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ILOAIDS
Implementing the ILO Code of Practice
on HIV/AIDS and the world of work:
an education and training manual

Introduction

It is a message that cannot be repeated too often: there is no cure for AIDS. A cheap, effective vaccine is years away. The only way to stop the spread of HIV infection is through prevention. HIV is a fragile virus. The ways it is spread are well known, as are the ways to prevent transmission.

It is therefore vital to

- constantly reinforce the simple facts about HIV infection, how it is spread and not spread, and how to prevent it;
- contradict the persisting myths about HIV and AIDS;
- combat the superstitions and taboos related to sexual behaviour;
- promote and support behaviour change.

This module looks at prevention and the role of governments, employers and workers in developing strategies and programmes to prevent HIV infection - in the workplace and also outside, in communities where the world of work can give a lead. It is followed by a module on care and support, although in practice prevention and care should not be developed as separate activities.

The World Health Organization says that:

Prevention, care and support are inseparable. The provision of good quality care and support prolongs and improves the quality of life, and provides opportunities for HIV prevention efforts. When HIV-positive people are treated with compassion and respect, not only are they more likely to act responsibly towards those around them, but they can also become powerful and credible advocates of HIV prevention. On the other hand, when the provision of care is undermined, or those affected by HIV/AIDS are stigmatized, the chances of success of preventative approaches recede.¹

¹ UNAIDS: *HIV Prevention Needs and Successes: A tale of three countries* (Geneva, 2001)

Success stories

As workplace activities take place within the framework of national policies, it is useful to look at some examples of national HIV/AIDS prevention programmes.

Several countries have been relatively successful at turning back the rate of increase in HIV infections. These countries nevertheless caution that there is a need for continued vigilance to ensure that progress is maintained and new areas of infection do not open up.

We will look at what three countries have done: Thailand, Uganda and Australia

Thailand

The national response to the epidemic in Thailand moved from a reluctance to take the issue seriously in the 1980s to the development of one of the most comprehensive HIV/AIDS programmes in the world. As a result, it is calculated that overall behaviour change reduced the annual number of new HIV infections from 143,000 in 1991 to 29,000 in 2000. An extensive and intensive prevention programme was introduced in 1990/1991, which combined mass media campaigns, focused interventions and community mobilization. A national multisectoral committee, chaired by the Prime Minister, oversaw the programme. Some of the main elements were:

- focusing on populations with high-risk behaviour, such as sex workers, injecting drug users and army conscripts;
- delivering safe sex messages to the general population through the mass media, with a special emphasis on young people;
- using the extensive family planning networks with their community educators for HIV/AIDS prevention;
- developing programmes to treat sexually transmitted infections (STIs) and reduce their prevalence in high-risk groups;
- promoting a policy of 100 per cent condom use among commercial sex workers;
- introducing legislation that protects the human rights of people with HIV and AIDS.

Even so, one in a hundred Thais is infected with HIV, AIDS is the leading cause of death, and the country is facing the challenges of care and of ensuring that prevention efforts remain adapted to changes in the epidemic.

Uganda

Uganda was one of the first countries in sub-Saharan Africa to experience the devastating effects of AIDS. By 1993 1.5 million Ugandans were infected, at that time the highest prevalence in the world.

According to President Museveni, the Ugandan government drew inspiration from a traditional saying, “When a lion comes into your village you must raise the alarm loudly”. An important part of its approach was to ensure the participation of all ministries, set out in *A Multisectoral approach to AIDS* (1993), and to build a consensus among religious, political and community leaders.

Measures taken to “raise the alarm” included:

- the use of radio and TV to get over a safe sex message;
- rallies in rural areas to mobilize communities;
- enlisting the support of churches and mosques;
- education in schools throughout the country;
- measures to empower women and promote women’s leadership.

Other measures such as same-day results for HIV testing, social marketing of condoms, and self-treatment kits for sexually transmitted infections have played an important part in reducing infections (as has ensuring the safety of blood transfusion supplies).

As a result of these measures:

- in Kampala the level of HIV infection among pregnant women attending antenatal clinics fell from 31 per cent in 1993 to 14 per cent by 1998;
- outside Kampala, infection rates among pregnant women fell from 21 per cent in 1990 to 8 per cent in 1998;
- infections among men attending clinics for the treatment of STIs fell from 46 per cent in 1992 to 30 per cent in 1998;
- the average age at which young people experience their first sexual encounter has risen from 14 to 16 and 17 for girls and boys respectively.

What is particularly significant about Uganda is that community action and leadership extended and reinforced government action. One example is the women’s section of the National Union of

Plantation and Agricultural Workers, which became known for taking messages about HIV/AIDS, among other issues, into villages all over the country through song, dance and drama.

Australia

Australia is often quoted as one of the earliest success stories in dealing with HIV/AIDS. The virus first spread through the gay community and was also a problem amongst intravenous drug users. The annual incidence of HIV infection peaked in 1983/84 and has continuously declined since then. The number of AIDS cases reached a peak in 1994 at just less than 1000 and by 1999 had declined to 196.

Amongst the reasons for this early success were:

- the development of a National Strategy to combat AIDS in 1989;
- partnership between government, the affected communities and medical, scientific and health-care professionals to ensure co-ordinated action, based on respect and open communications between them;
- the involvement of the gay community in framing education, prevention and care initiatives;
- existing networks in the gay community that ensured rapid mobilization to disseminate prevention messages and combat stigma and discrimination;
- the extensive use of needle and syringe exchange programmes;
- secure funding to support education and prevention.

As in other countries, leadership was an important component at both political and community levels, together with the active involvement of affected groups. In addition to the effective control of HIV infection, Australia has also developed considerable expertise in the treatment and care of people living with HIV/AIDS.

Key lessons

From these three countries, and other examples, certain key lessons can be drawn for prevention:

Leadership - The role of leadership is of crucial importance, both at the highest political level and in the community.

Multisectoral strategy and broad alliances - The national strategy should involve all ministries and a range of civil society bodies, not only those in the health sector; ministries of labour are often left out of national AIDS structures, but have a vital contribution to make, and it is essential that employers and workers be represented on national AIDS bodies.

Multi-level strategy - Action is needed at national, regional and local levels for the HIV/AIDS strategy to be implemented successfully.

Participation - People at risk from or affected by the epidemic, including people living with HIV/AIDS, should be actively involved in planning and implementing the national strategy at all levels.

Overcoming cultural barriers and taboos - It is vital to go into the 'no-go' areas and help people talk about attitudes and behaviour, even in difficult areas like sexual relations. There is a need to understand how the disease is spread in a community in order to develop initiatives to prevent new infections.

Behaviour change - Changing behaviour is difficult and requires helping individuals understand and learn to manage their own risk: it has to be based on accurate and accessible information and supported by practical support such as condom provision or clean needles.

Effective targeting - Messages must be aimed at the right group or groups: persuading sex workers to use condoms is of little consequence if the client determines whether they are used or not. The approach itself also needs to be appropriate to the local situation: communicating with isolated rural communities and illiterate people should involve participatory activities such as song and dance, and the use of local languages and existing channels of communication. Different messages are appropriate to different groups, for example adolescents as opposed to married men.

Zero tolerance for stigma and discrimination - Prevention can only succeed in an atmosphere of trust and security – discrimination discourages people from seeking help and encourages the spread of the virus.

The role of treatment - The use of antiretroviral therapies (ART) delays the progression from HIV infection to AIDS and is an incentive for voluntary counselling and testing (VCT).

Prevention at the workplace

Can we apply the lessons of successful national action at the workplace?

The workplace is an ideal place to contribute to prevention strategies. All workplaces include people at risk. Some workplaces and occupations operate in an environment that accentuates the risk of infection. Examples are mines that employ men and house them away from their families, or transport workers who travel away from home. Workplaces that employ a large number of migrant workers also fall into this category.

Ways of minimizing risk factors at the workplace can be worked out through social dialogue, as discussed in Module 3. But whatever the working environment, vital information about HIV/AIDS can be provided at the workplace.

Section 6 of the Code of Practice argues strongly for 'Prevention through information and education':

Workplace information and education programmes are essential to combat the spread of the epidemic and to foster greater tolerance for workers with HIV/AIDS. Effective education can contribute to the capacity of workers to protect themselves against HIV infection. It can significantly reduce HIV-related anxiety and stigmatization, minimize disruption in the workplace, and bring about attitudinal and behavioural change.

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The Code also provides comprehensive guidelines about the format and components of a prevention programme:

Information and education should be provided in a variety of forms, not relying exclusively on the written word and including distance learning where necessary. Programmes should be tailored to the age, gender, sexual orientation, sectoral characteristics and behavioural risk factors of the workforce and its cultural context. They should be delivered by trusted and respected individuals. Peer education has been found to be particularly effective, as has the involvement of people living with HIV/AIDS in the design and implementation of programmes.

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The Code presents prevention as a process whose main stages are:

- information and awareness-raising,
- participatory education programmes that include assessing and managing one's own risk, and
- practical measures to support behaviour change.

Information and awareness-raising

Most workplaces already provide information and training on occupational health and safety, as well as messages about working conditions, rights, and behaviour. Campaigns aimed at raising awareness about HIV and AIDS can and should be run for all working people. The Code suggests that:

6.1 (a) Information programmes should, where possible, be linked to broader HIV/AIDS campaigns within the local community, sector, region or country. The programmes should be based on correct and up-to-date information about how HIV is and is not transmitted, dispel the myths surrounding HIV/AIDS, how AIDS can be prevented, medical aspects of the disease, the impact of AIDS on individuals, and the possibilities for care, support and treatment.
(b) As far as is practicable, information programmes, courses and campaigns should be integrated into existing education and human resource policies and programmes as well as occupational safety and health and anti-discrimination strategies.

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Education programmes

Education programmes are an essential part of prevention, building on information and awareness campaigns. They help people apply general messages to their own situation and behaviour, and give them the tools for taking personal decisions about their exposure to risk and how they will manage it. The 'Guide to the manual' explains the importance of an interactive, participatory approach to education. The Code talks of giving workers "the opportunity to express and discuss their reactions and emotions caused by HIV/AIDS".

Risk assessment and management

Education for prevention means creating an environment which avoids judgement, and recognizes that individuals may do things outside work which the enterprise, union, or society officially disapproves. Attitudes towards risky behaviour need to be discussed openly. As the Code suggests,

6.2 (c) Where practical and appropriate, programmes should:

- emphasize that HIV cannot be contracted through casual contact, and that people who are HIV-positive do not need to be avoided or stigmatized, but rather should be supported and accommodated in the workplace;*
- emphasize the debilitating effects of the virus and the need for all workers to be empathetic and non-discriminatory towards workers with HIV/AIDS;*
- give workers the opportunity to express and discuss their reactions and emotions caused by HIV/AIDS.*

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Education gives workers tools to help them take personal decisions about their behaviour and how they will manage risk.

6.2. (c) Where practical and appropriate, programmes should:

- *include activities to help individuals assess the risks that face them personally (both as individuals and as members of a group) and reduce these through decision-making, negotiation and communication skills, as well as educational and preventative and counselling programmes;*
- *give special emphasis to high-risk behaviour and other risk factors, such as occupational mobility, that expose certain groups of workers to increased risk of HIV infection;*
- *provide information about transmission of HIV through drug injection and information about how to reduce the risks of such transmission.*

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For example, an individual may be a regular client of commercial sex workers. He (and it almost always is he) may recognize the risk this involves and decide to manage it by always using a condom.

Practical measures to support behaviour change

Help may be needed to sustain changes in behaviour – peer pressure, especially the encouragement of colleagues at work, can be very positive. Practical measures are also essential to support behaviour change: the most important is the provision of free or affordable condoms. In Brazil the price of condoms was reduced by half in the late 1990s, which led to a five-fold increase in condom use. This has been identified by the Brazilian government as a key factor in reducing HIV incidence in the course of the 1990s. In Uganda the provision of same-day testing services has made an impact. These services, which include pre- and post-test counselling, have provided important opportunities for delivering safe sex messages and have led to risk reduction behaviour. Other measures try to address specific risk factors. For example, there are ongoing discussions in South Africa between the National Union of Mineworkers (NUM) and the Chamber of Mines about ending the single-sex hostel system and providing accommodation for families.

6.5 Practical measures to support behavioural change

- (a) In providing workers with sensitive, accurate and up-to-date education about risk reduction strategies, and, where appropriate, male and female condoms should be made available*
- (b) Early and effective STI and tuberculosis diagnosis, treatment and management, as well as a sterile needle and syringe-exchange programmes, should also be made available, where appropriate, or information provided on where they can be obtained.*
- (c) For women workers in financial need, education should include strategies to supplement low incomes, for example by supplying information on income-generating activities, tax relief and wage support.*

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6.2. Educational programmes

- (a) Educational strategies should be based on consultation between employers and workers, and their representatives and, where appropriate, government and other relevant stakeholders with expertise in HIV/AIDS education, counselling and care. The methods should be as interactive and participatory as possible.
- (b) Consideration should be given to educational programmes taking place during paid working hours and development materials to be used by workers outside workplaces. Attendance should be considered as part of work obligations.
- (c) Where practical and appropriate, programmes should:
- include activities to help individuals assess the risks that face them personally (both as individuals and as members of a group) and reduce these through decision-making, negotiation and communication skills ...;
 - give special emphasis to high-risk behaviour and other risk factors, such as occupational mobility, which expose certain groups of workers to increased risk of HIV infection;
 - provide information about transmission of HIV through drug injection and information about how to reduce the risks of such transmission; ...
 - promote HIV/AIDS awareness in vocational training programmes ...;
 - promote campaigns targeted at young workers and women
 - give special emphasis to the vulnerability of women to HIV and prevention strategies that can lessen this vulnerability (see Section 6.3);
 - emphasize that HIV cannot be contracted through casual contact, and that people who are HIV-positive do not need to be avoided or stigmatized, but rather should be supported and accommodated in the workplace;
 - emphasize the debilitating effects of the virus and the need for all workers to be empathetic and non-discriminatory towards workers with HIV/AIDS;
 - give workers the opportunity to express and discuss their reactions and emotions caused by HIV/AIDS;
 - instruct workers (especially health care workers) on the use of Universal Precautions and inform them of procedures to be followed in case of exposure;
 - provide education about the prevention and management of STIs and tuberculosis, ...;
 - promote hygiene and proper nutrition;
 - promote safer sex practices, including instructions on the use of male and female condoms;
 - encourage peer education and informal education activities; ...
 - be regularly monitored, evaluated, reviewed and revised where necessary

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Gender-specific programmes

Education programmes need to take into account the different situations and needs of women and men, the social and cultural pressures on each, and other issues related to gender – especially power and control in relationships.

6.3 Gender-specific programmes

(a) All programmes should be gender-sensitive, as well as sensitive to race and sexual orientation. This includes targeting both women and men explicitly, or addressing either women or men in separate programmes, in recognition of the different types and degrees of risk for men and women workers.

(b) Information for women needs to alert them to and explain their higher risk of infection, in particular the special vulnerability of young women.

(c) Education should help both women and men to understand and act upon the unequal power relations between them in employment and personal situations; harassment and violence should be addressed specifically.

(d) Programmes should help women to understand their rights, both within the workplace and outside it, and empower them to protect themselves.

(e) Education for men should include awareness-raising, risk assessment and strategies to promote men's responsibilities regarding HIV/AIDS prevention.

(f) Appropriately targeted prevention programmes should be developed for homosexually active men in consultation with these workers and their representatives.

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Where a workplace has a women's committee, or where a union committee has a women's section, these should be involved in drawing up the programmes.

In many cultures and countries, homosexuality still has great stigma attached to it, and may be against the law. In these circumstances, it is very unlikely that homosexual men will identify themselves as such. In many societies, men who have sex with other men are also married and have children.

HIV/AIDS prevention programmes must take into account the reality of the sexual behaviour of men and women. Discussion about sexuality may be difficult and uncomfortable; in some cultures it is taboo. But what is far more uncomfortable is thousands of unnecessary deaths from AIDS because people were too embarrassed to talk about sex, or did not approve of certain types of sexual behaviour.

Module 5 of this manual deals in more detail with gender aspects of HIV/AIDS and the world of work.

Peer educators

It is widely accepted that peer education is one of the most effective ways of delivering HIV/AIDS education to a specific community at risk. Peer educators are informal leaders who come from the group that is being trained. For example, if your programme is aimed at staff in a large hotel, you train a core group of employees as educators. Peer education works on the idea that people are most likely to change their behaviour if they are persuaded to do so by people they know and trust.

In Thailand, a government office set up a programme to train six people from each department, at all levels of responsibility, to become HIV/AIDS focal points. They were then authorized to hold regular information and discussion sessions for their colleagues during working hours. COSATU, the largest South African trade union centre, has developed a peer education programme and encourages its member unions to do the same.

Peer education:

- is inexpensive and able to reach a large number of people
- strengthens community leadership and responsibility
- maintains confidentiality
- is the most effective way of delivering a message to a specific target group
- can bring about sustainable behaviour change.

Recruiting and training peer educators should be a major component of any education programme at work. Management and union should work together to identify and train a pool of peer educators for each workplace or group of smaller workplaces. The Code of Practice (Section 7.2) says that peer educators should receive specialized training so as to:

be sufficiently informed about the content and methods of HIV/AIDS prevention so that they can deliver, in whole or in part, the information and education programme to the workforce; be sensitive to race, sexual orientation, gender and culture in developing and delivering their training; link into and draw from other existing workplace policies, such as those on sexual harassment or for persons with disabilities in the workplace; enable their co-workers to identify factors in their lives that lead to increased risk of infection; be able to counsel workers living with HIV/AIDS about coping with their condition and its implications.

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Peer educator training will need to be delivered as close to the workplace as possible. Trade union educators, staff from personnel and training departments, and members of occupational safety and health committees could attend 'training the trainer' programmes to enable them to recruit, train and support peer educators. Training of trainers should be made available through employers' and workers' organizations, ministries of labour, and the ILO, where necessary with the support of experienced NGOs.

People living with HIV and AIDS

Workers who are HIV-positive and are willing to take part in education and training activities have a vital role to play in ensuring the development of effective programmes, and strengthening the credibility of prevention messages. Efforts among UN agencies to encourage this approach have been focused in a programme called Greater Involvement of People Living with AIDS, or GIPA, with very good results. People openly living with HIV/AIDS take up jobs in participating workplaces, help draw up company policies, and take part in awareness-raising, education, and informal counselling. An article at the end of this module describes how this works in some South African enterprises.

Links to general health programmes

HIV/AIDS education programmes need to be linked to general health programmes at the workplace, where they exist. These programmes may deal with issues such as:

- reproductive health and the management of sexually transmitted infections
- nutrition and healthy living
- substance abuse/ alcohol abuse
- stress
- malaria
- blood-borne diseases such as hepatitis B
- tuberculosis (TB) prevention and treatment.

Where these general health programmes exist, it makes sense to integrate HIV/AIDS education. The ILO's SOLVE programme develops this integrated approach and may be in use in some workplaces in your country (more details at the end of this module).

A further level of integration will be with education programmes on occupational health and safety. HIV/AIDS issues and programmes should be addressed by workplace health and safety committees, especially where no dedicated HIV/AIDS committee exists, and their members should be trained to help with the implementation of AIDS policies and the provision of education and training.

Prevention in the community

In developing programmes to prevent the spread of HIV/AIDS, management and unions should include families and the local community. The Code of Practice encourages such initiatives.

6.6 Community outreach programmes

Employers, workers and their representatives should encourage and promote information and education programmes within the local community, especially in schools attended by workers' children. Participation in outreach programmes should be encouraged in order to provide an opportunity for people to express their fears and enhance the welfare of workers with HIV/AIDS by reducing their isolation and ostracism. Such programmes should be run in partnership with appropriate national or local bodies.

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Large enterprises will, in many cases, already have good links with their community - sponsoring education, health and welfare institutions, and other activities. The question of HIV/AIDS could be introduced into a suitable programme. This is in the interests of any enterprise, since the community is a source of workers both today and in the future and has an impact on behaviour and morale. The Ford Motor Company of Southern Africa sponsors HIV/AIDS education in the schools neighbouring its factories.

Training

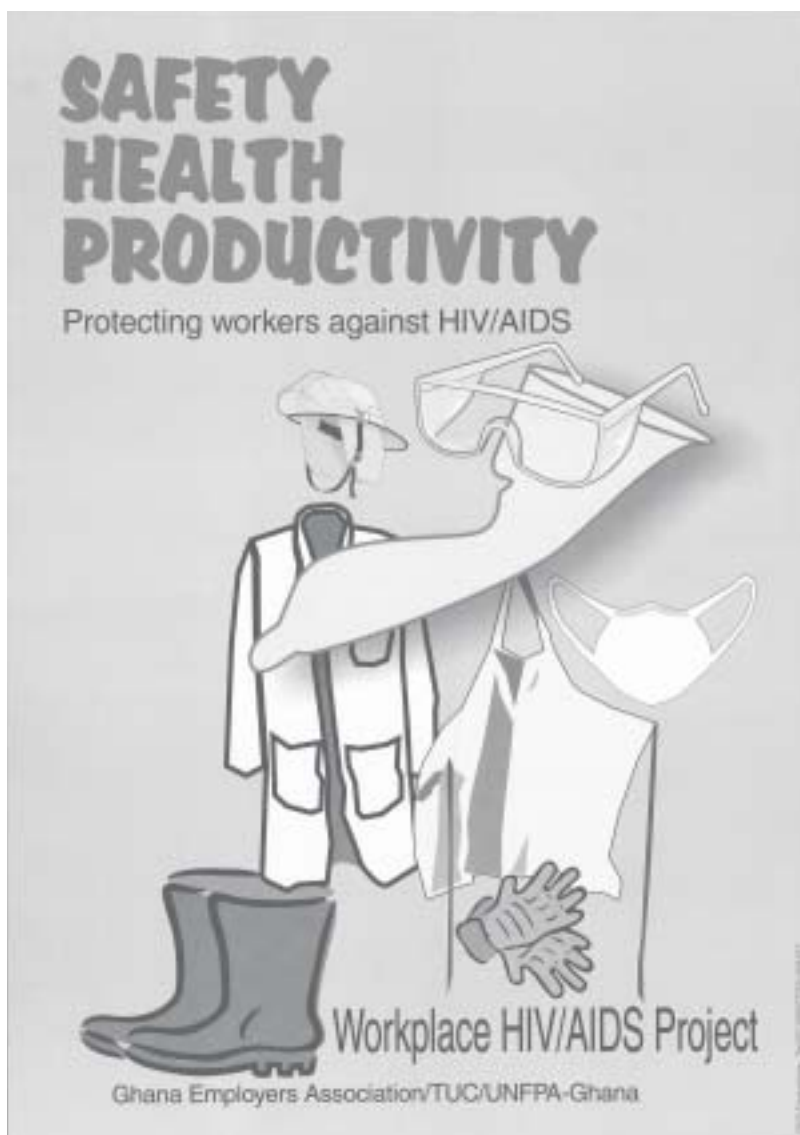
Training is essential at all levels in the workplace to ensure that managers and supervisors understand the need for and support the development of AIDS policies and programmes, and that all key groups are able to implement them effectively. Section 7 of the Code states:

Training should be targeted at, and adapted to, the different groups being trained. Innovative approaches should be sought to defray costs. For example, enterprises can seek external support from national AIDS programmes or NGOs by borrowing instructors or having their own trained. Training materials can vary enormously, according to available resources. They can be adapted to local customs, the different circumstances of women and men. Trainers should also be trained to deal with prejudices against minorities, especially in relation to ethnic origin or sexual orientation. They should draw on case studies and available good practice materials. The best trainers are often staff themselves, and peer education is therefore recommended at all levels. It should become part of a workplace's annual training plan, which should be developed in consultation with workers' representatives.

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The Code identifies the following groups of people who will need to be trained and gives advice as to what training is needed for each group:

- managers, supervisors and personnel officers
- workers' representatives
- health and safety officers
- factory/labour inspectors
- workers who may come into contact with blood and other body fluids.



Protecting young people

According to UN studies, the vast majority of the world's young people have no idea how HIV is transmitted or how to protect themselves from the disease. Yet adolescence is the time when the majority of people become sexually active. This is one reason virus continues to spread so rapidly.²

We have two dovetailing trends here that are, in large part, driving the HIV/AIDS crisis. One is that young people have sex, something the world must acknowledge as a pre-condition to mounting effective prevention programmes. The other is that young people actually don't have the proper knowledge to protect themselves. The tragic consequence is that they are disproportionately falling prey to HIV.

Carol Bellamy, Executive Director of UNICEF

In some of the countries most at risk from the disease, the proportion of young people who have correct knowledge to protect themselves is as low as 20 per cent. The result is that half of all new infections today are in people between the ages of 15 and 24. A recent UNICEF estimate for Eastern Europe is that the great majority of those with HIV are under 30 years of age. It is particularly worrying that women are being infected at a much younger age than men. Their partners are often older men and coercion is clearly an issue.

In countries where the spread of HIV/AIDS is slowing or declining, it is primarily because young men and women are being given the knowledge, tools and services to adopt safe behaviour. It shows there is a strong linkage between what young people know and how they act, and that a safe and protective environment is crucial for them to develop the skills necessary to avoid infection. In addition, special efforts are needed to reach especially vulnerable young people, such as injecting drug users.

There are two things which workplaces can do to ensure that their HIV/AIDS programmes tackle this reality.

Firstly, young workers may need special messages, delivered sensitively, with the right language, and relevant to them. Information on HIV/AIDS is more likely to be received if delivered by young people. Peer educators, or outside facilitators such as NGOs, should include young people.

Secondly, workers in the enterprise will have children, grand-children or younger siblings, and they should feel both convinced of the need to discuss HIV/AIDS with the younger members of their families, and confident enough to do so. So education in the workplace must assist in this process. It is natural for parents to want to protect their children, but sometimes this protection takes the form of avoiding discussing issues such as sex or drug use.

² UNICEF, UNAIDS and WHO: *Young People and HIV/AIDS: Opportunity in Crisis* (New York, 2002)

Mother to child transmission

Transmission of the virus from infected mother to child is one of the three main ways that HIV is transmitted. This can happen just before or during delivery - between 5 and 15 per cent of infants born to HIV-infected mothers acquire HIV this way. Untreated STIs or other infections increase the risk. Another 10 to 20 per cent of children become infected through breast-feeding. So between one quarter and half of the babies of HIV-infected mothers may acquire HIV in this way.³

Mother to child transmission becomes a workplace issue because pregnant workers, or the partners of workers, may be infected. The workplace therefore needs to play a role in prevention.

An obvious starting point is the information and education programme, which should not only help workers understand how this type of transmission takes place, but also give support to women, and their partners, in making difficult choices about breast-feeding. Maternity leave policies also provide the opportunity for action. Companies should have maternity leave and support policies in place: these may need some adaptation to include the special needs of pregnant workers with HIV. Finally, companies may be able to provide antiretroviral therapy or administer State-funded treatment.

Maternity Protection

In 2000, the International Labour Conference adopted the new Maternity Protection Convention (183), which provides for leave, cash benefits, and other facilities. Article 3 states that pregnant or breast-feeding women should not be obliged to perform work which is prejudicial to the health of the mother or the child, or where an assessment has established a significant risk to the mother's health or that of her child.

If a woman does not know that she has HIV, preventative action will not be possible. In a workplace with a strong emphasis on confidential voluntary counselling and testing (VCT), workers may already have been tested and know their HIV status. VCT may also be available for the families of workers.

If a test is taken at the commencement of pregnancy and is positive, the woman will require continued support during pregnancy, at childbirth and afterwards. Limited doses of antiretroviral drugs can lower the viral load and reduce transmission by 40-50 per cent. Companies should consider making their facilities capable of administering the correct drug therapy regime.

Where women workers return to work after their maternity leave – but also in the case of new mothers in the families of employees or with other links to the workplace – due attention should be given to the guidelines on infant feeding which are available from the WHO. In summary, these give the following advice:

³ Department for International Development: *Prevention of Mother to Child Transmission of HIV* (London, November 2001)

- Exclusive breast-feeding should be protected, promoted and supported for 6 months. This applies to women who are known not to be infected with HIV and for women whose infection status is unknown.
- When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breast-feeding by HIV-infected mothers is recommended; otherwise, exclusive breast-feeding is recommended during the first months of life.
- To minimize HIV transmission risk, breast-feeding should be discontinued as soon as feasible, taking into account local circumstances, the individual woman's situation and the risks of replacement feeding (including infections other than HIV and malnutrition).
- HIV-infected women should have access to information, follow-up clinical care and support, including family planning services and nutritional support.

Workplace programmes: case studies

An increasing number of companies have set up prevention programmes, from simple awareness-raising campaigns to a combination of education, treatment for sexually transmitted infections (STIs), and condom provision - here are three examples. While co-operation between the social partners is essential to their success, technical support may be supplied by other stakeholders, for example NGOs with experience in AIDS education and training.

The Lesedi Project, South Africa

Lesedi means 'We have seen the light' and is the name given to a small intervention study and follow-up action based at the Harmony Mine in Orange Free State, South Africa. The study started in 1996 and was carried out in partnership with the Harmony Gold Mining Company, the National Union of Mineworkers, the National Reference Centre for STIs and Family Health International, along with local health service partnerships. Most of the miners at Harmony are from other parts of South Africa or surrounding countries, living in hostels. Faced with limited economic opportunities, many of the local women have sexual relations with miners for money or material support.

An analysis was carried out which indicated that most STI transmission took place between miners and a small number of commercial or casual sex partners. The study also showed that miners had access to information, condoms and STI treatment, but under-estimated the risk of HIV infection. The women, on the other hand, were at high risk of acquiring and transmitting STIs, but had poor access to prevention and care services, including information. The situation analysis suggested that control of STI and HIV transmission in the mining communities would depend on extending effective services to women; this was achieved by offering monthly treatment with antibiotics.

The outcome of the intervention was that rates of STIs were reduced among both the miners and the women at risk of infection. A cost-effectiveness assessment estimated that some 250 HIV infections were averted, a decrease of over 40 per cent. It was further estimated that the savings to the mining company were in the region of US\$ 540,000. After the study was conducted, the project was extended - initially to three other mining companies, and then to all mining companies in the region.

According to Family Health International:

"From the beginning the project sought to include all interested parties in order to build a broad base of support. The support of the union was critical. Union leaders explained the objectives of the intervention to the miners and obtained their co-operation and support. Union support also helped the project maintain a positive image and prevented discrimination towards women involved in the study."

Larsen and Toubro Limited, India

Larsen and Toubro is one of the biggest private companies in India, engaged in engineering, equipment manufacture and construction. It has manufacturing facilities in twenty locations across India.

Larsen and Toubro has a history of responding to HIV/AIDS dating back to 1985 when it first launched an awareness-raising programme. The company carries out:

Education programmes - These have involved training 85 trainers and social workers in 200 training programmes, which have thus reached 10,000 employees, 4,500 family members and 1500 schoolchildren. A particular focus of the programmes is youth, including apprentices, graduate trainees, employees' children and local municipal schools.

Care and support - The Company actively promotes non-discrimination and support for people living with HIV/AIDS. In partnership with the government and NGOs, the company provides counselling and assistance for those affected. Peer education is used to reduce stigma and promote acceptance of employees who are living with HIV/AIDS.

Spreading the message - Larsen and Toubro helped form 'The Industry Response to AIDS', a grouping of senior management from 13 companies based in Mumbai. The company has also contributed to the writing of policy guidelines for industry in India and attempts to share its programmes and expertise with other companies.

The following are some of the lessons learned from their long-standing experience:

1. A multi-layered response is necessary in large companies with several plants.
2. Education and prevention have to be built into the training strategy of the company.
3. It is essential to involve trade unions in the planning and implementation of programmes.
4. Peer educators play a key role in both prevention and care.
5. Education materials should be multicultural and multilingual, and appropriately directed at specific target groups.
6. The company's programme implementation department should be positioned as a professional, neutral and non-threatening body.

Cote d'Ivoire Electricité

The Ivory Coast power company, CIE, whose workplace anti-AIDS programmes include condom distribution and antiretroviral treatment for employees, is viewed as a model for the region and could serve as the basis for similar efforts by other African companies. CIE regularly distributes condoms to its employees and provides AIDS education for communities located near its offices, especially in areas where there is a high level of prostitution. HIV-positive workers receive

assurance from the company that they will not be fired because of their HIV status. The company also provides health coverage and confidential medical care to its 13,000 workers and their relatives; HIV-positive workers receive antiretroviral treatment through a company fund that is partly subsidized by employee contributions. CIE's policy to provide drugs sets it apart from most others.

Angelique Wilson, head of social affairs at CIE, said that the firm's anti-AIDS efforts are showing "clear signs of success." She stated that the rate of sexually transmitted diseases among workers had fallen by 65 per cent since the beginning of the programme. Since utility firms are among the largest employers in the Ivory Coast region, CIE's efforts serve as a particularly valuable example. In West Africa, approximately 10 per cent of people aged 15 to 49 are believed to be HIV-positive; Ivory Coast has the highest HIV infection rate in the region.

Adapted from Reuters, 14/1/2002.



ACTIVITY 1

What needs to be done

AIMS To help you think about a strategy for prevention.

TASK You are the human resources manager of a manufacturing company. The prevalence of HIV has been increasing alarmingly in the country and the workforce is vulnerable due to its average age, which is around 30, and the fact that the workplace attracts a number of men from surrounding rural areas, who are living away from home. You have been asked to prepare a presentation on action the company should be taking to protect the workforce and the company's investment in the development and training of its staff.

Prepare a short presentation on the measures the company could take to prevent the spread of HIV/AIDS, outlining the main areas or issues to tackle. Indicate in your presentation what assistance you might need from government, the ILO, and NGOs or community groups.

ACTIVITY 2

What needs to be done

AIMS To help you think about a strategy for prevention.

TASK In your group, consider this case study and prepare your report:

You are a trade union representing manufacturing workers.

The prevalence of HIV has been increasing alarmingly in the country. Most of the companies you negotiate with have done some basic awareness-raising about the issue, and several of them have policies on HIV/AIDS.

You think they should be doing far more. Prepare a brief for a meeting with the Chamber of Commerce where you wish to persuade the companies to expand and strengthen their response. Think about the issues you would raise with them and the proposals you would make.

ACTIVITY 3

Getting the message across

AIMS To help you work out ways of getting key messages about HIV/AIDS across to employees.

TASK In your group, consider the situation outlined below and prepare your report:

You are the personnel department of a mine in South Africa. A group of miners have demanded a mass meeting with the branch. They are angry that the mining company has developed a project with the local university and some researchers have been interviewing informal sex workers and insisting they persuade their clients to wear condoms. The researchers have now asked to see the miners to persuade them to drink less and use condoms. The miners feel that the company is interfering with their private lives. They are bossed about enough at work and what they do with their girlfriends is their business. How would you approach the meeting and what arguments would you use?

Note : This could be adapted to a union branch executive meeting.

ACTIVITY 4

Fear, anger and information

AIMS To help you work out ways of getting key messages about HIV/AIDS across to union members.

TASK In your group, consider this case study and your response.

You are union educators in a plantation in East Africa.

A women's group has sent a message that they are alarmed about the increasing incidence of illness on the plantation. A young girl has been raped by a local man. There is little accurate information available, and people do not have a high level of literacy or access to the media.

How would you approach the meeting, and how would you channel the anger and fear of the women into a positive campaign to

- increase awareness about the problem and
- produce an improvement in the situation?

Spend 20-30 minutes in your group to prepare your report.

ACTIVITY 5

Universal Precautions

AIMS To help you understand and apply the Universal Precautions.

TASK In your group, read through the Universal Precautions (see the end of this module for a short version and Appendix II of the Code of Practice). Remember that they were devised for use in hospital and medical facilities in order to protect medical personnel from the risk of infection.

As you go through the Universal Precautions, make a note of the points where you would like further clarification. Also decide whether you need to implement any of the protective measures in your workplace for any department or group of workers.

ACTIVITY 6

Developing a training plan

AIMS To help you to develop a training plan for your workplace.

TASK Working together in your small group, develop an outline training plan for your organization. The purpose of the plan is to ensure that all levels of management are aware of HIV/AIDS issues, the company policy and how to implement it. Your plan should include:

which groups need training, what issues the training should cover for the different groups, and how you intend to evaluate the training.

You may find the chart below useful in making your presentation. You should also refer to Section 7 of the Code of Practice when drawing up your plan.

Target group	Form of training	Main issues	How you will evaluate

ACTIVITY 7

Talking about risk

AIMS To help you think about risk.

TASK Stage one

In your group, decide what you would do and/or say in the following situations.

1. You are one of a group of shop stewards having a drink after a union meeting. Several of your colleagues are looking at a group of women. One of them says, "Let's go with those women. They don't make you use condoms."
2. You are one of a group of managers on a residential training course. One member of the group looks worried. You ask him what is the matter. He replies, "I met a girl and we got carried away last night. I have a regular girlfriend at home, and we are careful, but last night I did not use a condom."
3. You are talking about AIDS to your supervisor. He comments, "Don't worry if you get AIDS. I have a friend who is a teacher and he will arrange for you to sleep with one of the girls at his school. If you sleep with a virgin, you are cured of AIDS."
4. You are sharing a table at lunch in the canteen. A co-worker says to his friend, 'My wife says she wants me to use a condom with her. I told her nothing doing - I don't like the feel of them.' You know that he is married, but that he has casual relationships and also visits bar girls.

Report back to the plenary.

Stage two

Once you have discussed these situations, choose one as a role play. Divide into groups of four. Two can play the roles, and two should observe, to see where the discussion goes. Observers: keep careful note - how convincing are the arguments and counter arguments? When you have finished, change places - the observers should play the roles. Then, in your group, summarize what you have found out, before reporting to the entire workshop.

ACTIVITY 8

Starting to deal with risk

AIMS To think about how we can encourage behaviour change at work.

TASK Consider the first paragraph of Section 6.2(c) of the Code:

...activities to help individuals assess the risks that face them personally (both as individuals and as members of a group) and reduce these through decision-making, negotiation and communication skills, as well as educational and preventative and counselling programmes;...

How could this be handled at your workplace? How can shop stewards, supervisors, personnel managers, peer educators and trainers be supported in frontline work to challenge the kind of risky behaviour discussed in the previous activity?

ACTIVITY 9

The temporary worker

AIMS To consider how to support workers faced with sexual harassment.

TASK You are a union representative in the office, and have approached Jane, a new worker on a temporary 3-month contract, to ask her to join the union. Nobody else is nearby. This is what she says:

“How can your union help me? I only have a temporary contract. I worked hard at college to get qualified to get this job and now I must support my family. I asked the supervisor if I might be made permanent. He said he could arrange it, if I have sex with him. I have never even had a boyfriend, so that I could concentrate on my studies. I am avoiding him, but he is insisting that I should reply soon.”

What do you say?

Note : You might like to refer to Module 5.

ACTIVITY 10

Getting information and support

AIMS To help you work out how to find information and support for your prevention programme.

TASK In your group draw up a list of people and organizations that might help you develop some company initiatives on the prevention of HIV/AIDS at the workplace. You will need to think about how you find out about best relevant practice in your own situation. In drawing up your list you may find the following questions useful.

1. How do we find out about good practice in the country?
2. How do we find out about good practice in the industry?
3. How do we find out what assistance the government and local authorities can offer?
4. How do we find out which NGOs and community groups can help develop effective initiatives?
5. How do we make sure that the advice of people living with HIV/AIDS, and their associations, is included in all prevention and care initiatives?

ACTIVITY 11

Prevention in the community

AIMS To think about how the message might be spread in the community.

TASK Gerry, who worked in your factory for many years, has recently died from AIDS. He was a good worker, an active member of the shop stewards committee. He was respected by management in negotiations.

Gerry had accepted his diagnosis and at the last union meeting before he left work urged that the union and management should “do something in the community” about the disease.

It has been suggested that a delegation from the factory should visit the local high school and help start an AIDS awareness campaign there.

In your group, decide:

1. What key messages should be put across?
2. How will the delegation present these messages?
3. Are there any issues to be aware of?
4. What about Gerry’s children? Will they be there? If so, would that affect what you would say?
5. What follow-up should there be?

ACTIVITY 12

Learning from experience

AIMS To help you learn from other enterprises.

TASK You will work together in small groups and you will be given one or two case studies to consider. Read through the case study and then discuss the lessons to be learnt. Prepare a brief report of any lessons that might be relevant to your own situation, in relation to prevention.

The case studies can be from this module, or any others you may have. Examples from your own country or region are usually preferable.

ACTIVITY 13

Peer educators

AIMS To help you think how workplace peer educators can be identified.

TASK 1. In your group, prepare a report which indicates:

- what types of staff/employees would make good peer educators;
- how the peer educators should be selected;
- recommendations for the training of peer educators;
- whether you think they should be paid or not;
- whether you think their work should be assessed from time to time.

2. In your group, draw up a circular for distribution, asking if anybody would like to come forward to be trained as a peer educator for HIV/AIDS. The circular should explain what they are going to do. Do not forget that the idea is to encourage people to volunteer.

- I. The Greater Involvement of People with AIDS (GIPA)
- II. The ILO SOLVE Programme
- III. Universal Precautions

I. The Greater Involvement of People with AIDS is a UN-supported programme; this case study is from South Africa, where GIPA has a specific workplace focus.

GIPA, which started in South Africa in 1997, follows three simple steps to break the silence over AIDS, overturn myths and help businesses design appropriate strategies. Step 1: place individuals living with HIV/AIDS in key workplaces. Step 2: let other workers know about their presence with the help of devices like workshops and road shows. Step 3: make them central to the planning of a company strategy.

Giving AIDS/HIV a human face

Since the inception of the GIPA programme, eleven individuals have joined up. Two have died. The other nine are prime examples of living positively. They have been placed in working environments as diverse as mining companies, parastatal organizations, and UN departments.

A second group of GIPA ambassadors were being placed at the time of writing. One of their first tasks will be to give a human face to a disease so stigmatized and shrouded in mystery that ordinary people do not know what to expect. Placing articulate, open and often healthy HIV-positive people in workplaces can serve to shatter any number of myths.

A decade into the pandemic, conventional wisdom still dismisses AIDS as a black disease or a gay plague – something that does not happen to ordinary people. At the same time there is a belief that its contraction means instant death. Martin Vosloo, one of the best-known GIPA participants is keenly aware of how his very presence can alter stereotypes. A burly, bumptious, ruddy-cheeked artisan, Vosloo was placed in a firm called Eskom to work mostly with construction workers, but he also spent some months at their headquarters in the north of Johannesburg.

“Initially I was like an exhibition piece”, he remembers. “I was the face of someone living with HIV and employees would come and take a look”. After his time at head office he travelled to various sites giving talks on AIDS awareness and safe sex. He also gave support and advice to those workers who were already HIV-positive. “I think being a white, heterosexual man made these guys not believe I was HIV-positive. I mean, I weigh 130 kilos and I’m six feet tall. So I look very healthy.”

Martin Vosloo was, with the benefit of hindsight, an ideal vehicle for getting the message across. He was infected by HIV in the course of a hard-living, hard-drinking lifestyle – experiences he shares when he persuades migrant site-workers against easy sex and not-so-cheap thrills.

Tackling prejudice in the workplace

In her office at Transnet in Johannesburg, Maria Ndlovu – the assistant manager of the parastatal body's Education for Aids Project and a GIPA participant – works to demystify AIDS. This is a mission given impetus by her own experience. "I was dying to talk to someone who was HIV-positive, to ask them "Is what I'm feeling HIV? But they were so silent, so gloomy, so sad. It was as if they were waiting for the electric chair." She is recalling her first visit to a support clinic at the HF Verwoerd hospital in Pretoria.

Caught in the crosswinds of myth, prejudice and denial, the other people at the clinic would not engage in the spirit of community she was looking for. The whites created a psychological distance, "as if they were not part of us HIV-positive", and the blacks kept their replies to her curious questions curt and quick.

The GIPA programme has given Maria and the other participants a voice with which to cut through the silence by tackling prejudice at the workplace. This is important because one of the reasons for the silence is the fear of losing your job. Martin Vosloo came into GIPA after losing successive jobs because of his HIV status.

In her two years at Transnet, Maria has become integral to Transnet's response to the epidemic. She has used the company magazines and newsletter to let staff know she is there for them and gives talks and seminars every week. "I've been told that simply seeing me makes a difference." The GIPA participants also become a quietly effective "drop-in" counselling service for colleagues. This builds the kind of supportive working environment that encourages others to find out their HIV status and to manage their health.

A cleaner at Transnet got to know Maria and confided that her daughter was very ill – in and out of hospital and confined to bed. Her boyfriend had died of AIDS, yet the girl denied the disease. Maria visited their home and related her story. She told the young woman of her rape in 1996, the subsequent AIDS test and the cold realization that she was HIV-positive. "So am I" said the girl – a response that freed her mother from questioning her, and allowed her to care effectively for her daughter until her death a few months later.

The cost of AIDS to business

At the heart of GIPA is the idea that those individuals most intimately affected by HIV/AIDS should be shaping the response to it. The idea has been around since 1983, and at the Paris AIDS summit in 1994 forty-two countries formally accepted that GIPA was critical to an effective and ethical response to the epidemic.

In South Africa UNAIDS decided to implement what was called "the GIPA Workplace Model". This programme was the result of a strategic decision by the UN both to support President Thabo Mbeki's call for a partnership against HIV/AIDS and to break new ground by helping people living with it to become actively involved in areas not previously considered. Workplaces seemed a good choice. Research was beginning to show just how severely business was being affected by the epidemic – with the heaviest costs coming from absenteeism, lost skills,

training and recruitment, reduced work performance and lower productivity. While each of the participants has shaped the programme differently, there are common experiences. By their presence alone, they make people aware of the intense need for HIV/AIDS policies and encourage open contact with infected people.

- *The Courier*, No 188, September-October 2001, ACP-EU, Brussels

II. The ILO SOLVE programme

Stress, alcohol and drugs, violence (physical and psychological), HIV/AIDS and tobacco all lead to health-related problems for the worker and lower productivity for the enterprise. Taken together they represent a major cause of accidents, fatal injuries, disease and absenteeism at work in both industrialized and developing countries. These problems may emerge due to the interaction between home and work, they may start at work and be carried home or vice versa.

To address these problems at the enterprise level, a comprehensive policy should be implemented. Traditional approaches to occupational safety and health have addressed neither the policy requirements nor the action required to reduce the negative impact of psychosocial problems.

The SOLVE methodology is designed to allow for an organization or an enterprise to integrate psychosocial issues into overall enterprise policy and establish a framework for preventative action. Specific action is developed through **MicroSolve** packages, which target each of the five identified areas of SOLVE.

III. Universal Precautions

Universal blood and body fluid precautions (known as “Universal Precautions” or “Standard Precautions”) were originally devised by the United States Centers for Disease Control and Prevention (CDC) in 1985, largely due to the HIV/AIDS epidemic and an urgent need for new strategies to protect hospital personnel from blood-borne infections. The new approach placed emphasis for the first time on applying blood and body-fluid precautions universally to all persons regardless of their presumed infectious status.

Universal Precautions are a simple standard of infection control practice to be used in the care of all patients at all times to minimize the risk of blood-borne pathogens. Universal Precautions consist of:

- careful handling and disposal of sharps (needles or other sharp objects);
- hand-washing before and after a procedure;
- use of protective barriers – such as gloves, gowns, masks – for direct contact with blood and other body fluids;
- safe disposal of waste contaminated with body fluids and blood;
- proper disinfection of instruments and other contaminated equipment; and
- proper handling of soiled linen.

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