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IMPLEMENTING THE UN LEARNING STRATEGY ON HIV/AIDS:

Ten Case Studies

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ABBREVIATIONS, ACRONYMS and TERMS

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

Executive Summary

In April 2003, the Committee of Cosponsoring Organizations of the Joint United Nations Programme on HIV/AIDS (UNAIDS) approved a Learning Strategy to help UN system staff develop competence on HIV and AIDS. The goals of the Learning Strategy are:

- to develop the knowledge and competence of the UN and its staff so that they are able to best support national responses to HIV and AIDS; and
- to ensure that all UN staff members are able to make informed decisions to protect themselves from HIV and, if they are infected or affected by HIV, to ensure that they know where to turn for the best possible care and treatment. This includes ensuring that staff members fully understand the UN's HIV and AIDS workplace policies and how they are implemented.

To support UN Country Teams in implementing the Learning Strategy, learning facilitators were selected at country level. The learning facilitators are expected to ensure—along with the country teams—that the standards of the Learning Strategy are realized. This report is comprised of UN HIV/AIDS Learning Strategy case studies from ten countries, representing each country's unique experience in implementing the strategy. From the case studies, lessons have been drawn and 12 recommendations are made:

1. For the Learning Strategy to succeed and flourish, support and commitment from senior management is absolutely necessary. Global, regional and country-level UN senior leaders and managers should clearly demonstrate their commitment and support for its implementation.
2. Almost all countries reporting success emphasized the importance of having an interagency Learning Team to plan, manage and monitor implementation of learning activities. All UN Country Teams should establish and give ongoing support to an interagency team to ensure implementation. This should be built into the terms of reference for Joint UN Teams on AIDS or a sub-team of the Joint UN Teams on AIDS.
3. Assigning focal persons for Learning Strategy implementation is essential. All UN agencies, funds and programmes should appoint a focal point to give ongoing support to implementation. This should be built into the job descriptions for the selected focal points and included in performance evaluations. In larger countries, a dedicated interagency person should be considered to coordinate Learning Strategy implementation.
4. Different countries had different experiences with funding, but the common factor is that adequate funding was available for successful implementation and scaling-up of the Learning Strategy. Interagency sources should be discussed in UN Theme Groups and the Joint UN Teams on AIDS. Adequate resources must be allocated to implement the planned activities from the Learning Team.
5. Conducting a needs assessment will illustrate the current situation and identify specific areas to target. It is also a means to garner support of the UN system to move forward to support HIV and AIDS learning activities and a

means against which to measure progress. Learning needs assessments should be undertaken in all countries where this has not taken place. Learning needs assessments should be considered both for HIV and AIDS in the UN workplace as well as for professional officers working on programmes to support national responses to HIV and AIDS.

6. Taking into account the internal constraints and limitations on staff time, resources and expertise, a number of countries formed external partnerships, and the joint effort yielded highly positive results. Partnerships also provide opportunities to strengthen the principles of Greater Involvement of People Living with and affected by HIV and AIDS. UN country teams should explore external partnerships to implement learning activities for UN employees, including links to government, nongovernmental organizations, universities and people living with HIV.
7. It is highly critical to take into account the local context, and adapt learning programmes to fit accordingly. Learning Teams should adapt learning content and approaches to the local environment, including use of local languages as needed.
8. It is essential to ensure that commodities and services are linked to workplace-related learning. Country teams should ensure that male and female condoms are available and that staff members have access to essential services including voluntary confidential counselling and treatment.
9. Certain countries experienced logistical and administrative difficulties that seriously hindered implementation of the programmes. In moving forward, logistical issues need to be thoroughly addressed to avoid delays and roadblocks. In planning for Learning Strategy implementation, Learning Teams should pay particular attention to designing robust logistical systems.
10. Positive advocacy is necessary, but learning activities may need to be made mandatory for maximum participation. UN country teams should explore making participation in HIV- and AIDS-learning activities mandatory and making the work of Learning Team members and resource persons part of ongoing job responsibilities.
11. So far, almost all countries have been focused on learning related to HIV and AIDS in the UN workplace. Less progress has been made overall in trying to implement the national responses aspect of the Learning Strategy. Learning Teams should ensure that learning plans include both components of the Learning Strategy. Joint UN Teams on AIDS should be key partners in such learning.
12. In ways forward, many countries expressed concerns over sustainability of the programme—mainly its capacity, responsibility and logistical issues. Planning for HIV- and AIDS-related learning should be part of the ongoing responsibility of UN Country Teams, Joint UN Teams on AIDS and Learning Teams.

The lessons learnt and recommendations should be widely discussed at global, regional and country levels with senior leaders and managers, including Heads of Agencies, Human Resource Directors and learning departments in the UN system. As noted in the Zimbabwe case study, "Much has been done, much has been learned, but there is also so much more that is still needed."

Introduction

AIDS is the gravest global pandemic of our time. It has already claimed over 20 million lives, with another 39 million individuals currently estimated to be living with HIV worldwide, and millions more becoming newly infected each year. The epidemic is reversing gains in development that took decades to achieve, and is considered a threat to the economic well-being and social and political stability of many nations.

Fortunately much has been learned in the past two decades. HIV is preventable, and medication now exists for the treatment and care of those living with HIV.

The United Nations has, and continues to play, an active role in addressing HIV and AIDS in all regards ranging from leadership and advocacy to partnership development, resource mobilization and supporting programme implementation.

In April 2003, the Committee of Cosponsoring Organizations of the Joint United Nations Programme on HIV/AIDS (UNAIDS) approved a Learning Strategy to help UN system staff develop competence on HIV and AIDS. It represents an effort to implement Action 33 of the Secretary-General's report on *Strengthening of the United Nations'* by ensuring the organization's policy on HIV and AIDS is fully implemented and disseminated among employees.

The goals of the Learning Strategy are:

- to develop the knowledge and competence of the UN and its staff so that they are able to best support national responses to HIV and AIDS; and
- to ensure that all UN staff members are able to make informed decisions to protect themselves from HIV and, if they are infected or affected by HIV, to ensure that they know where to turn for the best possible care and treatment. This includes ensuring that staff members fully understand the UN's HIV and AIDS workplace policies and how they are implemented.

In his November 2003 memo to the Resident Coordinators and Heads of Offices at country level,[1] the Chair of the UN Development Group set out among country priorities the following:

> The UN Country Team is expected to implement the Learning Strategy on HIV/AIDS. This includes learning related to HIV and AIDS in the UN workplace, as well as ensuring that professional staff are competent to implement initiatives related to supporting national responses to HIV and AIDS.

Essentially, the strategy promotes learning approaches that contribute to building a UN that is knowledgeable and competent to:

- help prevent and control the spread of HIV;
- ensure effective care, support and treatment for those infected or affected by HIV and AIDS;

[1] *Operationalizing a Strengthened United Nations System Response to HIV/AIDS at Country Level*, 19 November 2003.

- eliminate stigma and discrimination against those infected and affected by HIV and AIDS; and
- mitigate the impact of the epidemic.

In supporting national responses to HIV and AIDS, the UN must make sure that its professional staff are well prepared to work together to support the most effective responses, in collaboration with partners in governments, nongovernmental organizations, civil society, donors and, importantly, within the UN family.

Addressing HIV and AIDS as UN workplace issues represents an opportunity to foster effective learning to ensure that all UN staff members experience a supportive and compassionate work environment, free of fear and discrimination. Learning efforts must ensure that staff members fully understand the UN's HIV and AIDS workplace policies[2] and how they are implemented. A survey conducted in 77 countries and three headquarter duty stations in 2002 revealed that a notable number of UN employees did not know what HIV was and how it could be prevented, and did not know the UN personnel policies on HIV and AIDS in the workplace.

To support UN country teams in implementing the Learning Strategy, learning facilitators were selected at country level and trained in a series of regional workshops. The learning facilitators were then expected to ensure—along with the country teams—that the standards of the Learning Strategy were realized. Approximately 250 such facilitators are working across all regions.

This report is comprised of UN HIV/AIDS Learning Strategy case studies from ten countries: Bolivia, Cambodia, Ecuador, Egypt, Georgia, Kenya, Lebanon, New York (United States), Philippines and Zimbabwe. It presents each country's unique experience in implementing the strategy since its adoption in 2003.

In the next chapter, we highlight important overall lessons learnt, including brief examples of the success stories as well as the challenges. Recommendations based on the lessons learnt are also noted. Details of the individual case studies appear in subsequent chapters.

The lessons learnt and recommendations should be widely discussed at global, regional and country levels with senior leaders and managers, including Heads of Agencies, Human Resource Directors and learning departments in the UN system. As noted in the Zimbabwe case study, "Much has been done, much has been learned, but there is also so much more that is still needed."

[2] See the UN System Personnel Policy on HIV/AIDS, adopted by all Executive Heads of UN organizations in 1991.

HIV and AIDS Learning Strategy: Lessons Learnt and Recommendations

1. Commitment, support and leadership from senior management are critical.

RECOMMENDATION

Global, regional and country-level UN senior leaders and managers should clearly demonstrate their commitment and support for Learning Strategy implementation.

For the Learning Strategy to succeed and flourish, support and commitment from senior management is absolutely necessary. Many countries reported remarkable leadership from the senior staff, and their activities and implementation in turn gained considerable momentum.

In New York, the involvement of senior UN leaders and active advocacy as part of the communications strategy placed the HIV and AIDS orientation sessions in the UN workplace in the limelight. There was tremendous support from the top-level, including the Secretary General and Heads of Agencies, validated by their personal attendance at orientation sessions. Several senior level managers repeatedly sent messages to staff asking them to participate. Most agency heads eventually made attendance mandatory, asking that staff attendance be noted in the annual performance appraisal.

Egypt has a committed Resident Coordinator and HIV/AIDS Theme Group Chair who supported and enabled the planning and implementation of the Learning Strategy. Furthermore, support from those agency heads who were on-board made a difference in their agency participation, especially if they were willing to make attendance mandatory.

The role of the UN Resident Coordinator and UN Heads of Agencies was noted as critical for the successful advocacy and implementation of the Learning Strategy in Georgia.

In contrast, in Bolivia the learning facilitators reported challenges in gaining full support for the Learning Strategy from senior management in some agencies, and low levels of participation in workplace activities. Because Bolivia is a low prevalence country, the learning facilitators often found it difficult to motivate people without this support since many staff members do not perceive HIV as affecting them.

In the Philippines, agency heads met every quarter, and were responsible for approving the UN Workplace programme on HIV and AIDS. That said, Philippines also reported difficulties maximizing the support of some agency heads. While they repeatedly expressed their support for the programme, when letters were sent asking them to endorse the sessions to their staff, not all did.

2. Having a committed and functional interagency Learning Team is key.

RECOMMENDATION

All UN Country Teams should establish and give ongoing support to an interagency team to ensure Learning Strategy implementation. This should be built into the terms of reference for Joint UN Teams on AIDS or a sub-team of the Joint UN Team on AIDS.

Almost all countries reporting success emphasized the importance of having an interagency Learning Team to plan, manage and monitor implementation of learning activities. The Learning Team function was sometimes part of a team with wider responsibilities, such as a Technical Working Group or a workplace taskforce, but Learning Strategy implementation was emphasized as a key result.

Lebanon has a committed Resident Coordinator, Country Team and Theme Group—all of whom supported and enabled the planning and implementation of the Learning Strategy. They provided the human and financial resources needed for implementation of the orientation sessions. The consistent reporting of the Learning Team to the Theme Group and Country Team maintained support for implementation. This support, in turn, continued to motivate the Learning Team's efforts.

For Kenya, having a committed and well-supported interagency Learning Team was key to the country's successful experience. The Learning Team was responsible for coordinating the major implementation, monitoring and evaluation of the learning sessions. The collaboration of this dedicated group of UN staff members was necessary to meet the ambitious learning plans.

In Ecuador, the level of cooperation of the interagency team largely determined the success of the overall programme. A large majority of staff members were trained, due to the work of the Learning Team. Each member was able to mobilize his or her agency to implement the sessions, and members of the Learning Team also served as the main trainers.

New York's interagency team brought together the various UN bodies in the headquarters' duty station for the first time for such a learning project. The team met regularly and found ways to pool resources, share responsibilities and plan flexibly.

Georgia's Learning Team was under the overall coordination of the UN Resident Coordinator, the Theme Group and the learning facilitator. Terms of Reference included elaborating a framework, planning, implementing, monitoring and evaluating a learning programme; and developing a management system and terms of accountability for implementation.

In contrast, the Task Force formed in the Philippines with the mandate to assist the Theme Group to operationalize the Learning Strategy has ceased to meet despite efforts to orient and pique the interest of the agency focal points. The Learning Strategy continues to face a number of challenges in this country, many as a result of numerous changes in the Learning Team membership.

3. Having focal points to ensure planning, motivation, implementation and follow-up is essential.

RECOMMENDATION

All UN agencies, funds and programmes should appoint a focal point to give ongoing support to Learning Strategy implementation. This should be built into the job descriptions for the selected focal points and included in performance evaluations. In larger countries, a dedicated interagency person should be considered to coordinate Learning Strategy implementation.

Assigning focal persons for Learning Strategy implementation is essential. Hiring a dedicated coordinator—that is, an individual with a full-time allotment to follow up on learning responsibilities—in larger countries should be considered.

Zimbabwe used the focal persons approach to ensure interagency harmonization. The 'UN Cares' team is comprised of Human Resources focal persons at agency level, medical personnel and operations managers, ensuring a mix of technical and management competencies to mobilize and advise the process. The learning facilitators in this team played a key role in driving the process. Learning Strategy agency-based focal persons and peer counsellors were also responsible for circulating training and post-session follow-up messages and information on-service provision to all staff.

Employment of a full-time professional coordinator has been vital to Kenya's effective implementation of the training programme. The training coordinator's contract is almost up and the Learning Team is advocating for a renewal of this position. Similarly in New York, the programme could not have been implemented without the coordinator working full time.

In Cambodia, the logistical arrangements of each training session were coordinated with the HIV and AIDS focal person for the agency. This was problematic within agencies that did not have a focal person. Additionally, agencies that have their own HIV programmes have had to coordinate their initiatives so as to not create an overlap of activities.

One of Ecuador's main recommendations for continuing and scaling up the Learning Strategy is to appoint a person exclusively devoted to programme coordination, to ensure consistent and thorough implementation.

4. Having adequate budgets and funding allows implementation to proceed more readily.

RECOMMENDATION

Adequate funding must be budgeted and readily available. Interagency sources should be discussed in UN Theme Groups and the Joint UN Team on AIDS. Adequate resources must be allocated to implement the planned activities from the Learning Team.

Different countries had different experiences with funding, but the common factor is that adequate funding must be available for successful implementation and scaling-up of the Learning Strategy.

In Zimbabwe, the United Nations Development Programme (UNDP) and United Nations Children's Fund (UNICEF) made pre-financing available, which helped establish systems and encourage broader participation of UN agencies in the training programme as well as general health support for staff.

The learning facilitators in Bolivia found it difficult to obtain the necessary funding for successful implementation of the programme. While the Operations Management Team and the Resident Coordinator covered some costs, the Learning Team struggled to provide resources and were unable to bring in outside experts due to the lack of available funds.

In Kenya, budgetary issues caused logistical delays. It took two months longer than expected for the Country Team to endorse the budget, resulting in a two-month delay in the intended implementation plan. Once begun, however, the plan progressed without further delay.

Georgia found funds for fees for national consultants, translation and adaptation of the training curricula and logistical arrangements. In-kind donations from UN agencies allowed for cost-saving for equipment and with monitoring the implementation of the Learning Strategy.

New York agencies were able to pool resources which allowed for the hiring of a dedicated coordinator and to cover costs of logistics and materials.

5. Undertaking a needs assessment allows implementation to be based on real needs and adapted to local realities.

RECOMMENDATION

Learning needs assessments should be undertaken in all countries where this has not taken place. Learning needs assessments should be considered both for HIV and AIDS in the UN workplace as well as for professional officers working on programmes to support national responses to HIV and AIDS.

Conducting a needs assessment locally—or using the country results from the global learning needs survey—will illustrate the current situation and identify specific areas to target. It is also a means to garner support of the UN system to move forward to support HIV and AIDS learning activities and a means against which to measure progress.

In Egypt, the assessment provided revealing results on the need to increase knowledge and awareness. Thus, the Learning Team was able to mobilize and involve all UN staff.

In Lebanon, two needs assessments were developed: one for all staff to assess knowledge of UN policies and basic HIV and AIDS information and a second to

assess professional staff knowledge of components of the national response to HIV and AIDS. The results from these surveys were used to create agency-specific learning plans and to inform future learning activities. The needs assessment results enabled sessions to be tailored to specific needs.

The Kenyan needs assessment helped the Learning Strategy initiatives to be tailored to the requests of the staff for both general learning sessions and learning sessions for children and families.

While the Philippines participated in the global learning needs assessment in 2002, there was low participation. As a result, the Theme Group agreed that a second needs assessment be conducted. With management support, twice as many staff participated in the second round and the results are now used by each UN agency to develop its respective learning plan.

6. Strategic partnerships helped implementation of learning activities.

RECOMMENDATION

UN country teams should explore external partnerships to implement learning activities for UN employees, including links to government, nongovernmental organizations, universities and people living with HIV.

Taking into account the internal constraints and limitations on staff time, resources and expertise, a number of countries formed external partnerships, and the joint effort yielded highly positive results. Partnerships also provide opportunities to strengthen the principles of Greater Involvement of People Living with and affected by HIV and AIDS.

New York's recruitment of facilitators from within and outside the UN system was a tremendous success. Volunteer interns from Schools of Public Health ensured a high level of HIV and AIDS knowledge, and pairing up UN staff volunteers with non-UN staff for each session resulted in high quality sessions and allowed sharing of time and effort.

UN Lebanon did not have enough qualified trainers internally. To supplement their internal capacity, they asked for help from nongovernmental organizations to ensure implementation.

Georgia asked representatives of a local nongovernmental organization to assist in the implementation of orientation sessions on HIV and AIDS in the UN workplace.

Zimbabwe had a robust network of external partners, including Zimbabwean people living with HIV groups, local university students, Ministry of Health and Child Welfare, plus professional organizations and nongovernmental organizations. These partnerships support the important GIPA component and added real value through testimonies, local knowledge and technical skills as well as an understanding of local situations and practices.

7. Adapting learning to the local context ensures relevance and increases interest.

RECOMMENDATION

Learning Teams should adapt learning content and approaches to the local environment, including use of local languages as needed.

It is highly critical to take into account the local context, and adapt the programme to fit accordingly. In many countries, the discussions of HIV and AIDS, sexuality and condoms is much against the cultural norm, and extra sensitivities are necessary. That said, care should be taken to ensure that any adaptations do not compromise the need to provide full and accurate evidence-based information. Furthermore, incorporating the local language whenever possible in presentations and facilitations is vital for effectiveness. Holding sessions for specific groups, such as women or men only, parents and specific departments was noted as useful in some situations.

When the Cambodia Country Team had the UNAIDS booklet translated, they took advantage of the opportunity to tailor it to the Cambodian context, including insertion of information about locally available services and the UN Cambodia post-exposure prophylaxis protocol. This is an excellent approach to disseminating country-specific information to staff and their families in the language in which they are most comfortable. Participants reacted well to the use of Khmer during sessions; it was reported that the liveliest discussions were also conducted in Khmer. Cambodia also experienced particular success with their interagency peer educator model, where local peer educators were given the flexibility to creatively design activities that met the minimum learning requirements according to the specific needs of their staff. This led to condom promotion, question boxes, distribution of cassette tapes to drivers and other innovative ideas.

The Egypt Learning Team identified the need to adapt the condom component of the sessions and ease participants into it by normalizing condoms. Separate gender sessions and same gender facilitators for the condom demonstrations were found to be more effective. There was more *anticipated* negative reaction from participants than there was *actual* negative reaction. Once the participants got to the training they enjoyed the interaction. The female participants, especially, were more responsive and requested that sessions be extended to their children. Some internal UN cultural preferences also need to be addressed: for example, some agencies' management expressed a wish for trainers who were physicians or more senior in age.

National consultants were contracted in Georgia to adapt learning activities. This included translation and adaptation of key messages from the booklet *Living in a World with HIV and AIDS*; a review of materials produced globally, regionally and locally about the epidemic and adaptation of guidelines for the facilitation of HIV and AIDS learning activities; and development of a training curriculum in Georgian and English.

In New York, special sessions were organized to target specific groups of staff: staff with teenagers, women only, men only.

8. Linking workplace-related learning to the availability of commodities and services is essential.

RECOMMENDATION

Country teams should ensure that male and female condoms are available and that staff have access to essential services including VCCT and treatment.

It is essential to ensure that commodities and services are linked to workplace-related learning. Otherwise, staff may have information about what is needed, but no access to take advantage of acquired knowledge. Behavioural change will be less likely in such circumstances.

In Bolivia, a local AIDS service organization is being contracted to provide testing and counselling for staff. All UN personnel will receive a voucher for free, confidential HIV counselling and testing at the local centre. Condoms are also provided for staff.

Cambodia funded voluntary confidential counselling and testing and laboratory expenses requested by service providers for staff under their treatment plan. Antiretroviral drugs are provided for staff already receiving them, but about to end their contracts with the UN system.

Egypt had a parallel objective to the orientation sessions to ensure access to post-exposure prophylaxis kits.

Kenya's 3Cs programme covers voluntary counselling and testing and 100% of the costs of consultation, laboratory, medication and counselling for outpatient HIV treatment.

Lebanon distributed a card to remind staff about the availability of post-exposure prophylaxis kits and voluntary confidential counselling and testing in English and Arabic. UNFPA obtained female condoms which are not available in the country, whereas the National AIDS Control Programme provided male condoms.

Philippines set up information corners with resources on AIDS registries, voluntary confidential counselling and testing services, post-exposure prophylaxis. They ensure provision of supplies, such as condoms, antiretroviral drugs, syringes, and safe blood.

An early and key component of Zimbabwe response was general health care and HIV and AIDS treatment access and support. A credit and direct billing facility has been established with over 30 service providers such as hospitals, practitioners and laboratories. Staff can now access services more easily. The UN clinic is providing antiretroviral drugs and other medicines to UN staff 150% cheaper than local retail outlets saving the UN system money and ensuring their availability to staff.

9. Logistical bottlenecks can seriously compromise the Learning Strategy's success.

RECOMMENDATION

In planning for Learning Strategy implementation, Learning Teams should pay particular attention to designing robust logistical systems.

Certain countries experienced logistical and administrative difficulties that seriously hindered implementation of the programmes. In moving forward, logistical issues need to be thoroughly addressed—preferably in the early planning stages—to avoid delays and roadblocks.

In Egypt, getting enough booklets of *Living in a World with HIV and AIDS* on time in English and Arabic for the training sessions was a challenge. Logistical aspects were difficult to control because sessions were conducted in different agencies and the available space differed significantly. A key logistical challenge was condom provision, and with the sessions underway, the Learning Team decided it was now timely to provide condoms in the restrooms of the agencies. The Learning Team plans to recommend that the agencies fund the cost and provision of the condoms.

It took Lebanon a number of months to get enough copies of the booklet in the appropriate languages for all agencies. Some agencies were unable to get the requested copies through the appropriate channels. At the time of the orientation sessions, the booklet was not yet translated into Arabic. In addition, there were not enough post-exposure prophylaxis kits available in Lebanon, and the kits had to be ordered from agency medical clinics.

In New York, getting the online registration system working properly took extra time and resources, resulting in delays in rolling out the learning activities. That said, the New York Interagency Taskforce, along with the full-time coordinator, were able to develop an excellent if complex logistical system to ensure that staff in all agencies were able to attend sessions over a full year.

10. Positive advocacy is necessary, but learning activities may need to be made mandatory for maximum participation.

RECOMMENDATION

UN country teams should explore making participation in HIV- and AIDS-learning activities mandatory and making the work of Learning Team members and resource persons part of ongoing job responsibilities.

Many countries reported time constraints as a significant challenge, for the Learning Team members, facilitators as well as the learners. A key lesson here is that a large percentage of staff will only attend HIV and AIDS learning sessions if attendance is mandatory from the beginning and, to a greater degree, when enforced through mechanisms such as reporting on annual performance reports.

In Bolivia, the learning facilitators and the Learning Team found it challenging to balance the additional responsibilities of implementing the Learning Strategy along with the demands of their regular workload. Also, the workload of all UN staff occasionally interfered with staff participation in the workplace activities and workshops.

Similarly, in Cambodia, the peer educators accepted a voluntary role on top of their regular job responsibilities that was not included in their terms of reference, which raised time management issues.

Ecuador also reported the difficulty of Learning Team members juggling their own jobs and responsibilities with the additional HIV and AIDS learning activities. Because of other daily job responsibilities, cooperation of supervisors and differences between agencies, some UN agencies were more involved than others, due to understaffing and other logistical problems. The final numbers were at 60%, far short of the goal of including all staff, in spite of positive mechanisms to reinforce participation such as issuing certificates of attendance and distributing pins and t-shirts.

In New York, motivating many staff members to participate proved difficult. It was initially challenging for most agencies to subscribe to mandatory attendance and all UN agencies, except one, initially resisted this approach. When mandatory attendance and the need to add certificates of attendance to personnel files were agreed upon, participation rates rose significantly.

Egypt reported that getting staff to sign up and attend the sessions was not always easy. Some did not see HIV as an issue of importance in a low prevalence country, and perceived it as more of a global issue with priority from UN Headquarters. Others felt that the sessions required more time than they were willing to commit. Also, some staff members were based outside the capital, and were reluctant to travel for training sessions.

The Philippines is a low-prevalence setting, and they found it challenging to keep staff interest sustained. Some expressed “HIV and AIDS fatigue”, questioning why more sessions need to be implemented. Joint activities were planned for family members of UN staff, specifically on adolescent reproductive and sexual health, based on responses to a staff survey, but the sessions were cancelled, due to insufficient interest.

11. Learning related to supporting national responses as the next step.

RECOMMENDATION

Learning Teams should ensure that learning plans include both components of the Learning Strategy. In those countries in which the base of workplace-related learning is now in place, progressing in the work of building competence to support national responses should be stressed. Joint UN Teams on AIDS should be key partners in such learning. Country plans should already be made to make use of the CD-ROM for professional staff that is being developed at the global level, to be issued by end 2006.

So far, almost all countries have been focused on learning related to HIV and AIDS in the UN workplace. Less progress has been made overall in trying to implement the national responses aspect of the Learning Strategy. In moving forward, UN country teams will need to explore ways to expand activities to implement learning related to national response support.

Georgia piloted a session for UN professional staff facilitated by UNAIDS, the learning facilitator and consultants from the National AIDS Centre. Following the pilot, additional sessions were held with nearly 80% of professional staff, including agency heads participation.

The Learning Team in Bolivia is committed to focusing their upcoming efforts on the goal of the Learning Strategy to support a national response to HIV and AIDS. Responsibility for meeting this goal is to be shared with a UN staff member in charge of the secretariat of the Technical Working Group and Theme Group. The Learning Team has also received invitations to implement their HIV workshop in bilateral agencies and schools in La Paz, and the team is considering this possibility for the coming year.

Lebanon expressed concerns over addressing the national response goal of the Learning Strategy. A lack of interest by professional staff halted this aspect of Learning Strategy implementation. Focal points in the various agencies were unable to garner enough support to hold meetings as planned. Suggestions have been made to incorporate the national response into general learning sessions to meet the basic requirement of the Learning Strategy for this goal.

12. Sustainability is not automatic and must be planned for.

RECOMMENDATION

Planning for HIV- and AIDS-related learning should be part of the ongoing responsibility of UN country teams, Joint UN Teams on AIDS and Learning Teams.

In ways forward, many countries expressed concerns over sustainability of the programme—mainly its capacity, responsibility and logistical issues. Setting in place a sustainable learning system includes more than just orientation sessions on HIV

and AIDS in the UN workplace. It includes ongoing learning for professional staff as global and national priorities shift and as new ways to respond to the AIDS epidemic are discovered. It may include ensuring staff participation in events such as World AIDS Day and other local AIDS events. Continuing education and information sessions, distribution of supplemental material to enhance staff knowledge on HIV and AIDS, and discussion of related topics during staff meetings are needed. Maintaining a system for capacity-building of newly recruited staff beyond the initial efforts is important.

Zimbabwe reported that success and achievement are often linked with personal interest and drive at the individual or agency level. Often when individual staff members are on leave, mission or transfer, activities flounder or cease and sustainability becomes an issue. Workplace support on HIV and AIDS is generally not linked to performance appraisal and development plans or the outputs of senior management. Dedicated capacity (financial and material) would mean HIV and AIDS issues can be prioritized instead of 'fitted in'.

For the Philippines, the workplace programme has reached critical crossroads. The programme made progress between 2004 and 2005, including greater awareness of HIV and AIDS among staff. The mandate of the Learning Team has already expired, and the issue must now be raised to the UN Theme Group on whether to reconvene the Learning Team or to possibly hand over the operation of the workplace programme to another, better institutionalized group, such as the UN Technical Working Group, for the ultimate aim of learning initiative implementation.

Egypt, Kenya, Lebanon and New York all communicated challenges with planning and coordinating follow-up sessions, to ensure programme continuity.

The Cambodia programme is two years old and runs within a manageable budget, which creates sustainability. The next step is to conduct another assessment of staff knowledge to find out if the programme has been effective in increasing knowledge and changing attitudes about HIV and AIDS among staff. These results will be compared to the baseline needs assessment conducted in 2002.

BOLIVIA

Overview and Background

In 2004, UNAIDS reported that approximately 4900 adults and children were living with HIV in Bolivia. The number of AIDS deaths was reported to be fewer than 200. Epidemiological data collected through sentinel surveillance in seven cities between 2000 and 2004 showed a HIV prevalence rate of 0.19% in the general population.[3] A sentinel surveillance site implemented in 2004 in a vulnerable population (sexually transmitted infection patients) showed an HIV prevalence of 0.75%. According to the national surveillance system, sexual transmission accounted for 97% of all reported cases, followed by blood (2%) and perinatal (1%).

Needs Assessment

Forty-six UN staff members from Bolivia participated in the UNAIDS global learning needs assessment conducted in 2002. Of those surveyed, more than three-quarters had received the UN booklet on HIV and AIDS for employees and their families. The majority of those who completed the survey had minimal familiarity with UN policy, but stated that they desired further information, especially with regards to benefits and issues of confidentiality. In addition, the survey revealed that staff felt less knowledgeable about using female condoms, and living and working with HIV-positive individuals.

As a starting point for implementing the Learning Strategy in 2005, the learning facilitators created and disseminated a brief survey to assess the country staff's basic knowledge of HIV and AIDS, previous experience with HIV workshops, knowledge of UN policy, and attitudes towards people living with HIV. In addition, staff members were asked to indicate what type of information or activities related to HIV and AIDS they desired in the workplace.

Nearly three hundred UN staff members completed the survey—more than five times the response of the 2002 survey. The results showed that almost all staff members were interested in gaining more information about HIV and AIDS, and participating in workplace workshops or conferences. The survey also revealed that the majority of staff had never received prior training or information about HIV through the UN workplace. Questions and suggestions posed by the staff in the questionnaire were used to structure the subsequent Learning Strategy workshops and activities.

Planning for a Response

Based on the survey, the following activities were identified:

- local needs assessment
- workshop #1 for UN staff on HIV and AIDS knowledge, transmission, prevention, and condom use
- basic workshop for the partners of UN staff

[3] See http://www.unaids.org/en/Regions/Countries/Countries/bolivia.asp.

- basic workshop for adolescents and children of UN staff
- workshop #2 for UN staff covering the UN policy, video of UN staff living with HIV, and post-exposure prophylaxis kits
- participation of the UN system in the International Book Fair (disseminate UN educational material on HIV and AIDS; present multimedia material on HIV and AIDS)
- conduct talks with the medical staff in the UN on human rights and post-exposure prophylaxis kits
- implementation of access to condoms throughout the UN system

In keeping with the overall goal of the Learning Strategy to develop the competency of the UN and its personnel to respond to HIV and AIDS, the Learning Team emphasized the creation of a safe, respectful and fair workplace. They stressed that everyone deserved to be informed about HIV and AIDS in an effort to create a united force to break down the walls of silence, stigma and discrimination that surround the epidemic.

In outlining the workplace learning needs, the learning facilitators stressed the importance of not just providing information through the workshops, but also encouraging behavioural change. As an example, the learning facilitators are in the process of contracting a local AIDS service organization in La Paz to provide testing and counselling for staff.

The primary focus of the first year has been on developing workplace knowledge and competence of the UN. However, in the coming year there will be increasing focus on the national response goal of the Learning Strategy.

Key Actors
Two UN staff members, from UNDP and WHO respectively, participated in the regional workshop held in Santo Domingo in November 2004. The regional workshop introduced the UN's HIV/AIDS Learning Strategy and prepared the learning facilitators to begin implementing the Learning Strategy in the UN system.

After gaining the support and commitment of the Resident Coordinator, Country Team and Theme Group, the learning facilitators formed an interagency HIV and AIDS Learning Team consisting of the learning facilitators and four additional representatives.[4]
In addition, an outside consultant was hired in September 2005 to assist with facilitating the second round of workplace-related workshops. The consultant is a person living with HIV, who is a prominent community activist and international advocate for women living with HIV.

The Learning Team developed a detailed workplan covering specific activities for 2005. The plan specified workplace activities, which included a needs assessment and workshops for all UN staff. For the national response, it was decided that the Technical Working Group would analyze the strategy and create interagency discussion groups and would then elaborate a further action plan to implement the Learning Strategy with the Theme Group.

[4] Representatives were from UNICEF, UNFPA, WFP, and UNDSS.

Advocacy and Promotion
The learning facilitators made concerted efforts to motivate staff to participate in the workplace activities. The learning facilitators sent out numerous e-mail announcements informing staff of the workshops and also placed posters throughout the workplace. In addition to encouraging staff to participate, the learning facilitators also sent out informational e-mails that contained links to different sites on HIV and AIDS as well as motivational messages or phrases to capture staff attention. Prior to the actual workshops, the learning facilitators sent multiple reminders to staff to encourage participation.

Substantial advocacy was required to gain the necessary support from senior level officials. The learning facilitators systematically met with the UN country team, the Office of the Resident Coordinator and the heads of individual agencies. Despite these efforts, only senior level representatives from the WHO, UNDP and the WFP have participated in any of the workshops. The following activities were identified:

- meetings for presentation of the Learning Strategy with the Resident Coordinator, Country Team, Theme Group, Technical Working Group, the Operations Management Team, and the UN staff association;
- flyers and pamphlets about HIV and AIDS in the offices; and
- individual and confidential consultations about general HIV and AIDS themes .

Implementation
The learning facilitators assumed all responsibility for implementation of activities and the Learning Strategy. The members of the Learning Team conducted all of the workplace activities. The team representatives from UNDP, UNICEF, UNFPA and WHO facilitated the first series of workshops. For the second round of workshops, the learning facilitators and an outside consultant facilitated the sessions. A UNDP human resources person also assisted with these sessions. The facilitators were selected for their prior experience working in HIV and AIDS as well as previous training experience; therefore, additional training was not provided for facilitation of the workplace workshops.

The first series of workshops focused on presenting the Learning Strategy to UN staff and covered information from the UN booklet, *Living in a World with HIV and AIDS* that deals with basic HIV and AIDS knowledge, including routes of transmission, proper use of male and female condoms and personal risk perception. In addition, the workshop facilitators provided information on country data for Bolivia and local resources for HIV and AIDS services. The second round of workshops covered the remaining information in the booklet on living positively with HIV and creating a compassionate workplace environment. The facilitators and the outside consultant created dynamic group exercises to encourage staff to think about the personal experience of living with HIV; the consultant also shared her personal experience as an HIV-positive individual. The facilitators discussed UN policy and the rights and responsibilities of UN staff regarding the creation of a safe and respectful workplace.

All workshop participants received a UNAIDS pin that was specially designed in Bolivia for the Learning Strategy initiative. Staff members who complete both

workshops will also receive a certificate of attendance. Additionally, all UN personnel will receive a voucher for free, confidential HIV counselling and testing at a local centre in La Paz.

Funding continues to be a challenge in implementing the Learning Strategy. The learning facilitators secured a small amount of funding from the Office of the Resident Coordinator to provide refreshments at the workshops, as well as additional funds to pay for the contract of the outside consultant and the contract for the teen group that performed during the children's workshop. Funding has also been provided from the Operations Management Team to pay for the testing vouchers, pins for workshop participants, books, and condoms for staff. Individual agencies must cover the costs of photocopying and stationery for the workshops. The learning facilitators hope to negotiate for more funding for 2006 that can be used to purchase female condoms for staff and to hold a workshop with a local HIV medical specialist and a psychologist.

Monitoring and Evaluation

Participants complete an evaluation form at the end of each workshop. While the full results of the evaluation had not yet been compiled as of the writing of this case study, the learning facilitators report high levels of satisfaction from staff.

According to the learning facilitators, approximately 90% of UN staff attended the first workshop and about 70% attended the second workshop. Approximately 40–50 spouses and partners attended the partner workshop and nearly 60 children and adolescents (ages 8–17) attended the youth workshop.

Staff members from UNICEF and UNODC did not participate in either of the workshops. In the case of UNICEF, the agency had already conducted similar HIV education sessions for staff in 2004. UNICEF willingly provided guidance and shared information about their experience with the learning facilitators, and the HIV focal point was part of the Learning Team and participated in several workshops. For UNODC, there was minimal commitment from high-level staff to the Learning Strategy, and as a result, no agency members participated in the workplace activities.

The Bolivia Learning Team worked diligently to implement the Learning Strategy. In the first year of the initiative, the Learning Team successfully focused their efforts on ensuring that all staff members were able to make informed decisions regarding HIV and AIDS in the context of their personal lives and the workplace. The Learning Team is committed to focusing their upcoming efforts on the second goal of the Learning Strategy to increase UN support for the national response to HIV and AIDS. The Team is recommending that responsibility for meeting this goal be shared with a UN volunteer in charge of the secretariat of the Technical and Theme Groups.

The Learning Team has also received invitations to implement HIV workshops in bilateral agencies and schools in La Paz. The team is considering this possibility for the coming year.

CAMBODIA

Overview and Background

Despite significant decreases in HIV prevalence rates in the past four years, Cambodia has the highest HIV prevalence in the Asia-Pacific region. The prevalence among reproductive aged adults is 2.6%,[5] which is a decrease from the 1997 peak of 3% prevalence. By 1998, largely fuelled by the commercial sex industry in the country, HIV prevalence among female brothel-based sex workers reached over 40%. Although a nationwide 100% condom campaign and peer education efforts reduced prevalence and reduced the number of men visiting sex workers, the epidemic has become generalized due to transmission from men—who have visited sex workers—transmitting it to their regular partners/wives. This is currently the main route of transmission. Although condoms are inexpensive and widely available, condom use among married couples is not widely accepted, leaving married women vulnerable to HIV transmission. In addition, rising HIV prevalence among married women has led to increased mother-to-child transmission rates and the number of orphans. Currently, 30% of new infections are among newborn babies. Other factors, such as widespread poverty, gender inequality and post conflict situation, increase Cambodians' vulnerability to HIV infection and limit society's response to the epidemic.

Reliable sources of voluntary confidential counselling and testing are increasing, thanks to the National Centre for HIV/AIDS, Dermatology and STDs (NCHADS) training for medical workers and services provided by nongovernmental organizations. Care and treatment for people living with HIV is a major challenge in Cambodia. The cost of antiretroviral drugs is impossibly expensive for many Cambodians. Although nongovernmental organizations and hospitals in the country provide free services and some provide free treatment, it is still not enough to cover the number of people living with HIV who need care and treatment. Some UN staff and even former UN staff and their families have been denied free care and treatment because of the perception that they earn high salaries and can afford to pay for private treatment.

UN staff members in Cambodia have been directly affected by HIV in the past few years. Since 1998, at least three staff members have died due to AIDS-related illness. Although the UN Dispensary Physician encourages staff to undergo voluntary confidential counselling and testing when the opportunity arises, many are reluctant to get tested for fear it may affect their careers. This illustrates the lingering presence of stigma and discrimination. There has yet to be a single voluntary disclosure in the UN workplace as a result of the stigma associated with the virus.

Needs Assessment

Previous to the development of the *Action Against HIV/AIDS in the UN Workplace in Cambodia* programme, the current UN Dispensary physician advocated for more HIV and AIDS education for staff. She organized information sessions and activities to disseminate health information, but staff participation was poor. The dispensary physician consulted with UNAIDS and the Technical Working Group on HIV/AIDS,

[5] See http://www.unaids.org/en/Regions_Countries/cambodia.asp.

and in July 2003, the dispensary physician proposed activities to increase staff knowledge of HIV and AIDS, including lunch hour information sessions and a question and answer box at the dispensary. In addition, she sought the approval from agency heads for two hours a month for HIV and AIDS education activities.

The dispensary's expertise and conviction that this issue needed to be addressed in the UN workplace was directed to the HIV/AIDS in the Workplace Programme. In September 2003, after the dispensary physician presented ideas for HIV and AIDS activities to the Technical Working Group, they in turn presented the Learning Strategy plans to the Theme Group.

Planning for a Response

The Workplace Programme in Cambodia was called *Action Against HIV/AIDS in UN Workplace in Cambodia*. Its primary goal was to ensure that all UN staff members in Cambodia—both national and international—and their family members are able to make informed decisions to protect themselves from HIV and, if they are infected or affected by HIV, to ensure that they know where the best possible care and treatment are available and that they are protected from discrimination on the basis of their HIV status.

It is a three-fold project led by a Learning Team and implemented through a system of peer educators. The programme was designed to reach all UN staff members in Cambodia with a special focus on the national staff members and their family members, which totals 2121 people[6] in a total of thirteen months, from October 2003 to October 2004. A secondary action plan projected 75% of UN staff having basic knowledge about HIV and AIDS and UN policies by the first quarter of 2005. Although the initial timeline was not met, the interagency Learning Team has reached the majority of the staff. Exact numbers are unavailable at this time.

Components of *Action Against HIV/AIDS in the UN Workplace in Cambodia*

Component I: The first component focuses on raising awareness and knowledge among UN staff members through behavioural change communication. The peer educators play a crucial role in this component. They are responsible for organizing and facilitating workshops on the basics on HIV and its prevention, care and support in each respective organization. At the writing of this case study, Component I has been successfully undertaken.

Component II: The second component intends to develop guidelines for dealing with HIV in the UN workplace, including recommendations for modification and improvement of the existing policies, regulations and processes. These recommendations are to be brought to the Country Team by the Theme Group, and, when appropriate, to the Joint Medical Services for action. In addition, this component includes the goal of strengthening the capacity of the institutional mechanism and the UN medical staff as well as training other staff authorized to deal with personal medical information, especially in the maintenance of confidentiality. As of the writing of this case study, Component II remains in future plans.

Component III: At the completion of the project, the Theme Group will write up Best Practices to deal with HIV in the workplace based on the process, progress and experiences recorded throughout the project's implementation. The Best Practices will then be shared with the Country Teams in other countries as well as with the

[6] Data as of September, 2004 from the UN security office.

wider public, including interested government and private sector organizations. At the writing of this case study, Component III remains in future plans.

Workplace Activity Objectives to facilitate the promotion of the Learning Strategy were developed and are outlined as follows:

Objective 1: To ensure that participants of the initiative understand about HIV, its prevention, care and treatment and staff entitlement, and know where and how to access the best possible HIV-related information, care and support both in and outside of the UN system. Activities to fulfil Objective 1 included periodic workshops and discussion sessions including the minimum learning requirements. Sessions were held in both Khmer and English by the Peer Educators and the focal points. Additionally, this objective included the inclusion of HIV and AIDS information in the orientation packet given to every new staff member. Each of these activities corresponds to Component I of the programme.

Objective 2: To create an enabling environment to implement the UN HIV/AIDS Personnel Policy (or others adopted by some of the organizations) by making necessary supplies available for all staff members. To increase comprehension among staff and their families, the booklet, *Living in a World with HIV and AIDS* and information on staff entitlements was translated into Khmer and distributed to all national staff members. In addition the *ILO Code of Practice on HIV/AIDS and the World of Work* was translated and made available to staff.

Resources and supplies, including post-exposure prophylaxis kits, condoms and a resource list of existing public and private sector health care and social support services (voluntary confidential counselling and testing, care and treatment including antiretroviral provision and counselling) are available to staff. Insurance issues are also addressed in an attempt to improve options to access care. Private insurance policies are extended to short-term employees and periodic medical exams are made available for UN staff. Additionally opportunities were explored to support family members of staff with HIV who are not entitled to UN staff benefits.

Objective 3: To establish a strict institutional mechanism in regards to "confidentiality" around HIV. This includes confidentiality of medical records and personal data. This policy is supported by staff members' rights to protect their privacy in legal proceedings. The activities to enforce this objective include tightening the processes of personal information and medical record handling within the UN and providing training for staff members who have authorized access to medical records.

Objective 4: To develop Best Practices to operationalize HIV and AIDS workplace policies. By recording the processes and experiences of the programme and reflecting on lessons learned, the Country Team will be able to develop and publish Best Practices to help other organizations, including the government organizations and private sectors implement similar programmes.

Key Actors

There are four primary groups that are fundamental to the leadership and support of the programme: the Theme Group, the Technical Working Group, the Facilitators'

Team and UNAIDS Secretariat. The Theme Group provides leadership and support for the programme. The Technical Working Group is made up of focal points from several agencies. The focal points support the Learning Strategy by supporting the Learning Team—called the Facilitators' Team—in Cambodia. They further support their peer educators in the implementation of HIV activities within their organization. Focal points are an important link in maintaining open communication and sharing experience. They are responsible for reporting the process and progress to the Theme Group and Country Team and make recommendations for the development of Best Practice on operationalization of HIV and AIDS workplace policies.

Peer educators are truly the muscle of this programme. Agency heads agreed to provide at least two peer educators among its national staff members, selected on a voluntary basis. They work in close collaboration with the Focal Points and staff members in the respective agencies. Peer educators are in charge of organizing and facilitating various activities for the national staff members in collaboration with the focal points. They meet quarterly to update each other on their activities. In March 2004, UNAIDS facilitated the establishment of an online network among the peer educators and the training team. The peer educators share information, discuss issues and ask questions of HIV and AIDS topic experts from various agencies through this network. A team of highly skilled and bilingual (Khmer and English) national staff members from ILO, UNFPA, and the UN Dispensary were chosen by the focal points to train the peer educators.

The UNAIDS Secretariat served as a catalyst and technical consultant and facilitator for the learning initiative, working closely with the Facilitators' Team. In addition, UNAIDS Secretariat provided funding for the majority of the training for the programme. Notably, the Country Coordinator commented that the programme is not as reliant on UNAIDS as it once was, having "taken on a life of its own."

Advocacy and Promotion

There were several encouraging factors that contributed to staff participation in the project activities. Primarily, the strong commitment and support of the programme from the Theme Group, Country Team and Technical Working Group demonstrated to staff the importance of the programme. The strong leadership from the Facilitators' Team and UNAIDS Secretariat coupled with the dedication and enthusiasm of the peer educators contributed to the high quality of the activities. Peer educators liaised with programme officers to schedule sessions and activities on dates that were convenient for staff. Scheduling sessions was approached in a cooperative way, accommodating the availability of busy staff members. Finally, quarterly meeting and training need assessments were regularly conducted among peer educators, which helped the programme to maintain its momentum.

Implementation

Peer educators were trained on the basic facts regarding HIV and AIDS in December 2003. In March 2004, a follow up meeting was conducted to answer questions and to share experiences. At this point, the online network for peer educators was launched to provide a forum for open discussion and idea sharing. Further training opportunities began in May 2004, and have included information and field visits on topics including voluntary confidential counselling and training and home-based

care. During the last quarter of 2004, peer educators conducted trainings for staff working in outlying provinces.

In March 2005, *Living in a World with HIV and AIDS* was translated into Khmer, published and distributed to national staff members. Each organization was encouraged to provide administrative support including venues and other necessary materials for the sessions. This contributed to the sustainability of the programme as it helps keep costs low. The peer educators work in close collaboration with the focal points and the staff members in their agency. Sessions have been limited to 20 participants, being two-and-a-half hours in length.

Peer educators were encouraged to devise and autonomously implement innovative ideas that would achieve the goals of the Learning Strategy. For example, a UNFPA peer educator and focal point developed an HIV education proposal for its staff and their family members, and then obtained the approval of resource support from the Resident Coordinator. The ILO peer educator, with assistance of the national programme coordinator and focal point, organized a learning session for the ILO Staff and their family members in Takhmao District, Kandal Province. This session was not exclusive to ILO staff, but was also open to other UN agency staff. UNICEF developed some materials such as booklets and cassette songs. The cassette songs were distributed to drivers and so they could listen while driving. A number of cassettes were copied and distributed to other UN agencies for the same purpose. UNICEF has also created an HIV and AIDS orientation for newly hired staff. Attendance at orientation sessions was considered part of the agency commitment and contribution and no individual incentives or certificates were issued in exchange for attendance at sessions. The Head of UNICEF offered opening remarks at the beginning of sessions.

UNAIDS funded some activities from their budget. The WHO global ACTION Project (Access, Care, Treatment and Inter-Organizational Needs Pilot Project) provided US$ 10 500 to the UN Dispensary; US$ 500 was specified for voluntary confidential counselling and testing and the remainder for specific use in the care and support of staff.

The budget has covered expenses for:

- sending two people to Facilitators' Training in Bangkok (Oct 2004);
- two-day workshop for Peer Educators by a nongovernmental group involved in psychosocial and experiential learning practices;
- the activities for UN agencies mostly funded by their respective agency;
- laboratory expenses as requested by service providers for staff under their treatment plan;
- purchase of antiretroviral drugs during the interim period for staff already receiving them, but about to be registered into the non-payment scheme on ending their contracts with the UN system.

Early on in the Workplace planning process, the Theme Group proposed that each agency contribute to an interagency workplace programme fund. This joint fund has not yet had to be tapped, because resources (e.g., specialists or transport) have been contributed by agencies or partners as needed and because the team has not yet

exhausted a small fund provided by the ACTION project. However, when the need arises, this fund can be used.

Monitoring and Evaluation
A feedback session was included at the end of the orientation session by a paper questionnaire. In addition, follow-up assessment was sometimes conducted during the staff meeting along with individual answers to the questionnaires. The evaluations showed that the majority of staff members were satisfied and appreciative of the session. Staff who had participated in the sessions requested future sessions with updated information. This request was fulfilled with follow-up sessions for peer educators every three months. No quantitative data were provided from evaluations; all data was qualitative. A few of the activities, including the condom demonstration, received mixed reviews from participants.

Additionally, peer educators have evaluated the work conducted within their respective agencies through surveys. The responses have told them which areas will need more focus. The UN Secretariat has also been monitoring all sessions and quarterly meetings, as well as assessing their work and future needs through surveys. The facilitators' team will be launching a UNAIDS survey for all UN staff in the beginning of 2006, to evaluate the effectiveness of the programme, as well as aid in future planning.

ECUADOR

Overview and Background

Recent UNAIDS statistics from 2004 estimate that the adult prevalence rate of HIV in Ecuador is approximately 0.3%, affecting 10 000–34 000 people.[7] In this same year, there were 1006 new detected cases, 711 male and 295 female. Moreover, 42.9% of the new cases were between the ages of 15–29 years.[8] Because HIV can present itself years before symptoms, many of these infections may have occurred during adolescence. According to UNAIDS, a study of 870 secondary school children at four schools in Quito and four schools in the Amazon region, showed that 41% of urban and 52% of rural respondents reported sexual activity. Among those sexually active, half never used condoms, and 70% had not used a condom during their last sexual intercourse. Sexuality is a taboo subject within Ecuadorian culture, one that is minimally addressed by the education system. Furthermore, reports have found that HIV and AIDS surveillance and prevention activities in Ecuador have decreased, while dengue and malaria control activities have increased.[9]

There are a growing number of cases of women. There are currently between 10 000 and 34 000 adults living with HIV; of these, between 4700 and 16 000 are women. Of the women infected in 2004, 66.4% are housewives and 11.2% are sex workers.

Needs Assessment

The 2002 global needs assessment on HIV/AIDS in the UN workplace showed that the majority of UN staff in Ecuador needed training on issues related to HIV and AIDS. Out of the approximately 300 staff in Quito's UN House, 78 people responded. Over 50% were not at all or minimally familiar with aspects of the UN system's HIV/AIDS Personnel Policy, including benefits and entitlements, job security, insurance and confidentiality issues. As well, over 80% of respondents had not participated in any UN sponsored HIV and AIDS learning activities; 63% stated that they were not aware of such learning or training opportunities. Furthermore, 42% reported that they had only limited knowledge about what HIV is, how it can be prevented and what AIDS is. While there was good self-reported knowledge on use of male condoms, familiarity with female condoms was reported by only 42% of respondents. Approximately 80% of respondents reported that they did not have good knowledge about treatments for HIV, such as post-exposure prophylaxis treatment, antiretroviral drugs and treatments for opportunistic infections. Of those who chose to answer an optional question on testing, 53% said that they feared being tested because of the negative judgements of others and 40% feared that testing information would not be kept confidential.

While the results were made available to the UN team in Ecuador, those contacted for this case study report that no use was made of the data. This is because no Technical Working Group was in place at that time to pursue any action.

[7] ONUSIDA, *Lazos*, Boletín Semestral #1, Marzo 2005.
[8] ONUSIDA, *Lazos*, Boletín Semestral #1, Marzo 2005.
[9] UNAIDS, *Ecuador: epidemiological fact sheets on HIV/AIDS and sexually transmitted infections*, 1/9/2004.

Planning for a Response
In 2004, a goal was set by the then established Technical Working Group to reach 100% of UN staff members with basic training on HIV and AIDS within a one-month period from October to November 2004. With the agreement of the Technical Working Group and the human resources units of UN system agencies, members from UNHCR and UNDP created PowerPoint presentations which mirrored the UNAIDS booklet, *Living in a World with HIV and AIDS*. Presentations were also planned to include male and female condom demonstrations. The training sessions aimed to convey basic knowledge on HIV and AIDS to all UN staff members, as outlined by the Learning Strategy's minimum standards.

Key Actors
The Technical Working Group was established by the Theme Group on HIV/AIDS in 2003. It has been the prime mover responsible for the development, implementation and evaluation of the HIV/AIDS in the UN Workplace Programme for Ecuador.[10]

It should also be noted that a learning facilitator was later identified by the Country Team to represent Ecuador at a regional training of learning facilitators at end 2004. The regional training was designed to introduce the globally agreed-upon UN Learning Strategy on HIV/AIDS, including its expected outcomes, standards and implementation modes. The Ecuador facilitator had already been a key actor in the workplace learning efforts in Ecuador and has since used his additional knowledge to enhance efforts in the UN.

Six members from the Technical Working Group participated as training facilitators. Other members were invited to the first few staff training sessions so that recommendations and suggestions could be made to improve them. The members facilitated the sessions on a rotating basis and all efforts were made to ensure that each session was led by a male and female facilitator. Each session took between two to two-and-a-half hours.

In addition to the six facilitators, there were two public health masters students from the San Francisco University in Quito interning with UNAIDS for three months. These students assisted with training sessions as co-facilitators and compiled and analyzed data from the training sessions.

Advocacy and Promotion
To disseminate news of the trainings, the various Human Resources units sent e-mails to staff in each UN agency in the Common House in Quito. These e-mails announced that the Technical Working Group, with approval from the Resident Coordinator and Country Team, were providing workshops for all UN personnel focused on HIV and AIDS, with the goal of reaching 100% of staff. Staff members were invited to participate in these sessions and asked to confirm a day and time within a one-month span. They also received an introduction to the UN website on HIV and AIDS in the UN workplace

[10] It includes active members from UNHCR, UNICEF, UNDP, UNFPA, WHO, WFP and UNIFEM. The FAO and UNESCO are members, though with less active participation.

Posters were also e-mailed and posted on public bulletin boards. These posters, by questioning levels of knowledge around HIV and AIDS, provoked interest and curiosity.

Soon after the launch of the first UNAIDS newsletter, "Lazos" (meaning both ribbons and ties) was launched. This effort was funded by the Programme Acceleration Funds obtained from UNAIDS in 2004, and aims to publish two issues per year. The first issue of the newsletter discussed women and HIV and AIDS and presented statistics and testimonies. While the newsletter's primary audience are partners in government, nongovernmental organizations and civil society, copies are also sent to UN staff members to keep them informed about HIV and AIDS issues in Ecuador.

Implementation
Each session was designed to last for two hours for a maximum of forty participants. As planned, it included a PowerPoint presentation along with male and female condom demonstrations. Agencies with few staff members participated in training sessions together. Similarly, in the case of larger agencies, such as UNDP, several sessions were held to accommodate the greater number of participants. During each session, the facilitators started by distributing a pre-test to the participants which queried basic knowledge of HIV and AIDS, routes of transmission, etc. In addition to such topics, "How Ecuador is affected by HIV and AIDS" was also a major topic of discussion.

At the end of the sessions, after the post-test, each participant was given a pin that said "*Soy Consciente*" – "I am Aware" and a colourful ribbon. The cost for producing these pins, approximately $US 400, were the only funds used for these sessions.

Monitoring and Evaluation
By World AIDS Day 2004, the head of the UN Theme Group gathered all staff in the UN House and told them that over 60% of staff had participated in the trainings and that the UN is "aware." It should be noted, however, that while agencies located outside of the common UN House had been invited to participate, none did.

During the sessions, many participants reported being shocked to learn of the statistics from Ecuador where there has been an alarming increase in the last few years of housewives affected by HIV and AIDS. Many participants did not know about the existence of the post-exposure prophylaxis kit, a topic that sparked much critical debate and discussion such as who should have the kit. Differences in levels of knowledge and shared personal experiences created a rich learning environment.

Public health student interns assisted with evaluating the training sessions. Their report showed results from the 12 sessions, held over two months with approximately 102 staff participants. While evaluation surveys were not distributed at all sessions, 59 out of 102 participants did complete the pre-tests. Findings showed that 51% of respondents reported insufficient knowledge of HIV and AIDS prior to the session. By the end, 97% felt they had gained sufficient knowledge; 20.3% had thought HIV and AIDS were the same thing, but after the sessions, only 1.7% still thought they were the same. After the sessions, 100% of those who took the surveys learned that mother-to-child is a form of transmission of HIV, but playing in school together is not, and that testing for HIV is not a prerequisite for working at the UN.

Ecuador aimed to train almost all staff in the UN system. While the results of 60% reached were short of the goal to reach all staff members, they were nonetheless notable and due to the work of the interagency Technical Working Group that served as the Learning Team.

EGYPT

Overview and Background

Egypt is a low-prevalence country with an adult prevalence rate of < 0.01.[11] However, from 1990 to 2005 there has been a gradual increase in new reported HIV cases. The most common means of transmission is heterosexual sex. Studies have shown that youth lack adequate knowledge of HIV and have a false sense of security. Behaviours identified through studies include very low rates of condom use overall (e.g. 87% of 999 male university students in Tanta reported having never used a condom), high use of non-sterile needles among drug users (59% of injecting drug users in Cairo); of the drug users 66% never used condoms and 62.8% reported extramarital sexual relations. A large number of injecting drug users who do not consistently practice safe sex and who have multiple sex partners make it likely that the growth of transmission will be rapid. The presence of these risk factors and determinants has necessitated immediate attention and action to control this epidemic at its nascent stage.

UN agencies, CARE and Ford Foundation (all members of the multi-agency Egypt Learning Team) are not exempt from the effects of the epidemic. Some UN and partner agencies in Egypt had some previous HIV and AIDS learning activities, but these activities were rare and generally sporadic. For example, UNICEF held a Regional Management Team meeting for the Middle East and North Africa (MENA) in 2002 to raise awareness of the importance of the epidemic in the region and work towards implementing HIV and AIDS goals. The UNDP piloted their 'We Care' programme with its staff in Egypt. Most offices had not implemented any learning activities on HIV and AIDS and those that had done so had conducted short briefings.

Needs Assessment

Egypt did not participate in the 2002 global learning needs assessment survey on HIV/AIDS. The Learning Team, therefore, decided to get baseline data on knowledge and attitudes towards HIV and AIDS among the UN staff in Egypt, to best learn to customize and implement the Learning Strategy and also to use its findings as an advocacy tool. In addition, the needs assessment was to help the Learning Team identify preferences of how to implement HIV- and AIDS-related learning. The Learning Team found it necessary to adapt the global needs assessment questions for use in Egypt by making it more suitable to the risk context in the country and to identify knowledge gaps and behavioural patterns.

The Learning Team was determined to attain the objectives of this survey. Members of the Learning Team spent a lot of time and effort designing and uploading the survey, promoting and participating in the assessment, collecting the hard copies, entering and analysing the data, writing the report and disseminating it. The questions were edited by the team and pre-tested before use. The survey was made available in Arabic and English. The survey was administered online and, for those staff who did not have access to a computer, in hardcopy.

Of the 900 staff members requested to complete the survey, 430 responded. Seventy-three hardcopy questionnaires were entered into the database by a CARE intern.

[11] See http://www.unaids.org/en/Regions_Countries/Countries/egypt.asp.

Results revealed that while most respondents have good basic knowledge about means of prevention and transmission, some misconceptions on prevention and transmission exist. More significantly, specific attitudes towards the issue were identified. For example, over one-third of respondents indicated discomfort in sharing an office with a person living with HIV. Findings showed that 57% had not yet received the UN booklet on *Living in a World with HIV and AIDS*, and of those who had received it, 12% had not read it. Only 15% reported they knew where to seek basic services such as voluntary confidential counselling and testing. The results also showed that the majority of respondents had never participated in an HIV or AIDS learning event.

This survey was particularly important because there are few of its kind in Egypt on this issue, and also one that produced very telling results. For example, misconceptions were revealed about men who have sex with men and the belief that sex with a foreigner would cause HIV (despite correct condom use), which explained some of the prejudices evident in the rest of the results. There was a perception that 'clean' people do not get HIV. The majority believed they were HIV-negative and yet only 11% had had an HIV test in the last year.

The findings of the needs assessment were compiled into a report and shared with senior management and the agency focal points for information, advocacy and support purposes.

Planning for a Response

Based on the findings from the needs assessment and to attain the minimum standards of the Learning Strategy, the Learning Team decided to hold a series of full-day orientation sessions for all staff. The objectives of the orientation sessions were to ensure that all staff had a greater understanding of HIV and AIDS and how to prevent infection, including condom demonstrations; how to live positively with HIV; HIV impact on the workplace; compassion and tolerance in the workplace; the UN Personnel Policy; availability and accessibility of voluntary confidential counselling and testing; treatment and care issues.

Forty-one sessions were planned between May and September 2005 (with Arabic sessions in July) to reach all 900 staff in the UN and partner agencies.

A parallel objective to the orientation sessions was to ensure that there was access to post-exposure prophylaxis kits. Members of the Learning Team ascertained kit availability, location and distribution in each agency since it was to be mentioned in the sessions. A list was compiled of those who were responsible for administering the kits and information shared with all staff during the sessions. In addition, a general information note on HIV and AIDS, including where and how to access the kits and other services and information were posted on the UN intranet.

The Learning Team met several times, and in the third quarter of 2004 drafted a learning plan that included conducting a needs assessment, staff orientation and technical staff training. Other activities included in the plan were World AIDS Day events and monitoring and evaluation. For early 2006, the Learning Team has planned to hold discussions for learning related to national responses to HIV, based on the Theme Group Resource Guide for all programme staff, and sessions for the Technical Working Group.

The learning plan included a preliminary budget which included funds for conducting the needs assessment. The Resident Coordinator system provided the minimal funds needed at the preliminary stage including website cost and posters for the needs assessment. The

additional budget for implementing the Learning Strategy was covered locally by each agency based on the number of staff in each office. The budget covers the cost of the trainers who were paid under contract, and for training materials for the sessions.

Twenty-seven out of the twenty-nine UN offices in Egypt agreed to participate in the learning sessions. The other two agencies opted not to join the learning activities.

Key Actors
The Country Team in Egypt appointed three facilitators to lead the efforts to implement the Learning Strategy. The three attended a regional workshop for the Middle East and North Africa organized by the UNAIDS Secretariat to train learning facilitators to assist the country team to advocate for, plan, implement and monitor the Learning Strategy. It is worth noting that one of the facilitators has also been called upon to assist other countries in the region with their efforts to plan for implementation of the Learning Strategy.

The Country Team in Egypt, Resident Coordinator, Theme Group Chair and members were subsequently briefed by the learning facilitators and the Theme Group appointed a Learning Team to oversee the process. Members of the Learning Team are from the Resident Coordinator's office, UNDP, UNAIDS, WFP, UNODC, UNICEF and CARE.

The Learning Team asked for each agency to nominate a focal point who would act as liaison between the Learning Team and the agencies to ensure effective and coordinated implementation of the orientation sessions. The focal points had to undergo an initial orientation session to be briefed on HIV and AIDS information, the Learning Strategy and their role in its implementation. The focal points were to build commitment within their agencies and get the buy-in of their colleagues to attend the learning sessions.

Advocacy and Promotion
A key component to implementing the Learning Strategy has been advocacy and promotion to create awareness, support and participation. The Learning Team used the information from the global and local needs assessments as advocacy tools for getting senior management buy-in as well as the general staff. The results of the needs assessment gave a picture of the present climate among the UN staff.

The very low HIV prevalence in the general population has made it more difficult to advocate with agencies to get their staff trained. This is visible in almost all agencies and especially with agencies that either refused participation or limited it to some staff.

Members discussed and planned how to get senior level staff to attend so as to motivate other staff to attend the sessions. In piloting the orientation session with the focal points, it gave them first-hand experience before other staff to make them stronger advocates among their colleagues. Other ways of promoting the sessions included screening short films on HIV and AIDS within agencies. In addition, many, though not all, agency representatives agreed to make the sessions mandatory.

Implementation
Whole-day sessions were carefully designed by the Learning Team to ensure that they reflected the needs apparent from the needs survey. Emphasis was placed on attitudes towards people living with HIV and also on correct condom use. While there were some

comments on the length of the sessions, a full day was seen as necessary to address the many misconceptions by giving sufficient time to address all issues.

Sessions were conducted in June, July and again in September and November 2005. In August many staff members were on leave and no sessions were held during the Muslim religious period of Ramadan in October. Approximately eight sessions were scheduled to be conducted in Arabic for September and November for WHO staff, and the rest in English. After completing a session, certificates of attendance were issued.

The Learning Team carried out the planning and most of the logistics involved in implementation with daily follow-up by the trainers conducting the sessions. Focal points helped secure room availability for sessions and booklets for staff. However, many of the agencies had not ordered enough of the UN booklets, *Living in a World with HIV and AIDS*, and by session time, the English version had to be downloaded and there were delays in producing the Arabic version.

Beforehand, the trainers were briefed on the minimum requirements and basic information to be covered at the sessions and also attended a 5-day training conducted by the WFP for their own facilitators and based on the *UNAIDS Facilitators Guide*. There were three female and two male trainers. All spoke English and Arabic, had substantial knowledge on HIV and AIDS and had strong communication and facilitation skills. This enabled them to address the issues and engage the participants.

Monitoring and Evaluation

Despite issues surrounding delays and distribution of print booklets, trainers report that they have been satisfied with the results of the training sessions, of seeing participants who were initially sceptical admit at the end of the session that they found the sessions very useful. The trainers mentioned the satisfaction of clarifying misconceptions for participants. Trainers also reported that dealing with stigma and discrimination was important and that they could observe changes in attitudes during the sessions.

Most of the feedback from participants was positive. A small number of staff (mainly female) expressed discomfort during the condom demonstrations; however, overall, staff were open to learning about them and expressed satisfaction with the demonstrations. Having received positive feedback from staff and requests for additional information and sessions, the Learning Team planned a one-day event on World AIDS Day to provide basic information to staff families and children, and also offer educational entertainment, which includes cartoons, films and games designed by members of the Learning Team to teach children about HIV.

Apart from an informal monitoring of staff knowledge and attitude changes by the Learning Team and focal points, a plan has been put in place for effective and systematic monitoring and evaluation.

- The initial needs assessment will serve as the baseline situation regarding HIV knowledge and attitudes of staff before their participation.
- After all sessions staff are requested to provide feedback in the form of an exercise and optional personal comments, and these are then written into reports. Overall, participants found the sessions very informative, and the discussions interesting. Participants praised the session environment as open and conducive to frank

discussions. Some even mentioned that the workshop exceeded expectations, particularly emphasizing that participating in the one-day training removed the fear they had of HIV and AIDS.

- The Learning Team plans to conduct another online assessment similar to the first one that will help measure information and attitude changes if any and elucidate comments on future activities.
- Ongoing monitoring takes place through regular contacts between the Learning Team and the trainers as well as among the Learning Team itself.
- The Learning Team reports to the Theme Group and the Country Team on Learning Strategy progress.

As sessions are still ongoing, a total compilation of the information will also be done to enable a final evaluation and report on the workplace sessions conducted with staff.

The implementation of the orientation sessions in Egypt exemplifies the strength of partnering and collaboration. The UN system in Egypt teamed up with partner organizations, CARE and Ford Foundation, to implement this Learning Strategy on a wider scale and draw on each other's strengths.

Georgia

Overview and Background

Georgia has an estimated HIV prevalence at the range of 0.01–0.03%. By December 2005, a total of 847 HIV cases had been registered in Georgia since the very first case in 1989, though the estimated number of cases is considered to range between 3000–5000.[12] The major routes of transmission include injecting drug use (67.3%) and heterosexual contact (29%). Major risk factors for the spread of HIV include high levels of injecting drug use, increased migration especially to high prevalence countries (Ukraine, Russian Federation), lack of disposable medical instruments, high prevalence of HIV in neighbouring countries, low awareness and traditionally low demands on condoms.

The Government of Georgia identified HIV and AIDS among the top national priorities in the early 1990s, becoming among the first former Soviet Union republics to develop a national AIDS programme in 1994. A National AIDS Registry was launched in 1989 and the Georgian National AIDS Programme was elaborated in 1993. The Law on HIV and AIDS was adopted in 1995, with amendments following in 2000.

Activities in Georgia have been coordinated by the "Governmental Commission on HIV/AIDS, STIs and other Socially Dangerous Infections" since 1996. The Country Coordinating Mechanism was built on the experience of the governmental commission in 2002 with expanded participation of the government, civil society and UN international development partners.

The UN Theme Group has been a key government advocate and partner for building sound and effective policy and programme framework on HIV and AIDS. By the end of 2005 joint efforts of the national AIDS programme, the Global Fund, UN and international development partners have ensured attainment of:

- free HIV diagnostics, treatment and care for all people living with HIV;
- free voluntary confidential counselling and testing for all pregnant women as part of antenatal services;
- free voluntary counselling and testing on HIV for key populations at higher risk;
- free testing of all donor blood for HIV, Hepatitis B, Hepatitis C and syphilis;
- expanded prevention interventions among key populations at higher risk i.e. needle exchange programmes and replacement therapy for injecting drug users;
- establishment of HIV Treatment Centres in Zugdidi and Batumi;
- expanded public awareness raising activities; and
- expanded network of information-education services for young people.

Needs Assessment

Out of 197 staff, 67 participated in the UN global learning needs assessment survey in 2002. The results of the survey showed the following.

- 35% of UN staff who responded to the survey had received the UN booklets; 41% had not.

[12] See http://www.unaids.org/en/Regions_Countries/Countries/phillipines.asp.

- Half of staff who had received the booklet had not read it.
- The majority of respondents who had read the booklet found the information useful, in particular that on the UN policy, facts on HIV and AIDS, testing issues and living with HIV and AIDS.
- The UN staff finds themselves minimally familiar or not at all familiar with the UN policy and expressed interest in knowing more about benefits and entitlements, job security, insurance and confidentiality issues regarding HIV and AIDS.
- 12% of staff participated in briefings within the UN learning activities on HIV and AIDS; 2–7% took part in workshops, online learning from website and peer education activities.
- 75% reported unawareness of existing learning and training opportunities as the main reasons for non-participation.
- Self-reported knowledge on HIV and AIDS was fairly high, though there was a reported need for learning more about treatment, post-exposure prophylaxis and issues related to living and working with people living with HIV.
- 80% of UN staff agreed that people living with HIV should be allowed to continue to work in the UN.
- 76% suggested that people living with HIV should feel comfortable talking about their status and experiences in the office.
- Sources of information on HIV and AIDS for UN staff were: television (92%); press media (88%); and radio materials from outside UN and friends (50%).
- 80% of staff reported not feeling comfortable responding to questions about their HIV status and sexuality issues.

Planning for a Response

In follow-up to the Learning Strategy launched in 2003, the Theme Group in Georgia initiated a country-level HIV and AIDS learning plan. The overarching goal of the Learning Plan in Georgia was to develop and implement country-specific learning approaches and training activities based on the Learning Needs Assessment results and the globally adopted Learning Strategy standards and expected outcomes.

By the end of 2004, it aimed to reach at least 80% of all UN staff, 80% of all professional staff, 100% of UN Heads of Agencies, Theme Group and HIV and AIDS programme/project officers and at least 50% of UN staff dependants and family members (approximately 100 participants).

In October 2003 UN Theme Group nominated the Learning Strategy facilitator to ensure follow-up to the globally endorsed Learning Strategy. The facilitator has been entrusted to coordinate with the UN Theme Group members for elaboration of the country-level strategy and action plan as well as follow-up to implementation of the projected activities.

The HIV and AIDS focal points from the UN Theme Group agencies have comprised the Learning Team for strategy planning, implementation, monitoring and evaluation. The Team was under the overall coordination of the UN Resident Coordinator, the UN Theme Group and the facilitator. Terms of Reference developed for the Learning Team envisaged: 1) development of the Learning Strategy for Georgia through the elaboration of the concept framework, planning of the outline, implementation and monitoring and evaluation; 2) development of a management

system and terms of accountability on the implementation of the Learning Strategy; and 3) defining learning approaches and activities.

Key Actors
The Resident Coordinator assisted by the Country Team, Theme Group, and Learning Strategy Facilitator, has been entrusted with the responsibility for coordinating the overall UN response to HIV and AIDS. The Theme Group on HIV and AIDS with participation of eight co-sponsor agencies[13] has ensured overall coordination, advocacy and follow-up to implementation of the HIV/AIDS Learning Strategy.

Four national consultants contracted by the UN Theme Group in May 2004 were hired to facilitate the training activities on HIV and AIDS for the UN staff. It was required that the national consultants have a graduate degree in public health, social sciences or a related field, as well as proven field expertise and knowledge on HIV and AIDS.
Terms of Reference were written to explicitly outline the responsibilities of these external consultants. Such terms included:
1) To ensure translation and adaptation of key messages from UNAIDS booklet;
2) To undertake desk-review and outsourcing of materials produced globally, regionally and locally with regards to epidemic trends, situation analysis review, and guidelines for the facilitation of the HIV and AIDS learning activities;
3) To develop a training curriculum in Georgian and English as well as an agenda for the half-day training activities on HIV and AIDS, and to identify and implement mechanisms and tools for monitoring and evaluation of the capacity building activities;
4) To facilitate and assess pilot training sessions;
5) To ensure the coordination with the UN Theme Group and Learning Strategy Facilitators on secretarial, logistics and/or technical arrangements; and
6) To provide a final report on the implementation of the capacity building activities.

Many of the goals as outlined above were accomplished within the proposed timeline. Three training curricula were developed:
1) Basic awareness on HIV and AIDS for all staff;
2) Competence building for UN professional staff; and
3) Mixed-training sessions.

Advocacy and Promotion
The role of the UN Resident Coordinator and UN Heads of Agencies was critical for the successful advocacy and implementation of the Learning Strategy in Georgia. Staff members were motivated to participate through institutional and human incentives. Peer education approaches for advocating active involvement were also explored.

Updated schedules of events for the Learning Strategy among all agencies were distributed by the learning facilitator through the HIV and AIDS focal points and agency heads to raise awareness of the learning activities. Constant networking, advocacy messages and invitation letters for the forthcoming sessions were critical in

[13] UNDP, UNICEF, UNFPA, WHO, World Bank, WFP, UNHCR and local support from IOM.

maintaining communication. Reminders of the strategy process and updated excel matrices were also sent out to the UN staff for promoting increased subscriptions.

Implementation

Training for all UN Staff and their family members

The pilot training sessions for UN staff and their family members on the basics of HIV and AIDS began in November 2004. Following the pilot and revision of the curriculum the Learning Strategy facilitator and national consultants supported 15 training sessions —14 in Tbilisi and 1 in Kutaisi (WFP office). Out of 197 staff member, 142 participated, comprising 72% of UN staff countrywide. Attendance of the UN Country Team staff based in Tbilisi amounted to 75% (122 out of 163).

Four facilitators (UNICEF Health Officer/Learning Strategy Facilitator and three representatives of the nongovernmental organization "Tanadgoma") facilitated the sessions. The one-day training agenda began with introductions, overviews of the Learning Strategy and the Learning Plan for Georgia, expectations, ground rules, pre-testing, and icebreakers. This was followed by brainstorming, and a slide presentation of the basic facts on HIV and AIDS. After a short coffee break, energizers were conducted, followed by an overview of HIV and AIDS worldwide as well as in Georgia, a brainstorming session and slide presentation on routes of HIV transmission. After lunch, another energizer was held and then a session on HIV prevention and how to avoid HIV. The facilitators then demonstrated how to use male and female condoms and went over HIV testing and possible test results. After another coffee break and energizer, the facilitators went over HIV care and treatment, post-exposure prophylaxis, and information about local services. A UNICEF film "Caring for Us" was shown as part of the sensitivity session which was followed by feedback and a discussion on stigma and discrimination, the UN HIV/AIDS Personnel Policy, *ILO Code of Practice*, a post-test and any final feedback from the participants.

Sessions were offered in both English and Georgian. All participants were given copies of the UNAIDS booklet, *Living in a World of HIV and AIDS* in either English or Russian. Additional handouts included the UNAIDS 2004 Epidemic Update, UNGASS Declaration of Commitment, and UN-produced publications on HIV, AIDS and sexually transmitted infections. Information, education and communication resources from the National AIDS Centre and nongovernmental organization partners were also distributed. All trainees were also given handouts of each PowerPoint slide presentation. Pre- and post-tests were administered that included 10 questions on basic facts, transmission, voluntary confidential counselling and testing, UN policy and stigma and discrimination.

In 2005 through two training sessions, 16 additional staff members were reached by basic HIV and AIDS training, comprising 80% of all UN country team staff in Georgia.

Training for UN Professional Staff

A two-day pilot session for UN Professional Staff was held in late June and facilitated by UNAIDS Country Coordinator, Learning Strategy Facilitator and the consultants from the National AIDS Centre. As the result of the pilot the training agenda was downsized to a one-day session and revised content-wise.

Two additional training sessions for UN Professional Staff were held in November and December 2004. Approximately 79% (34 out of the targeted 43) professional staff, including agency heads, programme coordinators/officers, HIV and AIDS focal points were enrolled in the training.

A total of US$ 13 500 was projected as the budget for the Learning Strategy implementation in Georgia. As per the action plan, funding was allocated for covering fees for national consultants, translation and adaptation of the training curricula and arrangements (venue, meals, stationery, printing and photocopying). In-kind donations from UN agencies allowed for cost-saving for training equipment (overhead, LCD projector, TV/Video equipment, etc), and associated with monitoring the implementation of the Learning Strategy.

Monitoring and Evaluation
The Learning Team was responsible for determining the process and outcome indicators for the monitoring and evaluation of the Learning Strategy activities as well achievement evaluation. According to the Plan of Action, the process indicators included the following.

1. Learning Team and Terms of Reference (completed)
2. Country specific Learning Strategy on HIV and AIDS developed and approved by Country Team (completed).
3. Compliance of the country Learning Strategy plan to the global outcomes and expected standards and learning needs assessment results (completed).
4. Relevant human resources and technical support for implementation of the country-specific Learning Strategy allocated and secured (completed).
5. Country-specific training programme for Learning Strategy developed (completed).
6. One training session on HIV and AIDS in the UN Workplace and one training session for professional staff piloted (completed).
7. Learning Strategy pilot phase evaluation (completed).
8. Monitoring and evaluation mechanisms for HIV learning activities developed and follow-up per each training event (completed).
9. Quarterly reporting on Learning Strategy implementation by the Learning Team (with the Theme Group being briefed on progress).
10. Status on Learning Strategy implementation reported and incorporated within the annual report (included in 2004 and 2005 Resident Coordinator annual reports).

The outcome indicators included the following.

1. Percentage of Learning Strategy budget projections allocated for implementation (100%).
2. Number of training sessions supported on HIV and AIDS in workplan (24 sessions).
3. Proportion of Learning Strategy activities implemented by end of 2004 (86%).
4. Number of UN staff involved in UN learning activities on HIV and AIDS (72% by 2004 and 80% by end 2005).
5. Number of professional staff trained through UN learning activities (79% by 2004 and 90% by end 2005).

6. Number of UN agency heads and Theme Group members trained through Learning Strategy activities (88%).
7. Number of UN staff dependants trained through HIV and AIDS learning activities (6%).
8. Pre- and post-test results of training activities—evaluation of 10 training sessions among 60 staff members (10 question-test) in 2004 improvement of the overall scoring results from 72% (pre-test) to 86% (post-test).

Another notable initiative of the UN Theme Group and the Learning Strategy Facilitator was development and printing of the special 2006 Diary—Yearly Planner for all UN staff and their family members called, *Explore More on HIV/AIDS*. The bilingual Diary (English and Georgian), divided into 12 thematic chapters on HIV and AIDS, carries over 160 key messages on prevention, treatment and care, stigma and discrimination, the trends and impact of the epidemic, global and national-level response and UN workplace policies on HIV and AIDS. Every staff and their family members have been provided with a copy of the Diary. The Diary ensures increased access for UN staff and their family members to updated information on the voluntary confidential counselling and testing and safe blood services, as well as briefing on the *ILO Code of practices on HIV and AIDS and the World of Work* and the UN HIV/AIDS Personnel Policy.

As a result of the Theme Group's two-year efforts, more than 80% of all Country Team staff (158 out of 197) and 90% (39 out of 43) of professional staff (agency heads, programme coordinators and officers, HIV and AIDS focal points) have been trained within the scope of the Learning Strategy.

In February 2005, upon request of the Resident Coordinator and the Theme Group UNAIDS Country Coordinator for Caucasus supported three orientation workshops on basic HIV and AIDS awareness in Abkhazia—the conflict affected zone. A total of 130 Staff and Military Servants have been reached by the training.

KENYA

Overview and Background
The Nairobi United Nations Duty Station is the largest in Africa, and includes the headquarters of two global UN programmes, one of the offices of the UN Secretariat and over fifty country and regional offices of UN Funds, Programmes and Agencies. Approximately 2500 staff members are employed here, including 1750 locally recruited staff.

At the end of 2003 in Kenya, UNAIDS estimated over 1.2 million adults and children were infected with HIV. These estimates indicate the adult prevalence rate is approximately 6.7%.[14] The main mode of transmission in Kenya is through sexual contact. Currently, women and young people are among the most affected. UNAIDS estimates that in 2004, 650 000 children were orphaned due to AIDS. Although the prevalence rate is down slightly from 2001, HIV and AIDS in Kenya is a serious health issue that must be prioritized.

Needs Assessment
In April of 2004, Kenya conducted a staff survey with approximately 1500 staff participating (a 57% response rate). The survey was prepared with significant participation and advocacy from the Learning Team. The results of this survey showed:

- low familiarity with UN policies;
- low overall participation in a UN learning activity;
- low knowledge on issues related to treatment;
- stigma and fear of discrimination were clearly evident among the staff;
- 50% had not received the UN booklet on *Living in a World with HIV and AIDS*;
- 32% had received the booklet and had read it;
- over 50% of respondents indicated they would like to learn more about all of the subjects noted; and
- international professionals seemed to be less willing to attend learning activities, less concerned about HIV- and AIDS-related issues and less interested in learning activities.

The staff who participated in the survey also suggested organizing HIV and AIDS learning activities on a systematic basis, ensuring that all staff at all levels are included, guaranteeing condom distribution and making voluntary confidential counselling and testing services available to all UN personnel. Staff also requested the coordination of learning activities that included families, spouses and children. The results of the survey were used to inform the creation of specific learning activities and a three-year plan of action.

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

A Closer Look:
Implementation of the 3Cs: Confidentiality, Counselling and Care for Staff Members in Kenya living with HIV*

UN offices in Kenya were seeing staff suffer because of lack of access to care and treatment. Absenteeism was high and offices were not functioning because of long term sick leave. It was clear that staff with HIV needed assistance accessing care and treatment. In response, an ad hoc committee (eventually becoming the Learning Team) created an innovative programme called the '3Cs' (Confidentiality, Counselling and Care). Coordinated by the UN Office in Nairobi, it offers access to a one-stop clinic for people living with HIV at a main hospital in Nairobi. UN agencies have participated in the programme by allocating money to '3Cs'.

The programme was open to locally recruited staff members who currently subscribe to the Medical Insurance Plan (MIP) and internationally recruited staff members who currently subscribe to a specific medical insurance scheme. Registered participants are issued a coded card that allows the staff member to access the one-stop clinic at no cost. On a monthly basis, invoices are forwarded by the hospital to the UN Joint Medical Service (UNJMS) and are processed for payment without any involvement of administrative staff of the employing UN Offices (staff members from all 61 UN Offices are covered by the policy). In addition, UNON has made a deposit of US$ 50 000 to the hospital to ensure uninterrupted service.

A number of problems did arise with the creation of this program. United Nations Headquarters and United Nations Development Programme Headquarters did not support the initiative because of the commitment to 100% reimbursement. One argument against the programme was that staff with HIV would be getting better care than those with chronic illnesses. The UN agencies in Kenya, however, felt strongly that this programme was a good solution for the major problem of lack of access to care and treatment and absenteeism in their duty station. In addition, the programme has worked to ensure that status will be kept in the strictest of confidence. The Learning Team hopes to start a support group for HIV-positive staff to reduce this fear of breach of confidentiality. In addition, the trust that staff members have in the long-standing drop-in clinic run by the medical service helps to ease some of these fears.

One last problem is the lack of continuity for staff members that leave the UN. When a staff member leaves his or her post with the UN, participation in the 3Cs programme is terminated.

The Cost of the 3Cs program:
Voluntary counselling and testing: Last year voluntary confidential counselling and testing cost US$ 1333 in lab charges. With free services increasing in number, this figure may be reduced.

The cost of treatment and care: 100% of the costs of consultation, laboratory, medication and counselling for outpatient HIV treatment are covered. Programme monitoring as of August 2005 (for the previous 18 months of services) revealed the following.

- The 20% extra that agencies have to pay on top of what they can claim from the medical insurance plan came to US$ 50 per staff member per year (if total cost was averaged over the total number of staff in the subscribing agencies).
- The cost per patient varied enormously.
- The first-line treatment cost US$ 100 per month accounting for two-thirds of the enrolled use. Of that, 80% is reclaimed from the medical insurance plan.
- The "all possible complications and opportunistic diseases and third line therapy" cost US$ 1300 per month; 80% was claimed from the medical insurance plan.
- First-line treatment in Kenya fails on average eight years after it is started, compared to sixteen years in the United States. Likely due to starting treatment late, this figure would be reduced if treatment were begun earlier. Sick leave was reduced to two to three days per year after enrolment in the '3Cs'.
- About 60% of the known HIV-positive staff members are enrolled in the program, with the total number of enrolled staff at 64. Other HIV-positive staff may not yet need treatment and others may belong to agencies that do not participate in the '3Cs' program.

*Only one C of the Kenyan Three Cs Policy is different from the UNAIDS/WHO Position Statement on HIV testing, which underlines the '3Cs' conditions fro testing as: confidentiality, counselling and consent.

Planning for a Response

For learning related to HIV and AIDS in the UN workplace:

> By the end of 2005, the goal was to train 80% of staff so that they would have a basic knowledge about HIV prevention, care and treatment, understand UN policies on HIV and AIDS and identify ways to reduce stigma and discrimination in the workplace. New staff would be expected to go through the training in subsequent years to meet these goals.

This goal is to be met through an orientation programme, the training of peer educators, attendance at World AIDS Day events and access to HIV and AIDS resources.

For learning related to supporting the national strategy on HIV and AIDS:

> By the end of 2005, the goal was to brief 80% of professional staff on UNGASS, United Nations Millennium Development Goals, the UN System Strategic Plan on HIV/AIDS, and national strategies and structures so that they would become effective advocates for HIV and AIDS issues and able to mainstream them into their work.

This goal was to be met by the Theme group and the Technical Working Group through a self-directed learning CD[15], an advocacy briefing session and workplace dialogue.

In August 2004, a Kenya-specific Learning Strategy and budget was developed by the Learning Team and approved by the Country Team. The needs assessment completed earlier in the year was used to inform the creation of this plan.

In September 2004, the Learning Team mobilized relevant human resources and technical support to develop a country-specific HIV and AIDS training programme based on the needs assessment results, key priorities, and global outcomes and expected standards. The training programme was piloted through one training session on HIV and AIDS in the UN Workplace and one training session for professional staff on building competence in supporting national responses to HIV and AIDS. The piloted programme was evaluated and refined for implementation throughout the UN agencies in Kenya.

As part of the learning plans, a resource inventory of HIV and AIDS resources in Kenya was completed by a special working group of the Learning Team and distributed to all staff.

In July 2005 an official plan of action was drafted called the "Strategic Plan for the Implementation of the UN Learning Strategy on HIV/AIDS in Kenya" for 2005–2008. This plan laid out the goals and objectives for the following four years. In 2005, the plans included:

- Baseline survey;
- World AIDS Day participation;
- Training of peer educators;
- Publish inventory of HIV and AIDS resources for staff; and
- Sessions for children.

Future plans would build on these activities and include:

- Training for families of staff;
- Impact assessment;
- Upgrading HIV and AIDS resource centre; and
- Refresher training for peer educators.

[15] The CD-ROM was expected from the global level. This has not yet been produced – it is planned to be ready by end 2006.

Key Actors
In June 2004 the official Learning Team was established with support from the Country Team, the Interagency Administrative Coordination Committee, and Theme Group on HIV/AIDS. Two individuals were chosen to chair the group which included members from several UN agencies, local staff associations, the staff union and representatives of People Living with HIV at the UN offices in Nairobi. The Learning Team was responsible for:

- developing an annual learning plan for the UN system;
- coordinating implementation, monitoring and evaluation under overall coordination of the Interagency Committee, Resident Coordinator and Theme Group;
- ensuring that HIV and AIDS workplace initiatives are a regular item on the Theme Group agenda;
- supporting the Learning Strategy through the allocation of human and financial resources;
- including a section on the implementation of the learning plan in the annual report for the Resident Coordinator describing the plans, implementation and achievements of the learning activities; and
- participating in Learning Strategy planning meetings every two weeks.

The Learning Team is split into working groups, such as the World AIDS Day group, the Orphans and Widows support group (working on 2006 action plan), a group for putting together the Resource inventory and the Peer Counsellors Group. There was also a Survey Group which put together a presentation for agency heads to garner support for the learning activities.

Advocacy and Promotion
In April of 2005, a letter was sent to the Heads of Offices of UN Funds, Programmes and Agencies in Kenya from the Director General in Nairobi regarding the HIV and AIDS orientation training for all staff. This letter discussed the Learning Strategy, particularly highlighting the expectation that all staff attend training sessions on HIV and AIDS in the Workplace. To further encourage staff to attend, Heads of Agencies were asked to release staff from their regular duties on the day of the training. All staff members were expected to attend and certificates of attendance given to attendees to be placed in personnel files.

In addition to memos from agency heads, a number of additional steps were taken to gain support for the Learning Strategy and to motivate participation in the learning activities:

- presentations were made throughout the system by agency heads and human resources and administrative personnel to gain support for the learning sessions;
- printed materials such as posters and leaflets were developed and distributed to promote the Learning Strategy and the learning activities; and
- an updated schedule of events for the learning initiatives were distributed to all agencies through HIV and AIDS focal points.

Implementation

Orientation Sessions: Orientation sessions began in April 2005. A full-time coordinator, working with two interns, was hired to coordinate the training sessions. This person is responsible for coordinating sessions at the Nairobi headquarters and in outside locations, booking the rooms for the sessions, writing reports on the progress of the sessions and procuring materials. The full-day sessions are given to groups of up to 30 participants (with 20 participants, on average) by a paid external trainer subcontracted from another company. The sessions covered the minimum standards set by the Learning Strategy; including using the booklet, *Living in a World with HIV and AIDS*, demonstrating male and female condoms, and informing staff on voluntary confidential counselling and testing, post-exposure prophylaxis kits, policy issues and discussing stigma and discrimination around HIV and AIDS. In addition, the sessions are interactive and involve the participation of People living with HIV. Posters were developed to be placed around the room while the training was taking place as an extra enforcement of the messages sent.

The cost of running these sessions, paid for by the UN Office, has been approximately US$ 41 per staff member. This has included tea and coffee for participants, a t-shirt and certificates of attendance. The participants also received the UN booklet, *Living in a World with HIV and AIDS,* the resource inventory list, and some informational sheets. The medical service attempts to attend all sessions to brief participants on the '3Cs' and voluntary confidential counselling and testing.

Feedback from staff after orientation sessions indicated that many staff members wanted additional sessions for their children. The Learning Team was able to organize full-day sessions for children during the school holidays to meet this request. The sessions were tailored to specific age groups (ages 10–14 and 15–20) and to be interactive, using theatre, music and dance. The training, which cost US$ 18 per participant and borne by the parents, included training, lunch, morning and afternoon tea, t-shirts and a certificate of attendance.

Peer Educators: Plans, as of August 2005 were also underway to train peer educators and counsellors to act as support systems for staff members who may be infected or affected by HIV and AIDS. The Learning Team noted that the goal is to ensure that peer educators are supported and have adequate supervision. The UN stress counsellor, who is already on staff on an interagency basis, will be responsible for offering support to the peer educators.

Resource Library: A document library was started in an already existing library where staff can borrow books, tapes and videos pertaining to HIV and AIDS.

World AIDS Day: The Learning Team organized World AIDS Day events that included ceremonies with music and poetry, organizing a mobile voluntary confidential counselling and testing van for staff, and placing informational tables in high traffic areas for staff and nongovernmental organizations. At these tables informational flyers were handed out along with t-shirts and stickers designed for the event. A "gift tree" was set up where staff could donate gifts to be sent to an orphanage for children orphaned due to AIDS.

Monitoring and Evaluation

The Learning Team is responsible for monitoring and evaluating the progress of the orientation sessions based on the outcome and impact indicators set forth in the learning plans. To assess this, participants were asked to fill out post-session evaluation forms developed to elicit comments about the content of the orientation sessions, the training methodology and the effectiveness of the trainers. Some results as of August 2005 showed that:

- 95% of participants said the sessions met or exceeded their expectations;
- 94.5% thought the methodology was good or very good; and
- 78% thought the one-day training course was too short.

In June 2005, monitoring showed that the programme has reached at least 80% of all UN staff, 80% of all professional staff, 100% of UN Heads of Agencies, Theme and Working Group members and HIV and AIDS programme/project officers in addition to at least 50% of UN staff dependants and family members. Staff came from over 25 UN agencies. The sessions averaged 24–36 staff in each session, with an average of 75 staff members attending sessions per week. In addition, by the end of August 2005, 120 children of staff members had been trained.

For the learning goal related to supporting the national strategy on HIV and AIDS (80% of professional staff by end 2005), no progress has been made.

LEBANON

Overview and Background
In 2003, UNAIDS reported the HIV prevalence rate among adults (age 15–49) in Lebanon at 0.1%.[16] However, no systematic surveillance of sexually transmitted infections, including HIV, is in place in Lebanon, making it difficult to accurately assess HIV prevalence rates. In Lebanon, the primary means of transmission is sexual, with 47% of reported cases from heterosexual transmission and 28% from men who have sex with men. Three per cent of transmissions were reported from injecting drug use which seems to be rising in the country. Additional reported cases were through mother-to-child transmission (6.7%) and through infected blood products (15.6%).

Prior to the current learning activities described in this case study, no systematic efforts were undertaken for staff members in the UN system with respect to HIV and AIDS.

Needs Assessment
The Learning Team decided that the first priority was to develop a country-specific set of needs assessments, one for all staff on issues related to HIV and AIDS in the UN workplace and another for professional staff only on issues related to supporting national responses to HIV and AIDS.

The workplace survey, administered in September 2004, was available online in English with an Arabic version administered on paper. Those individuals who were not computer literate were assisted in completing the survey and the responses were entered thanks to volunteers in the online database to be analyzed with the rest of the data. The Learning Team noted that the process of answering in this way was uncomfortable for some individuals as a few of the questions were considered personal and embarrassing when asked by others.

In some cases, the survey was given only to staff in a central office due to an inability to get the survey out to a large and dispersed staff population, as was the case for United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNRWA).

The needs assessment survey achieved a 62% response rate. The high rate may be attributed to a variety of factors: the Learning Team decided to wait until after the religious holiday period to launch the survey; a poster announcing the survey was developed and distributed; e-mail informed and reminded staff about the importance of completing the survey; and the Learning Team was persistent in follow-up to ensure the survey was seen as an important and productive tool.

[16]See http://www.unaids.org/en/Regions_Countries/Countries/lebanon.asp.

The results of the survey showed the following:

- 81% reported either not having received or remembered receiving the UN booklet on HIV and AIDS;
- 81% reported never having participated in various forms of HIV or AIDS-related learning activities in the UN system;
- 76% reported no or low familiarity with the female condom;
- 63% reported no or low familiarity with how to live and work with people affected by HIV;
- 74% reported no or low familiarity with benefits and entitlements associated with HIV and AIDS in the UN;
- 73% had no or low familiarity with the job security issue;
- 76% had no or low familiarity with insurance issues;
- 70% had no or low familiarity with confidentiality issues; and
- 68% indicated a desire to learn about these issues.

Each agency was provided with its individual results from the needs assessment. This information was later used to tailor the learning sessions to the needs of the staff. Although the sessions were based primarily on globally produced materials, activities were chosen for the specific needs of the staff in each agency according to the needs assessment results.

A second survey was developed for professional staff to gauge knowledge related to supporting national responses to HIV and AIDS in Lebanon. This survey also used online technology and was kept open for two weeks. Issues covered in this survey included:

- the UNGASS Declaration of Commitment and its implementation;
- the UN Millennium Development Goals;
- the UN "Corporate strategy" regarding HIV and AIDS;
- a broad overview of HIV and AIDS in the world;
- the country's national HIV and AIDS strategy and structures; and
- how to integrate or mainstream HIV and AIDS into all programmes and projects.

The results showed:

- 54% of professional staff reported little to no knowledge of the UNGASS Declaration of Commitment and UN Millennium Development Goals on HIV/AIDS;
- 54% of professional staff reported little to no knowledge of the country's national HIV and AIDS strategy and structure;
- 43% of professional staff reported little to no competence on how to integrate or mainstream HIV and AIDS into the programmes/projects for which they were responsible;

- 45% of professional staff reported little to no competence on how to take leadership and advocate on HIV and AIDS issues with national partners; and
- 47% of professional staff reported little to no ability to engage civil society and develop partnerships to respond to HIV and AIDS.

The results of the professional survey were reported to all professional staff.

Planning for a Response

The Learning Team, with the agreement of the Theme Group, agreed to the following goal:

> To ensure that by the end of 2005, 50% of staff members and 20% of family members would have basic knowledge of HIV and AIDS prevention, care and treatment, UN-specific policies and entitlements, the effects of HIV and AIDS in our world, and issues related to living and working with people living with and affected by HIV and issues of stigma and discrimination.

This goal was to be met through facilitated orientation sessions which would include basic information about HIV and AIDS, demonstrations on the use of male and female condoms, information regarding locally available services such as voluntary confidential counselling and testing and sensitization on issues such as stigma and discrimination. Printed material would also be developed and distributed to increase awareness of HIV- and AIDS- related issues.

For learning related to supporting national responses to HIV and AIDS, the following goal was agreed upon:

> To ensure that by the end of 2005, all professional staff with significant responsibility for HIV and AIDS programmes, including Heads of Agencies and Theme Group members attend learning sessions related to the National Response strategy.

This goal was to be met through the dissemination of a CD-ROM with documents related to the National Strategy including the Millennium Development Goals, and the UNGASS Declaration of Commitment and the subsequent gathering of professionals at learning sessions geared towards the National Response Strategy.

Each agency was asked to write a Plan of Action to be integrated into a unified Learning Plan by the Learning Team Chair. Upon request, the Learning Team representative from the various UN agencies met with the Learning Strategy Facilitator on an individual basis to discuss the plan for their agency. Although plans

were submitted by almost all the agencies and a Unified Plan of Action was compiled, much of the plan was compromised when the Prime Minister of Lebanon was assassinated in early 2005.

The main areas of action of the unified Learning Plan were to:

a. Incorporate learning activities into the annual workplan of each agency.
b. Advocate for the Learning Strategy with the representative of each agency in order to ensure maximum participation of staff members (and their families) in the learning activities.
c. Plan for follow-up and evaluation of implemented learning activities to improve future activities.

The learning plans also addressed different ways to communicate important information about HIV and AIDS to staff. This included developing and distributing printed material to staff. The *Living in a World with HIV and AIDS* booklet was to be ordered and distributed to all staff. Printed posters and brochures were created to raise awareness on the importance of this booklet for UN staff and their families.

Key Actors

The Theme Group sent two professionals—the Coordinator of Reproductive Health Projects from UNFPA and the Manager of the National AIDS Control Programme from UNDP—to attend a regional workshop on the UN's HIV/AIDS Learning Strategy early in 2004. Each facilitator took primary responsibility for one of the two major goals of the Learning Strategy:

- developing knowledge and competence of UN professional staff to best support national responses to HIV and AIDS; and
- ensuring that all staff members were able to make informed decisions regarding HIV and AIDS in the context of their personal lives and the workplace, including knowing UN policies on HIV and AIDS.

Upon their return to Lebanon, these two facilitators briefed the Country Team and Theme Group on the Learning Strategy and its implications. Both were in solid support of the Learning Strategy and displayed that support by financially backing the initiatives and agreeing to the creation of a Learning Team, eventually comprised of 20 representatives from 16 different agencies.

The Resident Coordinator requested that UN agency representatives each nominate a focal point to serve on a Learning Team.[17] The main mission of the Learning Team is to assist the Theme Group in implementing the learning plan, determining priorities, and advising on future recommendations to improve the plan. Learning Team members are expected to be HIV and AIDS learning "ambassadors" to their respective agencies and constituents within the UN system. Terms of Reference were written to explicitly outline the responsibilities of the Learning Team. The Chair of the Learning Team, also a member of the Theme Group, was able to brief the Theme Group regularly on progress and to report to the Country Team. The frequent communication between the Learning Team, Theme Group and Resident Coordinator helped to maintain support for the learning initiatives.

[17] The Learning Team includes members from the following agencies: UNRWA, UNDP, UNICEF, ILO, UNHCR, UNESCO, WHO, FAO, UNFPA, ESCWA and UNIDO.

Advocacy and Promotion
Memos and e-mails from agency heads were sent to staff to raise awareness about the orientation sessions. Follow-up memos were sent to staff informing them of times and dates. The orientation sessions were sometimes included within already established training programmes for staff. Less formally, word of mouth from those who attended also contributed to the successful implementation of the orientation sessions.

Posters were developed to promote the orientation sessions. Posters developed by the UN in New York were adapted for use in Lebanon to encourage staff to attend sessions. The booklet and workplace website were promoted by the posters in all UN agencies. A pamphlet was also created to give a preview of the booklet. Finally, a card was distributed to remind staff about the availability of post-exposure prophylaxis kits and voluntary confidential counselling and testing in English and Arabic. All of these were paid for by the Resident Coordinator's office.

Implementation
Orientation sessions for all staff were conducted by a number of trainers who based sessions on the *Living in a World with HIV and AIDS* booklet. A template was circulated to ensure that all sessions included objectives and a standard methodological approach. The agencies had autonomy to organize the logistics of the sessions, such as where the sessions would be held, and deciding if extras, such as a coffee break, would be provided.
Trainers primarily from outside the UN were used in the implementation of the learning sessions. This decision was made because of the unavailability of sufficient numbers of people within the UN with both technical HIV and AIDS knowledge and facilitation skills; although some were experts in HIV and AIDS, they lacked training skills. Another reason for engaging outsiders was the lack of time that UN staff could commit because of other work obligations. Thus, trainers from local nongovernmental organizations who were previously trained by the National AIDS Control Programme to facilitate sessions on HIV transmission and prevention, stigma and discrimination, were hired.[18]

The trainers first attended two orientation sessions before they began facilitating. In these sessions, the Learning Strategy was introduced, including background, minimum standards, needs assessments and their results, the Learning Team and the terms of reference for the trainers. Also covered were the activities for the orientation sessions (adapted from the global *Facilitators Guide on the UN Learning Strategy*) and the pre- and post-evaluation forms. The ILO facilitator presented the information on the UN HIV/AIDS Personnel Policy at all orientation sessions. The Resident Coordinator's office supported the implementation by providing funds for printing materials (posters and pamphlets), buying needed equipment (condom demonstration models) and paying for the training of trainers. UNFPA was able to obtain female condoms which are not available in the country, whereas the National AIDS Control Programme provided male condoms. For the orientation sessions themselves, non-UN trainers were paid by the requesting agency based on

[18] The trainers came from the National AIDS Control Programme, the Health Education Department of the Lebanese Red Cross, Global Youth Partners and the Lebanese Family Planning Association. From within the United Nations family, trainers came from WHO, ESCWA), ESCWA's medical clinic, ILO, UNDP, and the World Bank.

negotiated rates. Each agency, under the leadership of its Learning Team representative, was responsible for organizing its own learning sessions. Some larger agencies paired with smaller agencies to implement sessions, particularly to share costs of the trainers.

Some sessions were divided by sex to ensure more open discussion on sensitive topics. This was not always possible, however, as there were too few male trainers.

As sessions took place, the Learning Team Chair facilitated communication and lessons learnt between agencies during Learning Team meetings and individual agency meetings.

The sessions planned for professional staff members related to the national response have not yet been held, with these staff members claiming that their schedules are too overburdened.

Monitoring and Evaluation
Orientation sessions were monitored and evaluated by the Learning Team members for the sessions planned in each agency. Attendance at the sessions was noted and reported to the Learning Team to monitor the overall number of participants. Evaluation forms were also created to be filled out by participants to get feedback on the content and methodology of the sessions.

Pre- and post-tests were created and completed by the participants at each session. A local consultant will be recruited to analyze the data from the pre- and post-tests to report on the learning outcomes of the sessions.

This case study covers the first-year efforts of the Team and additional results from the learning evaluations will provide further insight into the year's plan to contribute to future HIV and AIDS learning plans. Despite unforeseeable challenges, the implementation of the Learning Strategy in Lebanon has yielded a number of successes. This has been due to successful collaboration between dedicated senior management and a committed Learning Team. Overall, it has set a strong foundation for preparing staff to live and work in a world with HIV and AIDS.

NEW YORK CITY

Overview and Background

The AIDS epidemic has altered demonstrably in the United States of America over the past decade. It is estimated that approximately 940 000 adults, between 15–49 years of age, are currently living with HIV in the US. The adult (15-49 years) prevalence rate is at 0.6%.[19] Every year, about 40 000 new cases of HIV occur, and about 14 000 adults and children are estimated to die of AIDS. It is estimated that nearly 240 000 women are infected with HIV in the country.[20]

At the end of 2003 in New York City, home to the United Nations Headquarters, 88 479 people were known to be living with HIV.[21] Approximately 31 163 persons were known to be living with HIV and 57 316 were known to have developed AIDS. The true number of HIV-positive individuals is higher since it is estimated that 25% of HIV-positive individuals have never been tested and thus do not know they are infected. Of the 4086 New Yorkers diagnosed with HIV in 2003, 1029 (25.2%) of them learned they were HIV-positive at the time they had already progressed to AIDS.

In a 2003 survey among UN staff in New York, 1% of respondents said they were infected with HIV but afraid to reveal their status for fear of job loss or being treated differently. However, the precise proportion of persons at UN New York headquarters who are infected is likely higher.

Prior to the current initiative, there had not been a system-wide effort in New York to address HIV and AIDS, although some agencies had earlier undertaken some ad hoc efforts in the city. Most staff had not undertaken HIV or AIDS in the Workplace Learning.

Needs Assessment

According to an online survey conducted, over 90% of NY-based staff said they understood what HIV is and how it can be prevented, although this was self-reported knowledge and the true levels would prove to be much lower as evidenced in the orientation sessions subsequently organized (see below). Less than half the respondents stated they knew the basics of treatment for HIV and AIDS. More than 90% of staff stated they understood the use of male condoms but less than 50% understood how to use female condoms.

Up to 20% of staff who did not know their HIV status believed seeking such information might be perceived negatively, suspiciously or judgementally. Only a quarter of respondents said they had been for an HIV test either within or outside the UN system. Five per cent of staff agreed that people living with HIV should not be allowed to continue working in the UN.

Nearly half of all respondents stated they were not at all familiar with the UN system's HIV/AIDS Personnel Policy and over 90% had not participated in any UN-

[19] UNAIDS (2004). UNAIDS Epidemiology Fact Sheets on HIV/AIDS: North America, Western and Central Europe.
[20] HIV Epidemiology Programme 4th Quarterly Report, New York City Department of Health and Mental Hygiene, October 2004. See http://www.nyc.gov/html/doh/html/dires/epi_reports.shtml#quarterly
[21] Ibid.

sponsored HIV or AIDS learning activities. Yet, a quarter of respondents claimed they already knew enough about HIV and AIDS.

About 35% said they had never received information on HIV and AIDS from the UN, despite wide circulation of the UNAIDS booklet that targeted staff on the subject. The majority of staff reported the media to be their primary source of information on HIV and AIDS—a source that may provide accurate information, but may also be prone to biases and discrimination.

It was clear from the survey results that much work was required to develop basic competence around HIV and AIDS, knowledge on UN system policies and establish a system free from discrimination and stigma. This included implementation of minimum standards for staff participation in HIV and AIDS orientation sessions; reduction of stigma and discrimination; requirement of senior managers to take more proactive roles; and distribution of information that would ensure people knew where to access counselling and testing services related to HIV.

Planning for a response

In June 2004, the Interagency Team planned implementation of orientation sessions for UN employees based in New York, to reach about 8000 people. The team discussed several options before agreeing on programme objectives, content, length and logistical arrangements, which are described in this chapter.

The sessions were meant to target all employees of the UN system, regardless of employment status, department or agency affiliation. The Assistant Secretary-General urged attendance for the orientation sessions, and stated they were designed to provide essential HIV- and AIDS-related information concerning transmission, prevention, care and treatment; introduce UN policies, initiatives and services related to HIV and AIDS in the UN workplace; and promote a culture of tolerance and understanding with regards to the AIDS pandemic.

A timeframe was initially proposed for 2004, but was overly ambitious. Sessions began in February 2005 and continued through to the end of 2005.

Key Actors

The main planning body for the orientation sessions was the UN Interagency Team that was established under the leadership of the United Nations Assistant Secretary-General for Human Resources.[22] While the Interagency Team ensured the day-to-day planning and follow-up actions, the direct support and involvement of the Assistant Secretary-General was crucial for system-wide support of the programme. The Interagency Team planned for the marketing and promotion of the orientation sessions within their agencies. They developed the content and format of the orientation sessions, approved the budget and worked within their individual agencies to secure funds, and followed through with adjustments and changes as required.

[22] The team, chaired by the United Nations Assistant Secretary-General for Human Resources, included representation from the UN Secretariat, UNICEF, UNDP, UNFPA and the UNAIDS Secretariat. UNOPS joined the team later in the process. It included representation from those working on HIV and AIDS in the UN workplace, learning managers, staff association representatives, human resource officers and the UN Medical Services.

Given the large number of New York-based staff (approximately 8000) and the logistical coordination that was foreseen, a consultant coordinator was hired for the purposes of planning and implementing the orientation sessions. The coordinator took the lead in bringing the sessions to fruition, and worked in close collaboration both with the UN Interagency Team and orientation session facilitators.

Volunteers were recruited to conduct the orientation sessions. They worked in pairs—one volunteer from inside the UN system and one from outside. Recruitment of insiders took place via e-mail alerts sent by Agency heads encouraging people who had some basic knowledge on HIV and AIDS and/or training experience to apply. Over 90 staff members applied. Although steps were taken to secure a balanced representation from all agencies, UNFPA provided the largest number of UN volunteers. Non-UN volunteers were recruited by requesting Masters of Public Health students from two major universities (Columbia University, New York University) to join the UN in this effort. Through individual and small group interviews, those most qualified in HIV and AIDS knowledge and facilitation skills were selected. In addition, volunteers were identified from the New York Department of Public Health, Carnegie Foundation of New York, People living with HIV and a UN spouse.

Two main trainers from the UN Interagency Team trained the volunteer facilitators who in turn, conducted the orientation sessions. Focal point persons from each agency from among the facilitator pool assisted with logistical preparation for sessions conducted in their respective buildings. The first two groups of volunteers were trained over one of two, three-day workshops (December 2004 and January 2005) to ensure they would effectively implement the sessions.

The main trainers modelled each session as it should be facilitated with UN staff, following a facilitator's manual approved by the New York Interagency Team. Two panel discussions were held to widen the knowledge base of volunteers on technical issues regarding questions about HIV and AIDS, the clinical aspects of testing, treatment and first line defence in case of accidents, and on UN personnel and insurance policies. Resource persons from the UN participated on these panels. Finally, each of the facilitators was asked to co-facilitate a full practice session at the workshop.

Following these first trainings, participants were given the option to participate in additional practice sessions with one another. This allowed them to build their confidence before facing a group of staff participants.

In view of the large numbers expected to attend, and to build a database of participants and of the session evaluations, UN procurement services selected a web-based event management system. The coordinator worked extensively with the agreed vendor to design the registration webpage, as well as the session evaluation form, though the extent of possible customization was limited.

Advocacy and Promotion

On World AIDS Day, December 1, 2004, the Secretary-General announced the upcoming orientation sessions. In his speech he stated, "The United Nations system in New York will be organizing half-day orientation sessions on HIV and AIDS in

the workplace… I am taking the opportunity … to ask all staff of the UN system in New York, from the most senior to junior, to make time for the orientation sessions…".

The Assistant Secretary-General for Human Resources played a key role in taking this statement to the next level and initiating advocacy to garner support for the HIV and AIDS orientation sessions in New York. A strategy was designed by the consultant to publicize the sessions and ensure maximum participation. As a result, the Assistant Secretary-General broadcast news of the orientation sessions to all UN staff.

Prior to the launch of the programme, a number of sessions were organized for the Office of Human Resources Management in the UN Secretariat and the Division of Policy and Planning in UNICEF, both to start advertising the sessions and to pre-test the content and methodology.

A key promotional event was a modified orientation session organized for the Senior Management Group, including the Secretary-General with the Heads of all agencies, funds and programmes based in New York. This helped acquaint them with the content and methodology of the orientation sessions and motivated them to strongly support staff participation.

In addition, posters, flyers and postcards were produced and put up in all UN buildings announcing the sessions and registration process. Posters were placed at key locations near staff cafeterias and lobbies for optimal viewing. The posters were changed periodically to keep the publicity fresh. The postcards included information on how to sign up for the orientation sessions and also included information about HIV and AIDS hotlines, websites and UN focal points. The flyers and postcards were distributed at events and by the medical services. E-mail alerts urging staff to register for orientation sessions were sent by Heads of Agencies and Division Directors. Most agencies included an advertisement for the orientation sessions on their internal websites.

In view of relatively low participation in the first few weeks, the messages were revised in consultation with the Interagency Team, to include the following.

- Quotes by Heads of Agencies who attended an HIV and AIDS session were widely publicized through e-mails and flyers.
- Extracts from session evaluations, which were overwhelmingly very positive, were advertised and widely circulated periodically in each agency.
- Participants were asked to print their certificates in colour and display them for everyone to see, as a means of removing stigma associated with attending the sessions (reported by some participants), and also to motivate participation by colleagues. They were also asked to give a copy to their human resources officer to add to their personnel file.
- It was suggested that the sessions be mandatory but the decision was initially vetoed by most agencies. However, over time, all but the UN Secretariat and UNAIDS Secretariat made attendance mandatory and within the UN Secretariat, some Directors took the initiative and asked their staff to attend as an obligation, but without any enforcement measures.

The design and printing of the orientation session flyers, posters and postcards were funded by the Interagency Team budget. UNICEF independently funded an additional round of flyers in August 2005.

Implementation

Each session was a half-day long, and based on the globally produced *Facilitator's Guide to Implement the United Nations Learning Strategy on HIV/AIDS.* It followed the format of the UNAIDS booklet, *Living in a World with HIV and AIDS*, and was divided into four sections.

- *Be aware*—facts and figures, basic knowledge, transmission routes.
- *Protect yourself*—methods of protection against HIV transmission.
- *Living in a World with HIV and AIDS*—voluntary confidential counselling and testing, UN HIV and AIDS personnel policies.
- *Let live*—living and working with HIV-infected and affected people, eliminating stigma and discrimination.

The interactive sessions included quizzes, discussions, condom demonstrations, self-reflection and screening the UN video, "Living in a World with HIV and AIDS".

It was agreed that the orientation sessions be implemented by having personnel at all levels from the range of UN organizations in New York attend the same sessions rather that having each agency implement its own specific sessions. This was agreed for several reasons. However, following specific requests, variations to the original model were added:

- Special sessions were organized to target specific groups of staff: staff with teenagers, women only, men only.
- In response to the high demand formulated by certain divisions and departments to train their staff altogether, special sessions were held for the Office of Human Resources Management in the Secretariat, UNDP and UNICEF, the Office of the Executive Director in UNFPA and the OHRLLS (Office of the High Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing Countries).
- Evening sessions were planned to include staff members who worked night shifts, but were not held due to issues of overtime.

Conference rooms throughout the UN system in New York were reserved to accommodate groups of 20–35 participants, prior to launching the programme. Rooms were regularly provided by the UN Secretariat, UNDP and UNICEF. UNFPA also occasionally provided rooms, as needed. A system was arranged to ensure that facilitators would have all materials needed for the sessions ahead of time. UN volunteers from among the facilitators were in charge of providing the materials from the central supplies managed by the programme coordinator, which included handouts, models to demonstrate condom use, the video, sufficient copies of the booklet, *Living in a World with HIV and AIDS*, and all necessary training supplies. In each building, there was at least one focal point in charge of this task.

Learning for the facilitators was further supported through provision of self-study materials on HIV and AIDS produced by UNFPA (from the *Distance Learning in Population Issues* programme), and the creation of an electronic workspace (eWs) to serve as a forum for sharing experiences and clarifying issues with the main trainers. The eWs provided answers to frequently asked question from sessions, links to HIV

and AIDS websites, additional readings, and enabled the coordinator to be in constant contact with facilitators for the purposes of coaching, recruitment for particular sessions, and help with readjusting teams based on observations of their performance during the orientation sessions. The coordinator was the manager of the electronic workspace.

The proposal for implementing orientation sessions for all employees in the United Nations System in New York necessitated sharing of costs among all UN system organizations in New York. While funding was shared, larger agencies assumed a greater share than smaller organizations.

A commitment of US$ 73 000 was requested to cover the initial costs of the project, to be shared among NY-based UN organizations. The breakdown was as follows:

- UN Secretariat: US$ 47 050
- UNDP: US$ 10 950
- UNICEF: US$ 10 000
- UNFPA: US$ 5000

The Interagency Team was able to operate within this budget. Expenses included a salary for the consultant coordinator, a lump-sum payment for the purchase of the orientation sessions' web-based registration system software and production of materials such as posters and handouts for the sessions.

Monitoring and Evaluation

Participants who attended sessions were asked to complete an online evaluation form subsequent to the orientation sessions. Although evaluations were anonymous, the database monitored demographic information of participants including their agency affiliation, level of employment and gender.

Results of completed online evaluation forms were compiled into online software and exported to excel spreadsheets for extraction and categorization of pertinent information. Feedback from individual sessions was sorted and relayed back to facilitators on a monthly basis through the e-Workspace. Consolidated feedback from all sessions was sent to the UN Interagency Team to monitor and uphold overall quality assurance of the HIV and AIDS orientation sessions. The coordinator fulfilled these tasks.

The database also facilitated monitoring by allowing each agency to see exactly who had attended a session by Division or Unit. Weekly reports allowed for follow-up at all levels in the UN system in New York and for further advocacy efforts to be made towards increased attendance.

The official start of the sessions was February 2005. As of December 2005, 3521 UN staff members had attended, which is 47% of all NY based staff. Agency statistics varied widely: UNFPA 97%; UNDP 83%; UNOPS 81%; UNICEF 74%; UNAIDS 56% and the UN Secretariat 32%. Of the participants who had attended as of October 15, 2005, females constituted two-thirds of all participants (66% females vs. 34% males).

A great majority of the evaluations were extremely positive: 91% found the session excellent or good. On the usefulness of the information communicated during the sessions, the "Very Useful" or "Useful" rating was as follows:

- HIV Prevention, Care and Treatment: 90%
- UN HIV/AIDS Personnel Policy 89%
- How to live and work with people living with HIV: 85%
- How we can all work to eliminate stigma and discrimination: 83%

Approximately 93% of participants found facilitators' knowledge of HIV and AIDS to be excellent or good, and 91% found facilitators' communication skills to be excellent or good.

As a result of the orientation session, 94% of staff were aware of where they may access services such as voluntary confidential counselling and testing in New York; 41% said they planned to get tested for HIV in the near future; 34% of staff said they intended to share the information learned on HIV and AIDS and the booklet with their children; 71% with their family, 59% with their friends, and 46% said they would share the information with their colleagues.

A majority of comments, even from staff who considered themselves knowledgeable about HIV and AIDS, stressed that the sessions were highly informative, enlightening and an eye opener. The video and the booklet were much appreciated. The facilitators were overwhelmingly considered excellent, professional and engaging. The methodology was welcomed as very interactive, allowing maximum participation from all attendees.

A few comments suggested that a medical doctor should facilitate the sessions. Some found the sessions would have benefited from role-play or simulation exercises to better illustrate the session on stigma. For instance, some staff suggested presenting strategies to address hypothetical scenarios related to HIV and AIDS in the workplace. A small proportion of attendees thought the condom demonstrations were embarrassing for the audience and should be omitted. Some requested further time for questions, and broader discussions on personal feelings and current sociopolitical views on HIV and AIDS. Finally, a few staff members thought it was important to always pair one female with one male facilitator.

A more in-depth evaluation of the programme is currently underway to understand the impact the orientation sessions are having on the professional and personal lives of the stakeholders involved—participants and facilitators. The evaluation will assess participants' perceptions about their degree of knowledge, attitudes, behaviours and practices surrounding HIV and AIDS issues prior and subsequent to their participation; and examine the facilitators' perceptions of changes in their knowledge, attitudes, behaviours and practices as a result of designing and implementing the strategy. This will help the Interagency Team better realize the true impact of the sessions in the New York workplace, and shed light on what motivated staff to participate in the Learning Sessions.

PHILIPPINES

Overview and Background
The AIDS epidemic in the Philippines has been characterized by some as "low and slow." As a lower middle income country, the Philippines has witnessed a low prevalence of HIV, with an estimated 10 000 cases of HIV and AIDS, or 0.01% of the population.[23] In spite of these low rates, an increasing pattern of behaviour such as unprotected sex, high rates of sexually transmitted infections and low condom use, suggesting that the possibility of an epidemic still remains.

In 1992, the government responded by forming the Philippines National AIDS Council (PNAC), and later, in 1998, enacted the Philippines AIDS Law. This law addresses many critical issues around HIV and AIDS, including the full protection of human rights and civil liberties of people living with HIV, the banning of mandatory testing for HIV antibodies, the promotion of confidentiality and the dissemination of information and educational programs. While promising, the "silent" nature of the epidemic and additional organizational constraints has resulted in delays in implementing these policies. However, HIV and AIDS are on the agenda—both nationally, and within the UN system.

Needs Assessment
The UN in the Philippines participated in the UN global learning needs assessment in 2002. Due to low participation rates in this first needs assessment (23% of UN staff in the country), the UN Theme Group on HIV and AIDS conducted a second learning needs assessment survey among staff in the first quarter of 2004, the results of which are now used by each UN agency to develop their respective learning plans.

Over 50% of staff members participated in the survey, with the majority of respondents from UNICEF. Results from this survey showed the following:

- 85% reported having learned about HIV and AIDS from magazines, newspapers and other personal readings;
- 52% reported having learned about HIV and AIDS from UN learning materials;
- 36% had heard of the UNAIDS booklet but had never read it;
- 39% and 45% of respondents did not know what AIDS and HIV stand for, respectively;
- 92% of staff were aware of modes of transmission (unprotected sex, exposure to contaminated blood and needles); while only 63% were aware of mother-to-child transmission;
- 18% thought HIV could be transmitted via wet kissing, while 10% thought that sharing utensils could lead to HIV infection;
- 100% reported that regular and proper use of condoms is a form of prevention;
- 18% were familiar with the UN HIV/AIDS Personnel Policy; and
- 39% had no or low familiarity with confidentiality issues.

[23] See http://www.unaids.org/en/Regions_Countries/Countries/philippines.asp.

Planning for a Response

Development of Learning Plans in the Workplace

- Basic HIV and AIDS, Gender and Sexuality Training

After the needs assessment, the next step was organizing a *Basic HIV and AIDS, Gender and Sexuality* training for human resources and personnel staff, as well as HIV and AIDS focal points. This was to develop the participants' understanding of the relevance of these issues as workplace issues, and to develop an appreciation of their roles in creating a workplace free of stigma and discrimination. Participants in this workshop were later convened by the UN Technical Working Group, and organized into the Task Force on AIDS in the UN Workplace.

Once organized, the Task Force reviewed the various policy statements on HIV and AIDS developed within specific UN agencies, using the *ILO Code of Practice and World of Work* frameworks. The results of the review revealed policies that fell under three overarching components:
1) Prevention through information, education and training;
2) Care and support for staff members and their families; and
3) Protection of rights of UN staff and families.

Operational Guidelines

Within each of these categories, the Guidelines discuss various activities and guidelines for implementing the activities, including:

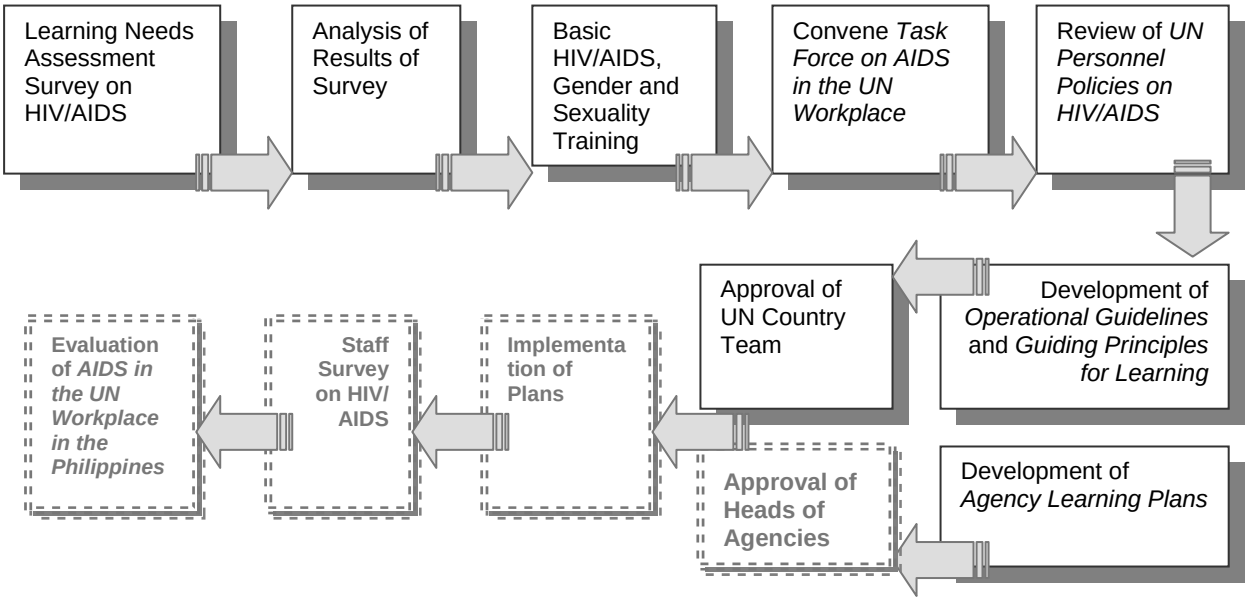
1. Education and Training:
    a. Distribution of the UN booklet on HIV and AIDS for United Nations Employees and their Families and post-exposure prophylaxis protocol;
    b. Orientation sessions on HIV and AIDS, and quarterly orientation sessions for new hires;
    c. Information corners with resources on AIDS registries, voluntary confidential counselling and testing services, post-exposure prophylaxis protocol; and
    d. Calendar of activities, and two learning activities per year on HIV and AIDS as a way to deepen the orientation sessions.
2. Care and Support:
    a. HIV and AIDS Personal Risk Assessment Test, to be taken by all staff;
    b. "Ceremonial testings" to be led by agency heads;
    c. Distribution of voluntary confidential counselling and testing kits; and
    d. Provision of medical supplies, such as condoms, Antiretroviral drugs, syringes, and safe blood.
3. Protection of Rights:
    a. Development of procedures to ensure confidentiality of test results;
    b. Training of focal persons on secured management of information; and
    c. Informing of all staff of their rights and opportunities.

Development of Learning Plans Related to National Support

The Philippines aims to achieve the following goals related to national support by integrating and converging UN agency plans, implementation, monitoring and evaluation, and resource mobilization. The three main objectives are:
1) complying with international commitments, particularly the Millennium Development Goals;
2) achieving sector-specific goals as detailed in the United Nations Development Assistance Framework; and
3) strengthening national and local capacity to implement the Medium Term Plan for accelerating the Philippine Response to HIV and AIDS.

In addition, there is support for the establishment of national and local partnerships among public, private and civil society organizations and national and local organizations. Participation of People living with HIV and vulnerable groups in programming, implementation, and monitoring and evaluation, as well as the strengths from different UNAIDS co-sponsors will help facilitate this commitment.[24]

A model was developed that clearly laid out the steps for the development of the AIDS in the UN Workplace Programme in the Philippines:



What remains pending is the approval of the agency heads, implementation, staff survey and the evaluation. Additionally, the UN Theme Group aims to endorse a consolidated learning plan for the UN System in the Philippines.

The Learning Plan on HIV and AIDS consisted of activities that each agency or the whole UN system must undergo to meet minimum standards. An agreement included "Must Have," "Must Do," and "Must Know" and was constructed as follows:

[24] Meeting of Task Force on AIDS in the UN Workplace, "Building competence of the UN and its staff to respond to HIV and AIDS," IOM Conference Room, January 12, 2005

"Must Have", "Must Do", "Must Know"

"Must Have" for All Agencies

- Information corner on HIV and AIDS with information on statistics, basic information, announcements of activities and other updates.
- List of service providers for voluntary confidential counselling and testing.
- Copies of the booklet on HIV and AIDS for UN Staff and Employees.

"Must Do" for All Agencies

- Provide condoms in bathrooms.
  —The Task Force was assigned to develop recommendations on the provision of condoms to UN staff.
  —To do so, they had to consider the sensitivities of staff and guests who use the restrooms; possible barriers for individuals (e.g., embarrassment in asking a clerk) to purchasing condoms despite availability, accessibility and affordability in the Philippines; and the need to fulfil the UN HIV/AIDS Personnel Policy.
  —It was agreed that condoms be made available through the UN in accordance with the UN Personnel Policy.
  —An assessment of what would be an acceptable and discreet way to dispense condoms and inclusion of condom desensitization/orientation in the learning activities was also agreed upon.
- Active participation in government-organized events on HIV and AIDS.
  —Participation in World AIDS Day was an agency-wide event.
  —Each agency was to distribute red ribbons and information explaining the significance of the ribbon, as well as encourage others to participate in government-organized World AIDS Day events.
- Develop strategies to raise awareness on HIV and AIDS in the workplace.
- Implement at least two learning activities per year for staff on HIV and AIDS-related subjects.
  —Each agency would be responsible for conducting two learning activities, primarily for its own staff, spouses and children, but would be open to all UN agencies.

"Must Know" for All Agencies

- All staff should be knowledgeable of the basics of HIV and AIDS, with respect to prevention, transmission, local and global statistics, (RA 8504, The Philippines AIDS Prevention and Control Act of 1998) and the UN Policies on HIV and AIDS.
- Pool of trainers. Identification of "internal consultants" (a designation of those within the UN to certain learning areas on HIV and AIDS) and the utilization of focal points, task force members and HR were agreed upon. It was later decided that this was not possible due to cost ineffectiveness of training, and possible problems due to workload, availability and turnover.
- Counsellors and installation of in-house hotlines on HIV and AIDS. It was later decided that this was not a good idea, given cultural constraints and the small size of the UN organization.

Key Actors

A Task Force, formed by the Country Team in the second quarter of 2004, was organized as a result of the *Basic HIV and AIDS, Gender and Sexuality* training detailed below. The overarching role of the Task Force is to assist the Theme Group on HIV and AIDS to operationalize the global Learning Strategy on HIV and AIDS in the Philippines. More specifically, the Task Force is the primary team responsible for planning, coordinating, monitoring and evaluating the first year of implementation

of the UN Workplace programme on HIV and AIDS.[25] Within each agency there is a designated Official Representative, Alternate Representative and a Staff Associate Representative. Members of the Task Force were also trained and equipped with skills to become facilitators for the UN Workplace Programme.

- Country Team: The agency heads met every quarter, and were responsible for approving the UN Workplace Programme on HIV and AIDS.
- Theme Group: The Theme Group, also comprised of agency heads, meets every quarter and is responsible for providing support and the submission of individual agency learning plans complete with activities and fund allocations, as well as the endorsement of a consolidated learning plan for the UN System in the Philippines. The Theme Group also has an important role with monitoring, as the agency heads can facilitate the communication from the focal points regarding progress related to the learning plan.
- Technical Working Group: This group also consists of programme staff members and coordinated the Learning Needs Assessment.
- Consultant: UNAIDS hired a consultant to assist the Task Force with the development of the operational guidelines.

Unfortunately, staff turnover interrupted the flow of Task Force meetings; however, it is worthy to note the content of the Task Force meetings. Despite efforts to orient and pique the interest of the new agency focal points, the Task Force ceased to meet after May 2005.

Advocacy and Promotion

In August 2004, the programme was presented to and approved by the UN Country Team. Soon after, the UNAIDS Secretariat e-mailed members of the Task Force and requested that each member develop and submit a learning plan for their respective agencies. Five out of seven agencies submitted learning plans in 2004. Let it be noted as well that at this time, most were still not yet aware of the UN Learning Strategy on HIV/AIDS.

Implementation

From 2004–2005, approximately 250 UN staff members were given orientation sessions on HIV and AIDS through the learning activities of the respective UN agencies. The learning activities ranged from half-day to one-day orientation sessions and short sessions were integrated into the programme staff meetings. Given the local situation, it was deemed most appropriate for each agency to organize its own activities.

In 2004, UNDP was able to implement its learning activities, specifically on the basic staff orientation on HIV and AIDS. During 2004–2005, UNICEF conducted five awareness sessions for staff, ranging from short, 45-minute exercises to half-day sessions, covering HIV and AIDS basics, consideration of risks, available services in the Philippines and a condom demonstration. An estimated 30–40 staff participated in at least one of the activities, covering more than half of the total staff. The UN booklet, *Living in a World with HIV and AIDS* was distributed to all staff members.

[25] The Task Force is comprised of human resources, personnel staff and focal points from ILO, IOM, UNDP, UNFP, UNICEF, WHO, The World Bank, and the UNAIDS Secretariat. The ILO provides technical inputs and guidance, while the Secretariat coordinates the work of the Task Force. While this group experienced many changes and permutations, it has consistently been an interagency committee.

UNFPA conducted similar activities, while ILO devoted a one-day orientation session for its 45 members in their annual planning workshop in December 2005. Finally, the UNAIDS Secretariat held two HIV and AIDS awareness sessions during the final quarter of 2005, one for staff of the smaller UN agencies and another for the security guards. Both sessions, conducted in Filipino, discussed HIV as well as other sexually transmitted infections, including a testimonial by a person living with HIV and condom demonstrations. A list of voluntary confidential counselling and testing service providers and a post-exposure prophylaxis briefer were distributed electronically to all UN agency focal points.

The World Bank is further along with its implementation. A committee was formed to implement the agency's HIV and AIDS in the UN Workplace Programme for its 70 staff members. The World Bank outsourced the tasks of conducting staff orientation session on HIV and AIDS and voluntary confidential counselling and testing to Remedios Foundation. Additionally, kits were made available to staff that contained condoms and follow-up information about the session content. The plan to make condoms available in the restrooms generated negative reactions from many staff members; therefore, condoms were placed in the kits rather than in public restrooms.

Presently, condoms are available in all male and female comfort rooms in all UN offices housed in Yuchengco Tower, RCBC Plaza in Makati City, Philippines. UNFPA is the sole agency providing the free supply of condoms. Since the condoms became available in November 2005, approximately 720 condoms have been distributed.

On an interagency level, day-long sessions for children of UN staff ages 12 and above were planned on the subject of children's rights and adolescent reproductive health. A session for parents on how to discuss sexuality and reproductive health with their children was also planned, with funding from UNFPA. However, these had to be cancelled, due to lack of sufficient interest.

Monitoring and Evaluation

Outputs of the Workplace Programme are included in the 2005 UN Country Team Workplan, and implementation was reviewed by the UN Technical Working Group on HIV/AIDS at their year-end review and planning meeting in December 2005. A more detailed evaluation of the Workplace Programme has been tabled for possible inclusion in the 2006 Country Team Workplan, but it remains to be seen whether it will be included.

UNAIDS and UNFPA are monitoring the distribution of the condoms, which are currently being provided free of charge. In 2006, they will evaluate the sustainability of the arrangement, and may consider providing the condoms for a small fee.

The Learning Strategy continues to face a number of challenges; most notable are the numerous and frequent changes in the membership of the UN Task Force on AIDS in the UN Workplace: This has been the biggest factor limiting the functioning of the Task Force, thus slowing down implementation of the learning activities since the latter half of 2004. Often, when a Task Force member left the UN, a replacement was not necessarily appointed, thus requiring the learning facilitators and UNAIDS to personally follow up with the respective agency heads. Newly appointed Task Force

members were not well-oriented on the Learning Strategy or HIV and AIDS, and did not necessarily place priority on either—echoing the national situation. The learning facilitators, with the help of the UNAIDS Secretariat, attempted to overcome this by including orientations on the Learning Strategy and the Workplace Programme for the new members in Task Force meetings of January, March and May 2005. However, the challenges they face are ongoing.

ZIMBABWE

Overview and Background
For the first time since the initial diagnosis of AIDS in Zimbabwe in 1985, overall HIV prevalence and incidence in the adult population is declining.[26] Adult prevalence rate (for 15–49 years of age) is now 20.1% (down from 24.6% in 2003) and the decline in prevalence has been attributed to a combination of factors including falling HIV incidence, high but stabilized mortality and some behavioural change in reduced sexual partners and greater condom use. Everyone needs to work hard to build on the emerging positive trends, if the country target of a prevalence rate under 10% is to be achieved by 2011.

A National Antiretroviral Treatment (ART) programme was initiated in April 2004. Before the Ministry began its plan, treatment was provided by the private sector, two research projects and one mission hospital. Currently 48 health facilities are providing antiretroviral drugs throughout the country. The number of people needing treatment in Zimbabwe has been estimated as 342 000[27] but treatment is only reaching 6% of this group. The main challenges are public sector capacity together with the lack of foreign currency to procure antiretroviral drugs and laboratory equipment.

Current strategic plans for the next five years must take into account the fact that morbidity and mortality will remain very high. The national response now focuses on increased access and use of prevention, care and treatment services. With 1.3 million orphans and vulnerable children nationwide, of which 980 000 have been orphaned by AIDS, only 20–30% are estimated to benefit from comprehensive support programmes. The sociocultural situation is also important as more UN staff members take care of increasing numbers of dependants and sick family members.

No survey of HIV prevalence among UN staff and their families in Zimbabwe has been conducted or is planned and therefore national prevalence rates are used as a guide for workplace HIV and AIDS planning and support.

Needs Assessment
Antiretroviral drugs are not always available or affordable in the general health system in Zimbabwe (the national programmes only reach 19 000 people with plans for the "3 by 5" treatment initiative expanding to 60 000 by the end of 2005). The UN now maintains stocks of antiretroviral drugs and opportunistic infection drugs at an accredited local pharmacy and the UN clinic located at the local UNICEF offices.

A national framework of legal requirements and workplace guidelines on HIV and AIDS issues was in place via the National HIV and AIDS policy for Zimbabwe from 1999 but has not been sufficiently enforced nor made mandatory. In 2005 , the Zimbabwe Public Service (the employer of all civil servants in the country) launched its HIV and AIDS policy and implementation strategy with the support of UN agencies.

[26] UN Zimbabwe country Profile October 2005
[27] UN Implementation Support Plans (UN-ISP) on HIV and AIDS in Zimbabwe 2005.

A baseline survey, spearheaded by the UN Country Team, across the UN Zimbabwe family in 2003, revealed there was an overriding attitude of HIV and AIDS being someone else's problem; stigmatizing behaviour around HIV and AIDS was evident amongst staff; and efforts across the UN family remained fragmented, with a good deal of inequity across agencies.

Only three out of the twenty UN agencies and offices present in Zimbabwe were actively supporting workplace HIV and AIDS programmes and policies. So even before the Learning Strategy guidelines were launched, the Zimbabwe Country Team initiated a joint UN workplace programme on HIV and AIDS workplace issues, which, for the first time, brought together key actors across agencies. Stronger interagency participation on HIV and AIDS activities was realized through the launch of the 'UN Cares' Zimbabwe.

Planning for a Response
The 'UN Cares' initiative is an overarching one. It aims at complementing and supporting agency-level initiatives while mobilizing the UN family to start, extend and broaden their own programmes of workplace support. The establishment of a 'UN Cares' interagency team supports the implementation of the HIV and AIDS Learning Strategy objectives.

The 'UN Cares' organogram

➲Resident Coordinator of the Country Team

➲Operational Management Team

➲UN Cares Team

➲All Agency Representatives

The team balances management and technical experience with good interpersonal skills. An early and key component of the response was general health care and HIV and AIDS treatment access and support. This has greatly improved the standard of health for staff and their families across UN agencies. The reimbursement system, which involves upfront payment by staff means many staff members cannot get the medical support when needed because of hyperinflation. To address this, credit and direct billing facility have been established with over 30 service providers such as hospitals, specialist practitioners and laboratories. Plans are being made to expand the programme to include broader paediatric, gynaecological and radiology support as well as specialized laboratory facilities that now have the capacity to do blood tests not available before locally. This has meant greater equity in health care and support. Staff can now access services more easily.

To increase and improve on interorganizational relationships an annual UN family Fair/Learning Event was planned for December 2005. The Staff Association will play an important role in mobilizing staff to participate and capitalize on the weekly sporting events they have initiated throughout the year.

Key Actors
The key UN actors at country level for the 'UN Cares' response have been the UN Country Team, the UN Theme Group, Technical Working Group, the Operations Management Team, the 'UN Cares' team and the two HIV and AIDS Country Facilitators[28], the Staff Association, the agency focal persons (who represent 18 agencies) and the Human Resources Focal Persons. The Country Team monitors the implementation of the Learning Strategy plan through monthly reports. UNDP is the focal agency for the 'UN Cares' workplace programme as Country Facilitator.

Key non-UN actors have been Zimbabwean People Living With HIV and AIDS groups (such as The Center), SHAPE (an organization of local university students), state players such as Ministry of Health and Child Welfare (MOHCW) for treatment literacy, PACT Zimbabwe on Home Based Care (HBC) and bodies such as Populations Services International[29] , Zimbabwe Women's Lawyers Association and Women, Leadership and Governance Institute and CONNECT. These partnerships add real value through testimonies, local knowledge and technical skills as well as an understanding of local situations and practices.

A professional staff counsellor is being engaged to support the workplace programme as part of the UN Clinic services. It is anticipated that the interaction and network will strengthen the peer counsellors that are being trained. The first group of 25 was trained in August 2005.

Advocacy and Promotion
It was quickly realized that the antiretroviral drug support programme and the initial interagency training conducted across agencies in 2003 needed to be broader. A programme of advocacy, care and support information to bring staff a more personalized experience of HIV and AIDS issues and to encourage voluntary confidential counselling and testing was put together. Lessons from UNICEF's 'Caring for Us' programme were used and expanded the training under the Learning Strategy framework beyond the minimum standards mandated to include spouses and dependants of UN staff.

'UN Cares' training asked staff and spouses to participate in two levels of HIV and AIDS education. Level A covers "Essential information on HIV and AIDS" and Level B focuses on "Building a Supportive Office Environment". Dependants have also been included and children, split into three age groups (8–12, 13–15, 16+ years) can access life skills training that covers a variety of topics, including gender and assertiveness, substance abuse, myths and misconceptions, relationships and communication and prevention.

The objectives for this ongoing three-fold training strategy are to:
- Disseminate information on UN policies, rules and regulations that enhance successful implementation of the 'UN Cares' programme;
- Give in-depth knowledge on HIV and AIDS to United Nations employees and spouses/partners;

[28] The facilitators are resource people who can advocate and assist in the planning, coordinating, organizing, implementing, evaluating and reporting of the learning activities on HIV and AIDS. They were chosen from UNDP and UNICEF.
[29] Populations Services International, an international private sector AIDS Service Organization .

- Redress myths, misconceptions, attitudes and risk behaviour among UN employees and spouses or partners;
- Motivate for sustainable behaviour change through advocacy for voluntary confidential counselling and testing services;
- Mainstream gender in UN Programme and HIV and AIDS initiatives
- Mitigate the impact of HIV by offering integrated life skills and information on living positively and community home-based care (CHBC) for UN employees and spouses/partners.

Implementation

The interagency training support in 2003 reached 420 staff from at least nine agencies.[30] In addition, under 'UN Cares' 363 people have been trained in 2004 involving staff from nine agencies, including Health Systems Trust, IOM and UNAIDS, with facilitation from a network of both UN staff and its partners. The following table outlines some of the key 'UN cares' training support to staff to date:

UN Cares training workshops	**UN Staff 2003**	**UN Staff 2004**	**UN Staff 2005**
Essential information on HIV and AIDS	420	110	41
Building a Supportive Office Environment	N/a	178	Not done
Life skills (8 to 16+)	N/a	75	38
Peer counselling training for workplace contacts	N/a	N/a	25
Total people trained	**420**	**363**	**104**

The table highlights the number of staff who attended. Spouse participation, although not listed here, has risen from 1% in 2003 to 9% in 2004. Included in the 2005 figures are some service and domestic staff and contractors. Agencies such as UNICEF have also expanded their training programme curriculum this year to include 'HIV and AIDS and domestic violence'.

Figures for 2003 and 2004 were high due to pre-funding support for the programme. However, not all agencies reimbursed the system. Pre-funding was not made available in 2005 and as a result numbers trained have significantly dropped or delayed.

Monitoring and Evaluation

How successful has the Learning Strategy been in Zimbabwe? The following table measures achievements against the expectations of the Learning Strategy guidelines.

Measuring success across agencies against minimum standards outlined in the Learning Strategy guidelines[31]	
Minimum standards expected of Learning Strategy	UN Zimbabwe indicators of success

[30] UNDP, UNIFEM, UNIDO, UNFPA, UNFPA Country Technical Services Team, UNHCR, UNICEF, FAO.
[31] Introduction to implementing the Learning Strategy on HIV/AIDS in the UN Workplace, Section 1, Page 1.

Measuring success across agencies against minimum standards outlined in the Learning Strategy guidelines[31]	
Facilitated orientations session for staff using UNAIDS materials and UN HIV and AIDS guidelines	✓ Eleven workshops held, 363 staff from all categories/levels including four Country Team members trained using the UN Booklet from July-December 2004. Distribution of UN Cares booklets and Personnel guidelines as part of training. ✓ A minimum of three days (combined) learning for level A and B training per staff member/person was achieved. ✓ Post-exposure prophylaxis kits made available to all staff and held by key staff known inside and across agencies; also strategically placed for universal access by staff and dependants at the Department of Safety and Security, Pharmacy, UN clinic and with Physicians.
Staff members to participate in a demonstration on the use of male and female condoms	✓ Free condoms (male and female) are available in strategic places within most offices; however, there is a general shortage of female condoms.
Staff provided with information on locally available services including voluntary confidential counselling and testing	✓ Agency focal persons circulate information to all staff regularly and include follow-ups from training and information on local services. ✓ Staff feedback indicates there is interest in outside counselling facilities such as New Start Centers and information has been shared.
Raise sensitivity and awareness towards people living with HIV	✓ Feedback from peer counsellors and agency focal person indicate an increase in staff interest on HIV and AIDS issues as well as requests for information and support. ✓ Anecdotal evidence and observations show attitudes around HIV and AIDS are changing with less stigmatization and language and attitude changes (e.g. in the handling of personnel records and health claims as staff understand the need to treat information sensitively).
Prominently display posters and other materials on HIV and AIDS	✓Ongoing display of posters and messages using the 'We Care – We Walk The Talk' themes. ✓ A 'resource corner' has been set-up in Takura House for access by all UN agencies and staff, which has general info, resource materials, videos on HIV and AIDS.
Additional desirable standards	UN Zimbabwe indicators of success
Participation of people living with HIV	✓ Ongoing work with The Center for people living with HIV and AIDS. ✓ Individual facilitators and couples living with HIV using personal testimony as part of training. ✓ Technical inputs from People Living with HIV.
Interagency network of peer	✓ Fourteen agencies and offices participated.

Measuring success across agencies against minimum standards outlined in the Learning Strategy guidelines[31]	
educators	✓ Network of resource persons and facilitators from 11 agencies.
Family members in learning activities	✓ 75 children ages 8–12, 13–15, 16+ trained on Life skills Programme. ✓ Spouse participation rose from 1% in 2003 to 9% in 2004.
Local intranet-based information on HIV and AIDS, including service availability	✓ Learning Strategy agency-based focal persons as well as peer counsellors circulate messages to all staff by e-mails as well as training info and follow-up information on service provision after training events.
Annual events organized to raise awareness about HIV and AIDS	✓ 2005 Interagency Fund Day planned for December with greater involvement and activity by the interagency Staff Association. ✓ Ongoing events including staff and families such as sports events, birthday messages and weekend picnics involving HIV and AIDS messages.
Additional areas of success	UN Zimbabwe indicators of success
Leadership and commitment	✓ UN Cares Workplace Team in place, with representation from all agencies as well as Interagency staff association. ✓ Some commitment at high level as some Country Team and spouses get involved in training—where this has occurred agencies have moved forward beyond training in the workplace. ✓ Skills transfer workshop held in April. ✓ Presentation of commitment/pledge certificates by or on behalf of the Resident Coordinator.
Treatment and support	✓ A move from 10 to 20 staff and dependants currently accessing antiretroviral drugs through the UN scheme since implementation of the Learning Strategy. ✓ More staff from a broader range of agencies enquiring on how to join the antiretroviral drug programme (Country team reports over 10 calls each month regarding drug access and training opportunities across the agencies) ✓ First Aid—agencies have already started training. ✓ Thirty health care and support services providers signed direct payment agreements allowing a broad range of quality health care for staff. ✓ A Pharmacy contract has been established for the provision of health care, antiretroviral and other essential drugs at a 20% upfront payment for staff. ✓ The UN clinic is providing antiretroviral drugs and other medicines to UN staff 150% cheaper than local retail outlets saving the UN system money and ensuring their

Measuring success across agencies against minimum standards outlined in the Learning Strategy guidelines[31]	
	availability to staff (according to a recent study).

Overall, monitoring at the interagency level is difficult. An online survey currently in progress is meant to address the lack of baseline on a wider scale, improve current programmes and act as a measuring tool. Monthly feedback by the interagency Operations Management Team keeps agencies informed but does not provide the added value of competition and learning brought about by a central evaluative tool which would monitor progress against agreed milestones or standards across agencies. Questionnaires are slow yielding and often have low returns. Analysis and forecasting and planning for the future are weakened by a less rigorous and less standardized process of data management.

Finally, interagency best practice could be shared more within the UN family and could build enthusiasm and target the right people for regular data flow from agencies.

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

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

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JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

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