



Training Manual on Economic Empowerment and HIV Vulnerability Reduction

HIV and AIDS Train the Trainer's Manual and Facilitator's Guide

Prepared under the ILO-Sida Project on Economic
Empowerment and HIV Vulnerability Reduction
along the transport Corridors in Southern Africa

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Resource Pack

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-retroviral
ARV	Anti-retroviral Therapy
CBOs	Community Based Organizations
CEEP	Corridor Economic Empowerment Project
HIV	Human Immunodeficiency Virus
HCT	HIV Counselling and Testing
ILO	International Labour Organization
MDGs	Millennium Development Goals
MTCT	Mother to Child Transmission
NGOs	Non- Governmental Organizations
OIs	Opportunistic Infections
PLHIV	People Living with HIV
POs	Partner Organizations
PMTCT	Prevention of Mother To Child Transmission of HIV
SADC	Southern Africa Development Community
SEOs	Social Economic Organisations
SIDA	Swedish International development agency
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNIFEM	United Nations Development Fund for Women
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization



DEFINITION OF TERMS

Antibody: A protein produced by B lymphocytes (B cells) in response to an antigen. Antibodies bind to and help destroy antigens.

Antibiotic: A drug used to kill or suppress the growth of microorganisms, such as bacteria and fungi.

Antigen: Any substance that is foreign to the body and triggers an immune response. Antigens include bacteria, viruses, and allergens, such as pollen

Bacterium: A single-celled microorganism. Bacteria occur naturally almost everywhere on earth, including in humans.

Baseline: An initial measurement used as the basis for future comparison.

Cardiovascular: Relating to or involving the heart and blood vessels.

Co-infection: When a person has two or more infections at the same time.

Communicable Disease: An infectious disease that is contagious.

Community-Based Organization (CBO): A public or private non-profit organization that provides services to local community members of an identifiable group, such as people with HIV.

Concordant Couple: Sexual partners in which both partners are infected with a sexually transmitted infection, such as HIV.

Coverage area: Size in which project activities are implemented

Dissemination: Is the process of spreading information

Dose: The quantity of a medication to be given at one time or the total quantity of a medication administered during a specified period of time.

Drug Interaction: A change in a drug's effect on the body when taken with certain other drugs, supplements, or food, or when taken together with certain medical conditions.

Drug Resistance: When a bacteria, virus, or other microorganism mutates (changes form) and becomes insensitive to (resistant to) a drug that was previously effective.

Embryo: In humans, an infant developing in the uterus (womb) from conception until about the third month of pregnancy.

Epidemic: A widespread outbreak of a disease in a large number of individuals over a particular period of time either in a given area or among a specific group of people.



Epidemiology: The study of the distribution, causes, and clinical characteristics of disease or health status in a population.

(XDR-TB): Extensively Drug Resistant Tuberculosis, which is a relatively rare type of multiple drug resistant tuberculosis (MDR-TB)

False Negative: A negative test result that incorrectly indicates that the condition being tested for is not present when, in fact, the condition is actually present. For example, a false negative HIV test indicates a person does not have HIV when, in fact, the person is infected with HIV.

False Positive: A positive test result that incorrectly indicates that the condition being tested for is present when, in fact, the condition is actually not present. For example, a false positive HIV test indicates a person has HIV when, in fact, the person is not infected with HIV.

Gender-responsive: The term 'gender-responsive' is usually encountered in conjunction with another word: gender responsive governance, strategies, treatments, budgets, etc. Its meaning is similar to gender sensitive.

HIV-negative: A person who is HIV-negative shows no evidence of infection with HIV on a blood test (e.g. absence of antibodies against HIV). Synonym: sero-negative. The test result of a person who has been infected but is in the window period between HIV exposure and detection of antibodies will also be negative.

HIV-positive: A person who is HIV-positive has had antibodies against HIV detected on a blood test or gingival exudate test. Synonym: sero-positive. Results may occasionally be false-positive, especially in infants up to 18 months of age who are carrying maternal antibodies.

Homosexual/homosexuality: It refers to people who have sex with and/or sexual attraction to or desires for people of the same sex.

Hot spot: is a location or area posing or recognised as a high transmission Area of HIV, STIS, TB, Substance abuse etc. within a community

Infertility: Infertility is “a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse.”... (WHO-ICMART glossary¹).

Implementation: Implementation is the carrying out, execution of project activities

Incidence: In general, HIV incidence is expressed as the estimated number of persons newly infected with HIV during a specified time period (e.g., a year), or as a rate calculated by dividing the estimated number of persons newly infected with HIV during a specified time period by the number of persons at risk for HIV infection.

Intervention: is a way of mediating or dealing with a social problem in an effort to influence behaviour change and to reduce HIV Vulnerability

Intersex: is an individual with both male and female biological attributes



Maternal mortality and maternal death: The terms ‘maternal mortality’ and ‘maternal deaths’ are reserved for deaths specifically due to HIV and other related issues..

Mobility: The movement of people from one social group, class, or level to another

Prevalence: The number of persons living with HIV disease at a given time regardless of the time of infection, whether the person has received a diagnosis (aware of infection), or the stage of HIV disease. Although prevalence does not indicate how long a person has had a disease, it can be used to estimate the probability that a person selected at random from a population will have the disease.

Serostatus: A generic term that refers to the presence/absence of antibodies for a specific virus in the blood.

Sexual orientation: The term ‘sexual orientation’ refers to each person’s profound emotional and sexual attraction to, and intimate and sexual relations with, individuals of a different, the same, or both sexes.

Sex worker: The term ‘sex worker’ is intended to be non-judgemental and focuses on the working conditions under which sexual services are sold.

Site facilitator: the one who monitor Peer Educators in a specific zone

Social facilities: facilities in a community which everyone can access

Target group: is a specific group of people within the community at which the services is aimed at.

Tarven: A place of business where people gather to drink

Topographical map: Topographic maps are maps that provide extensive close-up detail about a place.

Transgender: A transgender person has a gender identity that is different from his or her sex at birth.

Transvestite: A transvestite is a person who wears clothes associated with the opposite gender in order to enjoy the temporary experience of membership of the opposite gender

Tripartite: divided into or composed of three parts ; having three corresponding parts or copies or made between or involving three parties

Vulnerability: Vulnerability refers to unequal opportunities, social exclusion, unemployment, or precarious employment and other social, cultural, political, and economic factors that make a person more susceptible to HIV infection and to developing AIDS.

Zones: distinguished area from adjacent parts by a distinctive feature or characteristic.

PART 1: INTRODUCTION

The Corridor Economic Empowerment Project (CEEP)

The Corridor Economic Empowerment Project (CEEP) works across six countries, Malawi, Mozambique, South Africa, Tanzania, Zambia and Zimbabwe.

Background

Globally, poverty, gender inequalities, social and economic exclusions continue to pose major challenges to HIV prevention efforts. More than 30 years since HIV was discovered, AIDS has become one of the most devastating diseases humankind has ever faced.

By the end of 2012, an estimated 35.3 million people globally were living with HIV, with 1.8 million AIDS-related deaths and 2.3 million new HIV infections. Sub-Saharan Africa is still the region most affected, with 69% of all people infected with HIV living in Sub-Saharan Africa. Women are the most affected by HIV accounting for 58% of new HIV infections. According to the 2009 UNAIDS report in Sub-Saharan Africa young women aged 15-24 years are 3-5 times more likely to be HIV positive than their male peers. This has highlighted the importance of relational dynamics such as economic and power imbalances, which in turn influence women's vulnerability to HIV and AIDS. A fundamental difference between AIDS and other diseases generally linked with poverty in sub-Saharan Africa, such as tuberculosis or malaria, is that it's primarily route of transmission is sexual intercourse. It has been argued that the economic vulnerability of women increases their vulnerability to HIV and AIDS by keeping them dependent on men and constraining their ability to refuse sex, negotiate the use of a condom, discuss fidelity with their partners, seek out treatment or leave risky relationships. Women comprise almost two-thirds of the world's illiterate people and are often denied property rights or access to credit. They earn 30-40% less than men for the same work, and most of those who are working are employed outside the formal sector in jobs characterized by income insecurity and poor working conditions.

ILO and SADC HIV AIDS Economic Empowerment Programming

The International Labour Organization (ILO) implements different initiatives that support the SADC development agenda of controlling and reversing the impact of HIV and AIDS. From 2007-2010, the ILO supported the National Department of Transport, Employers and Workers in the transport sector under a previous intervention. This project achieved a number of results, including assisting the Transport Sector to develop policies, systems and programmes on HIV, AIDS, STI and TB in the workplace and the formation of Transport Sector HIV, AIDS, STI and TB coordinating committee in 2007.

Upon recognition of the project achievements, the ILO in consultation with SIDA extended the project to vulnerable groups along the transport corridors and communities, leading to implementation of the project on HIV vulnerability reduction through economic empowerment focusing women, men, young girls and boys to HIV.

The immediate objectives of the project with focus on the macro, meso and micro levels are detailed below:

Immediate Objective 1: Policy makers and promoters make evidence-based decisions to mainstream the economic empowerment model into HIV and AIDS regional and national agendas.

Immediate Objective 2: To economically empower targeted men and women along selected transport corridors by increasing the availability of economic services to prevent and mitigate the impact of HIV and AIDS in selected transport corridors.



Immediate Objective 3: To reduce HIV vulnerability by increasing access to effective HIV and AIDS prevention and impact mitigation and social services provided by targeted operators (members organizations such as cooperatives, informal associations, MSMEs) along selected transport corridors.

Understanding the picture

The Corridor Economic Empowerment Project draws on a systems approach to understand and address the spread of the HIV pandemic. The project focuses on reducing people's vulnerability to HIV and AIDS.

What do we mean by “Reducing vulnerability to HIV and AIDS”?

“Reducing vulnerability to HIV and AIDS” is a phrase that is used to encompass two aspects:

- ✓ The primary focus of CEEP is on the reduction of HIV vulnerability through a combination of HIV prevention strategies. These strategies include economic empowerment, behavioural strategies (e.g. reduce the number of partners and make correct and consistent use of condoms), biomedical strategies (e.g. medical male circumcision, prevention of mother to child transmission, voluntary counselling and testing), advocacy with national, provincial and local structures as well as the implementation of HIV workplace programs.
- ✓ The second area that the reduction of HIV vulnerability refers to the mitigation (or reduction) of the effects of HIV and AIDS on the individual, families and communities. Through the economic empowerment, HIV sensitization and referral to appropriate services, CEEP is able to reduce HIV and AIDS impact for people infected and or affected by HIV and AIDS.

How do we approach HIV vulnerability?

The ILO and CEEP make use of a systems model to understand issues including HIV vulnerability. Drawing upon the latest understandings from the countries national strategic plans, key drivers of HIV vulnerability have been identified. These have been organised into the systems model from a micro, meso and macro level.

The **macro level** considers the broad factors that influence a person's vulnerability to HIV and AIDS. This includes the way in which groups of people relate to each other and the social and cultural norms that influence these interrelations and behaviours. At this level the drivers focus on:

- Poverty and Economic disempowerment
- Gender norms that are adopted within society
- Stigma and discrimination
- Alcohol and drug use
- Local, provincial, national and regional governmental responses. This can include policy frameworks on Economic Empowerment (and poverty reductions strategies) and HIV & AIDS that speak to ensuring individuals have access to primary health care services, e.g. condoms and contraception's, TB or STI clinics, HIV treatment clinics, HCT services and sexual reproductive health.

The **meso level** focuses on the interactions between people and focuses on the communities/groups/family norms and values that influence an individual's behaviours. At this level these drivers have been identified as key:

- Migration
- Group and family norms (including business support structures)
- Local cultural practices



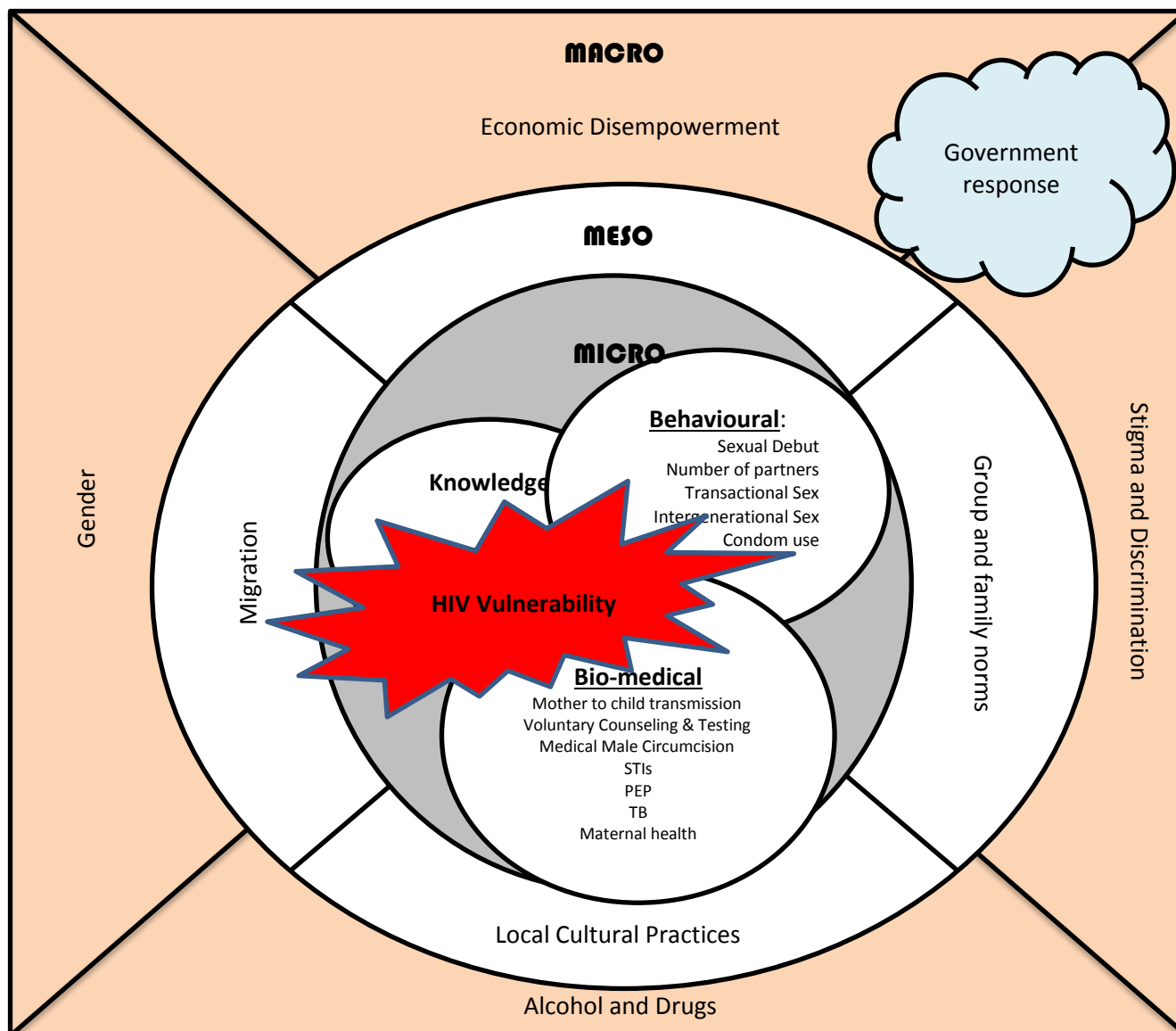
At a **micro level** we consider the individual themselves and the factors that increase or decrease their vulnerability to HIV and AIDS. At this level we consider:

- Knowledge of HIV, AIDS, TB and Other STIs
- Behaviour, including:
 - Age of sexual debut
 - Number of sexual partners
 - Transactional sex
 - Intergenerational sex
 - Correct and consistent condom use
- Bio-medical factors, including:
 - Knowledge of HIV status
 - Medical Male Circumcision
 - Family planning including maternal health and Mother to child transmission
 - STIs
 - Post Exposure Prophylaxis

While we have identified each factor individually, these factors are interrelated and may help or hinder a person's attempts at reducing their own vulnerability to HIV and AIDS.

Below is a diagrammatic representation of these drivers:

Figure 2: Diagrammatic representation of the key drivers of HIV and AIDS pandemic



Structure of the manual

The Peer Education Training Manual has been designed to be used in conjunction with the Trainer of Trainers manual (Trainer Guide). Participant's hand-outs have also been compiled in this particular document as well as training tools. The trainer needs to have both the trainer guide and the Peer Education Training Manual, not excluding the hand outs for participants and tools for reference during training. The trainer guide therefore follows the same sequence in guiding the trainer throughout the manual. The Peer Education Training Manual covers material meant for a ten day training programme for peer educators.

Success in combating HIV depends on peer educators who have the right skills and motivation to implement the relevant HIV education strategies, policies and programmes on HIV and economic empowerment.



The manual was developed and pilot tested by the International Labour Organization (ILO), Corridor Economic Empowerment Project. The result is a generic manual that may be adapted to suit the needs of individual countries, given the diversity in cultural and social environment in these countries.

Within this manual all the following topics are explored:

- Part 1: Presents the overall picture and the approach in addressing HIV Vulnerability.
- Part 2: Contains basic information on HIV and AIDS
- Part 3: Outlines the policies and frameworks that guide our responses.
- Part 4: We discuss each of these drivers and the manner in which each of these can help or hinder a person's vulnerability to HIV and AIDS.
- Part 5: Focuses on the strategies that are used to reduce HIV and AIDS vulnerability within the workplace.
- Part 6: Considers peer education as one method to reduce HIV and AIDS vulnerability in more depth
- Part 7: Peer Education reporting tools

Within each section and chapter there is a description of the important issues, with some country specific examples, followed by a summary of the key messages for this section.

PART 2: THE BASICS OF HIV AND AIDS

What is HIV?

HIV stands for Human Immunodeficiency Virus, and like all other virus it attacks the immune system. HIV is known as a lentivirus – this means that it is a slow virus which takes time to cause any harmful effects on the body. Unlike some other viruses, the human body cannot get rid of HIV. That means that once a person is infected with HIV, they will have it for life. As indicated above HIV destroys the immune system, which is the body's defence system against germs, bacteria and viruses.

What is the immune system

The environment we live in is filled with germs such as bacteria, fungi and viruses which can attack the body and make it sick. The body defends itself from these germs through the Immune System. There are a few parts that make up the immune system:

- ✓ **The skin** is an important part of the immune system, when it's unbroken it forms a barrier which prevents germs from entering the body to make us sick. Mucus membranes – a thin lining which is the inner part of the body produces a fluid that kills germs or keeps them inactive, e.g. mouth, throat and vagina.
- ✓ **White blood cells**, called lymphocytes are like soldiers patrolling the body from their base, the lymphoid organs, where they are produced. When they come across germs within the blood system they may absorb and destroy the germ.
- ✓ **The Lymph glands** are in the sides of the neck, in the armpits and in the abdomen around the intestines. These are dense tissues that contain the lymphocytes and this is where anti-bodies are developed.
- ✓ **Antibodies** are developed by the body in response to a germ or virus. These antibodies neutralize, disable or destroy germs that are in the body. If antibodies are present in the blood system this shows that the person has been exposed to this particular germ, e.g. HIV, small pox, etc.

So in general, the immune response recognizes and defends the body against bacteria, viruses, and substances that appear foreign and harmful. The main tasks of the body's immune system are:

- ✓ Neutralizing pathogens like bacteria, viruses, parasites or fungi that have entered the body, and removing them from the body
- ✓ Fighting against the body's own cells that have changed due to an illness, for example cancerous cells

HIV affects specific cells of the immune system, called CD4 cells, or T cells. Over time, HIV can destroy so many of these cells that the body can't fight off infections and disease. When this happens, HIV infection leads to AIDS.

What is AIDS?

AIDS stands for Acquired Immune Deficiency Syndrome. It is diagnosed when the immune system of a person infected with HIV becomes severely weakened (measured by CD4 cell count) and/or the person becomes ill with an opportunistic infection or illness. HIV infection causes AIDS to develop. However, it is possible to be infected with HIV without developing AIDS. Without treatment, the HIV infection is allowed to progress in the body and in many cases it will develop into AIDS. A person with AIDS can pass HIV to someone else if engaged in unprotected sex.

The link between HIV and AIDS

When a person is infected with HIV they are considered HIV positive but they do not have AIDS. AIDS is the acquired syndrome that develops when the immune system is weakened and the person is infected

with opportunistic infections. To understand how a person moves from being HIV positive to having AIDS, there are two terms to consider, and these are:

- ✓ **The viral load** refers to the amount of the HIV in the body. The higher the viral load, the more virus particles there are in the body destroying the white blood cells. It is important to note that as the viral load increases, the white blood cells – also referred to as the CD4 count drops, resulting in a weakened immune system.
- ✓ The **CD4 count** considers the number of white blood cells that are in a person's body to fight off germs and prevent disease. These are the cells indicated above, which are destroyed by the HIV. The average healthy CD4 count is between 500 and 1200 (cells per mm³). When the CD4 count drops to below 500, the immune system is weakened and opportunistic infections set in. The clinical definition of AIDS is generally when the CD4 count falls below 200.

HIV testing can identify HIV infection in the early stages. This allows the person to use preventive drugs which will slow the rate at which the virus reproduces, delaying the beginning of AIDS.

HIV	AIDS
HIV is the virus which attacks the T-cells in the immune system.	AIDS is the syndrome which appears in advanced stages of HIV infection.
HIV is a virus.	AIDS is a medical condition.

Modes of HIV transmission

HIV is transmitted through exposure to HIV infected blood or other body fluid such as semen, cervical or vaginal secretions. The primary modes of HIV transmission are:

- ✓ **Blood and blood products** – This could happen through transfusion or direct contact with HIV infected blood which can occur during sharing of needles or because of needle-stick injuries.
- ✓ **Sexual contact** – through unprotected vaginal, oral and anal sex
- ✓ **Mother-to-Child-transmission** – during pregnancy, labour and delivery as well as during breast feeding.

Progression of HIV from infection to AIDS

Acute Period

This is the time from infection until antibodies are developed by the body to suppress the virus. Upon initial infection the body is not familiar with the virus and it takes time to start producing antibodies (2 weeks to a month). As there is nothing to stop HIV from reproducing the viral load shoots up. It remains high until the body is able to co-ordinate an effective response to bring the virus under control. It is important to keep in mind that when the viral load is high, during this period and later in the progression of the disease, a person is highly infectious to other people. Currently, rapid tests used for HIV testing look for HIV antibodies, and at this stage antibodies are still developing, therefore a person testing for HIV at this stage may get a negative HIV test result, although they are infected. This is called the window period and it can take up to three months before antibodies are detected by the rapid test.

Latency

This is the time when there is a constant battle between the virus and the immune system on a daily basis. The immune system is able to contain the virus reproduction and attacks. During this time a person will be exposed to the variety of other germs that will make them sick but like anyone else they will recover as their immune system is still strong. A person is infectious to others during this time even



though the viral load has dropped. A person infected with HIV will live a healthy and productive life, and it is not possible to tell who is HIV positive and who is not just by looking at people. Additionally, nobody will know that they are infected with HIV unless they have been tested.

How long does this period last differs from person to person and can be as short as two years or longer. For example, some women in underdeveloped or developing countries, who are malnourished, regularly pregnant and often ill, develop AIDS much quicker than more privileged people in better socio-economic conditions. This is one of the reasons that CEEP seeks to address economic empowerment. The latency period can be affected by many factors such as:

- ✓ Access to treatment,
- ✓ Life-style,
- ✓ Socio-economic status,
- ✓ Disease management strategies,
- ✓ A person's health at the time of infection and
- ✓ The amount of times a person is exposed to the virus, e.g. through re-infection.

Symptomatic stage

After a while the immune system gets weaker and is not able to sustain the constant bombardment from the HIV. As the immune system and the body become weaker, the virus is able to reproduce more and the viral load increases again. With a weakened immune system, the ability to protect the body from other illnesses drops, resulting in an increase in infections that attack the body. These are called opportunistic infections and will be discussed in more details in another section below.

Acquired Immune Deficiency Syndrome - AIDS

Finally, the body becomes severely weakened by the attacks from the opportunistic infections. At this stage a collection of infections is common, they attack the body and there is no immune response to stop it. This stage is reversible with treatment but if treatment is not sought the infected person will die from any of these opportunistic infections. The most common opportunistic infection that results in death of people living with AIDS is TB, other common opportunistic infections include:

- ✓ Pneumonia
- ✓ Toxoplasmic Encephalitis
- ✓ Extra – pulmonary Tuberculosis
- ✓ Bacterial respiratory infections
- ✓ Herpes Simplex
- ✓ Hepatitis C
- ✓ Candidiasis (thrush)
- ✓ Varicella Zoster virus (shingles)

During this time a person may also be confined to bed for more than 50% of the time, have night sweats, chronic diarrhoea and loss weight.

What are Opportunistic Infections?

People with advanced HIV infection are vulnerable to infections and cancers that are called 'opportunistic infections' (OIs) because they take advantage of the opportunity offered by a weakened immune system. Almost any disease can become an HIV opportunistic infection when the immune system is weak. Some are more common than others, though, and some are more likely to occur at certain levels of CD4 counts than others. Here are some of the more common HIV opportunistic infections:

Common Infections	Opportunistic	Description
Candidiasis (Thrush)		Is a fungal infection of the mouth, throat, or vagina signified by reddening of the mouth, throat and vagina.
Cytomegalovirus (CMV)		Is a viral infection that causes eye disease that can lead to blindness
Herpes simplex		Blister like sores on the mouth, genital area or on the body caused by herpes simplex virus
Malaria		Condition caused by mosquitoes in malaria infested areas, Any person in Malaria infested areas can be sick of Malaria, however people with HIV have more severe symptoms due to lowered immunity
Mycobacterium avium complex (MAC or MAI)		Is a bacterial infection that can cause recurring fevers, general sick feelings, problems with digestion, and serious weight loss
Pneumocystis pneumonia (PCP)		Is a fungal infection that can cause a fatal pneumonia.
Toxoplasmosis (Toxo)		Infection of the brain caused by protozoa
Tuberculosis (TB)		Is a bacterial infection that attacks the lungs, brain and any part of the body.

Table 1: Common Opportunistic Infections Descriptions

Men are eight times more likely to develop a cancer called Kaposi's sarcoma. Women are more likely to develop bacterial pneumonia and herpes simplex infections. Women are also more at risk for certain infections that can lead to cancers of the reproductive system.

How to prevent Opportunistic Infections

The best way to maintain good health is to live a positive lifestyle, this can be achieved by accepting the HIV positive status, disclosing to a supportive person and seeking help where needed. Most of the germs that cause OIs are quite common, with a strong immune system some people may be living with the germs without noticing. To reduce the risk of new infections one can:

- ✓ Ensure good personal hygiene
- ✓ Reduce or avoid using drugs, alcohol, smoking
- ✓ Eat healthy food and exercise
- ✓ Avoiding known sources of the germs that cause OIs, e.g. keep your living environment clean

Avoid severe complications and suffering by taking prescribed medications that will prevent the development of active disease, known as prophylaxis. In case where a person has an OI, it is important to take treatment correctly as instructed by the health provider.

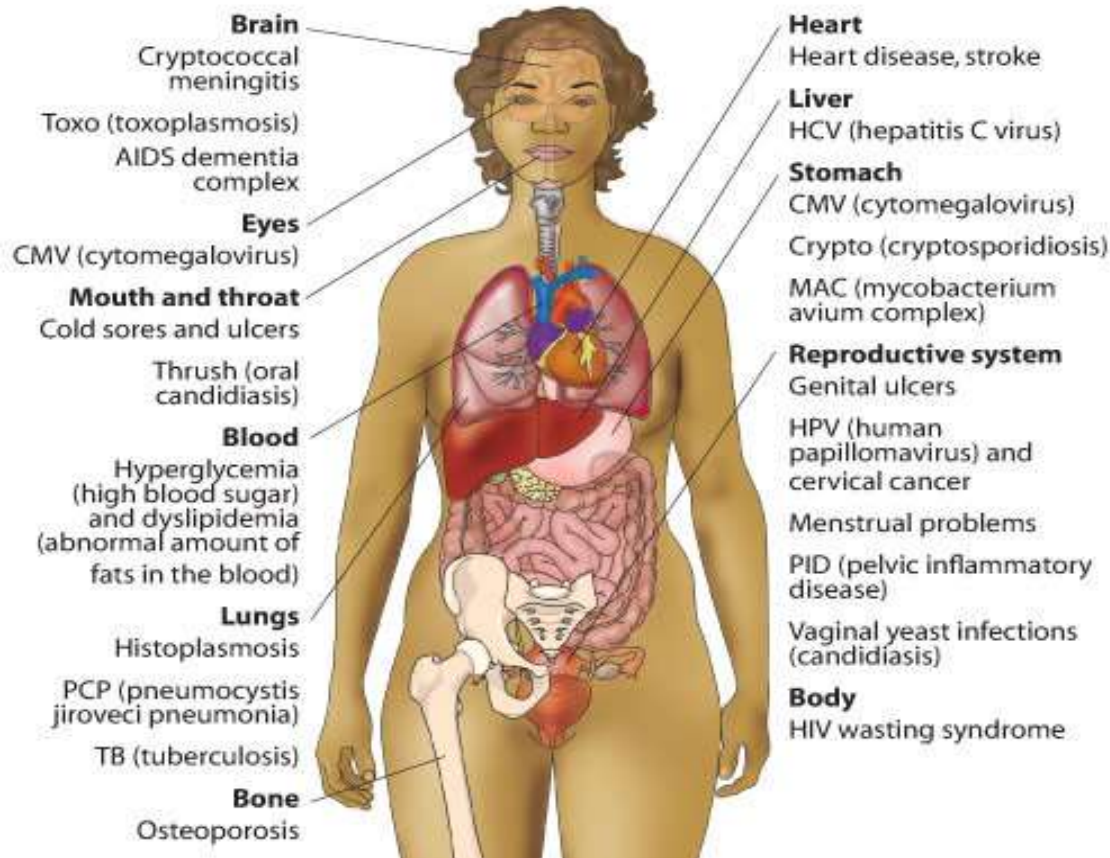


Figure 1: Common Opportunistic Infections across the body

Testing for Opportunistic infections

To see if one is infected with an OI, blood might be tested for antigens (pieces of the germ that causes the OI) or for antibodies which are proteins made by the immune system to fight the germs. If the antigens are found, it means the person is infected. If the antibodies are found, the person has been exposed to the infection. If a person is infected with a germ that causes an OI, and if the CD4 cells are low enough to allow that OI to develop, the health care provider will look for signs of active disease. These are different for the different OIs.

Treating Opportunistic Infections

For each OI, there are specific drugs, or combinations of drugs, that seem to work best. The main purpose of treating OIs is to allow the damaged immune system to recover and fight the HIV and other OIs better. Each OI should be treated as soon as possible

Non-Communicable Diseases and HIV and AIDS

As has been mentioned above HIV attacks the immune system, this not only makes people at risk of OIs but Non-Communicable Diseases (NDCs) as well. Non communicable diseases are also known as chronic diseases, and these are diseases that are not passed from person to person. They are of long duration and generally slow progression. The four main types of non-communicable diseases are cardiovascular diseases (like heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma) and diabetes.

It is expected that by 2030 in Africa the number of deaths caused by non-communicable disease will be higher than the number of deaths caused by communicable, nutritional, maternal and perinatal diseases combined.

Six non-communicable diseases that are common among people living with HIV

Heart disease

- ✓ Several studies have made the link between coronary disease and HIV infection; one presented at the 18th Conference on Retroviruses and Opportunistic Infections (CROI) in March 2011 found that HIV-infected participants had an increased risk of "acute - heart attack" compared with HIV-negative study participants with similar demographic characteristics and behaviour patterns.
- ✓ Another 2011 study found that HIV infection was a risk factor for heart failure, with ongoing viral reproduction associated with a higher risk of developing heart failure.
- ✓ The link between ARVs and heart disease is less clear; one study, also presented at CROI, found that HIV infection increased the risk of coronary heart disease, but ARVs and higher CD4 counts – a measure of immune strength - significantly reduced this risk.

Cervical cancer

- ✓ After breast cancer, cervical cancer is the second most common cancer among women worldwide; more than 80 percent of new cases and deaths from this disease occur in developing countries. Studies have found that HIV-positive women are at higher risk of human papillomavirus (HPV), a virus that leads to the development of cervical cancer; women with low CD4 counts seem to be particularly vulnerable to HPV.

Other cancers

- ✓ People living with HIV are more susceptible to several cancers, including Kaposi sarcoma, Hodgkin's and non-Hodgkin's lymphoma, anal cancer, skin cancer and liver cancer - than HIV-negative people, a new study has found.

Kidney disease

- ✓ Known as HIV-associated nephropathy, kidney disease is relatively common in people living with HIV. The virus interferes with the kidneys' ability to function correctly, particularly in people with advanced HIV who have a low CD4 count and a high viral load, as well as older people.

Liver disease

- ✓ A leading cause of morbidity and death among HIV-positive individuals, it is mainly caused by co-infection with hepatitis B or hepatitis C, alcohol abuse, insulin resistance or side-effects of medicines. Experts say early identification and proper management of liver disease in HIV-infected people are crucial to improve long-term outcomes.

Additionally, according to the World Health Organization (WHO), apart from the psychological impact of HIV, the virus has direct effects on the central nervous system, leading to neuropsychiatric complications, including HIV encephalopathy, depression, mania, cognitive disorders and dementia.

Experience in addressing HIV and NCDs shows that there are challenges that are common between them; such as organizing and delivering adequate prevention services; chronic treatment and care; addressing the social and environmental determinants of these health issues and reaching people without access to services and people who are disproportionately affected by these diseases and these challenges are particularly common in Sub-Saharan Africa regions.

HIV prevention

HIV transmission is when the Human Immunodeficiency Virus is passed from one person to another. HIV prevention refers to the use of a number of methods to reduce or eliminate the risk of HIV being passed from one person to another (transmission).

Modes of HIV infection and biomedical technologies for prevention

Mode	Technology	Intervention
Exposure to blood via blood transfusion	Scientific screening procedures	Screening of blood donors for risk factors Screening of blood suppliers
Exposure to blood in healthcare settings (health workers, patients)	Needle disposal systems Gloves Infection control practices	Implementation of guidelines for universal precautions Provision of Post Exposure Prophylaxis (PEP)
Exposure to blood in non-healthcare settings	Gloves Infection control practices	Implementation of guidelines for universal precautions Provision of Post Exposure Prophylaxis (PEP)
Injecting drug use – (IUD) needle sharing	Detoxification Harm reduction	Detoxification programmes Needle exchange programmes
Mother to child HIV transmission	Antiretroviral drugs and other regimens Caesarean delivery Controlled infant feeding (exclusive replacement feeding or exclusive breast feeding)	Implementation of Prevention of Mother to Child Transmission (PMTCT) programmes
Sexual intercourse	Sexually Transmitted Infections (STI) treatment Male condom	Syndromic management of STIs Implementation of condom distribution programmes

	Female condom Voluntary Medical Male Circumcision (VMMC) HIV testing	Implementation of VMMC programmes Implementation of Voluntary Counselling and Testing (VCT)Programmes
Sexual intercourse (rape, coerced sex, unintentional /accidental exposure)	Antiretroviral drugs for post exposure prophylaxis STI treatment Emergency contraception	PEP programmes STI treatment regimen available

Source: Parker, Colvin and Birdsall: 2006 in HIV/AIDS development and society in Africa

Key Messages

- HIV is a virus that attacks the body's immune system
- HIV causes AIDS
- HIV is transmitted through bodily fluids and is commonly transmitted through:
 - Blood and blood products
 - Through unprotected sex
 - From mother to child
- HIV transmission can be prevented
- There are four stages from HIV infection to AIDS, as the immune system gets weaker more opportunistic infections arise
- As the immune system gets weaker to the viral load increase so too does a person's level of infection to others.
- Treatment of HIV is effective, adherence is essential.
- Opportunistic Infection need to be treated as soon as possible to reduce their impact on the immune system
- A HIV positive person should take care to prevent opportunistic infections through:
 - Good personal hygiene
 - Stop smoking and drinking, these activities strain the immune system further and make ARVs ineffective
 - Eat healthy food and exercise
 - Keep your environment clean to reduce the build-up of germs

Understanding HIV and AIDS in Sub-Saharan Africa

Before delving into a discussion of HIV and AIDS in Sub-Saharan Africa, let us consider the global picture.

Globally

- ✓ 35.3 million people were living with HIV as of the end of 2012
- ✓ 2.3 million new infections occurred within 2011. This is a decline from 3.4 million new infections in 2001. AIDS related deaths have also decreased since 2001, in 2012 there were 1.6 million people who were reported to have died due to AIDS related diseases.
- ✓ Fifty two percent of those infected with HIV are women.

Sub-Saharan Africa

25 million people living with HIV are within Sub-Saharan Africa, this is 70% of the global spread of the pandemic. Below is a breakdown of the prevalence rates, number of people living with HIV and the gender breakdowns of the pandemic within the CEEP countries.

Indicator	Malawi	Mozambique ¹	South Africa	Tanzania ²	Zambia	Zimbabwe
Prevalence Rates ³	10.8%	11.1%	17.9%	5.1%	12.7%	14.7%
Number of people living with HIV and AIDS	1.1 million	1.6 million	6.1 million	1.5 million	1.1 million	1.4 million
Male	13.3%	9.2%	4%	4.7%	12.3%	15%
Female	10.2%	13.1%	8%	6.8%	16.1%	12%
Number of new infections per year	66 000	120 000	370 000	83 000	56 000	69 000

Table 2: Key HIV indicators across the 6 CEEP countries

The table shows

- ✓ Prevalence rates over 10% in South Africa, Zimbabwe, Zambia and Mozambique, with Tanzania having the lowest prevalence rate at just over 5%.
- ✓ Across these CEEP focused countries there are 12.8 million people living with HIV.
- ✓ The table also shows that the higher the number of people living with HIV the higher the levels of new infections.
- ✓ With the exception of Zimbabwe and Malawi, there are generally more women infected with HIV, specifically younger women.

Below is a typical example of the spread of the disease across age and gender, drawing on findings from Zimbabwe:

¹ National AIDS Council: 2012 Global AIDS Response Progress Report: For Period 2010-2011, Mozambique

² ILO. 2012. Economic Empowerment and HIV Vulnerability Reduction Project Along the Transport Corridors in Southern Africa. Report: Gender Sensitivity, Economic Empowerment & HIV and AIDS in Tanzania.

³ UNAIDS Global Report 2013

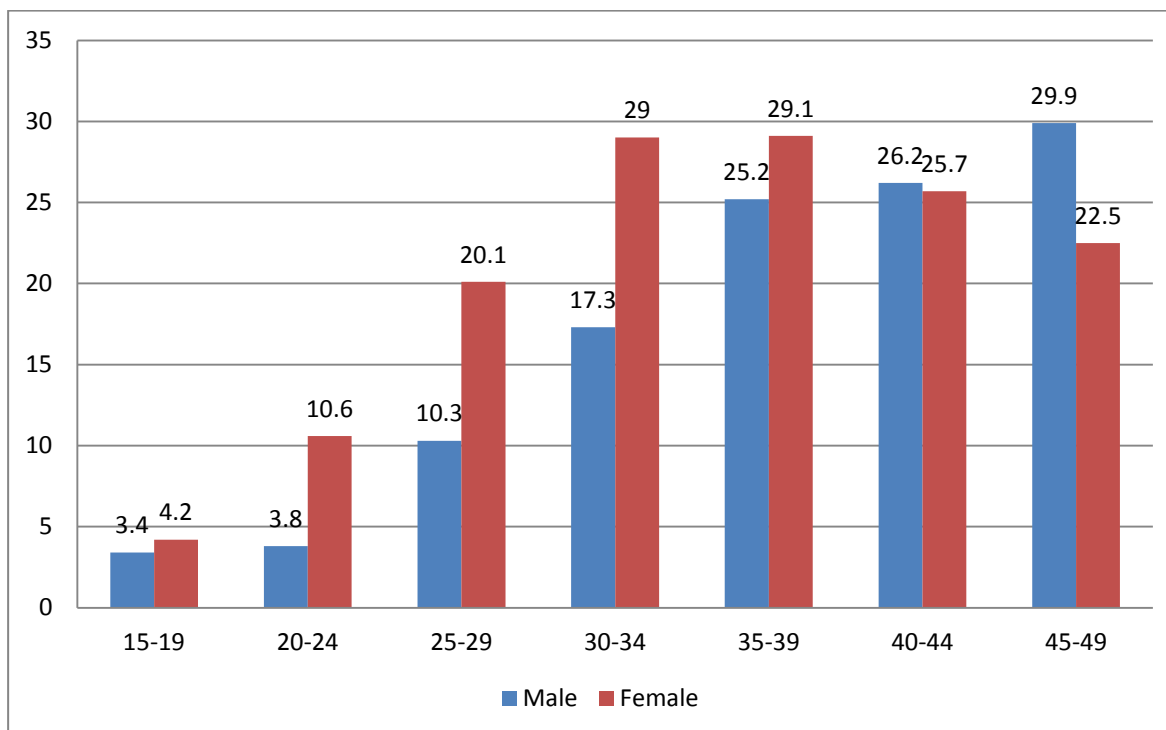


Figure 2: Prevalence rates in Zimbabwe by age and gender (2010 -2011)

In the graph above you can see that

- ✓ Generally women have higher prevalence rates compared to men. The reasons that women are more at risk of infection are more than just biological, there are social reasons that place women at risk of infection, e.g. their social standing
- ✓ The prevalence rates peak between the ages of 20 – 44, which is the socially and economically productive members of society, further highlight the threat that HIV places on society as whole.
- ✓ The highest peaks for HIV infection in women is between ages 20-34 and for men its older men 45 years and older.

Main Modes of transmission in Sub-Saharan Africa

Within the Southern African context HIV transmission occurs mostly through heterosexual sexual intercourse. Research shows that low risk heterosexual sexual intercourse accounts for 57% of the HIV infections, see table below⁴:

Source ⁵	Percentage contribution
Low risk heterosexual	57.6%
Casual heterosexual	7.5%
Partners of casual heterosexual	18.8%
Clients of sex workers	6.4%
Men who have sex with men (MSM)	4.0%
Male partners of MSM	2.7%
Female partners of MSM	0.4%
Sex Workers	1.4%

⁴ Reference all the strategic plans here.

⁵ Zimbabwe National HIV and AIDS Strategic plan 2011- 2015

Injecting Drug users (IDU)	1.1%
Partners of IDU	0.1%
Medical Injections	0.1%

Table 2: Modes of Transmission in Zimbabwe

The above table was taken from Modes of Transmission Studies conducted within Zimbabwe and this clearly highlights that the most dominant means of transmission is through heterosexual intercourse. There are other ways that HIV is transmitted within the region include, mother to child transmission, blood and blood products, Intravenous drug users, Men who have sex with Men and sex workers.

What can be done?

The picture that is presented above may leave a person feeling depressed and overwhelmed and feel like nothing has been done and nothing that can be done. This is not the case!

Remember a lot has been achieved over the years, including

- ✓ Noted drops in HIV infection in children 2-14 over the years primarily as a result of the Prevention of Mother to Child Transmission (PMTCT) programs. In some countries these programs were implemented as a result of pressure from communities and civil society, e.g. South Africa.
- ✓ Partly as a result of countries implementing ART programs, the life span of people living with HIV has been increasing⁶ over the years, resulting in increase in prevalence rates in the older age groups. Again these programs were implemented as a result to pressure from civil society.

What can you do?

Firstly, start with **you**, consider and understand the information within this manual and see how it relates to the lifestyle choices that you have made. Be clear where you are vulnerabilities to HIV infection. Always empower yourself to reduce your vulnerabilities. The information here applies to you. Think of some of the immediate things that you can do:

- ✓ Empower yourself with knowledge and skills on HIV and AIDS
- ✓ Test regularly – especially between and within relationships
- ✓ Use protection correctly and consistently
- ✓ Reduce the number of sexual partners that you have
- ✓ Get medically circumcised if you are a man
- ✓ Seek early treatment and social support (e.g. join a support group) if you are positive
- ✓ If you are HIV positive, adopt a healthy lifestyle like eating healthy, exercising and seeking medical assistance quickly should any opportunistic infections arise

Then consider how you can play an active role in reducing your **families and friend's** vulnerability to HIV and AIDS. The things you learn here can help others too, share the information and ideas contained in this manual. If the opportunities arise discuss these issues respectfully with your family and friends. Remember living by example teachers more than the just sharing of information. If you are asked about things you do not know, do not be shy to make referrals to those in the know. You can also refer people for services that are offered within communities.

Consider what you can do at a **community level**, is there a group or person who requires support to HIV services. What role can you play? Are there services that are missing and needed? At times we need to educate our local and national leaders towards action. Help them think about what it is that they can do.

⁶ South African National Survey 2008, 63.



Within your business and **workplace** you can ensure that you have an up-to-date workplace policy that promotes human rights and non-discriminatory practices against people based on gender, race, economic or HIV status. Then consider if a workplace program can be implemented, through peer education or other outreach activities to empower the employees to reduce their vulnerability to HIV and AIDS (this will be discussed more in Part 5).

Key Messages:

- HIV affects everyone and anyone is at risk of infection
- HIV's highest burden is felt in Sub-Saharan Africa
- Women carry the highest burden of the disease
- Young women (20-24) in particular are at risk of contracting HIV
- Heterosexual sex is the primary driver of the spread of HIV in Sub-Saharan Africa.
- HIV and AIDS threaten our whole society and will require a multi-levelled response
- There is a lot that you can do at a person, familial, community and work arena.

PART 3: KEY DRIVERS OF THE PANDEMIC

Key drivers of the pandemic: macro factors

The key focus of early responses to the epidemic has been knowledge of HIV and AIDS, assuming that if people were aware of the modes of HIV transmission they would take the necessary steps to protect themselves. It was also assumed that if people knew the progression of the infection including the symptoms they would test and take care of themselves. Unfortunately time has shown that while knowledge is a necessary condition for changing behaviours, it not sufficient to lead to these changes, other factors play a part. This realisation has meant that interventions have become more strategic and address a wider range of issues including gender norms, economic disempowerment, violence, etc. Similarly, CEEP makes use of a systemic approach in understanding HIV and AIDS vulnerability, and these can be divided into macro, meso and micro factors. Macro factors consider the relations between groups of people and the social and cultural norms that influence these interrelations and behaviours. This chapter explores these macro factors, which are:

- a. Economic Disempowerment and Poverty
- b. Gender Issues
- c. Alcohol and Drug Use and Abuse
- d. Stigma and Discrimination
- e. Leadership and Government support.

A. Economic Disempowerment and Poverty

Economic Disempowerment is a term that refers to person's or group's lack of decision making or control over their economic environment. This disempowerment can arise from a variety of factors including:

- ✓ The global recession which has led to the lack of resources to initiate or maintain economic activities,
- ✓ Social norms which restrict a person's decision making or activities within their social settings.

This economic disempowerment is wide spread within Sub Saharan Africa and is reflected by the high levels of poverty and unemployment rates. A breakdown of the poverty and unemployment rates across the six CEEP countries is presented below.

Indicator	Malawi	Mozambique	South Africa	Tanzania	Zambia	Zimbabwe
Population Size	14,389,000	20,579,265	50,586,000	43,600,000	13,459,000	12,754,000
% below poverty line of US\$1,25 per day	53%	54%	23%	34%	68%	72%
Unemployment rate	Data unavailable	17%	24.9%	Data unavailable	14%	80%

Table 3: A few key economic indicators across the 6 CEEP countries

Sources: http://www.sadc.int/member-states/country_reports; <http://data.worldbank.org/country> and http://www.unicef/infobycountry/country_reports

How does Economic Disempowerment lead to an increase HIV and AIDS vulnerability?

Economic Disempowerment results in increased HIV and AIDS vulnerability for **individuals** in two ways:

1. As a result of poverty and unemployment people engage in transactional sex in their efforts to gain access to resources. Transactional sex is defined as a relationship that involves the exchange of money or material goods for sex. While this transaction has both an economic and sexual component, it is often differentiated from formal sex workⁱ. Transactional sex is usually accompanied by power differences, where the person paying for the sexual encounter decides where, when and how intercourse is to be carried out. A typical example is that a man providing material resources in exchange for sex would then decide the time and place for sex and importantly would decide on whether protection such as condom is use during sexual intercourse.
2. Secondly, economic disempowerment can lead to increase HIV and AIDS vulnerability through the lack of access to resources such as adequate food, transport and health services.
 - ✓ The lack of adequate food directly affects a person's health because the body's natural resources and germ fighting abilities require well balanced food and vitamins. With the lack of these resources PLHIV are vulnerable to OIs and the development of the disease can be faster.
 - ✓ The lack of economic resources for transport to health services can result in persons being unable to access health care services when they get sick whilst infected with HIV (through opportunistic infections). This can lead to OIs attacking the body for longer periods of time which ultimately drains the person's immune system, making the person more vulnerable to other infections. It is advisable to treat OIs as soon as they attack to maintain a stronger immune system.
 - ✓ Similarly a person's health affects their ability to function well at work and be economically active; therefore illness can increase a person's economic disempowerment.

Economic Disempowerment does not only affect individuals but **communities** as well. Communities that are poorer carry the burden of HIV and other diseases much more severely than richer communities. The reasons for this include lack of resources for infrastructure, prevention and contraception, testing and screening, treatment and care. Examples of such communities include informal settlements or rural communities.

- ✓ Lack of resources and infrastructure here includes basic sanitation and hygiene facilities which increase these communities vulnerability to diseases, e.g. lack of toilets with sewerage systems can lead to leakage into water sources and leading to the spread of further diseases, e.g. bilharzia.
- ✓ The lack of easily accessible health facilities and resources can make the burden of the disease worse. Getting services such testing, treatment and care and support as well as condoms is difficult when the health facilities are far away and people rely on transport to get to them. Added to that these facilities may not have the right equipment to deal with the HIV positive clients or clients that seek testing services and even PMTCT. Ensuring that there are enough and proper resources for all require government support (see discussions below).

CEEP's Economic Empowerment Approach

The Corridor Economic Empowerment Project aims to reduce the vulnerability to HIV and AIDS through empowering governments, business support structures and beneficiaries on both economic empowerment and HIV and AIDS. In the context of CEEP empowerment refers to the provision of knowledge to understand the present circumstances and the skills to build the capacity to act and change their present situation. Another part of this empowerment model is the provision of resources to the beneficiaries to start or improve businesses.



Figure 3: Pillars of the CEEP Approach

CEEP draws on its systems approach and works with governments, employers and beneficiaries. For the purposes of this manual we will consider the framework used for the economic empowerment of business support structures and beneficiaries. CEEP provides training to both the BSS and beneficiaries, this economic empowerment training follows the following trajectory:

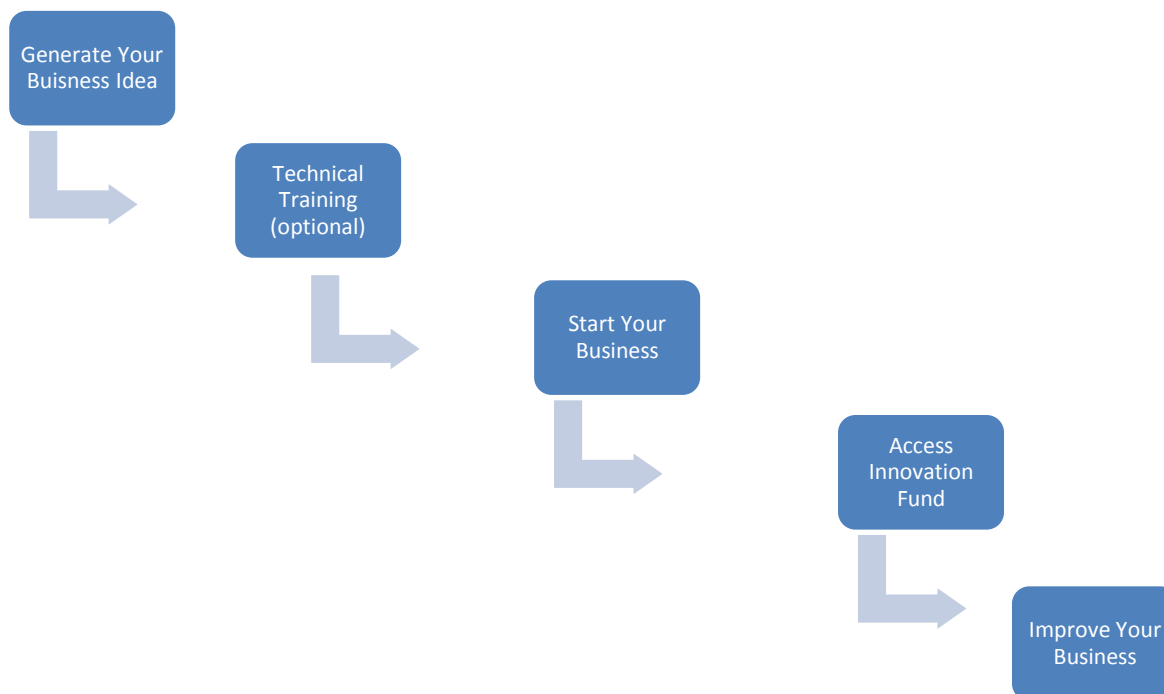


Figure 4: CEEP Training Process

The flow of the trainings for beneficiaries focuses on developing their business and management skills. There are five stages to this economic empowerment process:

1. Generate Your Business Idea:

- I. This training aims at clarifying and unpacking a beneficiary's business idea. From this training the beneficiary would have a formal and documented Business Idea.
- II. Before and during this training beneficiaries are encouraged to form co-operatives, business groups. These co-operatives not only provide beneficiaries with skills and experiences within the business fields and types of business but these co-operatives can be an invaluable resource for accessing loans, e.g. through standing a surety for its members (see more in the business section)

2. Technical Training (optional)

- I. At times the beneficiaries may require some technical assistance to develop the skills to begin a business, e.g. chicken rearing or bead work skills. At these times an outside consultant would be contracted to provide these ad hoc trainings.

3. Start Your Business

- I. The Start Your Business training focuses on developing a formal business plan. This training takes participants through the steps of:

4. Access to the Innovation Funds

- I. The Innovation Fund is accessible to each beneficiary that has been through the trainings. This provides the resources to kick-start a business.
- II. Each participant forms part of a co-operative or business group, and this group provides the surety to access the innovation fund.



5. Improve Your Business:

- I. This training is focused on the improvement of business skills that are needed to manage a business and focuses on topics such as buying, stock control, record keeping, marketing, costing and productivity management.

Key Messages:

- The greatest burden of diseases is felt by the poor due to lack of access to health care, living conditions and at times lifestyles
- Economic Disempowerment makes persons vulnerable to HIV:
 - Poverty increases the chances of persons engaging in risky sexual behaviour to obtain financial resources.
 - Poverty increases the vulnerability to the progression of the disease due to the lack of access to resources, services and good nutrition
- Economic Empowerment leads to a lifestyle change which can include a reduction of vulnerability to HIV and AIDS
- Economic Empowerment requires business skills and access to resources

B. Gender Norms and Beliefs

Gender norms held by societies and within communities are seen as another important driver that can increase or decrease one's vulnerability to HIV and AIDS.

Gender is differentiated from sex in that sex refers to the biological differences between men and women, whilst gender refers to the social expectations (values, roles and responsibilities) that are assigned to these biological differences. Gender is a learnt whilst sex is given. The implication of this is that gender values and norms can and do change overtime. They appear natural and stable as many people seem to live by these values but they can change, for example consider the gender norms that your grandparents held. Biologically, the way the vagina is structured leads to increased chances of exposure to the virus during sexual intercourse, if no protection is used. If there are small openings, abrasions or injuries in the vaginal lining which may have been caused by the friction of intercourse (with the lack of adequate lubrication) or the presence of a sexually transmitted infection these chances are increased. Below is a list of some gender norms and values which are common in Sub-Saharan Africa that can determine vulnerability to HIV and AIDS

Gender Norms-key risks and vulnerabilities of women and girls⁷

1. Sexual subordination is a common factor in relationships between men and women in traditional patriarchal societies. In these relationships, women are required to be ignorant about sexual issues and remain passive recipients of men's sexual advances and domination. This expected subordination results in women being unable to negotiate where, when and how sexual interactions occur, this includes condom use and other forms of protection.
2. Violence against women and girls is supported by the gender values and expectations whereby a women or girl can be threatened, beaten or worse if she does not conform to the social expectations for her gender. This violence can come from family members, partners, other women or acquaintances. This threat of violence increases a women's vulnerability to HIV infection by removing the space for her to negotiate sexual-decision making, including negotiating safer sexual practices. Additionally, the threat of violence silences or disempowers women from seeking out testing services, disclosing their status and accessing treatment and support services.
3. Economic disempowerment silences women from negotiating or setting boundaries on practices they disapprove of. Economic disempowerment results in women not having access to resources to get to health facilities and pay for health care services, inclusion ART and VCT services. At times, women require permission of their male partner to access services, creating a barrier. In Tanzania it was found that 40% of women do not have the final say in decisions over their own health, the children's health as well as say over the household expenditure⁸
4. In many instances women tend to be the care givers, as a result women carry more of the burden of the disease because they are required to care for the infected person within the family. Typically the time required for such care reduces their access to schooling or engaging in income generating activities.
5. These vulnerabilities are made worse by poverty, in case of poverty resources within families are allocated to men first, which can lead to women and girls having no resources to access health care services. During hard times girls are sometimes removed from schools to support the family through work or worse child labour. Women may also be forced to engage in transactional sex, selling sex for food, shelter, transport, etc.

⁷ ILO's (2011) Guide to mainstream gender in the workplace responses to HIV and AIDS.

⁸ Prime Minister's Office. 2013. Tanzania Third National Multi-Sectoral Strategic Framework for HIV and AIDS (2013 – 2017)

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6. Limited access to education and higher illiteracy rates amongst women means that they would struggle to access prevention and treatment information. Added to that, illiteracy and low levels of education limits the choices of employment women can access, maintaining their economic disempowerment even more. The kinds of work women do often do not offer any social protection e.g. lack of medical aids, pensions, etc. leading to further disempowerment.
 7. Some property, inheritance, custody, social and customary laws where assets are passed down through the male side increase women and girls' vulnerability to HIV and AIDS even more. In some cultures, women who are widows are abandoned leaving them vulnerable, or in some cases leading to engage in transactional sex to gain resources for food.
 8. HIV related stigma and discrimination can result in women being excluded from society and reduces their access to care and support services.

Gender Norms-key risks and vulnerabilities for men and boys

Due to traditional patriarchal norms that men are socialised in, they too may be at risk of contracting HIV. Below are some of the ways in which these masculinities increase their risk of infection and progression of the disease:

1. Norms, stereotypes and expectations about male behaviour affects men's knowledge of sex and expectations within relationships. Men may subscribe to the ideas that real men have multiple sexual partners, which is already known to be a risk for HIV infection especially if protection is not used consistently and correctly. Additionally, ideas about masculinities may be strongly linked with alcohol use and abuse which reduces risk assessments and increase risk of infection. Accessing treatment and care services may be hard due to the expectations that men are strong and if a man admits that he is sick and accepts help, he is considered weak. Men may be required to constantly prove their male powers and masculinity through violence even directed at women and girls sometimes.
2. Some of the jobs such as transport, construction and mining sectors, which are dominated by men may results in man being separated from their families increasing men's vulnerability to HIV infection. When men are separated from their spouses there is an increased risk of engaging in multiple sexual partnerships, and this might be done without using sexual protection.
3. Men may also engage in sex with other men and this practice is often considered a taboo and abnormal. Due to the stigma associated with this practice, it can lead to silence and result in this practice being kept hidden and reduces the chances that these men would access health information and services.
4. Often at a policy and service provision level, treatment and care programs are designed and targeted at women, encouraging women to take up these services. This reinforces the idea that women are solely responsible for sexual and reproductive health. This can increase men's vulnerability as it may be harder to find male orientated services.

C. Gender Based Violence

Gender norms also make Gender based violence possible and at times even provide a justification for these behaviours.

The United Nations (UN) Declaration on the Elimination of Violence Against Women (VAW) defines GBV as abuse and violence is any act 'that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life', and this definition was adopted by the General Assembly (GA) in 1993.

There are many parts to this definition and it highlights that GBV can take many forms, these include:

- ✓ Physical – pushing, punching, kicking, hitting, restraining
- ✓ Sexual – rape, sexual harassment
- ✓ Psychological – verbal attacks on a person's sense of self-worth, humiliations, swearing, shouting
- ✓ Economical – depriving economic resources

How prevalent are these forms of violence within our countries and communities? Below is a table that outlines the percentage of women who had experience some type of GBV and sexual violence within their life time, based on various research studies.

Indicator	Malawi	Mozambique	South Africa	Tanzania	Zambia	Zimbabwe
Percentage of women who have experience GBV	28.2%	<i>Unavailable</i>	45%	39%	40%	30%
Percentage of women who have experienced Sexual violence	25%	4.3%	7.3%	20.3%	15.1%	27.2%

Table 4: Gender Based Violence and Sexual Violence across the 6 CEEP countries

Source/s: United Nations Economic Commission for Africa, African Centre for Gender and Social Development (ACGSD) 2012. Violence Against Women In Africa: A Situational Analysis and Country Specific strategic plans; sentinel surveys and Dunkle et al. 2004: prevalence and patterns of Gender-based Violence and Re-victimization among women attending antenatal clinics in Soweto, South Africa. The table above shows that approximately one out of three women experience some form of Gender Based violence and one in four experience some form of sexual violence at some point in their lifetime, across all CEEP countries.

Socialisation (process of learning social norms and roles) of men and women is a vehicle through which gender based violence is normalised and even justified. Typically women are raised to be subservient or less than equal to men while the sexual powers and strength of men are often exaggerated and often used as a means to justify their behaviours and violence, e.g. men are more sexual or violent. These are justifications of GBV actions that excuse such behaviours and allow them to continue.

Who perpetrates GBV?

- ✓ Contrary to popular beliefs, sexual assault is perpetrated by people who are known to the survivor or victim of that assault.

- ✓ In Zambia it was found that the perpetrators of GBV against women were mainly their husbands or long term partners (67.5%), boyfriends (25%), male relatives (5.8%) former husbands or boyfriends (5.8%) and strangers (1.7%)⁹.
- ✓ The implication of this is that GBV occurs within the household or at home, and many times it is seen as a private affair by the people who should intervene.
- ✓ The violence is one symptom of the women's disempowerment and lack of control within her relationship, e.g. economically, socially, familial, etc.
- ✓ This often traps women within these relationships making it difficult to leave, for example due to economic dependence on the man she lives with, the woman may lack the resources she needs to leave.

Justifications of GBV

- ✓ GBV does not occur in isolation, there are many factors that influence GBV, and these range from perceived social norms to attitudes towards GBV.
- ✓ In national survey conducted in Zimbabwe and Tanzania's, both men and women were asked to indicate when a man is justified in beat his partner. These results are contained in the table below:

Country	Gender	Burns the food	Argues with him	Goes out without telling him	Neglects the children	Refuse to have sexual intercourse with him	Commits infidelity
Zimbabwe	Men	4.9	13.9	19.3	18.2	6.6	34.0
	Women	7.5	15.6	22.3	21.4	16.9	58.3
Tanzania	Men	6.2	21.7	23.5	26.2	14.0	
	Women	17.8	38.7	36.8	39.8	30.0	

Table 5: Justifications of Gender Based Violence in Zimbabwe and Tanzania

From this table it is interesting to note that a third of men and over half of women see violence against women as being justified for some reason. Justifiable reasons range from infidelity, going out without telling him and neglecting the children.

Dynamics of GBV within a relationship

- ✓ Research has also shown that GBV does not start with a punch or rape within a relationship, rather there are signs that are evident beforehand that can give an indication that GBV could arise soon.
- ✓ These are typically controlling behaviours of the perpetrators which include extreme possessiveness, jealousy and attempts to isolate the women from her friends and family.
- ✓ Below are findings from the Zimbabwe, Malawi and Tanzania's National survey that indicate the percentage of husbands who:

⁹ Zambian National HIV/AIDS/STI/TB Council (2010) National AIDS Strategic Framework 2011 - 2015

Country	Are jealous or angry if she talks to other men	Frequently accuses her of being unfaithful	Does not permit her to meet her female friends	Tries to limit her contact with her family	Insists on knowing where she is at all times	Does not trust her with any money	Displays 3 or more of these behaviours
Zimbabwe	52.5	16.5	15.6	11.5	49.7	12.2	23.7
Malawi	4.32	19.4	10.4	10	50.9	12.7	36.5
Tanzania	65.7	32.0	20.1	18.1	48.7	15.5	35.1

Figure 5: Percentage of reported partner controlling behaviours across Zimbabwe, Malawi and Tanzania

A study conducted in India showed that women who were unemployed at the beginning of the study but had begun employment by the next visit had an 80 percent higher chance of violence at home, as compared to women who maintained their unemployment status. Unfortunately, such results show that economic empowerment could make GBV worse, more research is needed to determine other factors that need to be considered when programs are designed to help women out of abusive relationships.

Alcohol and drug use makes these controlling behaviours worse as they lower a person's sense of control (this will be discussed more in the next section)

GBV and HIV

- ✓ Gender Based Violence, especially sexual assault can dramatically increase one's vulnerability to contracting HIV.
- ✓ The tears and abrasions that are caused to the skin and mucous membranes during forced sexual penetration or physical assault provide entry points for the virus into the body.
- ✓ High prevalence of physical and sexual assault combined with low levels of knowledge and use of Post-Exposure Prophylaxis all contribute to the spread of HIV infection (see more on PEP below).

Key Messages:

- Women are at more risk of contracting and being affected by HIV than men. This is not only as a result of biological differences but due to social expectations and norms of women. In traditional societies women are seen to be subservient to men because of socialisation and beliefs about a women's place, economic disempowerment, exposure to violence and lower literacy levels or education.
- Men are vulnerable to contracting HIV due to male norms of men's sexual prowess, e.g. number of sexual partners, alcohol and drug use. Men are also vulnerable due to them not accessing health services when they are at risk (e.g. testing) or sick. Types of work can also increase a man's vulnerability to HIV, e.g. migrant work
- GBV can be physical, sexual or psychological and it increases the chances of contracting HIV.
- PEP is an important medical prevention method for those who have been sexually assaulted.



D. Alcohol and Drugs

A Johns Hopkins Health and Education national survey conducted in South Africa in 2009 found that 57% of men and 33% of women had ever consumed alcohol. This indicates that consuming alcohol is not a social norm, however the use of alcohol and drugs appears wide spread and is generally accepted within our cultures. In fact some groups' activities encourage the use and abuse of these substances. Men in particular are often at greater risk as they tend to engage in more alcohol use and abuse as shown in the study above, which has been identified to be related to men's ideas of masculinity.

HIV, Alcohol and Drugs

1. Alcohol and drug use is associated with increased risk taking behaviours as an intoxicated person's inhibitions are lowered. As a result intoxicated persons are likely to engage in risky sexual behaviour such as decrease in condom use and increase in number of sexual partners, which they might have avoided if they were not intoxicated.
2. Alcohol consumption can also put a strain on the liver, resulting in the reduction of immune response as the toxins from alcohol need to be removed from the body. For people living with HIV, the anti-retroviral treatment used to suppress HIV put a lot of strain on the body especially the liver, use of alcohol will further compromise the liver and the immune system.

Key Messages:

- **Drugs and alcohol use can increase your chances of contracting HIV by diminishing your risk taking awareness.**
- **Drugs and alcohol use can increase the speed of the progression of the disease**
- **Drugs and alcohol use can increase the incidence of GBV which in turn further can increase the chances of contracting HIV**
- **Drugs and alcohol use whilst on ART is dangerous**
- **If HIV positive stop drinking and smoking**

E. Stigma and Discrimination

UNAIDS¹⁰ (2007) defines HIV-related stigma as: "...a 'process of devaluation' of people either living with or associated with HIV and AIDS...Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status."

From this definition it is clear that stigma and discrimination are closely related and yet different. Stigma is based on people's prejudices and assumptions of what others are like. Stigma devalues other in that it causes others to be viewed as disgraced or to have less value in the eyes of others. HIV related stigma builds on existing stigma within society such as stigma against sex workers, drug users or people in same sex relationships or transgender people. These groups are usually stigmatised and HIV becomes a convenient vehicle to reinforce stigma. HIV related stigma does not only affect the individual but also their spouses and families.

Discrimination is when stigma is acted upon, that is treating or responding to someone as if they are different because they belong to a certain group. HIV related discrimination would be treating someone as different due to their HIV status or suspected HIV status. These actions of families and communities discriminating against HIV positive people ranges from:

- ✓ Not sharing eating utensils
- ✓ Not sharing bathrooms
- ✓ Neglecting or isolating family members who are sick
- ✓ Barring them from joining groups or committees
- ✓ Segregating them from health care facilities
- ✓ Disclosing their HIV status to others without their consent
- ✓ Denying HIV positive or orphaned children access to schools
- ✓ Physical violence directed towards individuals who have disclosed their status
- ✓ Excluding people from employment due to their status

It is important to note that even if a person feels stigma towards another, s/he can decide not to act in a way that is unfair or discriminatory.

Internal stigma

- ✓ This form of stigma is self-directed, it refers to the way the HIV positive person feels about themselves and their diseases.
- ✓ With internal stigma often the person living with HIV feels shame with having the disease or the manner in which the disease was contracted.
- ✓ Internal stigma can lead to low self-esteem, low self-worth and even depression (the dangers of these will be discussed in the next section).
- ✓ The HIV positive person may isolate themselves from others due to their feelings of self-stigma, which reinforces the stigma and does not provide opportunities to break it¹¹.
- ✓ A study conducted in Tanzania found significant levels of self-stigma reported by most HIV positive persons including a sense of shame (44%), self-blame (63.4%), feeling worthless (85%), and feeling they should be punished (10%) and self-isolation¹².

¹⁰ Need a reference here? Which document was this

¹¹ People Living with Stigma Index: An index to measure the stigma and discrimination experienced by people living with HIV and AIDS: A users guide

¹² Prime Minister's Office. 2013. Tanzania Third National Multi-Sectoral Strategic Framework for HIV and AIDS (2013 – 2017)

Stigma and the discrimination that results from it can be a huge barrier to access to treatment and other HIV related services. Discriminatory acts can be in a form of threats, violence, as well as silence or alienating a person; these indicate intolerance and can prevent a person from seeking support and services. For this reason stigma and discrimination are seen as key factors that need to be addressed for success of all HIV and AIDS related programmes¹³.

People's willingness to be tested as well as adherence to ART programmes can be negatively affected by stigma and discrimination. As a result stigma can also be measured by assessing people's willingness to share or hide their own or their families' HIV status. From a national survey conducted in Zimbabwe, it showed that men were more likely to keep their HIV status a secret than women.

Indicator	Malawi	Mozambique	Zambia
Number of women expressing accepting attitudes on 4 selected indicators ¹⁴	19.7%	18%	41.1%
Number of men expressing accepting attitudes on 4 selected indicators ¹⁵	35.6%	18%	30.2%

Table 6: Malawi, Mozambique and Zambia percentage of accepting HIV related attitudes

Other examples of stigma and discrimination

- ✓ In Tanzania, it was reported that 15% of health care workers did not keep HIV positive clients status confidential.
- ✓ Common discriminatory acts that were reportedly conducted by health care workers included being told that HIV positive persons should not have children, that HIV positive persons do not need access to sexual reproductive health information, pressuring HIV positive persons to choose breast feeding options, to be sterilized or to terminate their pregnancies¹⁶.
- ✓ A study conducted in Zambia quantified levels of discrimination and it was found that 18% of respondents knew of someone who had experienced discrimination or verbal abuse in the past year due to their suspected HIV statusⁱⁱ. Although incidents of discrimination are seen to have decreased from the previous years, this is still high.
- ✓ In South Africa in December 1998, Gugu Dlamini was killed for revealing her HIV status to her community members. The community members remarked that she had brought shame upon them and the community for telling people about her HIV status. Today Gugu is remembered as HIV hero for speaking out. Her actions and untimely death have ensured that stigma and discrimination have become central to HIV and AIDS awareness programs.

¹³ Zambian National HIV/AIDS/STI/TB Council (2010) National AIDS Strategic Framework 2011 - 2015

¹⁴ These indicators include willing to care for a family member with AIDS, would buy from an HIV positive shop keeper, say that an HIV positive teacher should still teach and would not want to keep it a close secret that a family member is HIV positive.

¹⁵ These indicators include willing to care for a family member with AIDS, would buy from an HIV positive shop keeper, say that an HIV positive teacher should still teach and would not want to keep it a close secret that a family member is HIV positive.

¹⁶ Prime Minister's Office. 2013. Tanzania Third National Multi-Sectoral Strategic Framework for HIV and AIDS (2013 – 2017)



Key Messages:

- **Stigma is learnt and reflects social norms of how others are to be treated. This is important as these attitudes can and do change.**
- **Stigma and discrimination negatively impacts on people and communities**
- **Stigma and discrimination reduces the chances of people accessing services, like VTC, to begin early treatment.**
- **Stigma and discrimination can be abusive and even deadly at times.**
- **Stigma and discrimination is a human rights issue and one we must fight against**



F. Leadership and governmental support

To effectively address HIV and AIDS requires a political will from the governmental. Support can be provided through the adoption of policies and strategies that foster an enabling environment for the provision of HIV related services. Governmental support and responses to the HIV epidemic has varied across countries, for example the South African Government was focused on its political transformation when the epidemic first came to pass and there was little being done. The advocacy activities of the relevant stakeholders can ensure that this support is forth coming from the government, as was the case in South Africa between 1998 and 2008. Civil society organisations including the Treatment Action Campaign (TAC) mobilized their communities, partners and legal teams to take the South African Government to court. The TAC drew from the essential human rights that are guaranteed in the country's constitution, and was able to argue for the roll out of the PMTCT programme and treatment services to all South Africans.

Furthermore governments and national structures can encourage use of HIV related services and the reduction of HIV vulnerability through role modelling for their constituents. This role modelling can include making use of HIV related services for testing, medical male circumcision, ART.

Key Messages:

- **Support from leaders is important, this can be at all levels national, provincial, local, familial, ward, street**
- **Working with these leaders things can happen more easily and quickly**
- **Leaders can also be role models for others**
- **Empower leaders with information to make better decisions.**

KEY DRIVERS OF THE PANDEMIC: MESO FACTORS

This section we will focus on the meso factors, and these include:

- A. Migration
- B. Group and family norms
- C. Harmful cultural practices

A. Migration

Migration is one of the strategies in which people attempt to deal with economic disempowerment and or poverty is. It is estimated that globally there are 86 million people who engage in migration to seek employment¹⁷. This can be both internal or external migration, that is, movement within and movement outside of one's home country

Migration however is associated with an increased HIV risk and vulnerability. Factors that place migrant workers at risk include

- ✓ Separation from spouses and families,
- ✓ Exposure to unfamiliar social norms and values,
- ✓ Reduced efficiency in communication through foreign languages,
- ✓ Loss of familiar and familial support structures,
- ✓ Lack of knowledge of the national policies and programs of support for migrants,
- ✓ Substandard living conditions,
- ✓ Exploitative working conditions,
- ✓ Xenophobic attacks on these workers from intolerant and impoverished communities,
- ✓ The unfamiliarity, stress and isolation may lead to persons engaging in unsafe sexual practices (including transactional sex),
- ✓ The lack of HIV related services for these populations further increases the risk of infection and progression of the illness.

The decision to migrate is never an easy one for those who leave and also affects the persons who remain behind. Typically women remain and face worsened economic conditions as their spouse or partners leave to find employment somewhere else. When the partner has migrated, the need to look for employment still remains and there is now one less person to help. Sometimes women resort to transactional sex to maintain their households while their spouse is away, this in turn increase their vulnerability to HIV and AIDS. Sometime the spouse comes back infected with HIV and sick, adding further pressure on the household.

Key Messages:

- **Migration is an economic survival strategy that can make a person vulnerable including vulnerable to HIV infection**
- **Isolation is common and dangerous. Isolation stems from loss of significant others, differences in language and social norms**
- **Migration is accompanied by fear from discrimination and xenophobic attacks**
- **Persons left behind are also affected by migration at times they lose a human asset to support them and their families**

¹⁷ Policy Brief: HIV and International Labour Migration



B. Group and family norms

Norm refers to a standard of achievement or behaviour that is required, desired, or designated as normal in a certain group or an established standard of behaviour shared by members of a social group to which each member is expected to conformⁱⁱⁱ. Group and family norms affect the values and expectations that people place on certain behaviours. If a certain behaviour is considered valuable by the group, then there is a higher chance that an individual within that group would engage in this behaviour and when assessing their own self-worth they would consider themselves in a positive light. On the other hand if a person does not meet the expectations of the group, they may consider themselves to be less valuable and this may lead them to engage in further self-destructive behaviours, e.g. abusing alcohol and drugs.

Global values of behaviours

The media's power of creating and mediating our experiences (at an individual and global level) cannot be underestimated. From daily news programs, movies and TV or radio series the media models and suggests to us what are behaviours or objects are valued. The media also reinforces many stereotypes and prejudices, e.g. the illusionary innate sexual powers of men and the subservience of women.

Due to its ability to reach large numbers of people the media can be a valuable asset in reinforcing positive social norms and addressing negative social norms.

Local norms

Similarly to group and family norms, local norms are established standard of behaviour shared by members of a social group to which each member is expected to conform. Local norms also adopted from the many social groups that we interact with on a daily basis. The social groups that we come into contact with are held together by values and expectations that influence our behaviours and our assessments of our self-worth. For example, religious groups can inadvertently reinforce the idea that any discussions of a sexual nature are inappropriate. This silence can lead to the misinformation and the reinforcement of harmful norms.

Social norms versus perceived social norms

Social norms are behaviours and values that a social group considers important or unimportant, e.g. a group may value men who actively engage in fatherhood over men who assert their manliness through having many sexual partners. Perceived social norm on the other hand means that what we think others values and are doing may not be the reality. For example often it is said that men are very sexual and naturally have many sexual partners. However research in this matter indicates that only 30-40% of men report more than one sexual partner within their lifetimes, this is below the majority of men and as such is not a statistical norm.

Think about the men that you know. How many of these have actually had more than one sexual partner in the time that you have known them? The lesson here is that we cannot assume that norms are negative; there are positive norms that just need to be reinforced or redefined. In working with norms, we need to identify positive norms which can help us when addressing risky behaviours for example the notion of manhood as a protector of his family can be reinforced to encourage men to be caring and protective over themselves and their families. The basic principle here is to reinforce the positive social norms that can protect a person from HIV and AIDS, while working with the community, social groups and individual to address the social norms that increase a person's vulnerability to HIV and AIDS.

It should also be noted that norms and values can and do shift overtime. Consider the norms of condom use, initially young adults asking or seeking out condoms were frowned upon as this was an indication

that they are sexually active however these days young adults accessing condoms is seen as a positive reflection of caring for one's self and one's partner.

Key Messages:

- Norms have an effect on behaviours
- Some norms are positive in that they reinforce health seeking behaviours
- Some norms can be negative in that they increase a person's risk of infection
- Families and groups reflect these norms and can be positive or negative
- These norms can change
- The media, leaders and groups play an big part in shaping norms that we ascribe to – choose carefully
- Some perceived social norms are not real as they may not be as pervasive as we think, e.g. all men are bad

C. Potentially Harmful Cultural Practices

Some cultural practices may be seen to increase vulnerability to HIV and worsen the impact of HIV and AIDS on communities and families. However there is recognition that assessment of cultural practices, especially other people's cultural practices is likely to be an over simplification and stereotypical generalisation. This means that when assessing cultural practices, a person needs to be open minded and aware of one's own biases. It is also important to keep in mind that other cultural practices are positive and protective. It is also important to note that cultural beliefs and practices bind people together as a society and give the society a common focus and identity.

Some potentially harmful cultural practices include

a. Wife inheritance

This is called *chokolo* in Malawi¹⁸, *Ukungena* in Ngoni, Ndelebe and Zuhti. This practice seeks to ensure that the family is maintained by marrying the widow to her brother in law.

Kulowakufa is another potentially harmful cultural practice, in this practice the widow undergo sexual cleansing with their brother-in-law. Protection is not used for this practice

b. Traditional Circumcision

Traditional Circumcision can be considered potentially harmful if the same instrument (blade) is used across all initiates. Added to this the initiates may be encouraged to experiment with sex as a sign of adulthood – this usually occurs before healing has been completed, which provides entry points for the virus. Added to this is the fact that traditional circumcision maybe be partial circumcision which does not offer the same level of protection as a full circumcision (see discussions on medical male circumcision below).

c. Dry Sex

Dry sex is another cultural practice of considered common within Sub-Saharan Africa. Usually a woman will insert various substances (herbs or solvents) within the vagina to reduce the vaginal secretions during sex. This practice is considered a high risk activity as the reduction in vaginal lubrication increases the chances of tearing or formation of micro-lesions within the wall of the vagina. These abrasions can provide entry points for the virus during sex.

¹⁸ National AIDS Commission Malawi (2009) National HIV Prevention Strategy 2009 - 2013

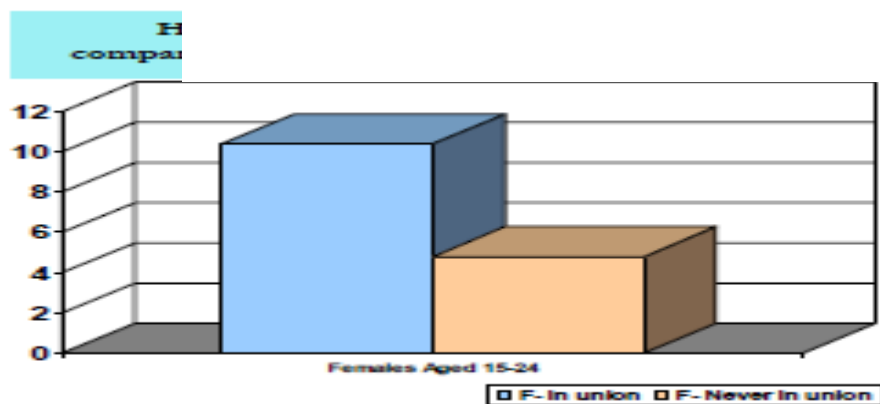
d. Polygamy

Polygamy is another cultural practice that can be potentially harmful, as it involves multiple concurrent sexual partners, which increases the risk for HIV infection. However, if this culture is practiced correctly, then sexual intercourse will be confined to the people within the polygamous marriage. In such cases, even though the sexual network is wider and involves more people, that polygamous marriage may be considered as risky as faithful monogamous relationship. Estimates are that 11% of women in Zimbabwe are within polygamous unions whilst 5% of men are in these types of unions. Slightly higher trends were found in Tanzania, where 16.8% of married women were within polygamous unions and 9.7% of men. Older women report being in these unions more than younger women and it appears to be more common in rural settings than in urban environments.

e. Marital Status and HIV

Traditionally marriage has been highly valued as a social practice and considered a protective factor against physical and psychological harm. Sex education programs promoted marriage as the benchmark for people to aspire to before engaging in sexual activities and it was assumed that the marriage would secure faithfulness and fidelity. This makes sense as marriage requires a public declaration that a person would remain faithful to one person. Assumable, this would reduce the number of sexual partners that a person has within a lifetime and thereby reduce one's exposure to HIV and other STIs.

However a different trend is appearing in Malawi¹⁹, where it appears that the percentage of people who are getting married is dropping over the years. Secondly, research shows that the prevalence of HIV in women 15-24 of age who were in long term relationships or marriages was far higher than those who had never been married. This suggests that marriage may not be a protective factor against HIV infection as it may be linked to reduced condom.



Source: MDHS, 2004

Figure 6: HIV prevalence among females (15-24) comparing those in union vs, those never in union

Another risk factor associated with cultural practice of marriage is the marriage of young girls (15 – 19) to older men, which is practiced in some countries in Sub-Saharan Africa (Tanzania, South Africa). These cultural practices predominantly occur within rural settings. Additionally, in some rural settings pregnant women are attended by traditional birth attendants and have no access to health facility, meaning they

¹⁹ National AIDS Commission Malawi (2009) National HIV Prevention Strategy 2009 - 2013



might miss out on HIV testing and PMTCT program²⁰. From the above it is clear being married may provide a false sense of security, leading to decrease in use of protection²¹.

Key Messages:

- **Some cultural practices can increase a person's risk of infection (vulnerability) to HIV infection**
- **Not all cultural practices can be deemed as harmful as some have protective aspects within them**
- **Traditionally it has been assumed that marriage is a protective factor from HIV infection**
- **The results are mixed, on the one hand marriage as an institution can be seen to encourage ideas of sticking to one partner**
- **On the other hand, marriage can place both partners at risk of infection, especially when condom use declines**

²⁰ Prime Minister's Office. 2013. Tanzania Third National Multi-Sectoral Strategic Framework for HIV and AIDS (2013 – 2017)

²¹ Tanzania Third National Multi-Sectoral Strategic Framework for HIV and AIDS (2013 – 2017)

KEY DRIVERS OF THE PANDEMIC: MICRO FACTORS

In this section we will focus on the micro factors, which are factors that are within the individual themselves that may help of hinder one's vulnerability to HIV and AIDS. The chapter explores three broad areas including

- A. Knowledge
- B. Behavioural
- C. Bio-medical factors

A. Knowledge

Early responses to HIV and AIDS had focussed on providing people with knowledge, assuming that once people had the knowledge they would take steps to protect themselves. One of the effects of these knowledge focused interventions is that there is a wide (even if inaccurate at times) knowledge base on HIV and AIDS. For example, within Zimbabwe 98% of people have heard of HIV and AIDS, similar results were found across other countries. However hearing about HIV and AIDS cannot be considered enough to empower a person to make decisions to protect themselves from HIV infection.

Subsequently, studies have begun tracking more in-depth knowledge of HIV and AIDS. This is where the concept of comprehensive knowledge comes into play. A person is considered as having comprehensive knowledge of HIV and AIDS if they are able to identify:

- ✓ the modes of transmission,
- ✓ the prevention methods available (knowing that the use of condoms and having one uninfected faithful partner reduces the chances of getting HIV),
- ✓ knowing that a healthy looking person can still have HIV and
- ✓ being able to reject two common misconceptions about HIV transmission or prevention (usually mosquitoes carry HIV and HIV is spread through supernatural means)

Another area of interest in assessing comprehensive HIV knowledge is assessment of mother to child transmission, specifically knowledge that use of anti-retroviral drugs can reduce the chances of infection for the baby and the knowledge of infant feeding choices.

Indicator	Malawi	Mozambique	South Africa	Tanzania	Zambia	Zimbabwe
Comprehensive knowledge of HIV and AIDS (men)	44.7%	35%	30%	48.2%	<i>unavailable</i>	52.8%
Comprehensive knowledge of HIV and AIDS (women)	41%	31%	28%	46.1%	<i>unavailable</i>	56%

Table 7: Comprehensive knowledge of HIV and AIDS across the 6 CEEP countries

The table above shows the breakdown of the countries with levels of comprehensive knowledge of HIV and AIDS. And whilst many people have heard of HIV and AIDS the levels of comprehensive knowledge are relatively low. To achieve the desired results in HIV prevention, treatment and care, provision of accurate knowledge that will empower people to take action is important.



Key Messages:

- Knowledge by itself will not lead to behaviour change
- Knowledge is however a good foundation for leading to behaviour change
- We seek to impart comprehensive knowledge of HIV and AIDS to empower people

B. Behavioural

Self-worth

High self-esteem and self-worth are seen as **protective factors** against HIV infection. The assumption here is that a person with a high self-esteem would not put themselves at risk of HIV infection as they see themselves as valuable. The reserve then is that if a person has a low self-esteem and sense of self-worth may be likely to put themselves at risk. They may do this by seeking self-validation through sexual interactions with many partners in an attempt to feel good about themselves. In many societies having many sexual partners is not an acceptable behaviour, and therefore the person may attract judgement from other community members – resulting in bad feelings and further low sense of self-worth. The person may seek further sexual interactions to attempt to feel good, this becomes a vicious cycle of risk. At the same time the person may not feel that they are good enough or valuable enough to negotiate safer sexual practices due to lower sense of self-worth.

Added to this people tend to think of themselves as being special or somehow immune to HIV even though they may know the ways in which HIV is transmitted. These skewed risk perceptions result in persons having high numbers of sexual partners and engaging in higher risk sexual practices, e.g. lower condom usage and multiple partners.

Key Messages:

- High levels of self-worth may be considered protective factors in placing oneself at risk of infection
- However high levels may influence a person's risk perception and make them feel invincible to HIV infection
- Aspirational work which creates hope is good for self-worth

Sexual Debut

Sexual debut refers to the Delaying sexual debut can also be a protective factor against HIV and AIDS vulnerability; studies have found that later sexual debut is associated with increased safer sexual practices, e.g. reduction of the number of sexual partners. Early sexual debut on the other hand has been linked to risky sexual behaviour such as decreased use of contraceptives and prevention. It is for these reasons that delaying the onset of sexual debut is seen as a worthwhile endeavour²².

Below is a table of sexual debut variables across countries

Indicator	Malawi	Mozambique ²³	South Africa ²⁴	Tanzania	Zambia	Zimbabwe
Median age of sexual debut for men	18.7	<i>unavailable</i>	<i>unavailable</i>	18.5	<i>unavailable</i>	20.6
Median age of sexual debut for women	17.2	<i>unavailable</i>	<i>unavailable</i>	17.4	<i>unavailable</i>	18.9
Young men aged 15-19 who had sex before the age of 15 years	22.1%	27%	11.3%	5%	6.9%	<i>unavailable</i>
Young women aged 15-19 who had sex before the age of 15 years	14.3%	23%	5.9%	15%	12.8%	<i>unavailable</i>

Table 8: Key Sexual Debut indicators across the 6 CEEP countries

The table above shows that women start having sex on average 1 year younger than their male counterparts. However more males than females indicated that they had sex before the age of 17 in 3 of the 5 countries presented.

Key Messages:

- Early sexual debut places people at risk of unwanted pregnancies, STIs (including HIV) and lower use of contraceptives and prevention strategies
- Women tend to have an earlier sexual debut than men but men have more partners
- Delay sexual debut

²² South African National HIV Survey 2008

²³ National AIDS Council: 2012 Global AIDS Response Progress Report: For Period 2010-2011, Mozambique

²⁴ South African National HIV Survey 2008

Number of partners and sexual networks

Multiple sexual partners refer to a person having more than one partner over a given period. These partnerships can be multiple in that there can be more than one partner over a period of time (e.g. serial monogamy) or there can be more than one partner at the same time, multiple concurrent partners. Risk of HIV infection is related to both the number of partners that a person has and the sexual networks that one finds themselves in, both of these will be discussed below.

Number of partners

- ✓ In a study conducted in Zambia²⁵ in 2009 analysing the sources of new infections it was found that highest contributions to new infections came from individuals who engaged in causal heterosexual sex, multiple concurrent partnerships being the highest contributor at 71%.
- ✓ This was followed by mutual monogamy (21%), mother to child transmission (10%), the clients who frequent commercial sex workers (4%) followed by men who have sex with men (1%)²⁶.
- ✓ This data supports the idea that the risk of contracting sexually transmitted infections, including HIV can be increased by the number of sexual partners a person has.
- ✓ The underlying reason is that the more sexual partners a person has the greater the chances of coming into contact with a person that has a sexually transmitted infection, including HIV. However, this situation is further complicated if we consider the sexual history of each sexual partner and their partners.
- ✓ Another study conducted in Tanzania showed a direct relationship between the number of sexual partners and a person's HIV status. The prevalence rate in women with 1 sexual partner was 2.9% while women with 10 or more partners had prevalence at 18.9%. Similarly for men 0.9% prevalence rates were found in men with 1 sexual partner versus 7.5% of men who report 10 or more within their life time.

The country picture

Indicator	Malawi	Mozambique	South Africa	Tanzania	Zambia ²⁷	Zimbabwe
Sexual Partners in a life time (men)	3.8	unavailable	unavailable	6.7	unavailable	6
Sexual Partners in a life time (women)	1.7	unavailable	unavailable	2.3	unavailable	2
More than one Sexual Partner in the last 12 months (men)	9.2%	20%	11%	21%	9%	11%
More than one Sexual Partner in the last 12 months (women)	0.7%	3%	19%	3.5%	1%	1%

Table 9: Key partner reduction indicators across the 6 CEEP countries

Table 9 above shows that men have more sexual partners over the last 12 months and in a lifetime than women. The number of partners is particularly rooted in traditional notions of gender and male norms.

Sexual networks

A sexual network is a group of people that are connected through sexual activities. The number of links within a group is influenced by the number of partners within that group. The more links the more

²⁵ Zambian National HIV/AIDS/STI/TB Council (2010) National AIDS Strategic Framework 2011 - 2015

²⁶ National AIDS Council (2009) Modes of Transmission.

²⁷ Zambia Sexual Behaviour Survey 2009.

chances there are of sexually transmitted infections (including HIV) to pass through the network. This helps to explain why even though there are two individuals with similar risk taking behaviours, they might have different levels of risk. It also highlights the importance of sexual histories when one is in a relationship.

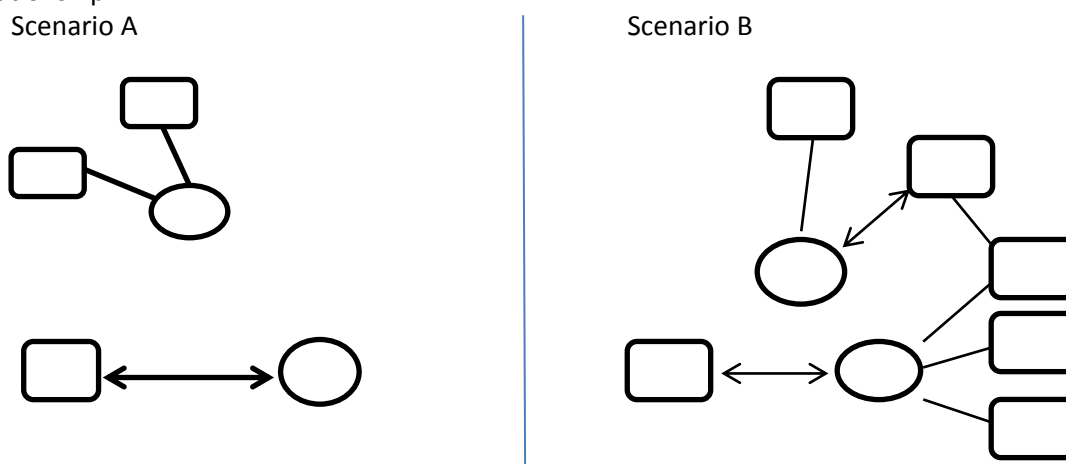


Figure 7: Diagrammatic Representations of different sexual networks

Above is a diagram of a two scenarios of examples of sexual networks. Scenario A represents two networks that have 5 people altogether however there is no link between the two due to the participants practicing monogamy within a closed network, as a result the risk of infection is considered to be lower. However in Scenario B, the network is larger and there are more links between the member within the network. This makes the spread of infection easier. This shows how a person's exposure to the virus can be high even when they have had few sexual partners due to the sexual histories of each of their sexual partners.

It has already been established that unprotected sex with casual or new partners increases a person's risk of contracting or spreading HIV. It was also stated above a person's viral load peaks before the body can mobilise defences against the infection. During this peak time the person is highly infectious and can easily spread the virus to others. Added to all that, if a person test at this time, the anti-body based tests would not detect the infection due to insufficient concentrations of antibodies to be detected – this is known as the window period. So, concurrent multiple sexual partnerships further increase the chances of spreading HIV quicker within the network.

When measuring MCP there are two measures that are used

Point prevalence – this is the number of concurrent partners that a person has had within the 6 months prior to the research.

Cumulative prevalence – the percentage of people reporting multiple concurrent partners they had within a year before the survey or research was conducted.

Indicator	Malawi	Mozambique	Zimbabwe
Point MCP Prevalence (men)	4%	<i>unavailable</i>	4%
Point MCP Prevalence (women)	<1%	<i>unavailable</i>	<1%
Cumulative Prevalence (Men)	7.3%	16%	9%
Cumulative	<1%	2	<1%

Prevalence (Women)			
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Table 10: Multiple and Concurrent Partnerships across Malawi, Mozambique and Zimbabwe

Key Messages:

- The more sexual partners that a person has the more risk they are of contracting STIs (including HIV and AIDS)
- The acute infection period ensures that people within a concurrent sexual network are at great risk in contracting HIV
- Reduce your number of sexual partners
- Multiple partners with low condom use is seen as driving the epidemic across a range of countries.

Transactional Sex

Transactional sex is the exchange of goods, services or money for sex. At times these transactions are explicit, for example the activities of sex workers. But at other times they are not that clear, e.g. within long term relationships. Within the context of poverty and economic disempowerment this pattern of relating is common.

In these relations for example a “sugar daddy” or “sugar mommy” the person paying is not always a wealthy individual. It can be an individual that is slightly better off than most of the community or a person that promises excitement in certain areas, such as a cell-phone, new clothes or transport by a fancy car. It could also be a person that promises some relief in some areas, such as lack of money for food or school fees. Vulnerability to HIV and AIDS is increased by these patterns of relating as generally the person who is paying for the sexual activity maintains most of the power within the interaction and would decide on the where and how the exchange takes place. This includes whether or not protection is used, and if so what protection is to be used.

Consider the table above, firstly it indicates that the number of men who pay for sex is very low, a minority. Secondly, it shows that of those that do an overwhelming majority of men are making use of safer sexual practices. These ideas support the modes of transmission studies in which sex work although a high risk activity at an individual level is not seen as a main driver of the epidemic.

Indicator	Malawi	Tanzania	Zimbabwe
Percentage of men who have ever paid for sex	9.7%	14.5%	3%
Percentage of men who paid for sex and used a condom during their most recent sexual encounter	60.7	58.9%	88%

Table 11: Transactional Sex in Malawi, Tanzania and Zimbabwe

Key Messages:

- Transactional sex is one of the key drivers of the epidemic
- This is the key driver the at Economic Empowerment approach seeks to address
- Transactional sex places an unequal power dynamic within a sexual relationship, where the buyer can set the conditions of the transaction
- Empowerment here means not only economic empowerment but also empowering people to set limits to activities that would place them at risk and reminding them that they do have power within these encounters.
- Unfortunately at times, due to poverty, families may condone this behaviour

Intergenerational Sex

Intergenerational sex is defined as sexual relations between two people who have an age gap of 10 years or more. Whilst this is a narrow definition, it attempts to identify relationships where the vulnerability or exposure to HIV infection can be high. The reason intergenerational sex is considered high risk for HIV transmission is that a big age difference can introduce a power dynamic within the relationship. For example a younger girl may not be in a position to negotiate safer sexual practise like condom use with an older male partner. An analysis of spread of HIV between different age groups shows that younger women and girls and older men have the highest rates of infection (see the graph below). This has been interpreted to mean that younger girls are having sex with older men.

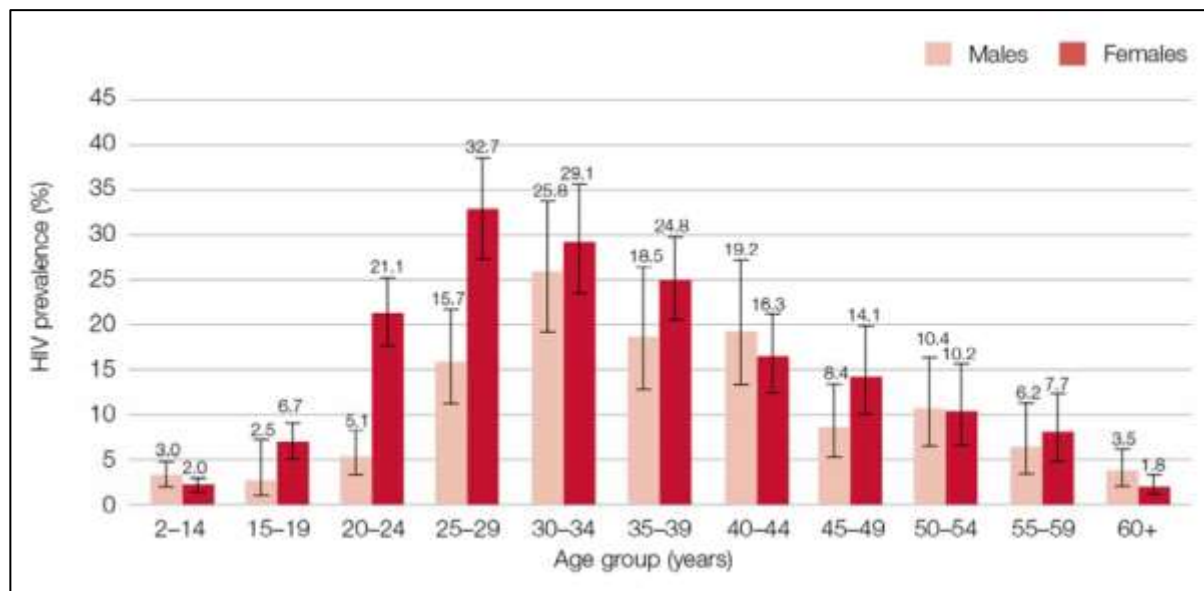


Figure 8: HIV Prevalence by age and gender 2008

In figure 8 above the differences in HIV prevalence between males and females is most evident in the age group 15 – 29. HIV prevalence is higher in men 49 years and older. The general thinking around this is that older men are engaging in unsafe sexual relations with younger women and girls. These relationships are also associated with higher numbers of sexual partners within a life time, further increasing the risk of HIV infection.

Indicator	Mozambique ²⁸	Tanzania
Men aged 15-19 years with sexual partners 10 years or older	13.5%	0.7%
Women aged 20-24 years with sexual partners 10 years or older	17%	27.6%

Table 12: Intergenerational Patterns in Mozambique and Tanzania

The table above clearly shows being involved in intergenerational sex is more common amongst women than men. Higher HIV prevalence rates and unplanned pregnancy rates within this age group are linked with having a sexual partners 5 years or older. Similar findings in South African study on teenage pregnancy indicated that pregnant girls were likely to have partners who were 5 years or older than their peers who were not pregnant²⁹.

Key Messages:

- Intergenerational sex is more common in some countries than others
- Intergenerational sex appears to have more potential dangers for women and girls including unwanted pregnancies, exposure to STIs and HIV
- Intergenerational sex creates an unbalanced power relations between partners where the one (usually the male) makes decisions about where, when and how sexual relations can occur – this includes condom use.
- Intergenerational sex is seen as one of the reasons for the high levels of HIV infection found in young girls and women and older men
- To address issues of intergenerational sex, we need to consider the male norms within areas, districts and countries

²⁸ National AIDS Council: 2012 Global AIDS Response Progress Report: For Period 2010-2011, Mozambique

²⁹ South African National HIV Survey 2008

Condom Use

Condom use is one of the main ways in which a person can protect themselves against STIs and HIV as well as unwanted pregnancies. For condoms to be effective in protecting a person from STI including HIV and in preventing unwanted pregnancies, it needs to be used consistently and correctly. However studies have found that patterns of condom use differ a lot across relationships and life times.

Laboratory studies have established that the male latex condom is impermeable to infectious agents contained in genital secretions, including the smallest viruses. Research has also been conducted with discordant couples, discordant couple mean that one of the persons is HIV-positive and the other is not. These studies have proven that consistently using condoms offers an extremely high level of protection^{iv}.

Condom use and Types of relationships

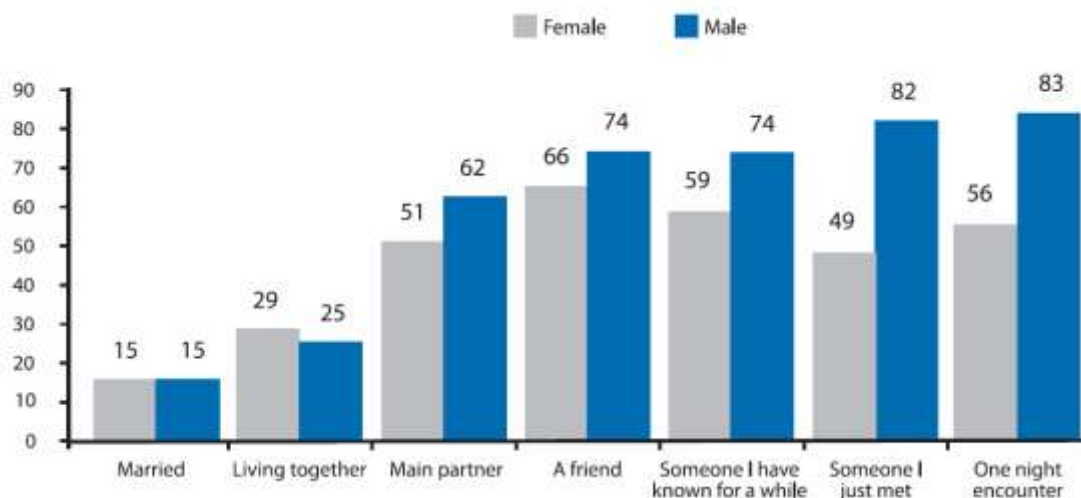


Figure 9: Condom use by Types of relationships

Johns Hopkins Health and Education in South Africa, Khomonani, Soul City and Community Media trust commissioned Health and Development Africa to conduct the Second National Communication Survey in 2009. The graph above reflects the results and considers the types of relationships and condom use. There is clear trend that condom use is more apparent in one night encounters, with persons who have just met or known a little while and with friends, whilst these rates drop with main partners, persons living together and persons who are married³⁰. Here the use of condoms becomes associated with the lack of trust in relationships.

³⁰ Similar trends have been observed in other countries, e.g. Zimba (Zambian National HIV/AIDS/STI/TB Council (2010) National AIDS Strategic Framework 2011 – 2015)

Results from the HSRCs 2008 household survey found the following

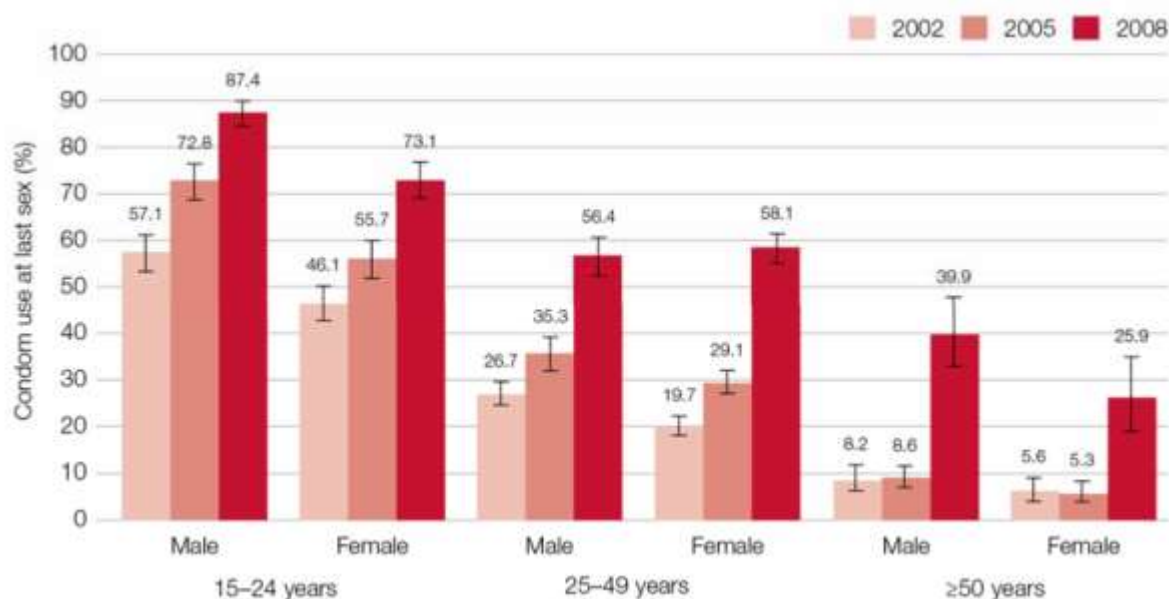


Figure 10: Condom use by age groups and gender

Over a life time condom use appears to change, this graph shows that condom use amongst younger men and women is high whereas this tapers off with older age groups.

Condom use across CEEP countries

Indicator: Condom use at last sex	Malawi ³¹	Mozambique	South Africa	Tanzania	Zambia	Zimbabwe
Male	57.2%	16%	30.3%	42%	50%	33%
Female	37.5%	8%	24.7%	41%	37.4%	48%

Table 13: Condom use at last sex by gender across the 6 CEEP countries

Although the trends across time are encouraging it is evident that there is still a large proportion of the population that is still engaging in unsafe sex. It also appears that condom use in women is lower than for men.

Knowledge about condoms is not enough to lead to condom use, other factors such as access, knowledge of how to use condoms and the ability to negotiate for condom use with one's partner influence condom use as well. Knowledge of condom and how to use them has to be accompanied by the ability to negotiate for condom use, and the opportunity or space to negotiate. From the national survey in Zimbabwe women were asked if they were able to negotiate safer sex with their husbands. It is encouraging to see that there is a high percentage of men and women (80%) who feel that women are justified in insisting that safer sexual practices, e.g. condoms, are used if her husband has an STI. However, only 63% of men felt that women were justified in insisting on the use of safer sexual practices, when the man is known to be engaging in sexual relations with other women.

There appears to be a slight gender difference in the ability to negotiate safer sexual practices, e.g. condom use. The national survey from Tanzania showed that a high percentage of women (90.7%) felt

³¹ National AIDS Commission Malawi (2009) National HIV Prevention Strategy 2009 - 2013

that they could negotiate safer sexual practices or even refuse sex with their husbands. Similarly, 93.8% of men felt that they could negotiate safer sexual practices and that they could refuse sex if needed. From the surveys conducted in Malawi 94.3% of men felt that they could refuse sex or insist on condom use while 89.8% of women felt that they could negotiate for the same.

Although the use of condoms has increase over the years there is still a large numbers of people that are not using them. This has been attributed to negative attitudes towards condoms, ability to negotiate for condom use with partner and access.

Attitudes towards condoms

In spite of their known effectiveness in protecting people from STI (including HIV) and unwanted pregnancies, attitudes towards condoms remains fairly negative especially within the older age groups. Myths are common and use of condom or discussion of condom use is linked to issues of distrust within the relationship³².

Ability to negotiate for condom use

Condom use is also reliant on two things; the person's ability to negotiate condom use within a relationship. It is encouraging to see in the above mentioned studies that many men and women felt like they could negotiate for condom use in their relationships.

Access

Whilst a person may want to use a condom and know how to negotiate this within their relationships, access is a crucial part in ensuring condom use. Stock-outs of condoms at government health facilities are common. Sometimes locations for condom distribution are not located in a manner that encourages people to pick up condoms, for example the condom container is often located at the front of the waiting area in a health facility.

How to use a condom

One condom used the correct way, each and every time, during oral, vaginal or anal intercourse can protect one from getting HIV, STI and unplanned pregnancy.

- ✓ Talk to your partner about what kind of protection you want to use.
- ✓ Condoms are readily available in public and private health facilities, chemist and some workplaces.

How to use a Male condom

Squeeze the air out of the tip of the condom. This is important because if the air is not squeezed out, the condom could break.

Open the condom using your hands not teeth

Check to see which way the condom unrolls.

Pull back the foreskin if the is uncircumcised.

Place the condom on the tip of the erect penis and roll it all the way down.

Have sex.

After orgasm and ejaculation, hold the condom at the base of the penis and withdraw the penis.

Carefully remove the condom from the penis, making sure that none of the semen seeps out.

Wrap the condom in tissue, and throw it away. Don't flush the condom down the toilet; throw it away in the trash.

Never use the same condom again.

³² National AIDS Commission Malawi (2009) National HIV Prevention Strategy 2009 - 2013

- ✓ Latex condoms are preferable, but polyurethane condoms works, too, for people who are allergic to latex.
- ✓ Until you and your partner actually have sex, store the condoms in a cool, dry place.
- ✓ Don't store them in your pocket or wallet, since heat from your body can damage them.
- ✓ Before having sex (oral, vaginal or anal) open the package carefully (watch your finger nails) and remove the condom.
- ✓ Check the expiration date before purchasing the condoms to make sure they have not expired

Female condom

The female condoms, is made of polyurethane as opposed to latex like the male condom. This product is becoming increasingly popular so there are several advantages and disadvantages to consider before usage

How to use Female Condoms

- ✓ Open the Female condom package carefully; tear at the notch on the top right of the package. Do not use a scissor or a knife to open.
- ✓ The outer ring covers the area around the opening of the vagina. The inner ring is used for insertion and to help hold the sheath in place during intercourse.
- ✓ While holding the Female condom at the closed end, grasp the flexible inner ring and squeeze it with the thumb and second or middle finger so it becomes long and narrow or makes a figure of eight - 8
- ✓ Choose a position that is comfortable for insertion – squat, raise one leg, sit or lie down.
- ✓ Gently insert the inner ring into the vagina. Feel the inner ring go up and move into place
- ✓ Place, the index finger on the inside of the condom, and push the inner ring up as far as it will go. Be sure the sheath is not twisted. The outer ring should remain on the outside of the vagina.
- ✓ The female condom is now in place and ready for use with your partner. When you are ready, gently guide your partner's penis into the condom's opening with your hand to make sure that it enters properly – be sure that the penis is not entering on the side, between the sheath and the vaginal wall.
- ✓ To remove the Female condom, twist the outer ring and gently pull the condom out.
- ✓ Wrap the condom in the package or in tissue, and throw it in the garbage. Do not put it into the toilet.

Advantages of a female condom

- ✓ The female condom is designed to give women more control over intercourse. With this product she is able to negotiate safe sex
- ✓ It is the only contraceptive for a woman that also provides protection against HIV. AIDS is not infectious
- ✓ There are no side effects and latex- sensitive women can use it.
- ✓ The female condom is an important measure to assist women with protecting themselves from HIV.

Disadvantages of a female condom

- ✓ The female condom may be difficult for some to insert.
- ✓ The female condom is more expensive than the male latex condom
- ✓ It is not available everywhere

Facts and myths associated to condom usage

a. HIV can pass through condoms

- A commonly held misperception is that latex condoms contains “holes” that allow passage of HIV. Condoms are manufactured by using a “double –dipping method”.
- Manufacturers have a special mould for the shape of the condom, which they dip in latex.
- At a point, the latex might have some big holes, so then they dip it again to cover any holes and make sure they are much smaller than a microscopic virus. The particles of a virus will be too big to get through minute holes in condoms.
- Condoms are then electronically tested to make sure there are still no holes.
- Two or three thin layers of latex are used, and holes would have to be aligned to let the virus pass through; enough viral particles would have to pass through to cause infection, not just one or two.

b. Condoms frequently break

- Another area of concern expressed by some is about the quality of latex condoms. Every latex condom manufactured is tested before it is for defects before it is packaged.
- During the manufacturing process, condoms are double-dipped in latex and undergo stringent quality control procedures.
- Several studies clearly show that condom breakage rates are less than 2 percent. Most of the breakage is due to incorrect use rather than poor condom quality.
- Using oil-based lubricants can weaken latex, causing the condom to break.
- In addition, condoms can be weakened by exposure to heat or sunlight or by age, or they can be torn by teeth or fingernails.

c. Condoms don't give the guy any pleasure

- Condoms are thin and do not prevent pleasure. If a couple is not using a condom, they will be worried about STIs and pregnancy, which can lead to less pleasure than using a condom can.
- You have to be certain age to buy condoms
- There is no age limit to buy condoms. Anyone of any age can buy condoms in a chemist or get them at a health clinic.

d. Condoms don't need to be used with any other method of birth control

- Casual sexual partners who are having intercourse should always use two forms of birth control-one to prevent unplanned pregnancy and another to prevent STI transmission (dual protection).
- The best combination is to use a barrier method, like a condom, along with a hormonal method, like the birth control pill. Condoms are the only form of birth control other than abstinence-that can protect against STIs.

Key Messages:

- **Correct and Consistent Condom use is a prevention strategy that effectively can reduce one's risk of contracting HIV and AIDS**
- **Correct and Consistent Condom use is seen as a social norm and this needs to be encouraged**
- **Correct and Consistent Condom use requires skill to use effectively and space to negotiate its use.**
- **Condom education should promote this product as well as attempt to increase women's confidence in the ability to use condoms in any situation. Along with this developing partner support to always use condoms is equally important. We also need to advocate for availability of female condoms.**
- **Correct and Consistent Condom use along with contraceptive use is seen as the best way to prevent unwanted pregnancies and STIs**
- **Oil based lubricants can break male condoms**

C. Bio-medical factors

Mother to Child Transmission

Mother to Child Transmission (MTCT) is considered the second most common means for HIV to be transmitted from one person to another in Sub-Saharan Africa³³. HIV can be transmitted from an HIV positive mother to her child at three stages within and after her pregnancy:

- ✓ **During pregnancy**, if the mother experiences some physical trauma which can rupture the lining of the womb and expose the child to the mother's blood.
- ✓ **During birth** the child is exposed to the mother's blood and vagina fluids which both contain high levels of HIV. If there is a long labour or trauma to the child, e.g. the use of forceps, this can create entry points on the child's skin for HIV.
- ✓ After birth, **during breastfeeding** it is possible for the HIV to be passed to the child, especially if the child is mixed fed with breast milk and other things such as formula feeding. It is for these reasons that exclusive breast feeding for the first 6 months is considered safe followed by early weaning and the introduction of other forms of nutrition for the child including formula feeding.

The maternal risk factors that can increase the chances of transmission include:

- ✓ High viral load
- ✓ Low CD4 count
- ✓ Advanced maternal diseases
- ✓ Viral or parasitic placenta infections
- ✓ Maternal malnutrition
- ✓ Cracked, fissures, mastitis or abscesses on the nipples

There are also risk factors that are associated with the infant:

- ✓ Being the first infant within multiple births
- ✓ Premature or low weight babies
- ✓ Duration of breast feeding
- ✓ Mixed feeding
- ✓ Oral diseases for the child

During the birth there are risks associated with:

- ✓ Rupture of membranes for longer than 4 hours
- ✓ Injuries to the birth canal during child birth
- ✓ Invasive childbirth procedures, e.g. infant scalp monitoring
- ✓ Vaginal delivery
- ✓ Delayed cleaning of infant especially the eyes
- ✓ Routine airway suctioning³⁴

Prevention of Mother to Child Transmission (PMTCT) aims to reduce the risk of transmitting the virus from mother to child. PMTCT has been integrated into the services that are offered at antenatal clinics. Although the specifics and the protocols may differ from country to country there are some basic similarities to these protocols. These include:

- ✓ Encouraging early first visits to the antenatal clinic if suspect that a person is pregnant
- ✓ Testing of pregnant women at antenatal visits

³³ Tanzania Demographic and Health Survey 2010.

³⁴ Federal HIV/AIDS Prevention and Control Office, Federal ministry of Health 2007. Guidelines for Prevention of Mother-to-child Transmission of HIV In Ethiopia

- ✓ Provision of ARTs to mothers with low CD4 counts (<350)
- ✓ Provision of ARTs to all mothers 4 weeks before the birth
- ✓ Quick natural births
- ✓ Post exposure treatment for the baby at birth and a week later
- ✓ Early testing of the child – at times these are Polymerase Chain Reaction tests (that look for the virus not the antibodies)
- ✓ Provision of further treatment to the child if needed
- ✓ Exclusive feeding practices – the mother and father need to consider what feeding practices best suit their situation and then stick to that:
 - Breast is best – breast feeding the infant is the best method to ensure that the child access to antibodies from the mother and nutrition that aids healthy development. It is recommended that infant should be exclusively breastfed for 6 months only and then there is rapid weaning. Exclusively breastfeeding means that only breast milk will be used to feed the infant for 6 months and the infant should not be given anything else, e.g. water, tea or gripe water. These substances can tear the lining of the infant's gut which would provide an entry point for HIV.
 - Exclusive formula feeding also provides protection from HIV infection. However it must be noted that the nutritional value of formula, whilst it's good, does not compare to that of breast-milk. Secondly, preparation of the formula requires that the family have access to clean water and means to boil the water and cool it. As simple as this process sounds, it is complicated if the family needs to collect water from a river, wood for boiling the water and keeping the bottle clean. More infants have died annually from diarrhoea as a result of unhygienic food preparation than from HIV. Additionally, in areas where breastfeeding is culturally condoned, the family, friends and community may put pressure on the mother to breast feed, and this may result in mixed feeding.

One of the most important aspects of the PMTCT process is the health of the mother. The aim is to keep the mother as healthy as possible and thereby reduce the viral load. This can be achieved through adoption of the positive living principles, including: getting plenty of rest, exercise, eating healthily and drinking lots of water. Added to this her partner can aid the process by being supportive and attentive during this time, e.g. accompanying the women to her antenatal classes, learning child rearing skills, like how to change a nappy or calming the baby.

As indicated earlier, during the initial stage of HIV infection the viral load is high and if a pregnant woman gets infected during pregnancy, they would have high viral load, therefore increasing the risk of HIV transmission to their child. As a result it is important that an HIV negative woman should practice safe sex during pregnancy to maintain their HIV negative status.

An important point here is that HIV positive couples have the right to have children and need to be informed about how best to follow this process through. Knowledge of PMTCT is an essential step in ensuring that people make use of these services. At present to measure people's knowledge of PMTCT in surveys, participants were asked if they know that HIV can be spread through breastfeeding and that the use of ART can reduce the chances of transmitting the virus to the infant.

Indicator	Malawi	Mozambique	South Africa	Tanzania	Zambia	Zimbabwe
Knowledge of PMTCT (men)	71.1	43.5	unavailable	66.5	78%	64%
Knowledge of PMTCT (women)	82.9	51.9	unavailable	72.2	63%	unavailable

Key Messages:

- The transmission from mother to child is preventable
- The transmission of HIV from a mother to a child is seen as the second biggest driver within Sub-Saharan Africa.
- The prevention of Mother to Child Transmission occurs through medical and behavioural factors:
 - Medical:
 - Use of ARTs during pregnancy to reduce the mother's viral load, thereby reducing the risk of infection to the infant before birth
 - The use of quick natural birth methods to ensure that the child's exposure to potential harmful bodily fluids is reduce
 - Provision of ART to the infant after birth is a form of PEP
 - Behavioural:
 - Exclusive Breastfeeding practices
 - If a mother is negative during the antenatal check-ups it is vital for her to remain negative as the acute infection period just after infection places the infant at risk of contracting HIV
- People require better knowledge of PMTCT

Voluntary Counselling and Testing / HIV Counselling and Testing

Voluntary Counselling and Testing of HIV is a dialogical process, whereby a trained counsellor helps a client to make an informed and empowered decision about whether to test or not. If the client is ready to test then the counsellor may draw blood and seek a result, which will be the client's HIV status. The process ends when the client is given the result and support is provided to keep the client negative or support is provided to help the client make important life style changes, if positive.

VCT or HCT make use of two different types of tests, antibody testing and testing for the HI Virus

Antibody testing –can be done in two ways:

- ✓ A rapid test which is done on site in front of the clients, and the results are available within 20 minutes. This is the most common type of test that is used and in most circumstances a drop of blood is taken and applied to a rapid test. Over the years these tests have developed in accuracy and precision, making their results very reliable.
- ✓ Eliza test is another test that looks for the presence of antibodies. Here a sample of blood is drawn and sent to a laboratory for the test to be conducted, the results of the test are available within a few days.

Anti-body tests are open to one flaw and that is, they require a certain level of antibodies to be present before an accurate reading can be taken. This is referred to as a window period and can be up to 3 months after infection. The implication of this is that if the person feels that they may have been exposed more recently than 3 months then they need to return for a follow up testing.

Antigen test

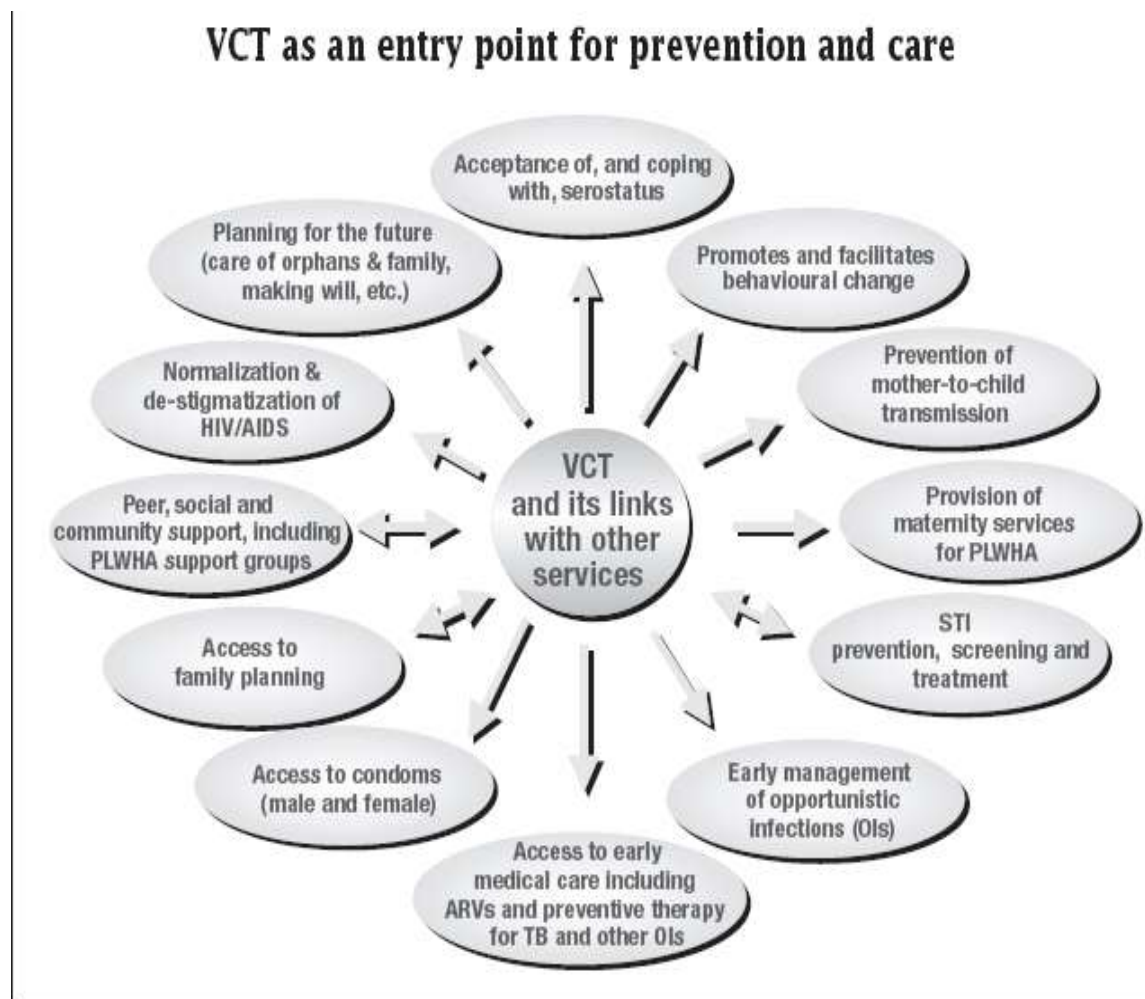
Testing for the HI Virus Polymer Chain Reactions: This type of test looks directly for the presence of the HI- virus and is often used with infants as part of the PMTCT process. –For this test a sample of blood is sent off to a laboratory and examined there.

Early detection of the HIV infection is crucial in ensuring its effective management and VCT/HCT services are offered free of charge in health facilities in most countries around the world. There is increased awareness that the more people know their HIV status and are managing their risk of infection or managing the impact of the disease on their lives, the better for the national effort to turn the tide against HIV and AIDS. Below is a table that outlines some of the countries' successes in HIV testing:

Indicator	Malawi	Mozambique	South Africa ³⁵	Tanzania	Zambia	Zimbabwe
Number of sites	636	unavailable	unavailable	unavailable	1 102	unavailable
Percentage of males ever tested		19%	43%	39.8		36%
Percentage of females ever tested		37%	56.7%	55.3%		57%
Percentage of males tested in the last 12 months	31.3	9%	43%	25%	11.7	36%
Percentage of females tested in the past 12 months	...	17%	56.7%	29.5%	18.5	57%

³⁵ South African National HIV Survey 2008

Over the years there has been a noted increase in the number of people testing. This increase can be the result of the improvements in test kits that are used and the national campaigns that have been run within various countries. It should also be noted that more women than men have tested for HIV. Encouraging men to test is an important strategy in addressing HIV prevention, care and support services. VCT or HCT is considered an important part of both prevention and as an entry point for HIV positive clients into treatment and care services. Consider the diagram below:



Source: VCT: UNAIDS Technical Update, May 2000

Figure 11: VCT as an entry point for prevention and care

HIV voluntary counselling and testing procedure

What is counselling?

UNAIDS defines counselling as an interpersonal, dynamic communication process between a client and a trained counsellor who is bound by a code of ethics and practice to resolve personal, social or psychological problems and difficulties. This means, counselling has to be provided by trained people.

In the context of HIV, there are lay/peer counsellors working through NGOs and health facilities to help accelerate access to VCT, HIV information, treatment, care and support services. VCT is a process whereby



a person voluntarily undergoes counselling to enable him/her to make an informed decision about being tested for HIV.

Factors THAT can hamper or enhance counselling

- ✓ Age
- ✓ Cultural beliefs
- ✓ Attitudes
- ✓ Knowledge
- ✓ Literacy levels
- ✓ Environmental factors

Counsellors need to be sensitive to these factors

- ✓ The increasing HIV prevalence is related to human behaviour amongst other things, and human behaviour can go a long way in addressing risk to HIV infection.
- ✓ Different HIV communication strategies are developed and implemented to foster positive behaviour change, individual empowerment to take responsibility for one's health and avoid putting others at risk.

Voluntary Counselling and Testing (VCT) can provide an entry point to communicate behaviour change.

- ✓ Studies indicate that VCT has proven to be the main an entry point to HIV and other health services.
- ✓ The VCT enables the counsellor and client to explore; HIV risk factors, knowledge of safe sexual practices, correct condom use, family planning and wellbeing awareness.

Pre-test counselling

- ✓ Provides information on HIV
- ✓ Explores the client's history of exposure to HIV
- ✓ Explores the client's coping mechanisms
- ✓ Clarifies what the results could mean:
 - HIV positive means that the person is infected with the virus
 - HIV negative means that the virus is not detectable which could mean that they are in the window period or that they are not infected.
 - HIV indeterminate, that is there has been an issue with the testing procedure and another sample would be required

Post-test counselling

- ✓ Discussion of HIV positive results and offering of emotional support
- ✓ Discussion of HIV negative results and reinforcement of healthy behaviour, to maintain the HIV negative status through behaviour change, partner reduction, promotion of correct and consistent condom use, possibility of medical male circumcision
- ✓ Referral for STI and TB testing and treatment if required
- ✓ Information on continued counselling and support

Follow up and ongoing counselling

- ✓ Follow up on clients coping with HIV positive results
- ✓ Follow up after referral on services provided
- ✓ Possibility of forming or joining support groups
- ✓ Counselling and testing of partner or children under the age of 18 months.
- ✓ Some clients HIV negative results imply that they might be in the window period, which is between 6 to 12 weeks after HIV infection.

- ✓ If a person was exposed to unprotected sex or body fluids, follow up counselling and testing may be required to exclude the window period.

If one tests HIV positive, VCT helps to:

- ✓ Make decisions on behaviour change, adopt safe sex practices to avoid being re-infected or infecting others
- ✓ Learn more about the virus and how it affects the body.
- ✓ Learn about health and wellness so that one can have productive, healthy and longer life,
- ✓ Get information and counselling on how to live positively with the virus.
 - This means understanding and accepting the positive HIV status,
 - Seeking emotional support, eating a healthy diet,
 - Learning how to control the amount of stress in our life,
 - Planning for the future.
- ✓ Learn to recognize the signs of opportunistic infections so he or she can get them treated promptly
- ✓ Find out what resources are available within the community to help manage HIV status
- ✓ Find out about prophylactic drugs. These drugs do not cure HIV and AIDS, but can prevent some opportunistic infections that are common with people living with HIV and AIDS e.g. T.B and some kinds of Pneumonia.
- ✓ Get emotional support by seeking counselling and joining support groups to manage the stress in one's lives.
- ✓ Be directed to services for care and support without delays, like
 - Prevention or treatment of opportunistic infections,
 - Treatment of Sexually Transmitted Infections (STIs) and TB
 - Early access to ARVs
 - Counselling on family planning, prevention of mother-to-child transmission of HIV
 - Support for adherence to medication
 - Ongoing counselling encourages acceptance and disclosure of one's positive status
 - Raised awareness and less stigma and discrimination (UNAIDS, 2002:122)

If HIV Negative, VCT helps

- ✓ One can learn how to have safer sex and stay HIV free
- ✓ VCT can motivate people to accept those who are infected

Effective counselling requires

- ✓ Creation of a quiet and private atmosphere
- ✓ Maintenance of confidentiality of information shared by the client and the results of the test
- ✓ Self-awareness of one's beliefs, values and assumptions
- ✓ A self-respectful, non-judgmental attitude
- ✓ Active listening skills, accurate reflection of the issues of concern
- ✓ Asking supportive questions that raise important issues, in a caring and non-judgmental way
- ✓ Awareness of one's verbal and non-verbal behaviours
- ✓ Ability to provide practical or refer for practical support, advice and information
- ✓ Discussions of prevention, care and support
- ✓ Ability to encourage the client and family to make their own decisions

Key Messages:

- **VCT is seen as a vital prevention strategy as well as providing an important entry point into care and support**
- **Testing positive is not a death sentence, rather VCT can be vital to refer people to good care**

and support

- **Testing negative does not mean that you will stay negative. If a person has been potentially exposed within three months of testing they will need to have a confirmatory test**

Medical Male Circumcision

What is medical male circumcision?

Medical Male circumcision is the surgical removal of the whole foreskin. The foreskin is the fold of skin that covers the head of the penis. Men are encouraged to go for MMC as it has lesser complications and health problems.

What are the benefits of medical male circumcision?

- ✓ Studies indicate that MMC reduce the risk of HIV transmission by 60% as the sensitive skin under the foreskin is removed.
- ✓ It is not 100% safe and does not replace safer sexual practices, e.g. partner reduction and condom use. Keeping the penis clean is easier.
- ✓ The skin becomes stronger which means that there is less chance of abrasions or bruising caused during sex.
- ✓ It lowers the risk of getting other STIs. It also has health benefits for the partner as there is the removal of the foreskin which often contains the human papilloma virus which has been shown to cause cervical cancer in women.

It should be noted that MMC is not recommended for men who are already infected with HIV. The main reason is that men with severe immunodeficiency are at an increased risk of complications following surgery. From a national perspective the effects of this prevention strategy on the spread of the epidemic is seen as invaluable as it will cut back infection rates dramatically.

Traditional versus medical circumcision

Below is a table of the rates of circumcision amongst men across the various CEEP countries. It can be seen that Tanzania and Malawi have high rates of circumcision.

Indicator	Malawi	Mozambique	South Africa	Tanzania	Zambia	Zimbabwe
Percentage of Male population MC	21%	51%	42%	72%	13% (2007)	9.2%

While these figures are encouraging, it is not clear whether these are medical male circumcision or traditional circumcision. In many African communities, traditional circumcision forms part of the process of entering adulthood. In cases of traditional circumcision there are some conditions that need to be considered:

- Does the actual circumcision make use of the same blade across the initiates? If this is the case then this can increase the risk of HIV infection.
- Does the circumcision remove the whole foreskin or is it a partial removal? At times traditional circumcision may only remove part of the foreskin or make a slit or cut into the foreskin. Both of these latter practices do not offer the same level of protection as the full removal of the foreskin
- Do traditional leaders work together with health care providers to ensure that safe circumcisions are performed that offer the greatest levels of protection

Medical Male Circumcision Procedure

MMC is a choice; all clients receive counselling to make informed choice about MMC and also HIV testing before undergoing circumcision.

One will also be examined for sexually transmitted infections and foreskin abnormalities.

Circumcision will be performed by a trained health provider and it is quick.

MMC is done under local anaesthetic, so besides a small injection, there is no pain and it takes only about 30 minutes.

Normally, the stitches should fall out after 10 to 14 days.

The wound is then stitched and dressed, and painkillers are given to help manage any mild pain or discomfort which may occur when the anaesthetic wears off.

Health staff educates the circumcised client on how to keep the wound on the penis clean while it heals.

Client should report any problem to the health facility to get needed help.

Circumcised men

- Must go for follow up at health facility to confirm healing before resuming sex.
- Must not have sex at least 6 weeks after operation to allow complete healing. During this time sex and even masturbation should be avoided as this could prolong the healing period

After circumcision, circumcised penis should be gently washed with soap and water, using a soft cloth.

Key Messages:

- **Medical Male Circumcision can reduce a man's risk of infection by 60% and other STI incl. HPV**
- **Whilst in some countries and areas there are high levels of circumcision, we need to keep in mind that there are different types of circumcision and these need to be considered when promoting MC as a prevention strategy**
- **A man should not have sex for 6 weeks after the procedure as it can cause damage and provide entry points for the virus if this act is unprotected**
- **Medical Male Circumcision is one prevention method but correct and consistent condom use is important as well**
- **Medical Male Circumcision only reduces the risk of contracting HIV through vaginal intercourse**

Anti-retroviral Treatment/Therapy

Anti-retroviral (ARVs) are drugs that have an effect against HI viruses, thus they are the main type of treatment for HIV, which is called Anti-Retroviral Therapy. The aim of antiretroviral treatment is to keep the amount of HIV in the body as low as possible. ARVs stop the multiplication of HI virus thus allowing the immune system to recover and fight better. As the viral load is kept low, the CD4 count increases, protects the body better and fight illnesses successfully. Counselling is an important part in management of HIV and adherence to treatment.

The major objectives of ART can be summarized as follows:

- ✓ ART causes sustained suppression of HIV multiplication
- ✓ Help restore and/ or preserve the immunity of the body.
- ✓ Enable the body to fight off most of the opportunistic infections,
- ✓ Help the person attain an improve quality and longer life.
- ✓ Prevent HIV transmission in cases of accidental injuries like in the health setting (Post Exposure Prophylaxis) and
- ✓ Prevent Mother to Child Transmission (PMTCT).

Who gets ART?

The World Health Organization developed treatment guidelines for HIV, TB and Opportunistic Infections, however, countries do develop treatment guidelines and protocols. Number of people on ART in CEEP countries

Indicator	Malawi	Mozambique	South Africa	Tanzania	Zambia	Zimbabwe
# started ART	148 000	170 000	371 000	200 000	285 000	593 000

- ✓ ART is given to people with confirmed HIV positive status, but ART can also be given as prophylaxis after exposure to infected body fluids and blood.
- ✓ Person in WHO clinical stage III or IV
- ✓ Person with CD4 cells less than 200 in any clinical stage

Other factors that determine whether a patient should start ARVs

- ✓ Patient's interest or readiness to take ARV's
- ✓ Financial barriers
- ✓ Psychological barriers
- ✓ The patients' potential for adherence to ARV's
- ✓ The existence of other illnesses like TB

Side effects of ARVs

Some ARVs may have side effects and some ARVs should not be taken with other drugs. Even if a person is experiencing some side effects they are advised not to stop taking their medication without consulting their health provider and to always report any side effects and complications to their health provider.

List of Major side effects of ARVs

Blue/black discoloration of nails	Nausea	Headache
Failure to sleep (insomnia)	Anxiety	Panic attacks
Abdominal cramps	Dizziness	
Diarrhoea		
Weakness	Loss of hair	Severe abdominal pain
Little blood in the body (anaemia)	Skin rash	Nightmares
Tingling, pain, numbness of the feet or hands	Skin rash which is accompanied by ever or changes in the distribution of body fat	Inflammation of the liver/yellow eyes
	ulcers in the mouth	

Drug Interactions of ARVs with other drugs or food supplements

ARVs can interact with other drugs, leading to decreased ARV concentrations in the blood thus allowing HIV to increase regardless of the fact that a person is taking medication. It is important to disclose one's HIV positive status to a health provider before taking other drugs. Some of the drugs that can cause drug interaction are:

- ✓ Chronic medications which might be taken by the elderly people.
- ✓ Oral contraceptives or hormone replacement therapy might cause drug interactions.

Key Principles for treatment counselling

Treatment Counselling helps clients to:

- ✓ Understand ones condition,
- ✓ Build a trusting relationship with the care worker,
- ✓ Build support network,
- ✓ Make an informed decision to start treatment,
- ✓ Understand the importance of treatment compliance,
- ✓ Have courage to report any negative effects of treatment to a health worker,
- ✓ Be motivated to continue taking treatment even when feeling better,
- ✓ Learn how to motivate partners to be treated to avoid re-infection,
- ✓ Rely on a trusting relationship with a team of health workers where treatment was prescribed.
- ✓ Develop treatment pattern to help one remember when to take the next dose.

- ✓ **Some herbs, like** garlic interferes with effectiveness of some ARVs e.g. saquinavir.
- ✓ Some TB drugs may affect ARV effectiveness
- ✓ Addictive drugs affect a person's wellbeing

Treatment Adherence

Treatment adherence means taking the treatment as prescribed, **correct time, dose and frequency** with or without food and attending to prescribed follow up.

Good treatment adherence of HIV treatment helps

- ✓ Medications to work properly to reduce the amount of HIV in the body (**viral load**)
- ✓ To prevent **drug resistance**
- ✓ To reduce spread of drug-resistant strains of HIV that can be transmitted to others
- ✓ Offers best chance for long-term treatment success

What helps people to adhere to treatment?

- ✓ Person understanding of his/her condition and the need to take treatment.
- ✓ Person's acceptance of the condition
- ✓ Disclosure to support system, family, friends
- ✓ A person's choice and decision to take treatment
- ✓ Ongoing follow up and counselling

Factors that can hamper successful anti-retroviral treatment

On a mental level	On a behavioural level	On a physical level	Social (environment) factors	Fears associated with HIV treatment
Denial of HIV positive status Forgetting dose, time and things to avoid. Misconceptions and misinformation about the treatment Lack of support	Possible difficulties in organizing and managing personal time, e.g. time to prepare food and eat before taking medication Concurrent consumption of alcohol or drugs while on treatment Difficulty to stop certain food, which might be causing drug interaction	When a person feels sicker due to drug effect and the body's response, one may think ARTs are making them ill, then stop treatment. When opportunistic infections disappear, some people feel they no longer need treatment and stop therapy.	Non-disclosure and lack of support (family, workplace, friends) Existing or perceived Stigma and discrimination, rejection and isolation Lack of financial resources and food Caring for other ill people, Experience of ART failure for a family, friend, colleague Travelling long distance to health facilities where treatment is obtained. Unsuitable consultation schedules.	Fears of Not being able to cope with side effects. Of physical discomfort, pain, tiredness. Of body changes. Real or perceived stigma. Treatment failure. Whether treatment will work well over long time. Of illness arising or returning. Whether one will live for a long time. Large treatment doses per day Severe side effects
Research shows that ART has improved life, wellbeing and quality of life people with HIV.				

The link between HIV treatment and HIV prevention

HIV prevention aims to prevent new HIV infections and reinfection. HIV awareness can lead to increased HIV Counselling and testing (HCT), and HCT increases early access to treatment. Increased number of people who know their status, helps to increase the number of people on treatment. Once people are on treatment their viral load is reduced. The risk of HIV transmission is reduced when the viral load is lowered, contributing to prevention of HIV infection. Additionally, provision of treatment will:

- ✓ Reduce fear and stigma around HIV and AIDS
- ✓ Increase utilization of related services, such care and support
- ✓ Improve quality of life for people with HIV (PWHIV) as they can continue working and providing for their needs and their families,
- ✓ Increase disclosure and acceptance of PLHIV in their families, workplace and communities,
- ✓ Increase access to safer sex counselling including: condom use, family planning, prevention of mother-to-child transmission and primary infection and re-infection.
- ✓ Increase access to more information on other prevention options, including reduction of sexual partners

When people know there is treatment, care and support there is hope among people with HIV (PWHIV), and more people are

- ✓ Encouraged to test
- ✓ Access treatment
- ✓ Accept and disclose their status
- ✓ More PWHIV look well and lead happier, healthier and productive lives

Comprehensive care and living with HIV

Living with HIV requires the management of a combination of factors to ensure that persons maintain low viral loads as well as keep the body's immune system healthy to fight off further infections. Some of the factors to consider when addressing positive living include biological health, psychological health and spiritual health.

Biological Health

Anti-retroviral treatment is not the only way to slow the rate of HIV reproduction, a healthier life style is another way to slow HIV reproduction. Healthier lifestyle includes

- ✓ Exercise – this is crucial to aid the body in maintaining its healthy state
- ✓ Eat health balanced diets
- ✓ Good personal hygiene as a means of infection control
- ✓ Clean and health living environments

All these factors would reduce a person's exposure to other illnesses and thereby maintain a healthy body.

Psychological Health

The progression of HIV from virus to AIDS can be influenced by the person's overall health, including psychological health. As a result it is important to make sure that people who have been diagnosed with HIV receive psychological and social support through professional counsellors, peers, friends and family. The relationship between HIV and depression is diverse, complex, and inter-connected; in most instances it is believed that HIV and depression go "hand-in-hand". Suicidal thoughts and bouts of depression are common, especially before the process of acceptance has been completed. The issue here is that depression affects the functioning of the body's immune system and as a result needs to be monitored carefully.

Depression among people living with HIV

Depression is a medical condition that affects your thoughts, feelings and ability to function in everyday life. A larger number of people with HIV are also affected by depression which is associated with sad mood, disturbed sleep, loss of appetite, and low energy, the symptoms of depression may be difficult to

distinguish from those of the infection itself. Depression has huge medical impacts on HIV patients; it has a negative effect on patients' sexual risk behaviour, substance use, and medication adherence.

What causes depression?

Depression results from abnormal functioning of the brain. An interaction between genetic predisposition – which means that something in the person's genes make it easy for them to get depressed and events in their life seem to determine a person's level of risk to depression. Episodes of depression may then be started by stress caused by difficult life events, side effects of medications, or the effects of HIV on the brain. Whatever its origins, depression can limit the energy needed to keep focused on staying healthy, and research shows that it may make the progression from HIV to AIDS fast.

Key Points about depression

- ✓ Depression is a physical and a mental illness.
- ✓ Depression is very common among HIV + people.
- ✓ Depression is associated with increased morbidity and mortality among HIV + people (and for other diseases). Depression releases a hormone called cortisol which has an immune suppressant function, this lowers a person's CD4 count and allows the viral load and opportunistic infections to emerge.
- ✓ There are effective treatments for depression, but many depressed HIV+ people never receive them.

The relationship between depression and HIV

In many instances depression is linked to broader community issues such as poverty, unstable housing, fostering/adoption, cultural disruption and substance abuse. Initial depression is associated with an HIV diagnosis which can be made worse by stigma and an accompanying fear of disclosure, loneliness and lack of significant supports from families and friends.

Depression associated with stigma

Since the onset of the epidemic, aside from being a medical condition, HIV has been associated with a high level of stigmatization. Individuals have often been blamed for the disease, as though they were personally guilty for having the infection. These attitudes may then become internalized and cause feelings of shame about having a condition whose modes of transmission include sexual contact and drug. Research on HIV-related stigma has identified links between stigma and depression. HIV-related stigma may be experienced in different ways by different populations. For example, the stress related to the stigmatization that gay people experience has negative effects on their mental health, but the added emotional burden of concern over disclosing their sexual orientation combined with HIV status can result in depression. Although the gay community can offer its members support, HIV-stigma exists within the gay community itself and is associated with increased levels of anxiety, loneliness, and depressive symptoms.

Support

HIV stigma can negatively influence interactions with family, friends, sexual partners, co-workers, and health professionals and often results in loss of social support. Some HIV-infected persons do not have

Symptoms of HIV depressed patients

- ✓ Appetite changes and loss of weight
- ✓ Helplessness and Restlessness
- ✓ Loss of interest or pleasure in hobbies and activities
- ✓ Decreased energy, fatigue, being slowed down
- ✓ Difficulty concentration, remembering and making decisions
- ✓ insomnia , early morning awakening
- ✓ Thoughts of death or suicidal attempts

adequate support network because they fear rejection from family members or friends. Risk for suicide may be increased when HIV disclosure to loved ones is met with rejection rather than support. In such instances, peer educators and lay counsellors can provide support for PLHIV.

The Role of Peers in supporting depressed PLHIV

- ✓ Help a person to get diagnosis and treatment. Check the prescribed medicines they are taking. Read the instructions to find out when they need to be taken, what foods to be avoided and any side-effects.
- ✓ Supporting relationships. Keep a watchful eye. Look around to see if the house is clean, that there are no hygiene problems and there is enough food. If the sick person lives alone, invite them to join your family for a meal. Encourage others in the community to visit them and invite them out.
- ✓ Involve the person in (your life) and activities. Spend time with the person living with HIV/AIDS. Discuss the food they need to maintain and gain weight and manage their illness. Get to know what kind of food they like and do not like. Involve them in planning their meals, Avoid pressuring the person to cheer up avoid patronizing or babying a person.
- ✓ Be encouraging and loving. If people want to have food of their choice at any time of the day, try to get it for them. They may suddenly stop liking their food of choice, refuse what has been prepared and want something different. Understand that they are not trying to be difficult. These sudden changes in taste are a result of their illness.
- ✓ Keep an eye on their weight. If possible, weigh them regularly and keep a record. Look out for any unexpected weight loss and take action. Be firm about the importance of eating and encourage them to eat frequently, but do not force them to eat. Giving them too much food at one time may cause them to refuse. If they are too sick to leave their beds, make sure that they have something to drink and a snack nearby.
- ✓ Be sensitive. Take any mentioning of suicide seriously and seek professional help. PLHIV will have their own concerns and worries, fears for the future, for their families and for their own health. It is important that they take care of themselves, get enough rest and have the appropriate information and support to carry out their difficult task.

Too much help may be overprotective and take away the dignity, independence and self-respect of the person with HIV while too little help may not provide the support that is needed to ensure that the person eats well and has the strength to resist infection.

Barriers to Access to Treatment, Care and Support

Even though treatment, care and support for HIV, AIDS and TB may be available; access to such services can be hampered by organizational, physical and social barriers.

Organizational barriers	Physical barriers	Social barriers
Lack of materials and skills for needed services Staff shortages Limited psychosocial support services Health facilities that provide comprehensive services for HIV at a convenient time are limited,	Health facilities may be far away Clients may not have adequate transport, or Have limited funds for transport. The terrain may be difficult to cross, for example because of hills, rain or big rivers.	Cultural and religious beliefs about the condition and treatment Low literacy levels Lack of community involvement in health and development programs Attitudes to HIV and AIDS can also prevent people from accessing HIV care, support and treatment. Lack of disclosure increases secrecy about a person's HIV status and

Staff shortage in health facilities. Drug and material shortages, Lack of information and clear policies to support effective treatment, Ineffective referral systems. Lack of coordination of Health and social services and Duplication of services – particularly amongst NGOs.	Civil unrests due to warfare or criminal activity.	disbelief. Fear of real or perceived stigma instils shame among PLHIV. Fear of being blamed or harmed for passing HIV to others. Fear of seeking treatment, care and support. Lack of confidentiality among health workers & NGOs providing services for people with HIV. Gender inequality, the belief that women are spreading HIV can prevent them from testing, getting; treatment, care and support. Fear of stigma, may prevent some women from exclusive breast or formula feeding, leading to mixed feeding which increases the risk for HIV infection of the baby
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Spiritual Health

Good spiritual Health is seen as a protective factor against depression and is positively associated with general good health.

Key Messages:

- **There is treatment for HIV. Although this does not cure the disease it makes it a manageable disease**
- **Medication is only one aspect of learning to live with the infection, physical, psychological and spiritual health all play part.**
- **Providing on-going support for depression is an important part of acceptance and health**

Post Exposure Prophylaxis (PEP)

Post-exposure prophylaxis (PEP) is short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse. Prophylactic treatment for HIV typically lasts four weeks (depending on country policies). It allows the person's immune system a chance to provide protection against the virus and prevent the HIV from becoming established in a person's body. The process for HIV to reproduce and establish itself in the body to cause an infection can take up to 72 hours, therefore after 72 hours PEP is may not be effective at all.

Does PEP work?

Studies of PEP in humans looking at occupational exposures to HIV such as in Healthcare workers who are at a higher risk of being infected due to the nature of their work. The result of occupational exposure study showed that taking a course of zidovudine after exposure reduces the risk of HIV infection by approximately 81 percent. Other evidence has been gathered from survivors of sexual assault, 480 South Africans rape survivors taking a 6 week course of zidovudine and lamivudine shows that only one woman became HIV positive. So the generally conclusion is that PEP reduces the risk of HIV infections but it is not a guarantee that a person will not be infected. It is also important that it is taken as soon as possible after the exposure, and it should be taken for the everyday at the same time for 28 days.

Who can benefit from PEP?

- ✓ Rape survivors
- ✓ Healthcare workers, as an important aspect of safety in the work
- ✓ Anybody who believes they have been exposed to HIV can ask for PEP (as per country policies)

PEP and workplace occupational exposure

- ✓ The availability of PEP may reduce the occurrence of occupationally acquired HIV infection in health care workers.
- ✓ It is believed that the availability of PEP for health workers will serve to increase staff motivation to work with people infected with HIV, and may help to retain staff concerned about the risk of exposure to HIV in the workplace.
- ✓ The proper use of supplies, staff education and supervision needs to be outlined clearly in institutional policies and guidelines.

PEP in the workplace can work better when

- ✓ Ongoing information, education and training workers on prevention methods (universal precautions) and to
- ✓ Provision of the necessary materials and protective equipment.
- ✓ Assisting staff to access condoms and confidential Counselling and STI treatment services.

Regular supervision in health care settings can help to deter or reduce risk of occupational hazards in the workplace. If injury or contamination results in exposure to HIV infected material, post exposure counselling, treatment, follow-up and care should be provided. Post-exposure prophylaxis (PEP) with antiretroviral treatment may reduce the risk of infection.

Pre-exposure prophylaxis (prep)

PREP consists of ART to be taken before potential exposure in order to reduce the risk of HIV infections. Pre-exposure prophylaxis, means taking medication before any exposure to HIV in anticipation of being in a situation which is likely to expose one to HIV infection. While PEP is recommended for any HIV negative person who has recently been exposed to HIV for any reason, PREP refers to the treatment that can be taken before exposure to the virus in an attempt to prevent infection.

- 
- ✓ The ARV that are being tested for PREP treatment are tenofovir and temtricitabine alone.
 - ✓ Taken once a day they have limited side effects and slow development of associated drugs.

Who would be likely to benefit from PREP?

- ✓ Couples wishing to conceive a child where one partner is HIV positive and the other is negative by using the antiretroviral drug form of PREP or PEP.
- ✓ Women and man who are victims of sexual violence or who are afraid to insist that their partners use condoms.
- ✓ PREP is a short term precaution that is used as an emergency precaution, while PEP is considered the last resort in HIV prevention and should only be used when all methods have failed.

Key Messages:

- **PEP is an effective means of preventing HIV infection after exposure to the virus**
- **PEP needs to begin within 72 hours after exposure**
- **Little is known about PEP and this should be a focus area for programs**

Tuberculosis (TB)

It has been established TB and HIV are epidemics that feed off each other. TB is one of the most common opportunistic infections that cause deaths in HIV positive patients. TB/HIV co-infection is common, with Malawi reporting 78% co-infection rates³⁶, however the treatment programs tend to be implemented independently of each other.

Facts about tuberculosis (TB)

TB is a disease caused by a bacterium called *Mycobacterium tuberculosis*. The bacterium usually attacks the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain.

- ✓ At least 50% of people with HIV are also infected with TB, and 50% of those infected with TB also have HIV.
- ✓ If not treated properly, TB disease can be fatal and TB remains one of the world's top infectious killers.
- ✓ About 95% of TB deaths occur in low- and middle-income countries and it is among the top three causes of death among women aged 15 to 44.
- ✓ Tuberculosis typically attacks the lungs, but can also affect other parts of the body. It is spread through the air when people who have an active TB infection cough, sneeze, or otherwise transmit respiratory fluids through the air.
- ✓ Most infections are asymptomatic and latent, but about one in ten latent infections eventually progresses to active disease which, if left untreated, kills more than 50% of those so infected.

What is the link between TB and HIV?

HIV, AIDS and TB are closely interrelated in the following ways

- ✓ TB suppresses the immune system, thus increasing vulnerability to HIV infection.
- ✓ HIV promotes the progression of latent TB to active disease and the relapse of the disease in previously treated patients.
- ✓ TB speeds up the HIV progression, so is HIV for TB, TB and is one of the leading causes of death among people infected with HIV.
- ✓ It also promotes both the progression of latent (inactive) TB infection in previously treated patients.
- ✓ TB is harder to diagnose in HIV positive people, and progresses faster.
- ✓ TB occurs earlier in course of HIV infection than many other opportunistic infections.
- ✓ However TB is treatable even in people living with HIV.
- ✓ A person who has both HIV infection and TB disease has an AIDS-defining condition.

Why is it important to have combined TB/HIV programmes?

- ✓ HIV and AIDS are dramatically fuelling the TB epidemic in sub-Saharan Africa, where up to 70% of TB patients are co-infected with HIV in some countries.
- ✓ For many years, efforts to tackle HIV and TB have largely been separate, despite the overlapping epidemiology.
- ✓ Improved collaboration between TB and HIV and AIDS programmes will lead to more effective control of TB among people living with HIV and HIV among TB patients leading to significant public health gains.
- ✓ Many donors currently encourage the implementation of joint TB/HIV programmes in countries with dual epidemics.

³⁶ National AIDS Commission Malawi (2009) National HIV Prevention Strategy 2009 - 2013

Classification of TB

Not everyone infected with TB bacteria becomes sick. As a result, two TB-related conditions exist: latent TB infection and Active TB disease.

Latent TB Infection	Active TB Disease
Latent /Silent TB occur when the bacteria are presents in the body, but this state is inactive and presents no symptoms. ✓ Latent TB is not contagious in most people who breathe in TB bacteria and become infected; ✓ The body is able to fight the bacteria to stop TB germs from growing. ✓ People with latent TB infection do not feel sick and do not have any symptoms. ✓ People with latent TB infection are not infectious and cannot spread TB bacteria to others. ✓ If TB bacteria become active in the body and multiply, the person will go from having latent TB infection to being sick with TB disease. ✓ Diagnosis of latent TB relies on the tuberculin skin test (TST) and/or blood tests. ✓ Chest X-Ray and sputum smear are negative ✓ Needs treatment for latent TB infection to prevent active TB disease	When the TB bacteria become active and the immune system can't stop them from growing a person develops TB disease (active TB). ✓ Active TB is the condition that can make one sick with symptoms, and it is contagious. A person with active TB disease: ○ Usually feels sick ○ May spread TB bacteria to others ○ Needs treatment to kills the TB germ. ✓ Untreated latent TB infection can quickly progress to TB disease (active TB) in people living with HIV since the immune system is already weakened. ✓ Without treatment, TB disease can progress from sickness to death. ✓ The most common type of TB, affects the lungs. ✓ Diagnosis of active TB relies on X-Ray, as well as microscopic examination and microbiological culture of body fluids.

Symptoms of TB disease

- ✓ A bad cough that lasts 2 weeks or longer
- ✓ Pain in the chest
- ✓ Coughing up blood or sputum
- ✓ Weakness or fatigue
- ✓ Weight loss
- ✓ Loss of appetite
- ✓ Sweating at night
- ✓ Fever

Extra pulmonary

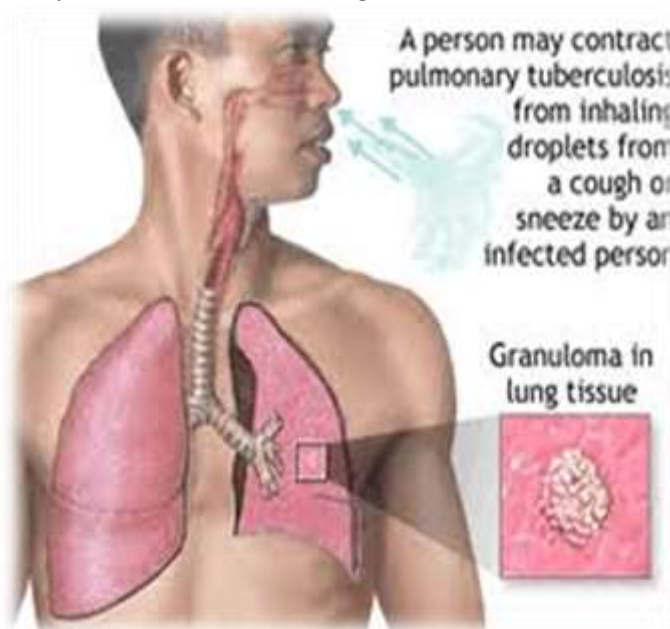
- In active TB, the infection can spreads to other parts of the body, including brain, bones, stomach etc.
- Extra-pulmonary TB is common among immunosuppressed persons, that is people with weakened immune system and young children.
- All types of TB are curable; treatment period differs on how each patient responds.
- If treatment is incorrectly taken, then the TB germ becomes stubborn and develops into multiple drug resistant TB MDR-TB.

Diagnosis of TB

1. Microscopic sputum analyses or cultures can find TB bacteria in the sputum.
2. Chest x-rays and computer tomography (CT) scans are also used to diagnose TB.- If the immune system traps the TB bacteria and creates scar tissue, this tissue and the lymph nodes may harden like stone in a calcification process. This results in granuloma (rounded marble –like scars) that often appears on x-rays and CT scans.
3. Blood test may also be used to determine whether TB is active or inactive
4. Skin test- the person is injected into the forearm and after 48 to 72hrs a doctor /nurse looks for a reaction at the injection site, a hand raised red bump usually indicates a positive test for TB.

Modes of Transmission

- ✓ TB spread through tiny droplets of infected sputum that travel through the air from an infected person to a vulnerable person like the common cold.
- ✓ If an individual with active TB cough or sneezes without covering the mouth and nose, droplets containing the tuberculosis germs are sprayed into the air and may be inhaled by anyone near the person and become infected.
- ✓ People with TB of the lungs are most likely to spread bacteria to those with whom they spend time with, like family members, friends and colleagues.
- ✓ When a person breathes in TB bacteria, the bacteria settle in the lungs.
- ✓ If that person's immune system is compromised, or becomes compromised the bacteria begin to multiply.
- ✓ From the lungs they can move through the blood to other parts of the body e.g. kidney, spine and brain.
- ✓ TB in these other parts of the body is usually not infectious



How can TB be prevented

Personal hygiene is very important in preventing TB, such as:

- ✓ Use a tissue when coughing (cover your mouth)
- ✓ Wash your hands properly
- ✓ Opening windows for fresh air to circulate (proper ventilation)
- ✓ Eating healthy diet that supports the immune system
- ✓ Getting a TB test regularly if you work, live in high risk environment
- ✓ Finishing TB medications
- ✓ Children to receive BCG treatment
- ✓ Using medication as a preventive measure in high risk cases.
- ✓ Support people who are taking treatment to ensure compliance and increase cure rate.
- ✓ The TB vaccine, (BCG) is given to children after birth to prevent TB including TB meningitis.

Treatment for Latent TB Infection and Active TB Disease

- ✓ If a person has latent TB infection but not TB disease, the health care provider may offer them treatment to keep them from developing TB disease.
- ✓ Treatment of latent TB infection reduces the risk that TB infection will progress to TB disease.
- ✓ Treatment of latent TB infection is essential to controlling and eliminating TB. The decision about taking treatment for latent TB infection will be based on a person's chances of developing TB disease.
- ✓ TB disease can be treated by taking several drugs, usually for 6 to 9 months.
- ✓ It is very important to finish the medicine, and take the drugs exactly as prescribed.
- ✓ If treatment is stopped before time, or not taken properly one can become sick again and resistant TB germs grow, then a person develops MDR-TB or XDR-TB

What is MDR-TB?

- ✓ MDR-TB is a form of TB that does not respond to the standard 6 month treatment using first line drugs (i.e. resistant to isoniazid and rifampicin).
- ✓ It can take 2 years to treat with drugs that are more expensive and more toxic.
- ✓ If these treatment is not taken properly, TB develops into XXDR-TB due to resistance

What causes MDR-TB?

Drug resistance is more common in people who:

- ✓ Spent time in the presence of someone with MDR-TB
- ✓ Do not take their TB medication regularly
- ✓ Take the wrong dose of their TB medication
- ✓ Take treatment with alcohol

Can MDR-TB be cured?

- ✓ Yes, MDR-TB is curable if treatment is taken as prescribed and the course is completed.
- ✓ Treatment for MDR-TB takes longer period and could have more side effects.
- ✓ If treatment is not taken properly, one can develop XDR-TB.

What is XDR-TB?

- ✓ XDR-TB is due to bacteria that are resistant to commonly used for MDR-TB. Because XDR-TB is resistant to first- and second-line drugs, treatment options are seriously limited and so are the chances of cure.
- ✓ XDR-TB also spread through air, and can be difficult to treat, but it is curable.

Can XDR-TB be cured?

- ✓ Several countries with good TB control programmes have shown that up to 50-60% of affected people can be cured.
- ✓ Successful treatment also depends greatly on the extent of the drug resistance, the severity of the disease and whether the patient's immune system is compromised.

TB Risk Factors

A number of factors make people more susceptible to TB infections. This is a particular problem in sub-Saharan Africa, where rates of HIV are high. Once a person is infected with TB bacteria, the chance of developing TB disease is higher if the person:

- ✓ Has HIV infection;
- ✓ Has been recently infected with TB bacteria (in the last 2 years);

- 
- ✓ Has other health problems, like diabetes, that make it hard for the body to fight bacteria;
 - ✓ Abuses alcohol or uses illegal drugs; or
 - ✓ TB treatment was not taken correctly in the past.
 - ✓ Inhabitants and employees of locations where vulnerable people gather (e.g. prisons and homeless shelters), medically underprivileged and resource-poor communities, high-risk ethnic minorities, children in close contact with high-risk category patients, and health care providers serving these patients.
 - ✓ Those who smoke cigarettes have nearly twice the risk of TB than non-smokers.
 - ✓ Tuberculosis is closely linked to both overcrowding and malnutrition, making it one of the principal diseases of poverty.

Key Messages:

- **TB and HIV form a deadly duo that is known to kill most HIV positive persons**
- **TB is preventable**
- **TB is curable**
- **TB treatment is for 6 months**
- **Adherence is crucial not adhering leads to the possibility of TB becoming resistant to treatment**

Sexual and Reproductive Health

Sexual and Reproductive Health is a broad concept that considers a person's health and well-being in sexual relations, pregnancies and births. It is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity.

Sexual health includes

- Positive and respectful approach to sexuality and sexual relationships,
- Having pleasurable and safe sexual experiences,
- Sexual activity that is free from coercion, discrimination and violence.
- Respect and protection for one's sexual rights

Whilst the areas of sexual reproductive health are broad, for the purposes of this manual we will consider sexual and reproductive health in relation to

- a. The basics sexual anatomy
- b. Family planning and contraceptives
- c. Maternal Health
- d. Sexually Transmitted Infections
- e. Cancer Screening

When dealing with these issues one needs to consider the appropriate social and cultural mores that dictate the manner in which sexual issues can and should be discussed. Luckily, peer educators and trainers would be familiar with the communities that they work in and would be sensitized to these cultural conventions.

A. The basic sexual anatomy

In order to understand sexual reproductive issues we first need to consider the male and female reproductive systems.

Male reproductive system

Several different organs and structures make up the male reproductive system. These include the testes, where sperm is made, several ducts (tubes) where sperm is stored, and the penis. Also included in the male reproductive system are the accessory sex glands, which include the prostate gland and seminal vesicles. These glands make special fluids known as semen, which are added to sperm as it travels through the ducts. The organs and structures of the male reproductive system give men the ability to fertilize a woman's ovum (egg) to produce a baby.

The Pubic Area

This is the area below the tummy and between the upper ends of the groins; hair grows on it from the time of puberty. If not kept clean the pubic area can keep lice (pubic lice).

The Groins

These are the spaces on either side, between the pubic area and the upper part of the thighs. The two folds of skin can become moist or wet from sweat or water if not dried properly after washing the body and this causes unpleasant smell. The groins have glands which can hardly be felt with fingers when there is no infection.

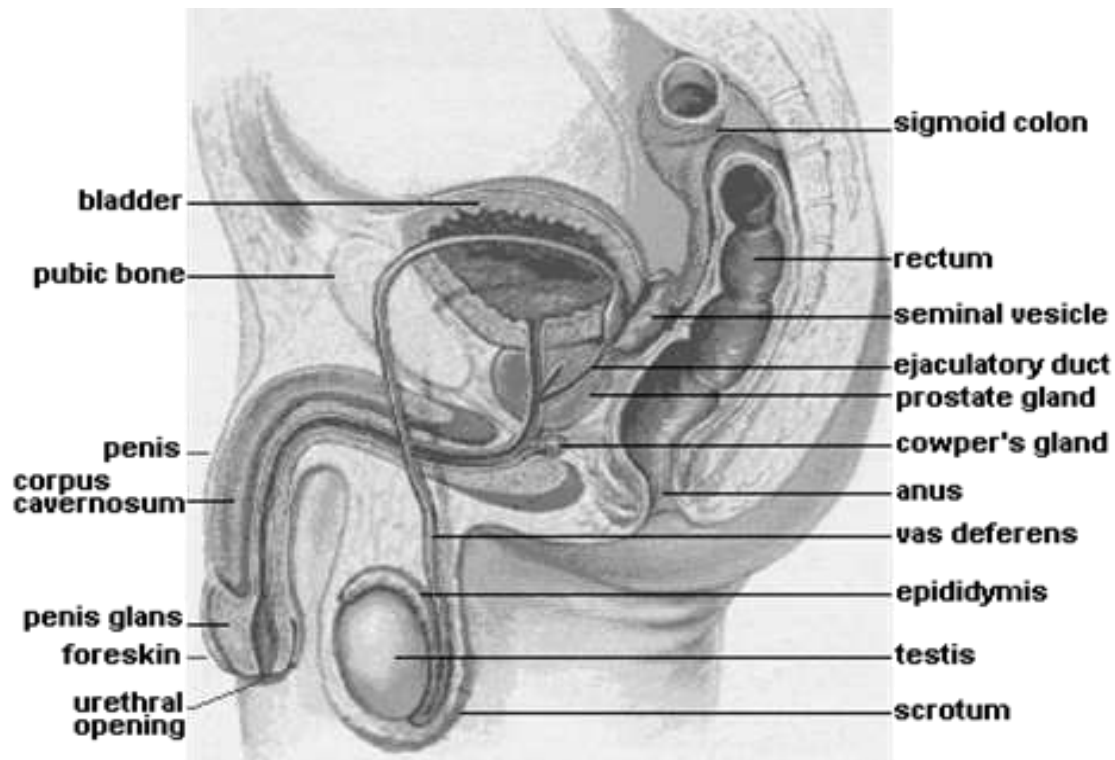


Figure 12: Organs that makes up the Male Reproductive System

The Penis

The penis is the part or organ which hangs from the pubic area. It is spongy and very rich in blood supply and nerves. The penis is very sensitive, it has erectile tissue which makes it firm or erect when aroused for sexual intercourse and also when a man passes urine. The tip of a penis is covered by a foreskin, which should be pulled back to prevent collection of germs. There are three main parts of the penis, the root, body and glands. The root is the part attached to the lower abdomen. The body of the penis is made up of a spongy type of tissue, which swells when blood enters during an erection. The glands is the slightly larger area towards the end of the penis and contains the opening of the urethra. The penis contains the urethra, which passes both urine and semen.

The Urethra

The urethra is an opening in the middle of a penis, It is the passage for semen (which contains sperm) when a men ejaculates during sexual intercourse. It also serves as a passage for urine from the bladder during urination. If there is infection due to an STI, urination is painful or difficult. The urethra can become blocked from repeated infections and will prevent the passage of sperm causing infertility.

The Testis

These are two pouches on either side of the penis which contain the sperm. When the testis is infected due to STIs they are painful when they are touched.

The Scrotum

The scrotum is made up of pouches or sack which contains testis.

What does the male reproductive system do?

Its main function is to give men the ability to fertilize a woman's ovum by producing and delivering semen. The testes also make hormones which help men develop the characteristics associated with being male. This includes the distribution of pubic hair, enlargement of the penis and deepening of the voice.

The female reproductive system

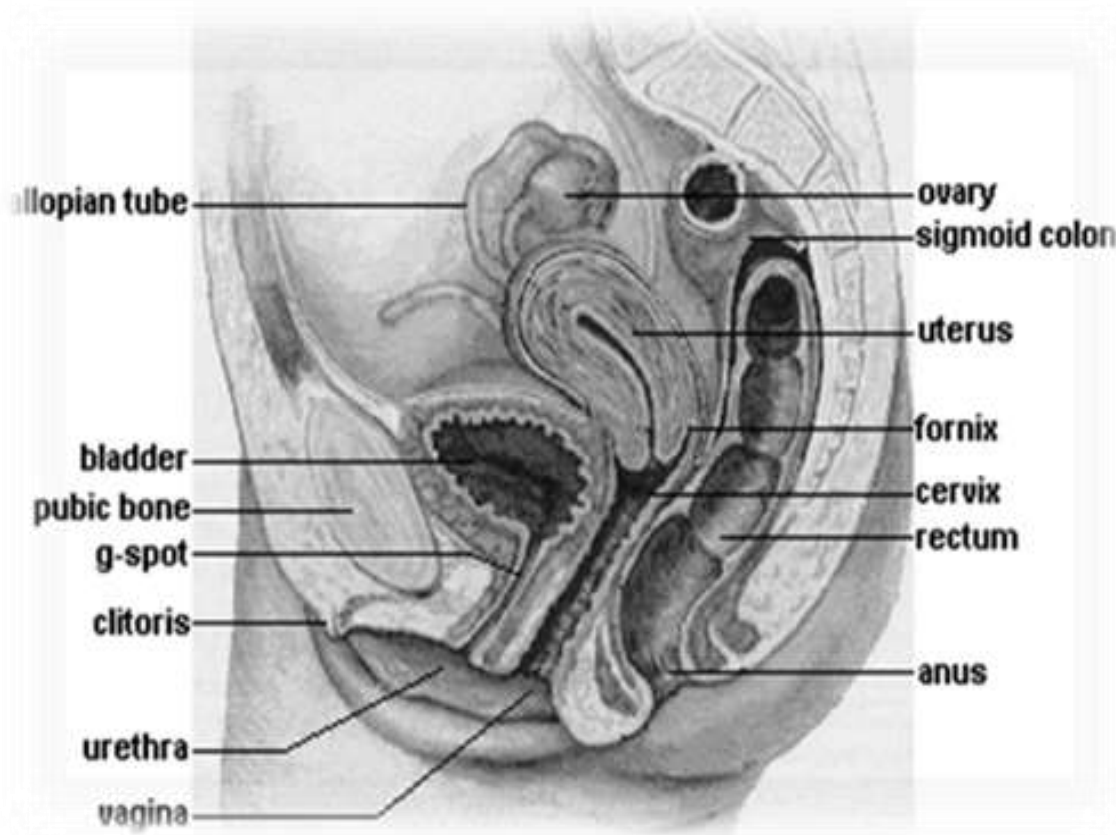


Figure 13: Organs that makes up the Female Reproductive System

The pubic area

This is the area below the tummy and between the upper ends of the groins; hair grows on it from the time of puberty. If not kept clean the pubic area can keep lice (pubic lice).

The Groin

These are the spaces on either side, between the pubic area and the upper part of the thighs; the two folds of skin can become moist or wet from sweat or water if not dried properly after washing the body. This causes unpleasant smell. The groins have glands which can hardly be felt with fingers when there is no infection

The Vulva

The external female genitalia are referred to as vulva. It consists of the labia majora and labia minora (while these names translate as "large" and "small" lips, often the "minora" can protrude outside the "majora"), mons pubis, clitoris, opening of the urethra (meatus), vaginal vestibule, vestibular bulbs, vestibular glands.



The Vagina

This is a hollow muscular passage which leads from the vulva to the cervix; it receives the male's erect penis and sperm from the penis during intercourse. It is a passage for menstrual blood during the time of puberty and also for the baby during delivery. The vagina has a small membrane, the hymen, which gets broken at the first sexual intercourse. The vaginal wall secretes mucus which makes it moist and kills germs; the mucus has no colour or smell. Pushing herbs, paper or other things into the vagina for the purpose of having dry sex will interfere with its normal working. This might result in infection since friction will cause lacerations through which STIs or HIV can enter.

The Urethra

This is an opening below the clitoris and it serves as a passage for urine from the bladder. Although it is not related to sex or reproduction, it is included in the vulva. Because the urethra is so close to the anus, women should always wipe themselves from front to back to avoid infecting the vagina and urethra with bacteria.

The Perineum

The perineum is the short stretch of skin starting at the bottom of the vulva and extending to the anus. It is a diamond shaped area between the pubis and the coccyx. This area forms the floor of the pelvis and contains the external sex organs and the anal opening. It can be further divided into the urogenital triangle in front and the anal triangle in back. The perineum in some women may tear during the birth of an infant. Some physicians however, may cut the perineum pre-emptively on the grounds that the "tearing" may be more harmful than a precise cut by a scalpel, that cut is called an episiotomy.

The Cervix

This is a narrow outlet from the vagina to the uterus. It is sometimes referred to as the mouth or neck of the uterus. It also secretes a fair amount of mucus. When there is infection, the cervix is very painful when touched or during sexual intercourse.

The Uterus

This is a hollow muscular organ which carries the baby during pregnancy. The **uterus** is shaped like an upside-down pear, with a thick lining and muscular walls. Located near the floor of the pelvic cavity, to implant and grow. It also allows for the inner lining of the uterus to build up until a fertilized egg is implanted, or it is sloughed off during menses.

The uterus contains some of the strongest muscles in the female body. These muscles are able to expand and contract to accommodate a growing foetus and then help push the baby out during labour. These muscles also contract rhythmically during an orgasm in a wave like action. It is thought that this is to help push or guide the sperm up the uterus to the fallopian tubes where fertilization may be possible.

The Ovaries

These are two organs, one on each side of the uterus; they produce eggs from the time of puberty till menopause.

The Fallopian Tubes

The tubes are found on each side of the uterus, their hollow passages carry the eggs from the ovaries to the uterus. When infected, the ovaries and tubes can be very painful if pressed from the outer abdomen. Infection causes lower abdominal pain and difficult, painful urination.

Differences between male and female reproductive systems

The differences between the female and male reproductive systems are based on the functions of each individual's role in the reproduction cycle.

MALE	FEMALE
Male has testes The males have sperm cells Males cannot get pregnant Males has breasts that don't produce milk	Female has ovaries The Females have the egg cells Females can get pregnant Females have breasts that produce milk
Produce the sperm to fertilize the egg and make the baby	Female reproductive organs are able to release eggs and once fertilized can grow and birth a baby
Males carry androgens and testosterone hormone Males produce about 300 million sperm on average a day	Females carry oestrogen and progesterone hormone Females have one (sometimes two) egg per month
Much of a man's is outside of the body. The man only has one opening to let out urine and semen Men make new sperm regularly	All of a woman's reproductive system is inside of the body A woman has separate openings for urine, and another menstruation and sexual intercourse Women have eggs already stored in the ovaries at birth, and the eggs are released every month
The male system does not require regular maintenance Male system has been developed to insert gametes	The female reproductive system requires a monthly period to renew the lining of the womb Female system has been evolved to receive the best gamete for fertilization.

Adolescents and reproductive health

More than half the world's population is young people under the age of 25, and a significant number of adolescents are sexually active. Adolescent" means a person, who has completed his or her fifteenth year of age but has not completed their eighteenth year (15-18years). From birth through childhood and adulthood, young people need effective services and information to enable them to lead healthy productive lives. While people of all ages should maintain good health, young people face special challenges, during the transition from childhood to adulthood.

Challenged facing young people

With the onset of puberty, the body changes to accommodate physical and emotional growth, but it also marks one of the most vulnerable stages in a young person's life. During this time, females tend to struggle more than males with body image and self-esteem issues, which can lead to dangerous eating disorders and even death. On the other hand substance abuse, depression, self-mutilation and suicide rates are higher in males than females and if left untreated these health concerns may lead to permanent mental and physical damage.

Some of the challenges faced by adolescents include

- ✓ Lack of information misinformation on sexual and reproductive health and their rights
- ✓ Negative influence by peers
- ✓ Peer pressure to experiment with sex
- ✓ Negative attitude by health providers
- ✓ Limited access to adolescent health services (inflexible clinic times, distance, etc.)

Possible solutions to identified challenges

- ✓ Promoting gender equality and empowerment of women and girls
- ✓ Advocating for adolescent friendly health services (clinic times, adolescent specific health talks)
- ✓ Partnership with community based organizations that support youth and adolescent health

B. Family Planning and contraceptives

Family planning is considered an important part of maternal health and healthy families. Through the use of contraceptives a woman is able to ensure that she gives birth at the healthiest time in her development (i.e. not too early or too late) which would reduce the chances of maternal death or disabilities for the infant and the mother. International data suggests that siblings that are born 3 to 5 years apart have twice as much chance of reaching their fifth birthday (Roudi-Fahimi and Ashford 2008).

C. Childbirth

Although there appear to be slight disagreement about the age range of when a woman is developmentally best equipped to have a child it appears that the ages ranging from 20 to 35 is the most recommended. However the ages ranges are based on a woman's biological development and do not consider the emotional or social development.

Age 20-29

During these years a woman is considered to be in her most fertile years. In addition a young mother may have vast reserves of energy to draw upon to complete childrearing activities and running after toddlers. Rates of miscarriages and babies born with disabilities and birth defects are considered the lowest for this age group. Emotionally, a woman of this age may have less life experience to draw on

Ages 30 -39

Women aged between 30 – 39 may experience a drop in fertility levels, especially after 38, and bio-medical support to increase conception may be required, e.g. invitro-fertilization. At this age it also appears that caesarean sections are more common than in younger ages. High blood pressure and gestational diabetes becomes more of a risk as well. Global trends suggest that more and more women begin families in this age range due to focusing on education and career goals. Emotionally, these women may feel more ready to start a family. On the negative side there is a slight increase in the chances of having miscarriages or birth defects.

Ages 40 and above

The chance of falling pregnant during this age drop dramatically but it is still possible. How well the baby is carried to term and delivered depends on the mother's general health and whether it is the mother's first baby. Miscarriages are more common with 1 in 3 pregnancies ending in this manner. Child birth abnormalities are their highest at this age, and as a result screening for Down's Syndrome and chromosomal abnormalities are routinely offered. Emotionally, women of this age group have a wealth of life experience to draw upon and tend to be more financially stable.

D. Contraceptives

Contraceptives are a means of birth control that do not prevent STIs, with the exception of male and female condoms. Some of these methods have been around for centuries and some have been developed recently.

The withdrawal method

This method of trying to prevent pregnancy whereby the male withdraws before ejaculation is not effective. This is because semen which contains the sperms is released in the pre-cum, which happens before ejaculation. Although it may reduce the chances of conception, it is not fool proof.

The rhythm method

The rhythm method requires knowledge of a woman's menstrual cycle and period of ovulation. Ovulation is the period when the egg is released into the uterus and is ready to be fertilized by sperm. The idea here is to avoid having sex during ovulation and thereby reduce the chances of conception. However, knowledge of the ovulation period in many communities is very poor. For instance, findings from Tanzania show that only 20% of women and 14 % of men could correctly identify the ovulation period.

The pill

These can usually be accessed from local clinics and pharmacies. This set of tablets helps to regulate the woman's hormonal cycle and thereby prevent ovulation.

Injections

Depo-Provera is synthetic progestin that is injected every three months. This injection prevents ovulation and the thickening of the cervical mucus and thereby prevents pregnancy.

The Intrauterine Device or IUD

The IUD is a small piece of plastic that is inserted by a medical practitioner. The device causes slight inflammation in the uterus to which the body responds. This response immobilises or destroys any sperm that may be present.

The diaphragm

This is a dome-shaped thin piece of rubber that women insert into the vagina. This dome covers the cervix and prevents sperm entering the uterus.

The condom

Available in male and female condoms, these are the only contraceptives that prevent both pregnancy and the spread of STIs (including HIV). These preventative methods have been described above.

E. Maternal health

During pregnancy regular visits to antenatal clinics is crucial in assessing and maintaining the health of the pregnant women and her growing child. Trends from Tanzania suggest that it is common for most pregnant women to source antenatal care during their pregnancy (96%). Of this care most is provided from a nurse or mid-wife (79.5%). Generally, women should start to attend antenatal clinics at about 4-5 months of the pregnancy (49% of first visits occur at this stage).

The process of care ensured that 58.9% of pregnant women received iron supplements, 67.7% took anti-malaria tablets, 52.9% were informed about the signs and symptoms of pregnancy including the

complications that could occur, 51.8% had urine samples taken, 76.6% had bloods taken, 47.6% received two or more neonatal tetanus injections within the last 5 years. Interestingly within Tanzania more women delivered at home (58.5%) than within public sector health facilities (40.5%). After birth care is also important for the development of the child with most women seeking this care a few hours after birth. There are of course obstacles that can arise to stop women from seek out this initial visit as well as follow up visits. Some of the most common obstacles that women face include: lack of money for the treatment (24.1%) and the distance of the health care facility (19.2%).

F. Sexually Transmitted Infections (STIs)

Sexually transmitted infections (STIs) are infections that are passed from one person to another through unprotected sex. Women can pass the infection to their babies during pregnancy or birth. STIs can be prevented and most can be completely cured in women and men of all ages. Common STIs include; chlamydia, gonorrhoea, syphilis, HIV, genital herpes and Human Papilloma Virus (HPV). Some STIs hide in the body and cause health problems; especially in women and can be passed to another person during unprotected sexual intercourse. The early identification and treatment of STIs, other than HIV, is a key factor in prevention of HIV. STIs usually not only provide entry points for the virus into the body but they also attack the immune system's response and resources thereby weakening the immune systems response to HIV.

Very often a person has more than one STI at a time, which may show in the following ways

- ✓ **SORE** on the penis, vagina or anus, this can be painful or painless.
- ✓ **PAIN or discomfort:** Lower back, when passing urine or during sex
- ✓ **SMELL:** smelly discharge from the penis or vagina or anus
- ✓ **DISCHARGE:** From the anus, vagina or penis, this can be thick or watery
- ✓ **Intense itching,** and redness may occur if one has pubic lice

It is important to visit a clinic or doctor with your partner, whenever one experiences any of the above signs.

¹ UNAIDS and the World Health Organization (WHO)

Name of STI	Mode of spread	Signs and Symptoms	Is it Curable	Complications
Genital herpes	Unprotected sexual contact including oral sex with an infected person, even if they don't have a sore	Small red bumps, blisters or open sores on vagina, rectum, penis or mouth. Pain when urinating Headaches Muscle pains Vaginal discharge Itching, burning or swollen glands in genital areas Pain in legs, buttocks or genital area	No cure But can be managed	Miscarriages Baby can be infected
Chlamydia	Unprotected sexual contact through anus, penis, vagina, mouth or throat, even during masturbation	Smelly, thick vaginal discharge Burning urination Bleeding between periods	Yes, both partners must take and complete treatment Babies must be screened and treated at birth	Infertility in men & women Ectopic pregnancy Feeling like vomiting Fever Pain during sex Pelvic inflammatory disease, leading to long term pelvic, abdominal & abdominal pains Babies: Eye or lung infection

Name of STI	Mode of spread	Signs and Symptoms	Is it Curable	Complications
Gonorrhoea	Unprotected sexual contact through anus, penis, vagina, mouth or throat, even during masturbation Mother to child transmission	Burning urination White /yellow / green discharge from penis Burning urine Discharge from penis or vagina Anal itching, pain or bleeding Sore throat Men: Painful or swollen glands penis, swollen testicles Women: often have no signs or symptoms Bleeding between periods,	Is it treatable	Infertility in both men and women, if untreated May destroy bones and tooth Bad abdominal pains, fever If untreated, it can spread to joints and blood and can be life threatening
Human papillomavirus (HPV)	Unprotected sex Through skin contact Mother to child transmission	Often unnoticed Sores on mouth and throat Genital, throat, cervical warts	Not curable but related health problems can be treated	Cancer of the vulva, vagina, penis, anus, head & neck cancer tongue & tonsils
Syphilis	Sexual contact with infected person From infected mother to baby	Primary stage Single or many firm, round, painless sores Secondary stage Skin rashes in hands, skin, mouth, vagina, anus Swollen glands, sore throat, patchy hair loss, headaches, weight loss, muscle pains and unexplained tiredness The signs may go without treatment	Yes	Latent stage Starts when primary & secondary signs disappear. If no treatment is taken, Muscle pains and weakness, Paralysis Loss of sensation Gradual blindness and memory loss Damages to internal organs: Brain, nerves, eyes, heart, blood vessels. Liver, bones, joints & can lead to death. Premature birth, Still birth Low birth weight of infected babies Cataract, deafness & fits or even death
Trichomoniasis	Unprotected sexual contact with infected person	Irritation or itching of vagina, anus and penis Burning urination or post ejaculation Smelly discharge, can be clear, yellow, white or greenish Redness, pain of vagina, penis or anus		Premature birth, Still birth Low birth weight of infected babies
Chancroid	Unprotected sexual contact with infected person No history of passing to babies during pregnancy or child birth	Painful bumps on penis, anus or vagina Men: tip of penis, scrotum, urethra Sore may have pus Pain in the genitals and groin. Women: Painful, bumps in the genital area that can develop into open sores, swollen lymph nodes in the groin.	It is curable Large glands may require operation	Glands may burst if left untreated Abscesses Destruction of genital or anal tissue
Pubic lice	Close body contact, most commonly	Intense itching, tiny eggs attached to pubic hair,	Yes, cutting pubic hair	Sores and irritation, which can open way for HIV infection

Name of STI	Mode of spread	Signs and Symptoms	Is it Curable	Complications
	sexual contact.	Itching in affected areas Irritation in the affected areas caused by scratching black powder in your underwear blue- coloured or blood spots or on skin, thighs or lower abdomen caused by lice bites	completely will aid treatment success	and other STIs

STIs and HIV

- ✓ Presence of an STI indicates that a person has been involved in unprotected sexual intercourse, with a person that has an sexually transmitted infection, this on its own is a risk factor for HIV infection. The presence of an STI stimulates the immune system, which increases the presence of white blood cells in the genital or affected area, making the transmission of HIV easier. White blood cells are the cells that HIV attaches to and attacks.
- ✓ STIs also require an immune response this can strain the immune system and weaken its effectiveness. Having a weakened immune system means that any infection is likely to be worse. This means more breakouts, more severe symptoms, longer treatment and other complications. For these reasons it is important to get STI treatment as soon as possible (for both HIV positive and HIV negative people).

Key Messages:

- The early detection and treatment of STIs is best
- Early treatment reduces the chances of HIV infection
- Early treatment aids the immune system's health

Key Populations

For the purposes of this manual the following populations have been identified as populations at risk of contracting HIV

- ✓ Young women between 15-24
- ✓ People living and working along the transport corridors
- ✓ People living in informal settlements
- ✓ Migrant populations
- ✓ Young people not attending schools
- ✓ People with the lowest economic status
- ✓ Uncircumcised men

Within Sub-Saharan Africa it is recognised that the spread of HIV is mainly through heterosexual intercourse, Internationally there are groups that have been identified as key populations that are vulnerable to HIV and AIDS and these can be divided into two groups, key populations at risk due to increased risk of infection and those that are at risk due to the effects of HIV and AIDS.

Key populations at risk due to increased risk of infection

Sex Workers and their clients

It appears difficult to obtain definitive evidence of the population sizes of this group. Some of the local evidence suggests that these groups are not contributing significantly to the spread of the epidemic, it should be noted this profession by its very nature is a high risk occupation. Anecdotally, we frequently hear that people are drawn into this profession through poverty and that more income is received if no condoms are used. Luckily other anecdotal evidence suggests that there are places where it is known that sex work occurs with condoms.

Incarcerated persons

Prisoners are also another vulnerable group where little work has been conducted. It is estimated that approximately 45 000 people move in and out of prisons each month in South Africa. This combined with high levels of sexual assault and the lack of condoms or other services, e.g. PEP make these an area that can accelerate the spread of HIV, other STIs and TB.



Military members

Military personnel are considered a high risk group. For example in Mozambique, 48,7% of the blood donors who were in the military were found to be HIV positive³⁷.

Persons with disabilities

Persons with disabilities tend to be vulnerable due to their mental and/or physical disabilities. They may also experience stigma and discrimination, further marginalising this group and making the more vulnerable. Additionally, often persons with disabilities have difficulty in accessing support structures and due to lack of skills they have difficulties in finding work and are further economically disempowered³⁸.

Men who have Sex with Men

Men who have sex with men are considered a risk group because of the nature of some of the sex acts, e.g. anal sex increases the risk of infection due to friction that is caused as a result of the lack of lubrication on the anus. Additionally, these relations may be considered culturally inappropriate or abhorrent, resulting in such groups living in secrecy to avoid stigma and discrimination. As a result of this isolation, even though this group may be involved in risky sex that requires protection, they may not access services.

Intravenous Drug Users

It is well known that HIV can be easily passed through blood and blood products. Intravenous drug users who share needles are at high risk of contracting the virus. Due to the nature of the drugs as well as its legal standing of these practices the chances of seeking out health care services is lowered.

Key population at risk due to the effects of HIV and AIDS

Orphan and Vulnerable Children

Children can be severely affected by HIV and AIDS if they lose one or both of their parents. . In certain areas child-headed households are common, where young children are looking after their siblings, with little or no support from their surrounding communities. These children become further vulnerable if they drop out of school and lack social protection. Governments, NGOs and other civil society organisations seek to capacitate communities and families to support these children. At times this is through direct financial support, e.g. child grants or through more indirect methods of capacitating and providing resources to social services sectors to aid these children.

³⁷ National AIDS Council Mozambique (2009) National Strategic HIV and AIDS Response Plan, 2010 - 2014.

³⁸ Zambian National HIV/AIDS/STI/TB Council (2010) National AIDS Strategic Framework 2011 - 2015



PART 4: WHAT CAN ENTREPRENEURS DO?

HIV is a reality that individuals, families; communities and countries have to deal with. Some businesses have been closed because of lost productivity as a result of owner or employees who take ill for long periods or even die due to AIDS related conditions. Every business owner should consider what would happen to the business or property should they be sick for a long time or die?

This section considers some tools that entrepreneurs and employers can use to address HIV in the workplace. The first section considers some of the policies that can be used to effectively reduce the impact of HIV and AIDS on the workplace. The policies relating to wellness, stigma and discrimination, and maternal protection are discussed. This is followed by a step-by-step guide to develop these policies. The second section explores peer education as a tool that can be incorporated into businesses, while the last section shares a tool for assessing the costs of HIV and AIDS on a business – this tool would help to develop intervention programs including appropriate referrals.

A. POLICIES AND FRAMEWORKS

HIV poses various challenges to humanity, development and the economy, promoting a need for a multidimensional response at global, regional, national and local levels. Development and health activists among the United Nations agencies, including the International Labour Organization (ILO) organized global, regional and national meetings to generate debate, consensus and frameworks that guide how policy makers and promoters, program planners and implementers should respond to the challenges posed by the HIV and AIDS epidemic. This part will focus on these key frameworks and policy documents

- A. HIV and AIDS as a Human Rights Issue
- B. Millennium Development Goals
- C. The Decent Work Agenda in Africa 2007-2015
- D. The ILO's response to addressing HIV and AIDS
- E. The World Health Organization's Guidelines on HIV and AIDS
- F. Getting to Zero Strategies (UNAIDS)
- G. A Summary of the 6 CEEP Country's National Frameworks

A. HIV AND AIDS: A HUMAN RIGHTS FRAMEWORK

One of the most fundamental frameworks that underlie the thinking behind policy development and intervention strategies that the ILO draws upon is human rights. Addressing HIV challenge requires recognition, respect and protection of human rights; these issues will be explored in this section.

The Core Human Rights in relation to HIV

People infected by HIV or affected by AIDS also have rights, including the right to respect, be treated with dignity and their affairs be kept confidential. They also have the right to access services for HIV treatment, care and support, to be employed and benefit from all conditions of service like all other workers. The Core Human Rights applied to HIV include the:

A. Right to be free from discrimination

- ✓ The state has a duty to include HIV in all anti-discriminatory laws, addressing the needs of those infected, affected, or vulnerable to HIV so that they are not disadvantaged.
- ✓ Each state has to protect groups particularly vulnerable to HIV such as women, children, gay men, intravenous drug users and sex workers.
- ✓ Violations of these rights are rife, e.g. some countries prohibit people living with HIV from entering their territory (e.g. China, Dubai and until recently USA).

B. Right to privacy

- ✓ Information on HIV status is confidential, medical records can only be shared with consent, HIV testing needs to be anonymous and voluntary.

C. Right to health

- ✓ PLHIV have a right to access health services, including GPs, dentists, family planning and sexual health services etc.
- ✓ Everybody has a right to access confidential and anonymous HIV testing,
- ✓ Women living with HIV have a right to access support and care to prevent mother-to-child transmission.
- ✓ Prisoners are entitled to the same level of prevention and care that people in the general population have (condoms, clean needles, ARVs),

D. Right to be free from inhumane and degrading treatment

- ✓ Advocates have been using this article to support the claims of HIV positive asylum seekers, who would get sick and die if deported to countries where they will not be able to access ARVs and/or where they will not be able to receive appropriate support and care.
- ✓ However as treatment has been made more available in developing countries many of those claims have been refused, even if ARV supply in their countries is not sustainable.

E. Right to life, liberty and security of person

- ✓ This is another right to protect people living with HIV from being forcefully isolated (e.g. quarantine).
- ✓ It also reinforces the duty of the state to provide appropriate treatment, prevention and care to everybody with HIV or vulnerable to HIV.

F. The right to marry and have a family

- ✓ This is an important right for people with HIV and one which is often violated.
- ✓ Women living with HIV around the world have been pressurized to have abortions or even sterilized without their consent.
- ✓ The state has a duty to provide access to HIV friendly reproductive services including: assisted conception, adoption and fostering.
- ✓ Integration of HIV services and the provision of sexual health and reproductive services are based on human rights and has been a priority on the advocacy agenda of HIV positive women activists for a long time.
- ✓ It is extremely important that we, people living with HIV, are aware of how the Human Rights Acts protect us and that it should not be taken for granted.

HIV and AIDS and Human rights themes

In summary the following themes can be highlighted between human rights and HIV and AIDS interventions and policies

- ✓ Awareness and respect of human rights by individuals and communities through education, free association, information and, creation of a non-discrimination environment.
- ✓ A non-discriminatory environment will lead to:
 - Protection of rights of people living with HIV,
 - Reduction of impact of HIV and AIDS on individuals and societies.
 - Creation of a supportive environment for those living with HIV,
 - Treat everyone with dignity and respect thus encouraging everyone to go for HIV testing.
 - Those who test positive to go for treatment, care and support and taking responsibility to avoid reinfections and infecting others, thus reducing the impact of HIV on themselves and in society.
- ✓ The protection and promotion of human rights is key to preventing the spread of HIV and mitigating the social and economic impact of the pandemic and enhancing effective HIV response through:
 - Reduction of HIV infection vulnerability by addressing the root causes and reducing the impact on those infected and affected by HIV.
 - Recognising that individuals and communities have greater ability to respond to the pandemic.
 - Stipulated international response grounded on the respect for all civil, cultural, economic, political and social rights and the right to development, in accordance with international human rights standards, norms and principles.



States are obliged to promote and protect HIV-related human rights as defined in existing international treaties, which include:

- a) **Non-discrimination:** Protection against discrimination people that seek help;
- b) **Right to privacy:** Protection against mandatory testing; HIV status must be kept confidential;
- c) **The right to liberty and freedom of movement:** Protection against imprisonment, segregation, or isolation in the family, community, at work or in a health facility;
- d) **Right to information and education:** To access information or education or training on sexual and reproductive health and on HIV prevention and management;
- e) **The right to Health:** access to health care services, including for sexually transmitted infections, TB, voluntary counselling and testing, P MTCT, MMC and male and female condoms.

Violations of human rights worsen the burden caused by HIV and AIDS:

- ✓ The lack of respect for human rights fuels the spread and increases the impact of the disease, while at the same time HIV undermines progress in the realisation of human rights,
- ✓ Disproportionate incidence of HIV among certain groups, especially the poor, women, girls and children due to, social, legal and economic conditions is as a result of lack of respect for human rights,
- ✓ HIV, AIDS and poverty worsens the socioeconomic conditions of the poor in many developing countries leading to increased vulnerability, stigma and discrimination and ineffective response to the epidemic.

Increased vulnerability to HIV infection

- ✓ Certain groups are more vulnerable to contracting the HIV virus because they are unable to realize their civil, political, economic, social and cultural rights. e.g. people with low literacy level or limited access to services like self-help groups,
- ✓ Women and young girls are more vulnerable to infection if they lack of access to information, education and sexual and reproductive health and prevention services.
- ✓ Women have limited capacity to negotiate safer sex.
- ✓ People living in poverty are often unable to access HIV care and treatment, including anti-retroviral and other medications for opportunistic infections.

Discrimination and stigma and HIV

- ✓ The rights of people living with HIV often are violated because of their presumed or known HIV status, causing them to suffer both the burden of the disease and the consequential loss of other rights.
- ✓ Stigmatisation and discrimination may obstruct their access to treatment and may affect their employment, housing and other rights.
- ✓ This, in turn, contributes to the vulnerability of others to infection, since HIV-related stigma and discrimination discourages individuals infected with and affected by HIV from contacting health and social services.
- ✓ The result is that those most needing information, education and counselling will not benefit even where such services are available.

Stigma and discrimination impedes an effective response

- ✓ Human rights violations make it difficult to address the epidemic, e.g. discrimination against and stigmatization of vulnerable groups such as injecting drug users, sex workers, and men who have sex with men leads to shame, regrets, isolation and inability to access social and health services by affected people.
- ✓ Fear of real or perceived stigma discourages people living with HIV to seek health and other services, which increases their vulnerability to HIV and negative AIDS impact.

- 
- ✓ When PLWHIV don't access education and information about HIV, or treatment, and care and support services further fuels the AIDS epidemic.
 - ✓ The successful HIV and AIDS response requires an environment where human rights are respected at all times.

Promoting non-discrimination in the workplace

- ✓ In 2001 governments, employers and workers agreed on the ground-breaking Code of Practice on HIV/AIDS and the World of Work.
- ✓ The Code of Practice has been translated into 58 languages, and ILO, together with other partners, continue to provide technical assistance to ILO constituencies in the form of legislative and policy advice and training and capacity building for a range of target groups in order to translate the Code into practice.
- ✓ This initiative has been implemented at regional level in Southern Africa, each resulting in:
 - Workplace policy on HIV and AIDS for the education sector adapted and specific to each region;
 - Implementation guidelines; and
 - Action plans/strategy outlines for each country participating in the development of the regional policy.
 - Regional policy formulation for Southern Africa,

The Code of Practice will now be complemented by a Recommendation on HIV/AIDS and the World of Work, of 2010. This Recommendation provides guidance for States, employers' and workers' organizations, among others, and also forms a basis for ILO monitoring and assistance measures.

B. MILLENNIUM DEVELOPMENT GOALS

The millennium development goals (MDGs) are eight [international development goals](#) that were officially established following the [millennium summit](#) of the [united nations](#) in 2000, after the adoption of the [united nations millennium declaration](#). All 193 united nation's [member states](#) and at least 23 [international organizations](#) have agreed to achieve these goals by the year 2015. These goals are:

- Goal 1: Eradicating extreme poverty & hunger
- Goal 2: Achieving universal primary education
- Goal 3: Promoting gender equality and empowering women
- Goal 4: Reducing child mortality rates
- Goal 5: Improving maternal health
- Goal 6: Combating HIV and AIDS, malaria and other diseases
- Goal 7: Ensuring environmental sustainability and
- Goal 8: Developing a global partnership for development

- **Eight Millennium Development Goals**

The relevant goals that help guide our thinking and programs include

Goal number	Target	Progress
Goal 2: Achieve Universal Primary Education	Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	• Enrolment in primary education in developing regions reached 90% in 2010, up from 82% in 1999 • In 2010, 61 million children in primary school going age were out of school with 33 million in sub-Saharan Africa and a further one fifth (13 million) in Southern Asia. • In 2010, 71 million young adolescents aged 12-15 years were out of school globally. • Globally, there were 95 literate young women for every 100 young men in 2010, compared with 90 women in 1990.

Goal number	Target	Progress
Goal 3: Promote Gender Equality and Empower Women	Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015.	• Globally, parity in primary education between girls and boys was achieved, while girls in some regions remain illiterate. • Gender inequality persists and women continue to face discrimination in access to education, work and economic assets and participation in government. • Globally, women are still underpaid compared to men doing the same job with more women doing menial work, or being care takers of home and the sick, and less women own business. • Poverty and violence against women continue to hinder achievement of these goals.
Goal 6: Combat HIV and AIDS, Malaria and other Diseases	Have halted by 2015 and begun to reverse the spread of HIV and AIDS Achieve, by 2010, universal access to treatment for HIV and AIDS for all those who need it Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	• New HIV infections continue to decline in the hardest-hit regions. • More people than ever are living with HIV due to fewer AIDS-related deaths and the continued large number of new infections. • Comprehensive knowledge of HIV transmission remains low among young people, along with condom use. • At the end of 2011, 8 million people were receiving antiretroviral therapy for HIV or AIDS in developing regions. • This total constitutes an increase of over 1.4 million people from December 2009, and the largest one-year increase ever. • The global estimated incidence of malaria has decreased by 17% since 2000, and malaria-specific mortality rates by 255. • Countries with improved access to malaria control interventions had 20% reduction of child mortality rates. • The anti-tuberculosis campaign in 1990 led to 50% reduction in TB related death rate as more TB patients are being successfully treated

Linking Reproductive health and Millennium Development Goals (MDGs)

1. Reproductive health is determined by the quality and availability of health care, the socio-economic development levels, lifestyles and women's position in society.
 - ✓ The International Federation of Gynaecology and Obstetrics asserts that improvements in women's health require state action to correct injustices to women.
 - ✓ The 1994 World Report on Women's Health, the Federation states that women's health is often compromised by violation of women's human rights.
2. Women's health status is affected by complex biological, social and cultural factors which are interrelated and can only be addressed in a comprehensive manner.
 - ✓ The disproportionate poverty, low social status, and reproductive role expose women and girls to high health risks, resulting in needless and largely preventable suffering and deaths.
3. Many women and girls die during pregnancy due to childbirth, forced marriages, female genital mutilation, sexual abuse, AIDS related conditions and increasing numbers of unsafe abortions.
 - ✓ These deaths could be saved by relatively low-cost improvements in reproductive healthcare.
4. Reproductive health is linked to the fulfilment of all eight MDGs and strategies.
 - ✓ The 3rd and 5th MDGs, to promote gender equality and empower women and to improve maternal health and reproductive justice through “the promotion of healthy, voluntary, and safe sexual and reproductive choices for individuals and couples, including decisions on family size and timing of marriage.”
5. Outcome Document of the 2005 World Summit reiterates the connection between the MDGs and their support of social factors that promote reproductive justice by committing the participating countries to:
 - ✓ “Achieving universal access to reproductive health by 2015, as set out at the International Conference on Population and Development,
 - ✓ Integrating this goal in strategies to attain the internationally agreed development goals, including those contained in the Millennium Declaration, ***aimed at reducing maternal mortality, improving maternal health, reducing child mortality, promoting gender equality, combating HIV/AIDS and eradicating poverty.***”
6. Women need reproductive health freedom, education for them to exercise their fundamental human rights, including access to health services, education and employment and ability to contribute to their family, community and societal wellbeing economic status.
7. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences.

C. THE ILO'S RESPONSE TO HIV/AIDS

What are international labour standards?

- ✓ International labour standards are ILO Conventions and Recommendations guiding the development of principles fundamental to work and employment.
- ✓ These standards are formally agreed upon at the International Labour Conference (ILC) held in Geneva, by government and worker's organizations.
- ✓ They guide national authorities to implement policies that promote human rights, improve working and living conditions and creation of employment opportunities.

Conventions

- ✓ The International Labour Conventions are drawn up under international law, followed by adoption of text and choice of country ratification.
- ✓ Once ratified, these conventions are now binding obligations requiring countries to change their laws and practices to their requirements and accepting international supervision.

Recommendations

- ✓ Recommendations are none binding guidelines, which aim to influence national policy and practice.
- ✓ They put obligations on all members to bring the recommendation before parliament to advocate for its translation into law or national policy.
- ✓ The ILO governing body will expect member states to report on what has been done with the recommendation
- ✓ Trade Unions can use this tool to lobby government to effect the recommendation.

Other ILO Conventions which can be applied to HIV and AIDS

The ILO also facilitates the development of conventions to support the implementation of the recommendation, to cover protection against discrimination and prevent HIV infection, these are;

- ✓ Discrimination (Employment and Occupation) Convention, 1958 (No 111).
 - This Convention is fundamental to human rights, and addresses discrimination at work,
 - It defines discrimination as: (a) any exclusion or preference made on the basis of race, colour, sex, religion, political opinion, national extraction or social origin, which nullifies or prevent equal opportunity or treatment, or employment or occupation.
 - The Convention also makes provision for prevention of discrimination on the basis of HIV status.
- ✓ Occupational Safety and Health Convention 1981 (No 155)
- ✓ Occupational Health Services Convention 1985 (No 161)
- ✓ Termination of Employment Convention, 1982 (No 158).
- ✓ Vocational Rehabilitation and Employment (Disabled persons) Convention, 1983 (No. 159).
- ✓ Social Security (Minimum Standards) Convention, 1952 (No 102)
- ✓ Labour Inspection Convention, 2006 (the only ILO Instrument to contain explicit references to HIV/AIDS as a question of safety and health.
- ✓ Work in Fishing Convention, 2007 (No.188).

The VCT@WORK Initiative

The VCT@WORK Initiative is an initiative to reach millions of women and men workers with Voluntary Counselling and Testing (VCT) services. Jointly launched by the ILO and UNAIDS in June 2013, the Initiative will mobilize 5 million women and men workers to undertake VCT by 2015. HIV Testing will not be limited to workers but would include families, dependents and surrounding communities.

Rationale

According to UNAIDS, approximately 8.0 million people are currently accessing life-saving Antiretroviral Therapy (ART) globally. Regardless of the unparalleled successes in scaling up access to treatment, an estimated 7 million people living with HIV and fit for treatment are not on treatment. Most of the people who should be on treatment do not know their status. In many settings progress towards the 2015 treatment target of 15 million people on treatment by 2015 is trailing behind. In 2011, fewer than 20% of treatment-eligible individuals were receiving ART in 10 countries and treatment coverage is under 40% in at least 40 countries. To achieve the global 2015 treatment goal, HIV testing must be significantly scaled up and the link to treatment and care must be strengthened. This is critical if our dream of ending AIDS is to become a reality. The VCT@WORK Initiative will be complemented by the 'Getting to Zero' at work campaign which aims to reduce stigma and discrimination in the workplace (see next section).

Phased Approach & Priority Countries

The VCT@WORK Initiative will be implemented in two phases. Phase 1 will be implemented between June and December 2013 and will focus on Brazil, Ghana, India, Indonesia, Nigeria and South Africa. Phase 2 will be implemented between January 2014 and December 2015 and will focus on other high impact countries. Opportunities will be provided to countries outside this list but interested in engaging in the VCT@WORK Initiative.

Target Populations

Priority will be given to workers in sectors disproportionately affected by the HIV epidemic due to the working and living conditions. The focus will be on mobile workers, migrant workers, miners, health workers, truck drivers, farm workers, young workers, workers in the uniformed services, workers in the informal economy and any other populations identified at the country level. In all countries and especially in concentrated epidemics, the Initiative may target key populations, such as sex workers and their clients; men who have sex with men; and injecting drug users.

Fundamental Pillars

The fundamental pillars VCT@WORK Initiative

- **Multi-disease testing:** To de-stigmatize HIV testing and facilitate increased uptake of VCT services, HIV testing will be promoted through integrated and multi-disease initiatives, e.g. diabetes, hypertension and TB screening.
- **Strategic Partnerships:** Networks of PLHIV, Country partnerships will be forged with Ministries of Health, National AIDS Councils, VCT Providers, ART Centres, Civil Society Organizations, etc.
- **Social Mobilization:** National world of work actors such as Ministries of Labour, Employers' organizations, Workers organizations', Business coalitions and other world of work actors (including CEOs) will be mobilized to undergo VCT in and through workplace structures.
- **Monitoring and Evaluation:** Country monitoring and evaluation systems will be adapted to track progress. A number of complementary monitoring approaches will be used to track progress and reports will be provided every 3 months. Good practices will be documented and disseminated



HIV Testing Modalities

The strategy is to build on existing country structures and not prescribe a one-size-fits-all. HIV Testing will be promoted through Client Initiated Counselling and Testing (CICT) commonly called Voluntary Counselling and Testing (VCT), HIV Self-Testing, Couples Testing, Multi-disease testing campaigns and Community based testing as appropriate. Testing may take place through:

- **Health facilities in and around the workplace:** Company clinics and hospitals, mobile VCT providers, public sector VCT providers
- **Integrated VCT Services:** Family planning (FP) services, PMTCT services, STI services, TB services, Youth services and SRH services
- **As part of other on-going programmes:** Community mobilization programmes; Mass media campaigns; Social marketing campaigns; Special promotions; and the use of mobile clinics and testing sites

HIV testing should be gender-sensitive and address the issue of equity, and be conducted in accordance with the provisions of the HIV and AIDS Recommendation, 2010 (No. 200).

Principles

Countries are encouraged to implement the VCT@WORK Initiative based on the following principles:

- Consent
- Confidentiality,
- Counselling,
- Convenience and
- Connection to Care

The ILO is working closely with networks of people living with HIV and other partners to develop Operation Guidance for the VCT@WORK initiative which will provide additional details on the principles.

D. THE DECENT WORK AGENDA IN AFRICA 2007-2015

The Decent Work Agenda is a global strategy that has been adopted by the International Labour Organisation (ILO). This agenda contributes to poverty reduction through equitable, inclusive and sustainable development. Through decent work, societies achieve productive work that provides fair income, security and social protection for workers and their families. It gives people freedom to raise their concerns, through organized structures and participate in decision making processes that affects their lives.

Pillars of Decent Work Agenda

The Decent Work is based on the following four pillars or strategic objectives, which are inseparable, interrelated and mutually supportive

Productive and Freely Chosen Work

This pillar proposes that employment promotion can be best achieved through creation of economic environment and policies that enable people to:

- ✓ Acquire needed work skills and enterprises
- ✓ Create economic activities that are viable, socially and environmentally sustainable
- ✓ Help enterprises to create more jobs for all

Social Protection

This pillar provides for extension and adaptation of national social security and labour laws and enforcing them to protect the rights of workers in informal economy as well including:

- ✓ Safe working environment
- ✓ Working conditions, including living wage policies, working hours etc
- ✓ Reduction of vulnerability and sustainable remedy for all in need can be achieved through;
 - The extension of rights and social protection schemes for workers in informal and precarious employment and
 - The provision of decent work

Social Dialogue

- ✓ It is believed that economic development can only lead to social progress if there is dialogue between business, government and workers
- ✓ Social dialogue can be achieved by building consensus around policies that impact on employment and decent work and making labour laws effective, promoting industrial relations and building effective labour inspection systems.

Core Labour standards

- ✓ The respect for fundamental rights at work is key for attainment of remaining decent work objectives.
- ✓ The Labour standards makes provision for freedom of association and right to collective bargaining to enhance dialogue among stakeholders, extension of social security and protection and creation of sustainable employment.

Gender a Cross Cutting Issue

Gender equality and non-discrimination are considered as cross-cutting issues in all four objectives pillars. Instruments like the decent work agenda, seeks to assist employers, employees and communities to address various socio-economic determinants that increase people's vulnerability to HIV infection and AIDS impact. These include; but are not limited to poverty, mobility and gender inequality. HIV affects individuals, families, communities, business and populations and requires a holistic approach to conquer it.

ILO, as part of the tripartite participants that adopted the decent work agenda in 2005, contributes to the achievement of this policy through the following programmes:

- Full and productive employment and enterprise development
- Social protection for all
- Improving governance in the world of work and the labour market

The International Labour Organisation's key policies and programmes that address HIV/AIDS

The ILO with its tripartite alliance facilitated the development of various tools that support workplace response to HIV, these include:

- The ILO'S Code of practice on HIV and AIDS In the World Of Work
- Recommendation Concerning HIV and AIDS and the World of Work, 2010 (NO.200)
- ILO Standards and HIV/AIDS

The ILO's Code of Practice on HIV and AIDS in The World of Work

The ILO/AIDS, developed the *Code of Practice on HIV/AIDS and the World of Work* as a document providing principles for "policy development and practical guidelines for programmes at enterprise, community, and national levels", which focuses on:

- ✓ Prevention of HIV
- ✓ Management and mitigation of the impact of AIDS on the world of work
- ✓ Care and support of workers infected by HIV and affected by [AIDS](#).
- ✓ Elimination of stigma and discrimination on the basis of real or perceived HIV status
- ✓ Methods of monitoring and evaluation

10 Principles of the Code	Principles Explained
Acknowledgement that HIV/AIDS is a workplace Issue	Recognizing HIV as a workplace issue encourages employers and workers to respond to HIV and AIDs through workplace interventions.
Non- discrimination.	There should be no discrimination of anyone on the basis of real or perceived HIV status or in relation to job opportunities, promotion and transfers.
Restricting & limiting testing for HIV	HIV testing should not be done for pre-employment
Employment protection.	Real or perceived HIV positive status cannot be a ground for termination of employment.
Confidentiality	No justification for disclosure by either current or prospective employees
Gender equality Care & Support	Solidarity, care and support should guide HIV responses in the world of work. All gender dimensions should be recognized to achieve effective HIV and AIDS response.

Prevention	HIV infection is preventable, employers and workers can contribute towards HIV prevention efforts through workplace programs.
Health & Safe work Protection	The work environment should be safe and healthy for everyone including being conducive to physical, social and emotional wellbeing. Exposure to body fluids including blood should be limited as much as possible.
Motivation for social dialogue	Successful response to HIV relies on mutual trust and ownership of workplace response within the tripartite alliance.

- **The ILO Code of Practice is expressed in ten key principles**

Recommendation Concerning HIV and AIDS in the World of Work, 2010 (No.200)

The ILO's Recommendation 200, concerns HIV and AIDS in the World of work, 2010 (No 200), and Resolution for the promotion and implementation of the ILO code of practice through the ILO's tripartite response recognize the HIV pandemic as a global challenge to health, development, economic and social progress, which also accelerate illnesses and deaths. The Recommendation is the first International Labour Standard on HIV and AIDS and the world of work. It reflects the principle of universal access to services for prevention, treatment, care and support. The Recommendation also reflects on the role of the Joint UN Programme on HIV and AIDS (UNAIDS) and partners in the global HIV response.

- ✓ The Recommendation recognizes that HIV and AIDS;
 - Has a serious impact on society and economies, the world of work, affecting employers, workers in all economic sectors, thus undermining the attainment of decent work and sustainable development,
 - Recalls the value and supports implementation of the ILO Code of Practice on HIV and AIDS and the world of work (2001) and the need to strengthen its impact,
 - Calls for continued and enhanced national and international cooperation in the fight against HIV and AIDS,
 - Recognizes that poverty, social and economic inequalities and unemployment increase the risk of HIV transmission by hindering access to prevention, treatment, care and support services,
 - Notes that stigma and discrimination against persons affected by HIV or AIDS and job loss are barriers to knowing one's HIV status and increase vulnerability of workers to HIV,
 - Recognizes that HIV and AIDS has more negative impact on vulnerable and at risk groups,
 - Highlights the important role of ILO and its constituents in responding to HIV and AIDS through the world of work.
- ✓ The Recommendation **defines workers** as persons working under all forms or arrangements; including:
 - Persons in any employment or occupation including; migrant workers, sex workers and workers in informal economy.
 - Persons in training, interns and apprentices
 - Volunteers
 - Job seekers and job applicants
 - Laid off or suspended workers
- ✓ The Recommendation **defines the workplace** as any in which workers perform their activities in all sectors of economy including:

- 
- The public and private sectors
 - The formal and informal economies
 - The armed forces and uniform services
- ✓ The Recommendation promotes the following (for more details see Part 5 topic C: Wellness in the workplace):
- No workers should be required to take an HIV test or disclose their HIV status. Access to information regarding a worker's HIV-status should be governed by rules of confidentiality consistent with the ILO Code of practice on the protection of workers' personal data, 1997, and other relevant international data protection standards
 - Testing must be genuinely voluntary and free of any coercion and testing programmes must respect international guidelines on confidentiality, counselling and consent. The results of HIV testing should be confidential and not endanger access to jobs, tenure, job security or opportunities for advancement
 - Real or perceived HIV status should not be a ground of discrimination, preventing the recruitment or continued employment, or the pursuit of equal opportunities consistent with the provisions of the employment policies
 - Real or perceived HIV status should not be a cause for termination of employment. Temporary absence from work because of illness or caregiving duties related to HIV or AIDS should be treated in the same way as absences for other health reasons, taking into account the Termination of Employment Convention, 1982
 - Migrant workers, or those seeking to migrate for employment, should not be excluded from migration by the countries of origin, of transit or of destination on the basis of their real or perceived HIV status
 - Persons with HIV-related illness should not be denied the possibility of continuing to carry out their work, with reasonable accommodation if necessary, for as long as they are medically fit to do so. Measures to redeploy such persons to work reasonably adapted to their abilities, to find other work through training or to facilitate their return to work should be encouraged, taking into consideration the relevant International Labour Organization and United Nations instruments
 - There should be no discrimination against workers or their dependants based on real or perceived HIV status in access to social security systems and occupational insurance schemes, or in relation to benefits under such schemes, including for health care and disability, and death and survivors' benefits.

E. WORLD HEALTH ORGANIZATION (WHO) GUIDELINES ON HIV

The World Health Organisation (WHO) global health sector strategy on HIV, 2011–2015 guides the health sector response to Human Immunodeficiency Virus (HIV) epidemics in order to achieve universal access to HIV prevention, diagnosis, treatment, care and support. The strategy:

- ✓ Reaffirms global goals and targets for the health sector response to HIV
- ✓ Identifies four strategic directions to guide national responses
- ✓ Outlines recommended country actions and WHO's contributions within each strategic direction.
- ✓ Defines the health sector's contribution to the broader, multi-sectoral response to HIV outlined in the UNAIDS strategy for 2011-2015.
- ✓ Promotes a long-term, sustainable HIV response through strengthening health and community systems,
 - Tackling the social determinants of health that both drive the epidemic and hinder the response, and
 - Protecting and promoting human rights and promoting gender equity as essential elements of the health sector response.
- ✓ Strengthens the integration between HIV and other health services, improving both impact and efficiency.
- ✓ It calls on the world to build on the collaboration, innovation and investment that have forged hard-won progress to date, establishing the foundation for success over the next five years. Figure 1 depicts the elements of the strategy schematically.

The WHO vision:

- ✓ Zero new HIV infections
- ✓ Zero AIDS-related deaths
- ✓ Zero discrimination in a world where people living with HIV are able to live long, healthy lives

WHO global health sector strategy on HIV/AIDS, 2011-2015 guides the health sector's response to HIV. Its goals, consistent with UNAIDS strategy for the same period, "Getting to Zero" and international commitments, are:

- ✓ To achieve universal access to HIV prevention, diagnosis, treatment and care interventions for all in need.
- ✓ To contribute to achieving health-related Millennium Development Goals and their associated targets by 2015.

Recommended country actions and WHO contribution in line with each of the core elements

- ✓ WHO provides normative guidance, policy advice and implementation guidance, and develop and disseminate a broad range of products and services to support country action, defining respective roles, responsibilities and collaborating organizations.
- ✓ WHO support seeks to improve the efficiency and effectiveness of HIV responses, better integration of HIV programmes with other health programmes, support the strengthening of health and community systems, improve health access and equity, and ensure that the health sector informs broader multi-sectoral responses, such as legal and policy reform.
- ✓ Country actions include; developing, adapting, implementing and evaluating national HIV responses towards national goals and targets and multi-sectoral HIV response strategy.

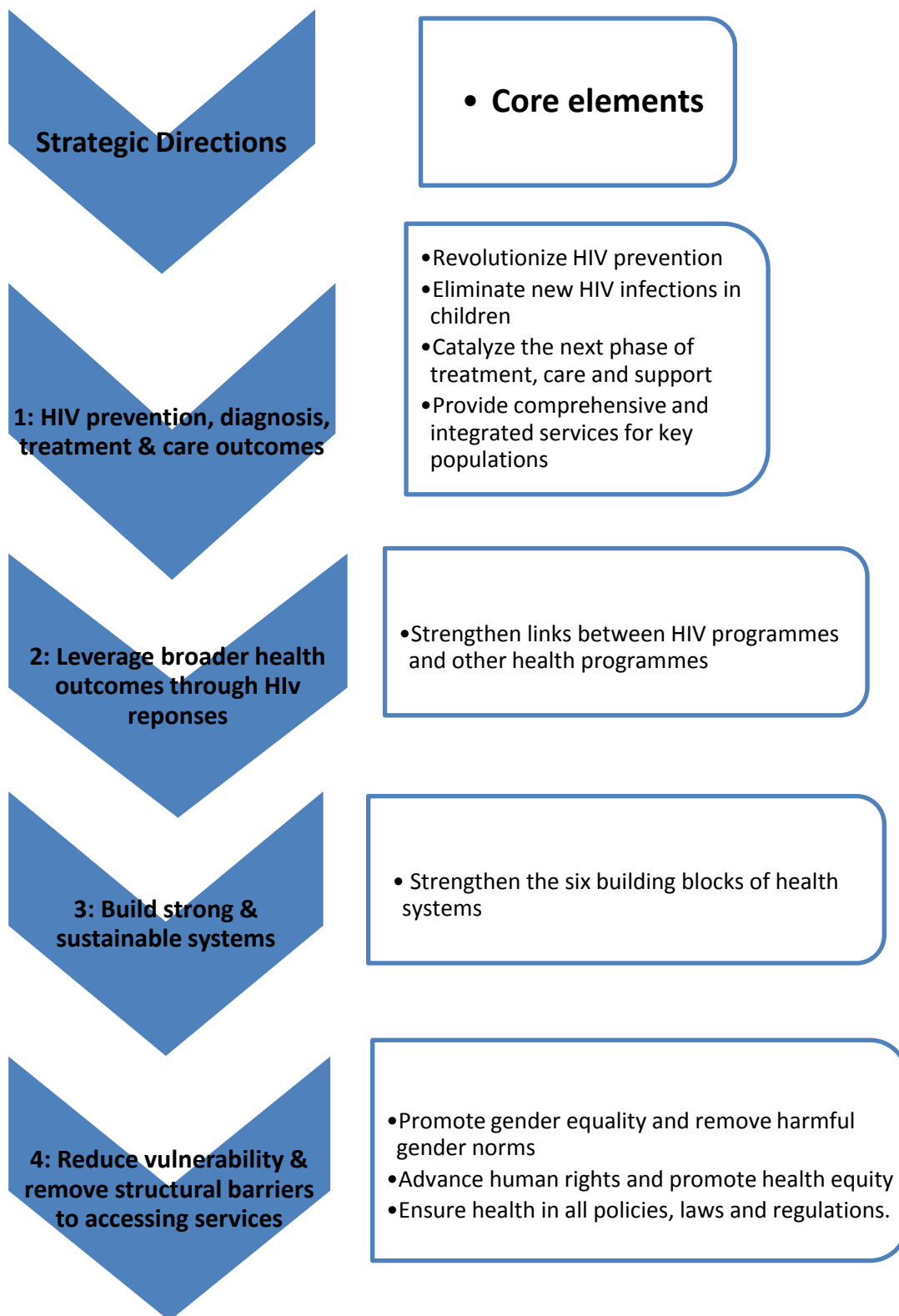


Figure 1: The Four WHO Strategic Directions with Core Elements



WHO Priority Actions

The World Health Organization (WHO) 2013 Global TB report and Countdown to 2015 report confirms that TB remains a major global health problem in the world, with about 8.6 million people developing TB and 1.3 dying from TB disease, and 320 000 having TB/HIV co-infection. In 2013 in response to these findings, the WHO identified five Priority actions to accelerate progress towards the 2015 targets as follows:

1. Reach the missed cases

- About 3million people with TB in 2012, were not captured in national TB notification system.
- This problem can be addressed through inter-sectoral collaboration with NGOs, workplaces, government departments to increase early diagnoses, access to treatment, improved reporting and reduced defaulter rates.

2. Address MDR-TB as a public health crisis

- There is a need to for increased capacity to diagnose TB, and provision of effective treatment and care.
- This can be achieved through high political will and leadership, more collaboration among partners, including drug regulating authorities and supply, civil society and technical agencies.

3. Accelerate the response to TB/HIV

- The first priority here is to achieve 100% TB treatment coverage for people living with HIV.
- Secondly, to prevent TB among people living with HIV.

4. Increase financing to close all resource gaps

- There is a need to increase financial resources by local and international funders to cover the increase TB management needs, including treatment, new TB diagnosis and vaccines.

5. Ensure rapid uptake of innovations.

- There is a need to increase uptake of new technologies, tools and strategies for better diagnosis, treatment and prevent of all types of TB.
- This can be achieved through country specific operational research and evidence based policy and practice.

F. GETTING TO ZERO 2011 – 2015 UNAIDS STRATEGY

The project on Reducing HIV vulnerability through economic empowerment contributes to the UNAIDS global commitments to achieve universal access to HIV prevention, treatment, care and support.

The United Nations strategy outlines the following vision and goals that must be achieved by 2015

Vision:	2015 Goals:
To get to Zero New infections	Sexual transmission of HIV is reduced by half, including among young people, sex workers, and men who have sex with men.
To get to Zero AIDS-related deaths	Universal access to ant-retroviral therapy for people living with HIV who are eligible for treatment. TB Deaths among people living with HIV reduced by half People living with HIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support.
To get to Zero Discrimination	Countries with punitive laws and practices around HIV transmission and sex work, drug use or homosexuality that block effective responses reduced by half. HIV related restrictions on entry, stay and residence eliminated in half of the countries that have such restrictions. HIV-specific needs of women and girls are addressed in at least half of all national HIV responses. Zero tolerance for gender-based violence.

The United Nationals Visions and Goals for “Getting to Zero”

This strategy aims to halt and reverse the spread of HIV and contribute to the achievement of the Millennium Development Goals through the following strategic directions:

Revolutionizing HIV prevention

- ✓ With about 7000 new infections every day, revolutionary prevention politics, policies and practices are required.
- ✓ These include: fostering political incentives for commitment and catalysing transformative social movement on sexuality, drug use and HIV education for all, driven by people living with HIV and affected communities including youth and women.
- ✓ Targeting HIV through high transmission areas, in cities and ensuring equitable access to high quality, cost-effective HIV prevention programmes that include speedy adoption of evidence based lessons and successes.

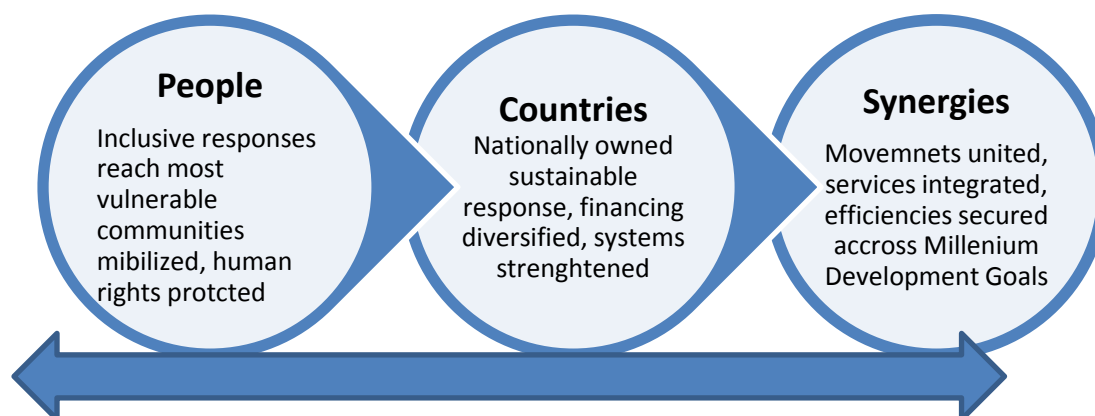
Catalysing the next phase of treatment, care and support

- ✓ The AIDS related deaths of about 1.8 million people in 2009, urges the need for accessible treatment for eligible people.
- ✓ Increased need for linkages between primary health care, maternal and child health services, sexual and reproductive health to reduce costs and increase efficiency of services.
- ✓ There is a need for capacity building in health facilities to increase early entry by people living with and affected by HIV into treatment programmes, nutritional support and social protection services including orphans and vulnerable children through use of social and cash transfers, and the expansion of social insurance schemes.

Advancing human rights and gender equality for the HIV response

- ✓ Social and legal environments need to protect against stigma and discrimination against people living with HIV, to enhance access to HI services.
- ✓ Countries need to ensure prevention of human rights violations for vulnerable communities including rights for women and girls, people living with HIV and those at higher risk of HIV infection.
- ✓ Nations are urged to invest in programmes that address intersections between HIV vulnerability, gender inequality and violence against women and girls.

It is envisaged that the above visions and goals will be achieved through the following core elements: people, countries and synergies.



CORE ELEMNTS FOR ACHIEVING THE 2011-2015 UNAIDS STRATEGY

G. SUMMARY OF COUNTRY SPECIFIC FRAMEWORKS AND STRATEGIES

All 6 CEEP countries have national strategic plans that seek are evidence informed and seek to address the drivers of the epidemic (see the next section). Below is a summary table of some of the key strategies that these countries seek to implement.

VARIABLES	MALAWI	MOZAMBIQUE	SOUTH AFRICA	TANZANIA	ZAMBIA	ZIMBABWE
Priorities for HIV& AIDS Response	2009-2013 Plan	2010-2014 Plan	2012-2016	2013-2017 Plan	2011-2015 Plan	2011-2015 Plan
	Reduce sexual transmission of HIV	Reduction of risk and vulnerability component	Address social & structural drivers of HIV and TB prevention, care and impact	Comprehensive sexuality, human right, gender, & health education & services	Prevention Treatment, Care and Support	Prevention of new infections
	Prevent MTCT	Prevention	Prevent new HIV, STI and TB infections	Condom provision and programming	Impact mitigation National Response	Treatment & Care Mitigation & Support
	Prevent transmission through blood, blood products and medical procedures	Treatment and Care	Sustain health and wellness	Counselling (HTC)	Coordination and Management	Coordination and Management
		Impact Mitigation Support	Ensure protection of human rights and improve access to justice	HIV Testing & Antiretroviral Therapy		Monitoring & evaluation
	Cross cutting objectives	Response Enablers		Response Enablers		
	Increase access to quality & linkages of health services	Multi-sectoral coordination		Voluntary medical male circumcision		
	Reduce HIV risk & vulnerability by addressing cultural, social and economic environment	Monitoring & Evaluation		Provision of safe blood		
	Promote legal & human rights	Operational Research		Prevention and treatment of STIs		
	Increase & strengthen support systems	Communication		Behaviour change communication		
	Monitor & Evaluate national prevention response	Resource mobilization				
		Systems Strengthening				

The Country Specific HIV and AIDS strategic areas



H. HIV, AIDS AND WELLNESS IN THE WORKPLACE POLICIES & PROGRAMS

An HIV and AIDS workplace policy guides development and implementation of programs to reduce the spread of HIV and address AIDS impact in the world of work. The existence and implementation of an HIV and AIDS workplace policy demonstrates a company's position with regards to their commitment to addressing HIV and AIDS impact among its staff and stakeholders. HIV and AIDS workplace policies also outlines the responsibilities, rights, resources and expected behaviour for management and employees, including organized labour.

Key principles of the ILO Code of Practice

The Code is based on three pillars:

- Non-discrimination and
- Protection of rights
- Prevention

These pillars are reiterated in the key principles of the code and the Recommendation 200 (see Part 3).

The recommendation concerning HIV and AIDS and the World of Work, 2010 (No. 200) reinforces the key principles and its application to guide development and implementation of the workplace policies.

The HIV and AIDS Recommendation 200 Preamble

The ILO recommendation concerning HIV and AIDS and the World of Work, 2010 (200) is the first International labour standard on HIV and AIDs and the world of work. The recommendation focuses on the following

- ✓ Reflects the principle of universal access to prevention, treatment, care and support services,
- ✓ Highlights the important role of the Joint UN Program on HIV and AIDS (UNAIDS) and its co-sponsors in the global HIV response,
- ✓ Recognizes that HIV and AIDS has a serious impact on society and economies and on the world of work, affecting employers and workers in all economic sector and undermines the attainment of decent work and sustainable development,
- ✓ Recalls the value of the ILO Code of practice on HIV and AIDS and the world of work (2001) and the need to strengthen its impact,
- ✓ Calls for continued and enhanced national and international cooperation in the fight against HIV and AIDs,
- ✓ Recognizes that poverty, social and economic inequalities and unemployment increase the risk of HIV transmission by impeding access to prevention, treatment, care and support,
- ✓ Notes that stigma and discrimination against persons affected by HIV or AIDS and job loss are barriers to knowing one's HIV status and increase vulnerability of workers to HIV infection,
- ✓ Notes that HIV and AIDS has more severe impact on vulnerable and at risk groups,
- ✓ Highlights the significant role of the ILO and its constituents in responding to HIV and AIDS through the world of work.



Themes and principles to guide workplace policies and programs development and implementation

- ✓ The response to HIV and AIDS is recognized as contributing to the realization of human rights and fundamental freedoms and gender equality for all,
- ✓ There should be no stigma and discrimination in employment or occupation on the basis of real or perceived HIV status (Recommendation, Parts III paragraph 3)

i. Gender Equality

The need to address the gender dimension in all aspects of the response to HIV and calls for measures to be taken in and through the workplace to:

- ✓ Ensure gender equality and the empowerment of women,
- ✓ Promote the active participation of both men and women in the HIV response.
- ✓ Promote the involvement and empowerment of workers regardless of their sexual orientation and whether or not they belong to a vulnerable group,
- ✓ Promote the protection of sexual and reproductive health and rights of women and men (Recommendation, Preamble, paragraphs 3, 14, 40)

Access to prevention, treatment, care and support services

- ✓ Workers, their families and dependents should have access to and benefit from HIV prevention, treatment, care and support services and the workplace should play a role in facilitating this access.
- ✓ Workers should benefit from programmes to prevent specific risks of occupational transmission of HIV and related diseases including TB.
- ✓ Measures should be taken to encourage worker's active participation and engagement in developing, implementing and evaluating workplace programmes (Recommendation, Part III paragraphs 3)

Member States should adopt workplace policies and programmes on HIV and AIDs that

- ✓ Are integrated into national HIV strategies, development plans, decent work and other strategies
- ✓ Are developed in consultation with employers and workers and people living with HIV organizations
- ✓ Take note of the key principles of the Recommendation, the Code of Practice and other relevant ILO instruments
- ✓ Take account of the views of relevant sectors, particularly the health sector (Recommendation, Part IV, paragraph 4 through 8)

ii. Non discrimination

Real or perceived HIV status should not

- ✓ Prevent equal access to employment or occupation
- ✓ Affect terms and conditions of employment, including working conditions, remuneration and access to benefits
- ✓ Be a ground for termination of employment
- ✓ Persons living with HIV-related conditions should be able to continue to work as long as they are medically fit, with reasonable accommodation if needed (Recommendation, Part IV, paragraph 9 through 14).

- ✓ There should be no discrimination against or stigmatizations of workers, particularly job seekers or job applicants, on the grounds of real or perceived HIV status or the fact that they belong to regions of the world or segments of the population perceived to be a greater risk of or more vulnerable to HIV infection (Recommendation, Part III, paragraph 3c).
- ✓ Governments, in consultation with the most representative employers and workers organizations, should consider affording protection equal to that available under the Discrimination (Employment and Occupation) Conventions, 1958 (No. 111) against discrimination on the basis of real or perceived HIV status (Recommendation, Part IV, paragraph 9).

iii. Prevention is a fundamental priority

HIV programs should include:

- ✓ Comprehensive education programs for men and women
- ✓ Effective occupational safety and health measures
- ✓ Measures to encourage workers to know their status as soon as possible,
- ✓ Access to all means of prevention strategies including supplies and availability of post-exposure prophylaxis
- ✓ Measures to reduce high-risk behaviours and harm reduction strategies (Recommendation, Part IV, paragraph 15 and 16)
- ✓ Voluntary Counselling and Testing
- ✓ Antiretroviral treatment and adherence education, information and support
- ✓ Proper nutrition in consistent with treatment
- ✓ Treatment for opportunistic infections including, sexually transmitted infections, and any other HIV related conditions particularly TB
- ✓ There should be no discrimination on the basis of HIV status in access to social security systems, occupational insurance schemes or in relation to benefits under those schemes, including health care and disability and death and survivors' benefits (Recommendation, Part IV, paragraph 17 through 20)

iv. Testing, privacy and confidentiality

- ✓ Mandatory HIV screening or testing should not be required of either a job seekers, or applicants or workers, including migrant workers
- ✓ The results of HIV testing should be kept confidential
- ✓ HIV testing must be genuinely voluntary and respect guidelines on confidentiality, counselling and consent
- ✓ Grievance procedure for alleged violations should be made available at the workplace (Recommendation, Part III, paragraphs 3(h) and (i) and Part IV, paragraph 24 through 29)

v. Treatment, Care and Support

- ✓ Programmes of care and support should include reasonable accommodation of in the workplace.
- ✓ Members should promote the retention in work and recruitment of PLWHA and extend support, including income-generating opportunities for persons living with or affected by HIV or AIDS.
- ✓ Where an occupational link can be established between an occupation and the risk of infection, HIV and AIDS should be recognized as an occupational disease or accident (Recommendation, Part IV, paragraph 21 through 23)



The right to a safe and healthy work environment

- ✓ All workers are entitled to a healthy and safe work environment, including those with an occupational risk of HIV transmission, calling for universal precautions, post exposure prophylaxis and other safety measures.
- ✓ Measures should be taken to protect workers in occupations particularly exposed to the risk of HIV transmission (Recommendation, Preamble, Part II, paragraphs 3(g) and Part IV, paragraphs 30 through 34).

A focus on children and young persons

- ✓ The Recommendation calls for members to combat child labour and child trafficking that may result from death or illness of family members due to HIV or AIDS and to reduce the vulnerability of children to HIV
- ✓ Special measures should be taken to protect these children from sexual abuse and sexual exploitation
- ✓ Members should also take action to protect young workers from HIV infection and to include the special needs of children and young persons in national policies and programmes on HIV and AIDS (Recommendation, Part IV, paragraph 35 and 36)

Social dialogue

- ✓ National HIV policies and programmes should promote social dialogue, including consultation and negotiation and other forms of cooperation among governments, employers and workers, organizations representing persons living with HIV and taking into account the views and other relevant actors.
- ✓ Organizations of employers and workers should promote awareness of HIV and AIDS among their members, including prevention and non-discrimination (Recommendation, Part V, paragraph 38 and 39).

Education, Training, Information and Consultation

- ✓ Training, safety instructions and guidance in the workplace on HIV and AIDS should be provided in clear and accessible form to all workers and should be adapted to the characteristics of the workforce.
- ✓ Workers should receive training on HIV infection control procedures and those whose occupations put them at risk of exposure to human blood, blood products and body fluids should receive additional training on exposure prevention and post-exposure prophylaxis (Recommendation, Part V, paragraphs 40 through 43)

Public Services

- ✓ The role of labour administration services in the HIV response (including judicial authorities and labour inspectorate) to be reviewed and if necessary be strengthened.
- ✓ Public health systems should be strengthened to ensure greater access to prevention, treatment, care and support (Recommendation, Part V, paragraphs 44 and 45).



Implementation

- ✓ National policies and programmes on HIV and AIDS should be given effect, in consultation with most representative organizations of employers and workers and other concerned actors, through: national legislation, collective agreements, national and workplace policies and programmed and sectoral strategies.
- ✓ The national judicial authorities competent in labour and labour administration authorities should be involved.
- ✓ Collaboration and coordination should be ensured among the public authorities and public and private services concerned, including insurance and benefit programmes (Recommendation, Part V, paragraph 37).

International Cooperation

- ✓ Should be encouraged between and among members, their national structures on HIV and AIDS and relevant international organizations, including through systematic exchanges of information
- ✓ Measures should be taken by countries of origin, transit and destination to ensure universal access for migrant workers
- ✓ Member States and International organizations should seek to reduce the price of supplies for the prevention, treatment and care of HIV and other opportunistic infections and cancers (Recommendation, Part V, paragraph 46 through 50)

The Workplace HIV and AIDS policy creates a vital platform for effective response to the epidemic in the following ways:

- ✓ Provides an opportunity for contact with the population most affected by the epidemic,
- ✓ Provides space for information, education, training especially through peer education,
- ✓ Provides human resource management structure, like workplace wellness services and employee assistance,
- ✓ It also provides opportunity for community outreach,
- ✓ Pre-existing systems to deal with stigma and discrimination and their impact on productivity,
- ✓ Assists employers, workers and worker representatives to translate the provisions of the Code and the Recommendation 200 by:
- ✓ Making an explicit promise for corporate action and raises morale.
- ✓ Providing a framework for action
- ✓ Outlining rights, principles and standards of behaviour
- ✓ Providing guidance to managers, supervisors and worker representatives
- ✓ Committing to confidentiality and non-discrimination for all employees.
- ✓ Ensuring consistency with appropriate national laws.
- ✓ Encouraging all employees (regardless of HIV status) to support an inclusive and no stigmatizing working environment.
- ✓ Explaining to employees living with HIV and AIDS the type of support and care they will receive, so they are more likely to come forward for counselling and testing.
- ✓ Helping reduce the spread of the virus through prevention programs.
- ✓ Making the policy available to all employees, in a format that is easily understood.
- ✓ Managing the impact of HIV and AIDS with the ultimate aim of cutting business costs and increasing productivity.

Workplace policy and include the following themes:

a) Information and educational activities:

- ✓ Be linked to the broader HIV and AIDS activities within the local community, country, sector and region. be participative and developed in consultation with:
 - Employers, workers, and worker representatives,
 - Local stakeholders including; government, NGOs, experts on HIV, AIDS, counselling and care.
- ✓ Be as interactive and participatory as possible.
- ✓ Be comprehensive and respond to general health and wellness challenges including; nutrition, environmental health and hygiene, alcohol and substance abuse, smoking, stress management, life skills and relationships.
- ✓ Be based on correct and up-to-date information on HIV, AIDS, STI, TB and other social ills, including;
 - Transmission of infections,
 - Identifying and dispelling the myths surrounding the epidemic
 - Prevention, including correct and consistent condom use, HIV counselling and testing, male medical circumcision, ongoing information and education,
 - Course of infection,
 - HIV and AIDS Impact on individuals, families, communities, the workplace and the workplace,
 - Services available; in the workplace and community including services treatment, care, support and referral networks.
- ✓ Courses and campaigns should be integrated into existing education and human resource programmes including occupational safety and health and anti-discrimination strategies.
- ✓ As far as possible educational programmes should take place during paid working hours and developing educational materials to be used by workers outside workplaces.
- ✓ Recognize attendance of courses as part of work obligations.
- ✓ Use peer education strategies that help individuals assess personal risk factors and vulnerabilities (both as individuals and as members of a group) and work out mechanisms to reduce these risks through decision-making, negotiation and communication skills, as well as educational, 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; – drug injection and information on how to reduce the risk of HIV transmission.
- ✓ Enhance dialogue among employers' and workers' organizations from neighbouring countries and at regional level; –promote HIV, AIDS and wellness awareness in vocational training programmes carried out by governments and enterprises, in collaboration with workers' organizations; –focusing on young workers, women and men; –giving special emphasis to women vulnerability to HIV and strategies that can lessen this vulnerability
- ✓ Emphasize that people who are HIV-positive do not need to be avoided or stigmatized, but rather should be supported and accommodated in the workplace
- ✓ Provide education on procedures to be followed in case of HIV exposure

- 
- ✓ Promote hygiene and proper nutrition, discourage abuse of addictive substances including alcohol, smoking; – Be regularly monitored, evaluated, reviewed and revised where necessary.

b) Gender-specific programmes

All programmes should be gender-sensitive, as well as sensitive to race and sexual orientations including:

- Separate education sessions for women, for men and for youth,
- Inclusive sessions to share commonalities in rights and responsibilities for addressing HIV, AIDS and other social ills,
- Reiterating the need to respect the rights of women as human rights not an effort to oppress men,
- Having dialogues on higher risk of, HIV infection to women and young girls,
- Helping 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.
- Programmes that help women to understand their rights and responsibilities, both within and outside the work-place and empower them to protect themselves.
- Education for men that include awareness-raising, risk assessment and strategies to promote men's responsibilities regarding the prevention of HIV and other sexually transmitted infections.

c) Maternity Protection

As part of the International Labour Organization's (ILO) contribution to the Millennium Development Goals (MDGs) on women and child health; the ILO developed a resource package on Maternity Protection (ILO: 2012). This resource package can be used by governments, trade unions, employer organizations, non-governmental organizations (NGOs) researchers, United Nations (UN) officials and other practitioners and it's designed to:

- ✓ Enhance contribution towards equitable economic growth, social cohesion and Decent Work for all women and men.
- ✓ Help consolidate information and tools, expertise and knowledge on every component of maternity protection at work.
- ✓ Serve as a resource and guide for actors who are ready to implement information and education campaigns ant to plan, design or monitor action that will bring about real improvements in maternity protection at work.
- ✓ Help contribute to the health and wellbeing of women and their children by:
 - Ensuring women's access to decent work and gender equality by enabling women to combine their reproductive and productive functions and
 - Prevent unequal treatment in employment due to women's reproductive function.

The ILO adopted three Conventions to support Maternity Protection to expand the scope and entitlements of maternity protection at work and guide national policy and action.

- No. 3, 1919;
- No. 103, 1952
- No. 183, 2000



The Maternity Protection resource package is divided into three parts which enable workers, employers, worker's representatives and stakeholders to implement Maternity protection.

Maternity protection at work aims

1. Preserve the health of the mother and her new born; and
2. Provide a measure of economic security for the concerned women and their families.

Importance of Maternity Protection at Work

Maternity protection at work supports the achievement of Millennium Development goals by contributing to the protection of human rights and development objectives; by providing a clear linkage with:

✓ **Fundamental human rights**

- Maternity protection is considered to be a fundamental human right;
- The woman and her unborn baby have a right to life, health and wellbeing.

✓ **Gender equality**

- It promotes the right of women in reproductive age to work without threat of discrimination, to work in conditions of economic security and equal opportunity, and to benefit from just and decent working conditions.
- It's a pre-condition for realizing gender equality between working women and men

Maternal and child health

- The health of the woman and her unborn child are protected,

✓ **Economic growth and poverty reduction**

- Working women are able to take responsibility for their health, the health of their children and family,
- Thus being able to afford basic needs of their children, like paying school fees, health services and other basic needs.
- The more children go to school, and are able to work, it is possible to eradicate poverty.

✓ **Decent work**

- Maternity protection contributes to the achievement of the MDGs, especially;
 - MDG 1, on eradicating poverty and hunger,
 - MDG 3, on promoting gender equality
 - MDG 5, on improving maternal health and
 - MDG 6, on combating HIV/AIDS, malaria and other diseases.

Main Stakeholders for Maternity Protection

Maternity protection at work cannot be achieved without the involvement of all relevant stakeholders, including:

✓ **Government is responsible for:**

- Working with stakeholders to develop enabling policies and social security,
- Implementing , monitoring and enforcing legislations

✓ **Employers and their organizations:**

- Employer's organizations can participate in international and national law dialogues
- Employers Advisory and assistance on legal provisions and share good practice among members,
- Employers together with workers and worker representatives can ensure compliance to working conditions to national law and practice, through workplace policies and negotiated agreements.

✓ **Trade Unions**

- Can campaign for improvements in maternity protection in national and international laws;
- Educate their members on maternity protection and
- Negotiate collective bargaining agreements that include elements of maternity protection

✓ **Civil Society**

- Facilitate community campaigns and action on maternity protection through improved living and working conditions for workers with family responsibilities.

✓ **Universities and research centres can help:**

- With the design and publishing research that informs and helps shape, monitor and evaluate public policy.

Core Elements for Maternity Protection at Work

✓ Maternity protection at work has the following core elements; which are summarized in the diagram below.

- Maternity leave and other care related leave provisions, their characteristics, benefits and trends
- Cash and medical benefits, and the importance of social protection,
- Health protection at work for pregnant and breastfeeding women, including issues relating to HIV and AIDS in the workplace,
- Employment protection and non-discrimination throughout maternity,
- Breastfeeding arrangements in the form of breastfeeding breaks, facilities in the workplace and family-friendly policies and
- Going beyond the concept of maternity protection to balance work with family responsibilities and in particular to child care, as caregiving needs continues beyond maternity leave, and policies to support care and gender equality are needed beyond ,maternity ends.

Maternity leave & other types of leave;

- Helps mothers to maintain labour markets
- Links maternity and parental leave policies to reduce poverty for families with children and improve child wellbeing
- Defines period of paid leave; not less than 14 weeks, including 6 weeks after birth
- Enables families to connect work & family responsibilities
- Promotes maternal & newborn health and gender equality at work
- Recognises father's role in supporting the mother, breastfeeding and bonding with the baby through paternity leave
- Provides for adoption leave as well
- Parental leave

Cash & medical benefits & social protection

- ILO standards guides development & implementation of social security measures and maternity cash and medical benefits
- Helps mitigate health & economic risks for women & their children
- Forbids discrimination of women due to maternity reasons
- Promotes funding for social security schemes for vulnerable women
- Advocates for keeping more women at work, to provide for their family and children health and education needs.

Health protection at work

- Promotes creation of a healthy and safe working environment for all workers
- Guides development of policies & procedures to identify and address hazards for pregnant & breastfeeding women
- Promotes health rights of pregnant women and their unborn children from workplace hazards
- Prohibits pregnant and breastfeeding women to do work that is dangerous to them and their unborn baby
- Includes measures to mitigate HIV, AIDS and prevent mother-to-child transmission
- Promotes workplace services for treatment, care and support.

Employment protection & non-discrimination

- * Promotes protection of women against maternity related discrimination
- * Protects women from dismissal on maternity related grounds
- * Prohibits pregnancy tests at time of job application
- * Entitles a woman the right to return to the same job, position after maternity leave
- * Protects the women to all employment entitlements
- * Promotes equal sharing of care, work and labour market opportunities for men and women
- * Fosters policies that discourage stereotypes that portray women as caregivers and secondary earners

Supporting breastfeeding at work

- Promotes exclusive breastfeeding
- Promotes safe, adequate
- Defines roles & measures to be taken by stakeholders to end transmission of HIV through breastfeeding
- Promotes breastfeeding through feeding breaks in the workplace
- Breastfeeding supporting Workplaces contribute to: less absenteeism, high staff retention, improved child health, high employee morale & productivity, good corporate image
- Workplaces can facilitate VCT@work
- Provide ongoing information & education sessions

Balancing work & family responsibilities

- Promotes measures & policies to balance family and work responsibilities including:
- policy research, education, information, advocacy, social care services including child care, leave policies, working time & arrangements, social security benefits, active labour markets, basic infrastructure & services
- Promotes dialogue on family work reconciliation
- Promotes gender responsive policies that supports workers & employers.

Core Aspects of Maternal Protection

Taking Action on Maternity Protection at Work

Making Maternity Protection real, involves utilizing different interventions and tools, including: Capacity building, by stakeholders in order to continuously develop, strengthens and maintains capabilities to plan and deliver their own development objectives. This can be done through the following dimensions:

Assessment of national legislation against international labour standards on maternity protection at work and childcare, this component;

- ✓ Defines identified maternity protection rights,
- ✓ Provides guidance on how to assess national legislation against the ILO Standards at various levels,
 - Regional level
 - National or federal level
 - Provincial, District and
 - Local, Municipal and community levels
- ✓ Provides tools that can be used for the assessment process
- ✓ This component can be used to monitor and evaluate progress on implementation of the Decent Work Agenda at national level,
- ✓ Provides statistical indicators on Combining work, family and personal life
- ✓ Explains how to use ILO Database of Conditions of Work and Employment Laws, including Maternity Protection Legislation which outlines country specific information on key dimensions of maternity protection at work.
- ✓ Helps with identification and prioritization of gaps, including opportunities, challenges and tools for addressing them.

Assessment of maternity protection in practice, at national, local or enterprise levels by;

- ✓ Guiding assessment of maternity protection in practice, providing examples and tools for such assessment,
- ✓ Providing direction on how maternity protection rights at work can be implemented and exercised based on the national context including:
 - National efforts for implementing maternity protection legislation by assessing the capacity to budget, monitor and enforce the law;
 - Employer's understanding of legal obligations and administrative requirements for implementing maternity protection at work or
 - Understanding the actual maternity protection conditions for women workers (the extent to which women take up maternity leave, experience maternity-based discrimination, or facing challenges in continuing to breastfeed upon return to work.
 - Approaches and Tools and examples are available on how to undertake this component, including questionnaires and checklists.

Advocacy at a wider level through communication strategies, building of alliances and awareness-raising activities

- ✓ This component provides guidance and tools for organizing advocacy and awareness raising activities.
- ✓ It is necessary to establish a group of involved and interested stakeholders that can function as allies.
- ✓ Determine the strengths and weaknesses of each group, who support or oppose the issues
- ✓ Awareness and advocacy are necessary for addressing any issue,
- ✓ All activities should be evaluated to track their impact and inform the next steps.

This component provides six steps for undertaking advocacy and awareness raising for maternity protection;

- ✓ Identifying the issues to be addressed and target groups,
- ✓ Identifying and developing potential solutions,
- ✓ Identifying decision-makers and anticipating their response to the solutions,
- ✓ Seeking alliances for planning and action,
- ✓ Developing key messages and
- ✓ Determining methods for advocacy and awareness raising.

Capacity building, including development of tools and methods as well as training ideas.

- ✓ This component provides guidance on tools for developing, implementing and evaluating a training program on maternity protection including how to develop:
 - Training aims, objectives, outcomes and learning interventions
 - Training program
 - Training monitoring and evaluation tools

I. ADDRESSING STIGMA RELATED TO HIV IN THE WORKPLACE

HIV and AIDS poses serious challenges on an individual, family, community and society due to related social, development and economic implications. This prompted ILO to facilitate dialogue on HIV and AIDS as a labour and workplace issues with employers, workers and trade unions based on the need to protect and promote human rights. Protection and promotion of human rights will enhance access to services for treatment, care and support for people living with HIV.

Employment settings remain a major source of HIV-related discrimination through:

- Mandatory testing,
- Dismissal on the basis of HIV status,
- Refusal of promotion or health insurance benefits
- Gossip and Harassment.
- ✓ As much as the workplace can be the source of stigma and discrimination, the same environment can be a good environment to challenge this problem,
- ✓ Some countries have included HIV in their Decent Work Country Programmes. However, much more needs to be done to ensure that HIV workplace policies and programmes are rolled out at a necessary scale and that people living with HIV have access to redress mechanisms in cases of discrimination in the workplace
- ✓ Networks of people living with HIV and other stigmatized groups are key actors in effective stigma and discrimination reduction efforts.
- ✓ These networks provide vital community support and are well placed to understand the legal and social challenges faced by communities.
- ✓ In addition, empowerment of people living with HIV and key affected populations in terms of knowledge of their rights and access to justice is important for them to be able to take the lead in reduction of stigma and discrimination.
- ✓ Strengthening the capacity of networks and providing access to social, legal and peer support is therefore critical.
- ✓ This support and capacity strengthening has so far not been systematically provided

The ILO Code of Practice on HIV/AIDS and the world of Work and Recommendation 200 of 2010, guide the workplace HIV and AIDS response using the ILO rights-based approach by applying human rights principles to the issue of HIV/AIDS.

Human Rights for PLHIV in the workplace

HIV/AIDS affects millions of people from all walks of life, including people in the workplace.

- ✓ The most important of these is that an HIV positive employee has the same rights and duties as other employees.
- ✓ They cannot be treated differently from other employees by employers or by co-workers.
- ✓ An employee cannot be fired, retrenched or refused a job simply because they are HIV positive.
- ✓ Employees living with HIV are also entitled to the same training, development and promotion opportunities as any other employee.
- ✓ No employer can require that a job applicant have an HIV test before they are employed.
- ✓ There is a small risk that HIV can be transmitted accidentally through contact with infected blood. It is important that all blood is treated as possibly infected.
- ✓ There are many positive steps employers can employees can take to deal with the HIV/AIDS epidemic.

ADVOCATING FOR HUMAN RIGHTS OF PEOPLE LIVING WITH HIV IN THE WORKPLACE

Human Rights Are universal legal guarantees protecting individuals and groups against violation of fundamental freedoms and human dignity. Human rights are: • Guaranteed by international standard • Legally protected • Focus on the dignity of the human being • Obliges state and state actors • Cannot be waived or taken away • Are interdependent and interrelated • Are universal • Are inherent to all human beings, despite nationality, place of residence, sex, colour, religion, language, or any other status. Regardless of who we are, • Address many aspects of our everyday lives including the right to food, shelter, education and health freedom of thought, religion and expression. • Fundamental to Human Rights are: fairness, respect, equality, dignity, autonomy, universality and participation.	Employers and workers can support protection and promotion of human rights through: • Leadership statements that denounce human rights abuses of human rights through campaigns and published reports. • Involvement of People living HIV in awareness HIV campaigns. • Involving Human rights activists in campaigns and HIV education workshops • Development of workplace policies that protect and promote human rights for all including people living with HIV. • Implementing and supporting workplace HIV and wellness programs that facilitate access to health, social and economic services for vulnerable groups including, women, girls and people living with HIV. • Employers can facilitate establishment and sustaining of workplace support groups for emotional support and treatment compliance for workers living with HIV and or TB. • Workers and employers can sponsor community driven initiatives that support for people living with HIV. • Workers can support orphans and vulnerable children in the local communities.
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Strategies to reduce stigma and discrimination

The underlying drivers of stigma and discrimination are consistent across different contexts and epidemics and include:

- Lack of awareness of stigma and discrimination and their harmful consequences;
- Fear of HIV infection through casual contact; and
- Social judgment linking people living with HIV to behaviours considered as improper or immoral.

These drivers can be effectively addressed through dealing with fears and misconceptions about HIV:

- ✓ Participatory education which involves activities that encourage dialogue, interaction and critical thinking on “taboos”, including gender inequalities, violence, sexuality, and injecting drug use; “contact strategies”, which involve direct or indirect interaction between people living with HIV or key affected populations and key audiences to dispel myths about people affected by HIV;
- ✓ Mobilizing community and religious leaders and celebrities to foster respect and compassion for people living with HIV and to encourage greater openness around sexuality; through strengthening networks of people living with HIV to take the lead in addressing stigma; and raising awareness through the media, including “edutainment”.

Key interventions

Workers spend most of their life time in the Workplaces, thus creating a platform to challenge different social ills including HIV and AIDS related stigma and discrimination through the following interventions:

a) Educational programmes

- This includes peer education programmes, distribution of HIV and AIDS leaflets and posters, and utilising the internet to emphasise the promotion of healthy lifestyles.

b) Awareness raising programmes

- Promoting awareness through the use of stationery with red ribbons
- Highlighting special events – for example candle lighting ceremony, World AIDS Day and Sexual and Reproductive health awareness week,
- Allowing PLHIV opportunity to giving talks on HIV and AIDS

c) Counselling services

- Voluntary pre- and post- HIV test counselling

d) Prevention programmes, like extensive condom distribution programme

e) Support groups

- For those living with and affected by HIV, AIDS and TB
- Managing the needs of staff living with HIV, through reasonable accommodation according to affected employee’s needs, through flexi hours, special leave

f) Formal HIV and AIDS messages promoted by the government include like;

- ‘Condomise’
- ‘Government departments provide support’
- ‘You will not be discriminated against if you are HIV positive’

- ‘Support people living with HIV ’
- ‘HIV is real’
- ‘We can do something if we know your status’

J. DEVELOPING A WORKPLACE POLICY ON HIV, AIDS, TB AND WELLNESS

Ten Steps for developing HIV Wellness Workplace policies

The development of HIV and AIDS Workplace Programme includes the following Key elements, which are aligned to the Key principles of the Code and Recommendation 200 include:

1. Establish a committee with top management, supervisors, human resources, occupational health services, safety and health committee, managers of business support structures including cooperatives (primary, secondary and tertiary), workers, union representatives and people living with HIV with men and women equally representatives,
2. Develop terms of reference for the committee to be adopted by top management, health and safety committees, the Committee must undertake the following key activities:
3. Review relevant national laws and how they impact on the enterprise, including anti-discrimination laws, e.g. the ILO Conventions,
4. Assess the impact of the HIV epidemic on the workplace, using a confidential baseline study,
5. Determine existing health and information services, in the workplace and the community to avoid duplication and cut costs. This will also enhance collaborations between enterprise and community services.
6. Drafts the policy, in language understood by all, communicate the policy for input and adoption to enhance buy-in and ownership by management and employees.
7. Determine activities, identify activities that need and that don't need funds, develop budget for policy implementation,
8. Develop policy implementation plan with targets, time lines and responsibilities, the appointment of an HIV or wellness coordinator is highly recommended to ensure implementation and accountability.
9. Communicate the policy and the plan through training of peer educators and coordinators, staff meetings, induction and training workshops, billboards, emails, pay slip inserts, including setting up programs for ongoing information, education, referral system, care and support,
10. Monitor the impact of the policy and review it as need arise, to ensure new developments are incorporated into the policy and workplace response.

Common Workplace Activities for HIV, TB and Wellness could include the following:

- ✓ HIV, AIDS, TB and Wellness awareness programmes.
- ✓ Voluntary HIV counselling and testing.
- ✓ HIV and AIDS education and training.
- ✓ Condom promotion and dissemination
- ✓ Education on treatment for STIs, TB, Opportunistic infections and other health conditions, including facilitating access to antiretroviral
- ✓ Referral system and follow up for ongoing treatment, care and support including peer counselling
- ✓ Universal infection control procedures.
- ✓ Greater involvement of People living with HIV or TB in education and training sessions,
- ✓ Facilitating access to all other forms of social and economic services for workers and their families.

- ✓ Reasonable accommodation for infected employees.
- ✓ Introducing strategies to reduce HIV impact on vulnerable employees and their families including economic empowerment approaches,

Steps 1- 10 for developing a work place policy including samples

Different organizations and institutions may approach this process differently, but could include the following steps. In order to comprehensive needs of employees, and address stigma and discrimination related to HIV and AIDS, most workplaces, are moving towards the HIV, AIDS and Wellness Policy instead of just an HIV and AIDS policy.

Step 1: General comments

Contents	Sample For Step 1
The policy begins with a general statement or introduction that relates the HIV/AIDS policy to the local context and existing business practices, including some or all of the following: -The reason why the company needs an HIV/AIDS workplace policy -A statement about how the policy relates to other company policies -Policy compliance with national and local laws and trade agreements	- Our _____ Company ===== recognises the seriousness of the HIV/AIDS epidemic and its impact on the workplace. - We support the national efforts to reduce the spread of infection and minimize the AIDS impact - The purpose of this policy is to ensure a consistent and equitable approach to HIV prevention and impact mitigation among employees and their families, and to the management of the consequences of HIV/AIDS, including terminal illness, loss of productivity, need for reasonable accommodation of PLHIV the care and support of employees living with HIV/AIDS. - The HIV and AIDS Workplace policy has been developed and will be implemented in consultation with employees at all levels. - It is in compliance with existing laws regarding HIV/AIDS [laws on discrimination, working conditions, and safety and health'] and with the ILO Code of Practice on HIV and AIDS and the World of Work.

Step 2: Policy Framework and General Principles

Contents	Sample For Step 2
The policy establishes some general principles as the basis for specific provisions:	• Our Company ===== does not discriminate or tolerate discrimination against employees or job applicants on any grounds, including HIV status. • While our Company ===== recognises that there are circumstances unique to HIV infection, this policy rests on the principle that HIV infection and AIDS should be treated like any other serious condition or illness that may affect employees. • It takes into account the fact that employees with HIV may live full and active lives for a number of years. • The Company's commitment to maintaining a safe and healthy work environment for all employees is based on the recognition that HIV is not transmitted by casual contact.

Step 3(a): Specific Provisions

Contents	Sample For Step 3(a)
The policy should include provisions in the following areas: a. The protection of the rights of those affected by HIV/AIDS b. Prevention through information, education and training c. Care and support for workers and their families 1) Stigma, discrimination and rights • No rights - from confidentiality to access to benefits - should be affected by an individual's HIV status, real or suspected.	Rights of employees who are HIV positive • HIV-positive employees will be protected against discrimination, victimisation or harassment. • Normal company disciplinary and grievance procedures shall apply equally to all employees, as will the provision of information and education about HIV and AIDS. Employment opportunities and termination of employment • No employee should suffer adverse consequences, whether dismissal or denial of appropriate alternative employment opportunities, merely on the basis of HIV infection. [A collective agreement could spell out the grounds for dismissal]. Testing • Our Company ===== rejects HIV testing as a prerequisite for recruitment, access to training or promotion. However, the company promotes and facilitates access to voluntary confidential testing with counselling (VCT) for all employees. Epidemiological testing • Testing programmes for epidemiological purposes will be subject to appropriate consultation with recognised employee representatives and will be subject to independent and objective evaluation and scrutiny. • The results of epidemiological studies will not be used as a basis for discriminating against any class of employee in the workplace. All testing will comply with accepted international standards on pre-and post-test counselling, informed consent, confidentiality and support.

Contents	Sample For Step 3(a) continued
- Stigma and discrimination compromise employee welfare and a safe and healthy work environment. - They also undermine HIV prevention efforts, which depend on an atmosphere of openness, trust and respect for basic rights.	Confidentiality - The Company recognises the sensitive issues that surround HIV/AIDS and undertakes to handle matters in a discreet and private manner. - Where an employee with HIV has revealed his or her status to management, the Company will keep the identity of such person confidential. - However in line with the Company philosophy on the virus, the employee will be encouraged to be open about his or her HIV status.

Step 3(b): Specific Provisions

Contents	Sample For Step 3(b)
The policy should include provisions in the following areas: - The protection of the rights of those affected by HIV/AIDS - Prevention through information, education and training - Care and support for workers and their families. Awareness-raising and education - In the absence of a vaccine or cure, information and education are vital components of an AIDS prevention programme. - The spread of HIV can be limited by informed and responsible behaviour, practical measures such as condom distribution are also important means of supporting behaviour change within the workplace community.	- Appropriate awareness and education programmes will be conducted to inform employees about AIDS and HIV which will enable them to protect themselves and others against HIV infection. - HIV and AIDS awareness activities will reach families of employees and the local community. Reasonable accommodation through special time off for PLHIV to access health, social services and participate in support groups. - The company recognises the importance of involving employees and their representatives in the planning and implementation of awareness, education and counselling programmes, especially as peer educators and counsellors. - Practical measures to support behaviour change and risk management will include the treatment of sexually transmitted infections (STIs) and TB [or - where impossible - referral to STI and TB treatment services in the community], - Supply of sterile needle and syringe for injectable drug users where applicable, - Promotion and supply of male and female condoms. - Training shall be arranged for key staff including managers, supervisors, and personnel officers; union representatives; trainers, (both male and female); peer educators; and occupational safety, health and wellness officers and health officers. - Reasonable time off will be given for participation in education and training.

Step 3(c): Specific Provisions

Contents	Sample For Step 3(b)
The policy should include provisions in the following areas: - Protection of the rights of those affected by HIV/AIDS - Prevention through information, education and training - Care and support for workers and their families. Care and support for workers and their families It is in the interest of both enterprise and employees if infected individuals are assisted to remain at work as long as possible	<i>The promotion of employees' wellbeing:</i> Our Company,-----will Treat employees who are living with HIV or affected by AIDS, or TB or other chronic conditions with empathy and respect. - Provide all reasonable assistance which may include counselling, time off, sick leave, family responsibility leave, and information regarding the virus and its effect. <i>Work performance and reasonable accommodation:</i> The policy of the - The workplace policy will respond to the changing health status of employees by making reasonable accommodation in the workplace for those infected with HIV. - Employees may continue to work as long as they are able to perform their duties safely and in accordance with accepted performance standards. - If an employee with AIDS is unable to perform his or her tasks adequately, the manager or supervisor must resolve the problem according to the company's normal procedure on poor performance/ill health. <i>Benefits:</i> - Employees living with HIV/AIDS will be treated no less favourably than staff with any other serious illness/condition in terms of statutory and company benefits, workplace compensation, where appropriate, and other available services. <i>Healthcare:</i> - The occupational health services will offer the broadest range of services to prevent and manage HIV/AIDS, including: - Provision of anti-retroviral drugs (ARVs), - Treatment for relief of HIV-related symptoms and opportunistic infections (especially TB), - Reproductive and sexual health services, and - Advice on healthy living including nutritional counselling and stress reduction. - The dependents of employees will also be eligible for medical treatment. - Appropriate support and counselling services will be made available to employees. <u>Possible alternatives to other Health Care services:</u> - This Company will help employees living with HIV to find appropriate medical services in the community, as well as counselling services, professional support and self-help groups if required. - Allow reasonable time off will be given for counselling and treatment.

Step 4: Implementation and Monitoring

Contents	Sample For Step 2
If the policy does not take the form of a negotiated agreement, a short clause could be added whereby management and worker representatives pledge their full support to the policy.	Our Company, ===== has established an HIV/AIDS, TB and Wellness committee [or in case of a smaller workplace; assigned a responsible officer] to coordinate and implement the HIV, AIDS, TB and Wellness policy and programme. • The committee consists of employees representing all constituents of the company, including [spell out constituents]: ○ General management, ○ Staff committee, ○ Medical service, ○ Human resource staff. • The committee/ responsible officer will report regularly to the executive board. • In order to plan and evaluate its HIV/AIDS policy and programme effectively, Our Company ===== will undertake a survey to establish baseline data, regular risk and impact assessment studies. The studies will include: ○ Knowledge, attitudes and behaviour/ practices (KAB/P). ○ Studies will be carried out in consultation and consent of employees and their representatives, and in conditions of complete confidentiality. • This policy, and related information on HIV and AIDS, will be communicated to all our Company ===== employees and the wider public using the full range of communication methods available to the company and its network of contacts. • This policy will be reviewed every 2-5 years and revised as necessary in-line with the changing conditions and the findings of surveys/studies conducted.

Possible approaches for addressing HIV, AIDS, TB and Wellness through Economic Empowerment in the workplace

Implementing the Greater Involvement of People Living with HIV and AIDS (GIPA) Model in workplace programs by empowering employees living with HIV to be HIV and Wellness Trainers or champions or peer educators or coordinators in order to:

- ✓ Participate in the development of workplace HIV, AIDS and Wellness policies and programs
- ✓ Train members of the business groups on HIV and Wellness
- ✓ Promote HIV counselling and testing, importance of disclosure; treatment adherence, positive living
- ✓ Help address stigma and discrimination
- ✓ Facilitate the establishment and functioning of support groups in the workplace and or the community.
- ✓ Support employees and families to deal with disclosure processes, discordant couples etc.
- ✓ Establish, facilitate and support treatment buddy systems for affected employees
- ✓ Assist with follow up of troubled employees and provide needed feedback to management and

	Our company=====will allocate resources for to motivate HIV and Wellness workplace program volunteers who could be (trainers, champions, peer educators and coordinators) by: • Giving priority to workplace volunteers in human resources, labour relations, public speaking, HIV and Wellness training programmes • Providing incentives in the form of uniform, promotional materials (caps, t-shirts, umbrellas etc.) • Allocating mentors for the workplace program volunteers to groom them in leadership and public speaking/motivational talks especially positively living ambassadors who are empowered and ready to disclose their status. • Compile case studies on positive workplace program outcomes. .
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Economic Empowerment Activities

- Providing allowance for public speaking by workplace program volunteers to address employees, management and other workplace and community driven campaigns
- Encouraging all members of business groups to save a certain percentage of their weekly and monthly income, e.g. using cash box
- Introducing loan schemes for business members including those living with HIV and workplace volunteers
- Train members living with HIV and their families on entrepreneurship and cooperate development
- Train members of business groups and NGOs on business skills to improve their sustainability including training on (food gardens, running tuck shops, marketing and selling products from small manufacturers).in order to improve their economic status, so that they can have better access to services for treatment, care, support, education.
- Prioritize workplace program volunteers, including people living with HIV in local communities in economic opportunities.
- Assist workplace program volunteers to access funding from other sources, to diversify or improve their business.

Key messages:

- HIV and AIDS is a global, regional, national and local issue. There are policy, frameworks and programmes that seek to guide and address HIV and AIDS at these levels. These include:
 - The Millennium Development Goals
 - The ILO Decent Work agenda
 - The World Health Organisation's Guidelines on HIV and AIDS
 - The United Nation's "Getting to Zero" strategy
 - Country specific policies and frameworks
- Your work place can be a central area that addresses HIV and AIDS. Workplace policies can reduce the impact of HIV businesses, families and communities.
- Common themes across these policies, guidelines and programs include:
 - Responses to HIV and AIDS requires a human rights approach including consent, confidentiality, non-discrimination, employment protection, connection to care.
 - Social dialogue with relevant stakeholders (government, employers and workers) is key to addressing HIV and AIDS in the workplace
 - The importance of Combination Prevention Strategies, that is bio-medical and behaviour strategies.
 - The promotion of Gender Equity
 - The universal access to treatment, care and support

B. PEER EDUCATION AS A BUSINESS STRATEGY FOR HIV PREVENTION, WELLNESS MANAGEMENT AND AIDS MITIGATION

1. Introduction

Peer education is the process whereby well-trained and motivated individuals undertake informative organized educational activities with their peers (those similar to themselves in age, background or interests) over a period of time, aimed at developing their knowledge, attitudes, beliefs and skills and enabling them to be responsible for and protect their own health.

Peer education can take place in small groups or through individual contact and in a variety of settings: in schools and universities, clubs, churches, workplaces, on the street or in a shelter, or wherever people gather. It is important in every area for a strong peer education programme to be established targeting different community groups to ensure issues towards reduction of new infections of HIV are discussed and behaviours are changed. The purpose of this Module is to enable participants to have a boarder understanding of peer education as a strategy used in HIV education, prevention of STIs, patient care and support.

What is Peer Education?

- ✓ Peer education is the process whereby well-trained and motivated individuals embark on informative organized educational activities with their peers (those similar to themselves in age, background or interests) over a period of time,
- ✓ Peer education is aimed at developing new knowledge, positive attitudes, beliefs and skills that enable participants to act responsibly for and protect their own health.
- ✓ Peer education can take place in small groups or through one-on-one contact and in a variety of settings, including schools, universities, clubs, churches, workplaces, on the street or in a shelter, or wherever people gather.
- ✓ A strong peer education programme is necessary to ensure continuous dialogue on risky behaviours on HIV infections and other social ills foster behaviour are changed.

Components of a good Peer Education Programme

- ✓ Peer education is regarded as one of the most effective ways of developing and delivering HIV,AIDS, TB and Wellness messages for a specific community or target group, by specially trained peer educators.
- ✓ Peer educators should be leaders, selected from the target group/community, be trusted and respected by such community. Studies affirm peer education as the most effective way of fostering positive behaviour change, which is less costly and sustainable.
- ✓ Peer educators should receive specialized training so as to:
 - Be sufficiently knowledgeable about the content and methods of HIV, AIDS and Wellness programmes that they can deliver, to the workforce;
 - Be sensitive to race, sexual orientation, gender and culture in developing and delivering workplace programmes, Be able to link into and draw from other existing workplace policies, that deal with issues of sexual harassment, gender based violence
 - Be aware of needs of different employees including persons with disabilities;–
 - Be able to respond appropriately to different employee's needs
 - Be able to help tolerance, acceptance and support of troubled employees among their co-workers

- Be able to help their co-workers to identify factors in their lives that lead to increased risk of infection
- Be able to provide basic counselling to workers living with HIV, TB and other social ills on how to cope with their condition and its implications.

Key objectives of any Peer Education initiative:

- Reinforce positive behaviours
- Promote and develop new recommended behaviours
- Change risky behaviours

Definitions

Peer	Education	Peer Education	Peer educator	Peer education activities
• People of same social group (age, interest, gender, occupation, religion, socio-economic status) working together to address common issues.	• Is a process of teaching and learning using different methods, with the ultimate goal of influencing behaviour change, attitude, beliefs and skills.	• Is a process through which an individual can affect change and reinforce positive behaviour among members in the same situation.	• Is an individual who effects change and reinforces positive behaviour among members in the same situation.	• Information sessions using quizzes, role plays or stories; a theatre play • Condom promotion & supply, • Group discussions; and informal conversations with young people at a nightclub, • Exploring and discouraging risky behaviours, • Reinforcing healthy behaviour • Providing more information and practical help. • Referral and Follow Up

BEHAVIOR CHANGE COMMUNICATION THROUGH PEER EDUCATION

The peer education strategy supports health and social services through the following:

Program integration, finding and keeping peer educators, training and supervision of peers, addressing gender, sexuality and socio-cultural issues affecting health, formative assessment and mapping and zoning of the intervention area, program activities that foster behaviour change, care and support people living with HIV (PLHIV), Stakeholder involvement, project sustainability, monitoring and quality assurance.

Key Questions to consider when establishing a peer education programme

Programme integration

- What service-delivery needs do peer education programmes generate?
- What barriers to behaviour change could be addressed by integrating other services/activities with peer education?
- What is the organization's capacity to integrate or link with additional program components?
- What are the attitudes of program staff and the intended audience towards program integration?
- What is the effect of programme integration on peer education programme focus, acceptability, and quality?

- What is the effect of programme integration on the intended audience's and peer educators' attitudes and behaviours?
- What is the cost and cost-effectiveness of program integration compared to stand-alone peer education programmes?

Finding and keeping peer educators

- What are the determinants of peer educator volunteerism?
- What individual and programmatic factors are associated with effective job performance and continuity (e.g., literacy level of the peer educator, compensation, supervision and support)?
- What is the cost-effectiveness of peer education programmes with salaried versus volunteer peer educators?

Training and supervision

- What constitutes an effective peer education training programme (e.g., length of training, curriculum content, training methodology) in terms of peer educator job performance and satisfaction, and behavioural outcomes in the intended audience?
- What constitutes an effective supervision and support program for HIV peer educators?

Gender, sexuality and the socio-cultural context

- What are effective tools and approaches for conducting gender analysis to identify gender bias among peer educators, staff, and the intended audience that may have an impact on HIV prevention, care, and support?
- How can peer education programmes increase understanding about the social construction of gender and sexuality relevant to HIV among peer educators and their intended audience? How can peer education programmes meet the gender-specific needs of women and men and also promote gender equity?
- What is the impact on the intended audience of efforts by peer educators to reduce gender-related barriers to HIV prevention, care, and support?

Programme activities to foster behaviour change

- How can peer education programmes move from imparting facts about HIV alone to fostering and sustaining behaviour change in their intended audience?
- Which peer-led or peer-linked activities (health talks, theatre, radio call-in shows, counselling, support groups, advocacy) are effective in facilitating HIV-related behaviour change?
- How often (number of contacts/timeframe) should such peer-led activities be implemented? What types of knowledge and skills do peer educators need to lead such activities?

Care and support for PLHA

- What type of training, tools, and resources are needed to effectively equip peer educators to provide and/or facilitate access to care and support to PLHA?
- What are the roles and limitations of the HIV-infected peer educator in providing and/or facilitating care and support to other people living or affected by HIV, given concerns about stigma, confidentiality, and health?
- How can PLHA be motivated and supported to become and continue as peer educators? What are appropriate outcome indicators for peer education programmes focused on providing care and support for PLHA?
- What are the health and psychosocial effects on PLHA of a program that trains and supports

- PLHA as peer educators? What are the effects on PLHA reached by the peer education programme?

Stakeholder involvement

- Who are the critical stakeholders that may affect peer education programme implementation and behaviour change in the intended audience? What contribution can these stakeholders make to the peer education programme (e.g., donate human and/or financial resources, advocate for program implementation)?
- What motivates stakeholder participation and support for the peer education programme?
- How can stakeholders be engaged, not only as facilitators of peer education programme implementation, but also as facilitators of behaviour change in the intended audience

Sustainability

- How can peer education programmes be marketed in order to procure funding from outside donors (e.g., development of a sustainability plan, documentation of program effectiveness)?
- What income-generation activities are effective in contributing to the sustainability of peer education programmes (e.g., interest from microcredit loans, clinic fees, condom sales)?
- Do linkages between government and NGOs reduce costs or increase the efficiency of PE programs and thereby contribute to sustainability?

Benefits of “Peer Education”

- It reaches the members easily and at lower cost.
- It enables target groups to address issues collectively.
- It has the advantage of providing information to the people where they are, at work or in the community..
- It helps people change their behaviours because of trusted peers in the same situation who act as role models.
- It ensures sustainability of programmes because peers spend more time together.
- It facilitates involvement of several target groups to enhance the expanded national response.
- Young people begin to take responsibility in maintaining positive behaviours.
- Educators and target group speak the same language.
- Peer educators gain skills which are important for their further personal development.
- Peer education can supplement other educational interventions, such as the work of teachers, social workers, health service providers, etc.
- Peer education is a community-level intervention which can create linkage to other community services.
- Peer educators can gain access to groups which are otherwise difficult to reach.

Recruiting, training and supporting peer educators

The recruitment, training and support of peer educators is an essential part of an effective peer education program. Management and workers representatives must work together to recruit, train and support a pool of peer educators for each workplace or group.

The Peer Educator should demonstrate the following qualities		
• Show interest in, and committed to, STIs, HIV and AIDS prevention and care initiatives • Take up the task voluntarily • Be mature • Be a good communicator • Be able to read and write • Be respectful of others • Be resourceful • Be reliable • Be creative • Be flexible	• A good friend • A good advisor • A role model • Confident and influential • Concerned about the welfare of his/her peers • A good listener • Liked by group members • Demonstrates confidentiality, trust, openness, honesty, patience and tolerance. • Has interest to network with others	• Is audible • Maintains good eye contact • Maintains good posture and mannerism • Appropriately uses audio-visual aids • Dresses appropriately • Uses appropriate, understandable language

Roles and Responsibilities of Peer Educators

As they implement peer educations, peers disseminate information materials and condoms.

Roles and Responsibilities of a Peer Educator	Essential Basic package items for Peer Educators
• Conducts outreach activities • Implements planned activities • Monitors and evaluates daily activities • Trains other peers/workers on health and wellness maintenance, utilization of workplace services like, VCT, condoms • Gathers and shares information • Establishes working relations and networks • Makes referrals where appropriate • Speaks behalf of his/her group • Distributes condoms and demonstrates the use and disposal of condoms. • Disseminate information about workplace programs, policies including materials like condoms. • Provides peer talks to groups or one-on-one • Keeps records of activities • Reports regularly to HIV and AIDS coordinator and participates in meetings • Always available to answer questions from co-workers. • Referral of co-workers for relevant services	• Inventory book for materials and list of peer facilitators • Directory of counsellors • Directory of NGOs and CBOs and other organizations • IEC materials e.g. pamphlets, posters, leaflets etc. • List of audio-visual materials available from various institutions and districts • List of condom distribution outlets • Penis model • Condoms (including female condom wherever available) • Peer facilitator's recording and evaluation forms

Networking

Peer educators also need to take initiative in networking with other people and organizations in order to be updated on current developments in their locality.

What is networking?

Networking is making contacts and connections with individuals who have the potential to provide you and your organisation with opportunities, identify threats and possibly learn new best practices. Networking should be like a two way street as you will probably be able to offer some benefits to others as well.

Why should peer educators network?

- Source support or expertise or support not present in the workplace/organization or community, e.g. Counselling and testing, treatment, care and support etc.
- Avoid competition and foster complimentary activities and services, may lead to Partnerships, funding.

How to Sustain the Peer Education Programme

Practical measures to support and sustain a peer education program include Mentoring, Supervision, incentives, on-going training and integration of peer educators in the development agenda of the organization or community.

Mentoring & Supervision	On-going Training	Incentives	Integration into Development
• Consistent follow-up • Mentoring & Supervision • Debriefing meetings • Consistent provision of project materials • Appointment of a monitoring and evaluation personnel for close monitoring and evaluation of programme activities and implementation methods • Adequate support to both peer educators, site facilitators and project coordinators • Motivation of project personnel • Proper reporting structure • Group discussions of difficult experiences and possible coping techniques	• Weekly on-going trainings • Debriefing sessions • Spiritual inspiration(inviting a Pastor to share the word) • Counselling • Care and support • Sending peer educators for relevant external trainings or workshops • Exchange visits • Best peer educator/site facilitator of the month • Best trainer of the month • Best recruiting person of the month	• Promotional materials • Uniforms • Umbrellas, caps and raincoats • Bags for carrying Daily Planning Diaries and other monitoring tools • Refreshments and Meals during weekly meetings and trainings • Partaking in the economic empowerment programmes such as SIYB, GYB, • Stipends	• Involving people from vulnerable groups such as those living with HIV and AIDS in peer education program development and implementation is motivating • Involving people with HIV in peer education can help reduce stigma and discrimination and influence behaviour change • Recruiting peer educators to workplace opportunities emerging from the community or the workplace • e.g. income generation projects, contract work, workplace counselling and testing services, facilitation of support groups in the workplace or community • Training peer educators on business skills and assisting them to start their own businesses • Training peer educators on

- Strengthen PEs facilitation skills - One-on-one discussions - Observation and evaluation of training and basic communication / counselling skills	Inviting a guest speaker where participants are given the opportunity to share their work experiences with guest speakers (e.g. a person living with HIV and AIDS) in workshops or educational sessions.		different savings schemes so they can build their own resources for micro-finance Integrating PE into their core business (business groups, cooperatives, micro finance or micro credit organizations/ institutions) helps reduce their vulnerability to HIV through improved income
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Notes on Mentoring and Supervision of Peer Educators

Consistent follow-up and weekly training for peer educators needs to be planned and communicated in order to:

- ✓ Provide additional guidance and skills,
- ✓ Share new developments or information in the field,
- ✓ Keep peer educators motivated and committed.

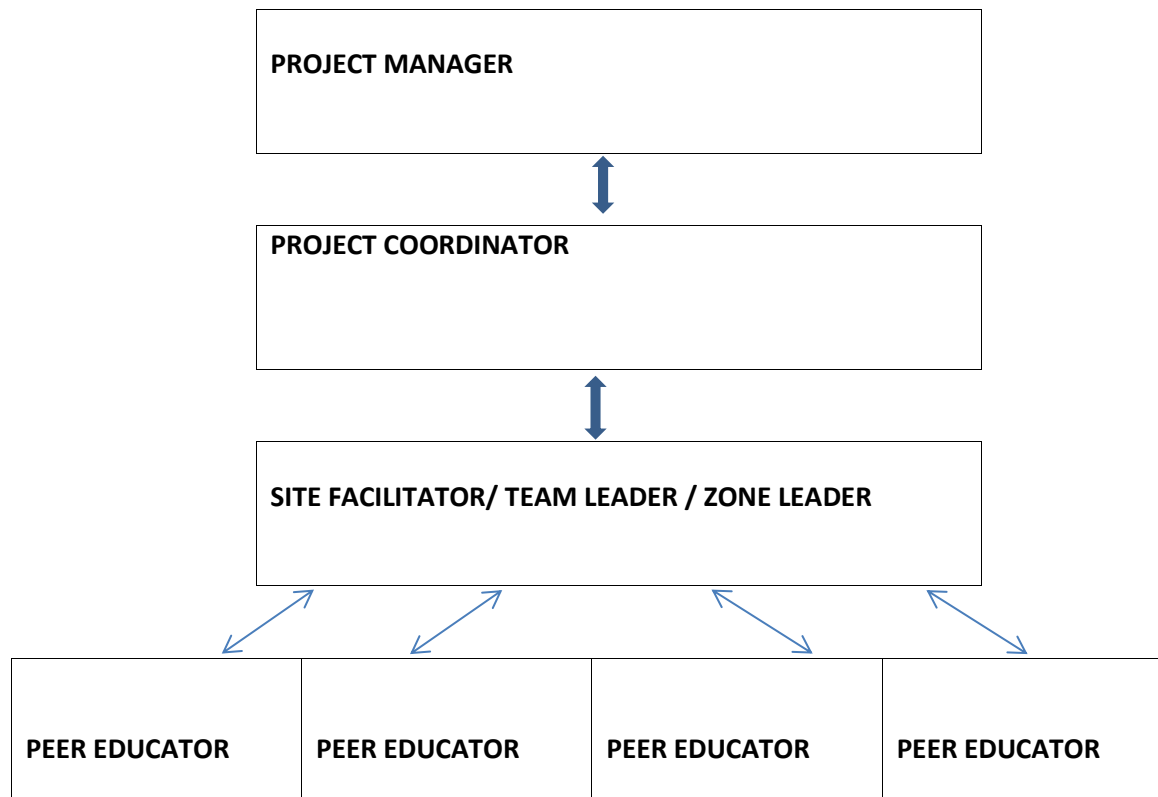
Supervision and mentorship

- ✓ The success of any peer education programme is reliant on on-going supervision and mentorship of peers by the project manager and coordinator.
- ✓ Supervision and mentorship in peer education can start with monthly sessions, then every second month and then every three months to help peer educators be acquainted with the program.
- ✓ The supervisor or mentor helps peers to deal with emotional and technical experiences.
- ✓ Mentoring and supervision also allows growth and keeps peers motivated.

Regular debriefing meetings for all peer educators and other peer education personnel

- ✓ Peer education team should meet at least once a week , where educators can discuss information sessions in terms of what worked, what educators could do differently,
- ✓ The team can share new materials or developments within the field,
- ✓ Peers can discuss new techniques, including facilitation of group discussions and roles plays as well as any personal difficulties.
- ✓ If peer educators work from different zones, it is important to bring all of them to together for such meetings.
- ✓ This also creates opportunities for experienced peer educators to teach and/or mentor new recruits.
- ✓ Providing both **monetary incentives** and **non-monetary incentives** such as; T-shirts, ribbons, materials etc. has been shown to act as a means of motivation for peers.
- ✓ The **project manager and or project coordinator** must provide regular up to date HIV, AIDS, STI, TB, other health and social information and services to peer educators.
- ✓ Providing peers with their **own educational materials**, such as a flipcharts or posters etc.
- ✓ Peer educators need to be **acquainted with Referral resources** to ensure beneficiaries are attended to as per need.

- ✓ **Team building activities**, the project manager and or coordinator need to plan **special activities** just for fun to uplift peer's **motivation** levels and enhance stress management and relaxation.
- ✓ Facilitate exchange visits between peer educators and other community based programs and groups.
- ✓ Establish a **Clear reporting structure**, which will ensure smooth management of implementation of activities and allows early identification and correction of problematic areas, .The recommended reporting structure for a peer education programme can be arranged as follows



- **Reporting structure for a Peer Education programme**

Formative Assessment as Part of the Setup of Peer Education Program

Definition of Formative Assessment

Formative Assessment is the process of gathering and analysing information to develop an intervention for dealing with a problematic issue affecting a community group/s.

The objectives of Formative Assessment

- ✓ The main objective is to obtain information to guide project intervention development (well known “a needs assessment”).

Important observations before conducting a Formative Assessment

- ✓ If the assessment is sex work orientated, it is important to learn the legal status of sex workers before conducting the assessment.
- ✓ It is vital to know the laws regarding sex workers and how and when they are enforced as this will influence one's entire approach to assessment and intervention. If, for example, sex workers are used to harassment or arrest after reports implicating them in HIV transmission they may be hesitant to

participate in an HIV prevention programme, and health workers will need to do even more than usual to prove their good intentions.

- ✓ As emphasized later, where police are badgering sex workers, intervention should try to educate the police to play a helpful role.
- ✓ It is important to remember that permission needs to be obtained and feedback given to different stakeholders, including authorities, owners of places (e.g. bars, shebeens, clinics, etc.) to be included in informative research and intervention and collaborating organizations.
- ✓ On the basis of the information and analysis obtained through Pre-setup Activities (Mapping) and the Logical Frame Work (Log-Frame) one will begin to examine whether it is feasible to initiate intervention in the entire town, or whether you must limit yourself to certain sites. These rough suggestions may be helpful.
- ✓ If the town's population is over 500 000 people, it may be advisable to limit yourself, at least initially, to certain sites.
- ✓ In widely dispersed towns, it is more difficult to begin an intervention in the entire town. In Zimbabwe, for example, the cities of Gweru and Mutare have comparable populations. However, Mutare's high density residential areas are very compact and Gweru's are widely dispersed. Logistically, it would require more time, effort and resources to cover all of Gweru.

Methods to be employed to gather information

- ✓ Key informant interviews (refers to the people who have the expertise and are professionally involved in driving the problem being targeted by the project e.g. sex workers.
- ✓ Direct observations of areas and events of interest (including bars, suburbs).
- ✓ Interviews of target audience/beneficiaries.

Types of Assessments for gathering information

Two types of assessments are carried out before implementing a peer education program, which is baseline interview assessment and triangulation.

Baseline Interview Assessment	Triangulation
Survey conducted before or just after intervention started usually in the form of a rapid assessment) to gather information: • To design an appropriate intervention. • To follow-up (after the project has been running for a while) • To compare knowledge, attitudes and practices with baseline to evaluate intervention effectiveness. • Focus groups or group interviews with different stakeholders, for example, community members (employees in case of workplace programmes) health care workers, traditional healers, community and traditional leaders, police services, etc.) • Secondary sources (including consulting academic journal articles and research study reports, newspapers, epidemiological and health surveys studies, hospital and clinic	Triangulation is a method used to verify the accuracy of information obtained through baseline survey. • To triangulate data, we take the major conclusions gathered from different data-collection methods and compare them for areas of agreement and disagreement. • Where discrepancies arise, it is important to look for evidence that help one to determine where the truth lies. • It is also important to suggest possible explanations for the discrepancies. Data is collected in the following ways: • Secondary sources • Key informant interviews • Participant observation

records and statistics).	• In-depth interviews with participants • Focus groups • Discussion of findings with participants.
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Collected information should reveal:

- ✓ Participating organizations (already determined prior to project development or need to be established).
- ✓ Possible implementing agencies (e.g. Local health authorities, hospitals, private sector, etc.)
- ✓ Possible and relevant intervention models (e.g. Clinic-based, health care workers as Peer Educators, community member Peer Educators, etc.)
- ✓ Services likely to be required (e.g. community outreach, condom provision, provision of STI services, etc.)
- ✓ An informed decision can be made after considering all the information gathered.

Product

- ✓ The project should have a formal report on formative assessments carried out, including methodologies used and results obtained. It should also include a description of the analysis and how the accuracy of information was determined.
- ✓ The conclusion and the decisions made regarding the project and intervention models should be stipulated.

2 . Mapping and Zoning: A tool for Peer Education and businesses

Mapping is an effective non-verbal way of finding out how people view their area. It is a good way for gathering and presenting site-specific data, understanding differences in perception and stimulating debate as a basis for joint planning. In the context of the Corridor Economic empowerment project, the target population is known. However, mapping and zoning will help project beneficiaries to understand their area of work better, including other health, social and economic activities within their communities.

After the initial recognition of the need for a Peer Education intervention the level of intervention should be decided (e.g. community or workplace level). Even a workplace may need to be mapped, to obtain all necessary information and plan accordingly.

- ✓ Mapping is a process of demarcating the project coverage area into manageable units to make it easy for planning and management of field activities by peer educators, which follows a formative assessment,
- ✓ It is conducted to learn the target environment, including legal status of the targeted group/s. e.g. laws around sex workers, informal traders and how and when they are enforced, as this will influence one's approach to the assessment and intervention.
- ✓ Mapping helps to outline information needed to design an intervention programme, such as recruitment of peer educators, from zoned areas within the coverage area, to enhance cost effectiveness and accessibility to assistance by targeted community members.
- ✓ The next step will be to choose the general area of intervention (which might not all be covered by the project).
- ✓ The site/s should then be mapped, using a suitable map, to indicate the different areas, types of settlements and availability of services such as transport, and to set the exact catchments area of the project.

Mapping is done to learn about

- ✓ Boundaries of an area, size, approximate population and dispersion of an area.
- ✓ Sub divisions in an area including major target areas e.g. sex work neighbourhoods, truck stops schools, etc. also needs to be mapped.
- ✓ Mapping also assist us in knowing the possible size of different target groups, area, major stable and mobile target groups and the relevant size of each.
- ✓ Understanding potential interactions in the area e.g. between stable and mobile populations.
- ✓ Commercial activities, particularly those related to HIV transmission, including sources of employment, sex work, truck stops, night clubs, bars etc. are observed.
- ✓ Target audience or the beneficiaries and to determine the feasibility of initiating interventions.
- ✓ Social problems and challenges encountered by the community are often examined geographically by considering the following:
 - Where are the targeted groups situated?
 - Where do the trucks stop, informal traders and sex-workers operate from?
 - What mode of transport does youths in school use to get home after school and what are the threats in between.
 - Where do youths in and out of school hang around the most, and what other activities pose as drivers to HIV transmission, alcohol and drug abuse?
 - Where and how dispersed are the clinics, hospitals, schools, truck stops, police stations, NGOs, CBOs, FBOs, Government Departments, trade markets and the border post etc.?
 - How big is the coverage area and how dispersed are the areas where intervention activities need to be implemented.
 - Where do cross border migrants reside or do they further travel to other towns?
 - How vulnerable are they to the social drivers of HIV transmission?
 - What kind of support structures are needed to enhance behavioural change?
 - What is the current use of developed land and identification of land available for development
 - What are the growth projections for the community (information can be obtained from Census data.
 - Who are the other community service providers e.g. police, schools, hospitals and utilities?

Where to procure maps? This may differ from one country to another, however the list below may help as a guide as to where topographic maps can be procured • Department of lands • Surveyors office • Local government • Census bureau • Universities, archives or public libraries • Development agencies e .g water and rural and urban development organizations working in the area. • Private corporations working in an area, especially mines, plantations and agro-industrial companies, who may have their own cartographers. • Aerial photograph agencies, such as mineral and agricultural surveyors. • Satellite mapping agencies. These are often more up-to date than hand drawn maps	What do we map? • Health, education, social and NGO services in an area. • Security and crime in an area. • Provisional zones or discrete sub-divisions in an area. • Potential interventions. • Approximate resources required for interventions • Major industrial • Major commercial • Major agricultural centres • Major uniformed services bases • Upper-income residential areas • Lower-income, formal-housing, authorized, residential areas • Lower-income, informal-housing, unauthorized, residential areas • Major migrant worker settlements or transit points • Major highways and public transportation arteries. Sexual risk behaviour is often more common along such routes • Border posts • Sex work neighbourhoods and residential areas, stations and Colleges and School • Social services, youth centres, NGOs and Religious centres
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The mapping process involves

- ✓ Obtaining topographic template maps of the catchment area for practical mapping exercise, and copies for transferring the data collected and indicated on the practical maps to be kept by the organisation for programme activity planning and for developing funding proposals,
- ✓ Preparing materials such as the topographic map template, markers, pencils and adhesive labels with different colours and shapes to symbolize different programme areas as identified during the practical mapping exercise.
- ✓ Identifying the area to be mapped by an individual or a group,
- ✓ Selecting people who are accustomed to the area and are enthusiastic to share their knowledge and expertise.
- ✓ Study the map and decide what the map or maps should show, e.g. hot spots, target mobility, social facilities available.
- ✓ Driving slowly across the target area, in order to be familiar with major features of the area.
- ✓ Developing a plan to divide the area into smaller, manageable units,
- ✓ Identifying focal points for further mapping.
- ✓ Map identified features
- ✓ Develop key for each feature identified
- ✓ Transfer the rough practical mapping onto a new map, complete with a key and a full list of all sites.

Benefits of mapping and Zoning

- ✓ Provides information on the population size, which informs recruitment of peer educators,
- ✓ To identify other influential stakeholders within the targeted area,
- ✓ Works as marketing strategy, as it makes the entrepreneurial group or organisation be known within the area,
- ✓ Provides information which is used to contribute to enhancement of the direction of the project
- ✓ It informs the layout of peer education activities by peer educators,
- ✓ The product is a tool used to describe the nature of the project, its coverage, hotspots, other high transmission activities within the area, distances, referral facilities etc.
- ✓ The product is a tool used in planning implementation of activities.

Benefits of Recruiting peer educators from target group

- ✓ Increases access to targeted groups based on the correlation which exists between peers.
- ✓ Confidentiality is maintained more than with any other method based on the peer to peer aspect.
- ✓ Communication is easier since language, social context and culture is the same between Peer Educator and the audience. This is especially important in addressing sensitive and culturally specific information.
- ✓ Messages are repeated to the same audience thereby creating opportunities for rapid impacts.
- ✓ The Peer Educator and the participants (audience) are empowered. Relationship between the community and the organization is promoted thereby creating acceptance by the community
- ✓ It increases community participation in prevention of HIV thereby initiating Behavioural Change patterns.
- ✓ The project coordinator recruits Peer Educators according to the number and size of zones in the project catchment area, as well as available funding.

A rough guide for a workable Peer Educator-Client ratio

Depending on how sparse the target population is, the number of peers might need to be adjusted.

Number of Peer Educators	Number of target beneficiaries
1	50 workers / entrepreneurs
5 to 20 peers	1 target area
15 – 20 peers	20 000 population

Case Study

The border town Nyautungwe

Nyautungwe is a border town whose population is largely made up of a poverty stricken community. A primary school and secondary school, a small shopping complex, a bus terminus, a small low density area, high density residential area and informal settlement make the important features of this town. The border town of Nyautungwe was growing and so were new expansions of informal resettlements taking place next to the high density areas of the town.

The influx of the trucks had increased and the truck drivers queued for longer hours, accumulating to days due to slow immigration processes. A truck stop had formed; consequently commercial sex work became rife. Due to poverty, both women and young girls in and out of school began to frequent the truck stop as commercial sex workers. Truck parking space also became a problem, which resulted in truck drivers finding anywhere to park, especially next to the informal settlements, where some commercial sex-workers had built informal structures for sexual activities.

Community members from high density area were pushing to make a living by trading various commodities to make a living. Traders competed to strike a sale; as a result many women resorted to commercial sex work to make a living, which left them vulnerable to HIV transmission or re-infection. Informal traders sold their commodities from bus stations, border post gates, truck stops, high density and informal settlement areas.

The only clinic within the town had reported a high number of TB and STI cases especially from informal settlement residents. Most clients would be referred to the nearest mission hospital for further treatment. An increase in teenage pregnancy was also reported, which resulted in young girls dropping out of school.

An organisation was established to intervene through peer to peer education for HIV transmission and re-infection, targeting informal traders and youth in and out of school around Nyautungwe. The question was how the organisation was going to implement the programme to reach out the intended beneficiaries and to monitor effectiveness of the activities and make impact.

3. PARTICIPATORY HEALTH TEACHING METHODS

What are Participatory Health Teaching Methods?

- ✓ Participatory Health Teaching Methods (PHTMs) are interactive approaches used to challenge people to confront, reflect on, develop their own response to, and build their own motive consensus concerning sexual behaviour.
- ✓ Participatory teaching methods are methods of teaching, used for mobilizing participants' enthusiasm and the cultivation of the spirit of innovation. A PHTM is used to portray health and social problem drivers in a real life situation.
- ✓ Participants of PHTMs have an opportunity to analyse their own problems as portrayed through participatory health teaching methods.
- ✓ From the analysis participants generate solutions and plan how to address such problems through voluntary decisions for behaviour change.
- ✓ PHTA utilizes flexible, diverse, direct teaching which encourages participants to actively participate in the learning process, thus, strengthening communication and feedback between the facilitator and participants and help them to put into practice all knowledge learned.
- ✓ PHTA can include; role-plays, picture codes, educational games or image theatre.
- ✓ These participatory exercises should be:
 - Genuinely participatory (for example, drama is not inherently participatory, but may frequently be prescriptive, presenting an obvious message).
 - Simple to use in field settings, robust, mobile and not dependent on expensive equipment, such as videotapes.
 - Entertaining and capable of attracting and holding audience interest.

5 Major categories for structured package of Peer Education activities	Other Common Teaching Methods	Songs as a method of teaching	Important considerations for using songs
• One-minute incomplete role plays. • Ten-minute dramas. • Picture codes. • Participatory games. • Image theatre	• Videos • Debates • Drama & Dance Theatre • Short Stories • Focus Groups Discussions	• Songs and dance are used as crowd pullers. • They are also used as entertainment in between other teaching methods.	• Message must be accurate Song must be short and appealing to the audience • Avoid religious tunes • Dancing to be appropriate to target audience or group • Involve your audience

i. Using incomplete role-play in peer education

A role-play is an activity which participants act out roles on a particular problem in order to help them gain insight into people's behaviours, feelings and attitudes. Incomplete role-plays are the nerve centre of our entrepreneurial peer education projects, because they pose a social problem and is left unresolved for the audience to discuss and find possible solutions to the problem.

Characteristics of Incomplete role play	How to conduct it	Advantages of incomplete role play
One-minute role plays are the cornerstone of the participatory package because they: • Can be performed with a small number of participants, • Are robust and require no special equipment, • Conducted by few players who are easily transportable, • Are easily audible and visible to large groups and • Are often enjoyable for peer educators to develop, rehearse and perform. • They help peer educators to develop confidence and communication skills. • Typical 1-minute role play raises an important social issue, and leaves it unresolved, hanging, frozen at a dramatic, emotionally engaging moment. • Set a tone for by the audience to think independently and objectively • Stimulate dialogue and interesting discussions on observations made.	• A role play does not take much time to rehearse. • Be sure that everyone can see and hear well enough to follow the role play. • Watch carefully to see if the actors are raising issues which are appropriate to the main problem. • Take notes during the role-play then refer to your notes during the discussion, which will follow after. • Stop the role-play in suspense at an abruptly crucial point (freeze). • Ask participants (actors) what they discovered by doing the activity. • Ask participants how this is related to what they already know and how this information can help them in their daily lives. • De-role actors after The role-play • Summarize the whole role-play, its objective and theme.	• They require no special equipment • Can be performed with a small number of peer educators. • They are easily audible and visible to a large group of people. • They develop peer educator's confidence and communication skills.

Some examples that a role-play might depict:

A truck driver is driving along the road, simulating engine noises, steering and gear changes. A woman is hitchhiking, he stops and she says: "Are you going to the border." He says: "Yes, that'll be 5 dollars". She says: "I don't have that much money." He pauses and then says: "Ok, I could do with someone to keep me warm when I sleep tonight, climb in." They look at each other without speaking.

A manager is interviewing a nervous woman for a job. The man says musingly: "Your qualifications aren't outstanding and you don't have work experience." He looks at her meaningfully. She says nothing. He says: "What can you offer to convince me to give you the job?" She looks uncertain. Impatiently he says: "Most women would do anything for this job." She looks down. He says: "Are you stupid you don't understand, let me spell it out. You can have the job if you go to bed with me."

Two visibly pregnant women are wandering down opposite ends of the same street, each looking at the house numbers and muttering, where is 550, as they gradually converge. They find house 550 at the same time and somewhat confused, knock on the door almost simultaneously. A man comes to the door sleepily, sees the two pregnant women and is visibly frightened. He slams the door, saying: "No, no, it wasn't me!"

A relatively young widow dressed in black is seated, looking sad and withdrawn. Several elders enter. The most senior stands up, calls the group to attention and says he has called them together to decide who will inherit the widow. They start to discuss the matter loudly as the widow sits sadly.

A woman comes home to her husband. She is walking with difficulty. He hardly notices her, as he is reading the football results and drinking beer. She says: "Do you know what happened today?" He grunts without looking up. She says: "I had stomach pains, so I went to the clinic." He growls, uninterested. She says, with controlled, but increasing anger: "They took a blood test." He pays no attention. She says: "Do you know what they found?" He rustles the newspaper, indifferently. Enraged, she pushes the newspaper aside and says: "Syphilis!" Shocked, he looks at her for the first time.

A young couple meets affectionately. The man says to the woman: "We have been going out for two years, without having sex, but today, my house is empty." They go excitedly to the house, enter the bedroom and start to undress. The woman says: "Before you do, where do you put the condoms?" He freezes, saying: "I thought you had the condoms." She says: "No, I don't." They look at each other sadly and start to dress again.

ii. Picture Codes

What is a picture code?

A picture code is a visual presentation of a problem, situation or issue familiar to the person or group by raising specific questions. These materials have a photograph on one side showing people in different situations and on the other side has questions for the peer educators. Picture codes are used in group education sessions to;

- ✓ Present a particular situation to a group of people,
- ✓ Stimulate a discussion about specific issues like behaviour which puts people at risk of HIV infection.
- ✓ Ask questions and get answers and solutions from the audience.

Some examples that a picture code might depict

- ✓ A middle-aged man sitting in his car, strokes the thigh of a schoolgirl in uniform. A school-aged girl, in the early stages of pregnancy, walks past her old school. A group of students in uniform, about her age, are looking at her.
- ✓ A schoolboy is dropped off around the corner from an orphanage by a big man. The schoolboy's brand-name boots are obviously new.
- ✓ A schoolgirl in uniform is sitting in the office of a doctor known for performing abortions.
- ✓ A man is sitting on his back steps showing a condom to three youths.
- ✓ Four young men leave a party late, but stop to pick up a young woman waiting for a taxi on the road.
- ✓ A minibus pulls up. The driver invites the girl standing by the road to come sit in front. She is, as the song says, "a girl with a front-seat face."
- ✓ A mother discovers a sportswear outfit in her daughter's school bag.
- ✓ A woman is cleaning up and getting ready to do the wash. She finds a condom in her partner's pocket.
- ✓ A man in a police uniform is shouting at and threatening a woman. She is covering her face and crying.

You might want to try imaginary picture codes, with participants visualizing scenes. After facilitating the educational activity, a five minute drama can be conducted to conclude or seal the message intended by the topic chosen for an activity.

iii. Drama

A drama is a teaching method that allows participants, to act roles on problems that they face in everyday life, generating possible solutions. It is action oriented, and based on real life situations within a given community. It exposes reality and responds to current problems or issues on what people think about an issue e.g. irresponsible sexual behaviour, STIs, HIV.

Questions to ask after a role-play or drama

- What have you seen or heard?
- Does this happen?
- Why does it happen?
- What problems can emerge from what we saw?
 - How can we solve these problems?

iv. Participatory Games

Participatory games are an excellent way of ensuring audience attention and participation. If the audience are fully involved and answer questions throughout each game, the game can also be an effective learning tool. Simple prizes or IEC materials may accompany games.

Points to consider when using participatory methods

- ✓ It is important to understand the strengths and weakness e.g. in songs, is the message clear;
- ✓ Check the advantages and disadvantages of each method and try to keep methodologies focused on objectives.
- ✓ Encourage participants to use their experience in developing the participatory methods.

Strengths of Participatory Health Teaching Methods	The Weakness of Participatory Health Teaching Methods
• The participants are actively involved during the discussion, so they are more likely to remember what was introduced during the discussion as they will they draw from their real life experiences. • Participatory teaching methods allow participants to discover principles for themselves and to develop problem-solving skills. • Participatory learning methods are relevant for everyone within different levels of understanding. • Participatory teaching methods involve everyone, which makes teaching and learning easier. • It makes people think for themselves and less dependent on the facilitator or information giver. • They aid in concentration which makes health education more enjoyable and creates a close feeling between the facilitator and the audience. • Participants build on knowledge that they already have. • They focus on the whole person, behaviours and attitudes. • They are innovative and creative • It is a simple way to convince people to change behaviour and it gives people greater pride in what they can do for themselves by making the right choices. • They are inexpensive and simple to use in a field setting. • They are entertaining and able to attract and hold attention. • Relevant to the learning objectives; • They are easy to p r e p a r e and use • Well understood by the audience • Interesting and entertaining; • Encouraging to participation and discussion	• It is easy to lose focus on the core of the message being communicated • Entertainment can overshadow the value of the message • It is difficult to control large groups

PEER EDUCATION OUTREACH ACTIVITIES

What is an Outreach?

An outreach is a planned activity which targets to educate a group or individuals with messages aimed at reducing HIV vulnerability amongst the targeted groups and supply of condoms, and health and social information and education materials. It also includes identifying and referring members with special needs for professional help.

The importance of Outreach activities

- ✓ Outreach activities are the most important ways of attaining the objectives of the project,
- ✓ Outreach activities are conducted by well-trained peer educators who educate other entrepreneurs on issues of HIV and other related issues, to promote behavioural change towards reduction of HIV infections.

How to plan and prepare for Outreach Activities

- ✓ Ensure the meeting is booked in advance and the venue confirmed, at least 2-4 weeks.
- ✓ Think about your target group/audience and select an appropriate topic for the target group.
- ✓ Collect up to date information on the subject, select and prepare visual aids where possible.
- ✓ List down the important points you want to say or communicate to the target audience.
- ✓ Choose appropriate participatory health teaching method.
- ✓ Ensure that peer educators are acquainted with the PHTM to be used and have rehearsed approaches and content for the day.
- ✓ Ensure that peer educators know and are allocated responsibilities to carry out during the outreach activity e.g. counting the number of women/men reached, the number of sex workers reached, condoms distributed, quality assurance, completing the post information checklist etc.

Facilitation of Educational Activities

During the outreach session, the peer educator applies learned facilitation skills to deliver the message and facilitate discussions.

What is facilitation?

- ✓ Facilitation is the process of directing a dialogue or conversation to achieve the intended objective of the discussion.
- ✓ Facilitation differs from lecturing, as lecturing is instructive while facilitation involves dialogues.
- ✓ A facilitator leads and directs the group to a conversation

Important aspects when facilitating

- ✓ The audience to be seated in a horse shoe structure.
- ✓ Don't praise one person and not the other
- ✓ Listening skills has to be applied when facilitating.
- ✓ Maintain eye contact with the audience
- ✓ Speak in a loud and clear voice
- ✓ Repeat the questions and answers of the audience
- ✓ Avoid facial expressions or any body language that shows your disapproval
- ✓ Involve everyone in the discussion, discourage people who dominate politely and respectfully and encourage the quieter ones to speak up.

Questions to ask when facilitating

- ✓ What have you or heard seen?

- ✓ Does this happen in our community
- ✓ What are the causes it to happen?
- ✓ What problems do this cause in our community?
- ✓ How can we solve these problems?

Other things to be observed

- ✓ The facilitator should summarize the whole discussion to help those who came late to catch up and understand the discussions.
- ✓ Don't forget to remind the audience where your offices are situated for more information and for collection of condoms.
- ✓ Facilitate the Condom demonstration in each and every meeting
- ✓ Condoms should be issued to the audience voluntarily after every meeting
- ✓ The distribution of material should be distributed after the meeting

Recommended Facilitation Skills	Outreach facilitators / peer educators must avoid the following:
• Respect • Language must be appropriate to your target audience • Good listening • Absence of facial expressions • Encourage questions, and if answer is not known, refer to the relevant person/organisation • Reaching out at different levels • No use of body language • Creating debate and controlling it • Speaking audibly and clearly • Paraphrasing • Maintaining eye contact • Use of names that are culturally acceptable for private parts • No labelling of target audience or other groups • Try to work with a group of 10 to 12 people, which will be is easy to manage	• Dominating the group • Be involved in a lengthy discussion or debate with participants • Taking sides • Being biased • Jumping into conclusions • See self as an expert on the subject • Create a lengthy dialogue with a particular participant • Criticize on a personal basis • Put participants on the spot • Allow domination of discussions by some participants

Important considerations for the Trainer/Facilitator

- ✓ Avoid information overload
- ✓ Use a range of teaching approaches, such as
 - Short talks,
 - Group discussions,
 - Exercises and interactive learning methods.
- ✓ Build in frequent breaks between sessions
- ✓ Encourage participants to read on their own

Additional Notes for making an outreach activity effective:

Foster Active learning - makes students think and apply the knowledge through a task.

Be clear - use visual aids, speak clearly, use simple language

Make it meaningful - explain in advance what you are going to teach, explain all new words and ideas, relate what you teach to participants' lives and work, give examples, summarize the main points at the end.

Encourage participation - stimulate discussion and involve the group in the learning.

Ensure mastery - check understanding and competence reached.

Give feedback - tell participants how far they have progressed.

V. Quality Assurance in Peer Education Programme

What is Quality Assurance?

- ✓ Quality assurance is the process of maintaining quality of Peer Education activities by establishing commitment to factual accuracy and quality of all peer education activities.
- ✓ It involves the completion of relevant monitoring tools by peer educators and motored by site facilitators as a true reflection on how the activity was conducted.
- ✓ All activities are recorded by Peer Educators, summarized by each zone's group leader and compiled and analysed by the project coordinator.
- ✓ Peers conduct participatory approaches to systematically monitor activities in the project area.
- ✓ The coordinator develops plans to remedy areas where performance is not satisfactory, including offering ongoing training on specific areas observed.

Objectives of Quality Assurance

Quality Assurance in Peer Education is done to achieve the following objectives:

- ✓ To develop a structured system to enable day-to-day management and monitoring of Peer Education activities.
- ✓ To help peers monitor outcomes in the project area to ensure consistent and complete coverage. To ensure schedule for zonal activities are coordinated and monitored.
- ✓ To create an opportunity for sharing of lessons among peer educators.

The Two Critical Features Of Quality Are:

- ✓ Transmission of correct, balanced, factual information during peer education sessions,
- ✓ Using well organized and structured meetings for each session,
- ✓ Using participatory techniques to engage interest and to challenge people to confront, reflect on and develop their own normative response to HIV, AIDS, STIs, TB and other social ills.

- ✓ Reviewing pre and post information checklists to plan and monitor each meeting looking at the following:
 - Selection of venue,
 - Seating arrangements,
 - Inclusion of participatory approaches, and the ration of lecture presentation to discussion and facilitation of discussion.
 - Checking performance against several concrete criteria and assign a score for quality.
- ✓ Information and quality checklists should become established early in programmes and be, used during:
 - Peer Education training,
 - Field supervision visits,
 - Day-today Peer Education meetings and
 - Monitoring reports

Pre and Post Information Checklist

- ✓ **Pre Information checklist** – carries information on HIV, AIDS, STI, TB and other health based on each topic. A pre-information checklist is used to:
 - Construct information framework based on selected topics,
 - Helps Peer Educators to focus on accurate, priority information and avoid interpretive errors.
 - Summarize the most important facts about selected topics that each Peer Educator should learn and present.
- ✓ **Post Information checklist** – checks on information disseminated based on selected topics and covered for a particular activity of the day.
 - A post checklist is used after every educational activity to check if the information passed was as per pre information checklist.
- ✓ **Quality checklists will provide the following:**
 - Updated Information Checklist for Peer Educator with HIV information.
 - Quality Assurance Checklist for organizing and conducting meetings.
 - Summary reports on the Quality Assurance Checklists.

Weekly Ongoing Trainings

Weekly ongoing training is an on-going process of building capacity of peer educators,

- ✓ It is implemented soon after the initial 10 days Peer Education Training.
- ✓ Weekly on-going trainings are the activity nerve centre for sustaining the peer education programme and are important for the project coordinator and Peer Educators.
- ✓ They strengthen group unity, assists in management, motivation of community volunteers and ensure programme quality.
- ✓ Meetings run consistently throughout the year between the coordinator and peer educators allow, learning key lessons among peers, early problem identification and resolution.
- ✓ They help with formulation of new strategies and development of new training content.
- ✓ Each Peer Educator holds about three to four meetings weekly,
- ✓ The project coordinator can only get to a few of these meetings, making the weekly contacts essential for programme maintenance.

Weekly Trainings yield benefits for on-going peer training, project management and monitoring:

Peer Educator Training: • It reinforces learning obtained during the initial 10-day training; • Helps identify plan for other training needs or topics • Sharing of experiences and skills; • Rehearsal of participatory approaches including new topics.	Management: • Giving reports, quality and statistical assessments; • Planning for the coming weeks meetings; • It helps strengthen group unity; • Collecting of materials e.g. condoms & pamphlets;	Support: • Solving of any problems; • Motivation and support; • Sharing of personal problems – one to one, peer to peer counselling, debriefing; • Specifically inviting other professionals in during training times (or other) to provide emotional, social or spiritual support.
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vi. Client Referral and Follow up System

What is a referral?

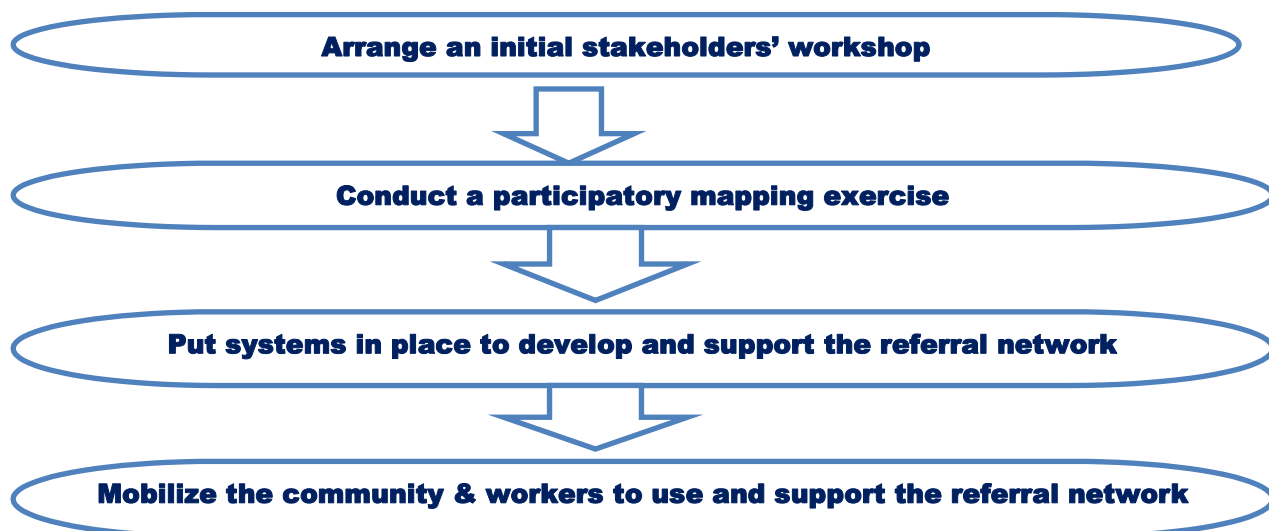
In the context of HIV and TB, a referral is the process of assessing immediate client needs for treatment, comprehensive HIV care and support services and referral to facilities that provide them. It includes setting up appointments or giving directions to facilities and preparing a referral note.

The purpose of referral is to:

- ✓ Help people with HIV (PWHIV) or TB or any other condition, their family and caregivers attain and maintain healthier, happier, productive and quality of life,
- ✓ Facilitate client's active participation in decisions affecting their lives and
- ✓ Promote social acceptance and respect for people with HIV and TB and those caring for them.
- ✓ **Clients' needs include;** physical, psychosocial, human rights, food resources, economic security and spiritual needs.
- ✓ Effective referral includes follow-up to obtain feedback on whether the client's needs were met.
 - In the context of workplace programs, immediate supervisor and or assigned peer educators can be tasked to refer and follow up referred clients.

The referral system entails a process of coordinating service delivery to ensure that:

- ✓ Confidentiality is maintained within the network of treatment, care and support (family, health facility and community based caregivers.
- ✓ Tracking of referrals between the organizations within the network.
- ✓ Those referred access needed services.
- ✓ Documentation and communication of referral outcomes for the continuum of care.
- ✓ Members of the referral network discuss quality issues through regular meetings.
- ✓ Missing information in referral and feedback forms are constantly updated to meet client's needs.
- ✓ The referral network directory is developed, updated and shared.



- **Starting And Strengthening A Referral Network**

Steps for starting and strengthening a referral network	
Step 1: Arrange an initial stakeholders' workshop	• Stakeholder identification. • Obtain buy-in by stakeholders through community dialogue • Train people with HIV and TB to be program ambassadors
Step 2: Conduct a participatory mapping exercise	• Conduct mapping and zoning, to identify health facilities, social and financial support structures, organizations of people with HIV and TB, NGOs, FBOs, academic institutions, etc. • Generate an inventory or list of all organizations and facilities providing HIV and TB related services for referral network. • Identify social services key entry (government and non-government) and potential barriers, Identify community's own resource persons, including traditional leaders, Organizations or people with HIV,
Step 3: Put systems in place to develop and support the referral network	• Establish a referral system with a health facility or an NGOs, • Agree of on clear roles and responsibilities within the referral network, • Hold regular stakeholder meetings to discuss referral and feedback outcomes. • Develop clear guidelines on confidentiality within the referral network. • In the workplace, referral forms and registers must be shared with supervisors and peer educators.
Step 4: Mobilize the community to use and support the referral network	• Obtain input from PWH and TB, their families and caregivers to on how best the referral system can respond to their needs. • Conduct multi-sectoral workplace and community awareness campaigns to market available services for HCT, HIV and TB treatment, care and support.

Step 5: Implement the referral system	• Work with the client to determine referral needs • Offer health and social service options, and allow the client to choose the most suitable one; in terms of distance, service hours, cost, culture, language, gender, sexual orientation and age. • Assure client of shared confidentiality with members of referral network, • Indicate that you will follow-up with the client to check if they were helped. • Document the referral in the organization's referral register. • Give the client a list of other available services with addresses, telephone numbers and hours of operation. • Ask the client to report on quality of services to which he or she is referred
Step 6: Monitor the referral system	• Develop and communicate referral system objectives, outputs, outcomes and indicators • Check with client if the referral met their needs and improve services • Tools for referral system (Appointment Books, reminder cards, call log book)
An example of a Referral System Monitoring Grid	
Total number of the referrals made Reasons for referral (legal, nutritional, financial, spiritual needs) Number of referral follow ups done	Number and Percent of clients who report satisfaction with the referral process Number and Percent of clients who report their needs were met

Staff responsible for worker's wellness must give special attention to people might be lost to follow up:

- ✓ Children and spouses of very ill workers and or orphans
- ✓ Sex workers
- ✓ Migrant workers
- ✓ Workers with history of
 - Substance abuse
 - Family conflict
 - Financial problems

Other Support Systems for People with HIV, TB and their Carers

On-going support for PWHIV	Home-based care, including palliative care	On-going Support for Carers
People with HIV (PWHIV) or TB may still need support, even if their physical needs are met. • Stigma and discrimination related to HIV and TB may cause conflicts in the family and at work, • Workplaces, can establish buddy system to ensure treatment adherence; coping with side-effects, • Effective support systems for individuals,	Home based services help: • To supplement limited health facilities, • Provide an entry point for HIV counselling and testing • With counselling, as well as identifying eligible candidates for ART; • With follow up of clients discharged from health facilities but still requiring direct monitoring of	Carers can be supported in the following ways: • Identify their needs, • Encourage carers to use local support services, • Encourage peer support among carers • Exercise confidentiality in all affairs of carers, • Defend and discourage from idle talk. • Confront any situation as soon as its reported to avoid conflict from impacting on carers work

families and groups can improve coping mechanisms and wellbeing of those affected. • Specialized support; legal aid, adoption, estate, • Counselling of children • Disclosing HIV status to children • Disclosing children HIV status.	treatment, care and support and side-effect management. • To offset the financial burden on individual and family. • Clients to access quality community- and home-based care programmes. • Get client's consent for telephone or home visit	• Seek consent from affected or reporting carer before approaching others. • Make the contact and set up appointment for carers, • Train carers on conflict resolution among carers instead of seeking quick-fix solutions • Provide practical support, financial, medical, housing, etc.
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Home visit by Peer Educators or Treatment Supporters

- ✓ A comprehensive workplace wellness program should include home visit for clients with special needs including:
 - Bedridden clients, or
 - Clients who don't show up after referral or for follow up and
 - Clients who need treatment support (TB treatment, ART)
 - Clients with reported family problems.
- ✓ Home visits can be done by peer educators, wellness coordinators or through collaboration with community based organizations or Health facility staff.
- ✓ The workplace policy should provide for worker consent to home visits, where need arise.

General tips for conducting a home visit

- ✓ Depending on the organization's policy; the wellness manager/coordinator must issue an instruction for home visit,
- ✓ Always be supportive and never judge clients for missing an appointment,
- ✓ Show respect to the client and his/her family,
- ✓ Greet and introduce yourself indicating your name, and the purpose of your visit,
- ✓ Find a way to talk to the client in person and in a private,
- ✓ Ask if it is a good time to talk, or if you should come back another time that is more convenient,
- ✓ Do not disclose confidential information family, colleagues or community. If need be, encourage and support the client to disclose confidential information themselves,
- ✓ Discuss the reason for your visit, including concern for missed referral, follow up and or treatment,
- ✓ Explore the client's reasons for missing the appointment,
- ✓ Help clients to make a concrete plan on how they will honour the appointment next time,
- ✓ Remind the client how important it is to return to the clinic for specific services,
- ✓ Ask clients if you can check in every now and again to see how things are going,
- ✓ Write down the outcomes of every home visit conducted and report to s, even if you were not able to find clients,
- ✓ Discuss the outcomes of home visits with relevant members of the referral network,



- ✓ If the client is very ill, arrange that they go to clinic or hospital right away,
- ✓ If there are small children, arrange relative or friend to remain with children,
- ✓ If the worker has business activities, arrange someone to assist, while the client is in hospital and
- ✓ If you don't find client at first visit keep trying, ask relatives, friends etc.

4. PEER EDUCATION REPORTING TOOLS

Standardized monitoring and evaluation templates

A. Meeting Schedule/ Booking Form

Name of Zone Leader/Peer Educator: _____

Name of Zone/Site: _____

Date	Time	Venue	Peer educator’s Responsibility and Topic/s to be covered	Type of meeting	Authorising manager’s Signature

B. PEER EDUCATOR’S FIELD ATTENDANCE REGISTER

ZONE/GROUP LEADER’S SIGNATURE: _____

DATE: _____

No.	DATE	NAME SURNAME	TIME IN	SIGN	TIME OUT	SIGN

C. Peer Educator's Daily Summary

Date: _____

Peer Educator's Name: _____

Signature: _____

Activity	Totals
Number of meetings held	
Number of one on one activities conducted	
Number of men reached	
Number of women reached	
Number of LGBTI reached	
Number of Youth in and out of school reached	
Number of IEC materials distributed	
Number of Male Condoms distributed	
Number of Female Condoms distributed	
Number of safer sex pack for gays & lesbians distributed	
Number of HCT and STI referrals	
Number of PMTCT referrals	
Other referrals (specify)	
Number of Sex Workers	
What were the most important achievements?	
What were the greatest difficulties faced	
What can be done to overcome these difficulties?	

D. Peer Educator Planning And Monitoring Diary

Day of the Week	
Date	
Planning Section	
Time	
Venue	
Planned Activities:	
Type of Meeting	

Monitoring Section

Number of meetings held	
Number of one on one activity conducted	
Number of males Reached	
Number of females Reached	
Number of LGBTI reached	
Number if PLWHIV reached	
Number of youth in and out of School reached	
Number of single mothers reached	
Number of Male Condoms Distributed	
Number of Female Condoms Distributed	
Number of Safer sex pack for gays & lesbians distributed	
Number of IEC Material Distributed	
Number of other referrals	

E. Coordinator's Monthly Summary

Date _____ Month: _____	
Coordinator's Name _____ Signature: _____	
Activity	Totals
Total number of meetings held during the summary period	
Total number of one on one activities conducted during the summary period	
Total number of men reached during the summary period	
Total number of women reached during the summary period	
Total number of LGBTI reached during the summary period	
Total number of PLWHIV? to discuss during the summary period	
Total number of Youth in and out of school reached during the summary period	
Total number of IEC materials distributed during the summary period	
Total number of Male Condoms distributed during the summary period	
Total number of Female Condoms distributed during the summary period	
Total number of safer sex pack for gays & lesbians distributed during the summary period	
Total number of HCT referrals during the summary period	
Total number of STI referrals during the summary period	
Total number of PMTCT referrals during the summary period	
Other referrals (specify) during the summary period	
Total number of Sex Workers during the summary period	
What were the most important achievements during the summary period?	
What were the greatest difficulties faced during the summary period	
What can be done to overcome these difficulties?	

F. Site Facilitators Weekly Summary

Date _____		Week no: _____		Zone _____	
Site facilitators Name _____		Signature: _____			
Activity					Totals
Total number of meetings held during the summary period					
Total number of one on one activities conducted during the summary period					
Total number of men reached during the summary period					
Total number of women reached during the summary period					
Total number of LGBTI reached during the summary period					
Total number of PLWHIV during the summary period					
Total number of Youth in and out of school reached during the summary period					
Total number of IEC materials distributed during the summary period					
Total number of Male Condoms distributed during the summary period					
Total number of Female Condoms distributed during the summary period					
Total number of safer sex pack for gays & lesbians distributed during the summary period					
Total number of HCT referrals during the summary period					
Total number of STI referrals during the summary period					
Total number of PMTCT referrals during the summary period					
Other referrals (specify) during the summary period					
Total number of Sex Workers during the summary period					
What were the most important achievements during the summary period?					
What were the greatest difficulties faced during the summary period?					
What can be done to overcome these difficulties?					

G. Quality Checklist

No	Questions	Yes	No
1	Was the meeting place as cool and airy as possible?		
2	Were the audience sitting comfortably on seats or mats, for indoor meetings, or sitting or standing under shade, for outdoor meetings?		
3	Was the audience in a horseshoe, within 5 meters of the presenter for lectures or discussion and 7 meters for drama or role plays?		
4	Were there at least 10 people in the audience, excluding the presenter?		
5	Did the presenter talk loudly enough for the audience to hear?		
6	Did the audience listen quietly, silencing any disruptive or drunk people, when the presenter spoke?		
7	If there was a lecture, was it no longer than 8 minutes?		
8	Was there at least one participatory exercise (picture code, 1- minute role play, 10 minutes drama or game), followed by a discussion?		
9	Did the audience show visible enthusiasm during the participatory exercise?		
10	Was all the factual information presented in the lecture, participatory exercise and discussions, in agreement with the information check list?		
11	Did the lecture and or the participatory exercise avoid blaming women for the spread of STIs/AIDS?		
12	Was there at least 20 minutes, preferably 30 minutes, for discussion?		
13	Did at least 5, preferably 10, members of the audience join in the discussion?		
14	Was the number of women contributing to the discussion proportionate to the number of women in the audience?		
15	During discussion, did the presenter listen to each comment without showing facial disapproval or interrupting (except where the speaker was drunk or deliberately disruptive)?		
16	Did the presenter (respond very briefly to each comment, asking the audience to comment further, without answering the comment personally? Did the presenter lead the discussion away from basic facts about AIDS, to attitudes,		

	values and personal concerns?		
17	When women and STIs/HIV and AIDS were discussed, did the presenter guide the audience to focus on men's responsibility for STIs/HIV and AIDS?		
18	Did the presenter offer condoms at the end of the meeting?		
19	Did the presenter end by telling the audience where and when they could contact the project for further information		
Below 10 Yes – Weak 10-15 Yes – Fair 16-20 Yes – Good 16 and above -Excellent		Score _____ 	 Total
			Total

H. Pre- Information Checklist

No.	INFORMATION
1	Acquired Immune Deficiency Syndrome (AIDS) is caused by an invisible virus called Human Immune-deficiency Virus (HIV
2	The HI- virus hides in the body until it attacks, causing AIDS disease, which is usual fatal.
3	Neither Western nor Traditional medicine can cure AIDS disease nor is a cure unlikely to be discovered for many years.
4	The HI-virus spread mainly via sexual intercourse
5	People who have more than one sexual partner, or have a partner who has more than one partner, are likely to contract the HIV.
6	A mother who has the HI-virus may transmit it to her baby during pregnancy.
7	Since most people infected with HIV look healthy, it is impossible to determine that person's HIV status by merely observing their physical appearance.
8	The best way to avoid HIV infection is either abstinence, in which one abstains completely from any sexual relations, or strict mutual faithfulness, in which two people who have never had sex before, remain completely faithful to each other for their entire lives.
9	After abstinence and mutual faithfulness, the next best way to avoid HIV infection is to use a condom correctly and consistently every single time during sexual intercourse.
10	People who have other sexual transmitted infections (STIs) should not have sexual intercourse, as they are much more likely to contract or transmit HIV infection.
11	HIV infection is not transmitted by mosquitoes or other biting insects.
12	HIV is not transmitted by social contact, so it is safe to live and work next to people who have AIDS and to care for them when they are sick

I. Post- Information Checklist

No.	INFORMATION	YES	NO
1	Acquired Immune Deficiency Syndrome (AIDS) is caused by an invisible virus called Human Immune-deficiency Virus (HIV).		
2	The HI- virus hides in the body until it attacks, causing AIDS disease, which is usual fatal.		
3	Neither Western nor Traditional medicine can cure AIDS disease nor is a cure unlikely to be discovered for many years.		
4	The HI-virus spread mainly via sexual intercourse.		
5	People who have more than one sexual partner, or have a partner who has more than one partner, are likely to contract the HIV.		
6	A mother who has the HI-virus may transmit it to her baby during pregnancy.		
7	Since most people infected with HIV look healthy, it is impossible to determine that person's HIV status by merely observing their physical appearance.		
8	The best way to avoid HIV infection is either abstinence, in which one abstains completely from any sexual relations, or strict mutual faithfulness, in which two people who have never had sex before, remain completely faithful to each other for their entire lives.		
9	After abstinence and mutual faithfulness, the next best way to avoid HIV infection is to use a condom correctly and consistently every single time during sexual intercourse.		
10	People who have other sexual transmitted infections (STIs) should not have sexual intercourse, as they are much more likely to contract or transmit HIV infection.		
11	HIV infection is not transmitted by mosquitoes or other biting insects.		
12	HIV is not transmitted by social contact, so it is safe to live and work next to people who have AIDS and to care for them when they are sick		

J. CEEP Vulnerability Reduction Training: Pre-Training Assessment Form

Date for training : _____

Trainer/ Facilitator Name : _____

Venue : _____

Welcome!!

We would like to know your background, your knowledge and skills level based on HIV training, of peer educators. There is no right or wrong answers. We are interested only in knowing your opinion.

Note that you do not need to give your name.

Personal Evaluation (Tick where applicable)	
1	Are you ☐ Male ☐ Female
2	How old are you? ☐ 18-22yrs ☐ 23-30yrs ☐ 31-45yrs ☐ Above 45yrs
3	What level of schooling have you completed? ☐ Primary school ☐ Secondary school ☐ Tertiary
4	What is the primary functional role in your job? (select one) ☐ Manager ☐ Coop member ☐ Peer educator ☐ Trainer
5	Would you be able to use knowledge and skills learned in this training? ☐ Yes ☐ No
6	How long have you been working in peer education programmes? ☐ Yes ☐ No
7	How long have you been working in peer education programmes? ☐ 0-2yrs ☐ 2-5yrs ☐ 5-10yrs ☐ Other (specify)

8. Is there a link between HIV and Genders? **Yes or No**

Briefly **explain** **the** **link**

9. What is your understanding between gender and sex?

10. How does gender orientation affects women sexual and reproductive health?

11. How does gender roles affect women's role in the social economy.

12. Are you able to calculate the cost of HIV on a business? **Yes or No**

13. Are you able to develop a budget for you workplace and wellness activities for your organisation?

14. Give three different participatory teaching methods to use in disseminating factual HIV information to different community groups? Explain how they work.

15. What do you think would motivate you (business people, informal traders) to be involved in HIV, AIDS, and STIs TB work?

16. List strategies that can be used in enhancing Behavioural change in your community?

17. Have you ever conducted a Monitoring and Evaluation at your workplace?

18. Is there a link between the spread of HIV and poverty? Explain

THANK YOU!!!!

K. CEEP vulnerability Reduction Training: Post-Training Assessment Form

Date for training : _____

Trainer/ Facilitator Name : _____

Venue : _____

Welcome!!

We would like to know your background, your knowledge and skills level based on HIV training, of peer educators. There is no right or wrong answers. We are interested only in knowing your opinion.

Note that you do not need to give your name.

Personal Evaluation (Tick where applicable)	
1	Are you ☐ Male ☐ Female
2	How old are you? ☐ 18-22yrs ☐ 23-30yrs ☐ 31-45yrs ☐ Above 45yrs
3	What level of schooling have you completed? ☐ Primary school ☐ Secondary school ☐ Tertiary
4	What is the primary functional role in your job? (select one) ☐ Manager ☐ Coop member ☐ Peer educator ☐ Trainer
5	Would you be able to use knowledge and skills learned in this training? ☐ Yes ☐ No
6	How long have you been working in peer education programmes? ☐ Yes ☐ No
7	How long have you been working in peer education programmes? ☐ 0-2yrs ☐ 2-5yrs ☐ 5-10yrs ☐ Other (specify)

8. Is there a link between HIV and Genders? **Yes or No**

Briefly **explain** **the** **link**

9. What is your understanding between gender and sex?

10. How does gender orientation affects women sexual and reproductive health?

11. How does gender roles affect women's role in the social economy.

12. Are you able to calculate the cost of HIV on a business? **Yes or No**

13. Are you able to develop a budget for you workplace and wellness activities for your organisation?

14. Give three different participatory teaching methods to use in disseminating factual HIV information to different community groups? Explain how they work.

15. What do you think would motivate you (business people, informal traders) to be involved in HIV, AIDS, and STIs TB work?

16. List strategies that can be used in enhancing Behavioural change in your community?

17. Have you ever conducted a Monitoring and Evaluation at your workplace?

18. Is there a link between the spread of HIV and poverty? Explain

THANK YOU!!!!

L. CEEP Vulnerability Reduction Training: Daily Workshop Evaluation Form

Workshop attended : _____

Date Of Workshop : _____

How would you rate the following?

Tick where applicable	Poor	Good	Very Good	Excellent
Information sharing				
Aims and objects being met				
Pace of sessions				
Facilitation				

What Topic did you find the most valuable? Explain why?

What topic did you find least valuable? Explain why?

What did you like most about the lessons today? Explain why?

What did you like least about the workshop? Explain why?

Which activity was helpful and states the reasons why?

What topics would you like to be discussed at the next workshop? Explain why?

What final comments would you like to make? Explain why?

Thank you!!!!

C. CALCULATING THE COST OF HIV, AIDS AND TB TO BUSINESS

Introduction

One of the most important issues management has to consider in making a decision about HIV, AIDS and TB workplace response, is the financial risk this epidemic presents to the organisation. Managers are likely to want to see some kind of cost–benefit analysis to help them make informed decisions. To date, the costs of HIV and HIV to businesses, as well as the benefits of prevention interventions, have been quite a challenge to estimate.

Determining the precise benefit or value of a prevention programme is still complicated and is likely to vary in relation to the quality and comprehensiveness of the programme, and the availability of other programmes in the community. This Module seeks to provide guidance on process of calculating the cost of an HIV programme and the impact of HIV on a business.

Budgeting for HIV, AIDS and TB programme in the workplace

From the beginning of developing programmes addressing HIV in the workplace, it is necessary to think of cost. Some of the questions that should be asked early in the process are:

- What are the rough costs of the activities (materials, staff, training etc.)?
- Is there opportunity for cost sharing and with whom?
- Is the budget limit affordable?
- Who else can support the programme?
- What public services can be accessed to minimise costs?
- What needs to be done first and what can be done at a later stage?

Who should be involved in budgeting?

- The task of developing a policy rests with a committee or task force comprising both staff and management.
- The same team should facilitate costing of planned activities.
- Consultations should be made with staff, management, the board, stakeholders and service providers.

In budgeting it is necessary to consider the following issues:

- Make sure all activities are costed, Activities can be phased in, not everything can be done at once
- Stakeholder collaboration and partnership, try to look beyond the workplace for support,.
- Source skilled personnel to facilitate the process, if needed, Determine whether the organisation is financially stable to sustain activities.
- Provide funding according to identified priorities.
- Create room for flexibility to accommodate any changes that may occur.

What costs could go into a budget for HIV, AIDS and TB Workplace program?

Depending on the level of intervention, some activities will involve time rather than money. Activities and items that need funding include the following:

• Information and education materials • Refreshments • Consultation and facilitation fees • Sometimes training venue, • Travel and accommodation • First aid kits	• Condoms, • Treatment • Health packages, health care medicines and ARVs • Counselling and testing services • Staff costs • Legal costs
--	--

Sample Budget for Workplace Activities

Activity/Item	Unit Cost USD	No.	Total	Notes
Four half day workshops for staff on stigma and VCT	200	4	800	Refreshment
Fees for 2 facilitators	50	2	100	Course fees and travel allowances
Purchase DVD on stigma	20	1	20	For awareness creation
Men of Women dialogues (1 hour) discussions	50	6	300	Lunch provided
Supply condoms to staff – Male condoms: 60, 000 Female condoms 2000	2 5	2 Boxes 0	120,000 12, 000	Stock for 6 months Obtained free from government
Total Cost	327		450	

The implementation plan should also include monitoring of the budget.

Calculating the Impact of HIV in the Workplace

- ✓ This is not an activity that can be undertaken by every organisation due to its complexity. Nonetheless, it will be helpful to have participants review the various categories of impact of HIV on workplace costs, as they are many and broad. For companies that wish to embark on the full analysis of costs, the additional material at the end of this module includes sample spread sheets and technical notes to assist them.
- ✓ There are several broad categories of data used in determining the economic impact of HIV (and other STIs) in the workplace. These can be plotted on a spread sheet against the staff categories in the organisation. The categories include:

The number of employees and average salaries

- ✓ Labour turnover
- ✓ Training
- ✓ Reduced productivity
- ✓ Funeral attendance
- ✓ Absenteeism
- ✓ Recruitment
- ✓ Annual health costs
- ✓ Burial costs and death benefits.
- ✓ For the purposes of the analysis, employees are described in several broad categories, in each of which HIV will have a varying impact on the overall costs. These are:
- ✓ Secretarial or support staff (SecStf)
- ✓ Manual labourers (ManLab)
- ✓ Supervising managers (SupMgr)
- ✓ Technical professionals (TecPro)
- ✓ Senior managers (SenMgr).

If the staff categories in your organisation are substantially different, you can make modifications as necessary. If a company decides not to use the suggested employee categories, different categories could be used or they could simply include all the employees in one column.

For a worked example of the spread sheet see attachment at the end of the Module

SUMMARY

- ✓ Information necessary for budgeting for a workplace programme includes human resources, materials, activities, support etc.
- ✓ Impact assessments will need the help of specialists in the field of Health Economics as external contractors.
- ✓ Consider cost-sharing as an alternative, when resources are limited.

Sample Spreadsheet To Determine The Financial Impact Of HIV On A Workplace

Below is an outline of the spreadsheet used to calculate the costs to business of HIV and AIDS. These costs can be used for budgeting purposes.

		Category of Employee*				
		SecStf	ManLab	supMgr	TecPro	Sengr
1	Employees/Salary					
A	Total number of employees in each category of staff					
B	Gross weekly salary of all staff in each category					
2	Labour turnover					
C	Number of weeks to hire new employees in each category					
D	Lost labour cost (C*B/A)					
3	Training					
E	Number of weeks trainer is training each staff category					
F	Trainer's gross wage per week					
G	Typical class size for training each staff category					
H	Trainees' time (number of weeks trainees are in training)					
I	Weekly training wage per trainee (% of gross weekly wage (B) paid to trainee)					
J	Training cost per employee ((E * F) / G)					
K	Total salary paid to employee during training (H * I)					
L	Total training cost (J + K)					
4	Reduced productivity					
M	Number of weeks after training before productivity reaches 100%					
N	Productivity immediately after training (% of normal)					
O	Percentage productivity lost (100 – N)					
P	Total wages paid to employee before productivity reaches 100% (M*B/A)					
Q	Total productivity cost (.5*O*P)/100)					
5	Funeral attendance					
R	Average number of paid leave days a worker takes to attend a co-worker's funeral					
S	Average number of workers who took paid leave to attend each co-worker's funeral this year					
T	Productivity loss per co-worker funeral attended (R/5*S*B/A)					
6	Absenteeism					
U	Average number of absent days for Employees					

V	Number of days during this year workers with AIDS were absent	
W	<i>AIDS cost (B/A*(V-U)/5)</i>	
X	Number of days this year workers with HIV were absent	
Y	<i>HIV cost (B/A*(X-U)/5)</i>	
Z	Number of days this year workers with STIs were absent	
AA	<i>STI cost (B/A*(Z-U)/5)</i>	
7	Recruitment	
AB	Recruitment cost per employee hired in each category	
8	Annual health costs	
AC	Total cost of all employee claims this year	
AD	Total number of employee claims this Year	
AE	<i>Cost per claim this year (AC/AD)</i>	
AF	Average number of health claims per employee with AIDS	
AG	Average number of health claims per employee with HIV	
AH	Average number of STI-related claims per employee	
AI	<i>Health care cost per employee due to AIDS (AE*AF)</i>	
AJ	<i>Health care cost per employee due HIV (AE*AG)</i>	
AK	<i>Health care cost per employee due to STI (AE*AH)</i>	
9	Burial costs/death benefits per employee	
AL	Cost of coffin (if paid for by organisation) plus other death benefits paid to family	
AM	Other costs (not paid to family), excluding lost labour due to funeral attendance	
AN	Total burial cost (AL+AM)	
10	HIV and AIDS Rates	
AO	AIDS prevalence (%)	
AP	HIV prevalence (%)	
AQ	STI prevalence (%)	
AR	AIDS cases (A*AQ/100)	
AS	HIV cases (A*AP/100)	
AT	STI cases (A*AQ/100)	
	Anticipated decreased revenues and increased expenditures <i>Decreased revenue</i>	
AU	Revenue for the organisation this year	
AV	Labour turnover (AR*D)	
AW	Training (AR*L)	
AX	Reduced productivity (AR*Q)	
AY	Funeral attendance (AR*T)	
AZ	AIDS absenteeism (AR* W)	
BA	HIV absenteeism (AS*Y)	

BB	STI absenteeism (AT*AA)	
BC	Decreased revenues in each category(sum of AV through BB)	
BD	Summary revenue impact of STI, HIV and AIDS across categories (sum of all categories in BC)	
BE	Total revenue with STI, HIV and AIDS (AU-BD)	
	<i>Increased expenditures</i>	
BF	Expenditures incurred by the organisation this year as reported	
BG	Recruitment (AR*AB)	
BH	Health care costs - AIDS (AR*AJ)	
BI	Health care costs - HIV (AS*AI)	
BJ	Health care costs - STI (AT+AK)	
BK	Total health care cost (sum BH to BJ)	
BL	Burial (AR*AN)	
BM	<i>Anticipated increased expenditures in each category due to STI, HIV and AIDS (BG+BK+BL)</i>	
BN	<i>Summary of anticipated expenditure impact of STI, HIV and AIDS across categories (sum of all categories in BM)</i>	
BO	<i>Total expenditure with STI, HIV and AIDS (BF+BM)</i>	

<i>Summary of HIV and AIDS Impact on the Organisation</i> Projected HIV & AIDS cases		
BP	AIDS cases this year (sum across AR)	
BQ	HIV cases this year (sum across AS)	
Distribution of costs		
BR	STI cases this year (sum across AT)	
BS	Organisation profits without STI , HIV and AIDS (AU-BF)	
BT	Organisation profits with AIDS (BE-BO)	
BU	Decrease in profits as a result of STI, HIV and AIDS (BS-BT)	

Distribution of costs		
Labour turnover (sum across AV)	\$	(sum across AV*100/BU) %
Training (sum across AW)	\$	(sum across AW*100/BU) %
Reduced productivity (sum across AX)	\$	(sum across AX*100/BU) %
Funeral attendance (sum across AY)	\$	(sum across AY*100/BU) %
AIDS absenteeism (sum across AZ)	\$	(sum across AZ*100/BU) %
HIV absenteeism (sum across BA)	\$	(sum across BA*100/BU) %
STI absenteeism (sum across BB)	\$	(sum across BB*100/BU) %
Recruitment (sum across BG)	\$	(sum across BG*100/BU) %
Health care (sum across BK)	\$	(sum across BK*100/BU) %

Burial (sum across BL)	\$	(sum across BL*100/BU) %
STI/HIV and AIDS impact per employee		

Technical notes for completion of impact spread sheet

The letters in the left-hand column correspond to the letters of individual lines found in the spread sheet. The technical notes describe the data needed for the individual lines and, in some cases, suggest where the data could be obtained.

a) Employees/Salary

- A. The number of employees, by each employee category in the organisation, obtained from organisation records.
- B. This number is obtained by dividing the gross wage (including benefits) of all employees in each category by the number of employees in that category.

b) Labour turnover

Labour turnover is treated as a loss in revenue since the number of weeks it takes to hire employees is a period of lost revenue (this cost may also represent increased expenditures if temporary workers are hired or existing employees must be paid overtime). The cost of training is treated as a decrease in revenue because new employees in training do not contribute to productivity

- C. The number of weeks it takes to hire an employee in each category.
- D. This number is obtained by multiplying line item B by line item C.

c) Training

- E. The number of weeks a trainer/supervisor spends in training an employee, by each employee category. This is based on how long it takes to train this cadre of employees.
- F. The trainer's weekly wage is their weekly wage.
- G. This number represents the typical class size for trainees in each employee category. If training is predominantly on a one-to-one basis, the average class size should be set to 1.
- H. This is the length of time in weeks that new or promoted employees receive training, by each employee category.
- I. The gross wage of a trainee per week, in each employee category. It is assumed here that the trainee will be paid a certain percentage of normal weekly gross pay. That percentage is multiplied by the average gross weekly wage. For example, if the average weekly gross wage is X (obtained from line item B), and a trainee is paid 90% of that during training, then the pay would be .9*X.
- J. This is the training cost per employee, by each employee category. The number is obtained by multiplying E by F and then dividing the product by G (weekly salary paid to trainer divided by number of trainees).
- K. This is the total salary paid to employee while in training. This number is obtained by multiplying H by (weekly training wage per employee by the number of weeks spent in training).
- L. This number represents the total cost of training each employee, obtained by adding J to K (training cost per employee added to total salary paid to employee while in training).

d) Reduced productivity

Once an employee has been trained, they will begin working but at less than 100% productivity. The organisation will provide:

- M. Information on how long it takes before a trainee reaches 100% productivity. If the information is in percentage (e.g. 30% of the year), multiply this number by 52 weeks in a year and divide the product by 100 to get the number of weeks the trainee is not yet at full productivity.
- N. The organisation will provide information on the employee's level of productivity after training.
- O. This number represents the percentage productivity lost. It is obtained by subtracting N from 100.
- P. Total wages paid to employees before they reach 100% productivity. It is assumed that the employee will be paid the same salary as regular employees after training.
- Q. The total productivity cost is obtained by multiplying O by 0.5 and by P, and then the product is divided by 100.

Note that O through Q refers to the reduced productivity of new employees who have not reached a level of full proficiency. There is also reduced productivity due to absenteeism, but this is calculated elsewhere: AZ to BB, revenue loss due to HIV and AIDS absenteeism.

e) Funeral attendance

Funeral attendance is seen as decrease in revenue, since those who attend a funeral take time off and do not contribute to productivity, thus resulting in a reduction in revenue generated by the organisation.

- R. The organisation provides the average number of paid leave days employees in each category take to attend each funeral.
- S. This is the average number of workers who took paid leave to attend each co-workers' funeral. The organisation provides the number of employees in each employee category.
- T. Productivity loss per co-worker funeral attended, obtained by multiplying T by R/5 and by B/A.

f) Absenteeism

Absenteeism because of STIs, HIV and AIDS is treated as a loss in revenue because absent employees do not contribute to productivity. Once again, depending on how the organisation responds to absenteeism, this cost may actually be an increased expenditure rather than lost revenue

- U. Average number of absent days for employees.
- V. The organisation provides information on the number of days during the year that employees with AIDS were absent. If not available, use 65 days.
- W. The cost of AIDS absenteeism to the organisation, obtained by multiplying the gross weekly wage of each employee category, i.e. B/A by (V-U) and then dividing the result by 5.
- X. The organisation provides information on the number of days during the year employees with HIV (but not AIDS) were absent. If not available, use 15 days. This represents the cost of HIV absenteeism to the organisation. This figure is obtained by multiplying (B/A) by (V-X) and then by dividing the result by 5.
- Y. The cost of HIV absenteeism to the organisation is obtained by multiplying the gross weekly wage of each employee category i.e., (B/A) by (X-U) and then dividing the result by 5.
- Z. The organisation provides information on the number of days during the year employees with STIs were absent. If not available, use 10 days. This represents the cost to the organisation of absenteeism resulting from STIs. The figure is obtained by multiplying (B/A) by (V-Z), then dividing the result by 5.

g) Recruitment

- AC The total cost of all health claims by employees in each category, this year. If not available, obtain the total number of claims made by all employees in all categories, this year.
- AD The total number of employee health claims made, by each employee category. If not available, obtain the total number of claims made by all employees in all categories, this year.
- AE This number is obtained by dividing AC by AD.

- AF This is the average number of AIDS - related claims made by employees during the year.
- AG This is the average number of HIV - related claims made by employees during the year.
- AH This is the average number of STI - related claims made by employees during the year.
- AI This is the health cost per employee due to AIDS, obtained by multiplying AE by AF.
- AJ This is the health cost per employee due to HIV, obtained by multiplying AE by AG.
- AK This is the health cost per employee due to STIs, obtained by multiplying AE by AH.

h) Burial costs/death benefits per employee

- AL The market price of a coffin this year plus benefits paid to the deceased's family, in cash or kind. If in kind, give cash value equivalent.
- AM The cost of organisational representation in funerals this year (excluding lost labour due to funeral attendance). Examples of this include transportation of employees to funerals, flowers, per diem, etc.
- AN This is the total burial cost, obtained by adding AL to AM.

i) HIV and AIDS rates

(Assume the same for each category of employee unless specific information is available)

- AO To obtain AIDS prevalence (%), use the rates of the city/area/region where the organisation is located. If this information is not available, use the national AIDS prevalence.
- AP Use the same rule as in AO above to obtain HIV prevalence.
- AQ Use the same rule as in AO above to obtain STI prevalence.
- AR This number is obtained by multiplying the AIDS prevalence, AO, by the number of employees in each employee category, A. For example, if the AIDS prevalence is X and the number of employees in the support employee category is Y, the number of new of AIDS cases will be obtained by multiplying X by Y and dividing the result by 100.
- AS This number is obtained by multiplying the HIV prevalence, AP, by the number of employees in each employee category, A, then dividing by 100. For example, if the HIV prevalence is X and the number of employees in the support employee category is Y then the new HIV cases is $X*Y/100$.
- AT This number is obtained by multiplying the STIs prevalence AQ, by the number of employees, in each employee category. For example, if the STIs prevalence is X and the number of employees in the support employee category is Y, then the new STIs cases in this category will be $X*Y/100$.

j) Anticipated decreased revenue and increased expenditures

- AU The organisation will provide the revenue figure for the year.
- A To calculate decreased revenue due to labour turnover, multiply D by AR.
- AW To calculate decreased revenue due to training, multiply L by AR.
- AX To calculate decreased revenue due to productivity loss, multiply Q by AR.
- AY To calculate decreased revenue due to funeral attendance, multiply U by AR.
- AZ To calculate decreased revenue due to AIDS absenteeism, multiply W by AR.
- BA To calculate decreased revenue due to HIV absenteeism, multiply Y by AS.
- BB To calculate decreased revenue due to STI absenteeism, multiply AA by AT. *Where the epidemic has hit some categories of workers especially hard, some companies have resorted to double hiring in anticipation of higher labour turnover due to HIV. Thus, the values in AV through BA will increase to reflect these costs.*
- BC To get total decreased revenue due to HIV, add AV through BB.
- BD To get total decreased revenue across all categories, add BC across all employee categories.
- BE To get total revenue in the presence of STIs, HIV and AIDS, calculate the difference between AU and BD.
- BF The organisation will provide the expenditure figure for the year.

BG	To calculate the increased expenditure for recruitment due to HIV, multiply AB by AR.
BH	To calculate increased expenditure due to AIDS, multiply AI by AR.
BI	To calculate increased expenditure due to HIV, multiply AJ by AS.
BJ	To calculate increased expenditures due to STDs, multiply AK by AT.
BK	To calculate the total health care cost, add BH to BJ.
BL	To calculate the increased expenditure due to burial, multiply AN by AR.
BM	To calculate increased expenditures due to HIV, AIDS and STIs in each category, add BG, BH, and BI.
BN	The summary of anticipated expenditure due to HIV, AIDS and STIs is obtained by adding BJ across all employee categories.
BO	Total expenditure in the presence of HIV, AIDS and STIs is the sum of BF and BJ.
BP	To get the total number of new AIDS cases in the organisation this year, add AR across all employee categories.
BQ	Total number of new HIV cases in the organisation this year is obtained by adding AS across all employee categories.
BR	To get the total number of new STI cases in the organisation this year, add AT across all employee categories.
BS	To calculate profits under the no-AIDS scenario, subtract the difference between AU and BF.
BT	To calculate profits under the AIDS scenario, subtract the difference between BE and BL.
BU	To calculate the decrease in profits due to AIDS, subtract the difference between BS and BT.

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