

Toolkit for Trade Unions on HIV and AIDS

Booklet 3:

Workplace action on
HIV and AIDS: contributing
to universal access

ILO Bureau for
Workers' Activities (ACTRAV)

INTERNATIONAL
LABOUR ORGANIZATION,
GENEVA

An effective HIV/AIDS programme is composed of three pillars: prevention, treatment, care and support. As we saw in Booklet 2, these pillars must rest on a firm foundation: the protection and promotion of human rights and gender equality.

This booklet presents guidance and good practices for trade union and workplace action in each area.

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1. UNIVERSAL ACCESS TO HIV PREVENTION, TREATMENT, CARE & SUPPORT

If the world is to achieve MDG 6 - to halt and begin to reverse the spread of HIV/AIDS by 2015 - people will require even greater access to HIV prevention and AIDS treatment, care and support than is currently available.

The shift towards universal access represented an important step forward in a number of ways:

- ▶ it restated the importance of prevention while stressing the need for a combined approach;
- ▶ it emphasized the importance of country ownership;
- ▶ it reaffirmed the importance of participatory processes and partnership.

Universal access is the only practical way to bring the epidemic under control. It also rests on the principle that everyone should be entitled to health care and social protection, and the entire international community must share responsibility to achieve that.

Universal access is about equity, inclusion and human rights. The aim is coverage of services to everybody according to their needs - without discrimination.

Universal access means what it says. That means all workers - including undocumented migrant workers in irregular situations, or sex workers even where sex work is illegal - should receive the same services as everybody else.

Booklet two of this toolkit stressed the importance of human rights in responding to HIV and AIDS.

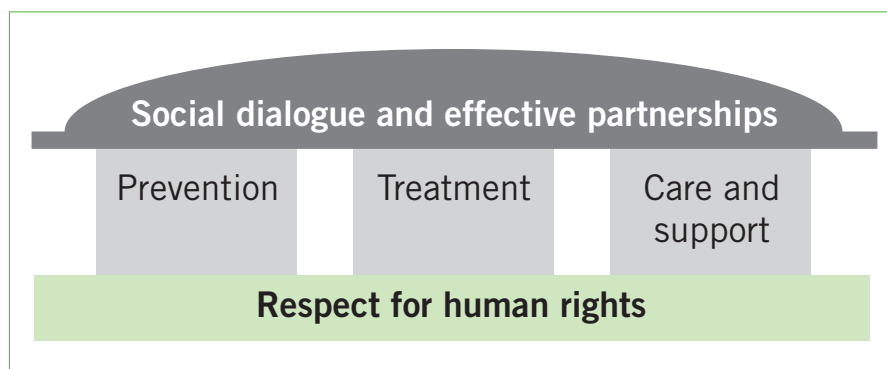


Diagram developed at trade union training course, Addis Ababa, 2009

1.1 The pillars of universal access

Universal access has three pillars:

- ▶ **Prevention of new infections** – including prevention of mother to child transmission, treatment of sexually transmitted infections, blood safety, as well as measures to address the root causes of infection, such as gender inequality and poverty. Prevention needs to include an increase in Sexual and Reproductive Health and Rights (SRHR) services and information.

Sexual and reproductive health and rights (SRHR) can be understood as the right for all - whether young or old, women, men or transgender, straight, gay or bisexual, HIV-positive/negative - to make choices regarding their own sexuality and reproduction, *as long as* these respect the rights of others to bodily integrity. SRHR also include the right to access information and services needed to support these choices and optimize health.

- ▶ **Treatment of HIV** with antiretroviral drugs and **treatment of opportunistic infections**, particularly TB.
- ▶ **Care and support** – including palliative care and pain relief, support for treatment adherence and HIV monitoring in untreated people, psychological support, home-based and end-of-life care, management of mother and child health for HIV-positive women, the care of orphans and vulnerable children, mitigating the impact of HIV including social protection and livelihood support, making adjustments so that people can continue working for as long as possible. (Note: care and support may be considered as separate elements, but there is a lot of overlap between them.)

Prevention, care and support should be developed as complementary not 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.*¹

Different countries have different epidemics, so the universal access package must be determined at the country level. It must be based on a detailed knowledge of the epidemic along with targets for coverage and time frames to ensure a response that is appropriate. The UNAIDS website sets out the targets agreed by countries and reports on progress through country profiles.

¹ *HIV Prevention Needs and Successes: A tale of three countries*, UNAIDS Best Practice Collection

The challenge

Achieving universal access is a huge task. The need for care, treatment and support continues to expand and while new infections are slowing, they are still at an unacceptably high level.

- ▶ HIV prevention services reach only a minority of prisoners, about one in 20 men who have sex with men (MSM) and less than 20 per cent of injecting drug users (IDUs), while less than 1 per cent of global funding for HIV prevention is spent on HIV and sex work².
- ▶ Antiretroviral drugs to help pregnant women avoid passing on HIV to their babies still only reach 45 per cent of pregnant women in low- and middle-income countries, though this is a significant increase from 35 per cent in 2007 and only 10 per cent in 2004 (WHO website).
- ▶ It is estimated that globally only between 10 and 20 per cent of people who are HIV-positive have tested and know their status (UNAIDS website).
- ▶ Less than a third of those in need have access to ARVs³.

² See: <http://www.avert.org/prisons-hiv-aids.htm>; <http://msgmf.org/index.htm>; UNAIDS Guidance Note on HIV and Sex Work, 2009

³ *Achieving Universal Access – the UK's strategy for halting and reversing the spread of HIV in the developing world*, Department for International Development, London 2008

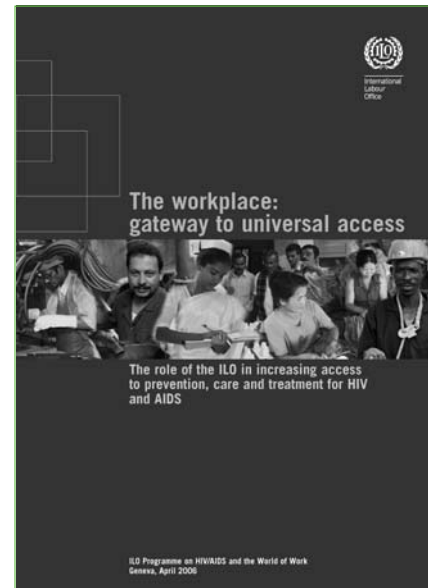
2. THE WORKPLACE: GATEWAY TO UNIVERSAL ACCESS

The workplace is a vital entry point for universal access. Nine out of ten people living with HIV go to work every day, and working people are the number one at-risk group in terms of age range.

2.1 Comparative advantage of the workplace

The workplace is ideally placed to convey the message about rights and HIV/AIDS, and can support all aspects of universal access:

- ▶ The workplace is an important setting for prevention, particularly behaviour change communication. Key messages are being given to workers through education and training, particularly peer education; condoms are being distributed; occupational safety and health structures are being used to coordinate HIV activities. TB infection control plans are simple to put in place and could avert many AIDS deaths.
- ▶ Workplaces are increasing access to treatment for HIV and for STIs and opportunistic infections. This may be through direct provision in the enterprise, through health insurance schemes, through 'know your status' campaigns to increase uptake of voluntary testing, or through referral systems to community services. Workplaces are also providing information about diet and helping employees keep up their medication through treatment adherence and wellness campaigns. Some employers, for example the Nigerian Ministry of Public Administration and Security, provide food supplements to staff on ARVs.
- ▶ Workplaces are providing information to female and male workers on the prevention of mother to child transmission and on managing child health in an HIV-positive household.
- ▶ Workplaces are offering one of the most important forms of support for HIV-positive workers: a continuing employment relationship, including making arrangements for workers if at times they are sick or weak. Many workplaces have outreach programmes which include contributing to the nutrition and home-based care to workers' families and the local community, and supporting orphaned and vulnerable children.
- ▶ Workplaces provide support by NOT tolerating discrimination or stigma. The message that a worker with HIV can remain at work, and be treated, is very powerful in overcoming hostility and stigma towards those who have been infected. Support for people so that they can continue working for as long as possible makes good business sense. And HIV can become part of collective bargaining agreements, workplace policies and incorporated into arrangements made for occupational safety and health.



The ILO Programme on HIV/AIDS and the World of Work

Key objectives:

- to raise awareness of the social, economic and development impact of AIDS through its effects on labour and employment
- to help governments, employers and workers support national efforts to prevent HIV and reduce its impact through action in the world of work
- to tackle discrimination and stigma related to HIV status

Principal activities:

- Technical cooperation: projects and activities in over 70 countries enhancing the capacity of employers, workers and governments to take action on HIV/AIDS;
- Research, policy analysis and legal guidance on HIV/AIDS issues in the world of work;
- Information, communications and advocacy through a range of channels including publications and technical meetings at global, regional and national levels.

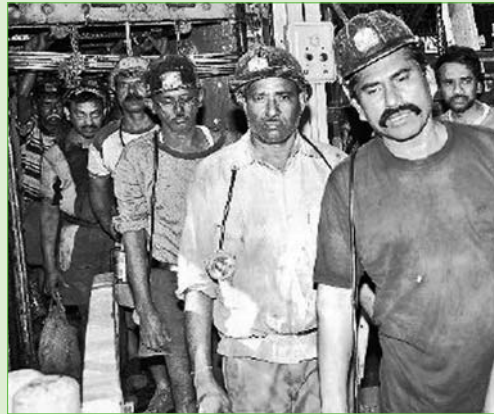
2.2 What about the costs?

Won't the investment in prevention, treatment, care and support be expensive? Not as expensive as the alternative - doing nothing.

- ▶ The 2005 Executive Opinion Survey by the World Economic Forum reported that the proportion of firms worldwide expecting AIDS to affect their operations in the next five years had risen to 46% from 37% in 2004.
- ▶ Costs associated with HIV in companies across sub-Saharan Africa range from 0.5% to 10% of total labour costs (UNAIDS Global Report 2008).
- ▶ A detailed analysis of the Lonrho Companies (mining, sugar, cotton, automotive and other industries) found that the cost of HIV/AIDS was about 1.1% of total costs for the company and 3.4% of gross profits (International Finance Corporation, 2006).

India

An ILO study at Singareni Collieries Company in India found that the cost to the company of providing termination benefits to 311 employees infected with HIV would be US\$ 21 million. The provision of antiretroviral treatment to these employees for a period of ten years would cost the company less than US\$ 1.24 million - and this would enhance the working life of infected employees, reduce absenteeism, and help them sustain their families⁴.



Singareni Coalfields (ILO)

South Africa

A study of construction companies in South Africa recommended a package of interventions and estimated the cost of providing these. It concluded that “Where prevalence is low, the interventions would cost 0.14 per cent of the cost of a major construction project. Where it is high (10 per cent of the workforce and above), intervention costs would still fall below one per cent of the total. These percentages are low enough to permit contractors to include the costs of such services among the indirect costs for worker injury protection, insurance and emergency care without substantially increasing total project costs.”

The measures included condom distribution to all workers; treatment of sexually transmitted infections; peer counselling; palliative care for HIV-positive persons showing symptoms; and treatment of opportunistic infections associated with HIV. The cost of the package, when prevalence is one per cent, was calculated at US\$6,970 a year for a thousand workers⁵.

Impact of TB on the world of work

The WHO Stop TB Department reports that:

- ▶ a TB patient loses on average 3 to 4 months of work time
- ▶ in many African countries, lost earnings due to TB are estimated at 16 per cent of GDP per capita, and 4-7 per cent in several Asian countries
- ▶ in India, the annual cost to the economy is estimated at \$300 million in direct costs and over \$3 billion in indirect costs
- ▶ nearly one-quarter of over 10,000 business leaders worldwide say that TB is affecting their business.

⁴ ILO New Delhi Office Press Release, “AIDS increasing costs to companies in India”, 25 November 2005

⁵ W. McGreevey, S. Alkenbrack, J. Stover, *Construction Workplace Interventions for Prevention, Care, Support and Treatment of HIV/AIDS*

3. TESTING

The entry-point to comprehensive care is confidential voluntary counselling and testing for HIV (VCT). Good quality VCT provides many benefits in addition to diagnosis of HIV and bridges the gap between care and prevention. Clients derive support from counselling and gain access to a range of HIV care interventions.

Testing is a controversial issue. It is worth restating some fundamental principles regarding testing.

The ILO *Code of practice on HIV/AIDS and the world of work* has a detailed section on testing. The ILO position is:

Screening is prohibited for exclusion from employment, and other employment issues, such as promotion, access to training (this includes screening of immigrants).

Voluntary testing is permitted in some situations, with safeguards for preserving the confidentiality of the worker. It is important to provide safeguards to ensure that a HIV-positive worker's identity does not become known accidentally.

Confidentiality of HIV-related data must be respected.

Voluntary testing

Voluntary testing requires safeguards. The ILO code of practice, section 8.4, says:

Where adequate medical services exist, voluntary testing may be undertaken at the request and with the written informed consent of a worker, with advice from the workers' representative if so requested. It should be performed by suitably qualified personnel with adherence to strict confidentiality and disclosure requirements. Gender-sensitive pre- and post-test counselling, which facilitates an understanding of the nature and purpose of the HIV tests, the advantages and disadvantages of the tests and the effect of the result upon the worker, should form an essential part of any testing procedure.

Mandatory testing is testing that is forced on someone, whether they formally consent or not (sometimes even without their knowledge). It arouses very strong feelings because it challenges fundamental rights and personal privacy, and almost inevitably leads to discrimination. It is also ineffective from a public health point of view. So why do people continue to do it?

It is important to understand that both governments and employers have responsibilities to protect the public health – in one case of their citizens, in the other of their employees. At the same time, the costs of infection are high.

It is argued that testing – for example, before someone enters a country or takes up employment – prevents a number of problems arising later.

However, there are many reasons why mandatory testing for purposes of exclusion from work is not useful:



The most important is that casual contact at the workplace, as at home, does not expose people to the risk of HIV, so mandatory testing does not protect the workplace and represents an unnecessary cost for governments or employers – it does not contribute to public health.

Secondly, a migrant, job seeker or employee may be uninfected today but catch the virus tomorrow.

Thirdly, the period between infection and the production of antibodies can be several weeks. Most tests look for the antibodies which are produced by our immune system to counteract the virus. During the 'window period' between infection and antibodies being developed, a person can test negative.

Finally, in an environment where rights are respected, employees are more likely to undergo voluntary testing and change their behaviour, and indeed become active agents for prevention. Many employers also speak of raised morale and improved labour relations where an atmosphere of trust has been built at the workplace, based on respect of rights and confidentiality.

However individuals – and their families and communities – have much to gain from undergoing a voluntary test with counselling.

3.1 Know your status

'Knowing your status' is an important step for individuals and helps in preventing the spread of the virus.

Those who are HIV-positive can seek the necessary care and support, hopefully including treatment, and can take steps to make sure they do not pass on the infection. Those who test negative receive information and support to protect themselves and their families.

A study by the British HIV Association (BHIVA) showed that 24 per cent of deaths in HIV-positive adults in the UK in 2006 were because the diagnosis of HIV was made too late for effective treatment. Many of these 'late presenters' had been seen in the recent past by healthcare professionals without the diagnosis having been made - they had not been offered testing.

Late diagnosis of HIV infection is associated with increased mortality and morbidity, a poor response to antiretroviral therapy or treatment and increased cost to healthcare services⁶.

Currently fewer than 20 per cent of people with HIV know their HIV status. So knowing your status is sensible and many trade union leaders, at different levels in the movement, have set an example by being tested and making the fact known.

⁶ UK National Guidelines for HIV Testing 2008, downloaded 28 November 2008 <http://www.bhiva.org/files/file1031097.pdf>

Principles of testing

Those who have the test should receive counselling before and afterwards. Testing should be based on key principles of voluntary, informed consent and confidentiality regarding the results. It should be accompanied by counselling, and linked to a certain level of services to follow up the test. If the result is negative, the individual needs information on assessing and preventing risk. If the result is positive, he or she needs information and advice on ways of maintaining health, protecting partners from infection, and services available in the community, including treatment. Employers can provide care and support at the workplace, including treatment where possible.

The ILO supports voluntary counselling and testing through workplace 'Know your status' campaigns.



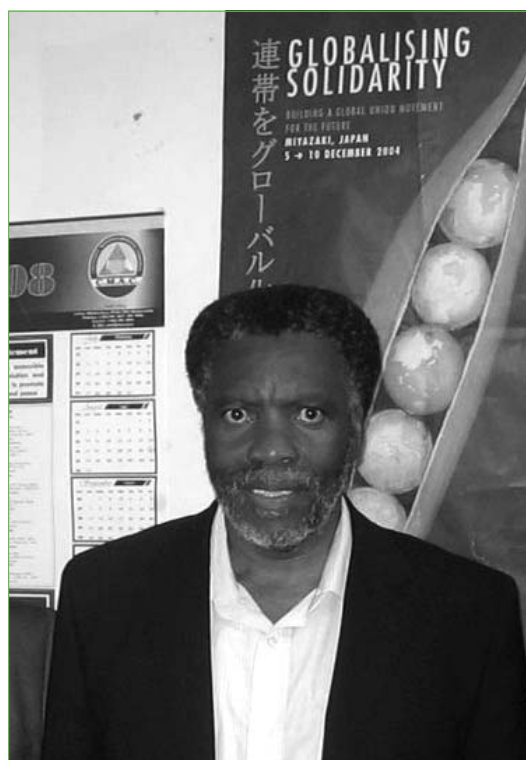
MBABANE, February 5 2005 (PlusNews) – In a move considered to be a breakthrough in the conservative kingdom of Swaziland, the Secretary-General of each of the two trade union federations publicly took an HIV test on Friday.

Jan Sithole of the Swaziland Federation of Trade Unions (SFTU) and Vincent Ncongwane of the Swaziland Federation of Labour (SFL) are the highest ranking public figures to take the test in the country with the world's highest HIV prevalence rate.

“I wish to send a message to all leaders in Swaziland, particularly traditional leaders, but also religious leaders, government leaders and business leaders, to take these tests, and to encourage their constituents to do so,” Sithole told PlusNews.

At a conference on HIV/AIDS at the Matsapha Industrial Estate, 30 km east of Manzini, the country's second city, Sithole chose to take a rapid test - and was found to be HIV negative. The SFL's Ncongwane also tested HIV-negative.

“I wanted to show how easy the new technology makes taking these tests – within 20 minutes I knew my HIV status.”



Trade union leader Jan Sithole leading by example – taking a test in Mbabane, Swaziland in 2005. (ILO/AIDS)



3.2 Health service-initiated testing

A recent development is what is known as provider-initiated counselling and testing (PICT).

In traditional VCT, it is the individual who must actively seek an HIV test. But uptake of such “client-initiated” testing and counselling has been limited by low coverage of services, fear of stigma and discrimination, and the perception by many people - even in high prevalence areas - that they are not at risk.

Current evidence also suggests that many opportunities to diagnose HIV in clinical settings are being missed. New approaches are therefore required if access to HIV testing and counselling is to increase.

Provider-initiated HIV testing and counselling involves the health care provider specifically recommending an HIV test to patients attending health facilities. In these circumstances, once specific pre-test information has been provided, the HIV test would ordinarily be performed unless the patient declines.

The ILO supports moves to ‘normalize’ the disease and screening arrangements, but insists that measures should be in place to ensure informed consent, protect confidentiality and offer follow-up care if needed.

WHO and UNAIDS have issued guidance on this new initiative. This can be found at http://www.who.int/hiv/pub/guidelines/9789241595568_en.pdf

Testing and treatment

According to a recent study, if it was possible to persuade everyone in the community to test for HIV infection once a year and then provide antiretroviral therapy to all who are HIV-positive, new infections could be reduced from 20 per thousand to 1 per thousand within ten years (a 95 per cent reduction) in high prevalence countries⁷.

⁷ The Lancet, November 26th 2008

4. PREVENTION

Prevention in short:

- Information – not just on HIV/AIDS but on available services (e.g. voluntary testing, PMTCT)
- Participatory & gender-aware education, personal risk assessment: the behaviour change communication (BCC) approach
- Practical support: condoms, needle exchange
- Promoting wellness, including STI treatment, & 'know your status'
- Occupational safety and health, Universal Precautions

For every two people who start antiretroviral treatment, five are newly infected, so prevention remains a priority. HIV is a fragile virus. The ways it is transmitted are well known (and explained in Booklet 1): the exchange of blood, semen and other body fluids through sex, the shared use of drug injecting equipment, blood transfusion and blood products, and from mother to child.

The world of work is the right place to provide clear information on HIV transmission and how to prevent it.

While the development of ARVs means that HIV infection can be managed in the same way as a condition like diabetes, the fact remains that prevention must remain at the heart of HIV/AIDS programmes.

Although studies show that many people still lack basic information on HIV/AIDS and access to condoms, there are many encouraging examples of changes in behaviour, attitudes and new infections brought about by workplace prevention programmes. There is clear evidence of what works. Information is not enough. People need to be supported and helped to change their behaviour - and the behaviour of their partners.

It is therefore vital to:

- ▶ constantly reinforce the basic facts about HIV infection, how it is transmitted and not transmitted, and how to prevent it – include the prevention of mother to child transmission (PMTCT) whether you're talking to women or to men;
- ▶ combat taboos related to sex, expose myths, encourage open discussion, defend rights and oppose the criminalization of risky behaviours;
- ▶ take a gender-specific approach that addresses the needs and situations of women and men separately, that involves men in education related to women (e.g. PMTCT) and vice-versa, that recognizes that men may have sex with other men, may be clients of sex workers, and may abuse alcohol or drugs;
- ▶ encourage confidential voluntary testing with counselling (VCT);
- ▶ provide access to male and female condoms, plus information on correct use;

- ▶ promote and support behaviour change through participatory education and messages tailored to known risks and vulnerabilities at work and in the community;
- ▶ increase access to male circumcision with counselling; to harm-reduction programmes for drug users; to treatment for sexually transmitted infections;
- ▶ assess the risk of TB and request/ initiate/ support an infection control plan;
- ▶ reduce the occupational risk of transmission where relevant.

Telling stories to save lives

The ITF has developed ground-breaking techniques with its affiliates. In Mombasa port, Kenya, a pilot project has used storytelling techniques to break the silence, fear and stigma surrounding HIV/AIDS.

On the move for days and weeks, transport workers often feel disconnected not only from their families and communities but from their own life histories. Fatigue, loneliness and frustration coexist with the need for human connection and a quest for adventure. Life on the road (or sea, or in the air, or on the railway) takes on its own reality. It is this change in reality that makes it easier for people to engage in unsafe sexual and drug-taking practices that can lead to HIV infection.

The ITF project in Mombasa used story-telling to break the silence, fear and stigma surrounding HIV/AIDS. In May 2009, forty transport workers from different sectors sat in a circle and listened to one another tell stories of their experiences, including the effects of HIV and AIDS. At the beginning of the sessions, only one person was openly HIV-positive. During the final storytelling ceremony, 12 people came out as HIV-positive and made the decision to become public advocates.

When asked about the impact of the storytelling workshops, one driver said: “For those who felt shy or hesitated, this workshop removed the stigma that had been present for so long. If we speak out together with our stories, we can speed up the search for solutions to the spread of HIV/AIDS.”

See HIV/AIDS: Transport Unions Take Action – Case Studies and Good Practices from ITF Affiliates, at <http://www.itfglobal.org/HIV-Aids/HIV-take-action.cfm>

4.1 Protecting young people

Almost half of new infections today - about 45 per cent - are in people between the ages of 15 and 24. Young people are also over-represented among the world’s poor and the unemployed – they lack access to HIV services and are at risk of social exclusion.

“In 2007 only 40% of young men and 36% of young women had accurate knowledge about HIV, showing that even basic HIV awareness programmes have had inadequate reach.... It is essential that we sustain efforts being made as well as scale up the response.”

Purnima Mane, UNFPA Deputy Executive Director and Michel Sidibé, UNAIDS Executive Director

Yet adolescence is the time when the majority of people become sexually active. This is one reason why the epidemic continues to spread so rapidly⁸.

Young women are particularly vulnerable. In many cultures, young women do not receive accurate information about sex, and sexual health services are not available to them. Hence the importance of the UNGASS target, “95% of the youth 15-24 should have the information education, services and life skills that enable them to reduce their vulnerability to HIV infection.”

The vital role of teachers

Teachers have a very important role to play in helping young people understand more about HIV/AIDS. Teachers’ trade unions have provided active leadership in this area.

The Swaziland National Association of Teachers decided in 2008, as part of a programme organized by Education International, to focus its work on AIDS-related stigma and discrimination.

Over 120 SNAT members took part in workshops to combat stigma and were trained to use a teaching pack ‘Inclusion is the Answer: A toolkit for educators and their unions’.

See <http://www.ei-ie.org/>

Young people in the world of work

The world of work is a vital channel for reaching young workers, the unemployed and young people in vocational training. Workplace settings provide an opportunity, particularly through apprenticeship and vocational training programmes, to share information about HIV and to influence behaviour.

Young workers need tailored messages, delivered sensitively, using the right 'language', and relevant to them. Peer educators, or facilitators from outside organizations, should include young people.

As well as speaking directly to young people, the workplace can inform and mobilize parents, grandparents and other family members, and support them in speaking to young people about safe and responsible sex, and other difficult issues such as the use of drugs and alcohol. It is natural for parents to want to protect their children, and sometimes this protection takes the form of avoiding discussing issues such as sex or drug use. But this can be more dangerous, because young people will get their ideas and information from other sources.

UNAIDS has produced a series of policy briefs for young people. One of these deals specifically with HIV Interventions for Young People in the Workplace:

<http://www.unfpa.org/hiv/iatt/docs/workplace.pdf>

⁸ *Young People and HIV/AIDS: Opportunity in Crisis* UNICEF, UNAIDS and the World Health Organization, 2002; and *At The Crossroads: Accelerating Youth Access to HIV/AIDS Interventions*, UNAIDS, 2004



Students at a Russian vocational training college discuss images from the manual, 'Your Health,' during a training workshop on HIV, (ILO/AIDS)

4.2 Combination prevention

New approaches to prevention acknowledge that there is no one correct method and promote the importance of tailoring responses to needs and risks, and of combining methods as appropriate. The main elements are set out below, with suggestions of how the workplace can contribute to each. It's of particular interest to trade unions that rights are recognized as being a critical factor.

Biomedical interventions

- Campaigns to educate male and female workers about PMTCT, male circumcision and microbicides (products applied to the surface of the vagina and/or rectum for the prevention of HIV transmission during sex)

HIV testing and links to treatment and care

- Build capacity of enterprise clinics, mobile testing in the workplace, referral and partnerships with community services

Community interventions

- Workplace outreach to family members, surrounding communities, supply chain (public-private partnerships)

Social justice and human rights

- Workplace policies protecting workers' rights (ILO Code of practice), skills development, employment and income-generating activities

Behavioural interventions

- Workplace peer educators implement evidence-based behaviour change strategies, condom provision and use

'KNOW YOUR EPIDEMIC' remains the watchword – make sure that programmes are relevant to your situation and needs.

4.3 Prevention at the workplace

The workplace is an ideal setting for prevention information and education, not only because it includes people at risk but because it has experience and structures for in-service training and health promotion. In addition, bipartite or tripartite social dialogue, including joint policy-making and/or collective bargaining, is the ideal mechanism for discussing ways of improving working conditions and protecting workers' rights so as to reduce HIV risk.

For example, the Chamber of Mines of South Africa and the National Union of Mineworkers concluded an agreement on HIV/AIDS as early as 1993. Over time it became clear that a key factor in the HIV prevalence in the industry was the separation of miners from their families for long periods. In 2003, the tripartite HIV/AIDS Mining Summit in South Africa, bringing together the government, employers and trade unions, adopted a declaration of intent which included a commitment to improve the housing conditions of workers, especially migrant mining workers:

“The parties commit to establishing measures to improve the standard of housing for mineworkers including the upgrading of hotels, conversion of hostels into family units and the promotion of home ownership for all employees.”

But whatever the working environment, the basic information about HIV/AIDS can be widely disseminated at the workplace.

Education for men and women should play a key part of this process.

It should take into account that not all workers are heterosexual – language and examples used should be sensitive to this.

Workplace education is also an opportunity to talk to the clients of sex workers, many of whom are working men, and encourage them to insist on safe sex while discouraging violence and the abuse of the rights of sex workers (see below).

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 provided to all working people. The ILO Code of practice, section 6, suggests that:

- (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.*

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 ILO Code of practice provides comprehensive guidelines about the components of an education programme, and the accompanying education manual has fuller details, including advice on group work and a number of learning activities (<http://www.ilo.org/public/english/protection/trav/aids/publ/manual.htm>).

“Programmes should be tailored to the age, gender, sexual orientation, sectoral characteristics and behavioural risk factors of the workforce and its cultural context.”



Peer educators from the Botswana Federation of Trade Unions at an ILO training session. (ILO/AIDS)

Prevention works: reaching workers in the informal economy

The Indian National Trade Union Congress, with the support of the railway workers' union NFIR, launched an awareness campaign aimed at informal workers on the railways in Hyderabad in the state of Andhra Pradesh. They were working as porters, cleaners, street vendors and contractors undertaking maintenance work.

The results have been impressive. At the start of the project, only half of the target group were willing to work with a co-worker who was HIV-positive. After three years, more than 90 per cent were willing to work alongside HIV-positive colleagues. There has been a tenfold reduction in the number of men having multiple sexual partners.

In the construction sector the Nirman Mazdoor Sanghatana (NMS), which organizes building workers around issues of health and safety and welfare, set up a team of 10 outreach workers in Mumbai, two of them who were themselves HIV-positive.

In eight months, more than 500 workers were referred for treatment of sexually transmitted infections; more than 350 were referred for HIV counselling and testing, and five for antiretroviral treatment.

Many of these workers are migrants from other parts of India, living on the construction site, with poor living and working conditions and limited access to basic services.

Prevention of HIV/AIDS in the world of work: a tripartite response. Documentation of good practices. ILO, 2009

Risk assessment and management

It is important that information and training are reinforced by giving workers the tools that will help them to take personal decisions about risk and how they will manage it. Attitudes to risk-taking need to be discussed openly.

For example, an individual may be a regular client of sex workers. He (and it almost always is he) may recognize this risk and decide to manage it by always using condoms. Trade unions are well placed to reach these male clients who are often in regular employment and thus can afford to pay for sex.

This means creating an environment that tries to avoid judgement, and recognizes that individuals may do things outside work which the enterprise, union or society disapproves.

4.4 Behaviour change communication

Behaviour change communication (BCC) is an interactive and participatory process for developing messages using a mix of communication channels to encourage and sustain positive and appropriate behaviours. BCC has evolved from information, education and communication (IEC) programmes to promote more tailored messages, greater dialogue and fuller ownership.



Main features of BCC:

- ▶ **Evidence-based** –facilitators discuss with the target audience (or conduct a survey) to understand their values, needs and aspirations
- ▶ **Customized** – the communication is tailored to the target audience
- ▶ **Participatory** - the target audience helps develop messages and materials, and takes ownership of the process
- ▶ Makes extensive use of **peer education**
- ▶ **Results-oriented**, so builds in monitoring and evaluation
- ▶ **Comprehensive** (need not only apply to prevention – especially useful in relation to discriminatory attitudes)

In the context of HIV and the workplace, BCC is an essential part of a comprehensive programme that includes services (e.g. care, counselling), commodities (e.g., condoms, drugs), and policies that promote non-discrimination and trust:

Stages in the behaviour change continuum:

Unaware => Aware => Concerned => Knowledgeable
=> Motivated to change => Modified behaviour
=> Sustained behaviour change

Participation of the workplace stakeholders is vital at every step of planning and implementation of the behaviour change programmes to ensure sustainable change in attitudes and behaviour.

The ILO/FHI Toolkit on HIV/AIDS Behaviour Change Communication at the Workplace provides more guidance. It is available at <http://www.ilo.org/public/english/protection/trav/aids/publ/bcctoolkit.htm>.

It consists of seven sections (see box) which can be used separately to learn more about specific elements or jointly to design and implement a comprehensive BCC programme at the workplace. The kit is designed for people with little or no experience in BCC planning.

ILO/FHI Toolkit on HIV/AIDS Behaviour Change Communication at the Workplace

1. **BCC programming for the workplace** –an introduction to BCC and overview of the contents
2. **Gathering data** –a step-by-step guide to doing a ‘formative assessment’, i.e. collecting the information needed to design ‘custom-built’ BCC programmes
3. **Designing the strategy** –a detailed guide to developing a strategy based on the formative assessment, tailored to the needs and interests of the target group
4. **Developing materials** –how to plan and produce a range of materials to support the programme
5. **Peer education at the workplace** –a guide to identifying, training & supporting workers to carry out BCC and other prevention activities with co-workers
6. **Tools for monitoring and evaluation** –includes tools to monitor progress and evaluate the impact of BCC objectives
7. **Training in the use of the BCC Toolkit** –provides facilitators with a guide to training BCC implementers to use the toolkit

Characteristics of effective messages:

Know your audience, and

- Clarity: keep it short and simple
- Communicate a benefit
- be Consistent
- Cater to the heart and the head
- Create trust
- Call for action

Practical measures to support behaviour change

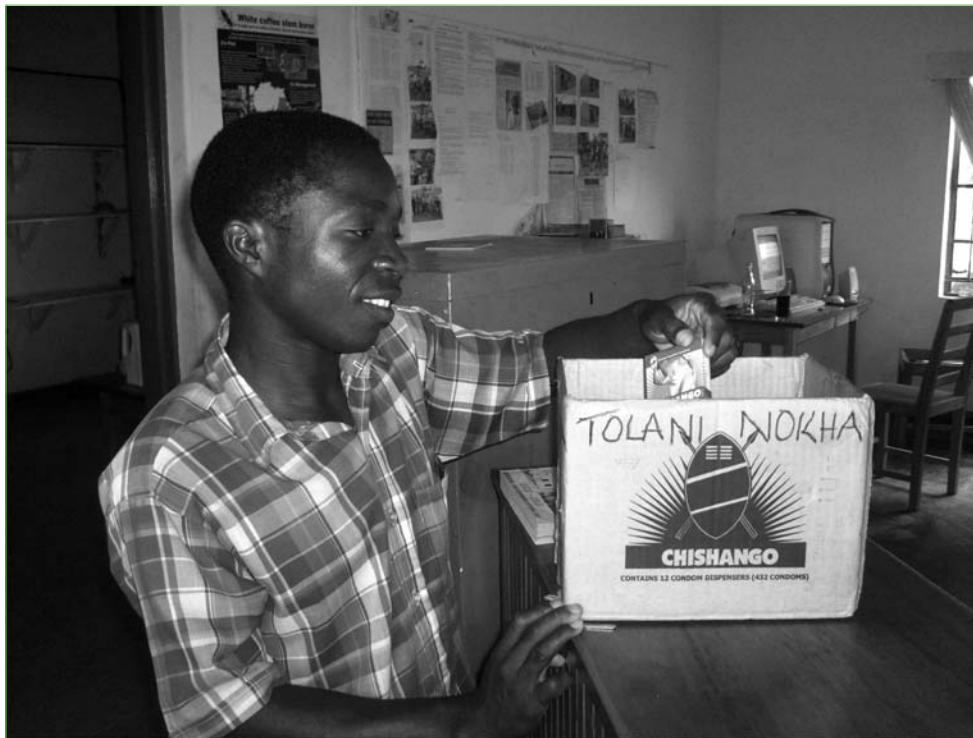
Practical measures are also essential to complement information and education, and support behaviour change: the most important is the provision of free or affordable condoms. In Brazil, once the threat of HIV was recognized, the price of condoms was reduced, which led to an increase in condom use. This has been identified by the Brazilian government as a key factor in reducing HIV incidence in the course of the 1990s.

The transmission of HIV from one partner to another is made much easier by the presence of other sexually transmitted infections (STIs). So preventing or treating STIs is another simple and effective way of reducing HIV transmission.

An example of how cost-effective this approach can be was demonstrated in the Harmony Gold Mine in South Africa.

The company, in collaboration with the National Union of Mineworkers and some NGOs, provided free STI treatment to miners and their partners. Because most of the miners were migrant workers, living in hostels, their partners were usually women in the local community. The outcome was that rates of STIs fell, and it was estimated that HIV infections were reduced by 46 per cent, resulting in savings to the mining company of US\$ 540,000. According to a report by Family Health International, one of the NGOs involved in the project:

The support of the union was critical. Union leaders explained the objectives of the intervention to the miners and obtained their cooperation and support. Union support also helped the project maintain a positive image and prevented discrimination towards women involved in the study.



Condom distribution on a tea estate in Malawi. (ILO/AIDS)

4.5 Peer education

“Programmes 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.” ILO Code, section 6

Peer education is one of the most effective ways of developing and delivering HIV/AIDS messages in a specific community. Peer educators are informal leaders who come from the group concerned, for example the workplace or the union. Peer education works on the idea that people are most likely to change their behaviour if they are informed and supported by people they know and trust.

Recruiting, training and supporting 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.

Peer educators are generally trained to:

- ▶ disseminate basic facts about HIV and other sexually transmitted infections;
- ▶ facilitate discussion on risk behaviours and help peers assess their own risk;
- ▶ train fellow workers on using, and negotiating the use of, condoms;
- ▶ distribute condoms;
- ▶ motivate workers to know their HIV status and seek treatment;
- ▶ disseminate information about HIV/AIDS services at the workplace and/or in the surrounding community;
- ▶ assist workers affected by HIV and put them in touch with support groups;
- ▶ lead large group meetings;
- ▶ provide peer counselling on a one-to-one basis (not all peer educators are trained in counselling);
- ▶ disseminate information about the HIV/AIDS workplace policy; and
- ▶ be available to answer any questions that co-workers may have.



4.6 HIV/AIDS and occupational safety and health

Is HIV an occupational disease?

HIV is not spread through normal workplace contact. It cannot survive outside the human body. It cannot survive on machinery, or on foodstuffs that workers may be preparing or packaging. Nevertheless, the working environment does have risks.

- ▶ Some workers may come into contact with body fluids as part of their work - the most obvious groups are health and emergency service workers, those engaged in embalming and crematorium work, and local authority services such as street cleaning/park maintenance/refuse disposal/public lavatory maintenance.
- ▶ Other workers are vulnerable to the risk of HIV more indirectly due to the nature and conditions of their work, especially mobile and migrant workers (see Booklet 2).
- ▶ Workers may come into contact with body fluids as a result of an accident at work, for example First Aiders.
- ▶ Workers who are ill are more susceptible to infection. If a worker is suffering from an occupational disease, then she or he is more at risk of contracting the virus when exposed to it. TB is increasingly a source of co-infection and the leading cause of death in those who die from AIDS-related conditions. It is relatively easy to apply TB prevention and control measures at the workplace (see section 5.3 below).

Applying the principles of safety and health at work

HIV/AIDS should be considered as an occupational disease in a limited number of cases. But occupational safety and health principles and structures, including the promotion of health and 'wellness', can be usefully applied to HIV/AIDS prevention and care across the board.

An occupational health and safety culture - easily applied to HIV/AIDS

1. *Develop a clear company safety policy which provides for collective responsibilities with respective roles, rights and cooperation between workers and employers*
2. *Set up an effective safety organization, including mechanisms for workers' participation, the election of workers' safety representatives and an OSH committee*
3. *Establish company safety rules and regulations, and safe working procedures to apply them*
4. *Provide safety training for all employees*
5. *Continuously supervise and monitor*

Health and safety committees

Many workplaces already have well-established arrangements for occupational safety and health (OSH). OSH is generally defined as “the science of anticipation, recognition, evaluation and control of hazards arising in or from the workplace that could impair the health and well being of workers.”⁹

The OSH approach to a culture of prevention requires a risk assessment and management system that includes workers' representatives. It has been shown that a unionized workplace has, on average, 50 per cent of the accidents of a similar non-unionized workplace¹⁰. Dealing with HIV/AIDS through existing OSH structures and workplace committees is a sensible use of ready-made structures for promoting safer workplaces.

In addition, one of the principles of the ILO Code of practice is that:

The work environment should be healthy and safe, so far as is practicable, for all concerned parties, in order to prevent transmission of HIV, in accordance with the provisions of the Occupational Safety and Health Convention 1981 (no 155).

The new Recommendation on HIV and AIDS in the world of work (see Booklet 2) includes the statement that “Occupational health services and workplace mechanisms related to occupational safety and health should address HIV and AIDS ... (paragraph 34)”.

Labour inspectors are becoming more involved in HIV and AIDS now that the disease is recognized as a workplace issue. As more countries adopt legislation dealing with HIV/AIDS and the world of work, and labour inspectors have the additional responsibility of enforcing this legislation, workplace inspections may well include HIV/AIDS along with traditional occupational safety and health.

See: *A handbook on HIV/AIDS for labour and factory inspectors*, ILO, Geneva, 2005

4.7 Protecting workers at risk

In workplace situations where there is a risk of occupational exposure to HIV, good practice is to follow the Universal Precautions (sometimes called ‘Standard Precautions’).

Healthcare workers

Workers in health care are of course particularly at risk. Trade unions representing healthcare workers are now engaged in implementing the guidelines developed by the ILO and the WHO in consultation with employers' and workers' organizations.

See the *Joint ILO/WHO guidelines on health services and HIV/AIDS* (Geneva, 2005)
<http://www.ilo.org/public/english/protection/trav/aids/publ/hsgl.pdf>

⁹ Occupational safety and health, General Survey, International Labour Conference, 2009

¹⁰ British Journal of Industrial Relations, 1995

Universal Precautions

Universal blood and body fluid precautions were originally devised by the United States Centers for Disease Control and Prevention (CDC). They set simple standards of infection control practice:

- Care in handling and disposal of sharps (needles or other sharp objects);
- Hand washing before and after procedures;
- Use of protective barriers, e.g. gloves, to prevent direct contact with blood and other body fluids;
- Safe disposal of waste contaminated with body fluids and blood;
- Proper disinfection to instruments other contaminated equipment; and
- Proper handling of soiled linen.

It is important to stress that these precautions *should always be followed*. There are other infections, apart from HIV, which can be transmitted through blood and body fluids. Using precautions should not be related to people's perceived or actual health status.

Training about occupational exposure

All workers who may come into contact with blood and other body fluids should receive training about infection control procedures. The training should cover:

- ▶ The provision of First Aid
- ▶ The Universal Precautions
- ▶ The use of protective equipment
- ▶ The correct procedures to be followed in the event of exposure to blood or body fluids
- ▶ Right to compensation in the event of an occupational incident

Post exposure prophylaxis (PEP)

There may be cases where a worker is concerned that he or she may have been exposed to the virus as a result of an incident at work. The most likely scenario is where a health care worker is exposed to the virus while caring for a patient, say through a needle-stick injury. The risk of getting HIV infection in the case of an injury by a sharp object has been estimated to be about three in 1000 (0.3 per cent), and lower in the case of blood splashing onto the worker, but some health unions believe this is an under-estimate. A worker might also be attacked and injured by someone who is HIV-positive, though it is normally only when this involves rape that there is a risk of infection.

In such situations it may be appropriate to offer post exposure prophylaxis (PEP) which lowers the chances of HIV infection even further. This means taking medication as soon as possible after exposure to HIV, and in any case within 72 hours. PEP has been a standard procedure for some years.

While healthcare workers in some settings may have swift access to the necessary medicines, other workers may not. It is useful for trade unions to ask how such treatment can be obtained.

The ILO and WHO have issued an updated and comprehensive guide to PEP:
Joint WHO/ILO guidelines on post exposure prophylaxis (PEP) to prevent HIV infection.

http://whqlibdoc.who.int/publications/2007/9789241596374_eng.pdf

Special considerations for First Aiders

For First Aiders at the workplace, the risk of being infected with the HIV virus while carrying out their duties is small. *There has been no recorded case of HIV being passed on during mouth-to-mouth resuscitation.* HIV can survive in saliva, but in quantities too small to cause infection.

The following precautions can be taken to reduce the risk of infection, but First Aiders should not withhold treatment for fear of being infected with HIV:

- ▶ Cover any cuts or grazes on the skin with a waterproof dressing;
- ▶ Wear suitable disposable gloves when dealing with blood or any other body fluids;
- ▶ Wash hands after each procedure;
- ▶ Clean up with bleach and/or very hot water.

5. LIVING AND WORKING WITH HIV

When prevention does not work, and people become infected, they need care, support and treatment. If they receive it, most can continue to lead a normal life, including working. It should never be forgotten that 90 per cent of people living with the virus go to work every day.

People affected by HIV and AIDS should be involved in decision-making about national treatment and care programmes. Trade unions should support their right to participate fully.

Care, support and treatment in short

A comprehensive but adapted programme:

- keeps workers at work
- ensures confidentiality, opposes stigma, encourages voluntary disclosure
- arranges reasonable accommodation
- enables support groups
- provides counselling, psychological support
- protects access to available benefits, sets up or supports workplace fund
- encourages PMTCT, VCT – the door to treatment
- sets up a referral system and links with health services in the community

If an occupational health service exists, provide where possible:

- palliative care, pain relief and treatment for opportunistic infections
- treatment for STIs (sexually transmitted infections), TB
- ART (antiretroviral therapy)

5.1 Treatment

More than five million people are currently receiving HIV treatment worldwide. This is over eight times as many as just four years ago. Treatment works. It can have a dramatic impact on people who thought they had only weeks to live. Of the estimated 9.5 million people in need of treatment in 2008 in low- and middle-income countries, 42 per cent had access, up from 33 per cent in 2007, according to the World Health Organization 2009 report on progress towards universal HIV treatment¹¹. But the rate of new infections means that millions more will be in need over the next years and decades.

¹¹ *Towards universal access - Scaling up priority HIV/AIDS interventions in the health sector: Progress report*, WHO, 2009. http://www.who.int/hiv/pub/towards_universal_access_report_2009.pdf

The global economic crisis threatens treatment

The global recession is expected to negatively impact AIDS treatment programmes in one third of countries surveyed - home to 61% of those on antiretroviral treatment. Much is at risk: treatment that is keeping 3.4 million people alive and healthy; the plans and global promises to expand access to the other two-thirds of all people with HIV who urgently need treatment now (whose numbers grow daily); and efforts to further reduce the number of new infections.

*Averting a Human Crisis During the Global Downturn:
Policy Options from the World Bank's Human Development Network, World Bank, 2009*

Because HIV is a retrovirus, the drugs used to treat it are called antiretrovirals. These powerful medicines control the virus and slow progression of HIV infection, but they do not cure it. The particular combination of ARVs is tailored to each individual patient. There is no one best regimen. ART may cause some side effects.

Treatment adherence

In order to work against HIV, medication needs to be taken properly every day. If not, viral load can increase and resistance to the drugs may develop.

According to the British journal, *The Lancet*, an emerging concern is that many patients who start treatment subsequently “default” from the programme. At least 20 per cent of patients are lost from programmes throughout Africa, Asia, and South America within 12 months of enrolment and are rarely traced¹².

Trade unions and workplaces can support those on ARV programmes, and encourage them to stay with their treatment.

Continuing to take precautions

Because treatment leads to people feeling better, and their viral load dropping, there is a danger of forgetting the importance of prevention. As HIV infection becomes a chronic manageable condition, sensible precautions to prevent transmission of the virus may be neglected. There is some evidence that suggests that this is happening. In a number of industrialized countries where treatment has now been available for several years, HIV infection rates are rising.

People should continue to take safe sex precautions, including the use of condoms, even if both partners are infected. There are several strains of HIV and it is possible for an individual to be infected by different strain, including those that have started to develop some resistance to drugs.

¹² *Improving the quality of HIV services globally*, The Lancet Infectious Diseases, Volume 8, Issue 12, Page 735, December 2008

Discrimination prevents treatment

It is estimated that about 16 - 30 per cent of mineworkers in South Africa are living with HIV. Although the big mining companies in the country report a high take-up of testing and treatment, and are investing considerable amounts of money to provide treatment and support, there have been reports that some miners resist voluntary testing. Among those who have tested positive, there is a low uptake of ARVs as they “are afraid of being subjected to discrimination by managers and supervisors”. This is where the trade union can play a crucial role in convincing workers of the need to get tested and seek treatment if they find they are HIV-positive. The National Union of Mineworkers has responded to the reports and is engaging with mining companies on the alleged victimization of infected workers and working with companies to make sure that treatment is available to them¹³.

5.2 The role of the workplace

While drugs have come down in price they can still be beyond the reach of most people who need them. In some countries, the cost of providing a year’s supply of antiretroviral treatment to all who need it would be equal to the entire national budget for health. The African Union recommends that at least 15 per cent of national budgets in the continent should be allocated to health and called, in May 2009, for an increase in health spending. There still remains a significant funding gap, which is why international donors have come forward to provide funding for ARV treatment, through PEPFAR, the Global Fund or directly to governments.

This is also why some employers have decided to pay for ARV treatment for their workers and even family members. Indian Railways, one of the largest employers in the world, is one such enterprise. Some unions have decided to push for this in collective bargaining negotiations.

Research from the ILO¹⁴ shows that providing ARVs results in a large and immediate increase in the number of people with HIV/AIDS who are able to continue working: within 6 months after beginning treatment, 20 per cent more are likely to be at work and 35 per cent more are able to work longer hours.

It is of course beyond the resources of most workplaces to provide treatment, though public-private partnerships have proved useful: for example the workplace becomes a point of delivery for drugs provided by government or donors.

However, any workplace can put in place two key measures to increase access to treatment, and unions should negotiate them with employers:

1. Advocacy campaigns to encourage workers to 'know their status' and seek voluntary testing and treatment, and
2. Referral systems to local health services.

In addition, where an occupational health service exists, it may be possible to adapt or upgrade its services so that opportunistic infections are treated and palliative care and pain relief provided, even if ARVs are outside its competency.

¹³ 'Business Day', South Africa, 11 November 2008

¹⁴ *HIV/AIDS and work: global estimates, impact on children and youth, and responses*, ILO, Geneva, 2006

Checklist: treatment in the workplace

- ✓ Does your workplace have any kind of occupational health service? This could be the basis for providing treatment.
- ✓ Do you have a workplace policy on HIV/AIDS? Does this include any commitment to treatment? If not, can this be raised through collective bargaining or consultation?
- ✓ Is there a clear commitment that there should be no discrimination against workers who are taking treatment, and that confidentiality will be respected?
- ✓ Has your workplace organized 'Know your status' campaigns and/or testing days for workers and their families?
- ✓ Has your workplace got a referral system linking workers with local facilities and services?
- ✓ Do you have any data for the numbers of workers who may be HIV-positive and therefore need treatment at some point? This would help to estimate the costs of treatment to the enterprise.
- ✓ Are there trained counsellors at the workplace who can help those workers who start treatment? This will be important to encourage those who might drop out of treatment? If not, some should be trained.
- ✓ Are workers living with HIV involved in planning and implementing any treatment programme at the workplace?

5.3 Tuberculosis and HIV

It has been estimated that 750,000 people who are HIV-positive will develop TB and one third of them will die. HIV and TB co-infection currently kills around half of all people living with HIV.

According to the National Union of Mineworkers in South Africa (NUM), 4000 miners developed TB in the country in the years 1999 - 2000. The NUM estimates that 60 per cent of these died within two years and that most were co-infected with HIV¹⁵.

In the early days of the HIV epidemic, less attention was given to TB because the major cause of death of people living with HIV was pneumonia. But with effective treatment available for Pneumocystis pneumonia (PCP), TB has become the number one killer of people living with HIV.

Since the development of combination therapy in the 1970s, TB has been a curable disease. However, without treatment, TB can kill someone living with HIV in a matter of weeks.

If TB and HIV programmes are integrated, many deaths from something that is both curable and preventable can be prevented. TB can be hard to diagnose in people living with HIV because they do not produce sputum in the same way HIV-negative people do.

¹⁵ COSATU Workers Handbook on HIV and AIDS, 2002



Occupational dust exposure and tuberculosis

Trade union safety activists are well aware that exposure to dust at work can cause a range of lung diseases. In many countries, dust-related lung diseases are routinely diagnosed as TB and the link with dust at work not made.

There is a well-established relationship between occupational lung diseases, caused by dust, and TB (Charles Thackrah, the founder of industrial medicine in England, noted it as long ago as the 1830s). A mine worker with pneumoconiosis is much more vulnerable to TB.

It is therefore important to be extra vigilant in situations where workers are exposed to dust at work. Occupational lung disease, tuberculosis, and HIV are a powerful and dangerous combination!

A workplace handbook on tuberculosis

The World Health Organization (WHO) and the International Labour Organization (ILO) have published joint guidelines for TB control activities in the workplace.

The guidelines describe cost-effective steps to protect workers' health and maintain productivity: TB infects 8 million and kills an estimated 2 million people each year – the equivalent of 5000 deaths per day. The toll is even more alarming because three-quarters of those with TB are in the most economically productive age group of 15-54 years.

Effective treatment, however, under the internationally recommended DOTS strategy, can prevent avoidable deaths and allow sick workers to return to productive work sooner.

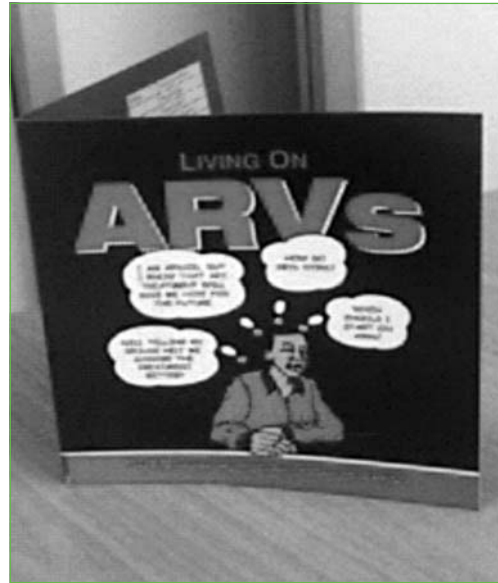
They are the first comprehensive approach to workplace TB control. The information in the guidelines is targeted at employers, employees and their associations, and health workers, all of whom can play a significant role in their implementation.

New policy guidelines and an accompanying guidance note are now available: *The Joint WHO-ILO-UNAIDS policy guidelines on improving health workers' access to HIV and TB prevention, treatment, care and support services* - see http://www.ilo.org/aids/Publications/lang--en/WCMS_149714/index.htm

You can find out more from ILO/AIDS and from the Stop TB Department at WHO: <http://www.who.int/tb/strategy/en/index.html>

DOTS

Directly observed treatment strategy (DOTS) is the internationally recognized strategy for the management of TB. It requires direct supervision and support for patients. Daily contact with workers makes the workplace an ideal setting for DOTS.



(ILO/AIDS)

5.4 Care and support

If care and support are NOT available for workers, there is no incentive to come forward to be tested. If a positive test result only leads to stigmatization and discrimination, why bother? Care and support are thus a vital part of preventing HIV.

Solidarity, care and support are critical elements that should guide a workplace in responding to HIV/AIDS. To mitigate the impact of the HIV/AIDS epidemic in the workplace, workplaces should endeavour to provide counselling and other forms of social support to workers infected and affected by HIV/AIDS. Where health-care services exist at the workplace, appropriate treatment should be provided.

Where these services are not possible, workers should be informed about the location of available outside services. Linkages such as this have the advantage of reaching beyond the workers to cover their families, in particular their children. Partnership between governments, employers, workers and their organizations and other relevant stakeholders also ensures effective delivery of services and saves costs.

From the ILO code of practice, section 9

What do care and support include?

Care and support for people living with HIV/AIDS are based on their right to continue working without fear of stigma or discrimination and to have:

- ▶ access to treatment through health insurance or social protection schemes
- ▶ information on living healthily and referral to relevant community services
- ▶ psycho-social support

- ▶ working conditions reasonably adapted to their state of health.

Workers with HIV may well be able to carry on working for a number of years, especially if they have access to medicine, good nutrition and rest. Shifts and work schedules may later need to be altered, and tasks and working environment adapted if a worker is unwell. Their skills, training and 'institutional memory' will thus be available to their employer for longer, and they can carry on earning.

Comprehensive care

Care involves a range of services which should be as comprehensive as possible:

- ▶ Clinical and nursing care to alleviate the symptoms of HIV and AIDS;
- ▶ Psycho-social support and counselling of HIV-positive individuals and their families;
- ▶ Financial support or opportunities for employment for persons who lose jobs or are barred from employment due to HIV status;
- ▶ Legal assistance to overcome discrimination at work and in the community;
- ▶ Care and support of orphans and widows after the death of the primary bread winner; and
- ▶ Information and training in HIV/AIDS care and prevention for care-givers at home.

Union helps with basic care

In March 2009, the Civil Servants and Allied Workers Union of Zambia (CSAWUZ) set up an HIV/AIDS committee.

As part of International Women's Day activities, the union tasked the Committee to talk with workers and the local community on sharing responsibilities for care.

They decided to go to a local hospice in Chilanga where they helped clean the wards and provide basic care such as bathing and feeding patients.

5.5 Reasonable accommodation

Reasonable accommodation means administrative or practical adjustments made by the employer to help workers with an illness or disability to manage their work. Workers with AIDS-related illnesses seeking accommodation should be treated like workers with any other chronic illness, in accordance with national laws and regulations. It is important that other workers see reasonable accommodation as providing necessary care and not favourable treatment. Employers, in consultation with workers and their representatives, should take measures on a case-by-case basis. Examples of reasonable accommodation include:

- ▶ Reducing or rescheduling working hours
- ▶ Modifying tasks or changing job
- ▶ Adapting the work environment and working equipment

- ▶ Providing rest periods and refreshment facilities
- ▶ Flexible sick leave
- ▶ Adapting existing sickness schemes to cope with the treatment of opportunistic infections
- ▶ Granting employees time off for medical appointments, counselling and other services
- ▶ Part-time work and flexible return-to-work arrangements.



Truck drivers in Paraguay contribute to awareness-raising on World AIDS Day. (ILO/AIDS)