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A Training Manual for Enterprises on HIV/AIDS Workplace Policy and Programmes & Public Private Partnerships

SECOND EDITION

www.ilo.org/hivaidsindia

A Training Manual for Enterprises

on

HIV/AIDS Workplace Policy and Programmes & Public Private Partnerships

Prevention of HIV/AIDS in the World of Work:
-A Tripartite Response

Produced by the ILO India HIV/AIDS Project

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Feedback from some of the users of the manual:

"Very useful and user-friendly manual in delivering training and clarifying myths regarding HIV and AIDS! I recommend this manual to every master trainer/peer educator. They should refer to the concepts and techniques given in the manual before conducting sessions/workshops."

Naresh Kumar Mathur
Master Trainer, SRF Group, Bhiwadi Unit.

"Thanks for the excellent manual and the accompanying CD. It has made our job easy! I have been using the ILO manual in my training programmes with different companies."

Asha Vernekar
Programme Officer, Technical Support Unit, Goa.

"We have been using this training manual and CD regularly in our training programmes and find it very useful. We would request the ILO to have it in Hindi as well".

N.K. Sharma
Master Trainer, JK Tyres Ltd

"*Having received this manual and other ILO materials in the ILO Skill Building workshop for SACS/TSU officials on workplace interventions/Public Private Partnerships in November 2008, we used this manual in the CII-APSACS HIV and AIDS industry intervention project, training 21 lead facilitators, and worked with 135 companies. We also used the ILO posters and booklets, and found them very useful".*

Siddhartha Srikar
Coordinator, Workplace Interventions
Andhra Pradesh State AIDS Control Society

सत्यमेव जयते

K. Sujatha Rao
Secretary & Director General

Department of AIDS control NACO, Ministry of Health and Family Welfare, Government of India

27th August, 2009

Message

Workplace interventions are an important component of our strategy. it is through such interventions that we sensitise society to not stigmatize and discriminate against those who are infected with HIV and also ensure that every individual worker gets access to information and other services that can help prevent getting HIV.

The training manual for implementing workplace interventions is very timely and addresses a very major programme need. I am sure that it will be widely used by State AIDS Control Societies for forging relationships with enterprises and build sustainable public private partnerships.

I compliment the ILO for their outstanding support to our fight against HIV/AIDS and more importantly, for bringing to the fore the important need to focus upon industrial workers, migrant labour and workers engaged in the informal sector. The work done by the Ministry of Labour and the ILO in getting the partnership between private industries, worker union, government bodies and other stakeholders is indeed exemplary and a model to emulate.

(K. Sujatha Rao)

6th Floor, Chandralok Building, 36 Janpath, New Delhi - 110001, Phones : 011-23325331, Fax : 011-23731746
E-mail : nacoasdg@gmail.com

अपनी एचआईवी अवस्था जानें, निकटतम सरकारी अस्पताल में मुफ्त सलाह व जाँच पाएँ
Know your HIV status, go to the nearest Government Hospital for free Voluntary Counselling and Testing

सत्यमेव जयते

श्रम एवं रोजगार मंत्रालय
भारत सरकार
श्रम शक्ति भवन, रफी मार्ग,
नई दिल्ली–110119
MINISTRY OF LABOUR & EMPLOYMENT
GOVERNMENT OF INDIA
SHRAM SHAKTI BHAWAN, RAFI MARG,
NEW DELHI-110119

Message

HIV/AIDS is a major threat to the world of work. It has shown maximum impact on the most productive segment of the labour force. HIV/AIDS affects rights at work due to discrimination and stigmatization of workers resulting in loss of employment and livelihood opportunities. In view of these factors, HIV/AIDS has emerged as a workplace issue requiring urgent attention from all stakeholders.

2. In India, nearly 89% of the 2.31 million population, affected by HIV/AIDS, belongs to the 15-49 years age group. India has a large (over 400 million) workforce of which almost 93% belong to the unorganized sector. The Ministry of Labour and Employment (MOLE) is providing leadership to the workplace initiatives on HIV/AIDS in the country. MOLE has developed a National Policy on HIV/AIDS and the World of Work with the objective to generate awareness about HIV/AIDS, encourage action to prevent its spread further, improve and develop the support and care initiatives and handle stigma and discrimination effectively.

3. ILO has played a key role in strengthening the workplace response to HIV/AIDS by offering comprehensive technical support. This manual prepared for training of master trainers/peer educators of enterprises is an important contribution towards the same. The manual has been finalized on the basis of experiences acquired through several training workshops. The manual has also been test checked by a number of large corporates and public sector enterprises who found it useful and relevant.

4. I hope all enterprises will put in place a workplace policy and programme on HIV/AIDS and use this manual extensively for organising trainings for their employees and families as also the contractual and supply chain workers and populations living in surrounding locations.

5. I congratulate ILO for preparing this manual which will go a long way in disseminating authentic information on HIV/AIDS and which will have a lasting impact on workers' attitude and behaviour

With best wishes

(S.K. Srivastava)
Additional Secretary

DECENT WORK
A better world starts here
90 years working for social justice

International Labour Organization
Organisation internationale du Travail
Organización Internacional del Trabajo

Message

Nine out of ten people living with HIV are of working age. HIV/AIDS hits the world of work in numerous ways. In badly affected countries, it has cut the supply of labour and slashed the income of workers. Increased absenteeism raises labour costs for the employers and reduces production and profitability. Stigma and discrimination have had serious effects on the lives of workers and their families.

The ILO has developed a pioneering Code of Practice on HIV/AIDS and the World of Work that provides guidelines to governments and employer's and workers' organizations to develop HIV/AIDS policy and programmes in the world of work.

The ILO Code has received wide endorsement in India from the Ministry of Labour and Employment, the National AIDS Control Organization, employers' and workers' organizations. Several companies have developed their policy and programme based on the ILO Code.

In collaboration with our constituents, NACO, UNAIDS and People Living with HIV, the ILO has been engaged in strengthening HIV/AIDS policy and programmes in the world of work in India since 2001.

I am happy to see this training manual for enterprises. It offers tested guidelines on a strategy and training. It also includes useful resource materials. It will be a good input towards the implementation of the National Policy on HIV/AIDS and the World of Work in India which has now been approved.

I hope enterprises, State AIDS Control Societies and all organizations working on workplace interventions and public private partnerships will find the manual useful. This is ILO's contribution towards strengthening the National AIDS Control Programme and promoting decent workplaces.

Leyla Tegmo-Reddy

Leyla Tegmo-Reddy
Director and
ILO Representative in India

ILO Subregional Office for South Asia
Core 4B, 3rd Floor,
India Habitat Center, Lodhi Road,
New Delhi 110 003, India

Tel. +91 11 2460 2101-02-03, 2460 2106
Fax +91 11 2460 2111, 2464 7973
E-mail: sro-delhi@ilo.org
www.ilo.org/india

Preface

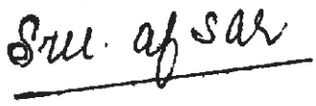
I am happy to present this manual and the accompanying DVD, developed for enterprises to provide them guidelines for workplace policy and programmes and public private partnerships (PPP). ILO is the lead UN agency for workplace programmes and private sector mobilization. We have developed this manual as part of our technical support to employers/the National AIDS Control Programme in India to help upscale WPI/PPP and facilitate implementation of the National Policy on HIV/AIDS in the World of Work, developed by the Ministry of Labour and Employment, GOI in consultation with NACO, employers' and workers' organizations, PLHIV and ILO.

We developed a draft manual in 2003, which was widely used by enterprises and other agencies. The manual was pre-tested in several workshops and was modified from time to time incorporating feedback from users.

As training has to be done in context of a strategy, the manual begins with a section on strategy for developing HIV/AIDS policy and programme and PPP. I would like to draw the attention of enterprises in India to the strategy first, which highlights the need for action on their part and presents a road map. As developing a cadre of HIV/AIDS peer educators within enterprises is an effective approach, tried and tested by several ILO- partner enterprises in India, the manual has a training section which provides guidelines for training of peer educators of enterprises. Documentation of good practices of enterprises on WPI/PPP are also included to provide specific examples.

Taking care of the health of workforce and protecting them from infections such as HIV needs to be part of the human resource strategy within companies. The need to act is now and urgency should be the key word driving this initiative. Prevention programmes work best when initiated at the low level of HIV prevalence. So, I would appeal to all enterprises that please do not wait for the manifestation of the problem at your workplaces. Your intervention today can save lives, and would also be useful for your businesses in the long run.

I hope this manual will be useful to enterprises and other agencies working for WPI/PPP for HIV and AIDS policy and programmes in India. I thank my colleagues and all partners who have contributed to the manual.



S. Mohammad Afsar
Technical Specialist (HIV/AIDS) and
National Programme Coordinator,
ILO Subregional Office for South Asia, New Delhi



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ACRONYMS

AIDS	-	Acquired Immuno Deficiency Syndrome
ART	-	Anti-Retroviral Treatment/Therapy
BCC	-	Behaviour Change Communication
CSR	-	Corporate Social Responsibility
DOTS	-	Direct Observation Treatment, Short course
HIV	-	Human Immuno-deficiency Virus
HRD	-	Human Resource Development
ICTC	-	Integrated Counselling and Testing Center
IEC	-	Information Education and Communication
ILO	-	International Labour Organization
KABP	-	Knowledge Attitude Behaviours and Practices
MOU	-	Memorandum of Understanding
NACO	-	National AIDS Control Organization
NACP	-	National AIDS Control Programme
NGO	-	Non-Governmental Organization
OIs	-	Opportunistic Infections
OSH	-	Occupational Safety and Health
PE	-	Peer Education/ Peer Educator
PLHIV	-	People Living with HIV
PPP	-	Public Private Partnerships
PEPFAR	-	United States President's Emergency Plan For AIDS Relief
SACS	-	State AIDS Control Society
SIV	-	Simian Immunodeficiency Virus
STI	-	Sexually Transmitted Infections
TB	-	Tuberculosis
UNAIDS	-	Joint United Nations Programme on HIV and AIDS
WPI	-	Workplace Intervention



Introduction to the Manual:



This manual has four sections:

Section-I describes the strategy for developing and implementing HIV/AIDS workplace policies and programmes/Public Private Partnerships within enterprises.

Section-II covers aspects of training for peer educators of enterprises such as training objectives, sessions objectives and methodology and important tips on logistics of training.

Section-III includes resource materials on all session of the training. It also gives references and useful web links for regular updates of information.

Section-IV includes handouts that can be used in training by peer educators.

The manual also includes a DVD, which contains the following.

- An advocacy video
- An advocacy film for enterprises
- An orientation to ILO materials/tools useful in Workplace Intervention (WPI)
- Power point presentations on different topics as mentioned below for use by peer educators in their awareness sessions
  - Advocacy with Enterprises
  - ILO Code of Practice on HIV/ AIDS and the World of Work
  - Basics of HIV/ AIDS
  - Global and National scenario of HIV/ AIDS
  - Behaviour Change Communication
  - Condom Promotion/ Education
  - Sexually Transmitted Infections and their link to HIV
  - Gender and HIV
  - Tuberculosis and HIV
  - Stigma and Discrimination
  - Trade unions and HIV
- A compendium of short video spots to be used in awareness sessions at the enterprise level
- PDF version of the manual

PRESS RELEASE

भारतीय रिज़र्व बैंक
RESERVE BANK OF INDIA

ELATIONS DIVISION, Central Office, Post Box 406, Mumbai 400001
Phone: 2266 0502 Fax: 2266 0358, 2270 3279

www.rbi.org.in
www.rbi.org.in/hindi
e-mail: helpprd@rbi.org.in

July 15, 2005

HIV/AIDS Workplace Policy Statement

The Reserve Bank of India (the Bank) has an enduring commitment to being and sensitive to the social, health and ethical issues confronting its employees and families. As the central bank of the country, it also seeks to catalyze similar oling conditions in the banking industry and indeed the country as a whole.

The Bank recognizes that HIV/AIDS is not only a health problem, but also an ue that impacts productivity and well being of individuals in the workplace. It, commits itself to having a work environment in which affected employees against and are treated justly, humanely and in a life-affirming

on the National HIV/AIDS policy
ovides the broad framewo
their families





POLICY ON HIV / AIDS

- **M**ECON will respect the right of confidentiality about the HIV status of its employees.
- **E**mployees at all levels shall be regularly imparted awareness on HIV / AIDS.
- **P**re placement and regular medical check ups will not include testing for HIV status.
- **H**ealthcare personnel shall follow "universal precaution" to prevent spread of the disease.
- **E**mployees and family members shall be provided counseling and support services on matters pertaining to HIV / AIDS.
- **M**ECON shall not discriminate or allow discrimination against employees with known or suspected HIV / AIDS at work place.

MECON
मेकॉन
ISO 9001 Company

(R K Zaroo)
Chairman-cum-Managing Director
MECON LIMITED
Ranchi -834002

BHEL

Bharat Heavy Electricals Limited, Bhop

HIV/AIDS PREVENTION POLI

The management is committed to maintain
work environment for all employees. HIV/AIDS
adverse impact on people in the most produ
BHEL as a proactive employer is keen to cr
for protection of its employees from the poten

BHEL will follow the guidelines of the Gov
major International bodies such as ILO and WHO
response to HIV/ AIDS.

Following are the key elements of the HIV/ AIDS po
Bhopal:

- Recognition of HIV/ AIDS as a work place issue.
- To observe non-discriminatory practices and to maintain
equality with infected employees in respect to recruit
training, promotion and other benefits.
- Creation of healthy work environment for combating HIV/ AIDS a
work place.
- Employee with HIV positive status will be allowed to continue
their work as long as they are capable. Company is committed to
provide necessary support and treatment.
- Fear or threat of other employees of acquiring infection from HIV
positive employee will be eliminated through effective health
education and psychological counselling.
- To educate the employees to follow safe practices
donation & transfusion.
- To set up a core committee to monito
programme of BHEL, Bhopal

COAL INDIA LIMITED

Date: 04.08.07

Ref: BCCL/ED(MS)/2007/Aids/466

HIV/AIDS POLICY AT WORK PLACE

We, the coal India Limited Parivar are committed to uphold the highest level of employees safety, health and environment, corporate & social responsibilities with total quality care as an integral part of our management.

Following are the key elements of the CIL HIV/AIDS workplaces Policy.

(1) We are committed to protect our workforce engaged in coal mining, directly or indirectly from HIV/AIDS, which is a workplace issue.

(2) We will not discriminate against any employee on the basis of his/her real or perceived HIV status and respect the dignity and human right of our employees.

(3) We will continue to implement a regular HIV/AIDS prevention, care and support programme for our employees, their family members and others living in and around coalfield areas through proper education and awareness campaign.

(4) We will respect our employees right to confidentiality regarding his/her HIV status.

(5) We will provide treatment including anti/rectroviral drugs to the employees, their family, members infected with HIV besides counseling and psychological support.

(6) We will not purse HIV/AIDS screening for the purpose of exclusion from employment or work process.

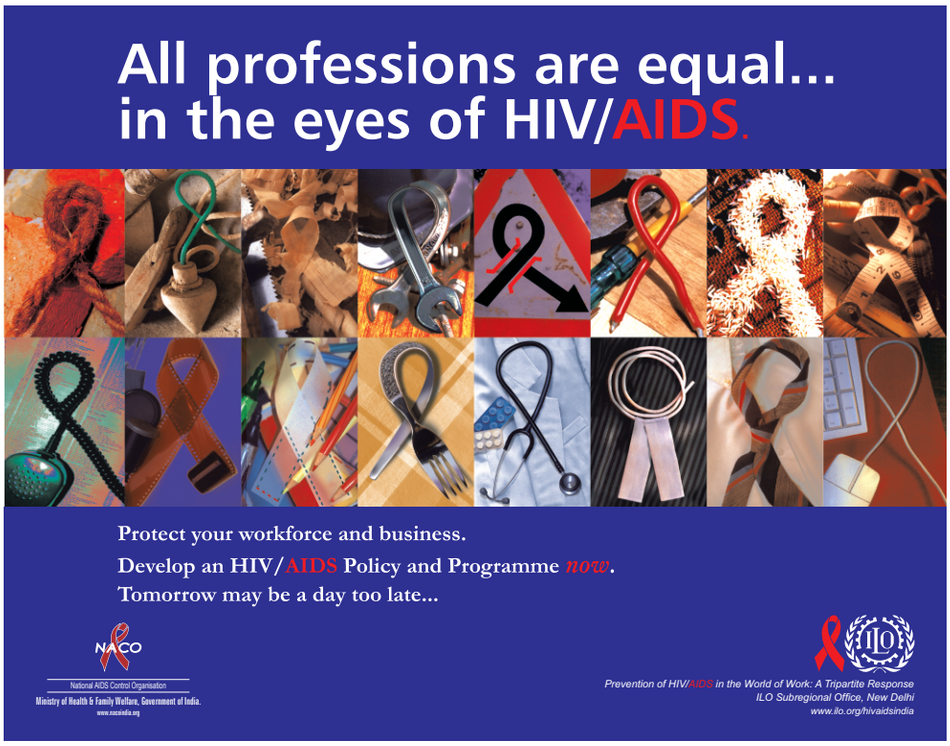
This has approval of Chairman, CIL.

Executive Director
(Medical Services),
Coal India Limited

SECTION-I

Strategy for Enterprises





From enterprises that are implementing WPI/PPP:

"HIV is recognized as a potential risk by the company for its key stakeholders and therefore its business. Proactive action to fight HIV is part of Apollo's risk management framework,"
- Onkar S Kanwar, Chairman and Managing Director of Apollo Tyres Limited.

"Our HIV/AIDS response is not about philanthropy. It is our responsibility as it is about our survival. So, it is a basic human resources (HR) function now,"
- Pavan Bhatia, Executive Director, Human Resources, PepsiCo.

"Success requires the highest standards of corporate behavior towards employees, consumers and the world in which we live. As a part of our corporate behavior HUL is strongly committed to ensure appropriate workplace prevention of HIV/AIDS and to share best practice across our supply chain and the communities in which we operate."
- Nitin Paranjape, Chief Executive Officer, Hindustan Unilever Limited (HUL)

"We have a responsibility towards our employees and the communities in which we operate. We have been working on HIV prevention and reducing stigma and discrimination related to HIV/AIDS. We intend to take it forward."
- Arun Bharatram, Chairman, SRF Ltd.

Strategy for Enterprises

It is important to discuss the need for action on HIV/AIDS on the part of enterprises, before presenting the strategy. Following are the frequently asked questions and their answers highlighting the need for an emphatic response to HIV/AIDS:

Why should enterprises respond to HIV/AIDS?

HIV/AIDS shows its impact on enterprises in the following ways:

- Increase in absenteeism due to illness and bereavement
- Increase in labour turnover due to illness and death
- Fall in production due to absenteeism, labour turnover, loss of skills/experience
- Increase in expenditure on employees' replacement and training, health care and social security cost, and
- Reduction in profit levels

"The HIV/AIDS epidemic has become a global crisis. Increasingly affected is the business world, which is suffering not only from the human cost to the workforce but also in terms of losses in profits and productivity that result in many new challenges for both employers and employees...

...Constructive and proactive responses to HIV in the workplace can lead to good industrial relations and uninterrupted production."
- ***Francois Perigot***, *President International Organization of Employers*.

"If you lose someone you have trained for twenty years, that's a great loss. Condoms and AIDS education costs peanuts." - A Kenyan Company Manager, excerpts from 'Putting HIV/AIDS on the business agenda', UNAIDS point of view 1998

Enterprises in the most seriously affected countries report increase in absenteeism, labour turnover, and cost of recruitment, training and staff welfare due to HIV/AIDS. For impact on HIV/AIDS on enterprises, please visit: www.ilo.org/aids; www.unaids.org; and www.ilo.org/hivaidsindia

What are the benefits of direct enterprise action against HIV/AIDS?

The return on investment in the prevention of HIV far exceeds that of standard capital investments. Studies have indicated that these returns, in terms of cost savings through preventing HIV, are as much as 3.5 to 7.5 times the cost of intervention

- the ILO guidelines for Employers

When is the right time for an enterprise to start its HIV/AIDS programme?

HIV infection goes unnoticed for several years because it has no immediate and exclusive symptoms. Therefore, response to HIV/AIDS should not wait for the manifestation of the problem.



Enterprises need to be proactive and learn from the experiences of their counterparts in Africa. The best time to respond is when the prevalence is low.

Need for enterprise action in India:

- Nearly 90% of the HIV infections have been reported from the most productive age group of 15-49 years.
- Knowledge, Attitude, Behaviour and Practice studies (2005-6) in some corporate groups undertaken under the ILO project indicate the need for action even in cases where enterprises engage educated and skilled workforce. 31% employees lacked correct knowledge of routes of HIV transmission; Only 11% knew about STI symptoms; 28.5% were willing to share equipment used by a PLHIV; 33% were afraid of using a toilet used by a PLHIV; 31% not willing to eat in canteen along with a PLHIV; and 5.6% reported to have had sex with non-regular partner, of which nearly 43% was without condoms.

> "Don't make the same mistake we made in South Africa we saw this coming but the first reaction of the business was that it wasn't our problem, it wasn't threatening us now, that we'd let the government sort it out."
> - Dr. Brian Brink, Medical Director for South African Mining conglomerate Anglo American in a conference of Global Business Coalition on HIV/AIDS

- Most of the enterprises engage migrant workers either directly or as contractual workers or indirectly as part of the supply chain. Reaching out to mobile and migrant workers is a priority of the National AIDS Control Programme and partnership with private sector, trade unions and NGOs is being envisaged.
- Prevalence of HIV may be low in India but estimated number of people living with HIV is high. There is no room for complacency as all vulnerability factors are present. A timely action will be cost-effective and it will save lives of the most productive segment of society.
- Strengthening Public Private Partnerships in HIV prevention and care is a key component of the National AIDS Control Programme. Private sector has an opportunity to be part of this national programme and complement the government's efforts.

Why did some Indian companies respond to HIV/AIDS?

Following are the most common responses from the companies:

- "HIV records do not give the true picture, prevention is better for any company"
- "We are responsible and good corporate citizen over and above our normal operations" (Corporate Social Responsibility)
- "A healthy workforce is the biggest asset for a company"
- "A healthy workforce means less absenteeism and translates into more production"
- "Satisfaction of being an active partner in welfare"
- "Any prevention effort will go a long way in slowing the progression of the disease across the globe"
- "We believe in creating a nurturing, enabling and non-discriminatory environment at our workplace"



How can enterprises respond to HIV/AIDS?

Enterprises can try out several options, depending upon the nature of their business/work, workforce, focus of their welfare and corporate social responsibility efforts.

- Enterprises can undertake workplace intervention for their employees/families as part of Human Resource Development Strategy.
- Enterprises can cover their contractual workers, workers in the supply chain under their welfare/CSR efforts or set up interventions for bridge populations of truckers/migrant workers under Public Private Partnerships.
- Enterprises can set up PPP for HIV care & support programmes.

The ILO has documented some good models of interventions/examples by enterprises on WPI as well as PPP, these can be seen at www.ilo.org/hivaidsindia.

A cost-effective, workable and sustainable strategy is the one that ensures integration of HIV/AIDS programmes within the HRD/welfare/CSR programmes of enterprises. This requires a careful review of existing strategies, and finding entry points for integration of HIV in existing programmes within enterprises.

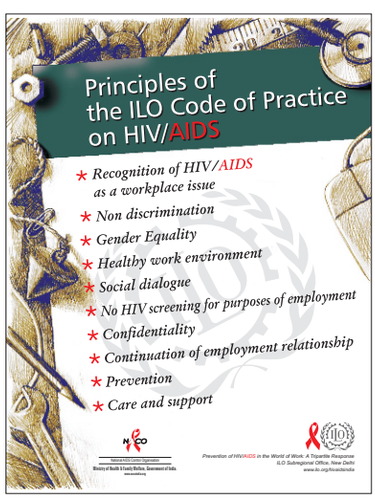
An HIV/AIDS workplace programme at the enterprise level rests on three pillars:

1. An HIV/AIDS workplace policy;
2. A programme for prevention of HIV/AIDS; and
3. A programme for care and support of infected and affected employees.

1. HIV/AIDS Workplace Policy at the enterprise level:

A policy statement reflects the management commitment towards provision of prevention, care and support programmes on HIV/AIDS.

The National Policy on HIV/AIDS and the World of Work, Joint statements of commitment by Indian employers and central trade unions in India have endorsed the ten key principles of The ILO Code of Practice on HIV/AIDS and the World of Work for development of workplace policies.



The ten principles of The ILO Code of Practice on HIV/AIDS and the World of Work are:

- **Recognition of HIV/AIDS as a workplace issue**

  HIV/AIDS is a workplace issue, not only because it affects the workforce, but also because the workplace can play a vital role in limiting the spread and effects of the epidemic.



- **Non-discrimination**

  There should be no discrimination or stigmatization of employees on the basis of real or perceived HIV status.

- **Gender equality**

  More equal gender relations and the empowerment of women are vital to successfully preventing the spread of HIV infection and enabling women to cope with HIV/AIDS.

- **Healthy work environment**

  The work environment should be healthy and safe, and adapted to the state of health and capabilities of employees.

- **Social dialogue**

  A successful HIV/AIDS policy and programme requires cooperation and trust between employers, employees, and governments.

- **Screening for purposes of employment**

  HIV/AIDS screening should not be required of job applicants or persons in employment and testing for HIV should not be carried out at the work place except as specified in this code.

- **Confidentiality**

  Access to personal data relating to a worker's HIV status should be bound by the rules of confidentiality consistent with existing ILO Code of Practice.

- **Continuing the employment relationship**

  HIV infection is not a cause for termination of employment. Persons with HIV-related illnesses should be able to work for as long as medically fit in appropriate conditions.

- **Prevention**

  The social partners are in a unique position to promote prevention efforts through information and education, and support changes in attitudes and behaviour.

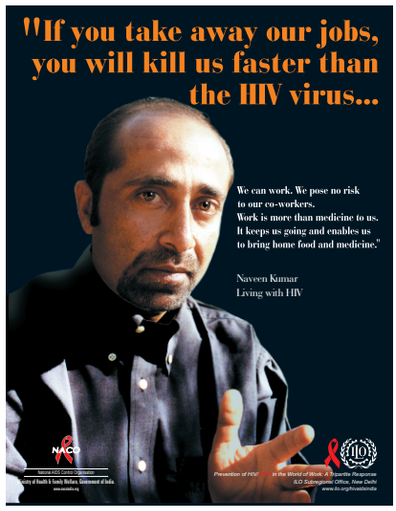
- **Care and support**

  Solidarity, care and support should guide the response to AIDS at the workplace. All employees are entitled to affordable health services and to benefits from statutory and occupational schemes.

HIV prevention programmes become more effective in the presence of a policy/programme assuring non-discrimination of workers.

Reasons why people living with HIV (PLHIV) need to be employed and kept in employment:

- *PLHIV can live a long productive life with proper care and support, including the Anti Retroviral Therapy.*
- *PLHIV pose no risk to their co-workers as HIV does not transmit through casual/social contacts or under normal workplace situations like shaking hands, sharing of utensils, working on same machines etc.*
- *The enterprise may be losing on a good human resource by not hiring an otherwise fit person or not keeping him/her in employment.*
- *Not employing an HIV positive person who is otherwise fit and eligible for the job, is violation of individual's right to work; and*
- *Employer's support means a lot to workers living with HIV. It can provide them social security benefits and helps them cope with the infection.*



The ILO Code provides guidelines for developing policy. It suggests that a cross functional committee, involving people from management/HR, trade unions, medical/OSH, welfare/CSR etc. should be set up to develop the policy, and also review its implementation.

The Terms of Reference of the HIV Committee

1. Review of the national laws and implications for the enterprise;
2. Assess the likely impact of HIV/AIDS epidemic on the workforce and the needs of workers infected and affected by HIV/AIDS;
3. Review of health and information services already available within the enterprise and in the local community;
4. Formulate a draft policy on HIV/AIDS and have it approved following consultations as per the procedures of the enterprise;
5. Identify and propose resource allocation for HIV/AIDS programme;
6. Identify and mobilize Technical Resources for the programme;
7. Develop a Plan of action within the enterprise. (This can be a yearly plan with clear activities, time line, budgetary allocation and the person responsible);
8. Disseminate the company policy and plan of action on HIV/AIDS as widely as possible through the existing channels such as notice boards, mailings, pay slip inserts, special meetings, induction courses, training sessions etc;
9. Monitor the implementation of policy and plan of action;
10. Regularly review the policy in the light of internal monitoring and external information about the virus and its workplace implications and national policy/programme approaches.



2. A programme for prevention of HIV/AIDS:

a. Behaviour Change Communication (BCC)

- BCC for Workplace Intervention begins with advocacy targeting management, unit heads, and other key stakeholders in the enterprise. Key changes expected as a result of advocacy are development of workplace policy, nomination of a nodal person within enterprise to coordinate the HIV response, set up internal committee, allocate budget for the programme, endorse the enterprise work plan on HIV/AIDS, and review the implementation of the work plan.

- **Formative assessment** is the next step to understand the existing levels of knowledge, attitude, behaviours and practices amongst employees and identify: what needs to change (emphasis behaviours). Formative assessment leads to developing a BCC strategy based on an audience-message-media matrix and an action plan.

- **Education and Training at all levels, following a peer education approach:** This requires enterprise to identify and train some selected workers as peer educators. Peer Educators can be chosen from different units: HR/welfare, medical, OSH at the enterprise level. The enterprise with the help of technical agencies can get its peer educators trained using this manual. If an enterprise has a large workforce, or has multiple locations, it can follow a cascading model of training. It can first get some of its employees trained as Master Trainers, who in turn can train peer educators at the unit/department levels. This group of Master Trainers/peer educators can provide regular HIV/AIDS education and training to all employees. (Please see the next section on training for more information/details).

- **Development and use of communication materials**: Based on the BCC strategy, enterprises can develop audience-specific communication materials, and use them in the awareness/training programmes. It is important to follow the right process of material development and ensure effective use of materials. ILO has provided a set of materials which could be used. In addition, enterprises can take materials in local languages from respective State AIDS Control Societies. Audio-visual materials like slide shows/film shows are very effective. Enterprises could also use their own media channels like intranet, newsletters/corporate communications, and local media like cable TV, street plays etc. and create special awareness events.

b. Enhancing access to treatment for Sexually Transmitted Infections (STIs) and condoms:

- Early diagnosis and treatment for STIs and condom education are successful prevention strategies for HIV.

- Enterprises having their own medical set-up can integrate counselling and treatment for STIs.

- Enterprises can set up referral linkages with nearby government /NGO facilities and inform the workers about it.
- While condom education should be part of BCC efforts, enterprises can set up condom outlets or condom vending machines at their workplaces. Partnership with SACS can be established for this purpose.

3. Care and support services:

- While the policy framework forms the basis for a non-discriminatory environment, some of the services that can be created are:
  - Provision of counselling for infected workers.
  - Counselling of workers' families and co-workers.
  - Treat HIV like any other illness. Enterprises should provide treatment, including ART to the infected employees as and when they need it. Contractual employees can be referred to the government treatment programme, for which information can be taken from the NACO's website:www.naco.gov.in
  - Provision for compassionate leave and work adjustment can be created.
  - Referral linkages with the nearby voluntary counselling and testing centre/ART can be made.
  - Referral linkages with agencies working on the care and support programmes, particularly the network of HIV positive people can also be set up.
  - Enterprise having their own medical set-up should get their doctors trained in HIV case management so that the right treatment protocols are followed.
  - Enterprises can also set up Integrated Counselling and resting Centers/ART centres in partnership with the SACS to enhance access to care and support services. ILO has documented some models of PPP which can be seen in the resource material section of the manual.

Monitoring, Research and Evaluation:

- An Internal Monitoring System has been designed by ILO for enterprises, which can be used. It is included along with other resource materials in Section-III.
- A Knowledge, Attitude, Behaviour and Practice (KABP) survey in a selected sample could be undertaken to assess the vulnerability of employees. The first KABP survey would serve as the baseline and subsequent surveys would demonstrate the progress made under the prevention and care programme.
- Enterprises should periodically review the cost of their HIV prevention programmes as well as cost of care and support provided to infected employees.



- An anonymous unlinked prevalence survey can also be undertaken if the company feels so. However, it need not be the starting point. This should follow the NACO and other international guidelines, and should be undertaken with technical support from State AIDS Control Societies.

Key steps for enterprises to help them develop their WPI:

Step 1 : Convene a meeting with top/senior management to discuss HIV/AIDS:

- To understand perceptions on HIV/AIDS; and
- To finalize the process through which the enterprise should develop its response to HIV/AIDS.

Expected output/management decisions:

- Nomination of a nodal person within enterprise to coordinate the HIV response
- Set up an internal committee to develop policy and work plan of the enterprise
- Seek necessary technical partnerships

Step 2 : Organize training of nodal person and committee members:

- Nodal person/committee members will require training in basics of HIV/AIDS, overview of National AIDS Control Programme and its components, national policy, process of developing enterprise policy, understanding of key principles of the policy, organizing meetings of AIDS Committee, development of work plans, programme monitoring and evaluation.
- In addition to the training, visit to an enterprise engaged in the WPI/PPP and interaction with key programme implementers will be useful.

Expected output: Nodal person trained and draft policy and work plan developed

Step 3 : Organize meeting (s) of Internal Committee:

- Internal committee meetings to approve the work plan and policy. The work plan will have specific objectives, activities and indicators for performance. It may take a few meetings to approve the policy

Expected output: an approved work plan and policy in place.

Step 4 : Implementation of annual work plan:

- Elements of BCC, peer educator training, enhancing access to services, effective dissemination of policy and other elements as per the work plan.

Expected output: outputs as per the work plan implemented.

Step 5 : Programme Monitoring and Evaluation:

- Nodal person to collect data, prepare progress reports and present the progress in the meeting of internal committee.
- Specific KABP surveys can be undertaken as per the work plan.
- An internal system of monitoring and evaluation developed by ILO for enterprises is given in the resource material section of this manual.

Expected output: Review of progress against key process and impact indicators.



Moving beyond workplaces

Setting up Public Private Partnerships for HIV prevention and care programmes:

Public Private Partnership (PPP) for HIV prevention and care is an important component of the National AIDS Control Programme (NACP). The National Policy and the NACO encourage greater participation of private sector in the national programme. NACO guidelines can be seen at www.naco.gov.in.

PPP in HIV Prevention:

a. Setting up HIV interventions amongst bridge populations:

The prevalence[1] of HIV is 2.59% and 0.99% among truckers and migrant workers respectively. Thus, reaching out to these bridge populations is a key focus of NACP in India. Both truckers and migrant workers are directly and indirectly associated with companies/industries. Therefore, developing pubic private partnerships for reaching them, in addition to the interventions carried out by NGOs, are being envisaged in the national programme.

Different models of PPP for bridge populations are possible:

- Interventions jointly funded by companies and some international organizations.
- Interventions totally funded by companies, implemented by an NGO/company's own foundation, with technical assistance/material support from organizations like State AIDS Control Societies/ILO.
- Interventions jointly funded by companies/corporate groups for setting up interventions at strategic points.

b. Mainstreaming HIV in CSR programmes:

Enterprises reach out to the communities through a range of social development projects such as community development, income generation, skill building, health and education, women empowerment, environment etc as part of their Corporate Social Responsibility (CSR) programme. Enterprises can mainstream HIV in their CSR efforts and reach out to the communities with HIV prevention services.

Enterprises can develop partnership with their respective SACS to get their CSR partners trained in HIV/AIDS; set up referral linkages with the government's programme for HIV testing and treatment and also procure appropriate communication material. This is a cost-effective and sustainable approach.

PPP for HIV care and Support:

The NACP envisages Public Private Partnerships (PPP) for enhancing access to HIV care and treatment that broadly includes services related to HIV counselling, testing and treatment. Under

[1] NACO Annual Report 2012-13



the National AIDS Control Programme, enterprises can get into partnership with their State AIDS Control societies for:

- Training of their doctors/counsellors and other staff,
- Setting up Integrated Counselling and Testing Centers (ICTC),
- Setting up Anti-Retroviral Treatment/Therapy (ART) centres.

Under this partnership, enterprises provide their infrastructure/staff and running costs; and SACS provide training to the staff, medicines and testing kits. Enterprises are expected to expand these services beyond their employees i.e. to communities.

Key steps to set up PPP:

Step 1 : The Nodal person of enterprises should develop an understanding of PPP programmes. He/she can visit some on going PPP interventions.

Step 2 : The Internal committee should discuss the company's approach and decide if company wants to develop PPP for prevention or for care and support programmes.

Step 3 : The nodal person should meet the SACS or other agencies and explore different options for PPP that fit within company's vision.

Step 4 : The nodal person should develop a concrete proposal for management's approval. The proposal will outline specific contribution from the company.

ILO is partnering with 12 large corporate groups for workplace programmes. Some of them have moved beyond workplace programmes and set up good models of PPP.

ILO has documented good practices and emerging models of workplace interventions and PPP being implemented in India by different enterprises. The documentation can be seen in Section-III.

SECTION-II

Training

Training

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Training of Peer Educators

HIV/AIDS awareness is not a one-off event. Employees need to have access to regular education and training. They need to have correct knowledge about HIV/AIDS delivered in a manner that enhances their risk perception and leads to behaviour change. Peer education approach, in which some selected employees are trained as trainers, is a viable option. Once peer educators are properly trained and given good quality communication and training materials/tools, they can provide regular awareness to their co-workers. Peer education, in addition to the workplace policy and its proper implementation, ensures that the enterprise has institutionalized the programme.

Training of peer educators on HIV/AIDS within enterprises

The number of Peer educators:

There is no fixed formula. It depends upon the workforce, nature of enterprise and existing levels of knowledge, attitude, behaviours and practices, which can be found out through a survey. Following points are critical based on ILO's experience with enterprises:

- It is the quality of peer educators that matters, not the number.
- In a WPI within enterprises, the number of peer educators is actually not a big issue because formal education and training programmes are possible. A more important issue is to provide peer educators a schedule for conducting regular sessions for employees and allow staff time to attend the sessions within working hours.
- Generally, there is a high turnover of peer educators for a variety of reasons. So, it is always good to train more than needed.
- Peer educators need to be given motivation by management and regular refresher training so that their knowledge is updated and skills are enhanced.

If a company has large workforce or multiple locations, it can put in place a cascading model of training. It can first get a group of employees trained as Master Trainers, who in turn can train peer educators in different locations/units.

Selection of peer educators:

Selection of employees for becoming peer educators, like proper selection of participants for any training, is a critical step. Look for:

- Employees who have an interest in social issues.
- Employees who have good communication/training and inter-personal skills.

PepsiCo, before starting their master trainers training, organized a session with all employees, which was conducted by the ILO team, involving a PLHIV. As per the plan, CEO of the company released the company policy, outlined the entire approach and requested employees to volunteer for receiving training on HIV/AIDS. A number of volunteers signed up, who were later trained by the ILO in four different training programmes.

- Employees having credibility/acceptance amongst their colleagues.
- Good gender balance, good balance of position/age.
- Employees who are good at their work. (Never select poor performers!).
- Peer educators are volunteers. Only those employees who show an interest voluntarily should be included for receiving the training.

"If they are not properly doing the work, they are paid for, very little are the chances that they will do justice to the role of a peer educator, which is a voluntary work. So, encourage good performers within the company to become peer educator - S.Mohammad Afsar, ILO.

- If the enterprise has its own training wing/institute, its faculty should also be trained in HIV/AIDS and be involved in the programme. This way, HIV/AIDS training can be integrated in the existing training programme of the enterprise.

Duration of training for peer educators:

Ideally, the training should be for five-six days, so that participants could be given sufficient practice in imparting HIV/AIDS education to their fellow workers. However, considering the tight work/production schedules, enterprises find it difficult to release their employees for such a long duration. Keeping this constraint in mind, ILO developed a structured training programme, and ran it in enterprises for two-three days. The experience revealed that the training course could be delivered in three days as well, provided there is proper planning, adherence to prescribed time in different sessions, and not much time is spent on rather ceremonial inaugural and valedictory sessions.

However, if enterprises could afford to organize a longer training for trainers it would always be better as it would give their peer educators more time to acquire training skills and practice their sessions.

Objectives of the training programme:

The training is proposed to be built around three key blocks:

The Knowledge block:

- To enhance the knowledge of participants about STI/HIV/AIDS.
- To enhance the knowledge of participants about the global and national scenario of HIV/AIDS and the National AIDS Control Programme.
- To enhance the knowledge of participants about HIV/AIDS policy and programmes in the world of work and the approach at the enterprise level.
- To orient the participants to the concept of BCC in the context of HIV/AIDS workplace programmes.
- To enable the participants to appreciate the rationale for condom education and develop an understanding of a system for condom procurement and distribution in WPI.



- To enhance knowledge of participants about STIs and their link with HIV.
- To enhance participants' understanding about the gender dimensions of HIV.
- To enhance the knowledge of participants about TB and HIV-TB co-infection.

The Attitude Block

- To enable the participants better appreciate the issue of stigma and discrimination associated with HIV/AIDS and modify their own discriminatory attitudes, if any.
- To enable the participants explore and modify their personal biases/attitudes that may hinder the implementation of programme /peer education.

The Skills Block:

- To impart basic communication and training skills to participants.
- To impart skills to help them undertake peer education work at the enterprise level.

A sample programme for three-day training with different sessions to meet the above objectives is given as resource material.

Preparations for organizing the training:

1. Number of participants:

- An ideal batch of participants for delivering an effective training is around 25. It could go up to a maximum of 30.
- The groups should be homogeneous as far as possible, in terms of position in the company, age group and educational status.
- Adequate gender balance should be ensured in the group.

2. Deciding the date/venue:

- Enterprises should use their own venue, wherever possible. It is cost effective, and also ensures participation of senior management for a short opening and closing sessions.
- Venue should be equipped with necessary infrastructure /equipment (U- shaped seating arrangement with enough space to allow for group work/role plays, projection and sound system to show presentation/films).
- Date of the training should be fixed in consultation with management.
- Availability of participants should be ensured before deciding the date of training.

3. Identifying Resource persons:

- A core team of resource persons should be engaged well in advance, based on their expertise to impart knowledge, handle sessions on attitude and facilitate skill building sessions. Resource persons can be from SACS, NGOs or any other expert agency. People

having experience of running WPI/PPP should be invited to share their practical experiences.

- A person living with HIV should be engaged to share his/her personal experience of life with HIV and concerns. ILO has trained PLHIV networks of INP+ and state networks, who could be involved.
- Discussions should be held with resource persons about the objective of their session. Most of the good trainers always do it but still it is important to request the resource persons to follow participatory methodology and avoid long lectures/presentations.

"We had done session on basics of HIV/AIDS using the ILO card game. The next session was on global and national scenario of HIV/AIDS. This resource person had a presentation which had some 40 slides, out of which 30 slides were on basic information about HIV. Information about scenario was not updated at all. And if this was not enough, even the PLHIV in a later session started by sharing his knowledge about HIV/AIDS. This was such a waste of time and participants got bored of getting the same information again and again.

Now, I share the session objective first with the resource person and make sure there are no repetitions. If people still insist on using PowerPoint presentations, I share the ILO CD, which has short and interesting presentations on each topic of the programme," nodal person of a corporate group

- Resource persons should be requested not to overload the participants with information. They should share the basic information, which the participants should have to help them do HIV/AIDS programmes at workplace. Resource persons should spend sufficient time on taking feedback to ensure that information given is well received by the participants. Participants should be suggested correct sources of information for further reference.

Logistics:

- Proper planning for logistics has a tremendous impact on the success of training.
- Resource materials and equipment needed for the training like projectors, flip charts, markers, audio-visual aids, note pads, pens, copies of resource materials etc. should be carefully planned and organized well before the programme.
- Proper coordination with participants/resource persons is a must. If there is a change in timing of sessions, that should be made in consultation with the resource person(s).
- Last but not the least, planning for tea/coffee and lunch should be properly done. A copy of the final agenda should be shared with the person in-charge for tea/lunch so that timings could be kept for these breaks. If any last minute changes occur in the schedule, keep the person in-charge informed.

Follow up of training:

- The report of the training programme, along with an analysis of pre and post- test questionnaire should be prepared and shared with participants/management.
- A work plan on how the peer educators will create awareness should be developed and



shared with the participants/management.

- Monthly feedback should be taken from peer educators and analyzed by the nodal person.
- Management/internal committee should regularly review implementation of the plan and set up a system of acknowledging good work of peer educators.

Training sessions

Opening session: Building the workshop environment.

Objective: To create an atmosphere of learning and sharing

Duration: one hour

Methodology:

- Ice-breaking exercise (15 minutes)
- Gathering expectations of participants and listing them on a flip chart (15 minutes)
- Setting ground rules through discussion (10 minutes)
- Administering the pre-test questionnaire (10 minutes)
- A short opening statement by the management (10 minutes)

Materials Required: Flipchart/Chart paper, copies of the pre test questionnaire and any material that is required for the exercise.

Activity 1: Ice-breaking

Think of any game/exercise to break the ice and allow for participants to know each other better.

Suggested exercise:

- Encourage participants to move around, look for a person whose birthday is closest to theirs. Once they find their pairs, they can be given 5 minutes to know each other on the following points:
  - **a.** Their partner's name and the work he/she does;
  - **b.** What does he/she like most about his/her work; and
  - **c.** Why does he/she want to become a peer educator.
- Then ask the pairs to introduce each other.

Any other technique of pairing or making groups can also be thought out. If the time is less, they can also be asked to know and share their partner's expectation from the workshop. This can then take care of the next activity as well.

Activity 2: Gathering expectations

Any technique can be thought of by the facilitator.

Suggested exercise:

- Go round the table, and ask each person to share one expectation from the workshop. Write on a flip-chart with some space in between so that you can club them together later



as expectations get repeated. Once the participants are done, use this opportunity to briefly present the agenda and match the sessions with the expectations.

Expectations	Matching with the agenda
▪ To get complete knowledge about basics of HIV/AIDS	▪ Will be covered in the session on basics
▪ To know the latest statistics about the problem	▪ Will be covered in the session global and national scenario of HIV/AIDS session
▪ What is the government's programme to combat AIDS?	▪ Will be covered in the session global and national scenario of HIV/AIDS session
▪ How to better communicate HIV & AIDS messages?	▪ Will be covered in session on BCC/practice session
▪ How to reduce Stigma and discrimination?	▪ Will be taken up in session on attitudes, PLHIV sessions and discussion
▪ How to convince the management about the need for HIV/AIDS programme?	▪ Advocacy with management will be discussed and there is a presentation in the DVD
▪ What will we do after the training?	▪ Will be covered in the session and tools will be provided

- If there are some expectations beyond the scope of the workshop, it should be specifically told to participants. If the resource person is confident of handling the expectation, he/she can decide to allow for some time on that.

Activity 3: Setting ground rules

It is important to set some ground rules right in the beginning. The best way to begin is from expectations which have one common point- **Expectation to learn**. This calls for collective action, and a cordial workshop environment to facilitate learning. The facilitator can quickly get participants to collectively agree to some ground rules which the facilitator can write on a flip chart and put up in the hall. The group can agree to points like below:

- Punctuality: Be on time in the beginning as well as tea/lunch breaks.
- Show respect to others: respect opinions and avoid arguments, only one will speak at a time, give opportunity for others to speak **(emphasize: these are the skills they will need**

as peer educators!).

- Put mobile phones on silent mode.

Activity 4: Administering the pre & post test questionnaire

A pre & post test questionnaire is provided in the resource materials. Sufficient copies should be made for the participants while preparing for the training programme.

- Distribute a copy to each participant at the beginning of the training and ask them to fill it.
- Emphasize that it is to assess individual's knowledge before beginning the training.
- Ask the participants to put the date and tell them that writing name is optional for them.
- Similar test (post test) will be administered towards the end of the training.



The Knowledge Block

Total number of sessions: Eight

Objectives:

- To enhance the knowledge of participants about STI/HIV/AIDS.
- To enhance the knowledge of participants about the global and national scenario of HIV/AIDS and the National AIDS Control Programme.
- To enhance the knowledge of participants about HIV/AIDS policy and programmes in the world of work and the approach at the enterprise level
- To orient the participants to the concept of BCC in the context of HIV/AIDS workplace programmes
- To enable the participants appreciate the rationale for condom education and develop an understanding of a system for condom procurement and distribution in WPI.
- To enhance knowledge of participants about STI and their link with HIV.
- To enhance the participants' understanding about the gender dimensions of HIV.
- To enhance the knowledge of participants about TB and HIV-TB co-infection

Session-1: Basics of HIV/AIDS

Objective: To enhance the knowledge of participants about HIV/AIDS.

Methodology: ILO Card game, discussion, presentation

Duration: Two and a half hours

Materials required: a set of Card game, ILO posters on routes of transmission, and Presentation on basics of HIV/AIDS given in the DVD.



Activity 1: ILO Card Game

It is a pack of 20 cards of questions & answers on HIV/AIDS.

- Questions 1-6 are on basic information on HIV/AIDS and the routes of transmission;
- Questions 7-13 are on the prevention of HIV/AIDS; and
- Remaining questions are on the issues of testing, treatment, stigma & discrimination and elements of workplace policy.

Question and answers of the ILO card game are given in section-IV for easy reference of resource persons.

Tips:

'Q' printed on the top left corner of the card indicates a question card.

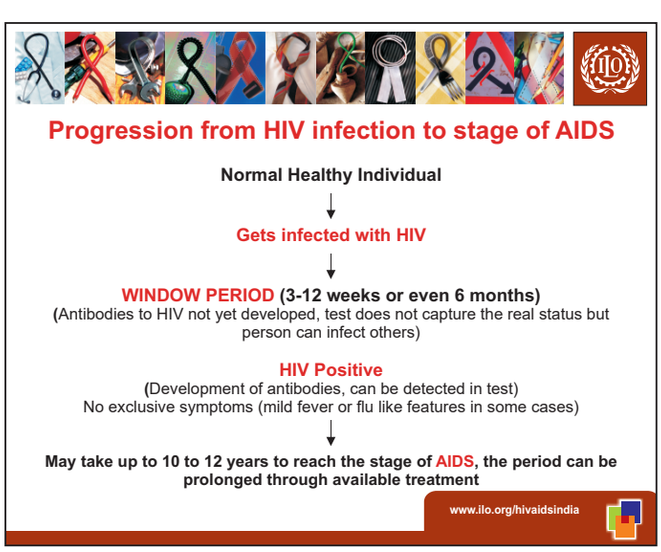
'A' printed on the top left corner of the card indicates an answer card.

The number of the question/answer card is mentioned at the bottom-right corner of the card.

The first two cards provide directions to use the card game.

Steps to conduct the card game:

- Depending upon the number of participants, select equal number of question and answer cards and distribute so that each participant gets a card, either the question or the answer card. For example, if the number of participants is 30, select only 30 cards: 15 questions and 15 answers for the first round; once the first round is over take the rest of the cards and complete the total 20 cards.





- Ask them not to open the cards till they are asked to do so.
- Now, ask the group to open their card but do not discuss with others. .
- Ask the person with card of question number 1 to stand up and read out the question aloud.
- Ask the group to answer the question, except from the person who is holding the answer card.
- After giving chance to one or two answers, ask the person who has the answer card to read the correct answer to the entire group. Clarify doubts, if any.
- Continue the same way till all the cards are done.
- Keep summarizing the learning from time to time and keep the participants engaged.

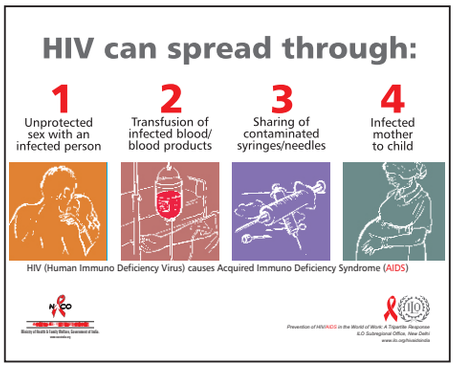
Activity 2:

The DVD contains a short presentation on basics of HIV/AIDS.

The presentation can now be shown to participants as it summarizes the learning and also introduces them to another method of doing the session on basics.

Now, participants have been oriented to the card game and power point presentation on basics of HIV/AIDS.

Finally, show the two ILO posters on routes of HIV transmission.





Notes for facilitator:

- Use innovative ways of using the card game. For example, you can make three groups and conduct a quiz based on the card game questions.
- Take feedback and summarize the key learnings.



Session-II: The AIDS Scenario and the National Programme.

Objective: To enhance the knowledge of participants about the global and national scenario of HIV/AIDS and the National AIDS Control Programme.

Duration: 1 hour

Methodology: Presentation and discussion:

Materials required: Computer/LCD projector for power point presentation

The facilitator first needs to update his presentation and present the latest estimates.

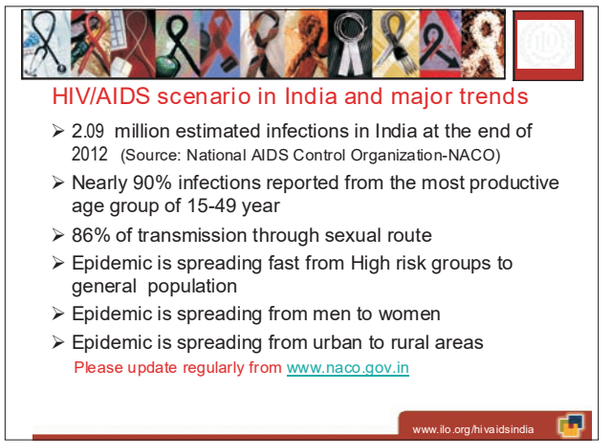
Participants may ask how these estimates are arrived at. The facilitator can then explain the process, in short, without going into unnecessary details.

The facilitator should present a quick overview of the national programme and particularly highlight the role that enterprises are supposed to play in the national programme, which are: WPI, PPP and mainstreaming HIV in their CSR efforts.

There is a short presentation in the DVD on this topic that could be used by the facilitator, which also mentions sources for updating the statistics.

The facilitator should ask the following questions towards the end of the session and summarize the learning:

- What is the estimated number of people living with HIV globally and in the country?
- What sources will you use to keep your knowledge about global and national statistics of HIV/AIDS updated?
- What are the key components of the National AIDS Control Programme?
- What are the roles of NACO and SACS?
- What is the role of enterprises in HIV prevention and care in India?
- What type of partnership is possible between enterprises and NACO/SACS?



Emphasize that HIV statistics change as a result of surveillance. So, keep updating the global scenario from www.unaids.org and the national scenario from www.naco.gov.in

Session III: HIV/AIDS Policy and Programmes in the World of Work/PPP and approach at the enterprise level.

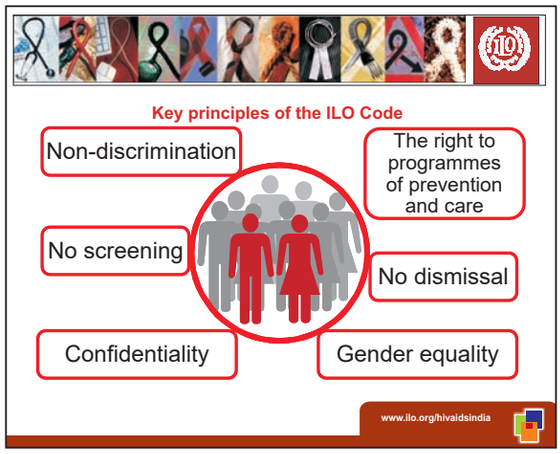
Objective: To enhance the knowledge of participants about HIV/AIDS policy and programmes in the world of work and the approach at the enterprise level.

Duration: One hour

Methodology: Presentation and discussion.

Materials required: Computer/LCD projector for power point presentation, flip charts.

The facilitator can inform the participants about the national workplace policy environment, and explain the ten key principles of the ILO Code of Practice, which are endorsed by the National Policy.



The facilitator can discuss the process of developing the policy and highlight the steps outlined in the ILO Code of Practice.

An overview of elements of WPI/PPP (as given in the section on strategy) can be presented now.

- Developing workplace policy and programmes
- Behaviour Change Communication (BCC)
- Enhancing access to STI and condoms at workplaces.

Moving beyond workplaces - developing PPP.

The DVD contains a short presentation, which could be used. Documentation of work of enterprises included in the section-III can also be used for reference by the facilitator.

An enterprise that is implementing the programme can be called to share the practical experience of implementing WPI/PPP.

In this session, facilitator should provide an overview of all components of WPI/PPP; explain the principles of workplace policy and the process of developing it. Specific sessions on BCC, STI and condom are to be done separately.

Session-IV: Behaviour Change Communication (BCC) in the context of WPI

Objective: To orient the participants to the concept of BCC in the context of HIV/AIDS workplace programmes

Duration: One and half hour

Methodology: Discussion and presentation

Materials required: Computer/LCD projector, flip chart

Activity: 1 Ask participants about any behaviour that they would like to change but are struggling with. Examples: quit drinking alcohol, quit smoking; going for regular exercise to keep fit etc. Pick any one of them and discuss: why is it difficult to change?

Discussion would result in acceptance that changing behaviour is difficult.

Now, emphasize the point that changing behaviours that enhance risk to HIV infection, particularly unsafe sexual behaviour, is all the more difficult.

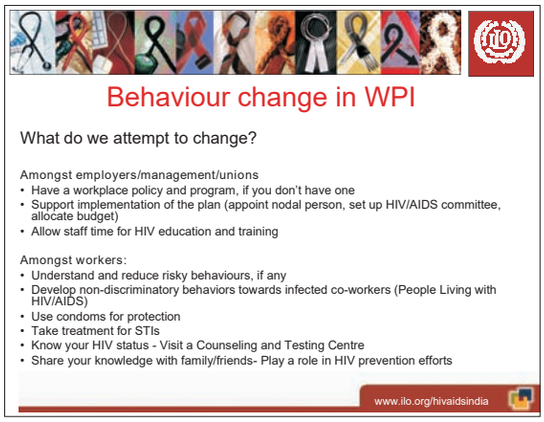
Key points:

- Behaviours are developed over years and are deep rooted into cultural, social, political, and economic factors. These are difficult to change.
- Mere information/knowledge does not lead to change in behaviours.
- Behaviour change is a slow process which goes through several stages.
- Communication plays an important role in changing behaviours.
- BCC is a strategy of influencing behaviours of an individual through effective communication. BCC involves:
  - Enhancing the risk perception;
  - Encouraging personal commitment to change;
  - Imparting the skills, necessary to introduce the change; and
  - Creating an enabling environment.

Understanding BCC in the context of WPI:

Enhance risk perception of management through advocacy. Main changes in behaviour of management (including unions) expected through advocacy are:

- Recognize HIV/AIDS as a workplace issue;
- Develop workplace policy and programme. (The policy and its implementation creates an enabling environment!);





- Appoint a nodal person, set up HIV/AIDS committee for implementation of programme;
- Allocate budget for the programme; and
- Allocate staff time for HIV education and training.

In case of workers, formative assessment will lead to identification of behaviours that need to change. Broadly, the BCC would attempt changes like below:

- Participate in the HIV/AIDS workplace programme
- Understand the risk and modify behaviours
- Develop non-discriminatory behavior towards co-workers living with or affected by HIV
- Use condoms for protection
- Seek treatment for STIs
- Volunteer to know ones HIV status - visiting an ICTC
- Share knowledge with family/friends - Play a role in HIV prevention efforts

Now, discuss BCC approaches in WPI. Particularly important is inter-personal communication.

The facilitator can use the presentation given in the DVD to further explain the concept and discuss various approaches of implementing it at workplaces. Reference to the documentation of good practice on BCC can be made, in section-III to illustrate the concept and give specific examples.

Session-V: Condom Promotion/ Education.

Objective: To enable the participants appreciate the rationale for condom education and develop an understanding of a system for condom procurement and distribution in WPI.

Methodology: Discussion, exercises, presentation.

Duration: One and half hours.

Materials required: computer/LCD projector, flip chart, condoms, penis model.

Activity-1

Ask participants: why are we talking about condom in HIV programmes. Write a few responses on a flip chart.

Discuss and link it up to the fact that changing high risk sexual behaviour is difficult. It takes time. Therefore, some protection is necessary, which condoms provide.

Condom education is done in the context of protection, in the interest of public health.

Activity-2

Discuss barriers in condom use. Ask participants to mention the barriers.

Some of the common barriers will be:

- Condoms reduce pleasure in sex
- Condoms are not totally reliable
- Hesitation to buy condom

List them and address them one by one.



Activity-3

Discuss the correct usage of condom.

Any exercise can be done depending upon the comfort level of the group. The idea is to make the group comfortable to talk about condom usage, its rationale and benefits. The correct usage can be demonstrated with the help of a penis model. Emphasize that most of the times condoms break because of incorrect usage rather than the quality of the product.

Condoms can be distributed among the group and they can be asked to try and explain the correct use of condom. This breaks inhibitions and makes them more comfortable to handle session on condoms.

Now the facilitator can explain the process of condom procurement and various options of distribution: through peer educators, through outlets or through condom vending machines.

The DVD includes a presentation on condoms that can be used.



Session VI: Sexually Transmitted Infections and their link with HIV.

Objective: To enhance knowledge of participants about Sexually Transmitted Infections (STIs) and their link with HIV.

Methodology: Discussion, exercises, presentation.

Duration: One hour.

Materials required: computer/LCD projector, flip chart.

Activity-1:

Ask the participants what are STIs. Why is it necessary to talk about STI treatment in HIV prevention programmes? Put answers on a flip chart and emphasize:

- People having high risk sexual behaviour (unprotected sex with multiple partners) carry the risk of STI as well as HIV.
- STIs can provide entry for HIV to the blood stream.
- Chance of HIV transmission increases 3-10 times in the presence of STIs.
- STI may be more severe and more resistant to treatment in HIV Positive persons.

Therefore, diagnosis and treatment of STI is a strategy for HIV prevention.

Activity-2: Ask participants why is it difficult to get STI treated?

Facilitate discussion which will highlight basically the following two reasons:

- Shyness to seek treatment for an infection of this nature; and
- Lack of knowledge of STI symptoms.

Now, explain the symptoms of STI in men and women.



- The facilitator can run the presentation given in the DVD and conclude by emphasizing the key points as below:
  - Most of the STIs are curable.
  - It is important to know the symptoms of STIs. (ask one or two participants to mention symptoms in men and women)
  - Self medication should be avoided. It is important to take the treatment from a registered medical practitioner only.
  - Full course of the prescribed treatment should be completed, even if symptoms start disappearing. If this is not done, the infection will not be cured completely.
  - It is important to get the sexual partner also treated.
  - Correct and consistent use of condoms protects from STI as well as HIV.

Session VII: Gender and HIV

Objective: To enhance participants' understanding about the gender dimensions of HIV.

Methodology: Discussion, presentation.

Duration: One hour.

Materials required: Computer/LCD projector, flip chart.

Activity: Make copies of the following case study and distribute it to the participants. The case highlights discrimination at workplace as well as from family/society, particularly in case of women. Ask them to read the case study and discuss why women are more vulnerable to HIV infection

"Driver of a nationalized bank died of AIDS. His wife was also HIV positive, but healthy and fit to work. In spite of the provision of offering job to the dependent as per the bank's rules, the wife was denied job because of her HIV status. To compound the problem, her in-laws demanded job for the younger brother of the deceased, not for the wife.

- Summarize with the help of the following.



HIV/AIDS affects women and men differently in terms of vulnerability and impact. There are biological and social factors which make women more vulnerable to HIV than men.

Biological factors:

- The vaginal walls of women have large surface area, which aid in collection of fluids that can facilitate in the transmission of HIV. While, in men the surface area on the penis is small thus cannot collect fluids.
- Walls of cervix and vagina are thinner and are easily torn. The micro-pores can allow easy passage to the virus.
- Women have more chances of getting Reproductive Tract Infections.
- Most often women suffer from Sexually Transmitted Infections, which are asymptomatic and do not get treated.

Social Factors:

- Power imbalance in the workplace exposes women to the threat of sexual harassment.
- Poverty is a noted contributing factor to HIV vulnerability. Women make up the majority of the worlds' poor. In poverty crises, a girl child is more likely to be deprived of education. Entry of women into prostitution and trafficking of young girls into sex is also linked with poverty.



- Many women experience sexual and economic subordination in their marriages or relationships and are therefore unable to negotiate safer sex or refuse unsafe sex.
- Women's access to prevention messages is hampered by illiteracy.
- Studies show the heightened vulnerability of women to the social stigma and ostracism associated with AIDS, particularly in rural settings as compared to men.
- Property/inheritance laws also put women at a disadvantaged position. There is evidence of women living with HIV losing their property after the death of their husbands, being thrown out of home by their in-laws, even losing their right to be with their children.

The Facilitator can show the presentation on 'Gender and HIV' and spots on discrimination, particularly those faced by women, given in the DVD.

Session VIII HIV and Tuberculosis

Objectives: To enhance the knowledge of participants about Tuberculosis (TB) and HIV-TB co-infection

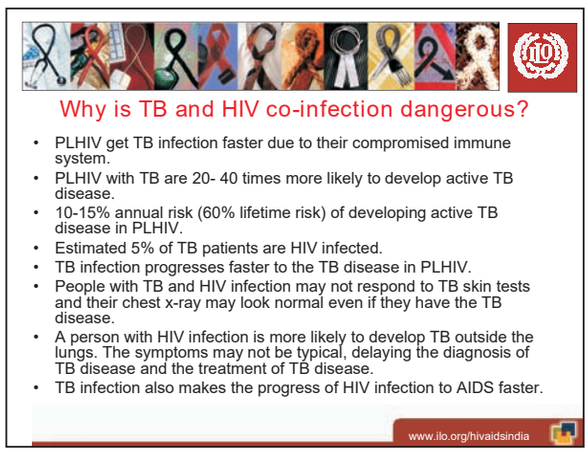
Methodology: Presentation and discussion.

Duration: 45 minutes.

Materials required: Computer/LCD projector for power point presentation

Begin by asking the following five questions, which the participants are expected to know by the end of the session:

- What is TB?
- How does TB spread?
- What are the symptoms of TB?
- What is the treatment for TB?
- What is the link between HIV and TB?
- Why is TB a workplace issue?



The facilitator can make a short presentation, included in the DVD; and towards the end can emphasize the following points:

- TB is one of the most commonly occurring Opportunistic Infections (OIs) among PLHIV.
- TB can be latent or active. It is important to know the symptoms and get the sputum examination done.
- TB can be fully cured if the prescribed course is completed, without interruption. So, treatment compliance is extremely important to avoid multi-drug resistant TB (MDR-TB). MDR-TB disease is difficult to treat.
- People need to know about the government's treatment programme: The Directly Observed Treatment, Short-course (DOTS).
- Latent TB Infection can progress into active TB disease if the immune system is weak, particularly in the case of PLHIV.
- The impact of TB and HIV on the workplace is significant. TB/HIV workplace programmes thus make business sense as they contribute towards reducing the impact and sustaining the profitability of businesses.

- Globally, there were an estimated 10 million cases of TB in 2017 of which 9% were HIV positive.
- 300,000 of estimated TB deaths in 2017 had HIV.
- It is estimated that 49% of people living with HIV and TB are unaware of their co-infection.

Source: WHO Global Tuberculosis Control Report 2018



The Attitude Block

Session Objectives:

- To enable the participants better appreciate the issue of stigma and discrimination associated with HIV/AIDS.
- To enable the participants explore and modify their personal biases/attitudes that may discriminate PLHIV/hinder the implementation of programme/peer education.



Session - 1 Stigma and Discrimination

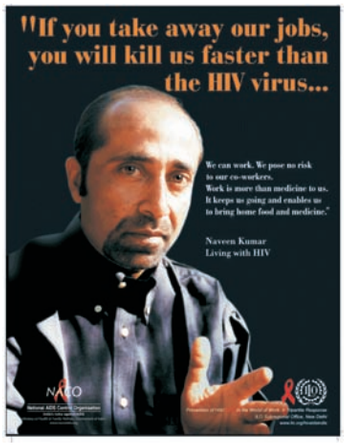
Objective: To enable the participants better appreciate the issue of stigma and discrimination associated with HIV/AIDS

Methodology: Ideally, a person living with HIV should be invited to speak at the workplace. In case, it is not possible, other options are-

- A case study and discussions
- Role-play and discussions
- Show advocacy spots given in the DVD

Duration: One hour.

Material required: sufficient copies of the case study (Necessary adaptations can be made as per the situation)



Activity 1:

Ask participants the main reasons for discrimination against PLHIV. Write them down on the flip chart. Broadly the reasons would have their roots in individual attitudes (biases) and fear arising out of ignorance.

Ignorance can be handled by providing correct knowledge and dispelling myths.

It takes longer to address discriminatory attitudes.

Either invite a PLHIV to interact with participants or show the advocacy spots of stigma given in the DVD.

Activity 2: Case study.

Make copies of the following case study. Divide participants into three groups. Ask them to read the case study and discuss the given questions.

A health and safety representative in a factory learns that a worker is HIV positive. It has become a common knowledge in the factory. Workers are known to be discussing their fears of working with him. They don't want to share the equipment or eat with him. There have been comments made by management too. The line supervisor is not so sure that it is safe to work with this worker.



The situation has reached a crisis. The health and



safety representative is afraid that there will be trouble unless immediate action is taken. How should the various people involved handle this situation?

- What should the health and safety representative do?
- What should management do?
- What should the line supervisor do?
- What should the infected worker do?
- What should his co-workers do?

The participants can also be asked to do a role play on the situation and their proposed solution.

Key points to be summarized

- Then main reasons for stigma and discrimination are ignorance and negative attitudes.
- Imparting correct knowledge is critical to dispel myths.
- Education and training is needed at all level in the enterprises: workers, supervisors, trade unions, health and safety representatives and management.
- There is no reason to isolate PLHIV at workplace. However, universal precautions need to be followed to take precaution when workers come in contact with human body fluids. (Please refer to resource materials).
- Work place should consider developing and implementing non-discriminatory policy, through a consultative process, at workplace. Several companies have done it in India.
- Revisit the principles of workplace policy.



Session -2 Exploring attitudes

Objectives: To enable the participants explore and modify their personal biases/attitudes that may discriminate PLHIV/hinder the implementation of programme /peer education.

Methodology: Group Game, debate and discussion.

Duration: one hour

Materials required: Flip chart, statements for discussion and colour papers.

Key statements for discussion:

- People with HIV infection should be isolated to prevent further transmission.
- AIDS is mainly a problem of people with immoral behaviour.
- There should be compulsory testing for HIV to prevent the spread of HIV.
- A person living with HIV must disclose his/her status.
- Women with HIV infection should not have children.

Activity

Write each statement on a chart paper (alternatively, statement can be shown one by one on LCD using the Power Point).

Designate three distinct corners/areas in the room and label it with three different colours using the colour papers. The corners will be **agree, disagree and undecided.**

Read one statement at a time. Ask participants to move to a corner as per their opinion.

Ask few participants from each of the three groups to justify their views providing reasons.

During the discussion ask if any of the participants has changed their mind. Ask for the reasons for change in their view. Allow them to move to other corners.

You may challenge each of the groups to convince other groups to join them so that their strength could be increased.

Although it is a fun game, anticipate arguments. Facilitate the discussion in a way that each person is allowed to express his/her opinion but must listen to others.

Summarize the discussion and emphasize:

- Discriminatory attitudes are not in the interest of HIV prevention programmes.
- We need to explore our own attitudes and modify them in the interest of the programme.



The Skills Block

Objectives:

- To impart basic communication and training skills to participants.
- To impart skills to help them undertake peer education work at the enterprise level.

Session 1:

Objective: To impart basic communication and training skills to participants.

Methodology: Discussion, role play, simulation and presentation.

Duration: Approximately three hours.

Materials required: Flipchart, slips of paper for role play situations.

Activity 1: Brainstorming on the qualities of a good communicator:

- Ask the participants to think of someone who they consider to be a good communicator and ask them to remember the qualities in the person.
- Invite participants to mention qualities of a good communicator.
- Write the responses as they are mentioned on the board/ flip chart.
- Segregate the responses if possible under skills and attitudes.
- **Highlight the importance of the right attitude for becoming a good communicator.**

Facilitate the discussion and summarize the following tips of verbal and non-verbal communication:

- Use simple language (the language that the target audience understands)
- Avoid using technical jargons
- Make the communication interactive. Take regular feedback from the audience
- Maintain eye contact
- Listen well
- Be observant
- Show respect to audience
- Be honest
- Shows genuine concern
- Be careful of the volume and tone of your voice.
- Encourage questions.

Activity 2: Interpersonal Communication (IPC)

Discuss the essential characteristics of IPC in the group. In the context of HIV programme, IPC is very effective in formal as well as informal sessions. Peer Educators must be very good at IPC.

Summarize the discussion and highlight key points:

- Initial rapport building with people is very important. This helps in understanding the target audience and relating the subject to their context.

- Assess the group' needs and create interest on the subject.
- Timing is very crucial. When to begin and when to conclude session is critical.
- Create a conducive atmosphere.
- Introduce the subject properly; provide appropriate information based on the needs of the group.
- Give relevant examples as much as possible.
- Involve your audience. Communication should be two way.



- Address questions, allow room for seeking clarifications.
- Use appropriate communication tools/audio-visual aids.
- Take feedback and summarize the key messages at the end of the session.
- Highlight the action points.

Activity -3 Role-play on Communication skills

It is important to know what to say and how to say while providing information on HIV/AIDS to people. The information giving is a skill that is required to make people interested in the information that you provide, recognize the risk that HIV poses, and seek some personal commitment on behalf of the audiences

Four situations are given for the role-play, to learn about the challenges in giving information and key points to keep in mind.

Situation one:
In your factory, Ramesh a worker comes to talk to you about the risk of getting HIV through sexual encounter. What will you tell him and how?

Situation two:
You overhear a group of people discussing on STIs and one of them informs the group that STIs are not completely curable. What will you do now?

Situation three:
Some young workers are discussing that condoms are not fun and they spoil the excitement. How will you address it?

Situation four:
A group of workers are concerned about a co-worker, who they feel has HIV. They are not comfortable working with him. They come to discuss this with you. What will you do?

- Divide the group into four small groups. Give one situation to each group.
- Allow about 5-10 minutes for preparation.
- Ask each group to perform the role play, while others watch.

Discuss and highlight the following points:

Please note that the role play may not bring out all points. Do not criticize the participants for that. Facilitate the discussion to bring out the key points for learning, also encourage new points/ ideas.

Situation one:

The peer educator should take Ramesh to a quiet place make him comfortable and talk.

- The peer educator should first try to understand the key concern/question of Ramesh.
- The peer educator should demonstrate a concerned, friendly, concerned and non-judgmental attitude throughout the discussion.
- Provide proper information on HIV/AIDS/STIs risk, referral for HIV testing and counselling, if needed.
- Offer help according to the problem.

Situation two:

- Get an entry into the group carefully.
- Try and take part in the discussions.
- Provide complete information on the STI symptoms and management.
- Stress on the importance of complete treatment, partner treatment and condom use correctly and consistently.
- Tell the group about facility for getting the correct treatment. If someone needs the treatment, refer to the treatment facility.

Situation three:

- Get into the group in a friendly manner.
- Find entry points and join in the discussion on condom.
- Discuss what makes them feel that condoms are not fun.
- Tell them that pleasure in sex depends upon so many things. Discuss pleasure and sex.
- Tell them about benefits of condom.
- Provide information on variety of condoms available these days.
- Highlight importance of using condoms for every sexual encounter in the context of prevention of HIV/AIDS/STIs and unwanted pregnancies.
- Provide brief information on HIV/AIDS /STIs.



Situation four:

- Talk to the group. Understand why the group feels that HIV person should be avoided.
- Address issues adding to discrimination, which may be related to ignorance and attitudes.
- Provide information about HIV/AIDS, how it spreads and how it does not spread.
- Tell them that HIV does not spread by shaking hands, using the same tools and toilets, eating together etc.
- Emphasize that having HIV positive persons at the workplace does not pose any risk to others.
- If there is a workplace policy, inform the group about it. If there is no policy, talk to management about importance of having a policy.

Checklist:

- Did the peer educator give key messages?
- Was the information appropriate and as per the needs of the group?
- Was the information more or less?
- Was it interesting?
- Did Peer educator ask questions to ensure that the group members understood his messages?
- Did Peer Educator provide opportunity for the group to ask questions?
- Were the questions handled well?
- What IEC materials were used?
- Did he sum up the discussions?
- Did he make effective use of the time available?
- Was he able to convince the people?
- Was his attitude appropriate?
- Were the people happy with the intervention of peer educator?

Activity 2:

Training skills:

It is closely associated with the communication skills. Peer educators will use these skills more in the formal session of training that they will later do for their colleagues.

The facilitator can tell them about the training cycle:

Understanding the training needs; setting objectives; planning and evaluation.

Emphasize the following:

- Assess the training needs of your participants with the pre test questionnaire and gathering the expectations in the session.

- Set a clear objective for the session.
- Think of an appropriate methodology as per the profile of the audience.
- Plan appropriate time/venue for the session.
- Plan logistics well.(First, make sure that the people who have to attend have been informed and they are coming. Ensure that the equipment like projector/flip charts etc. are organized)
- Update your materials and handouts.
- Make sufficient copies for distribution.
- Take feedback and evaluate the training.

Tips on an effective Training

- Three Ps of a good trainer: a Positive attitude, a Polite behaviour, and Patience.
- Building a good rapport with audience is necessary.
- Allow for every one to participate/ask questions
- Make the session participatory/interactive
- Use energizers from time to time. This keeps the audience ALIVE!
- Don't give too much information in one session. Stick to the session objective.

Practice session:

Duration minimum of 3 hours.

Participants can be allotted topics in groups to prepare and present their sessions.

(If an enterprise can afford to have longer duration training, more time should be allowed to participants to enable them practice their skills. Refresher trainings are necessary to hone skills, which should be arranged at regular intervals.



Session 2:

Objective:

To impart skills to participants to help them undertake peer education work at the enterprise level.

Methodology: discussion and presentation.

Duration: Two hours.

Materials required: flip chart, peer educator reporting format.

Activity 1: Role of Peer Educator

Role of Peer educators is very crucial in the workplace programme as they drive the programme on the ground. Role needs to be understood by the Peer educator. Conduct a small discussion on the role.

Broadly, the role of Peer Educators in HIV/AIDS programmes at the workplace is along the following:

1. **Impart HIV/AIDS education:**

- **Conduct formal session (talk to management and develop a regular schedule):**

  Organize and conduct at least a two hour session on HIV/AIDS as part of your regular training programmes. Using presentations on the DVD or card game conduct the Basics session for the employees. Screen the video spots on Stigma and discrimination provided in the DVD.

- **Conduct informal peer education sessions:**

  Peer education sessions should be conducted in one on one or in a small group whenever possible, over tea/lunch breaks, before or after the work schedules, while commuting to work. Many such options are possible workplaces/residential areas of workers, which can be used by peer educators.

- **Organize special events** for creating awareness like street plays, film shows etc. Show awareness spots in your canteen on TV. World AIDS day can be observed with programme like AIDS quiz, prizes, games, interaction with a PLHIV etc.

- **Use display materials properly**. Put up posters in canteens, around the company gates. Put up bill boards.

- **Disseminate the company policy properly**. Talk about it in IPC sessions and put it up on bill boards/notice boards/intranet.

2. **Referral for services:**

   Peer educators are the link between workers and the services. Peer Educators should keep themselves updated on the services available in the state/district and close to enterprise provided by the State AIDS control Society, NGOs or the private sector.

Peer Educator's role is to provide information on the nearest available services such as counselling and testing, ART, STI treatment to employees, develop a good rapport with service providers to ensure effective delivery to services for people refered by them.

Peer Educator should invite the service providers like counsellors to talk to workers whenever possible. Linkages with the networks of People living with HIV (PLHIV) will be very useful. PLHIV can be invited to talk to workers from time to time.

3. **Enhancing access to condoms at workplace:**

   Peer educators, in consultation with the nodal person of their companies/management can work to ensure that condoms are available at workplaces. There are several options. Condoms can be taken from government for free distribution, condoms outlets can be setup and condom vending machines can be installed.

4. **Keeping records:**

   Maintain record of the awareness/training programme and services is very important role of the peer educator. This information helps in monitoring internally. A format for monthly reporting by peer educators is given in the section-III, which all peer educators can fill in and send to their nodal person for compilation.

5. **Coordination between peer educators:**

   It is helpful to find time and meet with other peer educators to share the experiences and learn from each other at least once a month.

6. **Updating Knowledge:**

   If there are any difficult questions that the peer educators were unable to address, they should record them and forward to the nodal person. It is important for the peer educator to keep updating his/her knowledge/ and attend refresher training.

Activity 2: Situational exercises for peer educators

The facilitator can think of different situations, based on the above role of peer educators, and give the group to practice. Some examples:

- You have to take a formal session with middle level managers on HIV/AIDS. What topics will you cover ? What methodology you will use? Plan and demonstrate your session.
- You have to take a session with the floor shop workers on basics of HIV/AIDS. Plan your session and demonstrate.
- A worker contacts you after your training. He/She wants to know about HIV testing and treatment. How will you handle him/her? What information will you give him/her? Demonstrate to the group.
- You have to display HIV posters and company policy. Discus the places where you will put them up.
- You have to set up condom outlets/vending machines. How will you go about planning



the effort?

- How will you go about setting up referral linkages for STI treatment and HIV testing and counselling? Plan and present to the entire group.
- Role play on a monthly meeting of peer educators.
- Practice on filling the monthly reporting format for peer educators.

These exercises will give the participants a better understanding of their role, and will also impart them necessary skills.

SECTION-III

Resource Materials

Resource Materials

SECTION-III

SECTION-III

Resource Materials

Resource Materials

SECTION-III

Resource Materials

SECTION-III



Prototype Memorandum of Understanding between an enterprise and a technical agency
Areas of Collaboration:

Component	Goal	Main Activities	Contribution from a Technical agency like ILO, TSU, SACS, etc	Company Contribution	Timeframe (est.)
HIV/AIDS Workplace Coordination	- To ensure company ownership and sustainability of the HIV/AIDS workplace program	- Nomination of a nodal person - Creation of joint HIV/AIDS committee - Training of focal point and committee members	- Training of Focal Point and committee members - Technical assistance to focal point and committee	- Nomination of HIV/AIDS Nodal person with TOR - Designation of HIV/AIDS committee members and TOR - Staff time allocated to focal point to oversee HIV/AIDS activities	DATE: Nodal person named, Committee established by _____ DATE: Training schedule for nodal person and committee members
HIV/AIDS Policy	- To establish procedures and practices for dealing with HIV/AIDS issues in the workplace - -	- Drafting of policy in consultation with worker representatives - Adoption and publication of policy - Briefing to explain policy to all workers - Annual review	-Technical assistance to workplace to support the progressive integration of the ILO key principles for HIV/AIDS	- Drafting of policy in consultation with HIV/AIDS Committee - Dissemination of HIV/AIDS policy - Briefings to explain HIV/AIDS policy to workers	Process will be initiated in a year' time
HIV/AIDS Education and Information Services	- To support HIV/AIDS prevention, to promote non-discrimination, and to inform workers about resources in the community	- Management briefing - Training of trainers and peer educators - Workers' education - Training of OSH personnel - Incorporation of HIV/AIDS module into regular training programs - Condom availability - Creation and regular update of information on STI, VCT and care and support services outside the workplace	- Briefing of management - Training curriculum - Information, Education and Communication materials - Training of trainers	- Establishment provisions of quality information on STI, VCT and care and support services and establish a collaboration with available institutions for referral services for such services - Allocation of time and space for activities - Provision of condoms to workers - Incorporation of HIV/AIDS module into regular OSH or HR training programmes	Calendar for training and information services to be determined

Signature: _____

Chairman & Managing Director
XYZ Ltd

Technical Agency
India



Documentation of Corporate Good Practices on workplace Policy development and implementation

HIV/AIDS workplace policy and its implementation demonstrates management commitment to ensure HIV prevention among workers, creation of discrimination free environment, which is necessary for workers living with HIV. Over 400 HIV/AIDS workplace policies, based on The ILO Code of Practice on HIV/AIDS and the World of Work, were developed by public and private sector enterprises with technical support from the ILO Project. This documentation captures good practices as well as lessons in development, dissemination and implementation of policies. Read On…

"Initially employees resisted information on HIV… they took it lightly, but the policy with the chairman's signature changed it all," says Dilip Burade, Executive, CSR Ballarpur Industries Ltd, talking about the positive impact of having a policy. HIV education is taken seriously by employees.

Policy, however, means much more to companies who have employees living with HIV, no matter how small their number is. "We are providing treatment to one of our employees. He is able to work now. We are happy too because we could help him get proper counselling and treatment. A good example of implementing our policy," says Balwant Singh, Assistant Human Resource Manager at the Channo plant of PepsiCo.

Development of policy:

When Jubilant Organosys Limited (JOL) first encountered a worker with HIV, they were completely unprepared and did not know what to do. They felt the need to put in place systems to address such situation and take care of their employees.

"We came to know about an employee infected with HIV. We were unable to react at that moment. The need to deal with such a situation provoked the policy," says Ashok Ghose, Chief, & Environment Health Safety (EHS) & CSR, Jubilant Organosys Limited. Collaboration with ILO led to development of a comprehensive workplace policy and programme in Jubilant in all locations.

Advocacy by ILO and chambers like CII/FICCI led several companies to think about the need for policy. In case of multi national companies like SAB Miller and PepsiCo, the motivation came from their global programme. They took ILO's help to build their capacity and implement the policy/programme in India. ILO also assisted some public sector companies in collaboration with the Ministry of Labour and Employment and Standing Conference of Public Enterprises (SCOPE), who was one of the signatories of the Indian Employer Statement of Commitment on HIV/AIDS. "As around two-third of workers in the formal economy, some 20 million, work in the public sector in India, we felt that a national policy would be more effective. So, we assisted the Ministry of Labour and Employment to develop a National Policy on HIV/AIDS and the World of Work," says S. Mohammad Afsar, (Former) Technical Specialist and National Programme Coordinator at ILO Subregional office for South Asia in New Delhi.

Developing a policy through a consultative process, through internal committees involving trade unions is recommended by the ILO Code. Public Sector companies like Maharashtra Port Trust (MPT) in Mumbai, and Bharat Heavy Electrical Ltd in Bhopal set up representatives committees involving unions. In the experience of MPT, this transparent process opened channels of communication between employee and management and has resulted in increasing participation of employees in HIV prevention, care and support services.

Management commitment was the key to development of policies. The launch of policy by the Chairman or the Managing Director at the corporate level and by unit heads at the plan level was found to be very effective.

In case of Apollo Tyres, even when the policy was still being drafted, the management offered full support to an employee who was HIV positive and needed counselling and treatment. The worker had stopped coming to work after facing discrimination. When this was brought to the notice of Mr Pawar, the Human Resource Head in Baroda plant, he visited the worker's home and assured him of all support for him and his spouse. This response by the management not only helped to reinforce the confidence amongst the workers but also motivated others to voluntarily disclose their status and seek help from company.

Dissemination of Policy:

After the policy is developed, the next important step is to disseminate it effectively amongst employees at all levels.



Several mechanisms are being used by the Corporates to disseminate information on the policy. This includes the circulation of hard and soft copies, uploading it on the company intranet, putting policy on bill boards/notice board, printing it in the newsletter and in-house magazines. Policies are also translated into regional languages.

Information on policy is being given in induction programmes, health and safety training or during awareness sessions. “Our employees are aware of the policy…it has helped them to know what action the company is taking on this issue,” says Mr V Chandrasekhar, Senior Officer, Jubilant Organosys, at Nanjangad, Karnataka. The Jubilants' approach of printing the main points of their policy in pocket size cards and sharing it with the employees during the training sessions is a good way to disseminate the policy.

PepsiCo uses skits and role-play method to disseminate their policy. In awareness session, the peer educator shows the policy on screen and then explains the clauses one by one. Another good practice of PepsiCo, is sharing of company policy by the unit heads either in the beginning or the end of the awareness sessions.

"The best time to share the company policy in awareness programme is, immediately after the session on stigma and discrimination in which we strongly recommend an interface with a person living with HIV. This way, employees better appreciate the rationale for policy and get the message of non- discrimination effectively" advises Afsar, ILO.

Implementation of Policy:

The overall responsibility of ensuring implementation of the policy is with the internal committees set up by the management and the nodal persons nominated to coordinate the programmes. In the case of public sector companies, the policy is mostly integrated within the departments of Occupational Health and Safety (OHS), Medical and Welfare departments. In case of private companies, the responsibility is given to different departments like Human Resources, Corporate Communications or Corporate Social Responsibility. Some good practices emerging in implementation of policy are below:

As depicted by PepsiCo, engagement of the Human Resource Department in programme implementation is always useful. This ensures inclusion of HIV policy in the induction programme of companies. This is also useful in getting allocation of budgets for the programmes. This also ensured inclusion of the HIV/AIDS work of company's peer educators in their performance appraisal system (Key Result Areas).

Inclusion of HIV in existing polices is an effective way. Mumbai Port Trust (MbPT) has included HIV in its Maintenance Grant Policy. Under this policy, MbPT has a provision for a maintenance grant, which allows for two years of leave with a small financial support of Rs. 1200 per month to employees suffering from diseases such as TB, Paralysis, Cancer and Leprosy. In December 2005, HIV was included in this list. This is a good way of implementing the recommendation of the ILO Code which recommends treating HIV like any other illness. Similarly, Sri Ram Fibres Ltd. (SRF group) has included HIV within their death and disability policy to ensure compensation to their employees if they succumb to the disease.

HIV/AIDS Master Trainers and Peer educators by companies played a key role in policy dissemination. The identification of one key person as Nodal Person from the companies has been instrumental in keeping the organisation's focus on the issue and ensured effective implementation of the policies.

Involvement of people living with HIV/AIDS in awareness and training sessions by companies has proven to be a useful strategy in changing discriminatory attitudes. The message was well received by workers.

Companies like Bharat Heavy Electrical Ltd. (BHEL), Mumbai Port Trust and PepsiCo have made concerted efforts to cover family members of their employees as well. This has helped in breaking down barriers and promoted the acceptance of employees infected with HIV.

Experience from all companies shows that implementation of policy, and provision of care and support boosts the confidence of those infected by assuring them of security of their jobs. As a result, more employees come forward and voluntarily disclose their HIV status.



Maintaining the confidentiality of HIV positive employees remains a challenge. Organisations are taking measures to address this in their own ways. Mumbai Port Trust has a practice of counselling employees on the consequences of disclosing their status as well as colleagues who are practicing discrimination. This seems to be working well. Jubilant Organosys and BrihanMumbai Electric Supply and Transport Company have looked into procedures of medical reimbursements and strive to keep the HIV status confidential. .

Building effective referral linkages to facilitate access to services in partnership with State AIDS Control Societies/other organizations is being done by several companies. Companies have installed condom vending machines, set up Integrated Counselling and Testing Centres (ICTC)/ Anti Retroviral Therapy (ART) Centres. This is a trend that is picking up and good models of Public Private Partnerships are emerging.

Lessons:

- Management commitment is necessary in all levels of policy development, dissemination and implementation.
- Developing policy through a consultative process (internal committees, involving unions) ensures better understanding of the policy by key stakeholders in the company, which results in better implementation. This may take time but it is good to go through this process.
- Engagement of Human Resource Department ensures effective implementation of the HIV/AIDS workplace policy.
- Advocacy and engagement of PLHIV in policy advocacy. ILO advocacy tools and direct presence of ILO team along with a PLHIV was found to be very effective.
- Policy should be part of an overall HIV/AIDS work plan of the company. HIV/AIDS nodal person within organizations and presence of motivated trainers play a very important role in policy development, dissemination and implementation.
- Implementation of policy is linked with the capacity of organizations and preparedness to handle different issues, particularly care and support measures.
- Cost of implementing HIV/AIDS policies and programmes is not much, including the costs incurred for care and support. Companies are seeing the benefit of starting prevention programmes early
- Effective dissemination of policies helps in building trust and gaining the confidence of the employees.

Documentation of good practices of corporates on Behaviour Change Communication (BCC)

Behaviour Change Communication is an important component of HIV prevention strategies, since knowledge alone does not always lead to changes in behaviour. But how is BCC applied in the context of workplace interventions?

Twelve large corporate groups in India started to implement this approach in 2005-2006, with technical support from the International Labour Organization (ILO), at 167 workplaces involving 123,000 workers. The BCC approach begins with advocacy and leads on to the development of a workplace policy and the introduction of structural changes to create an enabling environment for HIV prevention care and support programme at the workplace. This approach resulted in improved knowledge, attitudes and behaviour towards HIV at all levels in the organizations involved. This documentation seeks to present the good practices that came out of the BCC approach as implemented by the corporate groups in India since 2005-6. Read on…

"HIV is recognized as a potential risk by the company for its key stakeholders and therefore its business. Proactive action to fight HIV is part of Apollo's risk management framework," - Onkar S Kanwar, Chairman and Managing Director of Apollo Tyres Ltd

"Our HIV response is not about philanthropy. It is our responsibility as it is about our survival. So, it is a basic human resources (HR) function now." Pavan Bhatia, Executive Director Human Resources, PepsiCo.

"Success requires the highest standards of corporate behaviour towards employees, consumers and the world in which we live. As part of our corporate behavior HUL is strongly committed to ensure appropriate workplace prevention of HIV and to share best practice across our supply chain and the communities in which we operate." Nitin Paranjape, Chief Executive Officer, Hindustan Unilever Limited (HUL).

"We have a responsibility towards our employees and the communities in which we operate. We have been working on HIV prevention and reducing stigma and discrimination related to HIV. We intend to take it [the programme] forward." Arun Bharatram, Chairman, SRF Limited.

"Enhancing risk perception is the first step in a BCC programme. Before going to the workers, it is necessary to change the management perspective of HIV. Therefore, our effort began with advocacy, targeting the management first and calling for specific action," says Syed Mohammad Afsar, (Former) Technical Specialist and National Programme Coordinator for the ILO in Delhi.

Advocacy with management was carefully planned by ILO. People living with HIV were actively involved to present the human face of the epidemic. Specific tools were developed for corporate organizations including an advocacy film and a short presentation highlighting the need for action.



The ILO organized short meetings with management, rather than longer sessions and also insisted on the involvement of all top and senior management from different departments down to unit head level.

V.K Jain, the head of Corporate Social Responsibility (CSR) at Ambuja Cement Limited, the first company to have developed a HIV workplace policy for the entire group, recalls, "The management meeting was organized, chaired by our Managing Director (MD) and all unit heads participated. The short presentation by Syed Mohammed Afsar from the ILO was followed by a brief questions and answers session that was extremely powerful and clarified our doubts. Meeting a person living with HIV (the first time for most people present) was also very moving. Our MD mentioned towards the end that, 'today we are more convinced [that we must act on HIV] than we were yesterday. Since then our programme has gone smoothly."

In advocacy meetings with the management, the ILO team presented the workplace programme approach and called for management to take the following action:

- Nominate a nodal person to coordinate the HIV response of the company;
- Set up an internal committee to develop the policy and workplan of the company;
- Allocate a small budget for the programme including the staff time that will be taken up with HIV education and training.

The ILO offered its technical assistance to corporate groups to help them implement workplace interventions in all locations, this included assistance with training the nodal persons/trainers within the groups; offering advice for the development of HIV workplace policy; sharing ILO tools and advice for running Knowledge, Attitude, Behaviour and Practice (KABP) surveys; and offering communication and training materials. The ILO also organized experience-sharing meetings and training for all corporate partners. This facilitated cross-learning, within and between companies.

All the 12 corporate groups that partnered with the ILO in this initiative now have a regular workplace programme in place. Change is evident. Partners are sharing their practices with others, expanding interventions to include smaller companies in their supply chains and developing good models of public-private partnerships. The impact of advocacy with management, the provision of technical assistance and regular follow up by the companies' nodal persons and the ILO, have all made a positive impact.

- **Eleven out of the 12 corporate groups involved have developed and implemented HIV workplace policies.**

"It took us time as it involved a review of our existing practices. But we finally launched our policy and now the programme has the total backing of our management," says Mariel Gonsalves, the nodal person at Crompton Greaves Limited, a major electrical engineering group.

Harshita Pande of Apollo Tyres also recalls a careful start up, "It took us time because we wanted to be clear about the cost implications, particularly the cost of antiretroviral treatment, so that we didn't commit to something that we couldn't implement."

- **All 12 corporate groups now allocate an annual budget for HIV programmes.**

Corporate groups have started putting in a specific budget for their HIV workplace programmes. The amount varies depending on the number of locations involved, the size of the workforce and the nature of the programme, but according to informal feedback, the ILO estimates the average comes to Rs (Indian rupees) 500,000 (US$ 10,500) per year.

"Initially companies were not keeping specific track of their expenditure for HIV programmes," says the ILO's Syed Mohammed Afsar. "It used to come from different budget heads like CSR, corporate communications, HR, training and others. We asked them to track their expenditure and to seek yearly allocations. This helped them as well as us. Now we can tell other companies that it does not cost much to implement an HIV programme for workers. If the average is Rs 500,000 to cover approximately 5000 workers annually, it comes to only Rs.100 (US$ 2 per worker per year. This is easily affordable, at least to large corporate groups. That is why we say that companies do not need extra funding for HIV workplace programmes. They only need the technical support that has been provided by the ILO in India."

- **How do corporate groups benefit from HIV workplace programmes?**

The common reaction from corporate partners is that HIV workplace programmes help them to connect better with their employees, who in turn see them as more caring. The initiative creates an atmosphere of trust and harmony.

Neeraj Kanwar, Vice Chairman & MD of Apollo Tyres explains the reaction at his company: "Apart from the sound business and economic reasons we have for running the programme, we feel that people get involved at an emotional level and until the belief in the cause comes from the heart, a workplace programme does not become dynamic. Actions speak louder than words and only an action-oriented approach wins the trust and confidence of the employees."

"Being associated with this programme has provided me with a sense of satisfaction," says Sumati Arora after attending an HIV session at Apollo Tyres. "The HIV programme is beneficial for the employees, the organization and our wider society. The roll-out to business partners helps to make our company relationships stronger."

BCC impact on workers

Numbers speak for themselves

The comparative findings of the baseline (2005-2006) and the end line (mid 2009) Knowledge, Attitude, Behaviour and Practice surveys showed the following improvements in key indicators:

- The knowledge about correct routes of HIV transmission improved by 20 percent point. (base line 68.97% to end line 88.70%)
- The knowledge about HIV prevention methods improved by 15.85 percent point (baseline 66.48% to end line 82.33%).

- Myths and misconceptions decreased by 8.4 percent points (baseline 13.4% to end line 7.64%)
- Significant reduction in discriminatory attitudes was noted. An overall improvement of 17.7 percent point in favourable attitudes towards People living with HIV (baseline 72.13% to end line 89.83%)
- Safer sexual behaviour developed. The condom use with casual/commercial sex partners increased by 28 percent point. (baseline 57% to end line 77.8%)

Training and peer education

The ILO assisted corporate partners in conducting training of 'master' trainers, who in turn go on to train more peer educators at plants or unit levels, using the ILO approach and communication and training materials. The ILO has trained over 600 master trainers from the 12 corporate groups through a number of two or three-day training programmes.

A kit has been developed for master trainers containing the following items:



- An ILO manual for workplace master trainers/peer educators ;
- A suggested HIV company policy;
- An ILO card game about HIV;
- A CD containing key audio-visual presentations prepared by the ILO;
- A red HIV ribbon;
- A T-shirt with an HIV message.

H.S Dua, Assistant Vice President, Human Resources, Chemical Business, SRF Limited, Bhiwadi, says, “For us, the best part of the programme has been that we have developed a cadre of highly enthused and committed volunteers from among our employees, who are self-motivated and trained by the ILO. They are doing a great job in terms of spreading awareness. They have created their own e-mail network and are constantly upgrading their skills with new knowledge, to maintain their effectiveness as peer educators and master trainers.”



A training session at Apollo Tyres

“The interactive methodology of the ILO training, and the focus on keeping it simple, were the keys to its success,” says Kishore Parikh, from Apollo Tyres. “When I attended the training for master trainers, I thought what new information will I get? But the training refreshed my knowledge on HIV. I learnt the technique of communicating about HIV in a simple and systematic way that could be easily understood. It gave me ideas for the training I was going to do myself.”

Balwant Singh, master trainer at the Channo Plant of PepsiCo says, “I take HIV sessions in my plant as well as outside in the community. An employee had stopped coming to work after getting diagnosed with HIV. When we came to know, we visited him and seeing the discriminatory

attitudes of the community we took a session with them. Now our colleague is on treatment and is back at work. It gives us so much satisfaction."

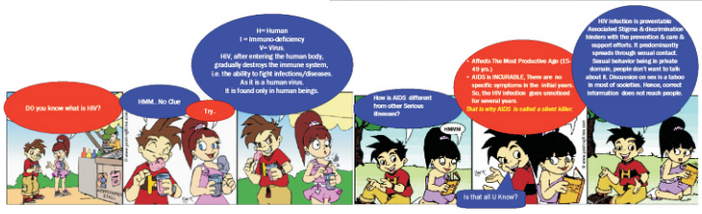
Keeping master trainers and peer educators motivated is always a challenge in the BCC programme. Corporates have developed their own systems and approaches. One good practice developed by PepsiCo is to make work on HIV an integral part of the Key Performance Areas (KPA) assessed by the company. "We have a system in place through which we reward our peer employees for their contribution to the HIV programme," explains Mridula Asthana, Manager Human Resources & Administration, PepsiCo.

Good use of communication materials and new approaches

Corporate partners used the materials provided by the ILO and also developed their own BCC materials and approaches. Here follow some examples of good practice:

- Ambuja Cement Limited has installed an Interactive Voice Response System (IVRS) at its sites in Darlaghat, Himachal Pradesh State; Ambuja Nagar, Gujarat State and Chandrapur in Maharashtra State. This unique system has 30 pre-recorded messages in a question and answer format in English and Hindi. This system is accessible to the employees, their families other workers and commuity in and around the plant site. In strict confidence the caller can listen to the information that he or she requires; if not satisfied, the caller can record a question and leave his or her contact number for the counsellor to respond. The caller can also dial a number to contact the counsellor during working hours. Around 70 to 80 calls per month are received across the three locations.





- At PepsiCo, the master trainers developed a short drama show on HIV and discrimination and used it in their programme with employees and spouses. They also developed a cartoon strip called, '*hum-tum*', on the basic facts of HIV. The questions from the ILO card game were used in the strip. PepsiCo also provided HIV information to its employees through screen savers, video spots at the cafeteria, posters in regional languages and quiz programmes.

- At Apollo Tyres, materials were developed and master trainers devised short dramas, songs and poems in their local languages to communicate with their fellow colleagues. For example, in Kochi plant, the company had a campaign with the theme, "Mission Prathyasa," meaning "Mission Hope".







Apollo's master trainers join a TV talk show in Gujarat on World AIDS day.

- The SRF Group set up booths and exhibitions outside their premises to provide information about HIV and to raise awareness of HIV among their employees.

Organizing special events

Corporate partners often hold special events, particularly around the annual World AIDS Day.

In 2008 on World AIDS Day, master trainers from Apollo Tyres joined a talk show broadcast by a TV channel in Baroda, Gujarat. The show included questions and answers from the ILO card game giving information about HIV.

Lessons Learned

- Advocacy with management in the initial stages workplace programme is very helpful.
- Short advocacy sessions with senior management helped to clarify myths and misconceptions. When they became convinced that people living with HIV can have a long, productive life and can work effectively, it became easier for them to commit to work against discrimination and to put an HIV policy in place.
- The involvement of people living with HIV was extremely useful in advocacy, training and awareness-raising efforts.
- The direct participation of management in training and awareness-raising programmes gave a strong signal of management commitment and was a useful strategy for keeping the peer educators motivated.
- The existing talent and expertise within the companies can be harnessed and used effectively in the BCC programme.
- The nodal persons appointed by the companies played a key role in the success of the programme.
- The BCC effort played a key role in imparting correct knowledge about HIV, developing non-discriminatory attitudes and increasing the use of condoms in casual sexual encounters.
- Innovative methods need to be found to keep the peer educators motivated. Getting some recognition from the management from time to time is essential.
- Regular training (including refresher training) of peer educators is essential at the enterprise level. This helps in managing the drop-out of peer educators which keeps happening due to variety of reasons such as transfers, changing of jobs in some cases not being able to do peer educators work due to work pressure/ lack of interest.
- Refresher trainings keep knowledge of PEs updated and also allow them opportunities to improve their skills.
- Combined meetings and training sessions organized by the ILO involving different companies were useful in facilitating cross-learning and also in keeping the peer educators motivated.

Documentation of good practices of HIV/AIDS initiatives amongst corporate supply chains

A large number of workers are engaged in supply chains of corporate groups in their network of retailers, distributors, transporters, storage facilities and suppliers. The network may include small, medium as well as large companies in today's world of inter-connectedness of business operations. Large corporate groups can influence and support their supply chains in responding to issues such as HIV/AIDS. Though a relatively new trend in India, some corporate have taken the lead and expanded their HIV programme to their supply chains. Read on…

Apollo Tyres:



Apollo Tyres has a network of 4500 dealers all across India and an initiative is being taken to reach them with the HIV/AIDS programme. In addition, the company is targeting small & medium business partners and helping them start their HIV programme.

Advocacy was the first step. Apollo conducted an advocacy meeting, presented its HIV/AIDS programme and also invited ILO to address the group. Going a step further, Apollo included HIV in the code of ethics which forms one of the criteria for selection of the supply chain companies.

As a follow up of the advocacy event, Apollo targeted small and medium companies in the first phase, and developed a plan to cover eight such companies each year. Apollo followed the ILO's model and materials, engaged its master trainers to conduct peer educators' training in their supply chain companies. Apollo has successfully covered 15 supply chain companies, which together cover some 3500 workers. Apollo team has trained over 300 peer educators in these companies. The Apollo trainers feel good to be associated with the supply chain programme. *"This Initiative has earned us respect from the suppliers,"* says **Mayank Malhotra, Apollo Peer educator who is engaged in their supply chain programme.**

The companies where Apollo team has conducted the programme are seeing the benefit too. "Our participants in the HIV/AIDS programme thoroughly enjoyed the workshop and returned with plenty of knowledge on the subject. We are grateful for the trust you (Apollo) have shown in us," says N. Holani, Managing Director, Acmechem Ltd., Kolkata

Apollo is also engaging its sales team with the dealer network through the 120 sales offices. “The potential of reaching out to the vulnerable population is huge through this network,” said Satish Sharma, Chief of India Operations, who chaired the sensitization programme organized for the unit heads and zonal heads of sales. Participation of top Apollo management and their emphasis on HIV/AIDS in their vendors meetings and internal meetings has been the key in the success of this effort.

PepsiCo reaches out to its bottle supplier

"...I have realized in the process (of training on HIV/AIDS) that HIV is still a taboo subject in India. Women can certainly play a very major role in spearheading this initiative", says Nisha Khanna, one of the Master Trainers at Pepsico India, who has been involved in the companies effort of expanding the workplace programme to the supply chain and other companies.



Pepsico mobilized the management of Hindustan National Glass, HNG, a major vendor for Pepsico and a leader in the Container Glass Industry in India, for initiating a workplace HIV/AIDS programme. HNG has a workforce of 5000 and has a pan-India presence with six manufacturing plants.

"Having some confidence through our workplace programme, we are now expanding our programme to our suppliers in a phased manner," says Pavan Bhatia Executive Director HR at PepsiCo.

As a first pilot, the Pepsi team narrowed down to the Northern unit of HNG, located at Bahadurgarh in the state of Haryana. This unit has a workforce of 1500, mostly young men who have migrated from neighbouring states. It took a well planned effort to convince the HNG management about the need for the Programme. Pepsi team gave the example of its own programme and also suggested a Knowledge, Attitude, Practice and Behaviour survey.

"When the initial idea came from Pepsico, we had reservations about the success of such a programme in our company. But the Pepsico team clarified our doubts. The training of our people went very well. We were surprised to see the difference between pre and post workshop test questionnaire. A few of our people have really carried forward the messages very well," says Somnath Basu, Manager HR, Hindustan National Glass, Bahadurgarh

The ILO model of initiating workplace programme was followed and a KABP survey among the employees was undertaken. The survey revealed that around 40% employees lacked correct knowledge about routes of HIV transmission. Discriminatory attitudes existed as 40% were not willing to share toilet with a HIV positive worker at the workplace. About 5.7 percent of the employees reported having had sex with non-regular and commercial sexual partners, and inconsistent condom use.

These survey findings convinced the HNG management about the need for the programme.

The PepsiCo team of master trainers along with one trainer from ILO and a person living with HIV conducted a two day trainers' training programe for HNG. The training had 22 participants, who were given material like ILO card game, posters and the other audio-visual aids to help them conduct regular awareness programmes for the HNG employees.

The participants found the training very useful. *"This training has opened up new directions for me. I got answers to so many questions,"* says Sanjay Singh., *"I am confident of giving HIV*

education to others now, adds K.K. Gupta. Both Sanjay and Gupta are now peer educators in HNG. The company has put together a regular programme and intends to cover the truckers as well.

Crompton Greaves Limited (CGL):

"Supply-chain of CGL involves interaction with large population of vulnerable professions like Truck Drivers/helpers, Service Technicians and semi-literate/illiterate employees of the dealers. Therefore, need was felt to make them aware about HIV/AIDS and the risks associated with it" say K.K Mehta, Senior Regional Marketing Manager, Commercial Motors, Northern Region and Master Trainer for HIV/AIDS.

CGL, one of the leading manufacturers of electrical products has 22 locations across India and a workforce of 5100. It has a huge supply chain that consists of large as well as small and medium companies, Clearing and Forwarding (C&F) agents and other vendors. The senior management of CGL is fully committed to the HIV/AIDS programme it is reflected in the commitment of the master trainers who are taking the programme to the supply chain.


A session at the C&F Agents' location in Lucknow, Uttar Pradesh

CGL master trainers follow a methodical process in carrying out the programme with Supply Chain workers. They identify the number of vendors and its employees and select a batch of 25-30 participants for the programme. The ILO card game, posters, material are used for these awareness programmes. During the period 2006-2009, more than 2000 supply chain workers have been reached across different units.

"Response from the participants was quite over-whelming. In fact most of them requested for increasing the frequency of such programmes. There was appreciable difference in the level of knowledge/awarenes of these persons after attending the programme", adds Mehta

Ballarpur Industries Limited (BILT) reaches out to small suppliers/ vendors:

"We believe that this will add value in terms of developing a good relationship with the suppliers and filling a much needed gap, where small business do not have the capacity to take up such initiatives." says Lalita Mahajan, nodal person of BILT's HIV/AIDS programme.



In 2007, BILT extended HIV/AIDS workplace interventions to its small and medium suppliers in Ballarpur and Yamunanagar.

The process began with initially sending a letter to the small and medium suppliers (workforce ranging from 10-100 workers) inviting them to join hands on HIV/AIDS. This was followed by a needs assessment on safe and healthy work



practices. The assessment revealed that most of the suppliers were willing to provide logistical support if BILT started the program Almost 50 suppliers in Yamunagar and Ballarpur showed interest in the topic of HIV/AIDS. They were then called for a meeting with the Commercial Department where the need for HIV programme was discussed. Based on their interest, a team of counselors and employee volunteers followed up with the suppliers and conducted awareness programmes on HIV/AIDS.

In Yamunagar, the programme was extended to the workforce of local suppliers. In 2007-08, sixteen local suppliers and 425 workmen including management staff at their worksites were reached through awareness sessions. In 2008-09, the programme shifted its focus from suppliers to adjoining industries in Yamunanagar. Nine such programmes were conducted reaching our 420 workmen and senior management staff.

'BILT is doing this great job of spreading the message on HIV and they should continue to conduct such programme in surrounding areas"- says a supplier at Yamunanagar.

Lessons Learned:

- Supply chain varies from company to company. It includes not only small and medium companies but large companies as well.
- A large company having a workplace programme can influence the programme in other large companies associated with its business. For example, HNG supplies bottles to Pepsi but is a large company having around 5000 employees in multiple locations. So, Company to company advocacy, followed by offer of HIV training through its own peer educators is a good practice.
- Supply chain initiatives of large companies provide a good channel to reach out to workers in the small and medium industries, who are otherwise difficult to reach.
- Apollo's example of including HIV/AIDS in the code of ethics/ terms of engagement with the supply chain partners, backed with technical support for HIV/AIDS programme, is a good practice in mobilizing dealers/suppliers for initiating a workplace response to HIV.
- Extending the HIV/AIDS workplace programme to supply chain generates good will among vendors/ suppliers and is good for the corporate image of companies.
- Direct participation of management in advocacy meetings with supply chains is effective.
- Confidence of a successful workplace programme (policy, trained peer educators) was the main factor enabling companies to expand their programme amongst their supply chains.

Documentation of good practices of corporates on Public Private Partnerships (PPP) in HIV prevention, Care & support programmes in India

The prevalence[2] of HIV is 2.59% and 0.99% among truckers and migrant workers respectively. Thus, reaching out to these bridge populations is a key focus of the National AIDS Control Programme in India. Both truckers and migrant workers are associated with industries in some way or the other. Therefore, developing pubic private partnerships for reaching them, in addition to the interventions carried out by NGOs, are being envisaged in the national programme. In addition, the National AIDS programme also envisages Public Private Partnerships (PPP) for enhancing access to HIV care and treatment. ILO is partnering with 12 large corporate groups for workplace programmes. Some of them have moved beyond workplace programmes and set up good models of PPP. This documentation captures good practices and emerging models of PPP under two broad heads: Prevention, and Care & Support. Read On…

Public Private Partnerships in HIV Prevention:

"… I never used condoms, but now I have started. I have also learnt about sexually transmitted infections, HIV/AIDS after participating in the sessions, organised by the company," says Ashik Khan, a 28-year-old truck driver, who is being reached through SAB Miller India's HIV intervention programme for truckers at their brewery in Neemrana, Rajasthan.

Like Ashik Khan, several truck drivers are being covered in the HIV prevention efforts of companies, set up under different models of Public Private Partnerships (PPP).



Bala Devi, a lady peer educator speaks to the truckers at Sanjay Gandhi Transport Nagar

Bala Devi runs a dhaba (small tea/food shop) at Sanjay Gandhi Transport Nagar, Delhi. She is now a peer educator, who educates truckers who come to her dhaba as part of an intervention set up by the Apollo Tyres. Her perception about HIV has changed. *"Initially, I would not allow Apollo's workers to sit and discuss HIV and condoms at my dhaba. I thought it was shameful. But now I myself have become a peer educator. I talk about HIV with truckers who come to have tea at my shop, and distribute pamphlets on HIV and condoms. I also refer people to the Apollo tyres clinic for in-depth discussions/treatment of sexually transmitted infections." she says.*

Tyre manufacturing companies like **Apollo Tyres and JK Tyres** consider their HIV intervention amongst truckers an investment. *"At Apollo Tyres we believe that our work in the community, especially the trucking community, is an investment and an opportunity to create a difference in the lives of our stakeholders and customers. Considering its importance to what we do, for us it is just like any other business process. Naturally, here too we set ourselves tough targets and ensure that they are achieved,"* says Neeraj Kanwar, Vice Chairman and Managing Director, Apollo Tyres Ltd.

[2] NACO surveillance data of 2007



Apollo Tyres Limited made a modest beginning in 2000 by setting up a Health Care Centre for Truckers in Sanjay Gandhi Transport Nagar, Delhi, with support from the Department for International Development (DFID), and later continued with support from Care India. The effort included HIV awareness in the area, treatment for sexually transmitted infections and distribution of condoms.

Three years later, the company took complete charge of funding, managing and running its clinic. In the middle of 2006, the company also started its partnership with the ILO for workplace programmes in all its locations. Confident after a successful intervention at Sanjay Gandhi Transport Nagar and the comprehensive workplace programme, the company expanded its truckers' interventions, seeking different partnerships with respective State AIDS Control Societies, International NGOs and other corporate partners.

As a result, nine Apollo Tyres Health Care Centres, were up and running in strategic trucking hubs across India by the middle of June 2009, with plans to add five more centres in Tamil Nadu. Three of the nine clinics are completely financed by the company. The interventions, since 2000 till date, have resulted in reaching out to a population of approximately 800,000, with more than 12,000 cases of STIs being treated and more than 5000 people being tested for HIV.

JK Tyres Limited started its intervention amongst truckers in November 2005, with support from the Bill and Melinda Gates Foundation through the Transport Corporation of India Foundation.

JK Tyres set up three clinics on National Highway number 8 at Indore (Madhya Pradesh), Dhanbad (Jharkhand) and Vishwa Karma Nagar (Rajasthan). The company created awareness about STI/HIV/AIDS amongst truckers and provided treatment for STI through clinics. Infotainment melas (fairs) were organised around clinics, where awareness was combined with entertainment.

Having gained some experience, JK Tyres began another clinic named 'Jeevan Kiran', fully funded by the company at Transport Nagar, Jaipur. For managing day-to-day operations, the company partnered with an NGO, Vatsalya.

The company is now expanding its interventions amongst truckers. In May 2008, another Jeevan Kiran clinic was started at Shahpura on NH-8, near Jaipur.

Till the end of June 2009, around 40,000 people have been attended to at the five clinics of JK Tyres for different ailments, following an overall health approach. Around 10,000 people, mostly truckers, were treated for STIs. For HIV counseling and testing, referral links were established with the government facilities.

The company began its partnership with ILO in January 2008 for a comprehensive workplace programme in all locations.

The company gives equal importance to the HIV/AIDS programme at and beyond the workplace *"Our products move the transport business and we care for the people who actually move the transport the Truckers. Five clinics on the National Highways supported by us help truckers to protect them from the HIV / AIDS. We are happy that many of them are availing of this facility.*

Not forgetting our own employees, an initiative in collaboration with ILO is aimed at awareness among our employees spread all over India, Mr. A K Bajoria President, J K Tyre.

In addition to the tyre manufacturers, other companies have also started interventions with truckers as part of their CSR efforts.

Ambuja Cement Limited is reaching out to approximately 6000 truckers.

"...We at Ambuja Cement Limited incessantly strive to mitigate the impact of HIV/AIDS not only at the workplace, but also in the neighboring communities as well as with truckers. We strive to create awareness and reduce HIV related stigma and discrimination," says Suresh Neotia, Chairman, Ambuja Cement Limited

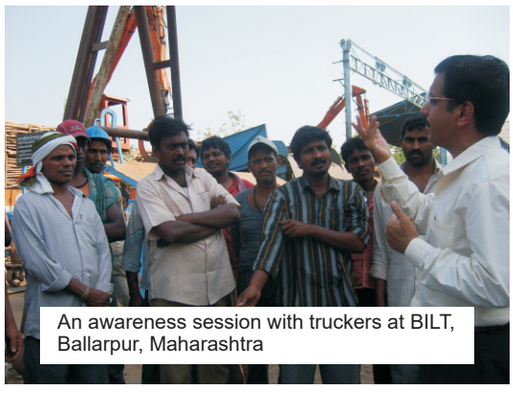
While truckers are reached as part of the composite targeted interventions around the plants and the villages nearby, specific interventions for truckers have been undertaken at the company's locations in Ropar, Punjab and Chandrapur and Panvel in Maharashtra, in partnership with State AIDS Control Societies and other agencies. Recently, Ambuja Cement Foundation partnered with Uttarakhand State AIDS Control Society for developing an intervention for reaching out to a migrant population of approximately 3,500 at their plant in Roorkee.



Transport Corporation of India (TCI) Limited started its intervention amongst truckers in December 2003 under 'Project Kavach', through the TCI Foundation (TCIF), with funding support from Avahan Project of the Bill and Melinda Gates Foundation. TCIF set up 17 interventions in the commercial transshipment locations (TSLs) and check posts covering 7,66,000 truckers at TSLs and 4,51,000 long distance truckers. In the phase-III of the national AIDS Control programme, the TCI Foundation is collaborating with NACO and is offering its experience and learning of the Kavach Project to the benefit of the national programme.

Ballarpur Industries Limited (BILT)

BILT has six manufacturing plants across four states of India. Most of its plant sites are located in remote areas. Around 850 to 900 truck drivers visit their plants daily either for dropping off raw materials or picking up finished goods.



An awareness session with truckers at BILT, Ballarpur, Maharashtra

BILT did a small HIV/AIDS pilot project for its employees at its plant in Yamunanagar, in the state of Haryana. Encouraged by this, the company developed a comprehensive programme for its employees as well

as truckers. For its employees across all locations, BILT got into a partnership with the ILO. International Finance Corporation (IFC) supported BILT to implement HIV/AIDS interventions amongst truckers in all locations, with BILT also contributing resources under its CSR programme. Now, HIV/AIDS is one of the key pillars of the BILT's CSR programme.

Fully staffed clinics have been set up for truckers at every unit where treatment and counseling on STI/HIV is provided. Awareness about HIV/AIDS, sexually transmitted infections and condom education is provided by a team of peer educators. BILT has also set up 17 condom vending machines, through which condoms are available not only to truckers, but to the nearby communities as well.

SAB Miller India started its truckers' intervention in Neemrana, Rajasthan in October 2007. "We at SAB Miller India have a strong focus on our HIV workplace programme for employees and their families. We are also equally committed to reach out to our supply chain (truckers). We believe that spreading the right information goes a long way in dealing with myths and stigma related to HIV," says, Mr. Jean Marc Delpon de Vaux, the Managing Director of SAB Miller India.



SAB Miller launched the intervention under the Humsafar campaign in partnership with Humana People to People, an NGO. The entire cost of the intervention is borne by the company. Partnership with the Rajasthan State AIDS Control Society (RSACS) was established for getting communication materials/condoms and setting up other referral linkages. Approximately 40 trucks visit the plant per day, to carry finished products from the plant. Since the launch of the programme, 1000 truck drivers have been reached through interpersonal communication. "Humsafar is a very innovative programme. Awareness about HIV/AIDS through sports events is indeed interesting, and the newly installed condom machine is also very beneficial to us," says Joginder Singh, a 36-year-old truck driver.

The success of the programme encouraged RSACS to set up a condom vending machine at the brewery. Approximately 3,500 condoms have been distributed till date.

Corporate joining hands for truckers' intervention:

Apollo Tyres and Ambuja Cement have given a new dimension to PPP by coming together to provide prevention care and support to truckers. In perhaps the first of its kind partnership, Ambuja Cement Foundation (ACF) and Apollo Tyres Foundation (ATF) have showcased a model where the two corporate have equally shared the costs of the intervention for truckers at Dhulagarh Truck Terminal, Sankrail, Howrah in the state of West Bengal.



The project reaches out to more than 5000 truckers plying on National Highway-6. The intervention involves behaviour change communication, condom education and diagnosis and treatment for sexually transmitted infections (STI). Condoms are distributed free of cost, as well as socially marketed. A clinic was set up in February 2009. Till April 2009, a total of 428 people had registered at the clinic. One hundred and sixty eight people, mostly truckers, were treated for STIs. Looking at the need, a partnership with the West Bengal State AIDS Prevention and Control Society is being looked at to set up an integrated counseling and testing centre at the clinic.

Lessons Learned:

- Different models of PPP are emerging.
- Interventions jointly funded by companies and some other international organisation.
- Interventions totally funded by companies, implemented by an NGO/company's own foundation, with technical assistance/material support from organisations like State AIDS Control Societies/ILO.
- Interventions jointly funded by corporate for setting up interventions at strategic points.
- Companies get into PPP to set up interventions for different reasons: Tyre companies find this a strategic investment amongst truckers; other companies got into PPP as part of their CSR efforts. Either way, the intervention proved to be very good for business relations and improved the corporate image of the companies.
- Interventions with truckers provided an opportunity to companies to be part of the National AIDS Control Programme - a national effort. Both BILT and Apollo Tyres were nominated into the Country Coordination Mechanism, set up under the Global Fund for HIV/AIDS, TB and malaria as representatives of the private sector.
- Usually, interventions started with some funding by international organisations. As companies got more involved and gained confidence, they started putting in their own funds into the programmes.
- Confidence about a successful workplace programme triggers PPP and vice-versa. Apollo Tyres, JK Tyres, Ambuja Cement were already into truckers' interventions before they started their workplace programme. On the contrary, SAB Miller got into interventions with truckers after they had started their workplace intervention.
- ILO's approach of partnering with corporate groups and encouraging them to develop workplace policies and programmes for all locations, including their contractual staff, was useful in getting companies to understand the need for starting interventions amongst truckers in-and-around their business areas and major trucking points.
- Technical support is the key in triggering PPP. ILO's training also gave companies the confidence to venture into interventions beyond workplaces.

Public Private Partnership in HIV care and support:

"My hope for life has increased," says Ram Kumar (name changed) a Mumbai Port Trust (MbPT) employee who is living with HIV and is on the life prolonging Anti Retroviral Therapy (ART).

Ram Kumar is one of 120 employees of the MbPT, who are getting ART from their company as part of the company policy of taking care of its employees and their families.

PPP in HIV care and support broadly include services related to HIV counseling, testing and Treatment (the ART). Under the National AIDS Control Programme, public and private sector companies can get into partnerships with their State AIDS Control societies for training of their doctors/counsellors, and setting up Integrated Counselling and Testing Centres (ICTC), and Anti Retroviral Therapy (ART) centres.

PPP for setting up HIV Counselling and Testing Centres

MbPT is an autonomous body under the Ministry of Shipping, Road Transport and Highways. MbPT caters to a population of 200,000 approximately: 20,000 employees and their dependants, 35,000 retired employees and their spouses.


Elize D'Silva conducting a session

Being in Mumbai, a high HIV prevalence city, MbPT was one of the first few companies in India to provide care and support to its HIV positive employees way back in 1999. The company began providing second line ART in 2002.

The company also has a comprehensive workplace programme, including a policy, developed with assistance from the Mumbai District AIDS Control Society (MDACS) and the ILO. A cadre of master trainers for HIV/AIDS has been developed in the MbPT.

"… Creating awareness about HIV/AIDS and dissemination of our policy helps. We want to protect our people and don't want to increase the number of infected employees. We already have quite a few to whom we are providing treatment," says Elize D'Silva, Health Officer, MbPT, who is one of the master trainers in the organisation and conducts regular sessions.

MbPT's policy emphasises on providing treatment, care and support to employees living with HIV/AIDS.

To back up the prevention programme with services, the company went a step forward and set up an Integrated Counseling and Testing Center (ICTC) in the MbPT hospital in Mumbai in collaboration with Mumbai Districts AIDS Control Society in October 2006. The centre is open to employees, their dependants and also the community

Under this collaboration, MbPT provided the space for setting up the ICTC centre and MDACS supported the personnel (counselor and lab technician) for running the ICTC. MDACS also provided training to the medical officer, nursing staff and lab technicians on different aspects for the proper running of the ICTC. MDACS also provides testing kits, IEC material, condoms and mobile vans to reach the employees and families with voluntary counseling and testing (VCT) services.

MbPT is creating awareness about the ICTC services both among the employees as well as in the community. On an average, in a month, 235 MPT employees/ dependants avail of the testing facility. Between October 2006 and July 2009 More than 5,500 people tested at the centre. One hundred MbPT employees have tested positive (65 men and 35 women).

The prevention efforts of MbPT seem to be making an impact. From December 2008, till June 2009, none of the HIV tests conducted on employees have come out positive.

The Central Coalfield Limited (CCL), Ranchi a subsidiary of Coal India Limited has partnered with the Jharkhand State AIDS Control Society (JSACS).


A doctor interacting with a person at the ICTC

CCL has a workforce of approximately 60,000 people spread across a mining area of 100-150 kms in Jharkhand and parts of Bihar.

The medical facility of CCL caters to employees and their dependants which comes to a total of approximately 300,000 people. Setting up ICTCs was the second step for CCL. The first step was developing their workplace policy and programme in collaboration with the ILO in 2003. The CCL developed its policy, based on The ILO Code of Practice on HIV/AIDS and the World of Work. In its policy, first by a public sector coal company in India, CCL committed to create a non-discriminatory environment within the company, and start HIV prevention as well as care and support to its employees /families, including ART.

Workplace interventions of CCL also built the partnership of CCL with JSACS. But the organisations felt that the medical facilities of CCL could be utilised for setting up ICTCs. The central hospitals of CCL already had blood banks and a TB treatment Centre (the Direct Observation Therapy - DOT). In 2007, JSACS and CCL began their collaboration for setting up ICTCs at the central and area hospitals of CCL. By the middle of 2009, a total of 13 ICTCs had been set up in the CCL hospitals under this collaboration.

Following the national guidelines, CCL provided its infrastructure/space for the ICTC, and staff (a doctor, a technician and a staff nurse) where as JSACS provided testing kits, consumables and condoms. JSACS also provided training to the CCL staff of ICTC.

The ICTC facilities of CCL are not confined to its employees alone. The facility is open for all in order to enhance access to HIV testing and counseling services. However, as of now, mostly employees and their dependants avail of the services. CCL plans to create more awareness about the facility amongst nearby communities in order to enhance its usage. On an average, 10-15 employees and their dependents come every month to the area hospitals to avail of the services. So far, two workers and two dependants have tested positive at CCL.

Jubilant Organosys Limited (JOL) is a private company that has also set up ICTCs at its units in Nanjangud (Karnataka) and Gajrola (Uttar Pradesh).



The initiative stems from a committment from the management. "Jubilant as a responsible corporate citizen, is committed to play its contributory role in the HIV awareness and prevention programmes," says Shyam Bang, Executive Director of JOL.

The facility at Nanjangud, Karnataka is only for the employees and is run completely by the company while the one at Gajrola is set-up in collaboration with U.P State AIDS Control Society.

At Nanjangud, Karnataka, a request came from the employees, who, after attending HIV/AIDS education programmes, wanted an HIV testing facility at the unit. The company set one up testing facility at its Occupation, Safety and Health (OSH) centre and workers went for testing. Three people tested positive. Since October 2007, 1000 employees have taken HIV testing. The testing facility is completely run by the company with technical support from the Karnataka State AIDS Control Society (KSACS). The testing kits are procured by the company while the doctor and counselor have been trained by KSACS. The company is now exploring the partnership with KSACS in order to expand their facilities to the wider population.

The company continues to give preventive education on HIV/AIDS. One of the employees who is positive has also been trained as a master trainer for HIV/AIDS education

The ICTC at Gajrola was set-up in March 2009 in partnership with the UPSACS as a result of the company's credibility in the TB DOTS programme, and also because of its success in its workplace programme in collaboration with the ILO.

"Encouraged by our work on DOTS, WHO and UP Health Department officials suggested that we add an ICTC facility at our health centre in Gajrola,', says Vivek Prakash, nodal person of the HIV/AIDS programme of Jubilant Organosys Limited.



The Gajrola unit is located in an industrial area on one of the national highways crossing Uttar Pradesh. The nearest ICTC was 22 kms away from Gajrola. By setting up this centre within the industrial area, workers and the nearby community members are benefited.

The company contributes by supporting the staff cost of a medical doctor, a lab technician and a counselor while UPSACS provides testing kits and other consumables. UPSACS also trained the staff. Though a rather recent initiative, till date, 19 people have been referred for testing out of which three tested positive. JOL is working at increasing the uptake of ICTC services by creating awareness through the company's HIV/AIDS master trainers.

PPP for enhancing access to treatment: Setting up ART Centres

"I am one of the first few who came to the Ballarpur ART centre. Earlier I used to go to the Nagpur centre which is 150 kms away from my place. This is a big help. Thanks to BILT for setting it up here," says Priya Devi (name changed) who is taking ART from the centre set up by BILT, a private sector company, at one of its locations, in partnership with NACO/Confederation of Indian Industry with support from the Global fund.

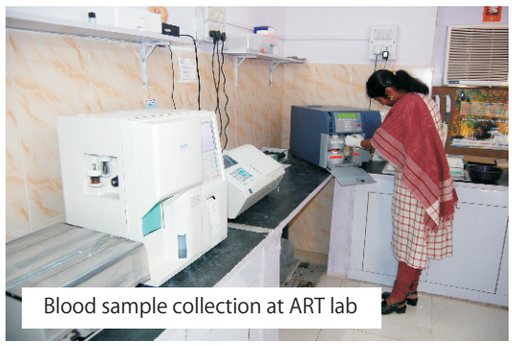
BILT, a paper manufacturing company with six manufacturing locations across India and a workforce of more than 10,000 came forward to partner with the national programme for setting up much needed ART centres. All of BILT's units are located in remote places, where a large number of migrants are working as contract labour. Four of these locations are in Maharashtra and Andhra Pradesh, where the prevalence of HIV is high and people are in need of care and treatment.

“BILT has a comprehensive anti-HIV/AIDS programme, which has impacted over 60,000 lives. BILT's ART centre at Ballarpur, Maharashtra, is nationally and internationally recognised as a pioneering effort at tackling the threat of HIV/AIDS at the community level,” says R.R. Vederah, Managing Director, BILT

The Confederation of Indian Industry (CII) received grants through the NACO under the round six of the Global Fund for AIDS, TB and Malaria for mobilizing the private sector in HIV care and support services. CII approached BILT, one of its members, to set up ART center at its manufacturing location in Ballarpur. The BILT management agreed to set up three ART centres in three of the states where it operates: Maharashtra, Orissa and Andhra Pradesh. CII provided technical support including approaching NACO with a request letter, signing of the MOU, as well as partial funding for infrastructure. BILT contributed the rest. NACO provided CD4 testing kits, ART drugs and medicines for Opportunistic Infections (OIs).

Two ART centres have been set up at Ballarpur, Maharashtra and Koraput, Orissa, while the third in Andhra Pradesh is yet to come up. The motivation came from the fact that both the districts are high prevalence districts, and there were no care and support facilities for HIV positive people in those areas. The nearest ART centres to Ballarpur was 150 kms away in Nagpur, while in Orissa, the nearest centre was in Barhampur which is more than 400 kms from Koraput. This caused a lot of inconvenience to PLHIV, including the loss of daily wages.

The ART center at Ballarpur is the first centre under PPP in Maharashtra. It was set up in August 2007. This is also the first centre which was set up inside the company premises but is open to the community. Most of the patients who are registered with the Ballarpur centre are from neighbouring districts, while some come in from Andhra Pradesh. A majority of the patients are daily wage earners; a few are in government services, while some come in from neighbouring industries. Presently the HIV positive employees hesitate to avail services at the workplace. The company is creating an enabling environment to overcome this situation by doing regular sessions with employees and disseminating its HIV/AIDS workplace policy.


Blood sample collection at ART lab

Currently 509 people (309 men and 200 women including 28 children) are enrolled in this ART centre.

The Ballarpur ART centre also provides CD4 testing for the government ART centre at Chandrapur and Gadchiroli, in Maharashrta

The second ART Centre was set up at the Koraput District Hospital in Orissa, in March 2009. For this centre, BILT is partnering with the district administration that provides space for the centre as well as electricity, and water, while the cost of the laboratory equipment and human resources is borne by BILT. Already around 200 patients have registered with the centre out of which 120 are on ART.

Both the centres have a part time medical officer, a full time counsellor, a lab technician, a pharmacist who also functions as a data entry operator. While NACO has trained the staff, BILT has incurred costs. In relating his experiences, one of the nodal officers said, *"Working in the ART centre has been a very enriching experience, I feel very happy when I help so many patients."*


Monthly meeting with PLHIV

BILT's experience has been quite positive and the staff associated with the ART centres has been very enthusiastic. As a result, the centre shows very good treatment adherence. BILT is also making efforts to educate private practitioners in the area. Referral linkages have already been developed with networks of people living with HIV and local NGOs working in this field.

Lessons Learned:

- Workplace programmes are a good entry point for PPP.
- It is important to have an interface agency that can provide a neutral platform for brokering partnerships and creating mutual trust between partners.
- Public sector companies like MbPT and CCL, who have large medical/occupational health and safety setups can also set up ICTC and ART centres in partnerships with their respective SACS. These models have a huge potential for up scaling in the national programme.
- Private sector can participate in enhancing access to services under the PPP mode. The models of private companies like Jubliant and BILT can be replicated.
- Initially employees may hesitate in accessing services (ICTC/ ART) at the company facility. An enabling environment needs to be created for which the effective dissemination of a workplace policy and regular awareness efforts are necessary.
- ICTC and ART centers when set up by companies, whether public or private, should be open to communities but this requires a planned effort to create awareness about the facility. Partnerships with local NGOs and networks of people living with HIV can be very useful here.
- PPP for HIV care and support provide opportunities for HIV counseling testing and treatment to contract workers/ migrant labours, who work with industries.

Monitoring System
For Enterprise-based HIV/AIDS Programme

Background:

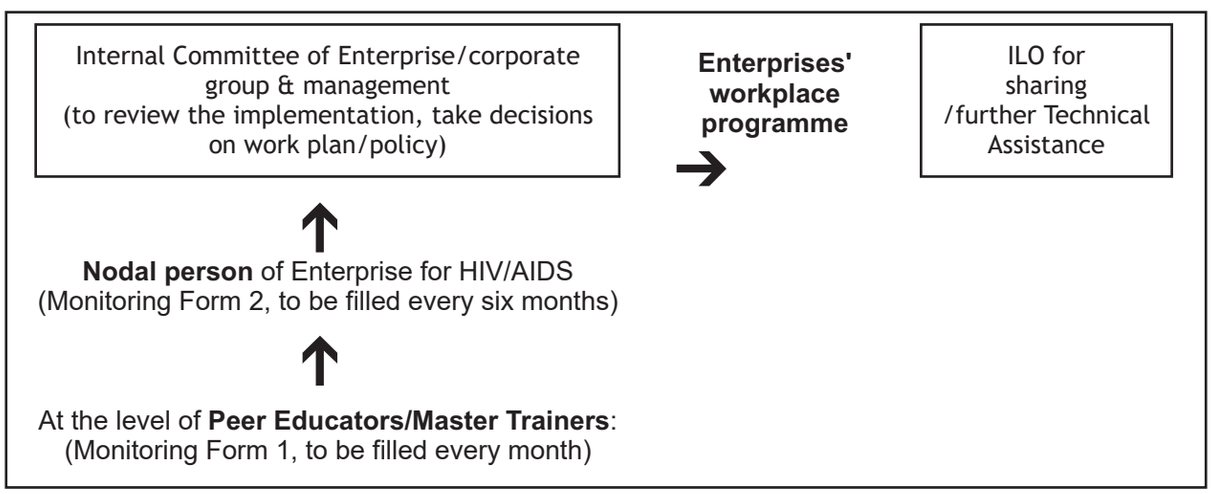
The International Labour Organization (ILO) in consultation with tripartite constituents and the National AIDS Control Organisation (NACO) has developed a three phase programme "Prevention of HIV/AIDS in the World of Work: A Tripartite Response" in India. The programme is aimed at establishing a sustainable national action on HIV/AIDS prevention, care and support in the world of work.

The project has been providing technical support to enterprises/ corporate house in India for development and implementation of workplace HIV/AIDS programmes and policies for the benefit of their employees/families, including contractual workers and workers in the supply chain.

It is important to develop a system for the enterprises themselves so that they could track the progress against key indicators of work plans/following three **sub- objectives:**

1. HIV/AIDS workplace policy or guidelines;
2. Availability and quality of HIV/AIDS workplaces services; and
3. Capacity of workplaces to offer comprehensive and sustainable HIV/AIDS policy and programmes.

This internal monitoring system has been developed by the ILO Project to meet this requirement.



The system consists of two simple forms:

1. Monthly Monitoring Form (1):

This form is to be filled every month by the Peer Educators / Master Trainers for reporting to Company's Nodal Person for HIV/AIDS or Unit Coordinators in case of Corporate Groups. The format will provide information on number of sessions conducted in the month, workers covered, number of informal sessions conducted etc., besides referrals made to specific HIV/AIDS services in the reporting period.



This form will also identify gaps in knowledge of peer educators. This will enable the Nodal person of enterprises to plan refresher training for their peer educators.

The forms filled in various units of Corporate Groups can be collected by unit level nodal person from Master Trainers (MTs) / Peer Educators (PEs) and compiled to be shared with the nodal person of the Group.

This form can be modified by the Corporate Group/ Companies in the light of their work plans and the specific targets given to their MTs/ PEs.

2. Monitoring Form (2):

Based on the monitoring form 1, and nodal person's records/ information, this form is to be filled once in six months, by the nodal person for HIV/AIDS programme in the enterprise/corporate group.

The frequency of compiling information on this form: twice a year

- For the period: January to June, to be completed by **1st week of July**; and

- For the period: July to December, to be completed by 1st **week of January**.

The data collated would be shared with the internal committee/management of the company to keep them updated on the progress being made, and modify work plans/policy from time to time.

The analysis of the information collected from MTs/PEs can facilitate key management decisions at the level of Company/ Group.

Some examples:

- The progress made in training of MTs/ PEs against the target (Qs.401 & 402). The nodal person can review the work plan and propose more training, if there is a shortfall.
- The information on Q.403 will let the nodal person to know the number and percentage of PEs/MTs who are regularly engaged in HIV/AIDS work. This can be useful in giving some incentives for performing PEs /MTs and advice to those who are not performing.
- ART cost as per Q.407 will enable the company to keep a track of the cost on treatment of employees/their families. Companies will also be able to compare the trends and do the analysis of cost of prevention versus the cost of treatment.
- The enterprise/corporate group will share this information with the ILO so that ILO can plan its technical support accordingly.



Enterprise-based HIV/AIDS Programme

Monthly Monitoring Form (1) [for company's internal use]

(Form to be filled every month by the Peer Educators for reporting to UNIT/ Company's Nodal Person for HIV/AIDS)

<table>
<tr><td colspan="6">Name of the reporting PE/ MT:
Department/ Unit/ Location:</td></tr>
<tr><td>1.</td><td>Number of sessions conducted with workers</td><td>Regular</td><td colspan="2">Contractual</td><td>Total</td></tr>
<tr><td rowspan="4">2.</td><td rowspan="4">Number of workers/ colleagues covered in the session</td><td></td><td>Regular</td><td>Contractual</td><td>Total</td></tr>
<tr><td>Male</td><td></td><td></td><td></td></tr>
<tr><td>Female</td><td></td><td></td><td></td></tr>
<tr><td>Total</td><td></td><td></td><td></td></tr>
<tr><td rowspan="4">3.</td><td rowspan="4">Approx. number of workers covered in informal sessions</td><td></td><td>Regular</td><td>Contractual</td><td>Total</td></tr>
<tr><td>Male</td><td></td><td></td><td></td></tr>
<tr><td>Female</td><td></td><td></td><td></td></tr>
<tr><td>Total</td><td></td><td></td><td></td></tr>
<tr><td>4.</td><td>Number of people referred for services:
a) STI treatment
b) VCTC
c) ARV
d) PLHIV network</td><td colspan="4"></td></tr>
<tr><td>5.</td><td>No.of condoms distributed at workplace (if applicable)</td><td colspan="4"></td></tr>
<tr><td rowspan="2">6.</td><td>▪ Type of IEC materials used</td><td colspan="4"></td></tr>
<tr><td>▪ No. IEC materials distributed (if any)</td><td colspan="4"></td></tr>
<tr><td>7.</td><td>The kind of questions asked on STI/HIV/AIDS during session</td><td colspan="4"></td></tr>
<tr><td>8.</td><td>The question(s) I was unable to answer:</td><td colspan="4"></td></tr>
<tr><td>9.</td><td>The areas in which I require further knowledge / training?</td><td colspan="4"></td></tr>
<tr><td>10.</td><td>Any new efforts/ initiatives undertaken during the period</td><td colspan="4"></td></tr>
</table>

Signature of the PE/MT ---------- Submitted to Company's Nodal Person on------



"ILO India - Prevention of HIV/AIDS in the World of Work: A Tripartite Response"

Enterprise-based HIV/AIDS Programme

Monitoring Form (2)

Form to be filled in every 6 months by the Workplace HIV/AIDS Nodal Person to be compiled for sharing with Internal Committee/ ILO for Technical Support.

DATE: ___/___/___

Enterprise:_____ Nodal Person:_____

Indicator		**Reporting period: From _____ to _____**	
Sub-immediate Objective 1: HIV/AIDS Workplace Policy or Guidelines			
		Yes / No	Comments
101 Does your workplace have a written HIV/AIDS policy?			
102 If so, is your workplace policy communicated to workers through sessions organized by management to explain the policy to workers?			
103 If your workplace has a written HIV/AIDS policy, which of the following policy components does it include? (Check each component that is in your written policy) **Note:** components drawn from principles of ILO Code of Practice	Recognition HIV/AIDS as workplace issue		
	Non-discrimination		
	Gender equality		
	Healthy work environment		
	Social Dialogue		
	No HIV screening for employment		
	Confidentiality of HIV status		
	No job termination if fit to work		
	HIV/AIDS Prevention Programme		
	Care and support a) counselling, b) ART provision		
104 Does your workplace policy have provision for periodic/ annual review			

Sub-Immediate Objective 2: Availability and Quality of HIV/AIDS Workplace Services				
		Yes / No	Quality Rating*	Comments
201 Which of the following HIV/AIDS services are available at your workplace and how do you rate the quality of	HIV/AIDS education			
	Condom availability			
	STI information services			
	VCT information services			
	Care and support information services			

Sub-Immediate Objective 3: Capacity of workplace to offer comprehensive and sustainable HIV/AIDS policy and programmes		
	Yes / No	Comments
301 Does your workplace have an active internal committee addressing HIV/AIDS issues? Please mention if unions are included.		
302 Over the last 6 months, has your workplace allocated official working hours to HIV/AIDS programme implementation?		
303 Does your workplace have a collaborative arrangement with an external HIV/AIDS resource organization to provide condoms to workers? If yes, please provide name of organization.		
304 Does your workplace have established referral system with community STI, VCTC, care and support services through PLHIV networks.		
305 Does your workplace have a specific budget (*if yes, please specify the allocated yearly amount and the amount spent in the last six months*) for implementation of HIV/AIDS programmes?		
306 Does your workplace have an HIV/AIDS component integrated into existing OSH or HR/other training programmes?		



Key Process/output indicators			
	Target	Achieved	Comments
OUTPUT INDICATOR: 401. In the last six months, how many HIV/AIDS master trainers have been trained in your workplace? *(please give male / female break-up)*			
OUTPUT INDICATOR: 402. In the last six months, how many HIV/AIDS peer educators have been trained in your workplace? *(please give male / female break-up)*			
OUTPUT INDICATOR: 403. In the last six months, how many HIV/AIDS training sessions have been organized in your workplace?			
OUTPUT INDICATOR: 404. In the last six months, how many employees have participated in HIV/AIDS workplace education training in your workplace? *(please give male / female break up)*			
OUTPUT INDICATOR: 405. In the last six months, how many employees have been covered in informal HIV/AIDS sessions? *(please give male / female break up)*			
OUTPUT INDICATOR: 406. If you are covering contractual workers, please indicate the number of workers covered in HIV/AIDS educational programmes in lat six months. (Comments can describe the approach briefly)			
OUTPUT INDICATOR: 407. Number of employees/families that are being provided with ART If provided, what is the cost involved?			
OUTPUT INDICATOR: 408. Any special efforts/initiative taken up during the period.			

Signature of the Nodal Person: _____

Date: _____

Sample Agenda for a three day HIV/AIDS training for Trainers of Enterprise(s)

Day I:			
Time	Topic	Specific Objectives	Methodology / Resource Persons
9.30-10.30 A.M.	Registration Brief welcome by the enterprise management Brief address by the ILO/ key resource person Administering Pre test Questionnaire Ice breaking /Capturing participants' expectations from the workshop	▪ To welcome the participants and orient them to the need and rationale for the workshop ▪ To ascertain the knowledge, perceptions of participants about HIV/AIDS at the start of the workshop ▪ To create workshop environment and capture key expectations of the participants	Attendance sheet Questionnaire. Exercise/ game for the icebreaking Listing expectations on a flip chart, Writing the expectations on slips of paper and sorting them topic wise broadly.
10.30 - 10.45 AM Tea/Coffee break			
10:45-1.15 A.M.	Basics of HIV/AIDS/STI (Different dimensions of HIV/AIDS, immune system, routes of transmission, myths about HIV transmission, prevention)	▪ To enhance the knowledge level of the participants on HIV/AIDS	Quiz/brainstorming/card game Facilitation by resource person
1.15-2.00 P.M. Lunch break			
2.00 - 2.45PM	Basics of HIV/AIDS/STI (continued) HIV Testing, symptoms, Treatment of OIs/ART, Global and national Scenario of HIV/AIDS, and others	▪ To enhance the knowledge level of the participants on HIV/AIDS	Quiz/brainstorming/card game Facilitation by resource person
2.45 - 3.45 PM	Attitudes and values	▪ To help participants to be aware of their own attitude to issues around HIV/AIDS ▪ To foster attitudes/perspectives among the participants, which contribute to prevention of HIV/AIDS	Debating on the value statement
3.45-4.00 P.M. Tea/Coffee break			
4:00- 4.45 P.M.	Sharing perspective of a Person Living With HIV (PLHIV)	▪ To provide an interface with a PLHIV ▪ To orient participants to the issues of stigma and discrimination associated with HIV/AIDS.	Address by a PLHIV, questions and answer, moderation by resource person
4.45 - 5.30 PM	Basic facts on TB	▪ To provide an understanding about Tuberculosis Disease and its correlation with HIV	Presentation, discussion
Day II:			
9- 9.30 A.M.	Recap of Day – I and feedback	▪ To review the previous day's sessions and workshop environment	Participants' feedback



9.30 - 10.30 AM	HIV/AIDS scenario, Why is it an issue for the world of work Why should enterprise respond to HIV Approaches and broad components of HIV/AIDS enterprise based programmes	▪ To discuss the extent of HIV/AIDS problem in the world and in the country and country's/state's response to HIV/AIDS ▪ To provide the rationale for HIV/AIDS workplace interventions and present an overview of the ILO code of practice on HIV/AIDS and World of Work. ▪ To enable participants discuss and appreciate the need for HIV/AIDS programme in their enterprise(s) ▪ To discuss the components of the HIV/AIDS response (policy and programmes) at the enterprise level	Presentation, Discussion
10.30- 10.45 A.M. Tea /Coffee break			
10.45 - 12.30 A.M.	Behaviour Change Communication (BCC)	▪ To familiarize the participants to the concept/process of Behaviour Change in the context of HIV/AIDS programme. ▪ To orient the participants to the Inter-personal skills in order to enhance the effectiveness of their Health Education sessions at the workplace.	Lecture, film, discussion Role plays Facilitation by resource persons
12.30- 1.15 P.M	Condom Education and condom accessibility at workplace	▪ To explain the need for condom promotion and approaches in HIV/AIDS prevention programmes ▪ To discuss key barriers to condom use	Discussion, brainstorming, presentation, condom demonstration, facilitated by resource persons
1.15- 2.00 PM. Lunch break			
2.00 - 2.45	Sexually Transmitted Infections and its link to HIV	▪ To provide an understanding about the STIs and its relevance in HIV prevention	Presentation and Discussion
2.45- 3.45 P.M	Counseling and Testing	▪ To orient the participants about the GOI policy for testing and inform about the places where testing is available ▪ To enable them share the experiences of a counselor of ICTC.	Presentation/experience sharing by a counselor (to be engaged in consultation with State AIDS Control Society), facilitation by resource person



3.45 - 4.00 P.M. Tea /Coffee break			
4.00-4.45 P.M.	Explaining use of the Trainers kit and IEC materials/training manual	▪ To orient the participants to the Trainers' kit and manual ▪ To explain the use of IEC materials (leaflet/poster/presentations CD /film etc)	Resource person
4.45 - 5.30PM	Question and Answers	▪ To provide opportunity to seek clarifications and share thoughts	Sharing and discussion
Day -III			
9.00 - 9.30 AM	Recap of Day – II and feedback	▪ To review the previous day's sessions and workshop environment	Participants' feedback
9.30 - 10.30.A.M.	Developing/discussing the HIV/AIDS work plan of the enterprise and role of Master Trainers	▪ To enable the participants understand the HIV/AIDS work plan of their enterprise /provide inputs into the fine-tuning of draft work plan. ▪ To enable the participants appreciate their role in implementation of the work plan	Enterprise management/ resource person
10.30 - 10.45 AM Tea/Coffee break			
10.45 - 11.30 AM	Training skills	▪ To provide understanding about the adult learning process and methodologies ▪ Key values of a trainers ▪ Orientation to training skills	Discussion and presentation
11.30-4.00 P.M. with a lunch break at 1.15 Pm	Practice sessions using ILO Card Game for Peer Educators training Programme	▪ To enable the participants understand the card game and its use	Resource person, mock session by participants
4.00 - 4.15 PM Tea/ Coffee Break			
4.15- 5.00 P.M.	Post Test Questionnaire and valediction	▪ To administer the post test questionnaire ▪ To get the participants' feedback	Participants' feed back and closing by resource person/ company management



Master trainers/Peer Educators' Training Programme
Pre/Post questionnaire on HIV/AIDS

A. Knowledge and understanding about HIV/AIDS

1. What is the full form of HIV and AIDS?
   HIV: _____

   AIDS: _____

2. What is the difference between HIV and AIDS?

3. List the ways through which HIV could be transmitted?

4. List the ways through which HIV infection could be prevented?

5. List at least two symptoms of Sexually Transmitted Infections in men and women:

   Men:
   i)
   ii)
   Women:
   i)
   ii)

6. Can you tell about a person's HIV status by his/her appearance?
   a. Yes b. No c. Don't know/not aware

7. It is known that there is no cure for HIV yet; are you aware that there is available treatment to prolong the life of people living with HIV?
   a. Yes b. No c. Don't know/not aware

8. The estimated number of people living with HIV in your state is ……

9. List the key benefits of using a condom.
   ……..

10. Where can one get tested for HIV?

.....

B. Please mark your response by putting a tick mark (✓) in the yes/no column:

	Statements	Yes	No
1.	HIV & AIDS is a problem of only truck drivers, homosexuals, sex workers and drug users.		
2	I feel there is no possibility for me/my family to be infected by HIV.		
3	People living with HIV should bear the consequences of their behaviors.		
4.	There should be regular testing for HIV at workplace		
5.	The best way to avoid the HIV infection is to keep away from people living with HIV & AIDS.		
6.	People living with HIV should be allowed to work		
7.	The HIV status of persons should be kept confidential		
8.	Workers living with HIV bring disrepute to the company		

HIV/AIDS: an issue for the world of work

1. Why do you think HIV/AIDS is an issue that enterprises need to respond to?

2. What should a company's response be towards HIV positive employees?

3. What should your company do to protect workers from HIV?

4. Does your company have a policy on HIV/AIDS?

   a. Yes b. No c. Don't know/not aware

5. If yes, list three key elements of your company's policy on HIV/AIDS?

   i)
   ii)
   iii)



Basic Information about STIs/HIV/AIDS

HIV **stands for Human Immunodeficiency Virus**. HIV is different from most other viruses because it attacks the immune system. The immune system gives our bodies the ability to fight infections. HIV is a RNA virus and is called a Retro virus. It destroys a type of white blood cell (T cells/ Helper cells or CD4 cells) that the immune system must have to fight against disease or infections. HIV replicates in these cells and produces about 10 billion new virus everyday. A common person will have a measure of about 600 -1200 numbers of CD4 cells/mm3 of blood. Destruction of CD4+ cells is the major cause of the immunodeficiency observed in AIDS.

AIDS stands for Acquired Immuno Deficiency Syndrome. AIDS is the final stage of HIV infection. It can take years for a person infected with HIV, even without treatment, to reach this stage. Having AIDS means that the virus has weakened the immune system to the point at which the body has a difficult time fighting infection. When someone has one or more specific infections, certain cancers, or a very low number of T cells, he or she is considered to have AIDS.

A	**Acquired**	Not hereditary but due to a virus encountered by the person
I	**Immuno**	Weakening of the immune system
D	**Deficiency**	
S	**Syndrome**	A group of symptoms that manifest

The modes of transmission of HIV are:

- Unprotected sexual intercourse with an infected person;
- Transfusion of Infected blood/blood products;
- Sharing of infected syringes/needles; and
- Infected mother to the baby during pregnancy, during delivery and while breast feeding

The conditions for the virus to transmit are
- Port of entry,
- Quantum of fluid and
- Viral load.

This means there should be adequate quantity of the body fluids, the route in which the exchange of fluids can take place should be established and the quantity of the virus in the fluids should be of high concentration to infect the other person.

Body fluids containing high concentration of HIV to infect and can be exchanged	**Body fluids containing too small a concentration of the virus to infect**	**Fluids containing the HIV but not likely to be exchanged between people.**
Blood	Sweat	Cerebrospinal Fluid
Semen	Tears	Amniotic Fluid
Menstrual Blood	Saliva	Faecal Matter
Vaginal Fluid	Skin Oils	
Breast milk		

Prevention of HIV: The best way to prevent HIV is by knowing about it. Getting correct information about the routes of transmission and taking precaution or modifying risky behaviours are the key issues as explained below:

- Sexual route is the most common mode of transmission of HIV, it can be prevented by:
  A: Abstinence from sexual relationships;
  B: Being faithful (mutual) in sexual relationship; and
  C: Correct and consistent use of condom as safer sex practice.
  The presence of an untreated STI like syphilis or gonorrhoea facilitates the transmission of infection with HIV from one person to another. Open sores and blisters provide an easy entrance into the body for STIs, including HIV. Having an STI is already a sign of risky behaviour. Prevention and treatment of STIs is another way to protect oneself against HIV infection.

- Transfusion through infected blood and blood products can be avoided through practice of universal precautions by health care workers; Sterilization of all medical equipment, avoiding sharing of syringe/needle, make sure needles and knives are sterilized or try to use disposable equipment, and screening of all blood/blood products before transfusion.

- Mother to Child transmission can take place during pregnancy, during delivery and during breast-feeding. This can be prevented by taking precautions during pregnancy, ensuring hospital delivery, avoiding breast-feeding and taking available Antiretroviral therapy at the onset of labour pains, and to the new born with in 72 hrs of the birth according to the weight of the baby. Counselling is very important to be aware of the factors which enhance the risk of the mother to infect the baby during pregnancy and to take precautions. Every couple considering pregnancy should seek advice and counselling. In many government hospitals, counselling and programme to prevent mother to child transmission is implemented. The services can be availed. Since the chances of transmission from infected mother to her child is 25 - 40% in Indian context, with the ART the risk can still be reduced to 5 -8 %. Thus, there is every chance that a HIV positive mother can have a HIV negative baby if she takes all precautions.

Ways in which HIV is not transmitted:

HIV is a fragile virus. It cannot live for very long outside the body. As a result, the virus is not transmitted through day-to-day activities or social contacts. One cannot get HIV by:

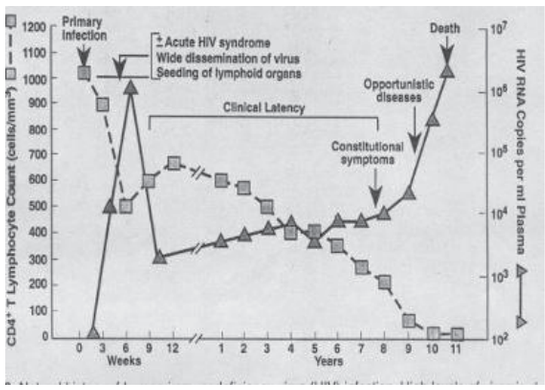
- Shaking hands with an infected person
- Drinking water or eating food from the same utensils used by an infected person
- Hugging, touching or kissing
- Caring and looking after people with HIV or AIDS
- Getting bitten by an infected person
- Use of the same toilets as AIDS patients or people with HIV
- Working together - Sharing telephones, computers, machines and other office equipment
- Sneezing and coughing
- Getting bitten by a mosquito that has already bitten an infected person

The progression of HIV infection Stages of HIV Infection:

HIV Disease progression -
Once HIV enters the body, it infects a large number of CD4 (T-4 helper lymphocytes) cells and replicates rapidly. There are various stages of disease progression -

Acute sero-conversation:
HIV spreads all over the body within weeks of entry into the body especially the lymphoid organs-lymph nodes, spleen, tonsils and adenoids. The patient may complain of fever, headache, cough, skin rash, night sweats and swelling of lymph nodes around 2-6 weeks after entry of HIV virus. The flu-like symptoms last for 1-2 weeks.

Window period:
Human body usually takes about 3 months (3weeks to 6 months) to react to the presence of the virus and produce antibodies in quantities that can be detected through standard HIV diagnostic tests in the blood tests. The period between the infection and the time taken for the body to produce antibodies is called Window Period. During this time, infected persons have the virus in their body, can spread the infection but do not test positive.



Asymptomatic stage:
Virus replicates in deep tissues such as testes and brain where it may remain without dividing for many months or years. It is those deep-seated reservoirs of viruses, which appear to be responsible for the continued proliferation of the virus over many years. This is the stage of clinical latency, which might last for 3 months to 17 years depending on the immune status of individual patients. The average range is between 10 and 12 years. During this stage, the person feels well, is able to work as before and shows no signs of being sick (this is what is "asymptomatic"). With the exception of having HIV in the body, the person is "fit for work."

Symptomatic stage:
Progression destruction and depletion of the CD4 lymphocytes disables the immune system. AIDS is defined as stage in which a person who has confirmed positive for HIV infection with any of the clinical manifestations such as Weight loss (> 10percent), Chronic diarrhoea (> 1 month) Disseminated Miliary tuberculosis, Neurological impairment, Candidiasis, Kaposi's sarcoma. Late stage is characterized by appearance of various opportunistic infections such as tuberculosis, candida, herpes, pneumocystis carnii, toxoplasmosis, cryptosporidiosis, cryptococcus and cytomegalovirus. When a person is diagnosed with AIDS, the length of time until death can be very individual depending on the number and type of OIs (Opportunistic Infections) and the availability of treatment and drugs.

WHO guidelines for the diagnosis of AIDS:

Major signs	Weight loss of over 10 % of body weight Fever for longer than one month Diarrhea for longer than one month
Major signs	Persistent cough for more than one month General itchy skin diseases Recurring shingles (herpes zoster) Thrush in the mouth and throat Long lasting, spreading and severe cold stores Long lasting swelling of the lymph glands Loss of memory Loss of intellectual capacity Peripheral nerve damage

Testing for HIV:
- **Enzyme Linked Immuno Sorbent Assays (ELISA) -** Testing serum for antibodies to HIV with a standard ELISA is currently one of the most common, cost-effective and accurate methods of screening for infection. 2 consecutive positive tests are required from 3 different kits before a result is confirmed positive.
- **Rapid test -** The other most commonly used HIV test in India with a high degree of accuracy (98percent). It again tests for antibodies.
- **Polymerase Chain Reaction (PCR) -** This is the only test available specifically for HIV and tests for the presence of HIV genetic material.

- **Western Blot test -** Another accepted confirmatory assay for the detection of antibodies to HIV and consider the "gold standard" for validation of HIV results. 3 positive ELISA tests have the same degree of accuracy as a Western blot test.

Management of HIV/AIDS:
Medical: The various levels of medical management of People living with HIV/AIDS includes:

- **Treatment of opportunistic infections:** Drugs are provided in all government hospitals for the management of infections like Tuberculosis, Pneumonias, fungal infection etc.
- **Preventive therapy:** People with HIV/AIDS can take preventive medicines so that they can prevent opportunistic infections.
- **Nutrition & Positive living:** All people living with HIV/AIDS must be encouraged to fight the disease within themselves, look after their own health, exercise regularly (20 minutes of brisk walk or aerobic exercises), decrease mental tension through relaxation exercises, meditation or Yoga, and dietary advice (lots of green, leafy vegetables & seasonal fruits, avoid red meat etc)
- **Anti-retroviral therapy:** While there is no cure, Anti-Retroviral drugs are available which can prolong the life of an HIV positive person. But once started, these drugs have be taken life long. These drugs are expensive and may have severe adverse reactions. The treatment needs to be administered under supervision of doctors who are trained in HIV case management. WHO recommends that PLHIV whose CD4 count falls below 500 cells/mm3 (Normal range 600 - 1200 cells/mm3) should initiate ART, which slows down the replication of virus within the body. But before starting therapy, patients must be counseled that it is not a cure, medicines need to be taken throughout life, serious side effects, expensive therapy, monitoring tests are essential and sometimes the medicines do not work.
- **Palliative care:** Providing care during the terminal stages of the illness through management of pain & supportive therapy is also important.

Care & Support:
A considerable amount of stigma and discrimination is associated with AIDS, which hinders in prevention as well as care and support efforts. And, because it predominantly spreads through sexual contact, which being essentially in private domain, it becomes difficult to address it. People with HIV/AIDS need empathy, love & affection. In addition, they need ongoing counseling to cope with their HIV status. Referral services to organizations that provide vocational training, nutrition, financial support or other support services must be made available to people with HIV/AIDS. Family members need to be taught about how to take care of health, hygiene, nutrition and ailments of their loved ones through home-based care approach. Widows & orphans need assistance.

Other important facts:

- HIV generally affects people at the most productive age, leading to premature death thereby severely affecting the socio-economic structure of families, communities and countries. HIV infection goes unnoticed in the initial years because it is not symptomatic in the initial phase. This makes early detection and consequently prevention a difficult proposition. That is why AIDS is often called a silent killer. There is no vaccine to protect people against getting infected with HIV and there is no cure for AIDS. This means that the only certain way to avoid HIV is to prevent getting infected in the first place.

- Both men and women are vulnerable to infection from HIV and other STIs, many of which have serious long-term consequences, especially for women e.g., pelvic inflammatory disease, tubal pregnancy, and even sterility.

- Drinking alcohol or using illegal drugs will reduce ones' judgment and your ability to act within the bounds of safe behavior. When one is under the influence of alcohol and/or drugs, he/she is more likely to indulge in risky sexual contacts.

- Being tattooed or body pierced with unsterile needles and knives/blades can result in infection with HIV and other STIs.



- Unprotected (without a condom) anal sex is a risky behavior. HIV can be found in the blood, semen, pre-seminal fluid, or vaginal fluid of a person infected with the virus. In general, the person receiving the semen is at greater risk of getting HIV because the lining of the rectum is thin and may allow the virus to enter the body during anal sex. However, a person who inserts his penis into an infected partner also is at risk because HIV can enter through the urethra (the opening at the tip of the penis) or through small cuts, abrasions, or open sores on the penis. If people choose to have anal sex, they should use a latex condom. Most of the time, condoms work well. However, condoms are more likely to break during anal sex than during vaginal sex. Thus, even with a condom, anal sex can be risky. A person should use a water-based lubricant in addition to the condom to reduce the chances of the condom breaking.

- There are no documented cases of HIV being transmitted during participation in sports. The very low risk of transmission during sports participation would involve sports with direct body contact in which bleeding might be expected to occur. If someone is bleeding, their participation in the sport should be interrupted until the wound stops bleeding and is both antiseptically cleaned and securely bandaged. There is no risk of HIV transmission through sports activities where bleeding does not occur.

- **Origin of HIV:** After a series of different theories, scientists have identified a type of chimpanzee in West Africa as the source of HIV infection in humans. The Simian Immunodeficiency Virus (SIV) jumps species and mutates in humans to be HIV. Humans hunted these chimpanzees for meat and came into contact with their infected blood. Over several years, the virus slowly spread across Africa and later into other parts of the world.

- **A person cannot get infected with HIV from mosquitoes:** The results of experiments and observations of insect biting behavior indicate that when an insect bites a person, it does not inject its own or a previously bitten person's or animal's blood into the next person bitten, rather, it injects saliva, which acts as a lubricant so the insect can feed efficiently. Diseases such as yellow fever and malaria are transmitted through the saliva of specific species of mosquitoes. However, HIV lives for only a short time inside an insect and, unlike organisms that are transmitted via insect bites, HIV does not reproduce (and does not survive) in insects. Thus, even if the virus enters a mosquito or another insect, the insect does not become infected and cannot transmit HIV to the next human it bites. There is no reason to fear that a mosquito or other insect could transmit HIV from one person to another through HIV-infected blood left on its mouthparts. Several reasons help explain why this is so. First, infected people do not have constantly high levels of HIV in their blood streams. Second, insect mouthparts retain only very small amounts of blood on their surfaces. Finally, scientists who study insects have determined that biting insects normally do not travel from one person to the next immediately after ingesting blood. Rather, they fly to a resting place to digest the blood meal. Since the beginning of the HIV epidemic there has been concern about HIV transmission through biting and bloodsucking insects, such as mosquitoes. However, studies conducted by the Center for Disease Control and Prevention (CDC), Atlanta, USA, have shown no evidence of HIV transmission through mosquitoes or other insects -- even in areas where there are many cases of AIDS and large populations of mosquitoes. Lack of such outbreaks, despite intense efforts to detect them, supports the conclusion that HIV is not transmitted by insects.

HIV/AIDS Global and Indian Scenario

Global figures of the HIV epidemic

Number of people living with HIV in 2017	
Total	36.9 million (31.1 - 43.9 million)
Adults	35.1 million (29.6 – 43.9 million)
Women	18.2 million (16.4 – 19.3 million)
Children under 15 years	1.8 million (1.3 – 2.4 million)
People newly infected with HIV in 2017	
Total	1.8 million (1.4 - 2.4 million)
Adults	1.6 million (1.3 - 2.1 million)
Children under 15 years	180,000 (110,000 - 260,000)
AIDS deaths in 2017	
Total	9,40,000 (670,000 - 1.3 million)
Children under 15 years	110,000

Source: Global Report : UNAIDS Report on the Global AIDS Epidemic, 2017

Global Scenario

- An estimated 36.9 million people living with HIV globally in 2017. Out of the total number of people living with HIV, 18.2 million are women, which is about 50% of the total global population estimate.

- 1.8 million people became newly infected with HIV and over 1.1 million people have lost their lives due to AIDS. Now the estimates include adults as 15 years and above as opposed to 15-49, as substantial proportion of people living with the virus are 50 years and above. In 2017 people aged 15 and above accounted for 59% of new HIV infections in people aged 15 and older.

Scenario of HIV/AIDS in India

Estimated Number of people living with HIV in 2011:	2.09 Million
Adult Prevalence rate:	0.27%
Number of people on ART	516000

Source: NACO (www.naco.gov.in)

Key Points:

- An estimated 2.1 million people living with HIV/AIDS
- Adults aged 15-49 years constitute 83% of the estimated number.
- Adult HIV prevalence 0.20%
- HIV prevalence among different populations:
  - Injecting Drug Users (IDU) – 6.3%
  - Men who have sex with men (MSM) - 2.7%
  - Female Sex Workers (FSW) - 1.6%



- Migrant workers - 0.2%
- Truckers - 2.59%

- Of the 116000 estimated new infections in 2011 among adults, the six high prevalence states account foronly 31%, while the ten low prevalence states of Odisha, Jharkhand, Bihar, Uttar Pradesh, West Bengal,Gujarat, Chhattisgarh, Rajasthan, Punjab &Uttarakhand together account for 57% of new infections.

The HIV/AIDS statistics keep changing on a yearly basis, for latest statistics on global and Indian scenario please refer to www.unaids.org and www.naco.gov.in

Factors contributing to the spread of HIV in India

- Complexities arising out of the size and diversity of the country
- Low levels of literacy leading to myths and misconceptions
- Migration
- Untreated STI due to lack of information and health care facilities
- Gender disparities

'India's response to HIV/AIDS'

- Department of AIDS control (DAC) /National AIDS control Organisation (NACO) within the Ministry of Health and Family Welfare; Government of India plans and coordinates the national responds to HIV/AIDS in India. After the first case of HIV was detected in India for the first time in 1986 in the State of Tamil Nadu, it has been reported by all States and Union Territories in both urban and rural areas.

- In 1992, the Government launched the first National AIDS Control Programme (NACP I) and in 1998 NACP II was initiated. Based on the learning from NACP I and II, the Government designed and implemented NACP III (2007-2012) with an objective to "halt and reverse the HIV epidemic In India" by the end of the project. NACP in India rests on two key pillars - prevention for those who are not infected, and care, support and treatment for those who have been infected. Since large proportion of the population is not infected with HIV, prevention remains the cornerstone of the programme. The strategies for prevention include targeted interventions for high risk groups, condom promotion and strong IEC campaigns for general population. Care, support and treatment aim at increasing access to testing and treatment services.

- Phase IV of NACP (2012-2017). The main strategies included intensifying and consolidating prevention services, increasing access and promoting comprehensive care, support and treatment, expanding IEC services, building capacities at national, State, district and facility levels and strengthening Strategic Information Management Systems.The main objective of NACP IV was to reduce new infections by 50% (2007 Baseline of NACP III) and provide comprehensive care and support to all persons living with HIV/AIDS and treatment services for all those who require it.

For detailed and updated information please visit NACO website www.naco.gov.in

- NACO is also working closely with UNAIDS and other UN agencies including the ILO. Ministry of Labour and Employment (MOLE) is also involved in the national efforts as V.V.Giri National Labour

Institute and Central Board of Workers Education & Employee state Insurance corporation (ESIC) key institutions of the MOLE have mainstreamed HIV/AIDS within their programmes.

- Several enterprises have developed good policy and programmes on HIV/AIDS for their workforce. Some NGOs are also working with industrial workers.
- The ILO India programme is working closely with the MOLE, NACO/SACS, employers' and workers' organizations to strengthen the world of work response to HIV/AIDS.

National Policy on HIV/AIDS and the World of Work, MOLE, GOI, 2009
Ministry of Labour and Employment, Government of India developed the National policy on HIV/AIDS and the World of work in 2009. The policy encourages enterprises in public and private sector to initiate workplace programme based on ILO code of Practice and recognizes their contribution in halting the spread of HIV.

Excerpts from the National Policy on HIV/AIDS and the World of Work Policy, MOLE, GOI regarding the enterprises.

"……..All enterprises, in public/private and formal/informal sectors, are encouraged to establish workplace policy and programmes at their workplaces based on the principles of this policy"

"…….Set up Workplace interventions covering their regular as well as contractual workers, and their families."

"……Enterprises can significantly contribute in enhancing the coverage of HIV prevention and care programmes by establishing partnership with NACO/SACS and other agencies under Public Private Partnership, which is a key component of the national programme."

Recommendation concerning HIV and AIDS and the World of Work, 2010 (No.R-200)

In 2001, the ILO adopted the Code of Practice on HIV/ AIDS and the world of work, which has been widely accepted and used in many countries. In 2007, ILO and its constituents decided that the time had come to raise the response of the world of work of work to HIV/AIDS to a different leverl through the development and adoption of an International Labour Standard. The Recommendation concerning HIV and AIDS and the World of Work, 2010 (No. 200) the new labour standard is the first human rights instrument to focus on HIV/AIDS in the world of work, and was adopted – by an overwhelming majority – by governments, employers' and workers' representatives from ILO member States at the International Labour Conference in June 2010.

Behaviour Change Communication (BCC)

Behaviour Change Communication is a process that affects/ influences individual behaviours.

Understanding the concept of BCC:

Behaviours play a major role in transmission of HIV. Changing people's behaviours is not an easy task, especially personal behaviours, like sexual behaviour. which individuals do not like to discuss. Mere knowledge does not lead to behaviour change. Statistics reveal that more than 86% of the HIV infections were through Sexual route of transmission. There is a strong correlation between Sexually Transmitted Infections and HIV. Sexual practices and sexual preferences of individuals are difficult to change. So, BCC attempts to:

- Increasing risk perception
- Encourage personal commitment to change
- Enhance skills to make changes
- Create an enabling environment

Theories of BCC:

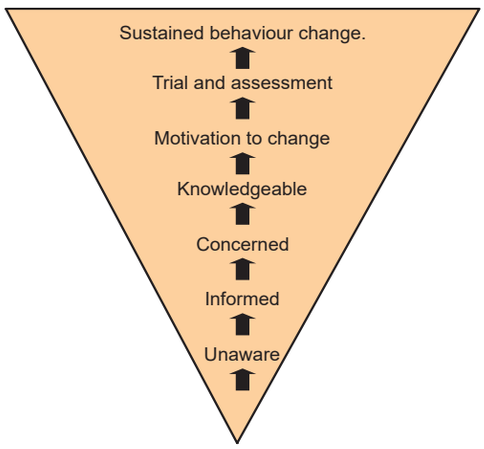
Behaviour Change can be attempted if we understood certain theories about how individuals change their behaviours. BCC concept founds on few behavioural theories, which reinforces that Knowledge is necessary but not sufficient to produce behaviour change. Perceptions, motivation, skills and factors in the social environment also play an important role.

- Health Belief model: This theory asserts that if an individual perceives the risk factors of behaviour and also understands the benefits of prevention, he is likely to change behaviours.
- Theory of reasoned action claims that people go through several stages/ process of behaviour change before actually changing their behaviours.

The Stages of Change Model. The Stages of Change Model looks at a person's readiness to change or attempt to change toward healthy behaviours. There are distinct stages identified in this model:

Understanding the stages of change is important for those who will be attempting behaviour change.

1. Having a realistic view of the work involved in behaviour change may better prepare individuals for the effort and caution needed to avoid impediments.
2. Individuals may better understand how progress toward change occurs even in the absence of action. Gaining awareness about one's self, experiencing the emotions that awareness of the problem may trigger, and changing beliefs, attitudes, and thoughts constitute progress.
3. It helps to distinguish between a lapse, that is, an isolated mistake or temporary slip, versus a relapse, that is, a complete setback. Knowing the factors that often precipitate a lapse or relapse, such as emotional distress, may help people recognize where work is needed in their lives.



In the context of workplace, the understanding of behaviour change communication and strategies for implementation are to be altered or tailored to suit the audience, and the setting. Therefore, BCC takes a slightly different form when it is implemented at workplaces.



Defining BCC in the context of workplace:
Workplace information and education programmes aims to operationalize key aspects of The ILO Code of Practice on HIV/AIDS and the World of Work, which provides internationally, recognized guidelines for the development of comprehensive HIV/AIDS workplace policies and programmes.

The key issues that are to be addressed at workplaces with the employer/ management and the unions are.

- Recognition of HIV/AIDS as a workplace issues
- Development of workplace policies and programmes based on the key principles of ILO code of practice on HIV/AIDS
- Support for implementation of the plan (appoint nodal person, set up HIV/AIDS committee, allocate budget)
- Allocation of staff time for HIV education and training

Issues that are addressed in BCC amongst workers in the formal settings:
BCC is part of a comprehensive workplace programme to inform workers about HIV/AIDS; promote behaviour change that will reduce the spread of the virus, reduce discrimination and support workers who are living with HIV/AIDS. The key issues are as below:

- Participate in the HIV/AIDS workplace programme
- Understand and reduce risk behaviours
- Develop non-discriminatory behaviors towards co-workers living with or affected by HIV
- Use condoms for protection
- Seek treatment for STIs
- Know your HIV status - Visit a Counselling and Testing Centre
- Share your knowledge with family/friends- Play a role in HIV prevention efforts



Condom Promotion/ Education

Condom is a thin sheath made of latex/plastic to fit on the penis to make sex safer. It protects both partners during vaginal, anal, oral intercourse. It prevents pregnancy by preventing sperm from entering the vagina. The latex condom protects against many sexually transmitted diseases including HIV, by acting as a barrier during sexual activity.

Effectiveness of Condom: In relation to HIV prevention, condoms are the present solution in prevention and substantially reducing the risk of HIV transmission. Condoms are only effective when used consistently and correctly. Using a condom during intercourse is more than 10,000 times safer than not using a condom. Condoms are 98 percent effective in preventing pregnancy when used correctly and up to 99.9 percent effective in reducing the risk of STI transmission when combined with spermicide. The first-year pregnancy failure rates among typical condom users averages about 12 percent and includes pregnancies resulting from errors in condom use. Studies of hundreds of couples show that consistent condom use is possible when sexual partners have the skills and motivation.

Handling condoms: Condoms should be stored in cool, dry place (long exposure to air, heat and light makes the condoms more breakable). It should not be stored continually in a back pocket, wallet, in vehicle dash board or glove compartment. If needed, water-based lubricant (KY Jelly) can be used outside the condom. Lubrication helps in preventing rips and tears and it increases sensitivity. Oil-based lubricants like petroleum jelly, cold cream, Mobil oil damage the latex condom. Condoms should be handled gently. Its latex will become brittle due to changes in temperature, rough handling and long storage. Damaged, discoloured, brittle or sticky condoms should not be used.

Correct use of Condom:

- Check the expiry date.
- Carefully open the condom package; teeth or fingernails can tear the condom.
- Use a new condom for every sexual intercourse.
- Put on the condom after the penis is erect and before it touches any part of a partner's body. *If a penis is uncircumcised, the person must pull back the foreskin before putting on the condom.*
- Squeeze the air by pinching the tip of the condom.
- Withdraw the penis immediately if the condom breaks during sexual intercourse and put on a new condom before resuming intercourse. *When a condom breaks, use spermicidal foam or jelly and speak to a health-care provider about emergency contraception.*
- Withdraw the penis immediately after ejaculation. While the penis is still erect, take hold of the rim of the condom between the fingers and slowly withdraw the penis (with the condom still on) so that no semen is spilled.
- Pull out the condom and dispose carefully (wrap in a paper and throw it in a bin, never flush in the toilet).

Quality of Condoms: Regulations and Tests done by manufacturers to ensure quality of condoms:

- In India, manufacturers follow the performance standards for condoms given by the Schedule R of Indian drugs and Cosmetics ACT. India may soon follow the WHO standards, which are more clear and precise.
- Before packaging, every condom is tested electronically for defects and pinholes. In addition, the samples from every batch using water-leak and airburst tests are conducted.
- Air inflation tests - Condoms are inflated to a diameter of 150mm and visually examined for pinholes and presence of foreign matter.
- The average batch of condoms tests better than 99.7 percent defect free.
- During the water-leak test, if there is a leak in more than four per 1,000 condoms, the entire lot is discarded. 50ml of water is filled into the condom and the end is gently squeezed for visual evidence of leakage.
- Tensile strength, elongation at break and tensile set test ensures that latex used in condoms is of a good quality and will not rupture.



- Laboratory studies show that sperm and disease-causing organisms (including HIV) cannot pass through intact latex condoms.

Condom promotion is necessary as an effective workplace HIV/AIDS prevention programme.

Education: The advantages of using a condom in prevention of STIs and HIV/AIDS, its quality, imparting usage skills through demonstrations should be done as part of the workplace education programme for STI/HIV/AIDS. Some of the common barriers to condom use that are encountered during discussing the need for promoting condom usage are as follows:

Addressing barriers to condom use

- **Condoms reduce sexual pleasure:** Sexual pleasure is a psychological experience of a physiological sensation as well as the thoughts, expectations and other emotions attached to sex. Amongst other factors, pleasure would depend on the relationship between the partners, their expectations, the novelty of the experience, the setting of the sexual activity, the degree and length of foreplay, and level of fatigue or freshness. Even with the same partner the same degree of pleasure may not be experienced every time. Also, the condoms now available are so thin that they do not in any way decrease sexual arousal or pleasure. Condoms should rather be seen in the context of providing protection from STI/HIV, enabling a person to enjoy sexuality for a longer time, free from the fear of getting any infections.

- **Condoms break and are not reliable:** The condoms now available are of good quality, handling them carefully and wearing it correctly, not using more than one condom at a time, using water based lubrication greatly reduce the chances of breaking. If the quality of the condom is ensured, and if the breakage occurs, it is more of a problem of usage. Properly, expelling the air matters a lot in reducing the chance of breaking.

- **Too shy to buy a condom:** It can be very difficult task to buy condoms. It is a public declaration of a private activity. We only overcome this shyness with practice. There are easier places to get condoms. However, you may find it easier to go to shop where you are not known. Some government clinics give them out for free; your doctor may sell condoms. A local community group focusing on health may also distribute them It may help you to be courageous if you think of why you are buying them. Condoms protect you from disease and pregnancy. Would it not be more embarrassing to get pregnant/ get someone pregnant by accident? Would you not feel shy about having to go to a clinic if you got STI/HIV? Feeling shy at the chemist is nothing compared to all this.

Availability: Condoms can be made available as part of the HIV prevention programme. Workplaces can access the need and accordingly set up condom outlets (even mud pots can be used as outlets) and condom vending machines at places that are accessible and where people do not hesitate to pick up. Creating condom friendliness among the workers, addressing the stigma attached to the topics of sex and sexuality, addressing the barriers to condom usage and replenishing the stocks from time to time are some of the critical points to be kept in mind while implementing Condom Education/Promotion.

Positive points about condoms:

- Condoms are reliable method of disease prevention and birth control
- Condoms have none of the medical side effects of other methods
- Condoms don't interfere with the way a woman's body works
- Condoms can be bought easily and do not require prescription
- Condoms help to prevent the spread of sexually transmitted infections including HIV
- Condoms help to provide protection from cancer of the cervix
- Condoms make sex a lot less messy. You don't have to argue about who sleeps on the wet patch and the woman does not have to put up with the sticky, wet, drippy feeling after sex
- Condoms can be checked after sex if they have been used properly
- Men can take responsibility for disease prevention.



Diagnosis and Treatment of Sexually Transmitted Infection (STIs):

Diagnosis and treatment of sexually transmitted Infections (STIs) can be an effective measure in preventing the spread of HIV, the virus that causes AIDS. An understanding of the relationship between STIs and HIV infection can help in the development of effective HIV prevention programmes for persons with high-risk sexual behaviours.

Link between STIs and HIV Infection:

- Individuals who are infected with STIs are at least two to five times more likely than uninfected individuals to acquire HIV infection if they are exposed to the virus through sexual contact. In addition, if an HIV-infected individual is also infected with another STI, that person is more likely to transmit HIV through sexual contact than other HIV-infected persons (Wasserheit, 1992).
- The predominant mode of transmission of both HIV and other STI agents is sexual, although other routes of transmission for both include blood, blood products, donated organs or tissue, and from infected mother to her child.
- Many of the measures for preventing the sexual transmission of HIV and other STI agents are the same.
- There is a strong association between the occurrence of HIV infection and the presence of certain STIs (Genital ulcer disease 10 times more chances, Genital discharges 3 times more chances) making early diagnosis and effective treatment of such STIs an important strategy for the prevention of HIV transmission.
- STI clinical services are an important access point for people at high risk of contracting both AIDS and other STIs, not only for diagnosis and treatment but also for education and counselling.
- STI prevalence rate in a community is a good indicator of the effectiveness of any HIV prevention program effort.
- There is substantial biological evidence demonstrating that the presence of other STIs increases the likelihood of both transmitting and acquiring HIV.

- **Increased susceptibility:** STIs appear to increase susceptibility to HIV infection by two mechanisms. Genital ulcers (e.g., syphilis, herpes, or chancroid) result in breaks in the genital tract lining or skin. These breaks create a portal of entry for HIV. Additionally, inflammation resulting from genital ulcers or non-ulcerative STIs (e.g., Chlamydia, Gonorrhea, and trichomoniasis) increases the concentration of cells in genital secretions that can serve as targets for HIV (e.g.; CD4+ cells).

- **Increased infectiousness.** STIs also appear to increase the risk of an HIV-infected person transmitting the virus to his or her sex partners. Studies have shown that HIV-infected individuals who are also infected with other STIs are particularly likely to shed HIV in their genital secretions. For example, men who are infected with both Gonorrhea and HIV are more than twice as likely to have HIV in their genital secretions as are those who are infected only with HIV. Moreover, the median concentration of HIV in semen is as much as 10 times higher in men who are infected with both Gonorrhea and HIV than in men infected only with HIV. The higher the concentration of HIV in semen or genital fluids, the more likely it is that HIV will be transmitted to a sex partner.

Need for STI treatment to slow down the spread of HIV infection: Evidence from intervention studies indicates that detecting and treating STIs may reduce HIV transmission.

- STI treatment reduces an individual's ability to transmit HIV. Studies have shown that treating STIs in HIV-infected individuals decreases both the amount of HIV in genital secretions and how frequently HIV is found in those secretions (Fleming, Wasserheit, 1999).
- Herpes can make people more susceptible to HIV infection, and it can make HIV-infected individuals more infectious. It is critical that all individuals, especially those with herpes, know whether they are infected with HIV and, if uninfected with HIV, take measures to protect themselves from infection with HIV.



- Failure to diagnose and treat STIs at an early stage may result in serious complications like infertility, fetal wastage, ectopic pregnancy, anogental cancer and premature death, as well as neonatal and infant infections. The individual and national expenditure on STI care can be substantial.

WHO classifies the STI into seven Syndromes:

i) Urethral Discharge; ii) Vaginal Discharge;
iii) Genital Ulcer includes Herpes; iv) Inguinal Bubos in men and in women;
v) Scrotal swelling; vi) Lower abdominal Pain;
vii) Neo Natal Conjunctivitis.

Common symptoms of STI in men	Common symptoms of STI in Women
▪ Discharge or pus from the penis ▪ Sores, blisters, rashes or boils on the penis ▪ Lumps on or near the genital area or penis ▪ Swelling in the genital area ▪ Pain or burning during urination ▪ Itching in and around the genital area	▪ Unusual and foul smelling discharge from the vagina ▪ Sores, blisters, rashes or boils around the genitals ▪ Pain in the lower abdomen ▪ Lumps on or near the genital area ▪ Pain or burning during the sexual intercourse ▪ Itching in and around the genitals

Diagnosis and Treatment of STIs: Most of the STIs are curable with a course of treatment from a qualified medical doctor. Diagnosis and treatment for STIs, focus on treatment compliance and counselling, become part of the comprehensive HIV prevention programme.

The key factors in complete cure of STIs are :

- Compliance of treatment for the full course: Usually the treatment may be for a period of 7 - 14 days depending on the type and extent of the infection, the medication should be taken regularly even after the symptoms disappear, as advised by the doctor.
- Partner notification or treatment: Partner Notification in STI treatment means that the sexual partner is also referred to the doctor for the same treatment. This is very important to prevent reoccurrence of the infection from the untreated partner.
- Condom use: it is suggested that the person should avoid having sex during the treatment and correct and consistent use of condom for all the sexual activities is a must.

Ideas for the enterprises:

- The medical and paramedical staff needs to be trained in Syndromic Case Management of STIs.
- Enterprises could set up referral linkages with nearby government or non-government health services for STI treatment.
- Health camps could be organized at workplace. Caution needs to be taken to sensitize the health care service providers to deal with the patients ensuring adequate confidentiality and privacy.



Gender Dimensions of HIV/AIDS

According to UNAIDS, at the end of 2011, out of 34 million total number of people living with HIV/AIDS, 30.6 million are adults of which 17 million are women. In India, 39% of total 2.09 million estimated PLHIV are women. While it is widely assumed that marriage provides protection from HIV, evidence suggests that in parts of the world it can be a major HIV risk factor, especially for young women and girls.

Gender inequality and violations of women's rights make women and girls particularly susceptible, leaving them with less control than men over their bodies and their lives. Women and girls access to prevention messages is hampered by illiteracy, they have fewer resources to take preventive measures, a state affecting more women than men world wide. Many women experience sexual and economic subordination in their marriages or relationships and are therefore unable to negotiate safe sex or refuse unsafe sex. The power imbalance in the workplace exposes women to the threat of sexual harassment. In many cases, HIV-positive women face stigma and exclusion, aggravated by their lack of rights. Women widowed by AIDS or found to be HIV-positive may face property disputes with in-laws. And regardless of whether they themselves are HIV-positive, women generally assume the burden of home-based care for others who are sick or dying, along with the orphans left behind.

Vulnerability of women is because of:
Physiological susceptibility:

- The vaginal walls of women have large surface area, which aid in collection of fluids that can facilitate in the transmission of HIV. On the other hand surface area on the penis is small thus cannot collect fluids
- Walls of cervix and vagina are thinner and are easily torn thus the micro pores can allow easy passage to the virus.
- Women have higher chances of getting Reproductive Tract Infections
- Most often women suffer from Sexually Transmitted Infection, which are asymptomatic and do not get treated.

Socio-cultural reasons:

- There is unequal access to education and economic resources.
- They enjoy less power than men in social and sexual relations.
- Women are more likely to experience rape, sexual coercion, sometimes forced to sell or exchange sex for their economic gain and survival
- Laws and policies that prevent women from owning land, property and other productive resources often support gender-related discrimination. This promotes women's economic vulnerability to HIV infection, limiting their ability to seek and receive care and support.
- Women with HIV infection also often experience more social blame and stigma than men in the same position.
- In addition to their own increased risk of HIV, women also carry the social burden of the epidemic, in terms of providing care for relatives with AIDS.

Thus gender inequality is a key driver of the HIV epidemic in several ways.

- **Gender norms related to femininity can prevent women especially young women from accessing HIV information and services.** Only 38% of young women have accurate, comprehensive knowledge of HIV/AIDS according to the 2008 UNAIDS global figures.
  HIV/AIDS programmes can address harmful gender norms and stereotypes including by working with men and boys to change norms related to fatherhood, sexual responsibility, decision-making and violence, and by providing comprehensive, age-appropriate HIV/AIDS education for young people that addresses gender norms.

- Violence against women (physical, sexual and emotional), which is experienced by 10 to 60% of women (ages 15-49 years) worldwide, increases their vulnerability to HIV. Forced sex can contribute to HIV transmission due to tears and lacerations resulting from the use of force. Women who fear or experience violence lack the power to ask their partners to use condoms or to refuse unprotected sex. Fear of violence can prevent women from learning and/or sharing their HIV status and accessing treatment. Programmes can address violence against women by offering safer sex negotiation and life skills training, helping women who fear or experience violence to safely disclose their HIV status, providing comprehensive medico-legal services to victims of sexual violence, and working with countries to develop, strengthen and enforce laws that eliminate violence against women.
- Gender-related barriers in access to services prevent women and men from accessing HIV prevention, treatment and care. Women may face barriers due to their lack of access to and control over resources, child-care responsibilities, restricted mobility and limited decision-making power. Programmes can improve access to services for women and men by removing financial barriers in access to services, bringing services closer to the community, and addressing HIV-related stigma and discrimination, including in health care settings.
- Women assume the major share of care-giving in the family, including for those living with and affected by HIV. This is often unpaid and is based on the assumption that women "naturally" fill this role. Programmes can support women in their care-giving roles by offering community-based care and support, including by increasing men's involvement.
- Lack of education and economic security affects millions of women and girls, whose literacy levels are generally lower than men and boys'. Many women, especially those living with HIV, lose their homes, inheritance, possessions, livelihoods and even their children when their partners die. This forces many women to adopt survival strategies that increase their chances of contracting and spreading HIV. Educating girls makes them more equipped to make safer sexual decisions. Programmes can promote economic opportunities for women (e.g. through microfinance and micro-credit, vocational and skills training and other income generation activities), protect and promote their inheritance rights, and expand efforts to keep girls in school.
- Many national HIV/AIDS programmes fail to address underlying gender inequalities. In 2008, only 52% of countries who reported to the UN General Assembly included specific, budgeted support for women-focused HIV/AIDS programmes.HIV/AIDS programmes should collect and use sex and age disaggregated data to monitor and evaluate impact of programmes on different populations, build capacity of key stakeholders to address gender inequalities, facilitate meaningful participation of women's groups, women living with HIV and young people, and allocate resources for programme elements that address gender inequalities.
  Source: www.who.int/gender

Gender equality and HIV/AIDS in the world of work

Some specific steps can be taken to address gender inequality in the context of HIV/AIDS:

- Workplace programmes for prevention and care should be gender-sensitive. Education and training are essential to changing attitudes, behaviour, and rules governing workplace and personal relationships between men and women.
- Work patterns should be avoided which separate workers from their families for prolonged periods. Problems are experienced where, for example, mine workers are living in single-sex hostels and are unable to live with their families. Even if these working patterns are difficult to change, conditions can at least be improved - facilities for rest and recreation could be provided as well as family accommodation.
- Employers' and workers' organizations can ensure that there is zero tolerance for violence and harassment against women at work. Procedures for complaints by women should be simple and support should be made available. Trade unions should make it clear to union members that this is regarded as a trade union issue. Employers should make it very clear that violence or harassment is a disciplinary offence.



Tuberculosis and HIV

Tuberculosis (TB) is a disease caused by a bacterium which usually attacks the lungs. Tuberculosis is normally abbreviated to TB. TB is caused by **Mycobacterium tuberculosis**. The bacterium can cause disease in any part of the body, but normally enters the body through the lungs and resides there. From there, the bacterium moves through the blood to other parts of the body such as the kidney, spine and the brain. When the bacteria are in the lungs and throat they can be infectious. TB in other parts of the body, such as the kidney or spine, is usually not infectious.

1. What is the difference between latent TB infection and TB disease?

A person infected with TB does not necessarily feel ill. Such cases are known as 'latent' infections'. At this stage, the person is said to have TB infection. When the lung disease becomes active and symptoms become prominent, we say the person has TB disease. People with latent TB do not feel ill, do not have symptoms and cannot spread TB. If they develop TB disease later, then they can spread it if it is not promptly treated. When TB bacteria become active because the immune system has become weak due to any reason, the bacteria multiply and cause disease.

Table showing the difference between Latent TB and TB disease.

A person with Latent TB Infection	A person with TB Disease
• Has no symptoms	• Has symptoms
• Does not feel sick	• Usually feels sick
• Cannot spread TB bacteria to others	• May spread TB bacteria to other
• Usually has a skin test or blood test result indicating TB infection	• Usually has a skin test or blood test result indicating TB infection
• Has a normal chest x-ray and a negative sputum smear	• May have a abnormal chest x-ray, or positive sputum smear or culture
• Needs treatment for latent TB infection to prevent active TB disease	• Needs treatment for active TB disease

2. How does TB spread?

TB is spread from an infectious person to a vulnerable person through air. Like the common cold, TB is spread through droplets after infected people cough, sneeze, speak, or laugh. People nearby, if exposed long enough, may breathe in bacteria in the droplets and become infected. People with TB of the lungs are most likely to spread bacteria to those with whom they spend time every day, including family members, friends and work colleagues. This is one reason why TB is a workplace issue.

3. How does TB not spread?

TB is spread through the air. People cannot get infected with tuberculosis bacteria through handshakes, sharing on toilet or sharing dishes, utensils and tables with someone who has tuberculosis.

4. How soon after exposure do TB symptoms appear?

Most persons infected with TB bacteria never develop TB disease because of their strong immune system. If TB disease does develop, it can occur 2 to 3 months after infection or years later. The chances of TB infection developing into TB disease lessen with the passage of time.

5. What are the symptoms of TB?

When the lung infection by Mycobacterium tuberculosis becomes 'active' (TB disease) the symptoms include the following:

- cough (more than 2 or 3 weeks),
- weight loss,
- loss of appetite,
- fever,
- night sweats,
- coughing up blood,
- weakness or fatigue,
- chills.

6. What is extra-pulmonary TB?

Extra-pulmonary TB affects other parts of the body outside the lungs example: lymph nodes, brains, kidneys or bones. In general it is more difficult to diagnose extra-pulmonary TB. Diagnosis may often require invasive procedures to obtain diagnostic specimen and more sophisticated laboratory techniques than sputum microscopy.

7. What is pulmonary TB?

Pulmonary TB is TB which affects the lungs. This is the more common form of TB. Pulmonary TB is also the infectious form of TB.

8. How is TB diagnosed?

The primary diagnostic test to confirm the most infectious form of pulmonary TB is sputum smear microscopy. Chest X-ray is also important and will often detect pulmonary TB. While large employers may have on-site health facilities for TB diagnosis (sputum smear microscopy and X-ray) or outsourcing arrangements for referral of TB suspects for diagnosis, many smaller employers will directly refer TB suspects for diagnosis at the nearest health facility.

9. Is TB curable?

TB is curable. It can also be cured in people living with HIV. DOTS is the internationally recommended strategy to control TB. It is important that people with the disease are identified as early as possible so that they can start treatment promptly. Contacts can also be traced for investigation for TB and measures can be taken to minimize the risk to others. It is however important to state that some strains of bacteria have now acquired resistance to one or more of the antibiotics commonly used to treat them; known as drug-resistant strains. There are more expensive medicines capable of treating drug-resistant forms of TB.

10. What is the duration of treatment for TB?

In most cases, TB disease can be cured with anti-TB drugs. To be effective, the drugs must be taken exactly as prescribed. Treatment usually involves a combination of several different drugs. Because TB bacteria des very slowly, anti-TB drugs must be taken for 6 months or longer.

11. What is DOTS?

DOTS or Directly Observed Treatment Short course is the internationally recognized strategy for TB control. It has been recognized as highly efficient and cost-effective. The five components of DOTS are:

- Political commitment with increased and sustained financing



- Case detection through quality-assured bacteriology
- Standardized treatment with supervision and patient support
- An effective drug supply and management system
- Monitoring and evaluation system and impact measurement

12. How do we promote treatment adherence?

A checklist for the successful promotion of adherence to treatment includes the following:

- Service and medication are offered free of charge and have guaranteed supply
- Directly observed treatment in the workplace should be in a private room to preserve confidentiality and comfort
- The TB treatment supporter who directly observes treatment must be acceptable to the patient
- The TB treatment supporter must be well trained and supervised
- The DOTS appointment is organized so as not to disrupt the patient's daily routine

13. Who is at risk & contracting TB?

Some people are at an increased risk to contracting TB. This includes:

- Babies and young children, often with weak immune systems
- People living with HIV
- People involved in substance abuse
- People with diabetes
- People with silicosis
- People with cancer of the head or neck
- People with Hodgkin's disease
- People with severe kidney disease
- People with low body weight
- People on specific treatments such as immuno-suppressant medication (example corticosteroid treatment)
- Elderly people
- People living and/or working in cramped conditions

14. What can I do to stop the spread of TB if I'm infected?

- Take your medicine.
- Always cover your mouth with a tissue when you cough, sneeze, or laugh. Put the tissue in a closed paper sack and throw it away.
- Do not go to work or school. Separate yourself from others and avoid close contact with anyone. Sleep in a bedroom away from other family members.
- Air out your room often (if it is not too cold outside), TB spreads in small closed spaces where air doesn't move. Put a fan in your window to blow out air that may be filled with TB bacteria. If you open other windows in the room, the fan also will pull in fresh air. This will reduce the chances that TB bacteria stay in the room and infect someone who breathes the air.

NOTE: Think about people who may have spent time with you, such as family members, close friends, and **co-workers**. The local health department may need to test them for TB infection.

15. What is MDR-TB?

Multi-drug resistant 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 drugs for MDR-TB are mismanaged, further resistance can occur.

16. What causes MDR-TB?

Drug resistance is more common in people who:

- Were not prescribed with correct medication
- Spent time in the presence of someone with MDR-TB
- Do not take their TB medication regularly
- Do not take all their TB prescription medication
- Take the wrong medication
- Take the wrong dose of their TB medication
- Take poor quality TB medicines

17. Can MDR-TB be cured?

Yes, MDR-TB is curable with second line TB medicines if taken as prescribed and the course completed. It is worth noting that second line TB medication is taken over a longer period and has more side effects.

18. What is the link between TB and HIV?

HIV/AIDS and TB are so closely interrelated that the term 'co-epidemic' or 'dual-epidemic' is often used to describe their relationship. The intersecting epidemic is denoted as TB/HIV or HIV/TB. HIV promotes the progression of latent TB to active disease and the relapse of the disease in previously treated patients. Each disease speeds up the progress of the other and TB considerably shortens the survival of people living with HIV. People who are HIV positive and infected with TB more likely to develop active TB in a given year than people who are HIV negative. HIV infection is the most potent risk factor for converting latent TB into active TB, while TB bacteria accelerate the progress of AIDS infection in the patient. Many people infected with HIV in developing countries develop TB as the first manifestation of AIDS. The two diseases represent a deadly combination, since they are more destructive together than either disease alone. Additionally,

- TB is harder to diagnose in HIV-positive people.
- TB progresses faster in HIV-infected people.
- TB in HIV-positive people is almost certain to be fatal if undiagnosed or left untreated.
- TB occurs earlier in the course of HIV infection than many other opportunistic infections.

19. What is the impact of TB and HIV on the workplace?

The impact of TB and HIV on the workplace may include any the following:

- Loss of skills and experience
- Disruption of workflow
- Reduction of productivity
- Increase in direct cost (treatment and care)
- Increase in indirect cost (replacement and retraining of workers)
- Increase in absenteeism
- Reduction in profits and investment

The impact of TB and HIV on the workplace is significant. TB/HIV workplace programmes thus make business sense as they contribute towards reducing the impact and sustaining the profitability of businesses.

20. How is the workplace positioned to effectively address TB and HIV?

The workplace is specifically suited to address TB/HIV because of the following:

- It provides access to a large number of workers (who spend a lot of time at work)



- Workers have the opportunity to attend regular sessions at work
- The workplace has communication systems in place which could be used to address TB/HIV
- The workplace has existing structures in place which could be used to address TB/HIV
- The workplace may have onsite clinic facilities available for prevention, treatment, care and support
- Companies have analytical processes useful in the battle against HIV/AIDS

21. What are some of the risk factors to TB in the workplace?

Some workplaces or some sectors could facilitate the spread of TB more than others due to certain associated risk factors. Workers in workplaces with the following characteristics are likely to be more at risk to TB infection:

- Workplaces where workers work in cramped conditions with overcrowding.
- Workplaces with very poor ventilated areas
- Workplaces in locations with high TB and/or HIV prevalence
- Workplaces where workers have poor diets and poor nutritional status leading to low immunities
- Workplaces where workers have high levels of stress
- Workplaces where workers have poor health care and poor access to health care facilities
- Workplaces where workers live in cramped living conditions
- Workplaces with exposure to silica dust and silicosis
- Workplaces where workers are exposed to substance abuse
- Workplaces where workers are exposed to people with TB

The selection of workplaces for TB/HIV workplace programmes should be influenced by TB risk factors.

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

HIV/AIDS is dramatically fuelling the TB epidemic. In many countries of sub-Saharan Africa, up to 70% of TB patients are co-infected with HIV. For many years, efforts to tackle HIV and TB have been largely separate, despite the overlapping epidemiology. Improved collaboration between TB and HIV/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.

For further reference:

- ILO/WHO Guidelines for Workplace TB Control Activities (2003)
- WHO Interim Policy on Collaborative TB/HIV Activities (2004)
- WHO Strategic Framework to decrease the burden of TB/HIV (2002)
- Guidelines for implementing TB and HIV collaborative programme activities (2003)
- A step by step approach to integrating TB into existing HIV workplace programmes (ILO draft)

Legal and Ethical Issues surrounding HIV/AIDS

It is now well-accepted that the HIV/AIDS epidemic cannot be looked at solely from the perspective of medical science. It requires approaches that are holistic and includes social, cultural, economic and human rights perspectives. Protecting human rights is the key.

"In the spirit of decent work and respect for the human rights and dignity of persons infected or affected by HIV/AIDS, there should be no discrimination against workers on the basis of real or perceived HIV status. Discrimination and stigmatization of people living with HIV/AIDS inhibits efforts aimed at promoting HIV/AIDS prevention".

- Excerpts from The ILO Code of Practice on HIV/AIDS and the World of Work

HIV and Law in India

The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome Bill, 2014, has been passed by the Indian Parliament and it received Presidential assent on 20 April 2017. The HIV and AIDS (Prevention and Control) Act, 2017, was notified on e-gazette on 21 April 2017. The Act came into force on 10 September 2018.

The Act has been seen as a progressive step in terms of safeguarding rights of people living with HIV and those affected by it by mandating right to treatment (HIV/AIDS and OIs), right to health, right to vote, right to stand for elections, right to privacy, right to informed consent, right to property, right to speedy justice, right to reside, etc. The Act also envisages a robust grievance redress mechanism in form of Complaints Officer at establishments and Ombudsman at state level to look into complaints of discrimination.

The Act empowers a person living with HIV to report discrimination meted out against them in fields of employment, health care services, educational services, public facilities, property rights, holding public office, and insurance.

The Act penalizes "propagation of hatred" against the protected person where a violator could be punished with a minimum jail term of three months to a maximum of two years and can be fined up to one lakh rupees.

The Act makes Anti-Retroviral Treatment (ART) a legal right for all HIV/AIDS patients. It has also adopted "test and treat" policy which means any person testing positive will be entitled for free treatment by the state and central government. Earlier, this was restricted by a CD4 count rate.

It also provides for confidentiality of HIV-related information and makes it necessary to get informed consent for undertaking HIV tests, medical treatment and research.

The law makes it mandatory for state governments to appoint an Ombudsman to inquire into complaints related to the violation of the Act and the provision of health care services.

If a person or an institution fails to comply with any order given by the Ombudsman within the stipulated period of time, they could be fined a maximum of Rs 10,000. A continuous failure could lead to an additional fine of up to Rs 5,000 every day until they comply.

The new legislation has provisions to safeguard the property rights of HIV positive people. Every HIV infected person below the age of 18 years has the right to reside in a shared household and enjoy the facilities of the household.



रजिस्ट्री सं॰ डी॰ एल॰—(एन)04/0007/2003—17 REGISTERED NO. DL—(N)04/0007/2003—17

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इस भाग में भिन्न पृष्ठ संख्या दी जाती है जिससे कि यह अलग संकलन के रूप में रखा जा सके।
Separate paging is given to this Part in order that it may be filed as a separate compilation.

MINISTRY OF LAW AND JUSTICE
(Legislative Department)

New Delhi, the 21*st April,* 2017/*Vaisakha* 1, 1939 (*Saka*)

The following Act of Parliament received the assent of the President on the 20th April, 2017, and is hereby published for general information:—

THE HUMAN IMMUNODEFICIENCY VIRUS AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (PREVENTION AND CONTROL) ACT, 2017

No. 16 OF 2017

[20*th April,* 2017.]

An Act to provide for the prevention and control of the spread of Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome and for the protection of human rights of persons affected by the said virus and syndrome and for matters connected therewith or incidental thereto.

WHEREAS the spread of Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome is a matter of grave concern to all and there is an urgent need for the prevention and control of said virus and syndrome;

AND WHEREAS there is a need to protect and secure the human rights of persons who are HIV-positive, affected by Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome and vulnerable to the said virus and syndrome;

AND WHEREAS there is a necessity for effective care, support and treatment for Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome;

ILO Standards:



The First International Labour Standard on HIV and AIDS "The ILO Recommendation concerning HIV and AIDS and the World of Work, 2010 (No. 200)" was adopted by the member states of ILO in June 2010. Recommendation No. 200's broad scope protects every worker. All workers are protected by the new labour standard, including:

- All sectors of economic activity in the formal and informal economies
- Persons in training and interns, job applicants, job seekers and laid-off workers
- Armed forces and uniformed services

The rights established in Recommendation No. 200 are not restricted to persons living with HIV. They extend to all workers, their families and their dependants.

The principles of Recommendation No. 200 are built upon and reinforce the ILO code of practice on HIV/AIDS:

- The HIV response should be recognized as contributing to the realization of human rights, fundamental freedoms and gender equality for all.
- There should be no discrimination or stigmatization of workers on grounds of real or perceived HIV status.
- Prevention of all means of HIV transmission should be a fundamental priority.
- Workplaces should facilitate access to HIV prevention, treatment, care and support.
- Workers should be able to participate in the design, implementation and evaluation of HIV programmes.
- Prevention efforts should address specific risks of occupational transmission of HIV, tuberculosis and related diseases.
- Privacy and confidentiality should be ensured with regard to HIV status.
- There should be no mandatory HIV testing or screening for employment purposes.
- The workplace response should be a part of national policies and programmes, including those related to labour, education, social protection and health.

Other conventions that are particularly relevant in the context of HIV and AIDS at work include:

- Discrimination (Employment and Occupation) Convention, 1958 (No.111)
- 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); and
- Labour Inspection Convention 1947 (No. 81) and Labour Inspection (Agriculture) Convention, 1969 (no.129)

For more information:
Download the text of the ILO Recommendation concerning HIV and AIDS and the World of Work, 2010 (No. 200) and the Code of practice on HIV/AIDS and the World of Work, 2001 atwww.ilo.org/aids
Access the HIV and AIDS legislation and policies database at http://www.ilo.org/aids/legislation/lang--en/index.htm



Care and support of Workers Living with HIV

"Often the HIV infected person dies not because of his HIV status but because his right to medical treatment is denied." – worker living with HIV

ILO's approach to workplace Care and Support, as summarized in The ILO Code of Practice on HIV/AIDS and the World of Work:

"Solidarity, care and support are critical elements that should guide a workplace in responding to HIV/AIDS. Mechanisms should be created to encourage openness, acceptance and support for those workers who disclose their HIV status, and to ensure that they are not discriminated against nor stigmatized. To mitigate the impact of the HIV/AIDS epidemic in the workplace, workplaces should endeavour to provide counselling and other forms of social support to workers infected and affected by HIV/AIDS. Where health-care services exist at the workplace, appropriate treatment should be provided. Where these services are not possible, workers should be informed about the location of available outside services. Linkages such as this have the advantage of reaching beyond the workers to cover their families, in particular their children. Partnership between employers and governmental and non-governmental organizations also ensures effective delivery of services and saves costs".

Comprehensive care
The ILO emphasizes that comprehensive care and support involves a range of services, responding to the needs of workers with HIV/AIDS for treatment, for material and psychosocial support, and for protection against discrimination and rejection:

Non-discriminatory workplace policy on HIV/AIDS:
Employers can demonstrate their commitment to providing equal treatment by having a policy on HIV/AIDS and ensuring the policy is implemented. Education and training programmes aimed at key staff such as human resource personnel, medical and supervisory staff will enable provision of care and support in a non-discriminatory manner. Workplace education and information campaigns should be undertaken to dispel myths and fears and remove stigma and discrimination against a HIV positive employee.

(a) HIV infection and clinical AIDS should be treated in the workplace no less favourably than any other serious illness or condition.
(b) Workers with HIV/AIDS should be treated no less favourably than workers with other serious illnesses in terms of benefits, workers' compensation and reasonable accommodation.
(c) As long as workers are medically fit for appropriate employment, they should enjoy normal job security and opportunities for transfer and advancement.
- ILO Code of Practice on HIV/AIDS and the world of work

Job security, promotion and training
Workers who are medically fit should not suffer discrimination either in terms of job security or opportunities for training or promotion. Workers who become HIV-positive can remain well for many years. They may contract an infection, which is successfully treated, and return to medical fitness. With ART (Antiretroviral Therapy), life expectancy and quality of life can improve dramatically. Even if it is only possible to offer treatment for opportunistic infections, and help to ensure adequate rest and a healthy diet, these measures will help to prolong life and extend a worker's ability to remain productive. Threatening job security or denying promotion is unfair and also robs the workplace of skilled employees able to make a real contribution for many years ahead.

Voluntary counselling and testing (VCT) is an important starting point for both prevention and care: Provision for voluntary testing accompanied by counselling should be provided to the workers. This

should normally be carried out by the community health services and not at the workplace. Enterprises can set up referral linkages with the nearby voluntary counseling and testing centre and inform the workers about the availibilty and accessibilty of testing facility closest to them. This can be done through the workplace HIV/AIDS education programme. In enterprises were adequate medical services exist. Public Private Partnerships with the State AIDS Control Society can be established for setting up ICTCs that can cater to the employees, their families and the community around the establishment. Here too, the national guidelines for voluntary counselling and testing should be followed where testing should take place with the informed consent of the worker after understanding the implications of taking a test. It should be performed by suitably qualified personnel with adherence to strict confidentiality and to disclosure requirements.

Disclosure and confidentiality
Voluntary disclosure of one's HIV status has many consequences and can only be a personal decision. The right to privacy is a basic human right. Confidentiality at the workplace means that a person infected with HIV has full control over decisions about if and how his or her colleagues are informed. Employees may choose not to disclose their status at work for fear of stigmatization by the employer or fellow workers. In a safe and decent workplace, where employees are educated about HIV and where discrimination is prohibited, people living with HIV are far more likely to be open about their status.

Reasonable accommodation:
The Employer can make practical adjustments to assist workers with an illness or disability to manage their work. Measures will vary with different workplaces but might include: reducing or rescheduling working hours; modifying tasks or changing jobs; adapting the work environment; providing more or longer rest periods; granting employees time off for counselling and other services. As with other working conditions, it is best if reasonable accommodation is defined in any particular workplace by agreement between management and unions or workers' representatives. It is important that other workers see reasonable accommodation as providing necessary care not favourable treatment. In countries with a high level of HIV infection there will be a greater need to think creatively as to how the needs of employees with HIV/AIDS and the demands on the company can both be met through reasonable accommodation measures.

Treatment
Employers and workers' representatives are both encouraged to take a proactive approach to counselling and Treatment and make sure that HIV-positive employees have access to professional counselling in the workplace or, preferably, outside it. General information on medical services and support groups should also be made available.Companies should extend these services to respond to the needs of people living with HIV/AIDS, including the provision of antiretroviral drugs. Where health services exist at the workplace these should offer, in cooperation with government and all other stakeholders, the provision of antiretroviral drugs, treatment for the relief of HIV-related symptoms, nutritional counselling and supplements, stress reduction and treatment for the more common opportunistic infections including STIs and tuberculosis.

Self-help and community groups
Where appropriate, employers, workers' organizations and occupational health personnel should facilitate the establishment of self-help groups within the enterprise or the referral of workers affected by HIV/AIDS to self-help groups and support organizations in the local community.Where there are well-resourced self-help groups in the community, then referring workers may be the best solution. Unions and management could consider helping to set up such groups in the workplace as an alternative way of providing support where they are needed. Financial support for community groups could also be provided.

Employee and family assistance programmes
Employee Assistance Programmes (EAPs) are programmes which provide counselling for employees on a broad range of personal, health and legal issues. They can provide an effective framework for



workplace health promotion services. EAPs vary among workplaces and countries - such flexibility enables them to cater for the specific requirements of individual companies and regions. Family assistance programmes involve ways of assisting the families of employees cope with their disease or dependency. A comprehensive family assistance is usually beyond the reach of an individual employer, but could be provided through collaboration between a number of different stakeholders, including local health authorities, community-based organizations and self-help groups.

In a low prevalance country like India, the enterprises have not seen the impact of HIV on workforce and their businesses. However, they are now becoming increasingly aware of the socio-economic impact of HIV at the household level. It is in the best interest of businesses to have a preparedness plan for workers, if detected positive. This can include:

- Developing and implementing a workplace policy on HIV-assuring non-discrimination.
- Setting in place a workplace HIV education programme based on peer education approach.
- Provision of counseling for workers living with HIV.
- Counseling of workers' families and co-workers.
- Medical support as per the enterprise norms; (this can include reimbursing the cost of the drugs; extend necessary medical care for hospitalization, treatment of OIs and CD4 test etc…). Companies should pick up the cost of treating their direct employees where as avail treatment from government for the contractual and supply chain workers.
- The company should orient all the master trainers and peer educators to the nearby testing and treatment facilities through exposure visits. This will increase the comfort level of workers to seek testing and disclose their HIV status so that they get timely support from the company.
- Referral linkages with the agencies working on the care and support programmes, particularly the SACS and network of HIV positive people can also be set up. More information about the networks can be seen at the website of Indian Network of People Living with HIV at ***http://www.inpplus.net and information about NACO/SACS facilities can be seen at www.naco.gov.in***



WHO Guidelines on AIDS and First aid in the workplace

(Reference: Your health and safety at work: A collection of modules, Bureau of workers activities, ILO)

HIV transmission
HIV has been isolated from many body fluids of infected persons. However, only blood, semen, vaginal and cervical fluids, and breast milk have been implicated in transmission of the virus. Epidemiological studies throughout the world have shown that there are three modes of transmission of HIV:

- Sexual intercourse (heterosexual or homosexual) and use of donated semen;
- Exposure to blood, blood products, or donated organs; exposure to blood is principally through the transfusion of unscreened blood or the use of unspecialized contaminated syringes and needles by intravenous drug users;
- From infected mother to foetus or infant, before, during or shortly after birth (perinatal transmission).

There is considerable evidence that HIV cannot be transmitted by the respiratory or gastrointestinal routes or by casual person-to-person contact in any setting (such as school, household, social, work, or prison). Nor is HIV transmitted via insects, food, water, toilets, swimming-pools, sweat, tears, shared eating and drinking utensils, or other agents such as clothing or telephones.

HIV has not been shown to be transmitted in the workplace except in health care or research laboratory settings. The few reported cases of HIV transmission to health care workers have resulted from exposure to the blood of an HIV-infected patient as a result of needle stick injury, blood or broken skin, or splashing of blood into the eyes or mouth (mucous membranes.) Although accidents such as these occur with some frequency of health care settings, they have only rarely led to HIV infection of health care workers.

In addition to HIV, other serious infections, such as hepatitis B and non-A non-B hepatitis can be transmitted by blood.

HIV transmission and the first aid:
In relation to HIV transmission, the major concerns in first aid are mouth-to-mouth resuscitation and the management of bleeding, two situations where contact with the body fluids of another person may occur.

a) Mouth-to-Mouth Resuscitation:
A worker who is unconscious and no longer breathing spontaneously (for example because of a heart attack, an electric shock or a blow to the head) may require mouth-to-mouth resuscitation. Resuscitation must be started immediately. Mouth-to-mouth resuscitation is a life saving procedure and should not be withheld through fear of contracting HIV or other infection.

HIV transmission from mouth-to-mouth resuscitation has not been reported. Although HIV has been found in saliva, it is present in extremely small quantities and no cases have been reported in which transmission has been shown to occur through saliva.

There is a theoretical risk that HIV could be transmitted is the person in need of resuscitation is bleeding from the mouth. First aiders should use a clean cloth or handkerchief, when available, to wipe away any blood from the person's mouth.

Mouthpieces, resuscitation bags, or other ventilation devices should only be used by people specially trained to use them. They are not recommended for use by general first aiders as incorrect use may lead to further injury and bleeding. The absence of such equipment should not be used as a reason to withhold mouth-to-mouth resuscitation.



b) Bleeding:
Workers who are bleeding require immediate attention. The first aider must not hesitate to help them as some wounds may be life threatening. Whenever feasible, the first aider should instruct the person bleeding to apply pressure to the wound himself or herself, using a clean cloth. If he or she is unconscious or uncooperative, or if the wound is too large or is located in a place the person cannot reach, the first aiders should apply pressure on the wound with a clean cloth or another barrier avoiding direct contact with the blood. Gloves should be used if available; if not available, another barrier such as cloth should be used to prevent skin contact with blood. If the first aiders' hands are contaminated with blood, he or she should take care not to touch his/her own eyes or mouth.

Cleaning up blood spills:
Spilt blood should be soaked up with absorbent material such as cloth, rag, paper towel, or sawdust, direct skin contact with the blood being avoided. The blood-soaked absorbent material should then be disposed of in a plastic bag, burnt in incinerator, or buried. The area contaminated should be washed with a disinfectant Household bleach. Rubber hand gloves should be worn if available when spilt blood is being cleaned up. Another barrier such as large wad of paper towels should be used to avoid direct contact with the blood. Hands should always be washed with soap and water after cleaning up blood or any body fluids. Clothes that are visible with contaminated blood should be handled as little as possible. Rubber household gloves should be worn if available, and the clothes or cloths should be placed in and transported in leak proof bags. They should be washed with detergent and hot water (at least 70 degree C (160 degree F) for 25 minutes; or if in cooler water (less than 70 degrees C (160 degrees F,) with a detergent suitable for cold water washing.

Additional measures
First aiders should be careful with broken glass and other sharp objects that may be in the accident area. They should also ensure that any open cuts or wounds they have are covered to prevent exposure to blood while they are providing first aid.

Workers who have been exposed to blood
If the guidelines given here are adhered to, the risk of acquiring blood borne infection, including HIV, will be significantly reduced. Even so, it is not possible to guarantee that exposure will not occur. Workplaces should therefore develop policies to meet those situations where first aiders are injured or are exposed to blood while administering first aid.

If first aiders are exposed to blood on skin that is not intact, they should wash the affected area with soap and water as soon as possible. Exposed mucous membranes should be washed with water.

A first aider who is injured by a sharp object that is contaminated with blood (e.g. a used needle) should encourage bleeding, wash the wound thoroughly with soap and water, and if appropriate, apply a dressing. To determine whether further action is needed, the injury should be assessed for the type and severity of the wound puncture, surface or deep laceration, contamination of non-intact skin or mucous membrane and for the extend to which the wound may be contaminated with blood.

Obviously, the more severe the wound the greater the concern should be, not only for HIV infection but for all blood borne infections. The decision whether additional evaluation is necessary should be made by the first aider jointly with the health care provider concerned.

In rare instances, a first aider may sustain injuries of sufficient severity to warrant further investigation, including assay of the first aider's blood for HIV and other infections such as Hepatitis B.

If a first aider requests HIV antibody testing, this should be performed as soon as possible after the exposure. If the initial test is negative, follow up testing should be performed three and six months later. In the interim, counseling should be available to the first aider and should deal with the low risk of acquiring infection as well as the first aider's concerns. He or she should be counseled on the need to

prevent possible transmission of intravenous drugs, and pregnancy. If a worker becomes HIV antibody positive at any point, continuing counseling should be provided. If the test immediately after the exposure is positive, it cannot be a result of the exposure; the person must have been infected with HIV previously. He or she should be referred for counseling, which should include advice on how to prevent transmission of HIV.

Training in first aid

First aid training provides an opportunity to disseminate accurate information on HIV infection and AIDS to members of the community. People who receive training in first aid will subsequently be able to further disseminate accurate information within the community.

First aid training in the workplace should include clear instruction on the ways in which HIV is and is not transmitted. This is especially important, since the myths surrounding this topic may interfere with potentially life-saving first aid measures.

First aid training should emphasize that, even after perinatal exposure to HIV-infected blood, the risk of acquiring infection is extremely low, about one in 250 exposures. First aiders should be taught the precautions needed to avoid contact with blood or body fluids, since such precautions significantly reduce the risk of blood borne infection.

First aid is generally given to alleviate suffering and in a spirit of compassion. This should be stressed. The first aider should be urged to weigh the extremely small and so far theoretical risk of acquiring HIV infection in providing first aid against the benefit gained by the person receiving first aid.

A number of organizations in many countries train large number of first aiders both within and outside the workplace. Employers should be encouraged to utilize the expertise of those organizations in planning first aid training courses of first aid interventions within the workplace.



Trade Unions and HIV

The immediate impact of HIV is on the workers and their families, who lose income and employment benefits, and face stigma and discrimination. Thus HIV has emerged as a serious issue for the world of work as it shows its its effect on workers and their families; enterprise performance and national economies.

Need for unions to be concerned about HIV/AIDS:

- As the representatives of workers, trade unions are in a special position of trust and leadership.

- Trade unions are the key actors at the workplace and well placed to work in arresting the spread of HIV/AIDS in collaboration with employers. Since they share the same background as the people they represent, their messages and their educators are likely to be more trusted and accepted.

> Employers and workers' organizations should develop and implement an appropriate policy for their workplace, designed to prevent the spread of the infection and protect all workers from discrimination related to HIV/AIDS.
> - Excerpts from The ILO Code of Practice on HIV/AIDS and the World of Work

- Traditionally, trade unions have a history to promote and protect the rights and dignity of workers, ensure safe and healthy working conditions, combat discrimination, promote access to fair income, provide social protection and participate in social dialogue on national issues that affect employment and human resources.

- In the light of the HIV epidemic and its consequences on the working people and their families, communities and workplaces, trade unions can play a major role.

Role of trade unions in HIV/AIDS programmes:

Trade unions can do the following at the workplaces:

- Raise education and awareness: Unions can collaborate with the employers' HIV/AIDS programmes in developing and implementing HIV prevention and care programmes for workers.
- Assist the management in implementing the policy on HIV/AIDS
- Work on reducing HIV related stigma and discrimination and protecting rights of workers living with HIV.
- Integrate HIV/AIDS in their education and training efforts by developing a cadre of HIV/AIDS trainers/peer educators.

** If an enterprise would like to make a presentation to a group of trade unions, a presentation on Trade Unions and HIV is included in the DVD which can be utilised.

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Handouts

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List of Handouts

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ILO Card Game Questions & Answers on HIV and AIDS

1. **How is AIDS different from other serious illnesses?**
   AIDS is different from other illnesses because:
   - It affects people at the most productive age (15-49 yrs.)
   - AIDS is incurable at the moment, particularly killing productive and younger people.
   - There are no specific symptoms in the initial years. So, the HIV infection goes unnoticed for several years.
   - HIV infection is preventable.
   - Stigma and discrimination associated with HIV and AIDS hinders with the prevention as well as care and support efforts.
   - It predominantly spreads through sexual contact. Sexual behaviour being in private domain, people don't want to talk about it. Discussion on sex is a taboo in most societies. Hence, correct information does not reach people.
   - We all need to know about HIV and AIDS as it can happen to anyone.
   - Everyone can play a role in prevention of this infection

2. **What is HIV and how does it affect us?**
   HIV stands for:
   - H= Human
   - I = Immuno-deficiency
   - V= Virus

   HIV, after entering the human body, gradually destroys the immune system, i.e. the ability to fight infections/diseases.
   As it is a human virus, it can survive and multiply only in the human beings.

   - Generally, there are no immediate and specific symptoms of HIV infection.
   - HIV infection does not mean that a person has AIDS.

3. **What is AIDS?**
   AIDS stands for:
   A = Acquired
   I = Immuno
   D = Deficiency
   S = Syndrome.

   - AIDS is caused by HIV, the Human Immunodeficiency Virus.
   - AIDS is the advanced and later stage of infection with HIV. It is a condition in which a group of symptoms appear as the immune system becomes very weak.
   - It may take around 10-12 years from the stage of HIV infection to the stage of AIDS. This time varies from person to person, based on health status, life styles and ability to afford the treatment.
   - With the introduction of Anti-Retroviral Therapy (ART), this duration can be further increased.
   - HIV infected people can live productive lives for years.
   - Life span of People Living with HIV can be extended with the ART.

4. **How is HIV transmitted?**
   HIV can be transmitted through:
   - Unprotected sex with an infected person;
   - Transfusion of infected blood or blood products;
   - Use of contaminated needles or syringes/injecting euipment
   - From a mother living with HIV to her child – during pregnancy, during delivery or as a result of breast feeding.

- These are the only four known routes of HIV transmission. This is because the concentration of HIV is high in blood, semen, vaginal secretions and breast milk.
- HIV does not spread through social contacts like: shaking hands, sharing equipment, eating from the same utensils, sharing toilets etc.

5. Can kissing lead to HIV infection?

- Kissing is a low-risk activity, as the concentration of HIV is very low in saliva.
- HIV is not casually transmitted, so kissing on the cheek is very safe. Even if the other person has the virus, unbroken skin is a good barrier. No one has become infected from social contact such as dry kisses, hugs, and handshakes.
- Prolonged open-mouth kissing could damage the mouth or lips and allow HIV to pass from an infected person to his/her partner(s).
- Kissing in presence of bleeding gums or ulcers in mouth can be risky.

6. How can a person avoid being infected through sex?

A person can avoid being infected by HIV through sex by:
A - Abstaining from sex; or
B - Being in a mutually faithful relationship with one partner; or
C - Using condoms correctly and consistently

- Casual sex and sex with multiple partners increases the vulnerability to exposure to infections, including HIV.
- Anal penetrative sex has a higher risk. Oral sex can also be risky.
- By looking at a person we cannot know his/her HIV status. Avoid casual sex or use condom consistently and correctly.
- Avoid sex under the influence of alcohol and drugs.

7. What is Sexually Transmitted Infection (STI)? Is there a connection between HIV infection and other STIs?

- Sexually Transmitted Infection (STI) can be caused by virus/bacteria etc. As the name indicates, STIs can be transmitted from one partner to another through sexual contact including vaginal intercourse, oral and anal sex.
- Some STIs can be transmitted through blood/blood products and from mother to child during pregnancy and child birth.
- Presence of STI can increase a person's risk of both acquisition and transmission of HIV from 3 to 10 times, depending upon the nature of STI.
- STIs may cause discharge from the genitals or sores/ulcers on the genital areas. These conditions provide easy entry point to the HIV.
- STIs can be cured while HIV infection cannot be. So, timely treatment of STIs is essential.
  People have several myths about STIs. They need to know the symptoms of STIs and take treatment from a qualified doctor.
- Use of condoms protects from both STIs as well as HIV infection.

8. What are the symptoms of STI in men and women?

STI symptoms in men:

- Discharge or pus from the penis
- Sores, blisters, rashes or boils on and around the penis
- Swelling in the scrotum and genital area
- Pain or burning during urination
- Itching in and around the genital area

STI symptoms in women:

- Unusual and foul smelling discharge from the vagina
- Sores, blisters, rashes or boils around the genitals
- Pain in the lower abdomen
- Lumps on or near the groin or genital area
- Pain or burning during sexual intercourse



- Itching in and around the genital area

Most of the STIs are curable with treatment, it is important to:

- Know the symptoms and take immediate treatment.
- Take the full course of prescribed treatment, even if the symptoms disappear.
- Get the partner(s) treated as well, as sexual partner(s) may also have the same infection.
- Use condoms during the treatment and during every sexual intercourse.

9. How can we prevent from getting infected through infected blood, needles and syringes?

The risk of HIV transmission is high from contaminated blood/blood products/injecting equipment therefore;

- In case of injury/surgery/illness requiring blood transfusion, blood should be taken from a licensed blood bank. All blood collected for donation is now tested for HIV.
- Health care providers are required to take standard precautions to prevent exposure to infection.
- People should insist on use of sterilized/disposable syringes for injection.
- Injecting Drug Users should avoid sharing of used needles/syringes as it may be contaminated.
- To prevent HIV infection through blood, both individuals as well as health care providers must take precautions.
- There is no risk in donating blood.

10. Is there a risk of HIV in going to a barber shop?

- There may be a possibility of risk in any situation in which skin piercing instruments are used, like in a barber's shop, beauty salons, tattooing, nose and ear piercing etc.
- HIV is a fragile virus i.e. it cannot survive when exposed to heat, detergent or disinfectant.
- Centre for Disease Control, Atlanta, recommends that instruments that are used to penetrate the skin should be used once then disposed of or thoroughly cleaned and sterilized to avoid any possibility of a risk in situation in which skin piercing instruments are used like in a barber's shop, beauty salons, tattooing, nose and ear piercing etc.

11. Can HIV spread through mosquitoes?

- Mosquito does not inject its own or previously bitten person's blood into the next person.
- Mosquito injects saliva, which acts as a lubricant so the insect can feed efficiently.
- HIV is not found in the saliva of mosquitoes.
- Diseases such as yellow fever and malaria are transmitted through the saliva of specific species of mosquitoes, but not HIV.
- In simple terms, mosquito does not become a carrier of HIV after biting an infected person. Therefore, mosquito does not transmit the HIV infection from person to person.

12. How can the HIV infection from mother to child be prevented?

- There is 25-40% chance that a mother living with HIV would pass on the infection to her child. HIV may be transmitted during pregnancy during delivery or as a result of breast feeding.
- If the couple knows their status, they could decide whether or not to have the child.

- In case couple wants to have the child or it is a very late discovery of mother's status, the couple should receive information, and counselling and services as part of the PPTCT programme which include
  - Provision of appropriate ART/ARV to the mother and new born child, as required.
  - Institutional delivery of all HIV infected pregnant women.
  - Counselling and support for infant breastfeeding and options available.
- Mother to child transmission of HIV can also be prevented.
- The couple needs to know the available options and act upon them.

13. What are the Symptoms of AIDS?

AIDS is a condition of weakened immune system. In this condition symptoms of various opportunistic

infections caused by HIV infection appear causing certain cancers, tumours, tuberculosis, pneumonia, brain and skin related problems.

According to WHO, main signs/symptoms are:
Major Signs:

- Unexplained Weight loss (> 10% of body weight)
- Unexplained Persistent fever for longer than a month
- Unexplained Chronic diarrhoea for longer than a month

Minor Signs:

- Persistent cough
- General itchy skin diseases
- Thrush in mouth and throat
- Recurring shingles (herpes zoster)
- Long lasting swelling of the lymph glands
- Only on the basis of symptoms,HIV and AIDS cannot be confirmed. A blood test is necessary.

14. How does one find out his/her HIV status? What are the different tests for HIV?

- The HIV status of a person can be known through blood test.
- The commonly available test: Rapid test/Eliza (Enzyme Linked Immuno Sorbent Assay) is based on detecting antibodies against HIV. Additionally, the Western Blot test is also available as a confirmatory test.
- The testing facilities are available both in private and government medical set-up.
- Integrated Counselling and Testing Centres (ICTC) are set up in Government Hospitals where free HIV testing, accompanied by pre and post-test counselling is available.

As per the policy of Government of India:

- HIV test should be voluntary;
- Test result should be kept confidential; and
- Testing should be done along with pre and post-test counselling.

15. What is window period in the context of HIV Testing?

- Our immune system produces antibodies to fight any infection. Window period is the time taken by the human body to produce antibodies in the quantity that it can be detected through blood test.
- It takes about 3-12 weeks (up to 6 months in some cases) after HIV infection to form antibodies in detectable quantity.
- In simple terms, window period it is the period in which a person is infected but his/her test result does not show it.
- During window period the HIV status does not show in the test but the person can infect others.

16. Is there a treatment available for HIV and AIDS?

- There is no cure available for HIV and AIDS at the moment; however a person infected with HIV can live a long and productive life with Anti-Retroviral Therapy (ART).
- These drugs are expensive but are available without cost at Government Hospitals. They may cause side-effects
- Once stated Anti-Retroviral drugs have to be taken lifelong.
- The ART need to be administered under supervision of doctors who are trained in HIV case management
- ART is not a cure but it greatly enhances the quality of life of PLHIV.
- ART is available in India. Information about availability/government programme on ART can be taken from the respective State AIDS Control Societies: or for more information visit the AIDS National AIDS Control Organization at www.naco.gov.in

17. Is it safe to work with a HIV positive person?

- It is safe to work with a HIV positive person as HIV does not spread through social contacts like shaking hands, sharing equipment, travelling in the same vehicle, eating together, using the same toilets etc.



- Mosquitoes and insects do not spread HIV, nor is it spread through water or air.
- Even healthcare workers like the doctors or paramedical workers, who come in contact with the body fluids, need not panic. They should follow Standard Precautions and infection control measures like gloves, masks, etc.

HIV positive person pose no risk to his/her co-workers.

18. What should be the elements of HIV and AIDS policy/programme at the workplace?

- HIV status of a person should not be a criterion for either employing people or keeping them in employment.
- There should be no discrimination of People Living with HIV and AIDS.
- HIV status of people should be kept confidential.
- Workplace should have HIV prevention, care and support programme.
- As women are more vulnerable and HIV affects women more adversely, the gender dimension should be suitably addressed.
- International Labour Standard, "Recommendation concerning HIV and AIDS and the World of Work, 2010 (No.200)" and the ILO Code of Practice on HIV/AIDS and the world of work provide guidance for developing national policies. Refer to www.ilo.org/hivaidsindia.
- The Ministry of Labour & Employment in India and National AIDS Control Organization have developed the "National Policy on HIV/AIDS in the world of work", based on the ILO Code of Practice. Refer to http://labour.nic.in/policy/nationalpolicy-on-HIV-AIDS.pdf

19. What support can we give to a Person Living with HIV (PLHIV)?

- We should not isolate an HIV positive person, as he/she does not pose any risk to us through social contacts. We can work, eat as well as live with the person.
- We should not pass moral judgments on the person.
- We should work for reducing stigma and discrimination related to HIV and AIDS by spreading correct information, dispelling myths and having a positive attitude towards the infected person (s).
- We should support the person in staying active and economically productive.
- We should respect the human rights of people living with HIV and provide the necessary care/affection and support to the family.
- Non-discriminatory attitude towards PLHIV helps in HIV prevention efforts.
- People can live with HIV infection for years. They need care and support, not isolation.

20. What did you learn and how can you play a role in fighting HIV?

- HIV affects our immune system. AIDS is the later stage of infection when different illnesses show up
- HIV generally goes unnoticed in the initial years
- HIV spreads in four ways
- HIV does not spread through social contacts, mosquitoes, working together or living together.
- We learnt that HIV can be prevented
- HIV testing is available for free in ICTC in our nearest government hospitals
- Even though AIDS is fatal, ART can prolong and greatly enhance the quality of life of an infected person.
- We learnt that people can live with HIV infection for years. They need care and support, not isolation.
- We can play a role in prevention of HIV by sharing information and providing our support to People living with HIV and AIDS.



Basics of HIV and AIDS

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What is HIV and AIDS?

HIV : Human Immuno-deficiency Virus
(Gradually affects our immune system, i.e. the ability to fight infections/diseases)

AIDS

A - Acquired
I - Immuno
D - Deficiency
S - Syndrome

- A condition caused by deficiency in body's immune system due to HIV.
- It is a syndrome: a group of symptoms of various illnesses

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Routes of transmission of HIV

- **Unprotected sexual intercourse with an infected person**
  - Both men and women at risk
  - Women more at risk
  - Risk increases further in the presence of STIs
  - Anal intercourse - higher risk
- **Transfusion of infected blood/blood products**
  - Fastest rate of transmission
  - Can happen through blood transfused or use of unsterilized infected needles / syringes

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Routes of transmission of HIV contd……

- **Sharing of Infected needles/syringes**

  Small amounts of contaminated blood left in needles or syringes can carry the HIV virus from user to user. Among IDUs, transmission occurs by sharing drug paraphernalia.
- **From infected mother to the baby**
  - During pregnancy in womb;
  - During birth; and
  - Post- delivery through breast milk

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How HIV does not spread?

- HIV does not spread by **normal social contact**
  - Shaking hands
  - Living together in the same house / hostel
  - Sharing clothes/towels
  - Sharing toilets
  - Eating together
  - Through mosquitoes bite
- **Sharing equipment** (telephone, typewriters, computers, machines etc.) or through the **mosquito bite**
- **Kissing**
  - Does not spread by social kissing as viral load in saliva is low
  - In the presence of ulcers in the mouth or bleeding gums - deep kissing or French kissing can lead to transmission

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Progression from HIV infection to stage of AIDS

Normal Healthy Individual

↓

Gets infected with HIV

↓

WINDOW PERIOD (3-12 weeks or even 6 months)
(Antibodies to HIV not yet developed, test does not capture the real status but person can infect others)

HIV Positive
(Development of antibodies, can be detected in test)
No exclusive symptoms (mild fever or flu like features in some cases)

↓

May take up to 10 to 12 years to reach the stage of AIDS, the period can be prolonged through available treatment

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Major Signs / Symptoms of AIDS

(A) Major Signs:
- Weight loss (> 10% of body weight)
- Fever for longer than a month
- Diarrhea for longer than a month

(B) Minor Signs:
- Persistent cough
- General itchy skin diseases
- Thrush in mouth and throat
- Recurring shingles (herpes zoster)
- Long lasting, spreading and severe cold sores
- Long lasting swelling of the lymph glands
- Loss of memory
- Loss of intellectual capacity
- Peripheral nerve damage

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Origin of HIV

After a series of different theories, Scientists identified a type of chimpanzee in West Africa as the source of HIV infection in humans.

(When humans hunted these chimpanzees for meat they came in contact with their infected blood).

The Simian Immunodeficiency Virus (SIV) jumps species and mutates in humans to be HIV.

Over several years, the virus slowly spread across Africa and later into other parts of the world.

Source: Centre of Disease Control and Prevention: www.cdc.gov

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How does one find his/her HIV status?

- Blood Test (Elisa/ Western Blot)
- Testing is available in Government Hospitals/Integrated Counseling and Testing Centers (ICTC)/private labs
- Window period

  (the period it takes for the human body to recognize HIV and produce antibodies to HIV, it may take around 3 weeks to six months)

GOI policy on HIV Testing:
- Testing should be voluntary
- Testing should be with pre and post test counseling
- Test results should be kept confidential

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Treatment for HIV and AIDS

- AIDS is still incurable but treatment to prolong life available, called Anti Retroviral Treatment (ART- a combination of three drugs)
- HIV positive person does not need ART immediately
- With ART, life can be prolonged substantially
- ART is available in government centres
- Basic ART costs around Rs.1000 per month, may be more depending upon the person's condition
- ART is life long, treatment adherence is the key as well as training of doctors

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The AIDS logo demonstrates:



- **Care and concern** about HIV and AIDS for those who are living with HIV, for those who are ill, for those who have died and for those who care for and support those directly affected.
- **Hope** that the search for a vaccine and cure to halt the suffering will be successful.
- **Support** for those living with HIV, for the continuing education of those not infected, for maximum efforts to find effective treatments, cures or vaccines, and for those who have lost friends, family members or loved ones to AIDS.

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HIV and AIDS scenario and Indian Response

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HIV and AIDS - Global scenario

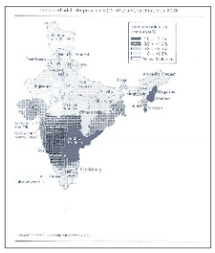
According to UNAIDS in the year 2011:

- 34 million estimated infections (3.4 million children less than 15 years of age)
- 17 million women (50% of the total global population of people living with HIV and AIDS)
- Sub-Saharan Africa accounts for 69% of all people living with HIV and AIDS.
- Since the start of epidemic, 75 million (63 million–89 million) people have been infected with HIV.
- HIV and AIDS is the leading cause of death in Sub-Saharan Africa, with nearly 1 in every 20 adults living with HIV.

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HIV and AIDS in India

- An estimated 2.09 million (20.9 lakh) people living with HIV and AIDS
- Adult HIV prevalence is 0.27% with 86% infections from the age group 15-49 years.
- Prevalence rate of 7.14%, in IDU, 4.43% in MSM, 0.99% in Migrants, 2.59% in Truckers and 2.67% in FSW.
- Priority to 156 category A districts (122 in six high prevalence states; and 34 in low burden states of North India.
- 39 Category B districts (five in TN, and rest 34 in low burden states.



Source: UNAIDS and NACO

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HIV and AIDS scenario in India and major trends

- 2.09 million estimated infections in India in year 2011
- Nearly 86% of infections reported from the most productive age group of 15-49 years
- Bridge population (Long Distance Truckers and High Risk Migrants) is the conduit of infection from High Risk Groups to general population
- 77% of transmission through sexual route
- Epidemic is spreading fast from High risk groups to general population
- Epidemic is spreading from men to women
- Epidemic is spreading from urban to rural areas

Please update regularly from www.naco.gov.in

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Some of the factors attributed to the spread of HIV in India

- Lack of correct knowledge
- Low literacy levels, low awareness
- Predominantly driven sexually, yet discussion on sex and sexuality is a taboo
- Gender disparities
- Poverty
- Migration
- High prevalence of STIs/RTIs (low health seeking behaviour)
- Inadequate/often delayed response to prevention, particularly by sectors other than health
- Prevailing stigma and discrimination around HIV and AIDS
- Low levels of voluntary testing

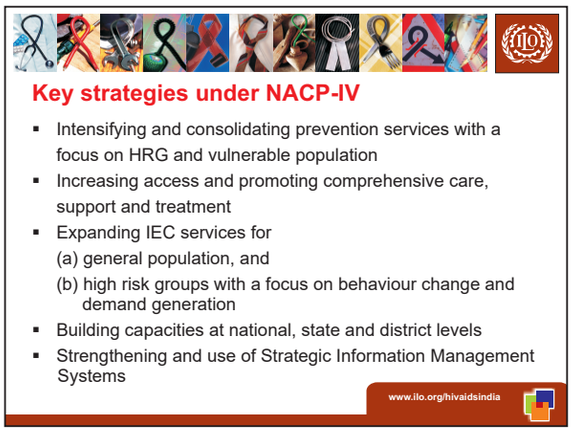
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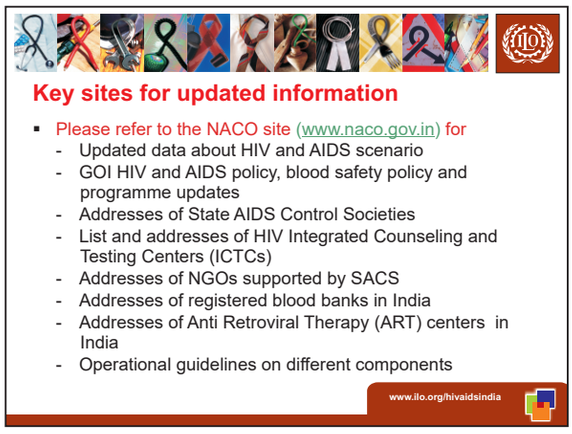
Indian response to HIV and AIDS

- National AIDS Control Organisation (NACO) is the apex level body within the Ministry of Health & Family Welfare, GOI, which plans and coordinates national response to HIV and AIDS
- First phase of National AIDS Control Programme (NACP) began in 1992 and continued till 1999.
- At present, India is in the Phase IV of NACP (2012-2017)
- State AIDS Control Societies (SACS) are the nodal agencies at the state level who receive support from NACO and work in collaboration with different agencies.
- Resources for the national programme are mobilized from GOI, World Bank, Bilateral/donor agencies and the UN agencies.
- The GOI has developed an AIDS policy.

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Key strategies under NACP-IV
Intensifying and consolidating prevention services with a focus on HRG and vulnerable population
Increasing access and promoting comprehensive care, support and treatment
Expanding IEC services for
(a) general population, and
(b) high risk groups with a focus on behaviour change and demand generation
Building capacities at national, state and district levels
Strengthening and use of Strategic Information Management Systems
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Key sites for updated information
Please refer to the NACO site (www.naco.gov.in) for
- Updated data about HIV and AIDS scenario
- GOI HIV and AIDS policy, blood safety policy and programme updates
- Addresses of State AIDS Control Societies
- List and addresses of HIV Integrated Counseling and Testing Centers (ICTCs)
- Addresses of NGOs supported by SACS
- Addresses of registered blood banks in India
- Addresses of Anti Retroviral Therapy (ART) centers in India
- Operational guidelines on different components
www.ilo.org/hivaidsindia


Key sites for updated information
UNAIDS site www.unaids.org for updated global scenario of HIV and AIDS and other relevant information
For updated information about the HIV and AIDS and world of work, ILO sites www.ilo.org/aids and www.ilo.org/hivaidsindia
www.ilo.org/hivaidsindia



Why are we talking about Behaviour Change Communication (BCC)?

Because

Knowledge and awareness does not always translate into safe sexual behaviour

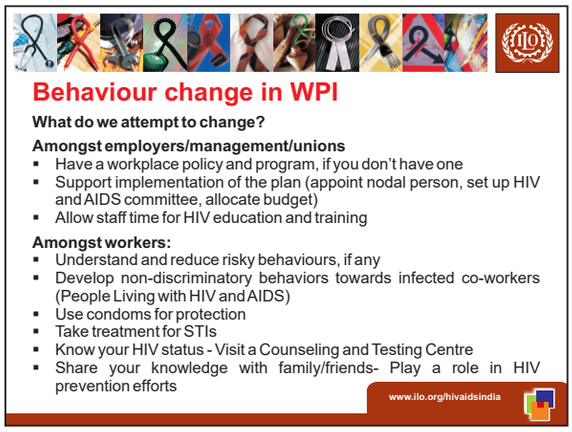
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Behaviour Change Communication

Behaviour Change Communication is a process of effecting individuals' behaviour change through effective Communication.

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Behaviour change in WPI

What do we attempt to change?

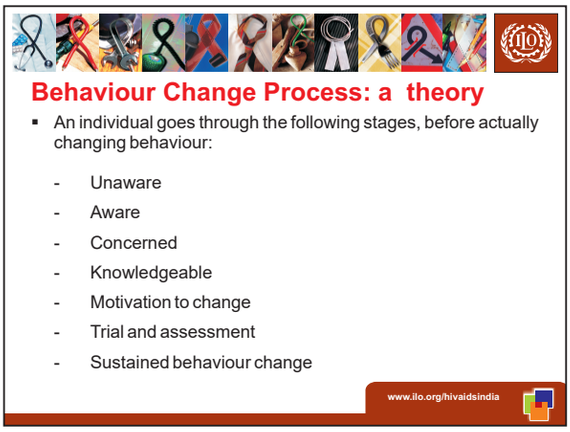
Amongst employers/management/unions

- Have a workplace policy and program, if you don't have one
- Support implementation of the plan (appoint nodal person, set up HIV and AIDS committee, allocate budget)
- Allow staff time for HIV education and training

Amongst workers:

- Understand and reduce risky behaviours, if any
- Develop non-discriminatory behaviors towards infected co-workers (People Living with HIV and AIDS)
- Use condoms for protection
- Take treatment for STIs
- Know your HIV status - Visit a Counseling and Testing Centre
- Share your knowledge with family/friends- Play a role in HIV prevention efforts

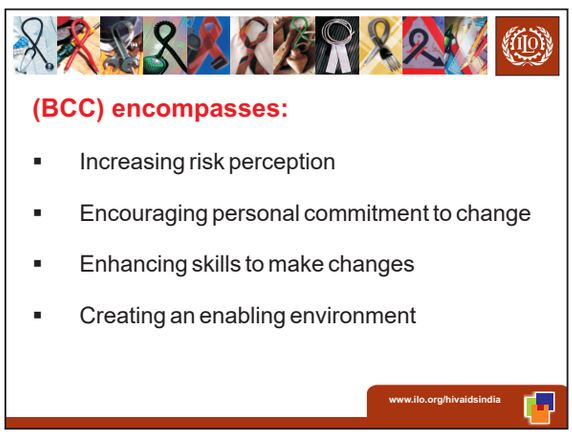
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Behaviour Change Process: a theory

- An individual goes through the following stages, before actually changing behaviour:
  - Unaware
  - Aware
  - Concerned
  - Knowledgeable
  - Motivation to change
  - Trial and assessment
  - Sustained behaviour change

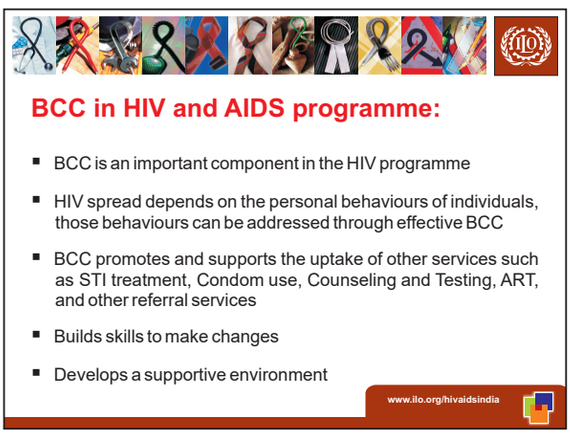
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(BCC) encompasses:

- Increasing risk perception
- Encouraging personal commitment to change
- Enhancing skills to make changes
- Creating an enabling environment

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BCC in HIV and AIDS programme:

- BCC is an important component in the HIV programme
- HIV spread depends on the personal behaviours of individuals, those behaviours can be addressed through effective BCC
- BCC promotes and supports the uptake of other services such as STI treatment, Condom use, Counseling and Testing, ART, and other referral services
- Builds skills to make changes
- Develops a supportive environment

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Some of the approaches of BCC:

- Most effective approach is the Interpersonal communication (one to one and small group informal discussions) sessions conducted by health educators, peer educators, etc.
- Use of small media - street theatre, folklore, etc
- Use of IEC materials

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Inter Personal Communication (IPC):

- To make the IPC session effective, the peer educator/ health worker should follow the points below:
  - should update the information from time to time on HIV and AIDS/STIs and services available
  - understand the target audience and their needs for information, and services and prepare the session as per the target audience' needs
  - demonstrate the respect for audience and create friendly atmosphere.
  - Deal with each topic separately and completely, do not give too much of information or too little information

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Continuation...

- Get the attention of the audience
- Create participatory atmosphere so that audience can ask questions and seek clarifications
- Take feedback
- Address key concerns and questions
- Use appropriate IEC materials
- Leave behind your contact details in case someone from the group would like to contact after the session in private.

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Efficacy of sessions depends on:

- Attitude of the service provider (Non judgmental, un-biased)
- Use of language (simple and non technical).
- Timing (when to start, when to finish)
- Rapport building
- Dealing with the noise (external and internal)
- Involvement of the target audience
- Proper use of materials
- Effective listening and observation
- Call for action and take feedback

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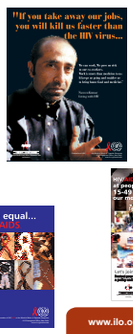
An orientation to IEC materials developed by ILO

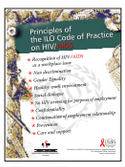
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A Set of Six Posters:

- Six posters on HIV and AIDS and the world of work in English, Hindi and regional languages
- Four posters for advocacy
- Two posters for creating awareness












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Posters replicated by INP+ with State level network members










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Card Game on HIV and AIDS

Card Game for use by Peer Educators/Master Trainers of Workplace Programmes.



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Employers' Statement of Commitment on HIV and AIDS

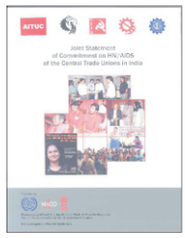
- The Indian Employers' Statement of Commitment was signed by Seven National level employers' organizations based on the ILO Code.
- Working paper is also attached



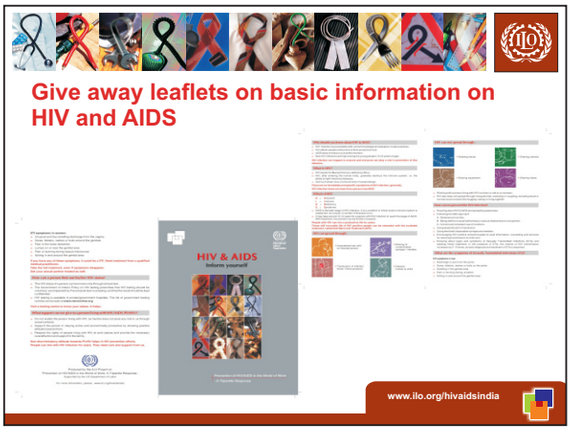
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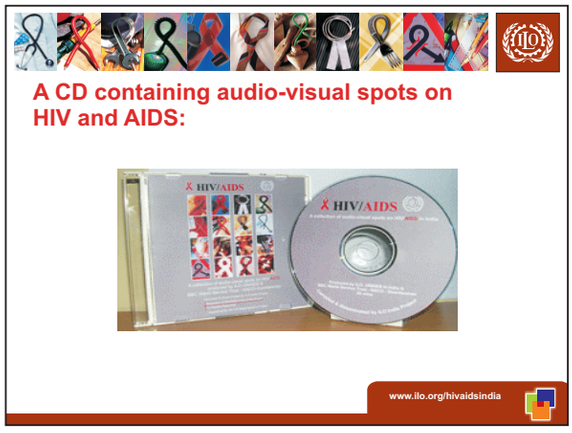
Joint Statement of Commitment on HIV and AIDS of the Central Trade Unions in India

- Five central trade unions came together and signed the joint statement of Commitment and was launched in August 2007.
- It contains the case studies of trade unions interventions with the informal sector workers also.



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Give away leaflets on basic information on HIV and AIDS
HIV & AIDS
Inform yourself
www.ilo.org/hivaidsindia


A CD containing audio-visual spots on HIV and AIDS:
HIV/AIDS
HIV/AIDS
www.ilo.org/hivaidsindia



Condom

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Condom

- A Condom is a thin sheath made of latex/plastic.
- Condom offer dual benefit:
  - prevents pregnancy by preventing sperm from entering the vagina
  - provides protection from STI and HIV by stopping transfer of the infected body fluids.

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Efficacy of condom

- Condoms substantially reduce the risk of HIV transmission, both in hetero & homo sexual contacts
- **Condoms** are only effective when used **consistently** and **correctly**

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Correct use of condom

- Check the expiry date
- Carefully open the condom package
- Squeeze out air by pinching the tip of the condom
- Put condom on erect penis before it touches any part of partner's body.
- If the condoms breaks, during sexual intercourse withdraw the penis immediately and put on a new condom before resuming.
- Withdraw the penis immediately after ejaculation, while the penis is still erect.
- Dispose carefully (wrap the used condom in a paper and throw it in a bin)

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Condom education

- Provide basic information about condoms, its efficacy and benefits
- Encourage audience to mention barriers in condom sue and address them, one by one
- Provide information about places from where condoms can be accessed.
- Provide skills to ensure correct use of condom
- Provide condom negotiating skills

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Condom programming at workplaces

- Provide condom education through peer educators (address barriers through IPC & impart skills to use)
- Organize events to promote condom use
- Set up condom outlets for free distribution
- Install condom vending machines
- Set up a system for condom procurement, storage and distribution

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Barriers to condom use
Condoms reduce sexual pleasure
Pleasure in sex depends upon a number of things: mood, convenience, relationship with the partner, health of partners, setting of the sexual activity, foreplay, level of fatigue or freshness etc.
Even with the same partner the same degree of pleasure may not be experienced every time.
Condoms available now and very thin and well lubricated.
Condoms provide protection from STI and HIV. Also from unwanted pregnancy.
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Barriers to condom use Contd..
Condoms break and are not reliable
Condoms available currently are of good quality, handling them carefully and wearing it correctly, not using more than one condom at a time, using water based lubrication greatly reduces the chances of breaking
If the quality of the condom is ensured, and if the breakage occurs, it is more of a problem of usage.
Properly, expelling the air, is very important in reducing the chance of breaking
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Barriers to condom use Contd..
Too shy to buy condoms
It can be a difficult task to buy condoms
There are easier places to get condoms
Some govt., clinics give them free of cost, the doctors may sell condoms
It may help to be courageous if you think why you are buying them. Condoms protects from disease and pregnancy
It would be more embarrassing to get/make pregnant by accident
It would be all the more embarrassing to go to STD clinic
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Sexually Transmitted Infections (STIs): Diagnosis and Treatment, Link with HIV

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Sexually Transmitted Infections (STIs):

- STIs- as the name suggests- are predominantly transmitted through sexual route
- Some STIs are transmitted through sharing of needles, syringes (syphilis, Hepatitis B/C, HIV)
- Transfusion of blood (syphilis, Hep B/C, HIV)
- Infected mother to child (syphilis, gonorrhoea, Hepatitis B/C, & HIV)

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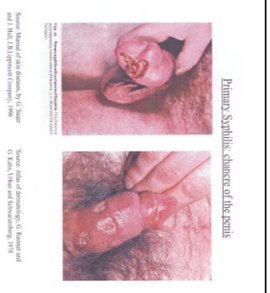
WHO classified STIs into Seven syndromes:

- Urethral Discharge syndrome
- Vaginal Discharge syndrome
- Genital Ulcer Syndrome
- Inguinal Swelling syndrome
- Lower Abdominal Pain
- Scrotal Swelling
- Neonatal conjunctivitis

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Symptoms in male:

- Genital ulcers, reddishness
- Itchy rashes, warts, blisters/ sores
- Burning/pain during urination, increased frequency of urination
- Flu like syndrome - fever, body ache, etc



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Symptoms continues

- Urethral discharge in male
- Thick pus like discharge



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Symptoms in women:

- Genital ulcers, warts,
- Unusual discharge from the vagina (foul smelling, yellow, frothy, curd like, pus like, blood tinged)
- Lower abdominal pain
- Painful intercourse
- Burning /itching around the vagina



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Complications of untreated STIs:

- Pelvic Inflammatory Disease (PID) - swelling of uterus, tubes, ovaries causing abdominal pain, vaginal discharge and fever
- Infertility (Male & female)
- Abortions, still birth, early childhood deaths
- Birth defects
- Cancer of the cervix
- Death due to sepsis, ectopic pregnancy
- Blindness

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Relationship between STI & HIV:

- Transmitted by the same route
- Presence of STI increase the chance of HIV transmission 3-10 times
- STI provide entry for the HIV to enter the blood stream
- Same modes of prevention and same target audience
- STI may be more severe and more resistant to treatment in HIV Positive persons
- Most of the STIs except HIV & Hepatitis are curable

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STI Management:

- Grouping of symptoms and treating patients for all the causes of the syndrome
- Compliance of treatment for the duration prescribed
- Partner notification, partner also needs treatment
- Condom use

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Key Messages:

- Most of the STIs are curable.
- Identify the symptoms, and seek early treatment from a medical practitioners only
- Complete the course of treatment, it is not done, the infection will not be cured completely
- Get partner also treated so as to avoid re-infection from the partner
- Use condoms correctly and consistently

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Gender and HIV/ AIDS

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What is Gender?

- **Gender is the social construction of the biological differences between men and women**
- **Gender is not "Sex"**
- **Gender is not "Women"**
- **Gender is learned, socially determined behaviour**
- **Gender is a focus on the unequal relations between men and women**

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GENDER DETERMINES…

"MASCULINITY" AND "FEMININITY" (GENDER ROLES)

Roles, status, norms, values | **Responsibilities, needs, expectations** | **Sexuality and Sexual behaviour**

GENDER

THE DIVISION OF LABOUR, POWER AND RESPONSIBILITIES

THE DISTRIBUTION OF RESOURCES AND REWARDS

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Gender has a significant impact on

- Male and female sexual activity, vulnerability, and risk behaviour
- The transmission of HIV and AIDS in both heterosexual and homosexual relationships
- HIV impacts women much more. Women often face the double burden of taking care of the ailing husband and earning for the family after the death of husband.

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Women are more vulnerable to HIV

A. Physiological factors

- Soft tissue in the female reproductive tract tears easily, producing a transmission route for the virus;
- Vaginal tissue absorbs fluids more easily, which has a higher concentration of the HIV virus;
- Women are more likely have untreated STIs, a risk factor for HIV

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Women are more vulnerable to HIV

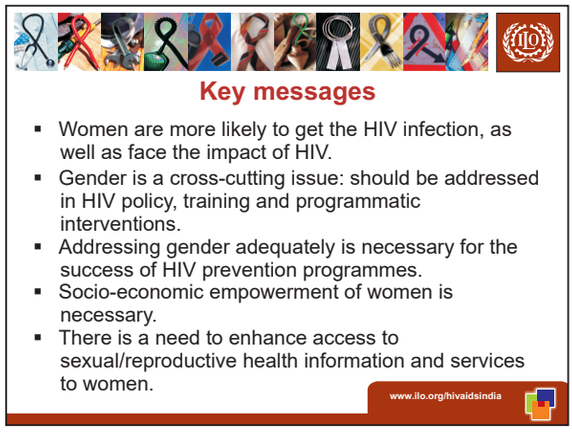
B. Socio-economic factors

- Due to lower socio-economic status, women often have lesser say in sexual matters.
- Women are not always empowered to discuss use of protection with their partner
- Women have lesser access to sexual health information and services
- Instances of rape also enhance women's risk to HIV infection.

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Mainstreaming Gender in HIV interventions
Advocacy to develop gender sensitive HIV polices and laws (*Gender equality is one of the ten principles of the ILO Code of Practice – to be included in the workplace policies).*
Gender training to stakeholders and trainers.
Having a gender balance in peer educators and development of gender-sensitive IEC materials.
Prevention with a special focus on women. *(e.g. Targeted interventions for female sex workers, mainstreaming HIV in programmes reaching women, e.g. ICDS)*
Prevention programme for Parent to Child transmission.
Access to women-controlled methods of protection (e.g. *Female Condom)*
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Key messages
Women are more likely to get the HIV infection, as well as face the impact of HIV.
Gender is a cross-cutting issue: should be addressed in HIV policy, training and programmatic interventions.
Addressing gender adequately is necessary for the success of HIV prevention programmes.
Socio-economic empowerment of women is necessary.
There is a need to enhance access to sexual/reproductive health information and services to women.
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Tuberculosis (TB) and HIV

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Overview of Tuberculosis

- More than 2 billion people, one third of the world's population are infected with TB bacilli.
- India accounts for nearly one-fifth of the annual new TB cases globally, one of the top five countries with the largest numbers of MDR-TB cases.
- Each year, there are almost 2 million TB-related deaths worldwide. In India 0.37 million deaths every year. TB is a leading killer of people with HIV.
- In India today, two deaths occur every three minutes from tuberculosis (TB). But these deaths can be prevented. With proper care and treatment, TB patients can be cured and the battle against TB can be won

Source: WHO Report 2009 Global Tuberculosis Control

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Tuberculosis (TB)

- TB-a communicable disease, caused by a bacteria called Mycobacterium tuberculosis
- TB spreads through air (when an affected person coughs, sneezes, spits, speaks or sings)
- It usually affects the lungs (pulmonary), but other body parts like kidneys, brain or spine (extra pulmonary) are also affected.
- Spreads from person to person

Information Source: Websites of Center for Disease Control, CDC, and World Health Organization, WHO

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Types of TB

Latent TB infection (LTBI)

- No symptoms
- Not sick
- Germs are not active
- Does not infect others
- Almost 40 % of Indians have TB infection

Active TB disease

- Sick
- Symptoms present
- Capable of spreading to others
- Coughing, sneezing, speaking, singing
- Germs survive in the environment

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Common Symptoms of TB

- Coughing/sneezing for more than 3weeks
- Chest pain
- Coughing up blood
- Weakness/fatigue
- weight loss
- night sweat
- Loss of appetite
- Fever

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Tests for TB

- A skin test or special TB blood test (to detect latent TB infection).
- Chest x-ray and a sputum test

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Treatment

- There is treatment for TB infection and also for TB disease
- For TB disease: Directly Observed Treatment, Short course (DOTS)

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What is DOTS?

- The Directly Observed Treatment, Short course (DOTS) is the key element in TB control strategy.
- DOTS ensures treatment
  - with the right drugs
  - in the right doses
  - at the right intervals
- A health-care worker meets the patient thrice a week.
- DOTS ensures treatment management and compliance.

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Duration of TB treatment

- TB bacteria grow very slowly. Antibiotics kill bacteria when they grow, so treatment of TB takes at least 6 months
- It is very important to comply with treatment prescription to avoid multi-drug resistant TB

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Why is TB and HIV co-infection dangerous?

- PLHIV get TB infection faster due to their compromised immune system.
- PLHIV with TB are 20-40 times more likely to develop active TB disease.
- 10-15% annual risk (60% lifetime risk) of developing active TB disease in PLHIV.
- Estimated 5% of TB patients are HIV infected
- TB infection progresses faster to the TB disease in PLHIV.
- People with TB and HIV infection may not respond to TB skin tests and their chest x-ray may look normal even if they have the TB disease.
- A person with HIV infection is more likely to develop TB outside the lungs. The symptoms may not be typical, delaying the diagnosis of TB disease and the treatment of TB disease.
- TB infection also makes the progress of HIV infection to AIDS faster.

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DOTS in the context of HIV

DOTS can:

- Prolong and improve the quality of life.
- Prevent emergence of Multi Drug Resistant TB (MDR-TB).
- Stop the spread of TB.
- Reverse the trend of MDRTB.

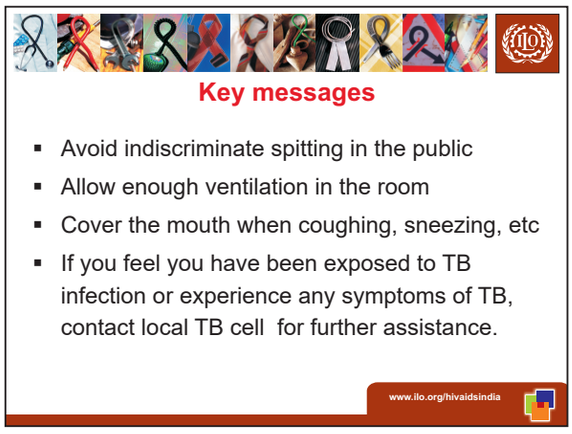
In the context of HIV, failure to use DOTS can result in rapid spread of disease, tripling of cases and increased drug resistance.

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Key messages

- TB is an air borne disease, spreads through cough, sneeze or spit
- TB infection can be latent for years. Detection requires blood and skin test.
- TB disease can be detected through chest X-ray and sputum examination.
- TB is curable. DOTS is the most effective way to treat.
- Full course of treatment is a must. Else it becomes drug resistant and incurable.
- PLHIV are more susceptible to TB.
- TB can be successfully treated even in PLHIV

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Key messages
Avoid indiscriminate spitting in the public
Allow enough ventilation in the room
Cover the mouth when coughing, sneezing, etc
If you feel you have been exposed to TB infection or experience any symptoms of TB, contact local TB cell for further assistance.
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Fighting HIV and AIDS related Stigma and Discrimination

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Ms. Mercy MAKHALEMELE addresses International Labour Conference, June 8, 2000

Mercy MAKHALEMELE addresses the International Labour Conference June 8, 2000

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Why Stigma & Discrimination:

- HIV and AIDS often seen from the moralistic lens - Only people with promiscuous/immoral behaviour get HIV and AIDS
- Due to ignorance- There are many myths about routes of HIV transmission

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Stigma & discrimination at workplace:

- Termination of services on the basis of HIV status
- HIV screening for recruitment and to remain in job
- Denial of promotion, benefits, opportunities etc.
- Non-cooperation by colleagues and management
- Forced early retirement

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A case of workplace discrimination



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Mr. Naveen Kumar



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ILO Study on socio-economic impact of HIV and AIDS

- Conducted by PLHIV networks in Delhi, Maharashtra, Manipur and Tamil Nadu
- Findings suggest that women (74%) faced more discrimination than men (68%)
- About 70% reported having faced discrimination
- Nearly 33% said they were discriminated by family followed by health care settings 32%
- Six percent reported having discriminated in workplace



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"After my family knew about my HIV status, they immediately kept my glass, plates, clothes, etc., separate and I was given a separate room."

A male respondent from Delhi

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"The hospital staff has given us a yellow card so that people can easily identify us as HIV+"

"The doctor asked my spouse to administer injection and saline fluids on his own"

"The remarks made by the hospital staff made me feel very ashamed"

- Women respondents from Tamil Nadu

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Discrimination at workplace:

- 6% reported discrimination at workplace. Could be higher as many did not disclose their HIV status to employers for fear of losing job
- Denial of promotion, voluntary retirement etc., were some of the forms of discrimination
- Discrimination by co-workers were also cited as main reason for changing jobs frequently (8%)
- Confidentiality norms are not being followed at workplaces

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Future concerns of PLHIV:

- Affordable anti-retroviral therapy and medicines
- Well being of children in the future
- Steady source of income and continued
- Employment
- Reduce HIV and AIDS related stigma & discrimination

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Key lessons:

- Fighting Stigma and discrimination is a good strategy for HIV prevention
- Integration of PLHIV helps the programme. Isolation is counter- productive
- Non-discriminatory workplace HIV and AIDS policy creates an enabling environment for PLHIV to access care and support services and encourages voluntary testing

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Trade unions and HIV and AIDS

Why and how to respond?

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AIDS estimates demand attention

- Globally 34 million People Living with HIV in 2012.
- 2.09 million in India at the end of 2011.
- HIV numbers do not give the true picture.
- A mere .1 % increase in prevalence rate amounts to 500,000 new infections in India.

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A WORKPLACE ISSUE

How does HIV/AIDS affect enterprises?

- Loss of skills and experience
- Reduces supply and increases cost of labour
- Falling productivity
- Reduced profit and investment

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HIV and AIDS: A world of work issue

How does HIV/AIDS affect workers?

- Loss of income and employee benefits
- Stigma and discrimination

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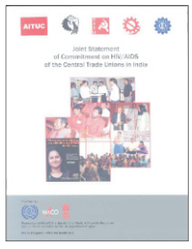
Discrimination at workplace- a case study

- Driver of a nationalized bank died of AIDS.
- Wife was also HIV+ but healthy and fit to work.
- Provision of offering job to dependant in Bank's rules.
- Wife was denied job because of her HIV status.
- Her in-laws demanded job for the younger brother, not for the wife
- Issues:
  Discrimination at workplace as well as from family/society.

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National Policy Framework

- Ministry of Labour and Employment (MOLE),GOI has developed a National Policy on HIV and AIDS and the World of Work.
- NACO has endorsed The ILO Code of Practice on HIV/AIDS and the World of Work.
- Indian Employers Statement of Commitment on HIV and AIDS launched.
- Joint Statement of Commitment of five Central Trade Unions finalized.



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Traditional roles of trade unions

- Protecting the rights of workers and combating discrimination
- Ensuring safe and healthy working conditions
- promoting access to fair income, social protection and basic health care to workers
- Participating in social dialogue on national issues affecting employment and human resources

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Role of trade unions in fighting HIV and AIDS

- Protecting the rights and dignity of those infected and affected by HIV and AIDS
- Prevention programmes on HIV and AIDS
- Care and support programmes on HIV and AIDS
- Understanding and managing the impact of HIV and AIDS
- Advocacy and partnerships
- Policy development

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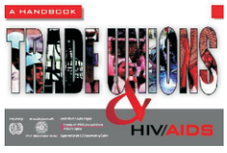
Some examples of trade unions' response to HIV and AIDS

- The International Confederation of Free Trade Unions (ICFTU) encourages its affiliated units to develop policy and programmes on HIV and AIDS
- ICFTU and IOE have joined hands to initiate HIV and AIDS programmes in 8 African countries
- The Philippines TUC has developed a policy and programme on HIV and AIDS
- National Union of mine workers is involved in South Africa along with employers.
- Kenyan National Union of Teachers and engaged in collaboration with the American Federation of Teachers.
- In India,Central trade unions launched their joint statement of commitment.
- HMS and INUTC in India have developed their policy on HIV and AIDS. Pilot projects have been initiated

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ILO India's efforts with Trade unions

- A handbook developed for trade unions on HIV and AIDS in English and Hindi
- A Training manual developed.
- Training programmes conducted for central/state level trade unions.
- Supported TUs to implement pilot interventions
- Facilitated TU's partnership with state AIDS Control Societies for interventions among the informal sector workers.



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Lessons from the pilot interventions

- The choice of the nodal person at the local level and peer educators holds the key to successful intervention.
- Involving a person living with HIV played a key role.
- Linkages with the State AIDS Control Society for services helped.
- In the initial phase, unions need regular handholding.
- The interventions of Unions need small funding - unions can mobilize local resources, particularly from the employers.

Key Conclusions

- Trade unions are a good entry points to reach out workers in the informal economy.
- National AIDS Control Programmes must partner with unions.

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How can unions respond to HIV and AIDS:

- Nominate a nodal person to deal with the issue
- Develop internal capacity to respond to HIV and AIDS. Seek technical support from expert agencies.
- Sensitize unions leadership and set up internal committee
- Integrate HIV and AIDS in education and training efforts
- Identify clusters of work in formal and informal sector and develop intervention with support from **State AIDS Control Societies.**
- Build partnerships with employers and other agencies

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Enterprises' response to HIV and AIDS in India

The need, key lessons from India and suggested approach

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Why should we discuss HIV and AIDS?

- HIV and AIDS affects the most productive age group of 15-49 years.
- It is never possible to get the exact magnitude of the AIDS problem.
- HIV infection can be prevented.
- Key challenges in prevention:
  - HIV infection goes unnoticed for years.
  - Primarily spreads through sexual contact discussion about sex is a taboo in many societies
  - Stigma and discrimination associated with HIV and AIDS

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Sharing an Indian case study *(name changed)*

- Ashok, 23 years, worker in a small private company, about to get married, presented with a STI at a hospital.
- Upon counseling, agreed for HIV Test.
- Status: Positive, Post test counseling provided.
- Narrated problems: How to disclose the status to family?
- Fears: Proposed marriage may get cancelled. Family will suffer stigma, younger sister may not get married.
- Outcome: Never turned up at the hospital.

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Impact of HIV and AIDS on Enterprises

The impact on enterprises

- Loss of skills and experience
- Reduced supply of labour
- Rising labour costs
- Falling productivity
- Reduced profit and investment

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A workplace issue

How does HIV/AIDS affect workers?

- Stigma and discrimination
- Loss of income and employee benefits

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Some examples of the impact of HIV and AIDS on enterprises

- *In a survey of 1006 firms in South Africa:*
  30% firms reported higher labour turnover;
  24 % increased costs of recruitment and training
- *A 14 firm study in Benin found that half of the HIV positive employees held important positions.*
- *Standard Chartered Bank responded to HIV and AIDS when in one country 10% of the staff was absent due to HIV related illnesses.*

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WEF Report: A Global Review of the Business Response to HIV and AIDS, 2005-2006 (covered 7386 firms, 100 in India)

Current impact of AIDS:

- Firms expecting serious impact - 6% globally; 7% in India
- Firms expecting some impact - 22% globally; **18% in India**

Future impact in the next five years:

- Globally, 17% expect serious impact
- **27% Indian firms expect serious impact**

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Direct cost of HIV and AIDS in SCCL, a coal company in AP, India:

1. SCCL spent Rs 65 lakhs (US$144,000) in previous five years in lump sum payment to 29 employees, declared unfit to work due to HIV and AIDS.
2. The company has 311 employees living with HIV. If they all reach the stage of being unfit to work, the company will have to pay Rs. 933 lakhs (US $ 2.1 million).
3. Provision of Treatment (ART) to these employees for ten years would cost much less - Rs. 559 lakhs (US$ 1.2 million)



(An ILO study, 2005)

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Economic impact of AIDS on families- ILO Study in India Average monthly expenses before and after HIV detection

Items	Avg. exp before (Rs.)	Avg. exp after (Rs.)	Avg. inc./ dec. (Rs.)
Food	1862	2212	+350
Medicine	444	912	+468
Education	333	166	-266
Entertainment	802	280	-522
Debts	–	–	4818

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AIDS is a case for linking up business to community under the CSR

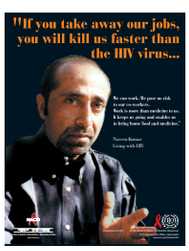
"*I have sent my daughter to an urban home to do household manual work to support her and me*"

"I have nobody in the world. After my time, I am sure that my daughter will be definitely abused"

- A woman from Tamil Nadu

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PLHIV key message to the world of work



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Key lessons from the business response to HIV and AIDS

- Businesses remained in denial for too long.
- Businesses responded to HIV and AIDS for different reasons: SOCIAL (CSR), HRD, AND ECONOMIC.
- Mandatory HIV testing did not work.
- Businesses who responded to HIV and AIDS were benefited with an improved corporate image.
- Business need technical support. Externally funded interventions at workplaces do not sustain.
- Peer Education model is good for providing HIV and AIDS education to workers on a regular basis.
- Leadership and management's commitment is the key in success of the programme.

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How to initiate the corporate response: key steps
Nominate a nodal person for HIV and AIDS
Integrate HIV and AIDS in existing HR/welfare/CSR/OSH… initiatives.
Set up a representative committee to develop a policy/work plan on HIV and AIDS.
Start small (WPI), learn about it and expand to supply chains/community
Get a cadre of Master Trainers/ peer educators trained on HIV and AIDS.
Build partnerships and seek technical support.
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An ILO Code of Practice on HIV and AIDS and the world of work



Guidelines for development of workplace policy and programmes

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What is the Code of Practice?

A set of guidelines for

governments, employers' and workers' organizations
to
help them develop concrete responses to HIV and AIDS
at the enterprise, community and national levels.

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HIV and AIDS - A workplace issue

- Because HIV and AIDS affects the workforce and the enterprise:
  - loss of income & benefits
  - loss of skills and experience
  - falling productivity
  - reduced profit & investment
- Because the workplace can help limit the spread and mitigate the impact of the epidemic:
  - protect job security and rights
  - ensure social protection
  - offer care support & treatment
  - help prevention through education and peer support

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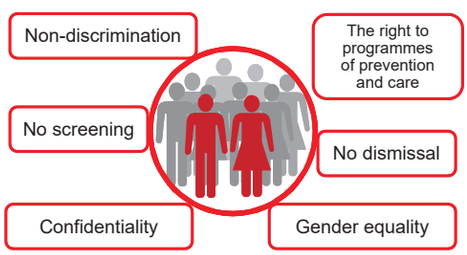
A workplace policy

The Code can be used as reference to develop workplace policy and programme on HIV and AIDS:

- it encourages social dialogue (consultation and collaboration between governments, employers and workers)
- it sets out key principles to guide working terms and conditions/HRD policies
- it highlights the responsibilities of governments, workers and employers organizations.

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Key principles of the ILO Code



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Key elements of the Code

1. **HIV Screening/Testing**
   - No HIV and AIDS Screening of job applicants or those in employment
   - **No Testing except:**
     - On the request of workers themselves
     - In the event of occupational exposure
     - Anonymous epidemiological surveillance

BUT only with CONSENT, COUNSELING AND CONFIDENTIALITY

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2. Non discrimination (A rights based approach)

- No termination due to real or perceived HIV status (fitness to work being the main criteria for keeping people in employment)
- Commitment of employers to act against stigmatization or discrimination at the workplace

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3. Confidentiality

- Confidentiality of a person's HIV status should be maintained
- No obligation for the employee to inform the employer regarding his/her HIV status.
- Status to be disclosed only if legally required or with the consent of the person concerned

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4. Prevention of HIV and AIDS

- Information and awareness raising campaigns
- Educational programmes
- Training programmes
- Community outreach programme
- Gender specific programme

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5. Care and Support

- Introduce reasonable changes in working arrangements wherever needed for employees living with HIV and AIDS
- Commitment to all standard social security benefits
- Counseling of employee/co-workers/families
- Wherever possible provide broadest range of health services to manage HIV and AIDS and assist workers living with HIV and AIDS
- Special care of health workers to protect from infection in case of occupational exposure

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Checklist for planning and implementation

- set up an HIV and AIDS - workplace committee
- establish TOR
- review existing legislation
- assess impact on & needs of workplace
- identify existing services & resources
- draft circulate and finalize policy
- draw up budget & seek funds
- establish plan of action with timetable and implementers
- disseminate policy
- implement plan of action
- monitor impact & change plan as necessary

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Key lessons

- The process of developing workplace policy – setting up internal tripartite Committee is the key.
- The committee allows for discussions on key issues of the ILO Code & leads to sensitization of key stakeholders.
- A review of the national policy framework/legislation and policies/experiences of other organizations is necessary in the process.
- The policy needs to be reviewed from time to time, to make necessary changes in the light of trends in the epidemic.

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Contributors:

Syed Mohammad Afsar
Pallapati Joshila
Divya Verma
Manjunath Kini

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ILO DWT for South Asia and Country Office for India
India Habitat Center
Core 4B, 3rd Floor, Lodi Road,
New Delhi - 110 003, India

Ph: (011) 24602101-03
Fax: (011) 24602111, 24647973
Website: www.ilo.org/hivaidsindia

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International Labour Organization
ILO DWT for South Asia and Country Office in India
Core 4B, 3rd Floor, India Habitat Centre, Lodi Road, New Delhi 110003, India
Tel. +91 11 24602101-02-03 Fax. +91 11 24602111 Email : delhi@ilo.org
Website: www.ilo.org/hivaidsindia

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