2005, a working paper was published along with employers' statement of commitment to help in advocacy with companies.

the case studies, as they indicate that other enterprises are already successfully implementing such programs.

6.2.3. **Research** is sorely needed to document the payback to a company that has HIV workplace policies and committees, programs, and focal points. Some managers are less visionary than others.

6.2.4. Communication using less formal means—through technical support in their companies/agencies, through meetings, e-mail exchanges—has been important at the level of decisionmakers.

6.2.5. Building the capacity of decisionmakers was not adequately covered in the PMP despite its importance for long-term sustainability.

6.2.6. Management needs a different approach in terms of awareness raising and behavior change than workers at other levels.

6.3. **Behavior Change Communication** appears at first to be a complicated concept and process, but it is not impossible to grasp, as sparsely educated factory workers, seamstresses, and waiters can attest. The underlying purpose of BCC is to change behavior, not simply to raise awareness, provide information, or educate. Therefore the process has to be fun, respectful, empowering, democratic, and participatory. In most cases, it was.

6.4. The **SHARE BCC Toolkit** is primarily oriented to HIV in the workplace and does not cover other types of stakeholders. Advocacy materials and training for decisionmakers in enterprises, government, employer and worker organizations, and partner NGOs could be covered in the toolkit.

6.5. Trainers

6.5.1. Be careful when selecting trainers! Some trainers still need more capacity strengthening to be able to effectively adapt their methods to their individual participants or listeners. Some do not understand the nuances of HIV and AIDS, or of the BCC process. The number of Master Trainers and managers who are knowledgeable on HIV and on BCC is gravely insufficient.

6.5.2. Increase the means to provide capacity strengthening for specialists on national panels to design, implement, and provide training on HIV in the workplace.

6.6. Gender issues, particularly women's rights, need to be addressed in more detail in capacity-strengthening exercises.

6.7. Develop a website or send e-mail to master trainers and peer educators so they can download materials and innovative ways to discuss HIV issues in the workplace.

6.8. Participants of relatively low literacy may need more time to understand the concepts and exercises if they are in a mixed-language workshop. The amount of time taken to explain in both English and Setswana further added to the BCC workshop running behind schedule.

6.9. HIV and AIDS should have policies separate from, for example, drugs and alcohol because of the issues of discrimination and stigmatization. This does not mean that activities, such as the development of health committees addressing wellness in general, and workplace events designed to raise awareness of alcohol and drug abuse, for instance, need to be separate from HIV prevention efforts.

6.10. Consider that turnover of permanent trainers means that capacity-strengthening programs need to be carried out on a continuous basis. When planning to establish a panel of experts, consider the geographic size of the country, accessibility to locations with factories, and its population size to ensure that a sufficiently large cadre of specialists exists.[140]

6.11. Although the KAP provides some useful input on how to approach HIV within the sector, size and internal complexity within companies requires flexibility on the part of the trainers and peer educators. Food Oil companies in **Benin**, for example, represented very different levels of sophistication. One had a doctor and two nurses on staff; the other was fighting to keep the business solvent. Both had highly successful AIDS programs. Their BCC strategies were the same but the activities were tailored to the culture of the workplace, the workers, and the wider community.

6.12. Addressing HIV as an isolated issue, especially where there is low HIV prevalence, means that gaining the attention of management and workers at all levels is much more difficult. It may be necessary to integrate the actions on HIV with other forms of support, such as improving other labor conditions, to gain the interest and cooperation of the target group.

6.13. Focal Points and Peer Educators are Both Very Important to the Project's Success

6.13.1. The choice of an effective focal person within enterprises is essential; a competent focal point contributes a great deal to the subsequent success of the workplace program. Likewise, peer educators must be carefully chosen. Focal points and peer educators should not be a nomination that management takes lightly. Turnover among the staff assigned to be the focal point within a company or agency affected continuity. Either the focal point was promoted or left the company for another position.

6.13.2. The project found that there are different advantages and disadvantages to the selection of focal points originating within different company departments. In the case of a focal point within the human resources department, it is easier to promote and develop a company policy. In the case of medical personnel selected as focal points the initial 'buy-in' may be a little slower because they are seen as coming from a type of niche area within the company. Medical personnel, however, have the advantage of often having developed a more comprehensive understanding of HIV and its ramifications.

6.13.3. Having peer educators and focal points at all levels—from management to the shop floor—enriches the entire workplace education program. Because there are different types of workers, within each company there needs to be several ways of handling the issues.

6.13.4. The role of peer educators was essential to effective behavior change. Peer educators necessarily need to adapt their approach 'on the spot' to take the particular type of person with whom they are discussing into account.

6.13.5. Design a system to ensure that new persons are trained to replace peer educators who leave their position or no longer wish to work as educators.

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[140] In some countries, large work sites with vulnerable populations can be found in isolated areas such as in the case of mines.

6.13.6. Some peer educators and master trainers asked for more monitoring and follow-up support to continue to implement their actions correctly.

6.13.7. Tips for Peer Educators

6.13.7.1.1. Peer educators need additional detailed background information for them to consult so that they can answer questions.

6.13.7.1.2. Peer educators who are not directly known to those they try to reach need to have identity cards that validate their work. In the case of the informal economy, peer educators do not always know their target group directly.

6.13.7.1.3. It was found to be essential not to push the discussions too quickly but to gain the trust of the workers slowly.

6.14. Materials and Activities

6.14.1. Materials were always pre-tested to be sure that they were accurately addressing specific sectors. This is an **excellent practice**.

6.14.2. At the beginning of the project, create a program to ensure that sufficient materials are available after the project ends. Several samples of all materials need to be available at country offices after a project ends.

6.14.3. Corporate groups need to continue to be encouraged to develop their own BCC materials for ownership and relevance.

6.14.4. Review the activities listed in Annex 7 and consider appropriate replication.

6.14.5. Additional materials and innovative activities need to be developed. Training and awareness raising often needs to be repeated and participants quickly become bored when the materials are repetitive.

6.14.6. Showing popular films that cover HIV issues during lunch breaks is effective. Short animated films would also be useful and can even be used to illustrate difficult points such as the attack of white blood cells. Super heroes in animated films are also popular and recommended by peer educators.

6.14.7. Materials used in training need to consider that some individuals have very little basic knowledge about the human body, so it is very difficult for them to understand anything that affects the reproductive organs. Additional materials that assist to explain the human reproductive system would be helpful.

6.14.8. Information on gender issues and how inequities are related to the spread of HIV, as well as other issues of vulnerability, should be highlighted in training materials.

6.14.9. Materials can also cover issues such as the economic consequences for the family if a member becomes HIV positive.

6.14.10. Using STIs as the initial point of discussion is helpful since most participants are already aware of STIs—as opposed to talking immediately about HIV.

6.14.11. Educated persons are effectively convinced through the use of data and other research results, but additional 'myth-busting' games could also be developed for less educated individuals.

6.14.12. At the Interactive Session on BCC, Caribbean participants noted that a board game "in the islands is not necessarily a good BCC activity, because there is always drinking involved."[141] Physical sports are better. In other countries, board games and cards were extremely powerful (and fun) message tools. Knowing one's milieu is essential to creating effective activities.

6.14.13. Athletic events, music, films, and community theater are very effective ways to reach out to the wider and multi-generational community. Even a television at the factory site provides a healthy leisure activity.

6.14.14. Advocate that companies take the opportunity of World AIDS Day to highlight the HIV in the workplace issues and organize events.

6.14.15. The promotion of HIV testing at staff gatherings such as parties is effective, particularly if management also participates.

6.14.16. Condom distribution is somewhat uneven across the partner companies and requires more attention to ensure access. Condoms can be given away free, but it depends on workplace culture. Companies can be encouraged to exercise their social responsibility and fund their AIDS programs, including purchasing condoms for their workers and to some extent their clients (as in the Hotel and Tourism industry). Managing condom distribution is not always straightforward. In the case of condom dispensers, they need to be maintained with a good supply.

6.14.17. Voluntary testing and counseling but also other forms of counseling related to HIV issues is often limited, so meeting workers' counseling needs is a challenge in many companies.

6.15. Peer educators who work on a number of labor issues, as opposed to working only on HIV, tend to be more effective. Workers are more willing to listen to those who can help them with different problems, particularly labor issues. Provide more training on other issues such as gender and drugs so that they can provide more well-rounded packaging of information.

6.16. Mainstreaming HIV is less costly for companies than having a separate training course on HIV. Having a separate HIV training is more likely to have in-depth impact but is less likely to be sustainable over the long term given the current relatively low prevalence levels in India and Cambodia.

6.17. Master trainers and peer educators can also provide their services to NGOs or other agencies willing to finance them to implement actions. They can then broaden their impact and reach. A small guide to help them promote their skills can be developed to assist them in this endeavor.

7.   Project Monitoring, Baseline, Impact Assessment

7.1. Staff and the PABs in the field fully appreciate the value and efficacy, and conscientiously fill in the Performance Monitoring Plans, but are less diligent in completing the Data Tracking Tables, especially as they relate to policy indicators. It would be instructive to understand more thoroughly why this is so. Policy issues are

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[141] This statement by a participant at the Caribbean workshop (and the agreement by fellow participants) was not stated as a strict admonition, but it demonstrates the depth of thinking that was done to develop constructive and valuable exercises to engage workers.

perhaps more difficult to measure, and are not measured at the enterprise level like other objectives. Interviews did not reveal that it was due to time limits, motivation, or misunderstanding.

7.2.   The current system includes important measures but the level of detail does not necessarily encourage the transition of the monitoring system to a national body. A post-project monitoring plan should be included in any sustainability plan to ensure that national entities can appropriate and implement it beyond the life of a project.

7.3.   The development of a limited number of common core indicators for the SHARE project is highly relevant. Common core indicators will allow for some comparison across countries. Individual indicators, suitable to each country, should be developed in accordance with the local situation. Additional indicators may also need to be developed over time to accommodate new methods to approach different target groups and situations.

7.4.   Indicators should include targets that are based on the level of change that can be expected after analyzing baseline results.

7.5.   Although it is ideal for the PMP measures to be the same over the life of a project so as to allow for comparison, it should be sufficiently flexible to allow for some adjustments as the project acquires experience on the usefulness and complexity of tracking.

7.6.   Data tracking tables were designed using the type of information collected in the baseline and impact assessments. Such data is not necessarily very useful for ongoing monitoring throughout the life of a project because of its level of detail. A review of DTTs shows that the indicators were mostly only measured at baseline and at the time of the impact assessment.

7.7.   Assessing the data tracking tables is somewhat complex because quantified targets are not provided. Assessing the level of improvement is highly dependent on the individual situation within a company or stakeholders' organization. Factors such as the baseline results are highly relevant to interpreting any level of improvement. Under usual circumstances it would be ideal to conduct a baseline and set achievable and acceptable targets based on the baseline results.

7.8.   The project would have benefited if there was some sort of control group and a test of statistical significance to compare baseline and impact results to ensure that possible differences between the baseline and impact surveys are scientifically significant. Respondents need not be the same individuals when the sector population is perceived as fairly homogenous. The samples used for the baseline and impact surveys need to correspond as closely as possible so that similar gender balance, age, and education do not confound interpretation of results.

7.9.   To measure results accurately and address the challenges of inadequate quality, consider applying statistical methods that take these aspects into account.[142] The consultants in Botswana, for example, expressed an interest in having a deeper understanding of the data collected. Gender issues need to be considered more in the design of baseline and impact studies and in formative assessments.

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[142] See Guerreiro Osorio, Rafael (2008) for examples.

7.10. There is a continued need for government, employer and/or worker organization to have follow up and monitoring once a company is no longer receiving support from the project.

7.11. All of the countries held formative assessments and additional discussions to deepen understanding of those findings that would be beneficial. The focus groups consisted of very small samples. Increasing the number of FGs costs more money but would increase the project knowledge about individual enterprises and sectors significantly.

7.12. In a conservative country such as India it is uncertain that workers will honestly report their sexual behavior to an interviewer. Other methods using anonymous reporting techniques exist for use even with non-literate persons and should be used.

7.13. While the purpose of the baseline studies was to establish a data baseline, it is important not to immediately extrapolate the results beyond the types of groups that were studied. In Cambodia, in the case of the hotel industry the companies selected were hotels of relatively high standing. The many small hotels that often employ less educated staff were not covered.

7.14. In **Cambodia**, the report on the formative assessment should have provided more details on the methodology and about the actual focus group participants; even the total number by gender or age is not reported. A study that is qualitative still needs to be well described in terms of methodology and demographic data so that readers can have a good understanding of the quality and type of population included.

7.15. Indicators need to be well based in project actions. In **India**, some indicators needed for cross-country comparison were introduced that were not well based in the project actions. At the same time, some of the existing project actions were not reflected among the indicators so the importance of such actions was under-highlighted in the data tracking.

7.16. Additional qualitative monitoring, preferably based within the workplace, needs to be developed. Qualitative monitoring would also help in the monitoring of actual behavior change, a factor that is under-highlighted in the current PMP. A system that includes input from workers using qualitative as well as quantitative input on core issues can be useful to improve the actions and sustain the interest of workers.

7.17. Confounding factors need to be considered when interpreting impact assessment results. If numbers of people reporting casual sex do not decrease or only decrease marginally, it may actually be because more people are admitting to casual sex after training.

7.18. Cross country comparisons also need to take into account that major recent regional studies have shown that sexual behavior is very different in countries such as **India** and **Cambodia** as compared to some other parts of the world. Differences in sexual behavior will influence the types of results on any common indicators reflected in the data tracking tables.

7.19. Internal monitoring systems need to be developed for use by implementing partners.

7.20. Capacity strengthening on implementing and monitoring quality actions in diverse settings is required. Benchmarking and quality assurance of packages of services on HIV in the workplace are not sufficiently developed. Currently, there are few monitoring methods in place to ensure that behavior change models and materials are correctly implemented in the enterprises.

7.21. The PMP does not include tracking of the informal economy actions, though they were of significant importance in both India and Cambodia. The projects in both countries also implemented some other activities that are not captured in the PMP. A more practical and

useful PMP could be developed in two parts: One part that could reflect the type of information collected at baseline and at impact assessment. A second, more reduced number of indicators could be developed to track and accurately reflect progress. It would be more practical to monitor.

7.22. The duration of the project needs to be extended for a longer period of time so that the relationship between KAP and impact assessment results can be effectively analyzed and tackled. The results did not show dramatic behavior change, but the time for behavior-changing between the two was short, and the project ended before the gaps identified in the final assessment could be addressed.

8. Target Sectors, Formal and Informal Economy

8.1. Target sectors that need more attention in the future include public sector workers, migrant workers, construction workers, and (other) informal economy workers. The model also needs to further be developed to cover workers in sectors that have, so far, received little attention. These include agricultural workers who may, on occasion, travel to the urban areas to sell their products and engage in casual sex.

8.2. Select enterprises that are economically strong as they can play an influential role, especially as a pilot. There is also merit to increasing attention to workers in small and medium enterprises. They were under-highlighted in the projects. Resources to reach small and medium enterprises are limited and such companies are less likely to be willing to provide internal resources to finance actions on HIV. Innovative methods to reach workers in small and medium enterprises need to be developed.

8.3. It is understood that some enterprises are more willing or more capable than others to participate in the project. It is worth evaluating the enterprises for the risk factor among workers. For most of the enterprises involved in SHARE, there have appeared to be high risk factors among workers, or in the workers in the supply chains.

8.4. Where an AIDS program is integrated directly into the overall workplace management system, it is more sustainable over the long term.

8.5. Ensuring participation by managers helps to institutionalize the project activities.

8.5.1. Support from senior management is key to successfully implementing a program on HIV in the workplace and needs to be fully acquired prior to trying to implement activities.

8.5.2. Top managers sometimes say they will support the program but do not attend training, although they are part of the workforce and are also at risk.

8.5.3. Top managers need to be directly provided with counseling on HIV in the workplace if they do not attend training.

8.6. Companies frequently do not provide training during any working hours or only provide a limited time for training on HIV. Where workers have to participate in organized training during their breaks or after work it is difficult to draw and keep their attention. "They also need their rest periods."

8.7. Enterprises should be assisted to establish comprehensive wellness programs to cater to the health and health-related needs of all employees, not just those infected with HIV. This would reduce chances of stigmatizing services rendered to PLHIVs.

8.8. Including people living with HIV in sensitization contributes to the potential of sustainability. PLHIVs convince companies of the importance of having prevention

programs, the long term consequences of ignoring HIV, and demonstrate their capability to continue working if infected.

8.9. Linkages with government AIDS offices should be embedded in the early stages so that companies continue to receive updated information on VCT, care, and support. A system needs to be developed so that enterprises are kept informed of new services near their worksites. Guides on VCT, care, and support need to be frequently updated as additional services become available and some centers and agencies close down.

8.10. Directly working with individual enterprises is very important in the initial stages of the project as it ensures that the project acquires necessary experience and insight into effective workplace approaches. It is difficult for project staff to provide credible and useful technical support to senior tripartite constituency representatives without direct experience in enterprises and other workplaces. It behooves NPCs to study the results of the worker surveys to understand the workplace culture.

8.11. Ensuring from the first meetings that the roles and resources needed from implementers of the programs were clear is key to success. Issues such as time, number of staff, and budget amounts to be allocated need to be very clearly stipulated. The economic ramifications of HIV are a key factor in raising awareness of the importance for companies to implement a program on HIV. The message is effectively communicated by PLHIV who have been key advocates in the project. Their advocacy often centers on explaining the cost of firing an employee and training new workers.

8.12. Increased capacity strengthening at enterprise level to promote non-discrimination beyond the world of work deserves increased attention. The model is currently mostly focused on stigma and discrimination in the workplace, but workers and their families are also part of communities. Companies could be encouraged to integrate the means to support workers beyond the workplace in the HIV program; e.g., ensuring that the children of workers living with HIV can attend local schools, providing capacity strengthening, and/or linking to groups that can provide support.

8.13. Monitoring systems designed with the corporate partners were primarily intended for long term use by the companies. A great deal of follow-up and technical support is needed to ensure that the monitoring system is effective. The focal point within the corporate groups needs to track all the data collection, which can be challenging since the corporate groups are large. Data collection still needs to be streamlined.

8.14. Differences between the multinational companies and the national companies were identified. It is often easier for the multinational companies to promote and implement HIV programs because their headquarter offices encourage it. In the case of national companies, success is easier to attain if someone at a high level in the company becomes interested in and promotes the issue on a personal basis.

8.15. There is no question that a **Workplace Policy** creates an environment of trust and security for workers. Depending on the size and culture of an enterprise, however, it may be more effective to work first on basic advocacy, develop and deliver training, and finally introduce concrete proposals for a Workplace Policy. Introducing policy without first having a good foundation of convinced and knowledgeable staff is more challenging.

8.15.1. The only way to ensure that the policies are supported by a broad platform, particularly among the management and supervisors, is to develop them through a consensus-building process. The experience in **Benin** of creating a Tripartite Declaration on HIV/AIDS in the World of Work built solidarity among PAB members and made the introduction of policies understood and therefore easier.

8.15.2. Pushing companies strongly to pass policies is not effective, as they might simply adopt a policy but not enforce it. Companies need to be fully in favor of the policy before adopting it formally.

8.15.3. Some companies finally adopted a policy because the project convinced them that doing so would contribute to improve their labor relations.

8.15.4. It takes about 2 to 3 years for a company to mainstream an AIDS program; thus, focusing on adopting policies, even if not complete, needs to be intensified. Additional clauses can be integrated once a company has internalized their usefulness to improve labor relations and economic ramifications.

8.15.5. That workers did not show awareness of workplace policy in final impact assessments is worrisome and indicates that (1) enterprises must be encouraged to publicize and distribute policies and guidelines sufficiently, and (2) flaws in the final assessments should be analyzed; for example, format of questions, who was surveyed at the beginning and end.

9. **Corporate Social Responsibility programs that build on SHARE objectives and workplace activities in the surrounding community are viewed positively, raise visibility for the issue and the enterprise, and should be encouraged.**

9.1. Strong reliance on Corporate Social Responsibility programs can be ineffective because funding for CSR may be decreased or its focus shifted to another area, whereby any existing program on HIV will decline. Advocating for mainstreaming of HIV efforts into human resources or other budgets is more sustainable. The use of CSR can still be advocated to implement corporate outreach programs.

9.2. Few companies would undertake such programs through their regular budget, so CSR offers important opportunities to reach a wider population.

10. **The Informal Economy sector represents a large segment of any country's work force and contributes to the economy. The SHARE model used with formal enterprises needs adjustments when used with the informal economy. A number of different models are needed in the informal economy, as opposed to one overall model. Reaching the informal economy worker is more complex and frequently requires more resources.**

10.1. In countries with high numbers of internal and external migrants it can be useful to review documentation and/or carry out a study on their vulnerability to HIV. Consider that migrant workers are a complicated group to address as, aside from mobility and high poverty levels, they have few factors in common. Develop strategies to reach migrant laborers in accordance with their situation.

10.2. The informal economy may be integrated into SHARE effectively through employer organizations and unions.

10.3. Employer organizations can motivate their membership to invest in corporate social responsibility programs on HIV with their informal economy supply chain and transport partners.

10.4. Formal sector Master Trainers and Peer Educators can also reach out to their local communities with BCC efforts through corporate social responsibility activities. Master trainers and peer educators in some unions with informal economy membership can be trained and can implement actions within their informal economy membership.

10.5. Some trade union federations have informal economy membership associations as members.

10.6.   Informal economy workers belong to trade and other 'fraternal' associations that the project can reach directly.

10.7.   The **Informal Economy Toolkit on HIV** that was developed in **Cambodia** is intended to be used by organizations, unions, and associations with their members, or with other workers they wish to include in the training. The Toolkit is generally well written and has good graphics but could be improved with more details on stigma and discrimination. The Toolkit is designed to be used for a single training, without a long-term strategy. Strategies to conduct monitoring and follow-up could be developed. One of the main challenges of reaching the informal economy worker is the geographic dispersion and wide diversity in ways of living and culture.

10.8.   The informal economy is expensive to reach but identifying innovative ways to reach them through their non-workplace membership groups can reduce costs. Informal economy workers can be members of other types of groups such as religious groups; migrant associations of people from the same community of origin; cultural groups; and even political movements. It can be argued that reaching workers through these types of groups goes beyond the ILO mandate. At the same time, they present viable means to reach informal economy workers that may otherwise be difficult or costly to reach. Options to reach such groups can be either through the creation of synergies with other organizations or through NGOs.

10.9.   Informal economy workers are difficult to reach if they are casual workers because they may be present for just one session and are no longer available for the next session. Innovative ways to ensure that such workers still receive sufficient input need to be developed.

10.10.   The number of workers in the informal economy and their diversity makes reaching them effectively a challenge; thus, it is most effective to work through existing worker organizations, local NGOs, and community-based organizations. The identification of community-based organizations and their involvement can be stimulated more, to reach informal economy workers effectively.

10.11.   In **Benin** and **Cambodia**, the project identified that it had reached the informal economy by creating a synergy with the ILO Informal Economy project (STEP in Benin).

11.   Sustainability

11.1.   Sustainability workshops and plans are most effective if the notion is embedded in the project from the beginning.

11.2.   Within the PAB, there could be a subcommittee which focuses on the long-term plan for the workplace education on HIV, as all participants will know from the start that the end of the project does not mean the end of the need for ongoing activities.

11.3.   Consider at project beginning the possible modifications for making the Project Advisory Board a permanent working group for implementing HIV in the workplace programs at project end.

11.4.   Establish permanent country officers on HIV in the workplace based within the ILO office.

11.5.   Having corporate groups invest financially in their HIV program is effective since it adds to their sense of ownership and interest in sustaining their program.

11.6.   A more gradual phasing-out of a project on HIV in the workplace is preferable. Phasing out should be followed up by some post–phasing-out activities to ensure complete sustainability.

11.7.   It would be useful to have a system to follow up or monitor project actions post project to occasionally track the results that developed. The system should cover all former project actions—not only those within enterprises. Such a monitoring system could be used to inform future sustainability plans both within the country and among other countries. The monitoring system could, for example, determine why some actions are more sustainable than others.

SECTION IV: ANNEXES

1. Tripartite Declaration and Law

2. India—a Special Case in the Evolution of the Project Design

3. Concept of "The Champion"

4. Participating Enterprises

5. History of Pre-testing and Training of the BCC Toolkit

6. Peer Educator Report

7. Creative Activities Organized to Educate and Serve by Workplaces and Surrounding Communities

8. Example of Best Practice

9. List of People Met

10. Terms of Reference—Cross-Country Study of the ILO/USDOL HIV/AIDS Workplace Education Program

ANNEX 1: Tripartite Declaration and Law (Benin)
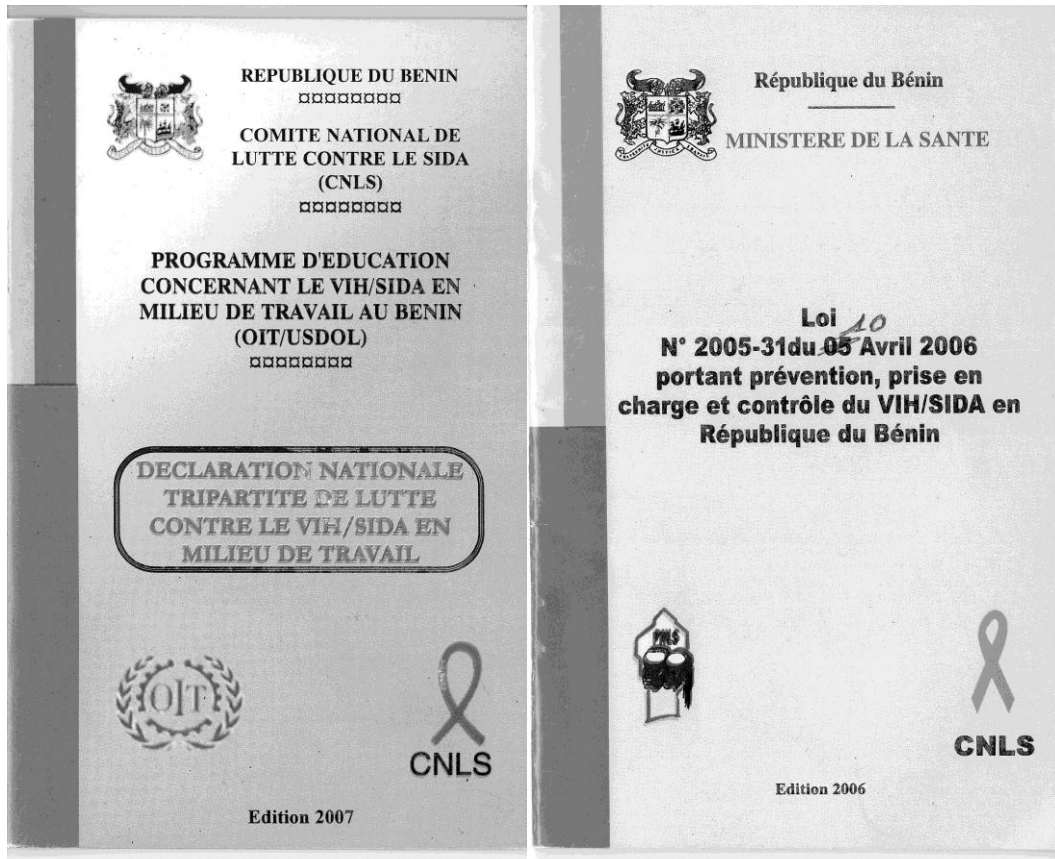
1**Photograph of framed Declaration**

ANNEX 2: India - A Special Case in the Evolution of the Project Design

First developed as a pilot initiative on HIV in the workplace in 2001, the India project on HIV in the workplace was developed gradually over time. The initial project design was adjusted in accordance with field realities, new options and availability of funding. The design and strategic framework of the first phase was logical, coherent and provided sufficient flexibility for later adaptations. The project deliberately avoided a rigid logical framework in the second phase and worked with conceptual frameworks, described in concept notes and work plans, instead. As a result, the project continues to have the flexibility of a pilot project to experiment with and develop innovative approaches. The flexibility also allowed for adjustments in accordance with the National Aids Control Organisation (NACO) policies and priorities.[143] The model developed in India evolved over time and included adaptations for different sectors and types of target groups, and consequently, many aspects of the India project are not found in the other SHARE programs. The India adaptations were not formally registered as alternative models but can be labeled as such. In Mumbai, for example, the principal partner within the Mumbai Port Trust was the hospital for Trust staff that also provides services to port casual workers. The program of the Mumbai Port Trust was channeled through the hospital and includes community outreach. The project reached casual and permanent workers in India's largest port city.

In the initial pilot phase, the project staff exhibited a willingness to learn from others and re-orient the design. The representative of the Indian Network for People with HIV/AIDS noted that their input and comments were seriously considered and the project design was adjusted starting in 2002.[144] As a result of the input of people living with HIV, increased focus was placed on issues of stigma and discrimination. The role of PLHIV in project implementation was also expanded. The project staff sought and made full use of opportunities to link to various agencies and interested partners. As another partner NGO representative noted, project staff were willing to invest time in the initiatives of others.[145] The pilot project implemented in India contributed to inspire the model that was developed and implemented in the other countries.

Perceptions of how to approach HIV in the workplace issues also changed over time as the model continued to be implemented. In the initial phase, efforts focused on awareness raising and method development in workplaces and with Tripartite partner organizations. Later, the model was adapted to increasingly focus on areas that were found to need additional attention. These included national and state level policy and strategy development as well as capacity building of a network of "champions" on the issue of HIV in the workplace. [146]

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143 Some of the policies and priorities were also influenced by the project input.

144 Celine D'Costa.

145 Mr. Sanjay Chaganti, Programme Director, PSI

146 See, The Champion Concept, Annex 3

ANNEX 3: The Champion Concept

In India, a particular cultural phenomenon of importance in promoting effective project implementation and sustainability is the "champion" concept. The same concept applies in other countries, but, according to one interviewee, it acquires special significance in India.[147] There,

the project director, Afsar Mohamed, was commonly cited as a champion for the cause of HIV in the workplace because of his passion for the subject. Some project staff members were also cited as being good champions. In workers organizations and at the enterprise level, having an internal passionate champion who guides and monitors implementation was frequently cited as essential to effectiveness and sustainability. Certain expectations exist concerning the role of the champion and he/she will only be respected if he/she fulfills that role.

> "As does the king so do his subjects. Such is the king so are his subjects. If the king has spotless character and is true to his thinking, speech and deed then the people will also meticulously follow him in everyday life."
>
> *Sri Venkateswara University Oriental Research Institute (2002)*

In the course of the study, stakeholders often pointed out the difficulty to transition to sustainable independent action because of dependence on the champion. As experience is acquired and broadened, however, groups and individuals are able to take on new more independent roles and become champions. One interviewee mentioned that there was a certain amount of angst among people working on this issue that if the champions go the sector will collapse, particularly at national level. Having room to be creative and try out different approaches is vital to developing actions that are sufficiently tailored to the individual situation that true independent ownership can be developed. A national NGO representative noted that champions are needed at all levels: *"Getting the politicians on board such as the chief minister is key. Wherever you find a success story it is also where the managers are personally interested. The workers are also more interested in these situations."*

Ensuring that top management in the enterprises was "completely on board before actual program implementation" was essential to success. This was accomplished through direct advocacy and a conference with management from factory units. Leadership from senior management was a factor during project implementation and for sustainability. A cascading effect of interest in the HIV workplace education program was visible among the organizations and companies. Peer educators talked of motivated master trainers who championed the cause. Master trainers talked of high level management staff that was fully supportive.

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147 Sri Venkateswara University Oriental Research Institute (2002)

Workers in one Railway Workers Union held utmost respect for their union organizer, who had helped them organize, resulting in improved labor conditions. The Railway coolies gave her "guru-like status" because of her support to them. They listened to her about this sensitive topic of HIV because of their respect for her. The organizer indicated that such achievements are only possible if one is completely committed and willing to spend more time and effort than would normally be expected. Constant monitoring and follow up are required to ensure acceptance and sustainability over the long term. A CBWE representative likewise commented,

"This work is very to be dependent on the person who is doing it -- their level of

Commitment, so if I am not committed then it will not work."

Charismatic leadership may be attributed to a personality trait, but the commitment and energy demonstrated by nearly every National Program Coordinator encountered in the course of the study shows that personality is not the only trait that takes to be a Champion. The process to recruit and hire a National Program Coordinator was unusually long in Benin but the attention paid to the hire was worth the effort. Similarly, the focal point on the Namibian border who is a known throughout the town as the focal point on HIV/AIDS despite the presence of doctors and health professionals, the peer educator who works goes door-to-door in the evenings after work in the palm oil factory in Benin, and the cadre of women building a network of professional talent in Barbados demonstrate willingness and drive, and a professional level for which the ILO is respected.

> "Successful work on any issue requires leaders or individuals who will champion a cause."

ANNEX 4: Participating Enterprises

INDIA	Coverage		Total	Master
All have MOC	Regular Employees	Contractual/ supply chain workers	coverage	Trainers Trained
Gujarat Ambuja Cement Ltd. – 13	7750	20000	27750	50
PepsiCo – 39	4066	1398	5464	83
SRF Group – 7	2517	1700	4217	25
Ballarpur Industries Ltd.- 6	11389	1210	12599	30
Apollo Tyres- 5	5000	5000	10000	24
Crompton Greaves Ltd.- 22	4771	3368	8139	32
Hindustan Lever Limited (Northern Region) – 7	2983	930	3913	33
Transport Corporation of India – 21	4600	25000	29600	25
Jubilant Organosys Ltd – 4	4900	Initiated in 450 Supply Chain companies	4900	32
SAB Miller – 14	2959	2500	5459	19
J.K Tyre & Industries 5	5800	1100	6900	To be trained
Sona Koyo Steering Ltd. 7	1800	1850	3650	To be trained
TOTAL 150	58,535	64,056	1,22,591	353

BARBADOS – All have MOC	
Accra Beach Hotel & Resort Rockley, Christ Church	195
Gems Of Barbados Hotels Rockely, Christ Church	350
Amaryllis Beach Resort Hastings, Christ Church	150
The Plantation St. Lawrence Main Road, Christ Church	87
Scotia Bank, Barbados Broad Street, Bridgetown	285
Barbados National Bank Independence Square, Bridgetown	450
Arawak Cement Co. Ltd. Checker Hall, St. Lucy	350
McBride Caribbean Ltd. Lowlands, Christ Church	70
Barbados Dairy Industries Ltd. P O Box 56B, Pine Hill, St Michael	190

BOTSWANA – All have MOC	
Purity Bakeries Lower Collymore Rock, St. Michael	185
Hanschell Inniss Fontabelle, St. Michael	190
Bridgetown Port Authority Taxi Association Port Authority, Bridgetown	150
Total	2652

BENIN: All of the partner industries have signed MOC	
OIL Industries Béninoises des corps gras (IBCG) and Cotonou, Porto-Novo and Hinvi	Approximately 500
FLUDOR Bohicon Parakou	Approx. 365
Société des Huiles du Bénin* Bohicon	445
MINES and Energy Société Béninoise d'Électricité et d'eau 6 départements	1600
Société fabrication deu Ciment (CIM-Benin) Cotonou Societe national des Eaux du Bein 6 departements	600
Societe des ciments fir Benin SCB Cotonou	254
SCB LaFarge Onigbolo	480

Construction COLAS SOGEA-SOTAM SBI-SONITRA OFMAS – Benin	
Informal Economy -- Centre de promotion de l'Artisanat	200

CAMBODIA:
Formal Economy Sector: Textile: 3 garment factories in Phnom Penh Hospitality: 5 hotels in Phnom Penh; 7 hotels in Siem Reap Sala Bai Hotel and Restaurant School
Informal Economy Sector: Construction workers in Siem Reap province through Cambodian Construction Workers Trade Union Federation-CCTUF
Others: TOTAL Cambodge CALTEX Cambodia Ltd.
Total: More than 4444

ANNEX 5: History of Pre-Testing And Training Of The Bcc Toolkit

Activity	Date
Pre-testing of the BCC Toolkit (Anglophone version) with National Project Coordinators from Belize, Cambodia, Ghana and Guyana, and project stakeholders from Ghana, Accra	April 2004
Pre-testing of the BCC Toolkit (Francophone version) with National Project Coordinators from Benin and Togo and project stakeholders from Benin, Cotonou	November 2004
Training on the ILO/FHI BCC Toolkit for project stakeholders from Barbados, Belize, Guyana, and Jamaica, Georgetown	March 2005
Training on the ILO/FHI BCC Toolkit for project stakeholders from Botswana, Ethiopia, Lesotho, South Africa and Swaziland, Maseru	October 2005
Training on the ILO/FHI BCC Toolkit for project stakeholders from Russia, Indonesia and Sri Lanka, Moscow	December 2005
Training on the ILO/FHI BCC Toolkit for project stakeholders from Burkina Faso and Cameroon, Burkina Faso	July 2006
Skills building workshop the ILO/FHI BCC Toolkit, XVI International AIDS Conference, Toronto	August 2006
Training on the ILO/FHI BCC Toolkit for project stakeholders in Nepal, Kathmandu	February 2007
Training on the ILO/FHI BCC Toolkit for project stakeholders in Trinidad and Tobago, Port-of-Spain	March 2007
Skills building workshop the ILO/FHI BCC Toolkit, VIII International Congress on AIDS in Asia and the Pacific (ICCAP), Colombo	August 2007
Training on the ILO/FHI BCC Toolkit for project stakeholders of China, Beijing	September 2007
Interactive Learning Event on HIV/AIDS Behaviour Change Communication for the Workplace for Barbados, Belize, Guyana, Jamaica, and Trinidad and Tobago	May 2008

ANNEX 6: Peer Educator Monthly Report

Transcribed Text from Peer Educators Monthly Report -- Delta and Desert Safaris, Botswana

Comments: "I have choosed these theme of HIV transmission and prevention for these month because I have heard one day some of the staff and giggling to each other about how can HIV can be transmitted to each other. How there were getting answers to each of each questions is what makes me to choose a theme because it was seems that they were not understanding. But now I can say they understood because they were asking questions and some were adding some ideas they know."

Problem Encountered: "The problem we have in Xugana [lodge] is how we can give condoms to the staff. We need boxes in toilets to get to put condoms where they can take them there. Recommendation: The policy, the staff they don't understand. If you can make it fast and simplify it and write it in Setswana."

ANNEX 7: Creative Activities Organized to Educate and Serve by Workplaces and Surrounding Communities

1. Soccer tournaments: The palm oil factory in Benin is located in the middle of several thousand acres of small and large palm plantations. The town and surrounding villages that have grown up around the factory serves as the major economic center to the population who would otherwise be isolated and impoverished. Among the activities implemented by the factory peer educators and the HIV/AIDS committee was a soccer tournament open to the larger community. The tournament of eight teams lasted for two months. At each playoff, HIV and AIDS presentations were made, and materials distributed, including condoms. The same concept is being used in the villages surrounding Charles Hill, Botswana.

2. Cheerleaders at the soccer games: In an effort to organize young otherwise idle teenage girls, Guyana project NGO partner *Artistes AIDS* created a support group which engages in several activities including wearing red and white uniforms and promoting behavior change as they do synchronized cheering at soccer games.

3. Call-in for answers: Ambuja Cement in India developed an innovative system using an automatic interactive voice response system where people can call and ask questions about HIV. Cards with the number are widely distributed to workers and others. If a person cannot get an answer to their question, they can leave their question and will be contacted with answer within 72 hours. Many people have already called the number.

4. On-line study: At one of the participating banks in Jamaica, staff is offered promotion opportunities by following training using online programs. Questions concerning HIV and AIDS now are part of the staff development.

5. Green Ribbons: Staff at Delta and Desert Safaris feels that their knowledge and awareness can go beyond the workplace to the clients. The Lodges serve extremely high end tourists, and the management has determined that it is good business for their clients to be involved in the fight against HIV/AIDS, and/or or that they deserve to understand HIV/AIDS, too, *if they wish*. Staff members wear badges that say, "I know my status" and are very open to sharing their knowledge about HIV and AIDS if clients ask. World AIDS Day is a big event the tourists camps.

6. Mr. Positive: Sort of like American/South Africa/Idol, the winner gets to travel the country as a peer educator (Botswana People Living with HIV AIDS). The NGO is a member of the PAB and participated in training.

7. Games: In Botswana, a game was developed called Snakes and Ladders, based on a popular children's board game. A correct answer about HIV-AIDS means the player ascends the ladder, but wrong answers result in a chute (going back spaces). Value is placed on winning, of course, so apt players must concentrate on understanding issues of transmission, treatment, and how to avoid behavior that puts one at risk to HIV AIDS. The game was apparently wildly successful in the Safari Camps where people had a lot of free time on their hands. In Charles Hill, the outpost eight kilometers from the Namibia border, the staff of the government District office scratched their heads and appreciated the heavy oilcloth with colorful green and red pictures of chutes and ladders, but time was not allotted to play games. Nonetheless, the local stakeholders were confident that the games were useful and appropriate and in the spirit of continuing the activities that the project had launched, discussed future events where the games could be played on a more regular basis outside of work hours.

8. Playing card games is acceptable during breaks at the Palm Oil factory in Benin.
Colorful and durable, the flash cards have questions and answers about HIV/AIDS. They are the most often used vehicle for building knowledge about the infection, risky behavior, prevention, treatment, stigma and discrimination issues at the factory. The Q&A cards have become a popular activity people in the community.

9. Similarly, at Delta and Desert Safaris, the consensus was clearly that games were logical and appropriate methods of communication for change. The games were well conceived and the connection between the relationship between risk behavior and HIV AIDS extremely clearly communicated. Workers had time in which to play the games and were motivated to do so.

10. The India project also developed a type of card game that develops understanding of all the key issues, which is very popular.[148] Although some of the contents such as the scientific definition of HIV seemed complex for people who may not be literate, all of the relevant interviewees are convinced of its efficacy. One PLHIV stated, "I have personally field tested the card game with over 400 people in Hindi. When they are sitting there and they have finished the card game, I give additional information. They really understand it." The interviewees also considered the inclusion of the definition useful as it provides an opportunity to explain the context of the HIV infection. Often companies provide small rewards for winners of the game, which adds to the success of the game. Peer educators considered that the content of the card game was highly relevant and not overly technical since it helped workers to understand the issues.

11. Films and Drama: Some companies also show existing popular films that cover HIV issues during lunch breaks. In one case, a company focal point reported that many workers are shy to buy condoms. The company responded by airing an Indian feature film at the staff canteen that shows a famous actor acting very shy while buying a condom. The result was laughter and a more positive attitude to buying condoms. Unfortunately actual results were only qualitatively reported.

12. A film shown by the project in Benin featured a wood sculptor whose apprentice contracted AIDS. "All the issues connected to including discrimination, eating of the same bowl, being in the same room, and the fact that that there is treatment came up in the story. Then it was explained that no, this person needs to be helped," explained the peer educator, coincidently a sculptor and seller of woodcarvings. Many crafts people in the informal sector related to the film.

13. With time on their hands, the Delta and Desert Safaris peer educators and staff; with a particular interest in drama organized a drama club. The troupe writes and presents plays, which focus on changing behavior and attitudes. The plays are wildly popular, often comical but sometimes deal with serious themes, such as domestic violence and gender inequities as they apply to HIV and AIDS.

14. The Barbados project has benefited from a relationship with Jennifer Walker, an employee of the Ministry of Labour and an actress with her own theatre company. She served as a resource person for the ILO Project and its stakeholders. She organized "Ambush Theatre" or street theatre events for the Project targeting taxi drivers and others, whereby actors initiate an unannounced public drama near a taxi stand on some HIV/AIDS topic. It has been a very effective vehicle to raise awareness in a dramatic way. The National HIV/AIDS Commission sponsors other theatre work by Ms. Walker on HIV/AIDS, so her work will continue even after the project has ended. Similar guerrilla theatre tactics were used in Trinidad to bring barbers on board to the project, and educate customers.

15. In August 2006, Scotiabank Barbados and the ILO in collaboration with several national partners embarked on "*Pledge for Life*" - a national drive to encourage individuals and corporations to advocate for zero tolerance to HIV-related stigma and discrimination in the workplace, home and community. The novel idea of a Motorcade which was implemented by Scotiabank's Marketing Department as part of its 50th anniversary celebration generated interest and encouraged widespread participation.

16. PepsiCo of India developed a storybook in comic/cartoon format, which they have found to be very effective with the people in the communities surrounding the plant where it was pilot tested.

17. One of the enterprises in Barbados reached out to the community with Know your Status Day, providing confidential testing and counseling in the context of a larger Health Day.

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148 The Benin project credits the India project with the inspiration for their card games.

18. In Botswana and elsewhere, project staff and stakeholders participate in Candlelit ceremonies remembering friends lost to AIDS, or commemorate special days by picking stones symbolizing the number of close persons they have lost due to HIV/AIDS.

ANNEX 8: Card Games – A Best Practice

Inspired by the experience of the SHARE in India, the Benin project also created a card game, called "Better Understanding HIV/AIDS/STI." Five thousand games were published, at a cost much cheaper than the over-used tee-shirt. It is judged by workers, NGOs and all the other stakeholders to be an effective and practical tool adapted to the needs and abilities out beneficiaries. It has been extremely successful among workers as an icebreaker for parents to be able to engage in dialogue on questions about sex with their children. As in many countries, the subject of sex is taboo and it is difficult for parents to speak with their children about HIV AIDS.

ANNEX 9: List of Interviewees (Benin, Botswana, India, Cambodia, Caribbean (including Barbados), Geneva and USDOL)

BENIN	
Organization	Name, position and/or stakeholder, Contact Details
ILO - SHARE	1.Dr Moucharafou Idohou, Coordonnateur National du Projet (NPC) 01 BP 6635 Cotonou, 00229 Tel. 316971 imoucharaf@yahoo.fr 2. Driver, Remi remiag9@yahoo.fr
Conseil National du Patronat du Bénin (CNP/Bénin)	1. M. Sébastien Ajavon, Président 2. Dr Philippe Johnson, Secrétaire aux affaires Sociales, représentant le CNP (PAB member) , 01 BO 426 Cotonou 22921321171 3. Zanou A. Pierre, Executive Director Conseil National du Patronat du Benin, Tel. 22921307406
Conseil des Investisseurs Privés du Bénin (CIPB) Private Investors of Benin	M. Serge PRINCE-AGBODJAN, 03 BP 4304 Cotonou 22921316531
Confédération des Syndicats Autonomes du Bénin Independent Workers Union	1. M. Gaston R. GOUTON, president and member CCP (PAB) 2. Lokossou Dieudonne, General Secretary 40 BP 1115 Cotonou 229 21 30 31 82 , Représentant de la Confédération des Syndicats Autonomes du Bénin (including informal sector)
Confédération Syndicale des Travailleurs du Bénin (CSTB) Workers	1. M. Gaston Azoua, SG Conseil Économique et Social Présent Commission Affaires, Sociales et Éducation (CES) 08 BP 679 Cotonou 2. M. Innocent Assogba, (CSTB) Focal Point, Représentant de la Confédération

Federation	Syndicale des Travailleurs du Bénin (CSTB) 01 bp 207 Porto Novo , Secrétaires aux relations, Extérieures, 3. Francoise Holonou, Professor de Biologie, (CSTB) BP 207 Porto Novo 2090034183
Enterprises	
CB-LaFarge	1. Stéphane Agostini, SCB LaFarge Administration and Finance Director , Lot C 11 Les Cocotiers, Cotonou, 229-21-30-6181

Complexe Oléagineux d'Agonvy (CODA)	1. M. Fabien Lali-Chacha, Factory Director Complexe Oléagineux d'Agonvy (CODA) BP 03 Pobe 229250071
	
	 2. Workplace Committee:
	
	     a. M. Antoine Bocco, Focal Point, Human resources
	
	     b. Azonnondo Jeanette, human resources representative
	
	     c. Simon Assagba, committee member
	
	     d. Marthe Crede, committee member
	
	     e. Alexandre de Medeiros, committee member

FLUDOR Cottonseed Oil Factory	1. M. Célestin Gnonlonfoun, Chargé du personnel, PF HIV/AIDS 2. Dr Prisque BAH, médecin d'entreprise 3. Adiatou Aboudou, Focal Point and committee member, Tel. 95861534 (Based in Cotonou) 4. Day Shift Nurse, Peer Educator 5. Evening Nurse, Peer Educator Workplace Committee, Peer Educators
Centre de Promotion de l'Artisanat (CPA) Handicraft Center, informal sector and Ministry of Tourism	1. Felix Chabi, Human Resources, Focal Point CPA, 2. CPA Mme. Moussa Aime, Peer Educator, Cashier, CPA 90918437 3. Workplace Committee, Artists, Peer Educators
Government	

Ministry of Labor and Public Works (MFPTRA)	1. Mme Mêmouna Kora Zaki, Directrice Générale du Travail 2. M. Emmanuel Tiando, MTFP 3. Dr Raouf Péreira, DST 4. Mme. __
National AIDS Commission Permanent de Lutte contre le SIDA (PNLS)	1.Dr Valentine MEDEGAN FAGLA-KIKI, Secrétaire Permanent du Comité National de Lutte contre le SIDA (CNLS), 229 21310020 06 BO 2586 Cotonou Secrétaire Permanente, Membre du CCP (PAB) 2. Members of the United Nations Theme Group
Other	
NGOs	1. Mme Lisette Adjou, Directrice exécutive, Formatrice des pairs éducateurs, Organisation de Recherche pour le Développement Humain (ORDH) **2.** M. Pierre-Clavère Ahouansou, Formateur des pairs éducateurs Recherches, Actions Communautaires, Initiatives pour un Nouvel Espoir (RACINES) 3. Georges Aballo CAFEB Centre d'Action et d'Education a la Base (up country Dass-Zoume)

BOTSWANA	
Organization	Name, position and/or stakeholder, Contact Details
ILO - SHARE	1. Jeffrey M. MAKGOLO National Project Coordinator Email: jmmakgolo@gov.bw Telephone: +267 36 11 505/525 Ministry of Labour and Home Affairs Block 8, Government Enclave - Floor 3/12 - P/Bag 0072 - Gaborone, Botswana 2. Marianyana Selelo, Former NPC Telephone: 2673603525 3. Semele, Driver
BBCA	1. Frank Phatshwane Coordinator Suite 269, Broadhurst Postnet, Private Bag BR 351, Gaborone, Botswana Tel.: +267 713 22 665 E-mail: frank@bbca.org.bw www.bbca.org.bw 2. Onkgopohe Moneni 71555695 Office 3164921
BFTU	Gadzani Mhotsha, Director, Botswana and Botswana Federation of Trade Unions (BFTU) Tel. 71321584
BOCCIM	Norman T. Moleele Deputy Executive Director Botswana Confederation of Commerce Industry and Manpower P.O. Box 432 Gaborone Botswana 395-3459
BONELA	Christine Stegling, Coordinator, The Botswana Network on Ethics, Law, and HIV/AIDS (BONELA) Medical Mews, Fairground

	Gaborone, Botswana P.O. Box 402958 Gaborone director@bonela.org
BONEPWA	1. David C. Ngele Executive Director 2. Sonya Wedin, PCV, assistant 3. Rosemary Makosi
Enterprises	
Charles Hill Textile Informal Sector	1. Monica Kandjise, PO Box 129 Tel. 71771234 (6592008) 2. Hazel O. Diterelo, Peer Educator 3. Ruth Katambo Webb, Peer Educator, PLWHA 4. M. Gangeas, Peer Educator
Delta and Desert Safaris	1. Adrienne Esterhuyse, Human Resources 2. Munihanco Sakhi Limbo, HIV/AIDS Coordinator, Trainer 3. Pastor, Canaan Chatukuta, Box 97, Maun 71462814 4. Okantse Phallo, Peer Educator, Living with HIV 5. Peer Educator
Murray and Roberts Construction	Dineo Koontse, Human Resources, project Focal Point
CRESTA Hotels	1.Vincent, Wait person (Maun) 2. Faith, Peer Educator (Gaborone) 3. Celeste, administration (Maun)
Government	
Ministry of Labour and Home Affairs	1. Mr. M.B. Palai (Permanent Secretary Ministry of Labour and Home Affairs 2. Ms. K. Mosienyane (Ministry HIV/AIDS Coordinator) 3. Claude Mojafi, Commissioner of Labour, Department of Labor and Social Security, Ministry of Labour and Home Affairs, Private Bag 0072, Gaborone 26732 1150
Ministry of Health	1. Priscilla Kapii, Acting Matron

	2. MOH District Health Coordinator
	3. Lucretia X, Sub-District Community Health Coordinator, Charles Hill
	5. *Monica Kandjise*, (See above, FP for District and head of informal sector (Tel. 6592008)
DMSAC	1.William Willie Goitheng, District Multi-sector AIDS Commission Coordinator, 72166038
	2. Margaret X, Monitoring and evaluation officer
	3. Mahupe X, Monitoring and evaluation officer
NACA	Mr. Peter Stegman Consultant, Strategic Planning and Policy Development, National Aids Coordinating Agency (NACA) African Comprehensive HIV/AIDS Partnerships (ACH AP) P/bag 00463 unit 19 Westgate Mall Gaborone 267-371-0314 pStegman@gov.bw
UNAIDS	Evaristo Marowa UNAIDS Country Coordinator, United Nations Place, 22 Khama Crescent P.O. Box 54 Gaborone 267395212
Other	
University of Botswana	Dr. Frank Youngman, Deputy Vice Chancellor (Academic Affairs) University Council , P/Bag 0022, Gaborone, ***Botswana***
Independent Consultants	1.Rose Onalethuso Mandevu BSc. MPH, Independent Consultant, BCC (SHARE Final Assessment) 2. Enoch Ngome (SHARE Final Assessment) 3. Phora Youngman, youngman@info.bw 4. Monica Brinn (Lesedi) 74219518, Charles Hill PCV

INDIA				
Date	Location	Name	Organization & position and/or type of stakeholder	Contact details
ILO				
5/5/08	ILO New Delhi Office	Mr. S. Mohd. Afsar	Technical Specialist (HIV/AIDS) – South Asia & National Programme Coordinator ILO	ILO Core 4 B, 3rd Floor India Habitat Center Lodhi Road New Delhi Ph: 91 11 24602101/02/03 Email: safsar@ilodel.org.in
5/5/08	ILO New Delhi Office	Ms. Yamin Zaveri Roy	Senior Programme Officer HIV/AIDS Project - ILO	ILO Core 4 B, 3rd Floor India Habitat Center Lodhi Road New Delhi Ph: 91 11 24602101/02/03 Email: yz-roy@ilodel.org.in
5/5/08	ILO New Delhi Office	Ms. P. Joshila	Programme Officer HIV/AIDS Project - ILO	ILO Core 4 B, 3rd Floor India Habitat Center Lodhi Road New Delhi Ph: 91 11 24602101/02/03

INDIA				
Date	Location	Name	Organization & position and/or type of stakeholder	Contact details
				Email: joshilla@ilodel.org.in
5/5/08	ILO New Delhi Office	Mr. Manjunath Kini	Programme Officer HIV/AIDS Project - ILO	ILO Core 4 B, 3rd Floor India Habitat Center Lodhi Road New Delhi Ph: 91 11 24602101/02/03 Email: mkini@ilodel.org.in
5/5/08	ILO New Delhi Office	Ms. Divya Verma	Programme Officer HIV/AIDS Project - ILO	ILO Core 4 B, 3rd Floor India Habitat Center Lodhi Road New Delhi Ph: 91 11 24602101/02/03 Email:divya@ilodel.org.in
16/5/08	ILO New Delhi Office	Mr. K.S.Ravichandran,	Programme Officer	
16/5/08		Mr. G.K.B Dasanayaka	Senior Specialist-Employers' Activities	gota@ilodel.org.in

Partners				
4/4/08	Bangkok	Dennis Broun	UNAIDS, India Country Coordinator	
6/5/08	V.V. N.L. I NOIDA	Mr. Kanwar Manjit Singh	Director VVGNLI	V.V. Giri National Labour Institute/ Member - PMT Post Box No. 68 Sector 24, NOIDA 201 301 Distt.-Gautam Budh Nagar (U.P.), Ph: 951202411474
6/5/08	V.V. N.L. I NOIDA	Dr. Ruma Ghosh	Faculty VVGNLI	V.V. Giri National Labour Institute/ Member - PMT Post Box No. 68 Sector 24, NOIDA 201 301 Distt.-Gautam Budh Nagar (U.P.), Ph: 951202411474
7/5/08	U. S. Embassy New Delhi	Mr. Robert Clay Lalita Shankar	Director – PHN USAID	U.S. Embassy Chanakyapuri New Delhi 110021 Ph: 24198000 Email: lshankar@usaid.gov
7/5/08	GTZ Office New Delhi	Ms. Scherry Signaporia & Ms. Susan Koshi, GTZ		GTZ B 5/1, IIIrd Floor Safdurjung Enclave

				Opp. St. Thomas Church Ph: 46036694 Mobile: 9971262517
7/5/08	FICCI Office New Delhi	Mr. B. P. Pant	Secretary – Coordination Council of Indian Employers (CIE)	Federation House, Tansen Marg New Delhi – 110001 Ph: 23316121/23738760
7/5/08	DSACS Office New Delhi	Dr. Anil Gupta & Ms. Nidhi Rawat	Assistant Project Director/ Mainstreaming Consultant Delhi State AIDS Control Society (DSACS)	DSACS Dr. BSA Hospital Dharamshala Block Rohini Sector 6 Delhi 110085 Ph: 27055722

8/5/08	Trip guide	Suweshi Sharma	Manager HR	PepsiCo International, suweshi.sharma@intl.pespico.com
	PepsiCo Concentrate Plant	Mayur Chaturvedi Ravinder Kumar Namraja Mishra Sukhvinder Singh	Manager HR Peer Educator Peer Educator Peer Educator	mayur.chaturvedi@intl.pepsico.com
	PepsiCo Snack Plant	Manish Sinha Partha Gangopadhyay Vijay Ranga Priya Arora Rajinder Lamba Balwart Singh	General Manager HR VP Plant Operations Master trainers and peer educators	Manish.sinha@intl.pepsico.com Partha.gangopadhyay@intl.pepsico.com
9/5/08	Ambuja Cement Ltd. Delhi	V.K. Jain Sanjay Kumar	Director, CSR Company Focal Point HIV	vkjain@ambujamail.com sanjay.kumar@amujacement.com
10/5/08	Hyderabad	Siddharta Srikar	SACS Co-ordinator Workplace interventions	siddu007in@yahoo.com

		M. Umanagendramani	General Secretary S.C.Railway Licensed Porters' Sangh Sec'bad (& 6 other union titles)	u_nagendra@yahoo.com
		Approximately 100 railway coolies, short focus group with 8 coolies.	Hyderabad Railway Station	
	Office Network HIV positive people	M. Swapna (with 7 other representatives of people living with HIV)	President CDC, PRO District Cooridnator Network HIV positive people	040-32362370

12/05/08	Field visit Mehruali	Pankaj Rastogi	CBWE Education Officer	rastogi.pankajkumar@gmail.com
		Vijay Laxmi Raj Kumar Rukhana Shadab Ahmed Chandra Kals Devrat Roy F. Hashim	Volunteer educators and peer educators	
	ILO Office	Mr. Naveen Kumar,	Delhi Network of People Living with HIV	
13/5/08	Avert Office Mumbai	Dr. Anjana Shanbagh,	Ex workplace coordinator, Mumbai Districts AIDS Control Society), Team Leader mainstreaming, Technical Support Unit, Maharashtra	
	Avert Office Mumbai	Anna Joy	Associate Project Director	anna@avertsociety.org
	Mumbai Port Trust	Dr. Vasumati Upahdye Dr, Aarati Ugeemkar	Chief Obstetrics and Gyneacology Senior Medical Officer	vasumati.pahdye@yahoo.com

		Prashant Vasant Guveco	Master trainers	
		Prakash L. Pande		
		Pramod Navare		
		Sunil Nalawade		
		Agit Zajakt		
		Rajesh Giovejar		
		Mukul Ambedkar		
		S.J. Tashonskar		
		Elise D'Silva		
	Union Organizers Avert Office	Shala Bhalearo Vinod Bhal	Union- Nirman Mazdoor Sangtana	
14/5/08	Crompton Greaves Office	Kaustav Chakraborty Suzanna D'Souza Sandeep Kumar Maria Gonzalves	Sr. Exective Sales Deputy Mgr HR Manager CSR Sr. Manager CSR	kaustav.chakraborty@cgl.co.in
15/5/08	US Embassy	Mr. A. Sukesh	Advisor, Labour & Political American Embassy	sukesha2@state.gov
	Union OfficeHind Mazdoor Sabha	Mr. R.A Mittal,	Secretary, Hind Mazdoor Sabha (HMS	

	(HMS			
	Ministry of Labour and Employment	Mr. Vikas, Indrani Gupli HK Mathur	Director Under Secretary Under Secretary	0237-11120
16/5/08	Indian Network of People Living with HIV (INP+	Ms. Celina D'Costa,	National Advocacy Officer Indian Network of People Living with HIV (INP+	celina@inpplus.net
	NACO office	Mr. Mayank Agarwal, Hari Mohan	Joint Director, IEC, National AIDS Control Organization (NACO), officials Team Leader-mainstreaming Cell	04-358-3241
	ILO Office-Phone Conference	Sanjay Chaganti,	Programme Director, PSI	

CAMBODIA			
Date and Time	Name	Organization and position &/or Type of Stakeholder	Contact Detail
4/3/08	Tony Lisle	UNAIDS-Cambodia Country Coordinator	Bangkok
(Two meetings)	Eric Carlson	Technical Specialist on HIV/AIDS in the World of work	calrson@ilo.org
4/26/08 ILO/JPO Office, Phnom Penh Center Building, Phnom Penh	Ms. Chuong Por,	Former Programme Assistant, ILO/AIDS	porchuong@yahoo.com Tel: 012 844 575
Department of Occupational Safety and Health Office: No. 482, National Road No. 2, Chak Angre, Khan Mean Chey, Phnom Penh.	Dr. Leng Tong and Dr. Yi Kannitha,	, Director of Department of Occupational Safety and Health (DoOSH), Ministry of Labor and Vocational Training (MOLVT), Deputy Director of Department of Occupational Safety and Health (DOOSH), Ministry of Labor and Vocational Training (MOLVT), and former focal point of the ILO/AIDS project with MOLVT	lengtong@online.com.kh Tel: 017 377 377 and kannithaosh@yahoo.com Tel: 012 25 89 89
House No. 255, Corner Mao Tse Tung Blvd and	- Ms. Chi Socheat	Programme Coordinator, CARE International	socheat.chi@care-cambodia.org

CAMBODIA			
Date and Time	Name	Organization and position &/or Type of Stakeholder	Contact Detail
Street 63, Chamcar Morn, Phnom Penh			Tel: 012 576 364
4/27/08 Address: CPN+ Office: House No. 99, Street 608, Sangkat Boeung Kak II, Khan Tuol Kork, Phnom Penh, Cambodia.	- Mr. Heng Sok Rithy, - Ms. Leap Srey Luch,	Coordinator, Cambodian People Living with HIV/AIDS Network (CPN+) Programme Manager, CPN+	sokrithy@cpn.org.kh Tel: 011 816 671 sreyluch@cpn.org.kh Tel: 016 865 032
CCAWDU Office: House 6c, Street 476, Sangkat Tuol Tumpoung 1, Khan Chamcar Morn, Phnom Penh,	- Mr. Ath Thorn,) Mr. Sok Thol, -Ms. Heng Chenda,	President of Cambodian Labor Confideration (CLC) Educator of CLC Educator (Master trainers)	clc.cambodia@online.com.kh Tel: 012 998 906 Secretary: 012 993 455
Cambodiana Hotel	- Ms. Mom Bunthy	Nurse, represents the member of HIV/AIDS Committee and peer educators of the hotel (peer educator)	Email: Tel: 012 360 453 Tel: 012 906 899

CAMBODIA			
Date and Time	Name	Organization and position &/or Type of Stakeholder	Contact Detail
	Mr. Teh Sing	Vice President of Cambodian Federation of Employers and Business Association (CAMFEBA)	Email: singteh@gmail.com Tel: 016 399 900 Secretary: 012 772 471
CCTU office: House #263, Street 107, Sangkat Boeung Prolit, 7 Makara, Phnom Penh, Cambodia.	Mr. Soy Sam On Mr. Soy Seyha Mr. Sophea	Secretary General CCTU (Union) Union educator,peer educator Union educator,peer educator	Email: cctu@online.com.kh Tel: 012 785 890 Office: 023 221 124
CLUF Trade Union Office	Mr. Chay Sophea	CLUF Union educator, former peer educator with Yangtzekiang Garment Manufacturers Co. Ltd (compnay out of business)	
UNAIDS Office: House No. 221, Street Pasteur, Chamcar Morn, Phnom	Mr. Pasi Rajender	UNAIDS-Social mobilization and partnership specialist	lislet@unaids.org Tel: 012 990 645

CAMBODIA			
Date and Time	Name	Organization and position &/or Type of Stakeholder	Contact Detail
Penh, Cambodia.			Tel: 012 300 961
M inistry of Labor and Vocational Training Office: No.3, Russian Blvd, Sangkat Teuk La Ak 2, Tuol Kork, Phnom Penh.	H.E. Dr. Huy Han Song,,	Under Secretary of States, Ministry of Labor and Vocational Training (MOLVT), former chair of the Project Advisory Board (PAB) of the ILO/AIDS project	huyhansong@yahoo. com Tel: 023 884 375 Fax: 023 884 376 Mobile: 012 552 448
4/29/08 Address: NACC Office: Phum Teuk Thla, Khum Teuk Thla, Khan Russei Keo, Phnom Penh	Mr. Va Chan Kosal	Peer educator of former YGM Cambodia Co. Ltd (one of the targeted factory that the project worked with	Tel: 016 783 823
FHI Office	Ms. Caroline A. Francis	Associate Director, Family Health International (FHI International)	Tel: 012 804 292
NAA Office: Kampuchea Krom Blvd, Phnom Penh	H.E. Dr. Teng Kunthy, Secretary General Dr. Hor Bunleng	National AIDS Authority (NA)A) Deputy Secretary General	Tel: 012 456 956 kunthy@naa.org.kh svitou@naa.org.kh
4/30/08 GMAC Office: House #175, Street 215, Phnom Penh, Cambodia.	Mr. Ly Tek Hen,	Manager of Garment Manufacturing Association of Cambodia (GMAC)	tekheng.gmac@onlin e.com.kh Tel: 012 889 110 Office: 023 331 183
Angkor Palace Resort and Spa Hotel: House. 555, Road to the	Mr. Ly Moeng,	Former focal point of the hotel, Angkor Palace Resort & Spa	Email: moengly@yahoo.com

CAMBODIA			
Date and Time	Name	Organization and position &/or Type of Stakeholder	Contact Detail
airport, Siem Reap province.	Mr. Phan Sokha, Mr. Samreth Phao Mr. Long Pheakday Mr. Sophat Lim Mr. Prak Kimly	Focal point of the hotel, City Angkor Hotel, master educator Peer educators	Tel: 012 836 101 sokha_sr@yahoo.com Tel: 012 823 256
Sofitel Hotel	Ms. Esther Khin Aye Mu	Focal point of the hotel. Sofitel Phokeethra Angkor Golf and Spa Resorts	Email: Human-Resources@Sofitel-Royal-Angkor.com Tel: 092 619 885
4/31/008 CCTUF Office	Informal Economy in Siem Reap Ms. Ken Chheng Lang Mr. Van Thol, President of CCTUF Phat Phort, Prak Samnang Soun Rang Ray Chreb	Vice-President, Cambodian Construction Workers Trade Unions Federation (CCTUF) in Siem Reap, master trainer Staff and peer educators	Email: chhenglang_ken@yahoo.com Tel: 012 366 859
Victoria Angkor Resort	Mr. Mehran Chinniah Victoria Angkor	Focal point of the hotel	Email:

CAMBODIA			
Date and Time	Name	Organization and position &/or Type of Stakeholder	Contact Detail
& Spa	Resort & Spa		hrd.angkor@victoriahotels-asia.com Tel: 012 832 877

TERMS OF REFERENCE

Cross-Country Study of the ILO/USDOL

HIV/AIDS Workplace Education Program

Strategic HIV/AIDS Responses in Enterprises

February 2008

Cooperative Agreement Number:	
Financing Agency:	USDOL
Type of Evaluation:	
Date and Duration of Field Work:	
Preparation Date of TOR:	February 2008
Total Project Funds from USDOL Based on Cooperative Agreement:	US $25,250,897
Vendor for Evaluation Contract:	**MACRO INTERNATIONAL, INC.** 11785 Beltsville Drive Calverton, MD 20705 Tel: (301) 572-0200 Fax: (301) 572-0999

I.   I.   BACKGROUND

In 2001, the International Labor Organization entered into a cooperative agreement with the U.S. Department of Labor to develop HIV/AIDS workplace education and prevention pilot programs, the Strategic HIV/AIDS Responses in Enterprises (SHARE).

The ILO had launched its first program in 2,000, in India, with USDOL funding amounting to $413,116. Since then, the Department of Labor has awarded a total of US$ 25,250,897 in funding to the ILO to implement its SHARE program worldwide. By the end of 2007, SHARE programs were operating in 24 countries working with over 600 enterprises and reaching approximately 700,000 workers.

II.   II.   ILO/USDOL PROGRAM STRATEGY

The SHARE strategy emphasizes social *dialogue,* embracing protection of workers' rights as well as enterprise competitiveness. It is anchored in the ILO's tripartite approach (government, employers, and workers) and draws upon the ILO *Code of Practice on HIV/AIDS and the World of Work.* In the SHARE program strategic framework (see Annex I), the active participation of the three levels of stakeholders is crucial in project implementation and vital for the program's achievement of the following two overarching development objectives:

1) Reduced HIV/AIDS Risk Behaviors of Targeted Workers and Families; and
2) Reduced level of Employment-related Discrimination against Persons Living with HIV/AIDS.

The development objectives were to be accomplished by pursuing four immediate objectives:

1. Improved knowledge and attitudes related to HIV/AIDS risk behaviors
2. Increased awareness and use of available HIV/AIDS workplace services
3. Reduced stigma against persons living with HIV/AIDS
4. Increased knowledge of HIV/AIDS workplace policy /guidelines

These immediate objectives are supported by the following sub-immediate objectives:

1. Increased availability of quality HIV/AIDS-Workplace services
2. Improved HIV/AIDS workplace policies.
3. Increased levels of workplace collaboration and commitment by labor and management
4. Increased capacity of workplace to offer comprehensive HIV/AIDS policy and programs on a sustained basis
5. Improved coordination and cooperation between tripartite constituents and other partners at the national level
6. Improved national level policy framework related to HIV/AIDS at the workplace
7. Increased capacity of tripartite constituents to support development of workplace policy and programs

The strategy builds on the comparative advantages of the ILO's networks, experiences and materials, including the *ILO's Code of Practice on HIV/AIDS and the World of Work* with its *Education and Training Manual* as well as the *ILO/FHI Behaviour Change Communication Tool-kit*.

The strategic framework is complemented with a built-in Performance Monitoring Plan, which has been developed, by the ILO and USDOL in collaboration with Management Systems International (MSI). The PMP which is adapted to each national context, measures the impact of the project at the:

- Individual (workers) level,
- Workplace (enterprise) level, and
- The national level

III. III. IMPLEMENTATION ARRANGEMENTS

IV. In Geneva

The ILO has established a separate team responsible for the unified management of the ILO / USDOL cooperative agreements concerning the SHARE programme. The SHARE Programme Management Team (PMT) is based in Geneva has been involved in every step of the way from project design to implementation, monitoring and evaluation. The PMT operates autonomously within the ILO's Global Programme on HIV/AIDS and the world of work (ILO/AIDS). It has formulated guidelines for every aspect of project implementation (as outlined below) and provides technical, administrative and financial backstopping to the National Project Coordinators (NPCs) on a continuous basis in close collaboration with the ILO Field Offices.

In addition, an on-line management and communication tool '**Community Zero'** has been introduced to link the PMT with all NPCs via Internet. This on-line community has a key feature, which allows continuous monitoring of project activities in each country according to the workplan. It also includes a common archive system, which allows the sharing of documents, calendars and images. This system also allows the NPCs to be in closer contact with each other, as well as with the network of ILO/AIDS Focal Points in their regions.

V. In the Field

SHARE projects follow a step-by-step implementation plan towards the achievement of the stated objectives as follows:

- Setting up the Infrastructure
  - o National Project Coordinator/Project Implementation Unit
  - o Project Advisory Board

- Getting started
  - Mapping exercise
  - Official launch/Stakeholders Meeting
  - Sensitization workshops
  - Selection of target sectors

- Building national capacity
  - Working with the Ministry of Labour
  - Working with the National AIDS Commissions
  - Working with the employers' organizations
  - Working with the employers' organizations
  - Working with NGOs/CBOs
  - Identifying and setting up a panel of national consultants/trainers

- Moving into the workplace
  - Identifying partner enterprises
  - Signing memoranda of cooperation
  - Setting up enterprise-level HIV/AIDS committees
  - Establishing and training enterprise Focal Points

- Implementing enterprise programmes
  - Conducting baseline surveys
  - Developing policy
  - Developing sectoral BCC strategies
  - Developing enterprise-level BCC programmes
    - Material development
    - Implementation
    - Peer education
    - Condom distribution
  - Establishing referral arrangements for VCT, PMTCT and treatment, care and support

- Working with the informal economy
  - Identifying a group of target workers
  - Finding partners
  - Building a strategy
  - Implementing a programme

- Monitoring, reporting and evaluation
  - Data tracking and reporting
  - Technical Progress Reports
  - Mid-term evaluations

- o Impact surveys and reporting
- o Identification and documentation of case studies of good practice
- o Final evaluations

- Sustainability
  - o Ensuring a multi-sectoral approach
  - o Maintaining a focus on national ownership
  - o Retaining a focus on policy and tripartite collaboration to overcome discrimination
  - o Securing anchors into national programmes
  - o Maintaining a knowledge hub: Ensuring access to expertise and technology
  - o Ensuring support to enterprises
  - o Identifying and linking with community-based services
  - o Networking
  - o Building Public-Private Partnerships
  - o Forging close relations with the media
  - o Local resource mobilization

VI.   IV.   SCOPE OF THE STUDY

A. Justification and Purpose of the Cross-Cutting Study

The SHARE projects have utilized a generic strategic framework, capitalized on the networks and strengths of the ILO, put into operations a similar methodology and utilized common tools, while being linked through an internet-based learning community. They have generated a wealth of information in terms of baseline and impact surveys, regular progress reports, mid-term and final evaluation reports, case studies of good practice, etc. As a result they provide an excellent opportunity to:

- Review the appropriateness and effectiveness of the strategy of the SHARE programme,
- Trace and assess the implementations steps,
- Examine the national tripartite (government, employers and workers) guidance, support and ownership,
- Analyze the value of the key tools used (the *ILO Code of practice on HIV/AIDS in the world of work,* the toolkit on Behaviour Change Communications and the PMP),
- Evaluate enterprise-level programmes as well as those targeted at the informal economy,
- Assess the sustainability plans,
- Highlight the key findings from the impact surveys together with the lessons learned, and
- Determine the degree of transferability and potential for adaptation and utilization in other countries.

The purpose of the study would thus be a compilation of lessons learned from what, in fact, represents a groundbreaking pilot initiative for both the ILO and USDOL in exploring ways and

means of addressing HIV/AIDS in the world of work. The emphasis would be on learning and identifying what elements have worked and which have under-performed and why. The aim would be to assist USDOL and other government agencies as well as the ILO and other international and national organizations to improve workplace programs and programming decisions and to shape the design of future programs.

B. Target Countries

The following target countries were selected based on availability of sufficient data, global geographic dispersion and prevalence rates (both low and high) in the target countries: Barbados, Benin, Botswana, Cambodia, and India.

C. Study Design

The evaluation team will consist of a lead evaluator and co-evaluator. The study will be done through a combination of a desk review of existing documentation; interviews with PMT members, NPCs and other relevant stakeholders; and site visits by the international co-evaluators.

The study should address the questions contained in Annex I in its analysis.

Conclusions should be supported by investigating the implementation of the project in the target countries on the basis of the key elements and steps outlined in section III.

To develop insight into the questions contained in Annex I, the analysis should consider each of the following project elements:

1. The strategic framework and its performance monitoring plan.
2. The generic project design.
3. The implementation arrangements.
4. Technical and administrative backstopping and information-sharing arrangements.
5. Progress made in influencing the overall legislative and policy framework.
6. Capacity established highlighting access to technical expertise, training capability, information, tools and resource material.
7. Enterprise-level programs as stated in section III.
8. Action in the informal economy as stated in section III.
9. The sustainability plans.
10 Based on the above provide a comparative analysis and identify:
    10.1   Components which have worked and those that have under-performed and why.
    10.2   Strengths and weaknesses both in design and in implementation.
    10.3   External factors and unforeseen developments, which have affected project delivery.
    10.4   Obstacles and action taken and innovations introduced to overcome them.
    10.5   Specific cases of good practice that would lend themselves to replication.

10.6   The cost-effectiveness of the program based on the overall external budget, national inputs and duration, the capacity established and the number of enterprises and workers reached.

The final report conclusions should provide an assessment of the following questions:

- Effectiveness: To what extent has the project achieved its objectives and reached its target group(s)?
- Efficiency: Did the results justify the costs incurred?
- Relevance: Does the project continue to make sense?
- Validity of design: Is the design logical and coherent? Is the hypothesis valid?
- Causality: What specific factors or events have affected the project results?
- Unanticipated outcomes: Did the project result in any significant effects or outcomes that were not foreseen?
- Alternative strategies: Is there, or would there have been, a more effective way to address the problem(s) and achieve the objective(s)?
- Sustainability: What is the likelihood that project benefits will be sustained after the withdrawal of external support? Can the project and its activities be adopted by governments or alternatively by enterprises and be implemented at national scale?

The report should also highlight lessons learned, and formulate a set of recommendations across the continuum of design-implementation-evaluation to be considered for future programming.

D. Level of Effort

Timetable and Workplan. The total duration of the evaluation process including submission of the final reports should be 75 days. The tentative timetable is as follows:

LEAD EVALUATOR – AFRICA – Lou Witherite		
Tasks	**# of Paid Days**	**Dates**
Desk Review of Project Materials and Interviews with DOL/ILO staff	15	May 2008
Field work and travel (assumes 6-day work week and includes 1 day rest per week)	25	May – June 2008
Incorporate Co-evaluators' Findings and Draft report	25	Due to Macro: 8/1/08 Due to USDOL: 8/4/08

Full comments due	NA	8/15/08
Finalization of Document	10	Due to Macro: 8/29/08 Due to DOL and ILO: 9/4/08
Total Work Days	**75**	

CO-EVALUATOR – CAMBODIA AND INDIA – Mei Zegers		
Tasks	**# of Days**	**Dates**
Desk Review of Project Materials	5	May 08
Field work and travel (assumes 6-day work week and includes 1 day rest per week)	20	May – June 2008
Draft Findings and Deliver to Lead Evaluator	15	Due to Lead: 7/8/08
Address Evaluator/DOL Comments	2	TBD
Total Work Days	**42**	

E. Evaluation Methodology and Timeframe

Time Frame and Site Locations. Field data collection the project will take place in Barbados, Benin, Botswana, Cambodia, and India from April to June 2008. Report writing and revisions must be complete by September 30, 2008.

Washington Briefing: Will commence on April 17 and end on April 17, 2008.

Geneva Briefing: Will commence on April 28 and end on April 30, 2008.

Botswana: Field work will commence on May 1 and end on May 9, 2008. Sites are mainly in or around Gabarone. Jeffrey Makgola, ILO project staff will assist with ground arrangements.

Barbados: Lead evaluator, Lou Witherite will attend the ILO training workshop in Barbados from May 15 – 20, 2008.

Benin: Field work will commence on June 23 and end on June 29. Sites are mainly in or around Cotonou..

India: Field work will commence on May 3 and end on May 17, 2008. Sites are mainly in or around Delhi and Mumbai.

Cambodia: Field work will commence on May 25 and end on May 31, 2008. Sites are mainly in or around Phnom Penh.

Field Work Logistics. For the purposes of travel coordination, the evaluator will be escorted by the project car (where available). It is requested that as much as possible, project staff will not take part or be visible to beneficiaries or stakeholders during the meetings, interviews, and focus group discussions. It may be necessary to have a recorder available for some of the focus group discussions [if included], but this will be coordinated with the project directors with sensitivity to the issue of confidentiality.

To guarantee confidentiality of sources and information, and to maintain objectivity in the evaluation process, it is requested by USDOL that any staff member who accompanies the evaluator is part of the field staff and not the project director or other senior member of the organization, as her/his presence may influence the outcome of the meetings.

F. Expected Outputs/Deliverables

The Evaluator will submit to the ILO and TAATC a cross-country study **report** that incorporates the results of the tasks outlined above in the format prescribed by ILAB/TAATC, which includes at minimum the following sections:

   a. Table of Contents
   b. Executive Summary, providing an overview of the evaluation and summary of main findings and recommendations
   c. List of Acronyms
   d. Evaluation Objectives
   e. Methodology of Evaluation
   f. Findings
   g. Lessons Learned and Good Practices
   h. Conclusions
   i. Recommendations
   j. Annexes, including list of interviews/meetings, site visits, documents reviewed,

meeting agendas and participants, TOR, cross-referenced list of the TOR questions and pages addressed in the report, etc.

The total length of the reports should be a maximum of **##** pages for the main reports, excluding annexes. The organizational format for the presentation of findings, lessons learned, conclusions, recommendations etc. is at the discretion of the evaluator.

The first draft of the reports will be circulated to key stakeholders for their review. Comments from stakeholders will be consolidated and incorporated into the final reports as appropriate.

While the substantive content of the findings, conclusions, and recommendations of the reports shall be determined by the Evaluator, the reports are subject to final approval by the ILO and ILAB/TAATC in terms of whether or not the reports meet the conditions of the TOR. **First drafts are due to MACRO no later than July 31, 2008 and to be shared with USDOL and the ILO. Final drafts are due to Macro no later than 10 working days after receipt of comments from the ILO and ILAB/TAATC. All reports, including drafts, will be written in English.**

G. Inputs

MACRO INTERNATIONAL, INC. will provide all logistical and administrative support for their staff and sub-contractors, including travel arrangements (*e.g.,* plane and hotel reservations, visas, purchasing plane tickets, providing *per diem*) and all materials (*e.g.,* access to computers, telecommunications, office supplies) needed to provide all deliverables. MACRO will also be responsible for providing the management and technical oversight necessary to ensure consistency of methods and technical standards.