

DESK REVIEW OF RESEARCH ON HIV/AIDS IN THE WORLD OF WORK

**Conducted by ILO/AIDS as part of the Inter-Agency
Task Team on HIV workplace policies/programmes
and private sector engagement (IATT/WPPS)**

2012



HIV/AIDS DESK REVIEW IATT/WPPS

Table of Content

Introduction	3
Methodology	3
Desk review:.....	4
A. VULNERABILITY STUDIES:	4
1 Migration	5
2 Gender:	15
B. STIGMA AND DISCRIMINATION STUDIES.....	21
C. IMPACT STUDIES	33
D. COST AND BENEFITS.....	66
ANNEXES:	83
a. THEMES AND SECTORS COVERED BY REGION:.....	83
b. SECTORS COVERED	85
c. TARGET GROUPS:	85
d. PROGRAMS:	85
References	86

Introduction

The HIV epidemic has emerged as one of the most significant challenges to health, development, economic and social progress. Its effects are concentrated among the most productive age group. The epidemic imposes huge costs on enterprises through falling productivity, increased labour costs and the loss of skills and experience. Fundamental rights at work are often violated due to HIV status and workers affected by HIV face increased levels of stigma and discrimination.

Mandated by UNAIDS, the International Labour Office (ILO) has set up an Inter Agency Task Team (IATT) to scale up HIV work place policies and programmes and private sector engagement. Memberships include UN agencies, global and regional employers, trade union organisations, business coalitions, networks of people living with HIV, donors and key development partners. Their mission is to strengthen partnership between the public/private sector and actors of national HIV/AIDS authorities and programmes, in purpose to encourage alignment and harmonisation across agencies towards effective coordination of HIV/AIDS workplace policies and programmes.

The IATT on HIV workplace policies/programmes and private sector engagement (IATT/WPPS) held its first face-to-face meeting in September 2011. Undertaking a desk review was one of the agreed outcomes of the meeting. The purpose of this desk review is to compile existing research on HIV/AIDS in the world of work in order to provide the IATT with a clear picture of existing research. The desk review is essentially a summary of reports and documents on vulnerability studies, stigma and discrimination studies, and impact and benefit studies. The aim of this report is to have a global overview on HIV/AIDS research and to highlight the regions, scopes, methodologies, findings and recommendations covered in the research studies.

Methodology

ILO/AIDS developed an online platform for the purpose of sharing key documents on research, policy, strategies, workplace private sector programmes, communication, advocacy, tools and guidelines between the IATT members. Relevant research documents were selected from this pool of IATT member documents and were supplemented by additional research documents from non-IATT members. A total of 38 documents are covered in this desk review.

This desk review is organized in four principal sections that correspond to themes of: Vulnerability studies; Stigma and discrimination studies; Impact Studies; and Cost Benefit studies. These themes have strong inter-linkages with each other.

Desk review:

A. VULNERABILITY STUDIES:

IATT member's documents research on vulnerability studies focus on formal and informal sector such as mining, transport, health, education sector targeting vulnerability groups such as migrants and women.

Regions covered included in the studies are India, China, Malawi, South Africa and Ukraine including migrants in construction, transport, mining and health sectors.

The following 10 documents are covered:

1. Migration:

- 1.1 Rapid assessment among migrant workers in the construction sector on HIV risk and vulnerability in Raigad district, Maharashtra, India. ILO/AIDS. 2008.
- 1.2 South African HIV/AIDS programming overlooks migration, urban livelihoods, and informal workplaces. African Journal of AIDS Research. 2011
- 1.3 Reproductive Health and Gender Awareness in Shenzhen's Migrant Population. ILO/AIDS. 2011
- 1.4 Study on mandatory HIV testing for employment of migrant workers in eight countries of Southeast Asia. ILO/AIDS. 2006
- 1.5 The role of economic empowerment in reducing HIV risk and vulnerability among girls and young women along selected hotspots of the transport corridors of Malawi. ILO/AIDS. 2011

2. Gender:

- 2.1 Esther S.Wigers. Gendered vulnerability to aids and its research implications. Wageningen University. 2007.
- 2.2 The epidemic in this country has the face of a woman: Gender and HIV/AIDS in South Africa. African Journal of AIDS Research. 2011
- 2.3 Women's health, HIV/AIDS and the workplace in South Africa. African Journal of AIDS Research. 2011
- 2.4 Approaches to Gender and Sexuality: Responding to HIV. International HIV/AIDS Alliance. 2011

1 Migration

1.1 Rapid assessment among migrant workers in the construction sector on HIV risk and vulnerability in Raigad district, Maharashtra, India. ILO/AIDS. 2008.

Region:

India

Sector:

Construction

Scope

ILO conducted a rapid assessment to generate evidence of HIV & AIDS vulnerability in the construction sector and use that knowledge to develop interventions in the construction sector. Specific objectives of the assessment were to identify geographical sites where migrant construction workers were present in the district, their origin and size; carry out a knowledge, attitude, behaviour and attitude (KABP) survey to assess the level of risk; and carryout stakeholders analysis to assess their role in reducing HIV risk among the migrant construction workers.

Methodology

Both quantitative and qualitative methods were adopted in conducting the assessment. Mapping was conducted in the identified areas of Panvel taluka at three types of locations (Nakas, Construction sites, and Bastis) using key informant approach. Information gathered during the mapping included – estimated number of migrants, migration behaviour, risk factors and HIV & AIDS services available. In all, mapping was conducted at 86 locations in Panvel taluka. KABP survey was conducted using standardized questionnaire developed by ILO for survey among workers of the unorganized sector. Survey was conducted among a randomly selected sample of 380 construction workers at 15 locations that had maximum concentration of construction workers. Stakeholder analysis was conducted using in-depth interviews among contractors, *mukadams* (group leaders of construction workers) and NGO workers.

Findings

Among 36,571 migrant construction workers mapped in Panvel taluka, 59% were seasonal migrants and about one-third lived singly who were likely to have high risk sexual behaviour. A large proportion of migrant construction workers were Maharashtrians from other districts in the state (51%) followed by those from Uttar Pradesh (14%) and Karnataka (12%). With the presence of sex workers in and around the work places and residential areas of workers, HIV risk behaviour was evident among the construction workers. Health seeking behaviour and access to HIV & AIDS services was also low among workers.

KABP survey revealed that the respondents were predominantly men with about three-fourth of them in the productive age group of 21-40 years and not living with their spouse or family. Overall, less than a third of the construction workers knew all the four routes of HIV transmission. A comparatively less proportion of construction workers in the Nakas and Bastis had knowledge about the four routes of HIV transmission. However, fewer workers had misconceptions about HIV transmission in general. Less than half of the construction workers knew about at least three means of HIV prevention. Knowledge about prevention was even less among Naka workers. In spite of less misconception about the spread of HIV, about half of the migrant workers did not have a favourable attitude towards HIV positive person. Further, very few workers knew about the symptoms of STIs in women and men reflecting poor knowledge on STI and treatment seeking behaviour. About a quarter of the migrant construction workers reported having sex with someone other than their spouse. Only about three-fourth of the respondents who had sex with someone other than their spouse used condom during their last two sex acts.

Recommendations

- Recommendations of the study highlighted the importance to involve all stakeholders in a proactive manner in implementing HIV & AIDS intervention.
- The knowledge of HIV transmission and prevention are very low, so the intervention should focus on creating awareness on both men and women migrant construction workers.
- In spite of low misconception about HIV & AIDS, about half of the workers had stigmatizing attitude towards HIV persons.
- Awareness about STIs being very low, the program should focus on STI/VCT services.
- With about a quarter of the respondents reporting high-risk sexual behaviour (sex with anybody other than their spouse), there is a need for promoting risk reduction through the use of condom and by reducing the number of partners.
- The experiences and lessons learned will benefit in proposing a framework for HIV risk reduction among migrant workers in the construction sector

1.2 South African HIV/AIDS programming overlooks migration, urban livelihoods, and informal workplaces. African Journal of AIDS Research. 2011

Region: South Africa

Sector: Migrants, informal economy

Scope:

This article synthesises existing research and draws on fieldwork data from a small-scale, focused, data-gathering exercise in Johannesburg, involving both internal and cross border migrants engaged in a range of informal livelihood activities. The three migrant groups are: 1) migrants residing in a peripheral urban informal settlement and working as waste-pickers on a local dumpsite; 2) migrant men working in bars in inner-city hotels where sex is also sold; and 3) migrants engaged in informal livelihood activities who are also members of burial societies, which have been shown to play a key role in mitigating the impacts of HIV, sickness and death for migrants. These groups were selected because they represent the

complexity and diversity of the informal livelihood activities of migrant groups in Johannesburg, and the choice assists us in exploring the informal workplace as a key space for HIV-prevention activities in the South African context. Additionally, the selection of these groups enables our exploration of possible ways to engage with migrant groups through different workplaces and existing social networks (such as burial societies).

The research was not envisaged as a large-scale study but as a focused, in-depth qualitative piece of work for exploring the penetration of HIV/AIDS programmes into migrant-dense, informal workplaces in urban areas of South Africa. Specifically, the HIV-programming implications of the informal economy as a key workplace for these migrant groups are considered here. After considering diverse migrant groups engaged in varied informal activities through the three case studies presented here, recommendations are made for how the South African national HIV/AIDS response should — as a matter of urgency — engage with migration and informal workplaces.

Methodology:

The research draws from the existing literature and from different spheres of engagement in Johannesburg in recent years: namely, work on migration, informal livelihoods and HIV, sex work, and burial societies. In addition to data from the previous research, fieldwork material from a small-scale, focused data-gathering exercise in Johannesburg was used. The fieldwork targeted migrants working at a dumpsite, in inner-city bars and hotels where sex is sold, and those engaged in various informal activities who are also members of burial societies.

The fieldwork utilised observation and unstructured and semi-structured interviews with the participants.

Findings:

Migrants engaged in these informal economic activities and workplaces fall under what the NSP considers ‘atypical’ forms of work; moreover, this article points out that current national responses ignore informal workplaces in HIV-prevention initiatives. This should be addressed in the development of the NSP for 2012–2016. Internal and cross-border migrants working in the informal sector in South Africa (a country with a generalised HIV epidemic) need to be reached through effective combination HIV-prevention programmes. With the principle of universal access to HIV prevention, treatment, care and support in mind, the article suggests that the *spaces* where these informal workplaces are located provide useful entry points to targeted programmes. The spaces included in this research — the informal workplaces of urban dumpsites and inner-city bars and hotels, as well as the social networks of burial societies — provide important opportunities to engage with migrants who work informally.

It is essential to acknowledge that many new (mostly internal) migrants who become engaged in informal work activities reside in urban informal settlements, thereby living and working in spaces that are associated with the highest levels of HIV prevalence nationally.

The migrant groups considered here represent examples of migrants engaged in informal livelihood activities who are currently overlooked in efforts to strengthen and implement HIV-prevention activities — both in the workplace and beyond. Given the importance of the

informal sector to the South African economy (ILO, 2001), and the large number of people associated with it, it is essential that national HIV/ AIDS responses should also engage with those who work informally.

Recommendations

Organisations should extend their HIV/AIDS-intervention activities to workers in informal livelihood activities in partnership with all relevant stakeholders, where appropriate, and support new initiatives to prevent the spread of HIV and mitigate the impacts of the epidemic among people in the informal sector. Workers engaged in the informal sector may be particularly vulnerable to contracting HIV or in need of support if already living with HIV. In line with existing United Nations declarations, people in informal workplaces must be included in workplace HIV/AIDS programmes. The guiding principle of working to achieve universal access to HIV prevention, treatment, care and support should form the cornerstone of any national HIV/AIDS response (United Nations, 2001 and 2006). As highlighted by the ILO, achieving universal access requires engagement with all sectors of society, including workers in informal workplaces.

Given that informal workplaces do not have easily identifiable employers, and that many workers conduct their livelihood activities independently within these spaces, it is imperative to consider who is responsible for developing and implementing HIV/AIDS responses within these spaces. It is suggested that the South African government is responsible for ensuring that those who are self-employed within informal workplaces are included in the national response to HIV and AIDS. This requires that local governments are provided with the guidance and assistance (both financial and human resources) to develop and implement appropriate HIV-prevention responses with migrant, informal workers.

It is suggested that the *spaces* where various urban migrant groups reside, socialise, and engage in informal livelihood activities provide opportunities for localised HIV/ AIDS programming, coordinated through local government structures. Migrants themselves are well placed to be engaged in both the design and implementation of HIV/ AIDS programmes in informal workplaces, such as brothels, bars, hotels and dumpsites, and through burial societies. Through making use of existing social structures (e.g. burial societies, informal workplaces), migrants can be engaged in implementing some of the activities outlined in the NSP.

The recent ILO HIV/AIDS workplace recommendations (ILO, 2010a) clearly highlight the need for the national response to engage with people in informal workplaces and with migrants. The article urges the South African government to implement HIV/AIDS programming that considers the principle of universal access to HIV prevention, treatment, care and support — through developing localised responses within informal working and living *spaces* for the benefit of urban migrant groups. This requires that the national strategic HIV/AIDS response includes explicit frameworks for how local government and other entities can enact the guidelines presented within the NSP. Importantly, local government structures must find appropriate ways to engage with migrants working informally, in terms of both the design and implementation of HIV-prevention programmes, as they are the ‘experts’ on their working spaces. In addition, we suggest that gaining entry

through burial societies can play an important role in reaching urban migrants who are engaged in informal livelihood activities.

The issues of both migration and informal workplaces should be explicitly included in the next NSP (for 2012–2016), as this will strengthen the national response. The article urges the South African National AIDS Council (SANAC) to set out explicit frameworks for achieving the goals of the new NSP, especially to assist local government structures and other entities in developing and implementing appropriate HIV/AIDS responses that engage with the issues of migration and informal workplaces.

1.3 Reproductive Health and Gender Awareness in Shenzhen's Migrant Population. ILO/AIDS. 2011

Region: Shenzhen, China

Sector:
Migration

Scope:
This report documents and analyzes the vulnerabilities of Shenzhen's migrant worker population with regard to labour rights, reproductive health and gender equality before providing a series of recommendations on how to move forward with programs to address the primary needs of migrant workers.

Methodology:
In order to better understand the vulnerabilities faced by migrant workers in China, the International Labour Office for China and Mongolia (ILO) and the Shenzhen Family Planning Association (FPA) conducted a survey on labour rights, reproductive health and gender among 3,029 migrant workers in December 2010. This was complemented by a series of focus interviews held with 27 young migrant workers in January 2011.

Research was conducted entirely in Shenzhen, a large city located within Guangdong Province. Shenzhen was chosen for this study as it possesses the largest migrant population of any city in China. It also has the largest registered migrant to urban resident population ratio, the youngest average age and the highest incidence of STIs of any city in China.

Findings:
Reproductive health - The study has shown that the majority of these women do not have access to reliable and accurate sources of information about reproductive health, with many relying on their sexual partners for this information. In addition to this, a large proportion of migrant women have STIs and reproductive health infections and more than 46% of the migrant women surveyed reported unwanted pregnancies. A significant number of these women will undergo abortions either in their home or in small private clinics. This is a clear indicator that reproductive health knowledge among young female migrants is low and

raises concerns about the accessibility of services. This could serve to reduce productivity in enterprises due to lost work time.

Gender Equality - Attitudes about the roles of women and their potential for careers and responsibilities outside the household have shifted considerably among migrant workers compared to their rural counterparts. Attitudes towards premarital sex have also changed significantly among male and female migrants. However, there appears to be a slower pace of change among male migrant workers, with many still holding conservative attitudes towards gender roles related to household responsibilities and work.

Vulnerability for HIV infection - Sexual behaviours reported in this and other surveys show that the sexual behaviour of both male and female migrant workers is fairly conservative. More than 80 percent of female migrants and over 70 percent of male migrants report only one sexual partner in the past year, and very few had more than three partners in the previous 12 months. Moreover the percentage of men who reported visiting sex workers was relatively low at 8%, and on par with non-migrants in other urban areas. However, STI rates among migrant workers in the Shenzhen area are high, with one large-scale study showing a rate of 9.7%. In addition to this, condom use rates were fairly low for these men, with only 22.2% consistently using condoms. Overall, this data suggests that while there may be vulnerabilities to HIV infection because of low knowledge and pre-marital sexual activity, the migrant population as a whole should not be recognized as being at significant risk for HIV.

Labour Rights – The findings clearly show that wage levels for migrants, both men and women, are much lower than urban residents for comparable work. Working times in the companies surveyed, however, tended to be on par with other non-migrant workers. With regards to access and use of social security, 33% of migrants did not have access to any social health insurance compared to 9% for non-migrants.

Occupational health and safety in industries that hire large amounts of migrant workers appears to be poor. For example in the electronic industry, the accident rate for men was 27% whereas the non-migrant rate was 9%. In the Bao'an district of Shenzhen, only 35% of all migrant workers had been trained on occupational health and safety.

Recommendations:

Reproductive health, gender equality and labour rights remain key challenges faced by migrant workers.

Improving reproductive health among young female migrants should be a core priority for enterprises, government and the health sector. Reproductive health training should be held in all enterprises that employ large numbers of female migrant workers. This will ensure that female migrant workers are empowered to protect themselves and make informed decisions about their reproductive health. Enterprises should complement this training by facilitating referral to approved clinics to improve reproductive health, unwanted pregnancies and unsafe abortions.

An assessment of reproductive health services available to migrant workers should also be completed. Furthermore, invasive procedures like abortions should only be performed by trained professionals in safe and sterile environments. However, a number of barriers may prevent migrant workers from benefiting from these services, such as accessibility and affordability. Conducting an assessment of reproductive health services available will enable key issues to be identified and later addressed at the operational and policy level.

Issues of gender equality should be addressed in all reproductive health training. It is important here to ensure that both male and female migrant workers alike receive training on gender equality as equality between the genders can only be achieved as a joint undertaking. Taking steps towards this goal is important not only for empowering women in employment and home settings, but also for navigating relationships and improving reproductive health outcomes.

Given STI rates are unusually high among migrant workers, STI training and referrals should be a priority in all reproductive health programs. If migrant workers are adequately trained on STIs and provided with a referral service, they will have the knowledge they need to protect themselves and determine when and where they can seek help. HIV information should also be integrated into these programs to ensure migrants are aware of the risks and what they can do to protect themselves.

Migrant workers should be trained on their rights at work. Any training should include elements on relevant laws and regulations such as the *Labour Contract Law* and the *Employment Promotion Law* to improve migrant worker knowledge on their legal rights. This should be complemented by education about policies related to STIs and HIV/AIDS, such as the *Regulation on the Prevention and Control of HIV/AIDS* and the 'Four Frees and One Care' policy.

Training on rights at work should be complemented by the establishment of a referral service for migrant workers to access legal aid in addition to scaling up efforts to establish more non-profit legal aid centers. Improving the accessibility of legal aid in this way will provide an avenue for migrant workers to take action when their rights are infringed upon.

Improving occupational health and safety should be a priority in all companies that hire migrant workers. Companies should be encouraged to implement comprehensive occupational health and safety programs for their migrant workers. This should include training for migrant workers on good practice as well as training for management on their obligations and good workplace policy. Incorporating consistent occupational health and safety into the day-to-day management will go a long way to protecting the migrant workers who work within these companies.

1.4 Study on mandatory HIV testing for employment of migrant workers in eight countries of Southeast Asia. ILO/AIDS. 2006

Region:

South East Asia (Cambodia, Indonesia, Malaysia, Myanmar, Philippines, Singapore, Thailand and Vietnam)

Sector:

Migration

Scope:

The purpose of this study is to promote an informed dialogue amongst representatives from governments and workers' and employers' organizations throughout South-East Asia on protecting the basic human rights of women and men who seek work abroad.

Methodology:

Findings:

Recommendations:

Migration should be viewed as a process driven by economic and social factors, and not as a 'problem' to be addressed by punitive measures. A study on mandatory HIV testing for employment for migrant workers in eight countries: Cambodia, Indonesia, Malaysia, Myanmar, Philippines, Singapore, Thailand and Vietnam, pointed out that despite the existence of national laws and policies protecting workers against HIV-based discrimination and mandatory HIV testing in these countries, those that are mainly countries of origin permit and facilitate pre-departure health examinations of migrant workers, and these include an HIV test where required by the receiving country. From an ILO and IOM perspective, however, any HIV testing related to entry and stay should be done voluntarily, on the basis of informed consent. Adequate pre- and post-test counselling should be carried out, and confidentiality strictly protected¹.

1.5 The role of economic empowerment in reducing HIV risk and vulnerability among girls and young women along selected hotspots of the transport corridors of Malawi. ILO/AIDS. 2011

Region:

Malawi

Sector:

Migration, Transport corridors

Scope:

Recognising the negative impact that HIV and AIDS has on human resource both in the formal and informal economy on the transport corridors, the ILO Malawi Office commissioned a study to explore the role of economic empowerment in reducing HIV risk. The study addresses gender issues and economic empowerment activities that can help reduce HIV vulnerability of target groups along the following selected Transport corridors:-

- Dar-es-laam corridor (Karonga Town and Songwe border).

¹ Study on mandatory HIV testing for employment of migrant workers in eight countries of Southeast Asia. ILO/AIDS. 2006

- Malawi Lakeshore Domestic Corridor (Nkhata Bay)
- Nacala Corridor (Mtakatika/Golomoti areas).
- Durban Corridor (Mwanza, Zalewa and Lunzu).

Specific objectives for the assignment are as follows:-

- a) To provide an analysis on the relationship between economic vulnerability and HIV risk and vulnerability and on the role that economic strategies may play as part of the solution to HIV prevention and mitigation in the ILO targeted areas.
- b) To determine why women and men are particularly vulnerable to HIV in these areas and how economic vulnerability intersects with gender inequality to exacerbate HIV risk and vulnerability.
- c) To determine to what extent these vulnerable groups are currently being reached by combined economic empowerment and HIV programs including access to financial and health services.
- d) To determine the intermediate factors at community and household levels, such as gender attitudes and access to education and economic opportunities that influence the level of risk and vulnerability of the targeted groups particularly girls and young women.
- e) To determine to what extent transactional sex (exchange of sex for money, goods or favours) exists among the beneficiaries and communities they operate.

Methodology:

The approach in the current study was largely, qualitative employing in-depth focus group discussions, key informants' interviews and literature review. A questionnaire was designed for use with the focus group discussions and a variation of the same for the key informant interviews. A total of six focus group discussions were held.

Findings:

The research suggests that women's economic and social reliance on men limits their ability to negotiate safer sex, sexual abstinence and faithfulness in relationships, which puts them at risk of HIV infection. In addition, low income and economic opportunities for women acts as a push factor to engage in transactional sex. In addition a norm around male masculinity encourages men to have multiple sexual partners, which women are unable to challenge due to economic disempowerment.

Target groups most vulnerable to HIV and AID - The findings of the study single out girls and young women as particularly vulnerable to HIV infection. The low socio-economic status of women and various cultural practices that prevent women from negotiating safer sex only worsen the risk. Women's subordinate position in Malawian society restricts the possibilities for women to take control of their lives to combat HIV/AIDS, leave a high-risk relationship or have adequate access to quality health care.

Intermediate factors at household and community levels that influence the level of risk and vulnerability -The study revealed some pathways through which economic stressors, combined with gender and generational disparities at the household level can contribute to increased vulnerability to HIV and AIDS among girls and young women. These include

cultural and gender-based practices (e.g. early marriages; wife inheritance and incest) and access to education.

Extent to which transactional sex exists- Respondents in all the six centres unanimously agreed that transactional sex occurs in their areas. Money is viewed as a driving force for sex and relationship formation. Clothes, fish, groceries, meat were some of the commodities mentioned as being involved in transactional sex. There are no particular times or seasons for transactional sex.

Availability of Economic Empowerment Programs- The study found different microfinance institutions (MFIs) are available and have various economic programmes. However, businesspersons encounter challenges to access these MFIs. These include harsh lending conditions as well as a generally unfavourable business environment currently being driven by a lack of forex, fuel and drugs. Another barrier successful business practice is poor business management.

HIV and health services -Generally, HIV and Health programmes are available in most of the areas. However, a key challenge is that most health facilities are not within reach of the rural masses.

Recommendations

Program Design

- While some generic interventions may apply to all hotspots of the transport corridors, it is also evident that each area has its own peculiarities. This would mean tailor-making the interventions to suit specific localities.
- Ensure that program components and approaches should be designed with input from beneficiary representatives in order to ensure full ownership and long-term sustainability.
- ILO has a number of time-tested tools that are suitable for interventions in various contexts. Specific tools need to be recommended in accordance with the nature of the intervention
- Undertake a mapping exercise of key players in the fields of economic empowerment, HIV and AIDS and gender in order to provide synergy to interventions targeting the vulnerable groups.
- Set up a tracking system for commitments made by government and other partners on matters related to economic empowerment, HIV and AIDS and gender.
- The business environment in the hotspots under study remains male dominated. Any intervention that targets young women and girls could meet male resistance if the men are completely left out. Male involvement will accelerate women's empowerment as the women will gain both the resources as well as the "agency" (ability to act in one's own interest).

Young Women and Girls' Focus

- Interventions that target commercial sex workers should consider a behaviour change component as some of the young women in this practice have expressed the desire to migrate to a more dignified source of livelihood.
- Since girls' education has been shown to be the single most important factor for delaying sexual debut, age of marriage and future earning potential, it could be

argued that the ultimate goal of economic activities involving girls should be to help them stay in school. To this end, projects could help facilitate a back-to-school programme for the youthful sex workers.

Access to credit

- Young women and girls need to receive specialized focus towards their economic empowerment as they are peculiarly disadvantaged. Partnership with women-friendly MFI's should be explored.
- The concept of microfinance transparency ought to be popularised to ensure that advertised interest rates do not have hidden costs.
- Caution should be exercised not to make credit too easy as this may promote over-borrowing.
- Business groups should be encouraged to register as cooperatives and being linked to relevant service providers.
- A strong component in basic business management needs to be a pre-requisite to approval of credit. This will ensure strong business entities and good repayment record.

Public Awareness

- A comprehensive communication strategy for the project needs to be designed to ensure that all potential beneficiaries are adequately informed of the project and desired outcomes are appropriately accounted for.
- Savings can be a powerful tool for poor women to escape poverty. But low-income women often are unaware of formal savings methods and their advantages. And women feel the need to secretly manage their finances because of gender power imbalances over the control of household income.
- Raise public awareness on the patients' charter and other human rights issues so that patients are aware of their rights and that these rights are not violated when they are seeking health services.

Other Recommendations

- Continue negotiations with government and related service providers to help improve the business environment. Areas of considerations to be:-
 - *Reduction of interest rates on loans from the money lending institutions*
 - *Reduction of excise duty to boost businesses for cross border traders*
 - *Extension of repayment periods and frequency.*
 - *Shortening of loan processing period.*
- Provide mechanisms for intensive monitoring of the performance of the businesses (Once access to credit has been realized).
- Strengthen linkages between business associations and Health and HIV programmes.

2. Gender:

2.1 Esther S.Wigers. Gendered vulnerability to aids and its research implications. Wageningen University. 2007.

Region:

Sub-Saharan Africa

Sector: Gender

Scope:

This thesis focuses on the gender aspects and methodological and ethical issues concerning HIV/AIDS impacts on rural livelihoods in sub-Saharan Africa.

Methodology

The research concentrated on three main thematic areas. First, by drawing on household data from the Northern Province in Zambia, it sought to understand how HIV/AIDS leads to vulnerability differentiation among affected rural households and what processes make households more or less vulnerable to the impacts. Second, through the use of case studies, it tried to provide insights into the resources female heads of households mobilised over time to respond to AIDS and the factors that enabled or disabled them in their response. Last, based on the literature and personal experiences, the research aimed at getting insights into the main methodological and ethical problems relating to micro-level investigations on AIDS, gender and rural livelihood linkages.

Findings

Vulnerability differentiation and its underlying processes - Research findings indicate a sharp decline in household food production among households affected by HIV/AIDS. These households reduced the area they cultivated, disposed of their liquid and productive assets, used fewer farm inputs, participated less in the cooperatives set up by the Government to access fertiliser at subsidised rates, received less financial support from their social network as they could no longer reciprocate the assistance, and increasingly resorted to low-profit activities such as food for work and beer brewing.

The households in the study that are impacted by illness and orphans as a consequence of HIV/AIDS and are headed by men, women and the elderly are not affected by the epidemic in a uniform way, but differ in their capacity to respond. Female-headed households that take care of AIDS patients and/or orphans and elderly-headed households in particular were less able to resist or adapt to the adverse impacts of HIV/AIDS on their food security as compared to other affected household categories.

Underlying causes that influence households' vulnerability levels include, amongst others:

- Restricted access to assets to dispose in times of need, which also hampers their capacity to build up social capital;
- Risk of property loss after the death of the husband;
- Weak ties to a social network on which households rely in times of hardship;
- Low membership in cooperatives set up by the Government to access fertilisers at subsidised rates;
- Lack of adult labour, especially male labour, needed for specific livelihood activities.

Female headship and responding to AIDS – findings show that not all female household heads are equally vulnerable to AIDS impacts and different interrelated factors contribute to their capability to respond. These include: a strong resource base and economic

independence at the onset of a livelihood crisis, access to strong support from kin, friends, community-based and faith-based organisations, access to ARV treatment, and access to medical insurance through the workplace.

During illness, resource mobilisation is particularly aimed at livelihood preservation and daily survival and responses adopted are more short-term. When widowed, responses appear more long-term oriented, aiming at rebuilding a livelihood as best as possible.

Findings illustrate that the number and type of resource mobilisation strategies adopted vary greatly and depend on the household head's endowment and entitlement base and her capability to use these to mobilise resources, as well as personality characteristics and personal circumstances. Social capital is central to the women's capability to respond to AIDS and they employ a range of claims by using various distinctive claiming systems. In particular, reciprocity support from kinship and friends is an important claiming system. Upon the death of the spouse or adult child, faith-based and local community-based organisations are important claiming systems for the female heads of households by providing food and schooling support for orphans as well as assistance with income-generating activities, small informal loans and emotional support. The female heads of households also rely much on their human capital to offset the loss of productive labour by hiring labour in exchange for beer, involving children in the household labour force, and restructuring the household by absorbing younger relatives to assist in child-care and domestic responsibilities. Paid sex as a strategy to sustain their households is another human capital-based response female-headed households fall back on, especially widows with dependent children who are not supported by their kin and have few other options to generate a livelihood.

Recommendations

Understanding the differences in AIDS impacts across households is important as it exposes the causal conditions for people's vulnerability and as such has important policy and programme implications. These must be sensitive to differentiation of households and challenge the inequalities that drive AIDS susceptibility and vulnerability. A 'HIV/AIDS lens' should be used in programme and policy formulation, through which to view the different causal factors that lead to increased or reduced susceptibility and vulnerability levels. In particular, efforts that address strategic gender needs are required. Depending on cultural contexts, these include: securing access to assets and resources, enforcing laws relating to ownership and inheritance rights, supporting economic independence, making financial services available to women, and ensuring actual enforcement of statutory laws for gender-based rights at local level are not undermined by customary laws.

Applying a 'HIV/AIDS' lens would also call for targeted social protection efforts for the most vulnerable in society to minimise asset-depletion. Targeted social protection measures should aim at reducing vulnerability levels to AIDS impact by protecting the household asset-base, ensuring continued access to education, and bridging temporary food gaps, as well as by rebuilding the asset-base for affected households who had to sell crucial assets.

To work towards a more systematic evidence-base, a common research framework is required that would allow for better comparison of empirical findings within and across countries and at a variety of scales rather than generalising from ad-hoc studies.

2.2 The epidemic in this country has the face of a woman: Gender and HIV/AIDS in South Africa. African Journal of AIDS Research. 2011

Region: South Africa

Scope: The HIV epidemic in the region is increasingly 'feminised' as a growing proportion of new infections occurs among and affects women. The aim of this report is to interrogate the contextual factors underlying the differential vulnerabilities of men and women, and the implications for HIV prevention, treatment and care.

Methodology The analysis is based on a review of documents and applicable literature.

Findings The analysis reveals that a perilous mix of biomedical, political, economic, and cultural forces shapes the gendered dynamic of the HIV epidemic in South Africa. The article identifies a theoretical framework to decode the most common components of this mix, namely: lack of access to material resources, cultural norms wherein women are subservient to men and masculinity is partly defined in terms of multiple sexual partners and intergenerational sex, combined with high levels of violence against women.

Recommendations

The authors conclude by offering a framework for gendered interventions for HIV prevention, treatment and care.

2.3 Women's health, HIV/AIDS and the workplace in South Africa. African Journal of AIDS Research. 2011

Region: South Africa

Scope:

This analysis considers the contextual factors underpinning the differential vulnerabilities of women and men in South Africa.

Methodology:

A review of the academic literature and relevant documents

Findings:

The analysis finds that a perilous mix of economic, political, biomedical and cultural forces has combined to produce today's feminised HIV epidemic. They identify the most common

ingredients in this mix as patriarchy, sexual norms (such as intergenerational sex and having multiple sexual partners), high levels of violence against women and women's subordinate position to men, as well as inadequate material resources.

Recommendations

The authors argue that intervention strategies, particularly in the sphere of HIV prevention, must therefore be gendered, taking into account the specific social and cultural contexts in which women's sexual risk behaviour and health-seeking behaviour is rooted. They put forward a gender-inclusive approach to HIV prevention, treatment and care which includes: addressing women's economic dependence on men, challenging social and cultural norms of masculinity and violence, understanding the social constructions of gender, and incorporating men into HIV/AIDS responses.

2.4 Approaches to Gender and Sexuality: Responding to HIV. International HIV/AIDS Alliance. 2011

Region: Global

Scope:

There are a growing number of HIV and broader health initiatives that not only highlight gender issues, but also aim to change harmful norms and practices. These are called 'gender-transformative' approaches. However, there are few approaches to achieve gender transformation, and many organisations within and outside the Alliance have struggled to overcome the controversies, sensitivities and structural barriers that impede progress. Many organisations within and outside the Alliance have struggled to overcome the controversies, sensitivities and structural barriers that impede progress.

Methodology

International HIV/AIDS Alliance carried out a survey of their national Linking Organisations to map current work; assess capacity, challenges and aspirations around gender and sexuality programming; and better understand the gender and sexuality context in which their partners work. Some 28 organisations from 19 countries responded.

Findings

1. Gender inequality and discrimination, fuelled by socio-cultural issues, are the most common gender concerns.
2. Alliance partners have mixed opinions about how much national programmes respond to these gender-related challenges – ranging from partial support to active exclusion.
3. Many respondents believe a gender and sexuality approach provides a useful way of understanding HIV work that is based on the roles and expectations that affect people's lives, choices and interactions
4. Alliance partners are involved in a wide range of work that is relevant to gender-transformative approaches.
5. Key challenges to gender and sexuality work include discriminatory gender norms and inequality; low male involvement in programming and interventions; limited access to

education for women and girls; poor understanding or consensus on gender and sexuality; inadequate opportunities to share good practice; low funding levels; stigma and discrimination; and a lack of leadership, human resources, capacity and tools on gender and sexuality.

6. Only 25% of respondents feel they have the capacity to apply a gender and sexuality approach.

Recommendations

1. develop a gender strategy for Alliance partners
2. carry out a more specific assessment of the capacity needs of Alliance partners for gender-transformative approaches, and develop a plan to address these needs
3. document examples of good practice of gender-transformative approaches by Alliance partners working in generalised epidemics, concentrated epidemics, and mixed epidemics
4. ensure that gender transformation is fully integrated and addressed in the Alliance's existing and future work on good practice responses to HIV.

2.5 Gender Aspects of HIV/AIDS in the World of Work in Ukraine. ILO/AIDS. 2011

Region: Ukraine

Scope:

The main goal of this research is to collect and analyze the data which directly or indirectly characterise the HIV/AIDS-related problems of men and women, and to determine the principal directions for a complex gender approach to HIV/AIDS prevention in the world of work and at the same time to develop some appropriate recommendations.

Methodology:

Respective laws, orders, and Ministries' directives as well as programs and working materials of the Ukrainian employers and trade unions were analyzed. Interviews and consultations with experts and interested parties were undertaken.

Findings

The study has shown that most studies and expert interviews tend to mainly view the gender aspects of HIV in the context of higher vulnerability of women (both in Ukraine and in the world in general) as compared to men, due to their biological features and extensive social and gender roles in the society. There are, however few, studies describing the problem of men's vulnerability as well. A specific feature of the available information is the fact that most attention is focused either on women's and men's HIV-related behavioural features, or on the labour market situation for women and men. At the same time there is very little sociological data (and absolutely no statistical data) which could be used for gender characterization of HIV problems in the world of work as a whole.

Recommendations

The study results show the necessity of a deeper investigation of gender features of the HIV problem in the world of work. First of all, the statistical data on women and men need to be

clearly isolated and structured; based on such data, a well-reasoned analysis of their position in the labour market can be carried out.

Some uncertainty, existing in the sphere of labour relations, regarding the tacit discrimination due to an employee's gender and his/her own HIV status as well as the HIV status of his/her personal surrounding and relatives must be resolved by increasing the employers' accountability and by improving the legal competence of female and male employees.

Intensification of Gender sensitive informational and educational work among employees in order to warn female and male employees about the dangers of HIV and the routes of its transmission, as well as to provide them with better access to medical services, including treatment of sexually transmitted infections, voluntary counselling and testing, as well as general medical examinations.

Taking into account the fact that male migrants have a greater tendency than women to risky behaviour connected with injectable drug use, unprotected sex, and change of sexual partners, it is recommended that the women whose husbands migrate for work be advised to use condoms after the husbands' return and have regular medical examinations.

Addition of a component for implementation of gender sensitive approaches to fighting HIV to the State Program for Assertion of Gender Equality for 2011–2015.

B. STIGMA AND DISCRIMINATION STUDIES

Research documents on stigma and discrimination studies focus on formal and informal sector such as health sector, education sector, transport sector and civil society organisation. In these studies we underline some cross-link themes such as knowledge, behaviour, attitude and practice (KABP), sexual behaviour, health promotion to HIV prevention, treatment and care, capacity building, education and economic empowerment.

The following 9 documents are covered:

3. Stigma and Discrimination in the world of work

- a. Evidence Brief. Stigma and Discrimination at Work: Findings from the People Living with HIV Stigma Index, GNP+ 2011.
- b. HIV and AIDS related employment discrimination in China. ILO/AIDS. 2011
- c. Discrimination against people living with HIV within healthcare settings in China. ILO/AIDS. 2010
- d. Perceived barriers to employment among persons living with HIV/AIDS. *AIDS Care* 2004

- e. Employment discrimination and HIV stigma: survey results from civil society organizations and people living with HIV in Africa. African Journal of AIDS research. 2011 (Kenya, Zambia)
- f. Supporting HIV positive teachers in ESA. UN Plus. 2006
- g. ITF study on: HIV/AIDS, Ports and Port workers, ITF, 2011
- h. Report, HIV in civil aviation sector. ITF. 2010
- i. Combating HIV stigma in health care settings: What works? International Center for research on Women. 2009

3. Stigma and Discrimination in the world of work

3.1 Evidence Brief. Stigma and Discrimination at Work: Findings from the People Living with HIV Stigma Index, GNP+ 2011.

Region: Global

Scope:

The People Living with HIV Stigma Index (PLHIV Stigma Index) was developed as a joint initiative of several organizations, including the Global Network of People living with HIV (GNP+), the International Community of Women Living with HIV/AIDS (ICW), the International Planned Parenthood Federation (IPPF) and the Joint United Nations Programme on HIV/AIDS (UNAIDS). The PLHIV Stigma Index has now been rolled out in more than 40 countries, providing an enormous quantity of data to improve national, regional and international responses to HIV.

This evidence brief, prepared by the Global Network of People Living with HIV (GNP+), includes PLHIV Stigma Index findings from nine countries in four regions: Kenya, Nigeria and Zambia (sub-Saharan Africa), Estonia and Poland (Eastern Europe), Malaysia and the Philippines (Asia-Pacific,) and Argentina and Mexico (South America). PLHIV Stigma Index data clearly shows that HIV-related stigma and discrimination directly impede access to work by people living with HIV by:

- obstructing entry to the labour market
- changing the type of work individuals are allowed to perform
- preventing promotion to more senior positions
- triggering people being fired from their jobs
- impeding access to adult education and training

Methodology

The PLHIV Stigma Index questionnaire includes more than 100 questions about experiences and understanding of stigma and discrimination. The survey instrument (the PLHIV Stigma index) has been used as the tool to accurately record, analyse and reflect the experiences of the thousands of people living with HIV whose lives are reflected in this briefing.

This briefing is based on answers to 11 of those questions. Data from all nine countries were reviewed and disaggregated across different factors, particularly gender and regional residential location. The data record instances of employment discrimination experienced by those interviewed.

Findings

Key highlights include:

- 13% of respondents in Poland to 40% in Kenya and Zambia reported loss of job or source of income during the preceding 12 months.
- 8% of respondents in Estonia to 45% in Nigeria had lost their job or source of income during the previous 12 months as a result of their HIV status alone.
- 15% of respondents in Malaysia to 45% in Mexico had lost their employment/source of income as a result of their poor health. This suggests the crucial link between access to effective HIV treatment and employment security.
- 5% of respondents in Mexico to 27% in Nigeria were refused the opportunity to work.
- 4% of respondents in Estonia to 28% in Kenya had had their nature of work changed or had been refused promotion due to their HIV status.
- Wide ranging discriminatory attitudes from employers and co-workers were reported. 8% of respondents in Estonia to 54% in Malaysia reported discriminatory reactions from employers once aware of employees HIV status. Similarly, 5% in Estonia to 54% in Malaysia reported discriminatory reactions from co-workers who became aware of their colleagues HIV status.

Recommendations

The PLHIV Stigma Index findings drawn from the nine national settings clearly demonstrated that HIV-related stigma and discrimination remains a barrier to people living with HIV accessing full and productive employment and decent work. In light of those findings, GNP+ recommends that:

- Governments increase efforts to deliver human rights based on the ILO Recommendation No.200 enabling access to full and productive employment and decent work for people living with HIV. Areas of focus should include the introduction or review of work based anti-discrimination laws or other mechanisms for resolving work based disputes, including effective restitution processes;
- governments, international and local HIV agencies review and modify HIV programming to more effectively promote human rights obligations, including the right to full and productive employment and decent work for people living with HIV;
- governments and international agencies increase funding for community based legal support services, as well as centred and driven education campaigns addressing the myths and beliefs that drive stigma and discrimination;
- people living with HIV, working through representative HIV organisations, need to be supported to actively participate alongside employers and trade unions in the development and review of policies around HIV, including issues of employment related stigma and discrimination;
- business and labour leaders be encouraged to champion HIV anti-discrimination measures and stigma-free workplaces, the delivery of HIV education in work settings, and other measures needed to support the employment of people living with HIV;

- that further qualitative studies be undertaken where required to improve the evidence base on work related stigma and discrimination so that targeted and effective intervention strategies may be devised

3.2 HIV and AIDS related employment discrimination in China. ILO/AIDS. 2011

Region: China

Scope:

This report aims to develop a better understanding of HIV and AIDS related stigma and discrimination in China is essential for identifying the root causes of the problem and developing solutions to address them.

Methodology

This report undertakes a literature review of a broad body of existing research and reviews new research conducted by the ILO and Maries Stopes International.

Findings

The findings point to a trend of increasing discrimination against workers that contradicts both national policies and international standards. This body of work highlights numerous cases of employment discrimination in several key practices including:

- Mandatory testing of workers and the denial of job opportunities – particularly in the services sector, healthcare sector and the civil service;
- Forced (or pressured) resignation of people with HIV by management and/or co-workers;
- Mandatory shifting and/or downgrading of job positions as a result of HIV status;
- Breaches of confidentiality that led to discrimination; and,
- Barriers to accessing health insurance schemes for HIV treatment due concerns about confidentiality.

•

This report also identifies areas where policies in China do not protect the rights of people working in certain professions. For example, health qualification tests are required for all people working in the China civil service. Those who test positive for HIV are prohibited from working for the government in any capacity, including as teachers. Similarly, guidelines on “public sanitation” prevent people with HIV or sexually transmitted infections from working in hotels, cafes, bars and beauty salons. Routine medical tests in the health sector also prevent people with HIV from working in hospitals, clinics and other health facilities.

These policies contradict the overall spirit of the 2006 national AIDS regulation, which prohibits employment discrimination against people with HIV. The practice of creating exceptions for certain professions is also in direct conflict with international standards such as ILO Recommendation 200.

Recommendations

HIV and AIDS related employment discrimination is a complex social problem that has direct bearing on multiple disciplines including Medicine, Epidemiology, Sociology, Psychology, Economics and Law. To address this issue, China needs to improve the legal system and

raise awareness of the law among officials, medical personnel, employers and people with HIV. China should also support legal assistance centers, so that underprivileged groups can get professional support when their rights are violated at work. Following through on these recommendations will be central to combating HIV and AIDS related employment discrimination and go a long way towards protecting the rights and interests of people with HIV.

As a member of the International Labour Organization, China should take steps to bring its policies and laws in line with ILO Recommendation 200 on HIV and AIDS and the World of Work and Convention 111 concerning Discrimination in Respect of Employment and Occupation, which it has ratified.

3.3 Discrimination against people living with HIV within healthcare settings in China. ILO/AIDS. 2010

Region: China

Scope:

In order to identify the key factors behind differential access and treatment of people living with HIV to medical services, the STD and AIDS Prevention and Control Center of the Chinese Center for Disease Control and Prevention (NCAIDS) and the International Labour Organization (ILO) undertook a joint qualitative research project in August 2010.

Based on the interview responses and related documents, this report describes the current state of discrimination by medical institutions against people living with HIV, analyses the underlying factors behind this discrimination and provides a set of policy recommendations designed to better protect the medical rights of people living with HIV.

Methodology

In-depth interviews were conducted with 20 medical professionals from four designated HIV hospitals and seven non-designated hospitals in five provinces (Henan, Beijing, Guangxi, Yunnan and Gansu). This report is based on the interview responses and analysis of related documents.

Findings

Government policies have clearly defined the medical rights of patients (including those of people living with HIV). However, despite the presence of these definitions, people living with HIV still encounter difficulties when attempting to access medical services. These include:

- Denial of surgery for people living with HIV by medical institutions
- Differential treatment towards people living with HIV by healthcare workers; namely, delayed treatment, poor service quality and high service charges. Other types of differential treatment involve the use of a discriminatory attitude and discriminatory language towards people living with HIV/AIDS.
- Practical problems surrounding access to medical services by people living with HIV.

The following four key factors were identified as contributing to the denial of medical treatment for people living with HIV.

- Perceived responsibility to other patients
- Lack of hospital resources
- Profit-driven hospitals
- Poor feasibility of policies and mechanisms

The primary reasons behind differential treatment of PLHIV by healthcare workers were concerns about occupational exposure and a lack of knowledge about HIV and AIDS.

Recommendations

- 1) Improve relevant policies, including clarifying hospital responsibilities
- 2) Promote awareness among hospital management about the rights of people living with HIV/AIDS to access medical services by:
 - strengthening awareness among hospital management of the *Regulation on the Prevention and Treatment of HIV/AIDS, Tort Liability Act and National Hospitality System and Staff Job Responsibilities*;
 - promoting understanding of the medical rights of people living with HIV among hospital management; and
 - Listing 'provision of treatment for people living with HIV' as a performance management indicator for hospital administration in the evaluation systems of health administrative departments. Hospital presidents should be held accountable for this indicator and reprimanded if denial of treatment occurs.
- 3) Strengthen implementation of the universal precaution principle through:
 - Training on the principles of universal precaution is integrated into existing training for healthcare workers;
 - Existing training on preventing occupation exposure should be strengthened
 - Policies should be developed to enable healthcare workers who have become infected with HIV to continue working; and,
 - All hospitals should establish a program on HIV/AIDS prevention and treatment whilst also taking steps to reduce the level of stigma and discrimination held by health care workers towards people living with HIV.
- 4) Improve protection mechanisms for healthcare workers who have been subject to occupational exposure

3.4 Perceived barriers to employment among persons living with HIV/AIDS. Brooks RA, Martin DJ, Ortiz DJ, Veniegas RC: *AIDS Care* 2004, **16**(6):756-766.

Region: United States

Scope:

This study examined factors associated with contemplating returning to work among unemployed persons living with HIV/AIDS (PLHA) in a large urban city in the United States.

Methodology

A mailed, self-administered survey gathered information from 757 unemployed PLHA. Chi-square and logistic regression analyses were used to determine associations between contemplating returning to work and socio demographic characteristics, health factors and perceived barriers to employment.

Findings

In summary, a substantial proportion of unemployed PLHA may contemplate re-entering the workforce.

The authors found that most unemployed PLHA (74%) were thinking of returning to work, but perceived significant barriers such as loss of disability income benefits (73%), loss of publicly funded health insurance (67%) and workplace discrimination (66%). Univariate analyses indicated that contemplating returning to work was significantly associated with socio demographic characteristics health factors and perceived barriers to employment in the following areas: (1) availability of health_insurance, (2) personal health and physical ability, (3) health concerns related to working and the_work environment, and (4) current job skills. Multivariate analyses indicated that: gender, age, race/_ethnicity, health insurance type, health status and the belief that health will improve if employed were independently associated with contemplating returning to work.

Recommendations

Assistance is needed to help PLHA address perceived barriers that may prevent them from seeking employment. The additional burden of co-morbid problems may decrease an individual's interest in employment, as well as his or her ability to seek and, more importantly, maintain employment. The lack of information in this area suggests the need for additional research with HIV/AIDS populations with co-morbid problems.

3.5 Employment discrimination and HIV stigma: survey results from civil society organizations and people living with HIV in Africa. African Journal of AIDS research. 2011

Region: Africa

Scope:

The work seeks to contribute to efforts by businesses and other organisations to effectively respond to the HIV epidemic within the world of work, and to deepen our understanding of the ways in which HIV stigma and employment discrimination persist in the workplace. The article presents findings from three surveys of people living with HIV (PLHIV) and civil society organisations about the experience of employment discrimination and stigma in the workplace.

Methodology

The article provides an overview of global research on workplace stigma and discrimination related to individuals' HIV status, with an addition discussion of specific survey data collected in Kenya and Zambia.

Findings

- Employment discrimination based on HIV status is pervasive in every region of the world and it includes forced disclosure of serostatus, exclusion in the workplace, and job termination.
- Employment discrimination based on HIV status, particularly exclusion in the workplace and job termination, was reported in all African sub regions surveyed.
- PLHIV in Kenya and Zambia reported significant barriers to employment, including discrimination in hiring, loss of promotions, and job termination because of HIV status.
- Wide variances were found in the percentages of HIV-positive employees who had disclosed their HIV serostatus in the workplace and in the level of support versus discrimination they experienced after disclosure.

Recommendations

The researches introduce a conceptual framework that maps multiple points of entry within the workplace to address HIV-related stigma and discrimination.

Additional recommendations include:

- Ensure equal opportunity of PLHIV in hiring and promotion, including by ending mandatory HIV testing.
- Evaluate workplace practices and norms for differential or hostile treatment towards PLHIV, and implement workplace HIV/AIDS programmes to eliminate stigma and discrimination.
- Establish a workplace environment in which mistreatment based on HIV status is not tolerated, with mechanisms to confidentiality and to resolve complaints.
- Communicate and strongly enforce legal and workplace confidentiality policies.
- Establish support groups in the world of work.
- Critically examine job-termination procedures to rule out the possibility of discrimination, allow for review, and support the continuation of care for PLHIV.

3.6 Supporting HIV positive teachers in ESA. UN Plus. 2006

Region: Kenya, Namibia, United Republic of Tanzania, Uganda, Zambia and Zimbabwe

Scope:

UNESCO together with the three partners in the EI-EFAIDS programme – Education International (EI), Education Development Center (EDC) and the World Health Organization (WHO) – convened a consultation with HIV-positive teachers and other key stakeholders from Ministries of Education and teachers' unions from Kenya, Namibia, United Republic of Tanzania, Uganda, Zambia and Zimbabwe. The consultation aimed to share experiences and articulate common, key elements of comprehensive responses for HIV-positive teachers. Specifically, the consultation aimed to:

1) Determine the unique needs of and the impact of HIV on HIV-positive teachers, who – to date – have received relatively little focused attention; and

2) Identify the type and level of support required to adequately address HIV-positive teachers' needs.

Methodology

The consultation provided an important opportunity to discuss in detail how teachers themselves wish to be supported.

Findings

With a special position in society, teachers act as custodians, serve as positive role models and provide education and adult supervision to our children. At the same time, just like anyone else, teachers are vulnerable to HIV infection and may be personally affected by HIV in their families and communities. Those living with HIV may be unwilling to disclose their status due to fear of discrimination, unfair treatment, or loss of employment.

Recommendations

Consultation participants concluded that to enable HIV-positive teachers to continue teaching in a caring environment free of stigma and discrimination and to promote their involvement in the education sector's response to the epidemic, Ministries of Education, teachers' unions, school management and development partners need to:

Identify the needs and impact on teachers living with HIV: Teachers are not a homogenous group and being HIV-positive is not a homogenous experience. For example; the needs of an HIV-positive teacher will vary according to his or her sex, geographic location (i.e. in an urban versus a rural environment), and level of access to services. A comprehensive response supporting teachers with HIV must recognise and address the various needs of teachers at several levels: the individual (e.g., health status and emotional state); the occupational (e.g., discrimination and absenteeism); the community (stigma); and the systemic (e.g., undermining the provision of quality education).

Ensure access to prevention programmes, treatment, care and support: One of the most urgent issues is to ensure that teachers with HIV who are in need of ART are able to access affordable and confidential health, treatment, care and support services. The consultation highlighted the importance of building upon existing public treatment services and partnering between education and other public sectors rather than creating parallel programmes specifically for teachers which may inadvertently increase stigmatisation.

Provide support for teachers by teachers: On a day to- day basis, some of the most significant challenges that HIV-positive teachers face are in their workplace – schools. Therefore, the first line of response must include the school level and needs to involve all teachers regardless of their HIV status. Networks of HIV-positive teachers have been vocal in many countries of East and Southern Africa in promoting and advocating for the needs of their members; however, these groups are fairly nascent and, thus far, are limited in membership, structure and sustainability.

Developing partnerships between HIV-positive teachers' networks and teachers' unions: The strongest potential allies of these networks are teachers' unions, the largest and most powerful bodies promoting the interests and welfare of teachers. The consultation provided

an important opportunity for unions and networks of teachers with HIV to begin developing partnerships and jointly advocating for the rights of HIV-positive teachers but more work is required to realise the full potential of these partnerships. Important programmatic components of comprehensive responses for supporting HIV-positive teachers include:

- HIV and AIDS workplace policies for the education sector
- Training and skills-building
- Strategic partnerships, including with school administrators and other sectors
- Community-based activities
- Monitoring and evaluation

3.7 ITF study on: HIV/AIDS, Ports and Port workers, ITF, 2011

Region: Global, with surveys conducted in Belgium, Guatemala, Kenya and India

Scope:

In order to deepen understanding on rights-based activities on HIV and AIDS in its services and plan more appropriately, the ITF decided to conduct a survey in the ports sectors, seeking the views of affiliated unions and carrying out a study of knowledge, attitudes and behaviour in selected countries.

In 2010 a study was initiated into HIV/AIDS in docks and ports. Its aims were:

- to gather and analyse information on the impact of HIV/AIDS in the port sector and the related trade unions;
- to increase understanding of the HIV/AIDS knowledge, perceptions and needs of ITF affiliates; and
- to prepare appropriate responses.

Methodology

A report on the views, activities and needs of ITF affiliated unions in relation to HIV/AIDS; second, summary findings of the KAB survey conducted among the members of ITF affiliates in the ports of four countries – Belgium (Antwerp), Guatemala (Porto Santo Thomas), Kenya (Mombasa) and India (Chennai and Mumbai).

Findings

Union members in the four countries in the KAB survey believed that HIV/AIDS was a concern for their countries and an issue for the workplace. Union officials in all but three of the 22 countries (29 affiliates out of 33 respondents) in the affiliates' survey asked for ITF assistance in starting or – more often - expanding HIV/AIDS activities for members and developing policies or agreements for their workplaces.

It was noticeable that even in very different settings there were significant information gaps. In some areas higher HIV prevalence correlated with higher knowledge but gaps remained in all of the countries.

In all countries some workers believed themselves – rightly or wrongly - to be at risk of contracting HIV.

In many workplace settings the involvement of people living with HIV in policy development, awareness raising and education has been one of the most effective ways of tackling fear and stigma.

Workplace action on HIV/AIDS

The numbers benefiting at the workplace from some kind of policy and programme on HIV and

AIDS were encouraging, and the efforts being made in Kenya in particular are bearing fruit. The fact that over half the workers in both Kenya and India were covered by a collective agreement (which has more force than a policy) is very satisfactory and deserves monitoring by the ITF in terms of the outcomes the agreements promote.

More of the workplaces had HIV/AIDS activities than policies or agreements, but there is clearly an unmet need according to the interest expressed by the workers

Recommendations

Establish an HIV/AIDS programme for affiliates in ports and docks

The ITF should respond to the needs and interest expressed by affiliates and their members by planning and implementing an HIV/AIDS programme for the port sector, in consultation with the affiliates concerned.

Its main focus would be to offer guidance on promoting workplace action in two main areas:

- i) negotiating collective agreements or workplace policies concerning HIV/AIDS, in order to protect rights, combat stigma and promote prevention and care; and
- ii) providing education and support for workers through the establishment and support of a network of AIDS focal persons at the workplace and teams of peer educators.

Work in partnership with employers and other interested parties, especially the ILO and UNAIDS, to develop relevant activities, perhaps including further research. The ITF can support the ILO's ports programme through the mobilisation of affiliates as well as benefiting from the training opportunities and materials offered by the ILO. A particular focus should be on collective agreements for sectors and specific workplaces, and in this and other areas the ITF should work with other global unions at international, regional and local levels.

Benefit from and contribute to the implementation of key international standards and agreements such as ILO recommendation 200 concerning HIV and AIDS in the world of work (2010), UNAIDS Strategic Priority Action Area no. 10 (2009) promoting corporate social responsibility and workplace action, and paragraph 85 of the UN General Assembly Declaration on HIV and AIDS

(June 2011) which "calls on employers, trade and labour unions, employees and volunteers to eliminate stigma and discrimination, protect human rights and facilitate access to HIV prevention, treatment, care and support".

3.8 Report, HIV in civil aviation sector. ITF. 2010

Region: Global, Argentina, Bulgaria, Ethiopia, India and Jordan

Scope:

In order to establish whether civil aviation is subject to the same risks and pressures from HIV/AIDS as other sectors, the ITF initiated a study in 2010 which compiled the views of affiliated unions and surveyed the knowledge, attitudes and behaviour (KAB) of a cross-section of individual members in five countries: Argentina, Bulgaria, Ethiopia, India and Jordan. The aim was to gather information that would help the ITF assess need and provide a basis for planning interventions.

Methodology

A questionnaire was sent to all of the ITF's affiliates in civil aviation; 25 replies were received from 22 countries, which compares reasonably well with the normal response rate for e-mail questionnaires in the organisation. Nine of the replies were from Africa (seven countries), five from the Americas (four countries, North and South), three from Arab States, three from Asia and the Pacific, five from Europe.

Five countries were also selected for a KAB survey: Argentina, Bulgaria, Ethiopia, India and Jordan.

Findings

The KAB survey revealed some information gaps and misconceptions, which tended to result in fear of contact with HIV-positive co-workers; at the same time there was a high level of interest in gaining more knowledge and in contributing to national responses to HIV/AIDS. The great majority of workers saw HIV/AIDS as a workplace issue, and in all countries respondents had witnessed incidents of stigma and discrimination; they expressed support for the ITF in its efforts to provide education in this area and defend rights.

Recommendations

The key recommendation is that the ITF should put in place an HIV/AIDS programme tailored to the civil aviation sector and taking account of local conditions and needs. More detailed points are made about:

- interventions to strengthen the capacity of affiliates to develop their own programmes and include HIV/AIDS in the collective bargaining agenda
- participatory education to promote behaviour change
- the provision of information, data and materials
- policy and educational measures to combat stigma and discrimination

3.9 Combating HIV stigma in health care settings: What works? International Center for research on Women. 2009

Region: Global

Scope:

The purpose of this review paper is to provide information and guidance to those in the health care setting about why it is important to combat HIV-related stigma and how to successfully address its causes and consequences within health facilities.

Methodology: Literature review

Findings

Research shows that stigma and discrimination in the health care setting and elsewhere contributes to keeping people, including health workers, from accessing HIV prevention, care and treatment services and adopting key preventive behaviours.

Studies from different parts of the world reveal that there are three main immediately actionable causes of HIV-related stigma in health facilities: lack of awareness among health workers of what stigma looks like and why it is damaging; fear of casual contact stemming from incomplete knowledge about HIV transmission; and the association of HIV with improper or immoral behaviour.

Recommendations

To combat stigma in health facilities, interventions must focus on the individual, environmental and policy levels. The paper argues that reducing stigma by working at all three levels is feasible and will likely result in long-lasting benefits for both health workers and HIV-positive patients. The existence of tested stigma-reduction tools and approaches has moved the field forward. What is needed now is the political will and resources to support and scale up stigma-reduction activities throughout health care settings globally.

Recommendation in awareness raising and education is the most effective way of tackling fear and stigma. The gaps in knowledge about HIV transmission are potentially dangerous and should be of concern to all stakeholders. More detailed points are made about: interventions to strengthen the capacity of members to develop their own programmes and include HIV/AIDS in the collective bargaining agenda; participatory education to promote behaviour change; the provision of information, data and materials; policy and educational measures to combat stigma and discrimination.

C. *IMPACT STUDIES*

This section presents impact studies from world of work projects undertaken by IATT members.

The following 12 documents are covered:

4. World of Work Impact Studies

- 4.1 Socio-Economic impact of HIV/AIDS on people living with HIV/AIDS and their families. India. ILO/AIDS. 2003
- 4.2 A Study on the Economic Impact of HIV/AIDS on People Living With HIV (PLHIV)
- 4.3 Accessing Anti Retroviral Treatment (ART) Centres in New Delhi. ILO/AIDS. 2010
- 4.4 Prevention of HIV/AIDS in the world of work: A tripartite response: Knowledge, Attitude, Behaviour and Practices (KABP) Study of Medical (Nursing) and Para-medical personnel of ESIC hospitals on HIV/AIDS/STI and TB. ILO/AIDS. 2010
- 4.5 Study Report on Economic Impact of HIV/AIDS on Singareni Collieries Company Limited (SCCL). India. ILO/AIDS. 2010
- 4.6 Impact Assessment of ILO/USDOL HIV/AIDS Workplace Education Project, ILO, 2009
- 4.7 Cross-Country Study of the ILO/USDOL HIV/AIDS Workplace Education Program Strategic HIV/AIDS Responses in Enterprises (SHARE), ILO, 2008
- 4.8 The cooperative model for the delivery of home based care services for people living with HIV. ILO/AIDS. 2011
- 4.9 Impact Study of HIV and AIDS on the United Nations System. UN Cares. 2007 The second national-HIV Communication survey. Health Department, USAID/PEPFAR & CDC. 2011
- 4.10 Addressing HIV and AIDS in Ugandan CSOs Applied Research, End report, STOP AIDS NOW!, 2009
- 4.11 Implementation of HIV and AIDS. Workplace Policies in Ethiopian NGOs, Applied Research, phase 3, report, STOP AIDS NOW!, 2011
- 4.12 Experiences and Lessons Learnt in the project 'Managing HIV and AIDS in the Workplace' in South Indian Non-Governmental Organizations End Report Applied Research, STOP AIDS NOW!, 2011

4. World of Work Impact Studies

4.1 Socio-Economic impact of HIV/AIDS on people living with HIV/AIDS and their families. India. ILO/AIDS. 2003

Region: India

Scope:

The study was undertaken with the objectives:

- (a) to document the overall experiences of PLWHA and their families ever since the discovery of their HIV status. (Stigma, impact on employment status, family income and expenditure, availability of care and support services, etc.)
- (b) To understand the impact of HIV/AIDS on women and children.

Methodology

The study was conducted in four states — Delhi, Maharashtra, Manipur and Tamil Nadu through the networks of people living with HIV/AIDS. In all, 292 respondents, of whom 42 per cent were women, were covered in the study. Data was collected from infected and affected people through interviews, focus group discussions and in-depth interviews.

Findings

The study revealed that HIV has, in general, made a deeper impact on women who have faced more discrimination, more hardships and had to assume more responsibilities to run the households once their husbands died of AIDS.

Most of the women (nearly 90%) got the infection from their husbands. So, marriage is a route of transmission of HIV for women.

The data revealed that HIV is infecting people with varied educational backgrounds. However, people with higher educational qualifications are coping better. Women, in general, had received lesser education, making them more vulnerable to infections and economic insecurity.

About 70 per cent respondents received pre-and-post HIV test counselling. The data shows that counselling was done mainly at the government hospitals and not in private institutions providing HIV-testing facilities. 78 per cent of those who had been counselled took precautions to protect their partner/child from getting infected. However, in most cases, people came to know of their HIV+ status only after a period of prolonged illness.

Around 47.54 per cent women respondents were widows. Given the mean age of women respondents (30.1 years), this shows that women are increasingly becoming widowed at a very young age as a result of AIDS.

About 89 per cent respondents said they needed someone to take care of them when they were ill and in most cases the care-givers were women. This places an additional burden on women who have to handle regular household chores as well.

Stigma and discrimination associated with HIV continues to be a major challenge. As many as 70 per cent of the respondents reported that they faced discrimination. Reported discrimination was more in the case of women (74%) than men (68%). Maximum discrimination was reported from within the family (33.33%), closely followed by health care settings (32.5%). Nearly 18.3 per cent people faced discrimination from their neighbours and nine per cent from community/educational institutes/ relatives.

Around six per cent respondents reported discrimination at the workplace. Many PLWHA had not disclosed their status to the employers as they feared losing their job. Denial of

promotion, forced to take voluntary retirement are some of the reported instances of discrimination at the workplace. Discrimination from co-workers was also highlighted as the main reason for changing jobs. This shows that confidentiality norms are not being followed or are difficult to follow at the workplace.

About 27 per cent of the respondents had other HIV+ members in the family. Of these 81 per cent were their spouses. Caregivers who looked after PLWHA were mostly spouses (60%), followed by parents (32%), children (6%) and siblings (2%).

About 29 per cent respondents were unemployed. Ill health was one of the major reasons for unemployment. Nearly 39 per cent were employed in public or private sector (mainly NGOs). Nearly 20 per cent of the respondents lost their income due to absence from work.

Average monthly income of PLWHA families was reported to be Rs.1,117, whereas the average monthly expenditure was Rs. 3,185. On food alone, the increase in the average monthly expenditure of families post-HIV infection was Rs. 350, while the rise in expenditure on medicines was Rs. 468 (almost double). Consequently, there was decrease in expenditure on entertainment by Rs. 522 per month and on education of children by Rs. 266. As their income was not sufficient to meet their expenditure, people had to sell off their assets and borrow from friends and relatives. As a result, debts in such families increased to the tune of Rs. 4,818 per family on an average.

Children of PLWHA also faced discrimination due to the HIV+ status of their parents. They were not allowed to play with other children, verbally abused or teased. Decrease in monthly expenditure on education clearly indicates that children are being withdrawn from schools. About 35 per cent children were denied basic amenities and about 17 per cent had to take up some petty jobs to fulfil the increasing monetary demands of the family. This indicates HIV may be exacerbating child labour in India as in other worst-affected countries.

Not surprisingly the key concerns expressed by PLWHA are: regular income in the households; care of their spouses and children, particularly after their death; and access to treatment.

Recommendations

- The findings show that a majority of the infected people fall in the highly productive and reproductive age-group. Thus, interventions should be developed for specific target groups. Intensive efforts should be made to reach out to the youth and lesser-privileged groups.
- Voluntary testing needs to be intensified further.
- Given the high costs of the epidemic, the need for preventive policies is generally accepted. Policymakers need to recognize that cost effective IEC (information, education and communication) must be well designed and target-group oriented.
- In addition to preventive efforts, government and non-governmental agencies should also emphasize the importance of proper diet, exercise, medication and healthy lifestyle to the infected persons. Medicines should be made available at highly subsidized rates, if not free of cost.

- The role of family becomes very crucial in planning various interventions for HIV prevention, care and support.
- Therefore, existing structure in healthcare settings needs to be strengthened. In addition, referral centres and facilities should be made available. Orphanages and adoption centres need to be opened to take care of the affected children.
- Corporate sectors should be encouraged to absorb infected people. All corporate organizations have some social objectives in their agenda. They should be motivated to plan and implement employee welfare schemes and modify existing schemes. Government may introduce some incentives for such initiatives. Some HIV+ persons also suggested introducing income-generation schemes so that they could make themselves economically strong.
- Policies should be made stringent so that HIV-infected persons are not thrown out of their jobs. There is a need to modify the workplace policies so that other family members can get the job during the illness/after the death of HIV+ persons.
- Policy options should also include ensuring access to education and basic health services; protecting inheritance rights of widows and orphans.
- The study has shown that close interpersonal interaction of NGOs with people has proved extremely useful. This can help in implementing behavioural interventions necessary for HIV/AIDS care and support and to shun discrimination.
- The study also highlighted the lack of counselling services at testing centres/hospitals. However, NGOs/networks often interact with the infected persons, which help them cope with their problems. This should be further strengthened.
- There is an urgent need to empower infected people and their families to demand their rights. Discrimination at any level is a violation of human rights.

4.2 A Study on the Economic Impact of HIV/AIDS on People Living With HIV (PLHIV) Accessing Anti Retroviral Treatment (ART) Centres in New Delhi. ILO/AIDS. 2010

Region: India

Scope:

The main objective of the study was to assess: The Economic Impact of HIV/AIDS on PLHIV Accessing Anti Retroviral Treatment (ART) Centres in New Delhi. The distinct objectives to be studied were:

- To assess the economic impact of HIV on PLHIV and their families.
- To identify the constraints and costs faced by PLHIV in accessing ART.
- To identify the stigma and discrimination faced by PLHIV.
- To assess the effects of ART on the PLHIV's ability to work and lead a productive life.
- Other socio-economic characteristics of the PLHIV.

Methodology

The ART centre operating in the Dr. Ram Manohar Lohia Hospital (RMLH) was selected for the study.

A sample size of 75 PLHIV, aged 18 and above, was chosen for data collection: comprising of 66 PLHIV on ART and 9 on pre ART.

A specific tool was designed for the compilation of data in the form of a questionnaire. The methodologies used for data collection were:

- Primary data collection via face-to-face interviews with the PLHIV accessing the RMLH ART centre.
- Qualitative information via in-depth discussions with PLHIV accessing the RMLH ART centre.

Findings

Generalising the analysis of the sample data to the PLHIV who access all the government run ART centres in New Delhi, the following were the key findings:

Socio-economic characteristics

- Forty-four percent of the PLHIV accessing ART centres are males, while the remaining 56% are females. Ninety-two percent of the PLHIV fell in the most productive age bracket: 18 – 45 years, with approximately half of them being between the ages of 26 – 35 years.
- Approximately 69% of the PLHIV were married and 21% were widowed. Ninety-four percent of the widowed PLHIV were women. Only 2% of the women were single, entailing that married women are vulnerable to HIV transmission through their spouses.
- Only 42% of the respondents were from Delhi originally, with migrants and outsiders constituting 39% and 21% respectively.
- The PLHIV accessing the ART centre had predominantly low educational qualifications.

Details of HIV test

- Three-fourths of the PLHIV had gone to a government hospital/facility to get tested for HIV, while only a fourth/25% had gone to a private facility/hospital.
- Almost 90% of the PLHIV who had gotten tested at a government facility/hospital had received pre-test and post-test counselling as compared to 63% of those who had gone to a private hospital/facility.

Disclosure of HIV test and facing discrimination

- Amongst those who had revealed their HIV status in their workplace, nearly 30% had suffered discrimination.
- Discrimination prevails at hospitals, in particular by government employees in charge of providing crucial public services such as ration cards, pension etc.

Impact on Employment

- While the percentage of PLHIV employed in the government sector pre HIV and presently has remained almost constant at 9 – 10%, while from the private sector, those in the formal sector have reduced (from 34% to 27%) and the PLHIV in the informal sector have increased (from 56% to 64%).
- Almost half of the PLHIV regularly employed changed jobs after being diagnosed with HIV. From these, 33% had to quit due to ill health, 9% were dismissed when their HIV status was found out and 10% quit after encountering discrimination at their workplace due to their HIV status becoming known.
- Seventy-two percent of the employed PLHIV felt that their HIV status affects their earning. The three major reasons were: fatigue and low strength effects work (cited by

22%), ill health affects work (cited by 24%), and the mental impact of being HIV positive affects work (cited by 16%).

Impact on Income

- Overall, the income levels earned by working PLHIV before HIV diagnosis were greater than those earned by working PLHIV currently.
- The overall monthly household income levels of the PLHIV were higher before they were diagnosed with HIV than currently.
- Approximately 77% of the PLHIV needed to buy additional medicines than the ones given free of cost at the ART centre.

Recommendations

The following recommendations are:

1. It is essential that the economic burden does not exacerbate the health of PLHIV. Support should be provided for a) Nutrition; b) Provision of OI medicines; c) Reimbursement of cost of transport; d) Reimbursement of opportunity costs of daily wage foregone; and e) An innovative referencing system for PLHIV who require additional medicines.
2. A greater awareness campaign (than the one at present) clearly listing the main routes of transmission of HIV through innovative mechanisms, such that even a completely non-literate person can understand, is recommended.
3. A rehabilitation scheme for widowed HIV positive women or possibly their integration into existing livelihood support/vocational programmes is recommended. Additionally, they must be aided with other difficulties, such as getting access to their late husband's pension.
4. Strong recommendations to private hospitals for pre-test and post-test counselling, and perhaps an inclusion under the National Policy's domain is advised.
5. Sensitisation of the doctors, nurses, paramedical staff and other employees at hospitals is recommended and non-discriminatory attitudes must be strictly enforced and monitored.
6. Sensitisation of government employees providing services where one's HIV status may come up, such as in the making of ration cards, and monitoring of behaviour to ensure it is non-discriminatory, are strongly advised.
7. The National Policy on HIV/AIDS in the World of Work should be implemented in workplaces to ensure that PLHIV are not discriminated against. Additionally, workplaces must be flexible in providing PLHIV who are suffering from constant fatigue or who are in deteriorating health less strenuous options to their prevailing roles at work.
8. The welfare of children of PLHIV, with regards to their education, nutrition and psychological impact must be a major priority, and link-ups with NGOs working for children must be made.

9. With 81% of PLHIV claiming to be physically fit to work by their own perception but earning low levels of incomes, linkages with income generation schemes or vocational training must be devised for them or they should be integrated into such existing schemes.

10. At least one of the counsellors in each ART centre should be a PLHIV who has had experience working in the field of HIV/AIDS.

14. Several employed PLHIV face constraints in accessing ART when their jobs require them to travel for months at a time. The ARV drugs are not given for more than a month at a time at the

ART centre, and this results in the PLHIV missing their dosage. An easily transferable system such that a PLHIV can access the ARV drugs in another state/city must be devised.

4.3 Prevention of HIV/AIDS in the world of work: A tripartite response: Knowledge, Attitude, Behaviour and Practices (KABP) Study of Medical (Nursing) and Para-medical personnel of ESIC hospitals on HIV/AIDS/STI and TB. ILO/AIDS. 2010

Region: India

Scope:

This study was commissioned as part of the technical support by ILO under the program “Prevention of HIV/AIDS at workplaces: A tripartite response” to the Ministry of Labour and Employment (MOLE). Objective of the study is to understand the current level of knowledge, Attitude, behaviour and practices of medical staff (nursing) and Para-medical staff (nursing orderlies) on HIV and AIDS, Sexually transmitted infections (STIs) and TB and its co-relation with HIV/AIDS.

Methodology

Personal interviews using a structured questionnaire and Focused Group Discussions (FGD) were the data collection methods and tool employed for this survey. Structured questionnaire was adapted and modified from the existing ILO’s tool on KABP and the WHO’s STOP TB programme. A total of 100 interviews were conducted with the Staff Nurses, Nursing sisters and Nursing orderly

Findings

Knowledge of Health care worker about HIV/AIDS, STIs and TB

1. 100% respondents reported that they have heard the word HIV and AIDS.
2. All the respondents were aware of four Routes of HIV transmission.
3. 59% respondents were aware of sexually transmitted infections other than HIV.
4. 53% respondents were aware of co-relation between STI and HIV.

Prevention:

1. Participants were aware of HIV prevention through condoms and using safe blood for transfusion. Although 11% respondents still believe that faithfulness to one’s partner is not guarantee of HIV prevention.
2. Only 66% respondents believe that mother-to-child HIV transmission may be prevented by adopting special measures.

Myths:

1. 10% respondents (staff nurses and nursing orderlies) believe that HIV may transmit through toilets used by a person affected with HIV while 7% are not sure about this.
2. 14% respondents (staff nurses and nursing orderlies) believe that HIV may transmit through mosquito bite.
3. 7% respondents (staff nurses and nursing orderlies) believe that HIV may transmit through cough or sneeze.

Practices:

1. 18% respondents (staff nurses and nursing orderlies) either refused to acknowledge universal precautions necessary for a health care worker or they didn't have much information about this.
2. "Pricks from infected needles" was most common response from the participants about HIV infection in hospitals..
3. More than 90% staff nurses and nursing orderlies mentioned (first response) use of gloves as best way to protect from HIV infection while 94% nursing sister said about use of double gloves as means of protection.

Attitude:

1. 13% respondents said they would not use same toilet used by person affected with HIV.
2. 94% respondents from three categories admitted that they won't feel uncomfortable in attending HIV+ patient.
3. 96% respondents felt that they would be comfortable in doing duty at the wards where HIV+ patients are admitted.
4. 90% respondents did not recall any incident which involves any discrimination with staff or with patients in hospital.
5. 88% respondents believed that ESIC won't terminate service of an employee on the basis of HIV+ status.
6. 65% respondents said emphatically that ESIC don't have policy on HIV/AIDS while 33% were not sure about this.
7. 60% respondents said that there is no provision of mandatory testing of HIV for new recruits in ESIC hospitals
8. 79% respondents were aware of HIV/AIDS services provided by the hospital.

HIV and TB

1. TB infection through droplets was the most common response in all the three categories.
2. 99% respondents believed that TB is curable.
3. All the nursing sisters (100%) and nearly half of the respondents (48%) among the categories of staff nurses and nursing orderlies believe DOTS as specific and permanent cure for TB.
4. 81% respondents believe that a person affected with HIV should be careful about TB infection.

Recommendations

1. Mother to child transmission of HIV and its prevention needs to be highlighted through display of posters at the hospitals.
2. There is an urgent need to orient the staff on Sexually Transmitted Infections (STIs) and its co-relation with HIV

3. BCC material should be prepared and displayed at appropriate places at the hospitals to address the commonly prevalent myths about transmission of HIV especially through “use of toilets”
4. Hospital should organize training/orientation programme on Universal precautions necessary for a health care workers to protect from HIV. This should also include information on Post Exposure Prophylaxis (PEP) in case of an emergency.
5. Appropriate BCC material should be displayed highlighting negative impact of stigma and discrimination with PLHIVs or with a patient suspected of being HIV+ in hospitals.
6. ESIC should evolve a mechanism to inform the staff about its stand on HIV/AIDS and policy to take care of interests of staff and patients in the hospital so that staff must understand that they are also part of the strategy to fight against HIV. This should also include dissemination of Government of India’s (GOIs) guidelines about testing of HIV.
7. Staff, patients and relatives should know that Integrated Counselling and testing center (ICTC) are there to take care of those affected with HIV.
8. A proper training calendar for HIV/ADS, STIs and TB should be prepared and distributed. This is necessary as staff members who have received trainings/orientation on HIV were not sure about the event or its purpose.
9. BCC material on TB, DOTS and co-relation with HIV should be widely displayed at the hospitals. Currently very few posters were displayed.
10. All the staff needs periodic orientation on HIV updates and safety procedures necessary for a health care worker.
11. BCC material like posters, handbills and display boards are not sufficient.

4.4 Study Report on Economic Impact of HIV/AIDS on Singareni Collieries Company Limited (SCCL). India. ILO/AIDS. 2010

Region: India

Scope:

SCCL is a joint enterprise of the Government of Andhra Pradesh and the Government of India. SCCL produces about 10 percent of the country’s coal production.

The study aimed at:

- Assessing the vulnerability of SCCL employees to STI/HIV/AIDS.
- Assessing the impact of HIV/AIDS on SCCL in terms of:
 - a) Loss of production, if any
 - b) Medical expenses; and
 - c) Increased expenditure on employee replacement, in case of AIDS-related illnesses and deaths, if any
 - d) Any other expenditure incurred by SCCL in support of the employees infected and affected by HIV/AIDS.
- Assessing the future impact of HIV/AIDS on the company in the light of workers’ vulnerability and present trends.

Methodology

1. Desk Review of Reports and other documents including medical records of the company were perused for obtaining the necessary information.

2. KAP Survey among a sample of 500 workers (0.05 Percent of 1 lakh workers approx.) with the help of a structured questionnaire. All mines of SCCL were covered under the survey.

3. Focus Group Discussions: Two focus group discussions were held at two important sites i.e. Ramagundam and Bhuplapalli mines.

4. In-depth interviews among key informants at different levels i.e. Management Personnel, HRD personnel, Medical personnel and representatives of the Labour unions were also held as part of the study. Thirty-one Key informant Interviews were conducted at the different sites.

Findings

Costs of HIV to SCCL are already substantial, even if calculated only on the basis of reported infections. The costs of supporting estimated number of infected employees and their dependents, even at the most conservative estimates, are huge. These costs are likely to go up as the infection spreads further and the prevalence levels go up.

Key conclusions that can be drawn from the SCCL case study, which enterprises need to take note of, are as follows:

- There is a strong case for action against HIV/AIDS at the enterprise level - both social as well as economical.
- The HIV/AIDS costs remain hidden for years and enterprises may not realize as they don't keep separate records for HIV/AIDS. This highlights the need for monitoring and documentation of health records at the enterprise level.
- Recorded HIV cases at the enterprise level will always be less than the actual or even estimated numbers as HIV infection does not show immediate/ exclusive symptoms for years; stigma and discrimination associated with HIV/AIDS keeps people away from seeking information and services, and due to very personal nature of STI/HIV infections, people generally go to outside facilities, rather than coming to the company facilities/hospitals.
- Early prevention helps. This is best done through internal people in order to integrate HIV/AIDS into the ongoing welfare programme for employees.
- Enterprises must seek technical support from expert agencies to help them start their HIV/AIDS response.
- The quality of prevention programme is the key in order to address gaps in knowledge, enhance risk perception of individuals and develop non-discriminatory attitudes towards people living with HIV/AIDS.
- A comprehensive response at the enterprise level means both prevention as well as care and support of those infected and affected. Provision of ART to infected employees is cost effective rather than paying huge sums in compensation to infected employees when they die or lose their capacity to work.
- Enterprises need to define their policy on HIV/AIDS to guide their response.

Recommendations

Following recommendations are made to SCCL on the basis of this study:

- The Company may develop its policy, through an internal committee, following the

recommendations of the ILO Code of Practice on HIV/AIDS and World of Work and the National HIV/AIDS Policy framework.

- The Company should consider providing ART to infected employees by building effective partnerships with relevant agencies.
- There is a need for sensitization and training programmes for different levels including top and middle level management, unions, doctors etc. for ensuring a comprehensive programme at SCCL. This will also create an enabling environment for implementation of policy and programmes.
- Interpersonal education needs to be intensified in the company to raise the quality of awareness and dispel several myths and misconceptions.
- More systematic documentation of medical information including maintenance of records and recording of data needs to be given priority by the medical department for review and monitoring the diseases and planning preventive and care and support services in the Company.
- At present PMTCT/VCCTC facilities are not accessible to the company employees and their families. These may be extended through company facilities. Appropriate linkages could be developed with State AIDS Control Society and other agencies for this purpose.
- Medical staff/Welfare officers can be the key points for facilitating the HIV prevention work and extending care and support services. Their capacities need to be built to carry out long-term health education and other prevention and care services.
- Condom access and awareness on the use of condoms needs to be improved in the mining areas and supply of condoms must be monitored regularly.
- Staff capacity building needs to be given priority particularly in nodal departments like Medical and Welfare. All welfare officers should be given training on HIV/AIDS so that they can serve as focal points for information and awareness on HIV/AIDS.
- There is need for specialized counsellor at health facility/hospital who will extend counselling services on HIV and other health matters like alcoholism, occupational diseases etc.
- Labour Unions can play an effective role in spreading the awareness on HIV and facilitating the prevention and care and support services. Union meetings should begin with a sensitization component on HIV with a discussion on prevention and care issues.

4.5 Impact Assessment of ILO/USDOL HIV/AIDS Workplace Education Project, ILO, 2009

Region: Global

Scope:

The ILO/USDOL SHARE programme has collaborated with approximately 650 partner enterprises from various sectors to reach almost a million workers and their families through projects in 24 countries worldwide. This report provides a comprehensive endline impact assessment of the programme.

Methodology

A Performance Monitoring Plan (PMP) with country-specific indicators was developed to assess the impact of projects in various locations. This monitoring system was designed at three levels i.e. worker level, workplace level and national level. The study intended to gauge the level of worker's knowledge regarding HIV/AIDS and STI's. It also makes an attempt to explore the attitude and behavioural aspect of management/ workers towards HIV infected co-workers besides the sexual and behavioural practices adopted by the workers.

Findings

The knowledge of workers was analyzed based on their knowledge about transmission of disease, identification of some common misconception and their awareness about various methods of prevention from HIV/AIDS. A significant overall increase of 15 percent point in usage of condom with a non-regular partner was observed. The knowledge levels on modes of HIV prevention was observed among the workers over the baseline. The endline reported 68.8 percent respondents with correct knowledge about three modes of prevention from HIV. They were now more aware about the risk associated with not adopting preventive measures for HIV/AIDS. Almost all of the respondents accepted that condom should be used while having sex with a person other than regular partner and a significant increase of 14% was observed in the behaviour of workers regarding this issue.

When the attitude of survey respondents towards a co-worker infected with HIV/AIDS was analyzed, an overall increase in non-discriminatory attitude towards HIV positive co-worker was found. The change was further found to be statistically significant with 17.5 percent point increase with endline at 67.7 percent. The interventions were also found to have positive impact on employer's attitude towards HIV+ employee.

The workplace interventions were not limited to increase in awareness knowledge level of workers regarding HIV/AIDS but it focused on workplace level interventions also. This is reflected in the adoption of policy on HIV/AIDS at workplace level. Most of the workers accepted the presence of services related to HIV/AIDS in their workplace. The kind of services which were available at the work place as recalled by respondents are – HIV prevention education, availability of condoms, care and support information, STI information, and VCT information.

One of key objective of ILO's workplace intervention is to advocate with the management to have an HIV/AIDS policy at workplace ensuring fair and just treatment to all workers. The present study shows significant increase of 67 percent point change in policy related indicators from baseline to endline. Apart from incorporation of policy on HIV/AIDS, the workplaces also recognized adoption of policy on STI and VCT. It was observed that globally, 88% enterprises included promotion of VCT as a component of their workplace policy in the endline. Also, a significant increase of 63% was reported in the endline in the number of enterprises with active joint committees addressing issue of HIV/AIDS. There was a significant increase in the percentage of workplaces allocating specific budget for implementing HIV/AIDS program. The endline reported 77.7% workplaces that allocate official working hours to HIV/AIDS educational program implementation. India, China, Benin, Russia and Ethiopia are some countries that have reported most significant change in terms of adopting policy on HIV/AIDS within the workplace.

4.6 Cross-Country Study of the ILO/USDOL HIV/AIDS Workplace Education Program Strategic HIV/AIDS Responses in Enterprises (SHARE), ILO, 2008

Region: Barbados, Benin, Botswana, Cambodia, and India

Scope:

This study of SHARE, Strategic HIV/AIDS Responses in Enterprises, was jointly conceived by the International Labour Organization (ILO) and the United States Department of Labour (USDOL) to gather insights into the project and to inform future programming. The following target countries were selected based on availability of sufficient data, global geographic dispersion, and prevalence (both low and high) in the target countries: Barbados, Benin, Botswana, Cambodia, and India. Except for Botswana and India, and to some extent Cambodia, most companies participating in this multi-country study had very little actual experience with workers who had AIDS, but all of the governments involved rightly perceive the vulnerabilities of segments of their population to HIV infection.

Methodology

The two-person study team used a combination of methods to ensure a thorough and well-rounded understanding of how each country's experiences, with nuances and modifications, could be carried out. The team worked in India, Cambodia, and Thailand; and in Barbados, Benin, Botswana, Geneva, the Caribbean, and Washington, DC. The approach involved document review, background interviews, and field visits, which included in-depth interviews, individual and small group discussions, and observation. The types of stakeholders interviewed included current and former project staff, government and NGO personnel at the national and provincial/state levels, workers' organizations and individual enterprises, as well as networks of people living with HIV (PLHIV). The purpose was to study the project linkages to existing national policies and frameworks, as well as the effectiveness and degree of implementation of project materials.

Findings

The outcome of the ILO/USDOL SHARE project demonstrates that an effective government response to HIV in the world of work should be characterized by a tripartite structure (involving ministries of Labour, and employer and worker organizations) with an ability to reach workers and mobilize enterprises for the prevention of HIV. Effectiveness is further enhanced by the multiplier effect of this approach, with the positive impact filtering through to families and communities. This study finds that SHARE is a project well worth the investment, as it provides examples and strategies useful to address HIV in workplaces. Its design responds to the complexity of the AIDS phenomena with a set of sequential interventions to address stigma and discrimination, build capacities at several levels, and alter risky practices.

Key Strengths of the Project

The SHARE Model components, including the results-oriented Project Advisory Board and its role in national-level policy advocacy; the specially-designed and well-received Behaviour

Change Communication methodology, the creation of Workplace Policies, and HIV committees added to the list of valuable interventions. Other features of the program that were done well were most aspects of monitoring and evaluation, and the enterprise-based data collection. It is also worth acknowledging the efforts and achievements of the project in the informal economy. Finally, the project strategy utilized human capital and built capacity among various levels of stakeholders. The capacity of enterprises was strengthened through the education gleaned, the services made available, and the increased solidarity and understanding between management and workers. Focal Points and Peer Educators gained new skills and knowledge. The tripartite constituency was strengthened in many ways as well.

Workplaces

The capstone of the project was the strength that emerged in workplaces. Enterprises, through managers and workers, recognized the responsibility that they had to address HIV and AIDS in the locus of economic productivity in their society. The establishment of committees, and open discussion and development of guidelines and policies, plus activities designed to address specific workplaces, empowered workers at all levels.

ILO's Professional Approach As the international agency dedicated to the World of Work, the ILO brings a presence to the project that local or international NGOs do not have. The relationship with governments and the credibility that it has with its tripartite constituents is significant and for the most part unflinching. For some employers and workers, it was the first time they had been involved in an ILO technical cooperation project, but the technical assistance and support that was made available through the National Project Coordinators (NPC) caused them to become aware of the agency and appreciate its strengths.

Addressing the National Policy and Legal Framework

Addressing National Policy and influencing and bringing about legislation are never easy, but the PABs were influential in affecting policy in some manner in every country included in the study.

Lessons Learned

1. To advocate and inform the development of national policies and/or legislation, it is essential to create an environment of trust and mutual respect through a national mechanism in which many voices can be heard; in this case, it included all tripartite constituents, experts, and other stakeholders concerned with HIV in the workplace and in the national arena. The success of SHARE in doing this is largely attributed to the pre-existing framework of the tripartite constituency, the climate created in building the PAB, and the professional comportment and determination of the NPC.
2. Ensuring that the voices of people living with HIV be heard was part of the initial project design. But the value of that principle was not appreciated until it was put in practice. At each instance where PLHIV participated, the project objectives to dispel stigma and discrimination made more sense, and stakeholders better understood the need to enact national and enterprise policy and to draft national laws.
3. Worker Organizations need more capacity-building opportunities. Issues such as lack of clarity of purpose for trade unions and the effect of political affiliations were two of the challenges that these groups faced in the SHARE countries. While tripartite constituent

employer groups also have some complexities, the worker groups lack resources and, more importantly, institutional development and technical assistance.

4. The selection of target sectors was sensible and, once made, led to good choices for participating enterprises.

5. The subject of AIDS makes people uncomfortable, and some aspects of HIV and AIDS are often overshadowed by obsession over the cause and transmission. This is unfortunate, and while education in the workplace certainly included transmission, the project also addressed those factors which can be resolved. This included examining risk behaviours (unprotected sex, drug use) and understanding how the risks can be avoided. A first look at how the behaviour of an individual relates to contracting AIDS was the foundation of the BCC process.

6. The project used the time wisely by investing in building foundation at start-up. It is important to note that this project is about banking social capital through the establishment of collaborative bodies.

7. Replication of the model or its components depends on the financial resources of the tripartite constituency within a country. Also, much depends on the strength of the economy overall to determine whether companies are willing to develop and sustain HIV in the workplace programs over the long term. Governments have varying resources to replicate the model at central and local levels. Given the need to establish a strong start-up base of project components—national and workplace foci, building an advisory board, mapping, etc.—a minimum of 5 years project length (LOP) is necessary.

Recommendations

There are several areas where more can be done to strengthen the ILO/USDOL interventions and to enhance any Workplace Education Program on HIV and AIDS.

1. Activities focused on improving the protection of workers in the AIDS arena can delve deeper into the consequences of unchanged behaviour. Workers expressed interest in knowing more, despite the fact that sometimes issues were difficult. As long as they understood the key benefits, workers were interested and so were managers.

2. The BCC is an area where more can be done to raise awareness about vulnerabilities and strengths related to gender, and how HIV and AIDS are related. Some programs, particularly in the Caribbean, did work to further illuminate the connections between gender, violence, and financial dependency.

3. Research is sorely needed to document the payback to a company that has HIV workplace policies, committees, programs, and focal points, as compared to companies without such programs. Some managers are less visionary than others. Those with vision should be recognized, rewarded, and tapped as accessories to HIV and AIDS workplace education efforts.

4. Changing attitudes towards PLHIV were documented in the project through the Knowledge, Attitudes, and Practices (KAP) survey and through anecdotal accounts.

Project objectives tried to address stigma and discrimination head-on, and according to impact assessments, there was definite improvement in how PLHIV will be perceived in target industries.

Stigma and discrimination was addressed in the development of policies for workers, along with ensuring that PLHIV will not be cast out of the formal workplace. The policies need to be enforced, and there needs to be continued vigilance. This would be done by workers' organizations, which need more capacity-building opportunities. Issues of care and support of workers infected and affected by HIV needs to receive more attention in project design and implementation. Further, efforts to focus on analyzing the nature of discrimination can be connected to BCC strategies. The ILO's role in encouraging formalized, national, concentrated attacks on stigma and discrimination as workplace issues is an important one.

5. Some interesting outcomes of this project came not in formal enterprises, but in the **informal economic sector**. Entry into the informal workplace for a project is difficult because there are few definitions common to the informal sector. Some of the groupings have formal associations which bring them together, either for professional or fraternal reasons. It is in that venue where normally the NPCs were often able to gain entry, and ultimately make successful inroads. The informal economy benefitted from SHARE inputs in each of the countries studied. The activities were interesting and innovative, but sometimes demanded more time and effort to implement. The SHARE model must be adapted more precisely when used to reach the informal economy.

6. As has been mentioned, the project was ambitious for the time period. Realistically, the project was too short to become truly institutionalized. The follow-up programs in Botswana and Guyana with PEPFAR (U.S. President's Emergency Plan for AIDS Relief) funding will help to keep the momentum going, even if the program changes slightly. With the two major thrusts—a national policy approach and the workplace education activities—the activities of the projects overall have been inserted into government multi-sectoral efforts. National AIDS Commissions appreciated the outcome, but many are too distracted by health responses, ARV availability, and funders' priorities, to put emphasis on the workplace.

4.7 The cooperative model for the delivery of home based care services for people living with HIV. ILO/AIDS. 2011

Region: Kenya and Lesotho

Scope:

HIV and AIDS impact on the social and economic spheres of society, including within the world of work. With regards to cooperatives, like other organizations, are directly affected by the pandemic through loss of their members, their workforce and their leaders. This in turn indirectly affects members' revenue and the cooperatives' capacity to address members' needs.

Home-based care (HBC) is an innovative approach to providing a comprehensive continuum of prevention, care, treatment and support services to meet the needs of people living with HIV in settings that have resource limitations. HBC calls for partnership among family members, health care workers, health facilities, local communities, community-based

organizations (CBOs), non-governmental organizations (NGOs) and people living with HIV (PLHIV).

Considering the features and values of the cooperative model, the CoopAFRICA and the ILO/AIDS programme commissioned this study in 2009 to examine whether this model would be suitable for the delivery of HBC for members and non-members with HIV.

Methodology

The study reviews literature and considers cases in Kenya and Lesotho.

Findings

There are several characteristics of the cooperative model that are relevant for HBC programmes that respond to HIV and AIDS. For instance, the governance structure of the cooperative model gives members control over the decision making process, which subsequently ensures that members' priorities and specific needs are at the forefront of the cooperative's activities. Thus, through democratic member control and voluntary membership, members are empowered to take responsibility for satisfying their needs. The cooperative model provides a platform for discussion that can help identify individuals' capacities and strengths, which HBC programmes could use to optimize its services.

Nevertheless, the outcomes of this study found that cooperatives are not yet fully involved in HBC strategies. Members do not have a comprehensive understanding of what HBC is and how it is undertaken in communities. Consideration for HIV is often not included in cooperatives' strategic plans and therefore members often see it as a side issue that diverts them from their key activities. For those that have started HBC activities, the main HBC service in which they seem to be fully involved is the continuum of care through the implementation of income generating activities (IGAs), such as small scale agricultural production and/or animal husbandry. The objective is to enhance the living conditions of affected and infected members. A second area where cooperatives are active is often linked to IGAs, and involves transport for referrals to health facilities. With funds derived from the proceeds of the IGAs, some cooperatives are able to provide transport – instead of the cost of transport falling onto the individual. Education through awareness-raising activities is the third service in which cooperatives appear as a player, although the study pointed out that stigma and discrimination can still prevent members from disclosing their status, and thus to access treatment and care. Cooperatives seem to be less involved in the provision of care mainly due to the limited training that caregivers (who are often volunteers) receive, the limited access to equipment and general financial limitations.

Recommendations

Despite the positive aspects, several questions remain in regard to the legitimacy of the involvement of the cooperatives, particularly cooperatives whose primary objective is not the provision of health services, in the health sector to cope with the failure of the public health system. The partnership with other organizations and/or the state can also be questionable regarding the autonomy and independence of cooperatives. Therefore, further research needs to be undertaken on the relevance of the cooperative model as vehicle for the provision of HBC for HIV/AIDS.

Considering the lessons learnt in terms of provision of HBC for PLHIV by organizations registered as cooperative, the following recommendations can be made:

- Cooperatives can act as a focal point for mainstreaming HIV as a critical issue within the cooperative movement and broader civil society. A holistic approach that includes, among others, preventative education as well as healthy living (nutrition) can be promoted;
- Cooperatives should develop linkages with the health sector so that they can get access to training and materials supply and support on technical and logistical matters;
- Meeting economic as well as social and health needs is highly important for PLHIV and initiatives that couple health services with IGA improve the overall situation of PLHIV.

Further research on the comparative advantage of the cooperative model for provision of care and support for HIV/AIDS would be valuable. This should include comparative studies between programmes offered by cooperatives (any type) and programmes offered by other organizations. Such a study should consider the working conditions and status of health workers and volunteers involved in HIV/AIDS HBC care.

4.8 Impact Study of HIV and AIDS on the United Nations System. UN Cares. 2007

Region: UN system

Scope:

In this current global environment and due to the potential high infection rate among UN staff, the Inter-Agency Human Resources Task Force on HIV and AIDS in the UN System Workplace developed terms of reference for a study on the financial impact of HIV on the UN System.

Study Objectives

- Conduct a quantitative and qualitative analysis of the impact of HIV and AIDS on the United Nations system;
- Develop a multi-year analysis by region with estimates of the impact of UN Cares prevention and treatment strategies on averting future HIV infections and cost savings; and
- Provide recommendations for future actions to respond to HIV and AIDS in the UN workplace through the UN Cares initiative.

Methodology

Instead of a standard economic impact analysis of HIV and AIDS on the United Nations system, the Steering Committee for this study agreed that it would be more helpful to obtain an analysis of the impact of workplace prevention strategies on economic costs and new HIV infections. Such an analysis required both quantitative and qualitative research methods. To estimate the impact of workplace prevention strategies such as prevention education and condom distribution, a customized impact model was used. Because there are several areas for which quantitative data could not be obtained or captured in an impact

model, the study team performed a desk review of several key documents and convened focus groups via teleconference with United Nations system staff in several key regions.

Findings

The results of this analysis support the conclusion that the United Nations *should implement a Comprehensive strategy for its UN Cares programme* both to avert the maximum number of HIV infections and to be consistent with the organization's role as a global leader in the development and dissemination of best practices for workplace programmes and employer involvement in the response to HIV and AIDS.

The analysis demonstrates the impact of broad coverage of prevention and treatment services, measured not only in saved lives and improved quality of life for staff and families, but in the conservation of future UN system resources.

If the UN system adopts the UN Cares action proposals, Comprehensive efforts (defined as covering 80% of staff and dependents with services) can prevent an estimated 213 infections, *or 30% of HIV infections that would otherwise occur*. Proceeding without HIV prevention and treatment programmes for staff and their dependants will lead, according to estimates, to 722 new HIV infections from 2008-2013.

Associated with those infections are many costs that the UN system would incur. These costs include funerary benefits, death benefits and recruitment and training costs for new workers needed to replace those who are disabled by HIV-related illness – all to be paid from UN agency budgets. The total costs to the UN system of 'doing nothing' total more than US \$57 million over the six-year study period.

Besides the "human gain" of saving lives, the financial analysis provided by this study provides convincing evidence that the UN Cares programme offers good value for money to the UN system. Financial savings to the UN are *four times greater* than programme costs. If 80% of UN staff and their dependents access prevention and treatment services, the UN system will save about US \$16 million in replacement costs for employees unable to work because of AIDS, and US \$20 million in death and funerary benefits for staff that die of AIDS-related causes.

Recommendations

The study recommends *expanding the current and proposed UN Cares offerings* to include initiatives that specifically target stigma and discrimination. As the programme has done with the current Minimum Standards, the UN Cares programme should link measurable outcomes to all new initiatives, whether through utilization rates (as in counselling) or survey results (to measure improvements in perceptions of stigma and discriminations). Given the number of learning sessions and other interventions done to date, many United Nations personnel are knowledgeable about HIV transmission and risk behaviour. The UN Cares programme should, therefore, in collaboration with the harmonized Learning Strategy, seek to move the discussion beyond transmission and basic HIV facts to address more sophisticated HIV and AIDS issues that could have a greater impact on change of risk behaviours described in this study.

To address some of the data limitations outlined in this report, the United Nations should *consider incorporating a data-centered evaluation and monitoring component for the UN Cares programme*. Evaluation and monitoring does require resources, but encouraging and requiring better data collection is an investment with long-term benefits for conserving programme resources and improving budgeting and planning processes. If the UN Cares programme incorporated surveys into an evaluation and monitoring plan, it might be more able to track some of the data evaluated in this study – consistent condom use, for example – and better positioned to make resource allocation decisions for the greatest prevention impact.

Finally, the *significance to the UN Cares programme of the United Nations as a leader in the global response to HIV and AIDS cannot be understated*. The United Nations has, since the Universal Declaration of Human Rights in 1948 and more recently the Declaration of Commitment on HIV/AIDS adopted by the General Assembly in 2001, been at the forefront in leading national governments and organizations to take the necessary actions to guarantee protections for human health, and specifically in addressing HIV and AIDS. These international commitments cannot be made to the exclusion of United Nations employees and their families. The United Nations must continue to promote global best practices for workplace programmes and lead by example with a Comprehensive strategy for the UN Cares programme and convened focus groups via teleconference with United Nations system staff in several key regions.

4.9 The second national-HIV Communication survey. Health Department, USAID/PEPFAR & CDC. 2011

Region: south Africa

Scope:

The Second National HIV Communication Survey (NCS) examined the impact of HIV communication programmes in South Africa on improving knowledge and reinforcing positive beliefs, norms and attitudes, which in turn sustain or bring about behavioural change in relation to HIV prevention, care, support and treatment. The intention of this report is to assist policymakers and planners in the design of future HIV communication strategies and programmes.

Methodology

A national quantitative survey was conducted between June and August 2009. The survey involved approximately 10 000 respondents in all provinces of South Africa and was designed to be representative of 16-55-year-olds across all race groups. The questionnaire covered socio-demographic characteristics, exposure to various HIV communication programmes, and indicators of HIV and AIDS knowledge, attitudes and behaviour.

In this survey, people were interviewed and asked about their values and behaviours, regardless of whether they had been exposed to any of the HIV communication programmes (HCPs). The evaluation used quantitative methods, which allow for

measurement of the joint impact of HIV communication programmes on the South African population. By comparing the knowledge, attitudes and behaviours of survey participants who had interacted with these HCPs and with those of participants who had not, it was possible to measure changes attributable to mass media exposure.

Findings

The reach of HCPs is impressive, with 90% of the population aged 16-55 years exposed to one or more HCP. Exposure to HCPs was highest in the segments of the population that such programmes intended to reach. These comprised individuals who are most likely to be at a higher risk of HIV infection: younger Africans who live in urban formal areas and report experiencing some aspects of poverty.

The study has established that HCPs have been successful in improving knowledge levels and building positive beliefs and attitudes in relation to HIV prevention, care and treatment. Exposure to HCPs was also responsible for a number of positive behaviour changes in relation to HIV.

These links between HCPs and the consolidation of knowledge and positive behaviours were shown most clearly in areas such as condom use and HCT which have been the focus of campaigns for relatively long periods. However, there was also a suggestion that HCPs could have an impact in such complex and sensitive areas as multiple sexual partners.

The significance of the study for those who design and fund national communication interventions lies also in its identification of gaps and constraints in HIV prevention. Many of the findings help to pinpoint specific audiences or specific messages that require attention in the future. The results also encourage communication experts to consider how community interventions and interpersonal interventions such as counselling can be designed and implemented to address some of these issues, and conversely, how future mass media programmes can be used to support and reinforce efforts at the community level.

Key findings:

- Multiple sexual partnerships - Since 2006 there has been an *increase in knowledge about faithfulness and partner reduction* as means of reducing HIV infection risk as well as a decline in the number of people reporting multiple sexual partners (MSPs) in the past year. This may be attributed to HCP programmes addressing these behaviours during the preceding year.
- Condoms - *Knowledge of the importance of condoms* as an HIV-prevention measure is very high in South Africa. Condom use has been promoted intensively in the last two decades as the primary means of HIV prevention and this level of knowledge indicates the relative success of these communication initiatives.
- HIV counselling and testing - Exposure to HCPs has had a *direct effect* on large numbers of people *getting tested for HIV* in the past 12 months.

- TB knowledge - Knowledge of TB treatment duration was high. Since the *duration of TB treatment* has been a focus of a number of campaigns in recent years, this high level of knowledge is probably attributable to these campaigns.
- Knowledge of ARVs - *Knowledge of ARVs as treatment* for AIDS was high and has increased considerably since 2006.

Recommendations

- The data clearly indicate that young men aged 20-29 years and older men are more likely to have MSPs than women. It is important for future HCP programmes to investigate innovative ways of engaging men on this aspect of HIV risk. Communication directed at men needs to be combined with the development of appropriate male-friendly services.
- A high number of people of all ages believed that cheating was pervasive in relationships. However, this impression was not borne out by the actual number of people with MSPs. HCPs may need to focus their efforts on challenging people's beliefs that cheating is pervasive in relationships.
- It is important for HCPs to continue to promote partner reduction and faithfulness, but to do so more explicitly within an approach of combining prevention methods.
- HCP campaigns have been particularly effective in reaching younger people and now need to focus on encouraging continued condom usage amongst the adult population. Future HCP programmes also need to support young men in continued condom use while finding innovative means to increase condom use among young women.
- There were lower levels of awareness of the linkages between TB and HIV. This was to be expected as the relationship between HIV and TB has not been a major focus of communication interventions. There is therefore room to strengthen future communication about TB and its link to HIV.
- As the national male circumcision programme rolls out, there is a need to increase awareness of the risk reduction benefits of male circumcision while reinforcing messaging on partner reduction, and correct and consistent condom usage.

4.10 Addressing HIV and AIDS in Ugandan CSOs Applied Research, End report, STOP AIDS NOW!, 2009

Region: Uganda

Scope:

The report focuses on specific themes that are important in the development and implementation of HIV and AIDS workplace policies: the project structure and its approach, social networking, access to services, involvement of people living with HIV and AIDS

(PLHIV), the influence of internal mainstreaming on external mainstreaming, stigma and discrimination reduction, and spill-over effects.

Methodology

The report is based on findings from the three applied researches (AR) that were aimed at providing policy makers, programme staff, and beneficiaries in the STOP AIDS NOW! partner organizations with information about how to direct or redirect activities for successful workplace policy development and implementation. The three phased AR concerned:

1. CSOs developing workplace policy (June to December 2006)
2. Start of implementation (January to June 2007); and
3. Implementation and effects (July 2007 to June 2008). Additional information for this report was collected through key informant interviews with CSO directors and HIV and AIDS focal point persons and a workshop with members of the local project group.

Findings

Overall, the STOP AIDS NOW! project has been successful, with 50 out of the 76 CSOs having developed and (partly) implemented a workplace policy.

Good practices identified include:

Project structure - The STOP AIDS NOW! project structure, with local ownership by a steering committee (local project group) of strong CSOs with a wide network, is a promising practice. The local project group decision to install lead organizations in the regions was a wise practice.

Capacity building by the STOP AIDS NOW! Project - The capacity building facilitated by the project office and partners is a good practice. CSOs were highly motivated by the training. Besides building knowledge and skills, this training provided a forum where CSOs could exchange experiences with peer CSOs and network. Starting capacity building with sensitizing CSO directors and senior managers is considered best practice to get CSOs initiated on workplace policy development.

Adaptability - It is a good practice to adapt to upcoming challenges with practical solutions. The budgeting tool 'What's it likely to cost' was written in the course of the project when it appeared that budgeting was a problem for many organizations (not knowing what could be included and how to make a budget).

Write proposal for funding during STOP AIDS NOW! project period - A good practice was to scout for funding opportunities during the STOP AIDS NOW! project period. The project coordinator and local project group have put in a proposal and were granted funds from the Civil Society Basket Fund to continue the activities that were started under the STOP AIDS NOW! project.

Policy - A participatory workplace policy process, involving all staff, is a way to sensitize staff and create opportunities for more open discussions about HIV and AIDS. It also facilitates workplace policy development and implementation when senior management are committed and the board gives support.

Promote VCT - Promoting VCT through a VCT day, where family members and neighbours are also invited, is a good practice. Not only does it increase uptake of VCT, but it also generates more open discussions about HIV and AIDS.

Starting activities which do not require much funding It is a promising practice that organizations have started implementing their workplace policy before it is finalized and funded.

Networking- A good practice is that organizations network with Government, other CSOs (national and international), UN agencies, and the private sector, for IEC, preventive measures (condoms), counselling, and (free) service provision.

Education and training - Education and training of staff is always a good practice. Specific promising practices include awareness raising sessions by technical staff training support staff.

IEC and prevention materials - A good practice is to make information on HIV and AIDS available in the organization, for instance in AIDS corners or on notice boards. If decided in a democratic way, it is a good practice to let staff have access to condoms in the workplace.

Involvement of PLHIV - Involvement of PLHIV is always good practice, and this has been strived for at project and CSO level. When inviting PLHIV for sensitization and training it is good to look for people whom the target group can relate to, such as EASSI and NUDIPU did. They got testimonies from, for instance, discordant couples, married women, young men and women, a woman who had a child while HIV positive, and women with disabilities. In conclusion, use HIV positive peer educators.

Putting in place sustainability measures - Already thinking about the sustainability of projects, and putting in place sustainability measures before the end of a project, are good practices. CSOs were training their own peer educators, writing proposals for funding – possibly using the STOP AIDS NOW! guidelines – mainstreaming HIV and AIDS in other organizational budgets, putting the workplace policy in the organizational work plan, and conducting internal fundraising mechanisms for workplace policy activities.

Having an focal point person with dedicated time - CSO management assigning an focal point person with a clear terms of reference and dedicated time is a good practice. A well functioning focal point person was found to facilitate workplace policy implementation and reporting to the project coordinator office.

Recommendations

To CSOs:

- Continue with internal awareness raising on the workplace policy and IEC, focusing on issues which staff would like to know more about
- Provide all new staff with a copy of the workplace policy, and explain the contents
- Start/continue implementing workplace policy activities that do not require much funds
- Link with services, IEC, and training institutions; be keen to identify free services
- Specify the job description of the focal point person with attached time allocation

- Internally share what has been gained in training of individual staff. For instance, internally train more peer educators.

To local project group and Project Coordinator

- Rotate part of the membership of local project group
- Provide more training to the focal point person of the lead organizations and provide more funding
- Call future STOP AIDS NOW! training ‘training of trainers’
- Organize refresher training for new CSO staff
- Continuous sensitization of CSO senior managers and directors
- Repackage Good Donorship Guidelines and budgeting tool What’s it likely to cost? into simpler formats for use by organizations, e.g. CDs, leaflets, posters, etc.
- Improve use and functions of the information database – by making it more attractive and by giving more feedback to CSOs.

To STOP AIDS NOW! donors (Oxfam Novib, Hivos, Cordaid, and ICCO)

- Screen submitted budgets in a timely fashion and release funds promptly to allow the Ugandan CSOs to implement their workplace policy programme activities
- Initiate new programme managers in workplace policy at the start of their job
- Share lessons learnt and promising practices identified from this project with other agencies/countries.

To STOP AIDS NOW! – Dutch project coordinator

- Be at the forefront to identify, link, and negotiate for further/continued funding from other donors
- Share lessons learnt and promising practices with other agencies and in other countries.

To (future) similar projects

- Establish a local project group; membership should comprise of credible organizations with useful networks and different fields of expertise
- Install lead organisations if the country is too big or partner CSOs too many. lead organisations should be credible and established organizations with strong networks
- Create guidelines and memorandum of understandings for all the stakeholders; review them periodically
- Involve key stakeholders right from the inception and design stage. These should include national level stakeholders, e.g. National AIDS Commission, Ministry of Health, ILO, CSOs, associations, organizations of PLHIV, organizations of employers, etc.

4.11 Implementation of HIV and AIDS. Workplace Policies in Ethiopian NGOs, Applied Research, phase 3, report, STOP AIDS NOW!, 2011

Region: Ethiopia

Scope:

Between January and March 2011 STOP AIDS NOW! Ethiopia conducted a study of twenty NGOs – out of a total of thirty five NGOs in the project. The study sought information with the objective of explaining and evaluating the status and degree of implementation of HIV and AIDS workplace policies (WPPs) and the subsequent effects of the policies at staff and organizational levels. It is expected that the outcome of the study will help to share good practices and challenges, and provide recommendations for implementation of effective HIV and AIDS workplace policies in NGOs.

Methodology

Data were collected at the headquarters of twenty NGOs, which were selected because they had a (draft) policy in place. The study utilized three data collection methods:

- 1) interview of 113 mid level and support staff using a structured questionnaire – the survey;
- 2) in-depth interviews (IDIs) with thirty-four senior managers and HIV and AIDS focal point persons (FPPs) using a semi-structured questionnaire; and
- 3) observations. Managers and FPPs reported on the NGO level, while staff mainly reported on the organizational and personal level.

Findings

Status of workplace policies (WPP)

Nineteen NGOs had developed a final WPP document and one NGO had a draft. The documents commit to ensuring a consistent and equitable approach to the prevention and management of the consequences of HIV among employees and their families. Ten NGOs involved staff starting from the development process of the WPP. Most staff (87%) was aware that their NGOs had a WPP. Seven NGOs met with controversial issues during development regarding what to include in the WPP; most were resolved. In eleven NGOs the process of developing an HIV and AIDS workplace policy was a catalyst for reviewing HR policy in order to include selective issues from the WPP – the aim was to fully integrate the WPP into their HR policies.

WPP Implementation

To varying degrees the WPP was being implemented in nineteen NGOs; ten had a fully operational policy, seven a partially operational WPP, and three NGOs had a weakly implemented policy. NGOs had designed regulations concerning disclosure by staff in order to access benefits, and had guidelines to maintain confidentiality. To coordinate WPP activities, nineteen NGOs had a (mostly part-time) FPP. The majority of staff (71%) was aware of the FPP and his or her activities. Only five NGOs reported having an HIV and AIDS committee to run WPP activities. In one NGO all branch offices had their own HIV and AIDS committees. Main WPP activities were as follows:

- **Awareness raising** about HIV and AIDS and the WPP was done in all NGOs through the availability of IEC materials, staff meetings, and staff awareness workshops specific to HIV and AIDS.
- **HCT promotion** was done by all NGOs in a variety of ways: during staff meetings, in staff awareness sessions, and through informal discussions. Some NGOs facilitated HCT through established relations with local health facilities; others provided information on where HIV related advice, counselling, and referrals can be accessed.

- **Condoms for staff** were available in eleven NGOs and nine NGOs reported high utilization.
- **An AIDS fund** had been established in six NGOs, with financial contributions by staff and management. This is an official support mechanism for (future) HIV positive staff. In the different NGOs the management's regular financial contribution to the fund encouraged staff to also volunteer contributions for the fund.
- **An AIDS Corner** had been set up in sixteen NGOs with the financial and technical support of STOP AIDS NOW! Ethiopia. In the AIDS corners staff have access to the WPP document, IEC materials, and condoms. The majority of staff were aware of the corner and also used it, especially for IEC materials.
- **Involvement of PLHA** by NGOs in WPP development and implementation: NGOs invited PLHA during awareness raising workshops for staff, for the celebration of World AIDS Day, or for condom sensitization.

Effects of the WPP

All IDI and survey respondents observed positive effects on staff and the workplace as a result of WPP development and/or implementation. These effects included (to differing degrees): increased employee awareness about HIV and AIDS in the workplace; increased openness to discuss HIV and AIDS related issues; more willingness to go for HCT; employee willingness to contribute to an AIDS fund; improved management commitment for HIV and AIDS related activities; reviewing the human resource policy to address standards of behaviour expected from employees regarding HIV and AIDS; increased disclosure of HIV status; availability of benefits after disclosure, and considering support for employees' family members; better clarity among organizations and employees concerning rights and duties in relation to HIV and AIDS in the workplace.

The majority of staff (93%) stated that they noticed personal changes as a result of the WPP activities: their attitude towards PLHA had changed; they had increased knowledge on HIV and AIDS; they now felt free to discuss HIV and AIDS in the workplace and with family and community members. An encouraging finding was that the majority of staff (85%) reported having undergone HCT one or more times, many of them as a result of the WPP. No staff indicated or foresaw any negative effects of the WPP.

Four NGOs indicated specific external activities as an effect of the WPP: either helping other NGOs and local schools and factories in developing a WPP, or assisting orphan children through the NGO's AIDS fund.

Recommendations

To NGOs

- Strengthen efforts of planned and regular awareness raising sessions and training for staff;
- Involve all levels of staff in WPP activities;
- Establish and communicate confidentiality procedures to all staff;
- Put greater effort and emphasis into condom promotion;
- Set up structures that are central to the workplace, such as an HIV and AIDS committee;

- Design a clear job description for the FPP with a defined and agreed time for WPP; appoint staff who are most likely to keep their job, and who are sufficiently senior to have the trust and respect of other staff and who can make decisions;
- Develop and strengthen a peer education programme;
- Establish relationships with local health and training facilities;
- Positively and meaningfully involve PLHA and establish relations with PLHA organizations;
- Plan WPP activities and make a budget for these;
- Involve family members;
- Train FPP and peer educators in HIV and AIDS counselling to help them cope with the pressure of their work;
- Pay attention to occupational risk;
- Network among STOP AIDS NOW! Ethiopia partner NGOs;
- Continually monitor the effectiveness of HIV and AIDS workplace initiatives.

To STOP AIDS NOW! Ethiopia and steering group

- Disseminate STOP AIDS NOW! Ethiopia partner NGOs' achievements to other sectors;
- Organize experience sharing workshops for partner NGOs and stakeholders;
- Provide training for new FPPs;
- Support and motivate NGOs without an AIDS corner and those lagging in implementation to have one;
- Continue support for the process of establishing and strengthening the network among partner NGOs.

To STOP AIDS NOW! Netherlands and donors

- Scale up financial and technical support for WPP implementation – helping NGOs to have appropriately funded programmes integrated into existing structures.

4.12 Experiences and Lessons Learnt in the project 'Managing HIV and AIDS in the Workplace' in South Indian Non-Governmental Organizations End Report Applied Research, STOP AIDS NOW!, 2011

Region: India

Scope:

This report presents the experiences of the STOP AIDS NOW! project 'Managing HIV and AIDS in the Workplace' in thirty-five non-governmental organizations (NGOs) in South India (SAN!SIP) that lasted from 2007 to 2010. The overall goal of this project was to strengthen the capacities of partner NGOs in South India to develop and implement HIV and AIDS related workplace policies (WPP), in order to create an enabling environment for the prevention of HIV, and care and support for people living with HIV and AIDS (PLHIV) among staff and their families.

The objectives of this end of project report are to:

1. Review the experiences of SAN!SIP, focusing on the structure, processes, and effects;

2. Focus on some specific themes which are important issues in workplace projects;
3. Identify promising practices and challenges, and so be able to provide recommendations for future projects for WPP development and implementation.

Methodology

This report is based on findings from the applied research (AR) that was part of the project. The AR – in two phases, AR1 (2008) and AR2/3 (2010) – used quantitative and qualitative data collection at project, NGO, and staff levels. In AR1, fourteen NGOs and 138 staff were sampled; in AR2/3, twenty-four NGOs and 315 staff. Other sources of information for the end report were SAN!SIP project and workshop reports, the project baseline study of 2007, and case studies conducted in 2009. To fill some gaps in information, self-administered questionnaires were sent to the different stakeholders in India, and those in the Netherlands were interviewed.

Findings

WPP development and activities in NGOs

NGOs developed their WPP in a participatory way with involvement of staff at all levels, from directors

to support staff. In AR2/3, 75% of NGOs had a final draft or a fully functional WPP in place. Most NGOs mainstreamed the WPP within other organizational policies, including those on gender, welfare, or health, or were planning to do so.

SAN!SIP considers it essential for effective WPP development and implementation for NGOs to have a focal point person for HIV and AIDS (FPP) and a committee. FPPs and the committee are the NGOs' liaisons with the SSIPG and local PC, and oversee the development and coordination of addressing HIV and AIDS in the workplace. In AR2/3, 70.8% of NGOs had appointed an FPP.

NGOs considered the resource package received useful for policy drafting. The ILO document was the most used and preferred, while NGOs made less use of the BT and GDG: these were considered too long and complicated, and some cited language as a barrier for usage. STOP AIDS NOW! launched the new 'CSO guide for workplace policy development and implementation' in June 2010.

Some NGOs started HIV and AIDS related activities for staff even before funding had been received. Awareness building of staff was the most common activity, and this increased over the course of the project. All NGOs conduct training programs and workshops for staff on HIV and AIDS issues. Almost all (96.8%) staff reported receiving information about basic facts of HIV and AIDS, and a high 88% of all survey staff in AR2/3 reported having received training in HIV and AIDS.

Effects of the WPP:

- More openness about HIV and AIDS - The major effect of WPP development and implementation is increased awareness among staff about HIV and AIDS issues. More than half of the managers reported that the availability of IEC materials for staff had

increased. This was reported by a similar 52.2% of staff in FGDs, and by 84.9% of staff in the survey. Because of increased awareness and knowledge, managers and staff reported more openness to talk about HIV and AIDS in the workplace; 54.5% of managers, 61.9% of staff in FGDs, and 87.6% of surveyed staff in AR2/3. Increased openness was most reported in non-HIV NGOs.

- Linking, learning, and social networking are some of the main thrusts of STOP AIDS NOW! and SAN!SIP. SAN!SIP developed partnerships with different national and international organizations. The SAN!SIP workshops for partner NGOs helped in building linkages, and sharing experiences and knowledge. NGOs in AR2/3 mentioned that increased networking for services and information was an effect of the project. They network with a host of public institutions, such as the State AIDS Prevention and Control Society (SACS), ART centres, VCT centres, and other NGOs for project related work.
- Access to services - Over the course of the project, more NGOs facilitated access to treatment, and VCT information and promotion have also greatly increased. VCT is promoted through training, encouragement, and by providing information on where to access it. NGOs facilitate access to treatment through medical reimbursements, networking with service providers, and supporting staff through leave and transport allowances. The medical schemes in most NGOs cover all staff, and sometimes also family members. Condom provision in the office remained a contested issue. While all NGOs promote condom usage in the community, only six organizations made condoms available for staff. However, a majority of staff, both men and women, were in favour of condom provision in the workplace.
- Involvement of PLHIV - SAN!SIP actively promotes the GIPA (greater involvement of PLHIV) principle. SSIPG invited the three state networks for PLHIV to be SAN!SIP partner NGOs, and invited the Indian Network of People living with HIV (INP+) to be a member of SSIPG. PLHIV have been increasingly involved in the NGOs in different ways, either passively, as motivation for managers to develop a WPP, or actively, facilitating during workshops, engaging in advocacy to make staff aware of HIV and AIDS, and addressing the importance of tackling stigma and discrimination.
- HIV stigma and discrimination - Stigma and discrimination reduction is a key component of effective HIV and AIDS management in the workplace. NGOs reported a shift in the mindset of staff with regards to HIV, in the form of reduced stigma and discrimination in the workplace. AR2/3 shows a very positive response to recruiting PLHIV, with very low or no reported stigma in work settings and highly positive attitudes expressed regarding working with HIV positive staff. In all NGOs, stigmatization and discrimination is considered a serious disciplinary offence that will lead to stringent action, up to and including termination of employment.
- Disclosure and confidentiality - In AR2/3, three (13.6%) NGOs reported increased disclosure of HIV status as an effect of the WPP. In the initial research stages, some NGO managers had mentioned confidentiality as a possible challenge, and staff did not regard confidentiality as a priority. However, AR1 found that seven out of ten NGOs had confidentiality as an element in their WPP, and three NGOs in AR2/3 had guidelines for maintaining confidentiality. A large majority of staff (96.2%) trust their organization to preserve confidentiality, and 52.1% believe that their NGO will take punitive measures if confidentiality is breached. A majority of 68% of surveyed staff confirmed increased confidentiality in their NGO; this is a very important indicator. Staff feel that their

workplace is conducive for disclosure, as there is complete acceptance of HIV positive staff and confidentiality will be maintained.

- Gender- Four NGO managers in AR1 (29%) and eleven in AR2/3 (46%) reported addressing gender issues in their NGO. They address gender as an element in their WPP, have a gender policy, have a committee to examine gender related issues and sexual harassment, and/or have sexual harassment guidelines. There were hardly any gender differences in terms of HIV and AIDS related knowledge, attitudes, and practices in the surveys. Managers and staff across all NGOs and levels felt that the WPP had not had an effect on gender in the workplace, since gender equality and equity in most NGOs is already practiced.

Recommendations

To NGOs

- Continue to raise awareness of staff on HIV and AIDS, the WPP, and related issues; translate the document if needed;
- Continue or start implementing WPP activities that do not require (much) funds;
- Specify the job description of the FPP and/or the committee, with attached time allocation;
- Continue to deliberately involve PLHIV and positive networks;
- Open or continue dialogue with donors and other funding bodies about managing HIV and AIDS in the workplace.

To Indian PC, SAN!SIP secretariat, and SSIPG

- Continue enhancing awareness in NGOs about the FPP and his or her roles;
- Advocate usage of the new STOP AIDS NOW! CSO guide to NGOs;
- Organize smaller regional meetings to understand why some NGOs are not interested in developing a WPP, and involve those NGOs that have experienced positive effects from their WPPs;
- Facilitate forming meaningful linkages and channels for cross-learning among NGOs, and help NGOs to network with service providers within their respective geographical areas;
- Encourage employers to offer free condoms as both a family planning and HIV prevention tool, to enhance uptake and lessen inhibition;
- Keep paying attention to lobbying and involve other organizations in lobbying activities. Making use of each others' networks can create a multiplier effect;
- Let TAPS work with a wider range of NGOs, not only organizations working in the health sector or with high risk groups. The TAPS program can increase the reach of the SAN!SIP project, and hence is a good way to scale up the project;
- Have an open attitude to share and learn from others, including from those outside the partnership and the Indian context, to increase conditions for success and innovation;
- Keep the steering role in mind, but also be flexible towards the other actors in the project structure, and give them a feeling of confidence to do their work.

To STOP AIDS NOW! donors (Cordaid, Hivos, ICCO, Oxfam Novib)

- Screen submitted budgets in a timely fashion and release funds promptly;
- Open/continue dialogue with partner NGOs about managing HIV and AIDS in the workplace;
- Have a role in keeping partner NGOs updated and supporting them, rather than leaving it all up to the project.

To STOP AIDS NOW! Netherlands PC

- Organize more meetings in the Netherlands with the STOP AIDS NOW! partners' program officers, to increase cooperation with equal trajectories in the region and avoid duplication;
- Share results and lessons learnt of the project earlier.

Suggestions for (future) similar projects

- Project set-up
- Make sure that the project is based on local needs, and fits the context;
- The beginning is important. Let the NGOs in the partnership select the host organization and the core/steering group from among their midst according to criteria they set. Let them decide on the roles, responsibilities, and key thrust areas of the project and TOR for all stakeholders;
- Appoint a PC who is accountable to the steering group and participating NGOs.

For steering group

- Select a project name, vision, and key thrust areas;
- Involve NGOs with experience in the field and let them share their experiences – learn from them;
- Agree on the roles of all members;
- Operate on a regular basis, and be realistic about the time members can put aside – make firm agreements on this;
- Make feasible budgets for training and sensitization;
- Keep the donor agencies of partner NGOs involved in the project.

For host organizations

- Keep the steering group informed of all updates and challenges faced;
- Keep the programs participatory and use the assistance of partners to accomplish the objectives and strengthen the program;
- Try to be objective and focused on the vision in order to keep organizations with varied backgrounds, budgets, philosophies, and cultures together.

For local PC

- Ownership by local NGOs is key. Give them enough room to decide on their WPPs;
- Try to move things in such a manner that they are not offended, and let the NGOs actively pursue inputs from you;
- Partners are associated voluntarily, so do not impose too much work on them;
- Make yourself available whenever they need you.

D. COST AND BENEFITS

This section presents studies that measure the economic and social costs/benefits of HIV/AIDs in the world of work.

The following 7 documents are covered:

5. Costs and Benefits

- 5.1 The Organisational Impacts of HIV/AIDS on CSOs in Africa *Regional Research Study: Uganda, Malawi, Tanzania*, INTRAC 2006
- 5.2 HIV/AIDS services through the workplace: a survey in four sub-saharan african countries, USAID. 2008.
- 5.3 Private sector's response to the AIDS epidemic in Africa. WHO. 2003.
- 5.4 Perception of Indian employers about HIV/AIDS in the world of work. ILO/AIDS. 2002
- 5.5 Care and Treatment to Extend the Working Lives of HIV-Positive Employees: Calculating the Benefits to Business, *South African Journal of Science* (July 2000)
- 5.6 Patterns of disclosure and antiretroviral treatment adherence in a South African mining workplace programme and implications for HIV prevention, *African Journal of AIDS Research*, 15 Dec 2011
- 5.7 Cost Benefit Analysis of HIV Workplace Programmes in Zambia. CHAMP. 2007

5. Costs and Benefits

5.1 The Organisational Impacts of HIV/AIDS on CSOs in Africa *Regional Research Study: Uganda, Malawi, Tanzania*, By Rick James with Brenda Katundu, Betsy Mboizi, Emily Drani, Daudi Kwebwa and Rogers Cidoswa, INTRAC 2006

Region: Uganda, Malawi, Tanzania

Scope:

To date, there is no information as to how serious a problem HIV/AIDS is for CSOs. Consequently, neither CSOs nor their donors are really talking about it openly, and appear to be doing little to build organisational resilience to the disease. A three-country research study was designed to address this knowledge gap through a collaborative effort by INTRAC; the Capacity Building Unit for NGOs (CABUNGO), Malawi; the Community Development Resource Network (CDRN), Uganda; and the Organisational Development Training and Facilitation Centre (TRACE), Tanzania.

The research aimed to:

- assess the economic and social costs of HIV/AIDS infection on the organisational capacities of selected CSOs in Malawi, Tanzania and Uganda
- provide information to enable CSOs throughout Africa better to predict the strategic and budgetary implications of HIV/AIDS.

Methodology

Ten NGOs in each of Malawi and Uganda, and nine in Tanzania, were selected for their diversity of size, age, type and leadership. The researchers used the same semi-structured questionnaire to interview about four members of staff from each NGO (n = 112), always including the Director, the Finance Manager, and the person responsible for human resources. Recall was the primary data-gathering method used. Eighty-four respondents also completed a leadership impact-monitoring questionnaire, to quantify the personal impact on them as leaders and track gender differentials. Semi-structured interviews also took place with three INGOs and two private-sector companies in each of the three countries. This was for comparative purposes, to find out what was possible and good practice in each context.

Findings

HIV is clearly affecting CSOs in these three countries:

- 62% of the CSOs had experienced at least one staff death in the past 5 years
- 72% of CSOs suspected that one or more of their current staff were HIV+
- Yet CSOs were considerably underestimating the extent of staff infections.

Working in a context of high HIV prevalence is costing CSOs more money to achieve fewer results. Respondents estimated that their staff budgets would increase by an average of 7%, and that performance would reduce by 10% (through staff being absent or distracted from work). The most serious costs of having HIV+ staff were extra medical costs, reduced office morale, the need to repeat work, and sick leave. The most serious costs of having staff affected by HIV were the psychological distress of looking after dying family members, time off for funerals, and the extra management time that responding to HIV/AIDS involved. It is even possible that the real impact is worse than the figures suggest, as relatively conservative assumptions were used in the calculations.

CSO leaders are particularly affected by HIV, as they have to take responsibility for sickness in their extended families, their communities and also their organisations. There is a significant gender dimension to these costs, as working women are expected to perform the cultural roles of care and support as well as providing financial support.

Some CSOs are responding to the situation, but in limited and informal ways – for example:

- providing some support through existing general medical schemes and pensions
- allowing staff time off for caring, visiting the sick and attending funerals – but few of the CSOs actively monitored and managed absences
- providing HIV awareness training for staff – although these were usually ad hoc and one-off
- drafting an HIV policy – although only 25% had finished the drafting process, and only 10% were implementing the policy.

None of the respondents had undertaken impact and risk assessment or strategic human resource planning; had developed systems to measure or manage the impact; or had budgeted comprehensively. Few CSOs had approached donors to cover the extra costs of responding to HIV/AIDS. Some were even apparently changing policies and procedures to avoid paying the costs.

The impact on CSOs is worse than the impact on the private sector. This may be because of their small size, and even greater denial among CSOs who are 'meant to know and meant to behave morally.'

Recommendations

Such a considerable organisational impact, and such a limited CSO response, raise critical strategic issues for CSOs. The future prediction for many countries in sub-Saharan Africa is that the impact of HIV/AIDS will become worse. The survival of CSOs is at stake. Yet HIV/AIDS provides an opportunity. It is exposing many of the inconsistencies and anomalies in both CSOs themselves, and the aid system as a whole. HIV/AIDS has such extreme costs that the only way to build resilience is to implement the good management practices and donor practices.

An appropriate local CSO response to HIV needs to:

- start with leadership, ensuring that leaders are committed to the process
- consider the organisation's values and culture – an effective response to HIV requires a culture of openness and responsibility
- look to the strategic implications inside and outside the organisation – it should integrate external and internal mainstreaming responses
- build on informal systems and be appropriate for the stage of the organisation's development
- develop responsibility at all levels, including the individual level
- not equate the response to HIV with just policy – it is about strengthening whole organisations, not just the HIV component
- not equate HIV policy development and implementation
- invest in staff awareness and prevention and, where possible, link with others for more resource-intensive treatment and care programmes
- actively learn from others' experiences in this field
- look for long-term resourcing, including individual contributions, but also ongoing support from donors.

International non-government organisations (INGOs) and donors cannot remain comfortably on the sidelines as their partners struggle with the disease. They must become actively involved in assisting their partners to respond in a strategic and cost-effective way if they are to remain relevant in the region.

Working in a context of high HIV/AIDS prevalence will cost partners more money to achieve less output. However unpalatable, donors must adjust their plans and targets. It will require donors to invest not just in capacity building, but also in simple capacity maintenance. Donors will also have to change their ways of working, moving beyond the project mentality

to take much more seriously the responsibilities that come with partnership. For many CSOs, their survival will require that development rhetoric and jargon finally become reality.

5.2 Cost Benefit Analysis of HIV Workplace Programmes in Zambia. CHAMP. 2007

Region: Zambia

Scope:

This study attempted to answer the question, “What are the costs and benefits of workplace HIV and AIDS programmes in Zambia when viewed across several companies?”

Seven companies that are part of the Global Development Alliance Programme in Zambia were included in this research. The companies range in size from 350 to 10,000 employees, and each company has an HIV workplace programme in place. All were within either the mining or agricultural sectors. Four are located primarily in the Copperbelt and are mining-related firms. The agricultural firms were headquartered in three different provinces in the country with productivity in an additional two provinces.

Methodology

Data were collected during the months of May and June 2007 from seven companies. All GDA companies were included in the study. Four of the GDA companies are involved in the mining sector; three in the agricultural sector. Several data collection and analyses methods were used: structured schedules designed to elicit specific cost, programme structure, and labour structure information, cost, structural and HIV data obtained from the CHAMP’s (GDA technical support partners’) databases, printed information and staff, informal discussions, focus group discussions with employees, structured interviews with community members and administrators, and observations.

The study was divided into three main areas:

- (1) a cost-benefit analysis of the workplace programmes,
- (2) employee and community perceptions of the programme, and
- (3) the programme’s impact on nonpermanent employees.

Findings

The net benefit of an HIV preventative programme is the costs avoided and reduced (the benefit) minus the costs of the programme itself. This analysis extended the usual definition to include costs and benefits of treatment and care. Six of the seven companies examined showed net benefits for their workplace programme. On average, these benefits amounted to 47 USD per employee for the year 2006. Companies with new HIV programmes appear to have smaller benefits than those with programmes of longer duration.

The bulk of the programme costs are attributable to the education and training effort. Considerable time and effort had been spent on educating and training peer educators in awareness, care, and treatment of HIV and AIDS. About the same amount of value was

spent on employee time - the value of time spent in education, training, and workshops of employees who, under different circumstances, would have other duties.

About 14 percent of employees are estimated to be HIV positive. Of 50,000 employees, employee turnovers due to HIV and AIDS are estimated to be about 500 in the last year. Another 316 turnovers, however, were likely avoided. One hundred and fifty-one employees are estimated to have improved their health by converting from untreated HIV positive status to some sort of treatment. The figure includes those who were HIV positive without treatment, to cases of HIV positive who received treatment, possibly ARVs. Nearly seven percent or 3,296 employees avoided infection in 2006, while two percent were on ARVs and enjoying improved health and productivity.

The typical company spends an average of nearly 9,000 USD per employee to both cover funeral costs of an employee dying of AIDS, and to replace that employee. Replacement employee costs, whether from early retirement or death, average around 8,000 USD. The largest cost was in the value of time spent by a supervisor in helping the new employee to learn the job. Supervisors are expensive and the time devoted to helping a new employee, particularly a skilled employee, is large. New employees' low productivity was also a high cost.

Twenty eight percent of benefits accruing to the GDA companies with HIV programmes can be attributed to reduced productivity losses from sick employees. The typical company saved nearly half a million dollars in productivity that otherwise would have been lost.

Uniformly, treating patients diagnosed with HIV or AIDS was cheaper than treating undiagnosed patients. Costs of treating undiagnosed HIV positive patients were estimated to be about seven times that of those who had been diagnosed and were on ARVs. Given that ARVs are free, and most ARV patients are seen to be relatively healthy and stable, this is of little surprise. The estimated costs across companies of treating an undiagnosed patient, neither monitored, nor on ARVs was 371 USD in 2006. This contrasted with the cost of treating (but not medicating) an ARV patient, an estimated annual cost of 55 USD.

Employee Morale and Community Impact

Knowledge and other benefits from the workplace programmes are also spreading to the surrounding communities. Access to HIV related information, condoms, VCT, and in some cases, ARVs have improved the lives of community members and these efforts are much appreciated. Most of the employees in focus group discussions and interviews confirmed that the companies have implemented the HIV workplace programme and most companies provide monetary assistance for funeral costs, to purchase the coffin, and food for the funeral house. Employees observed that seminars and workshops conducted in the workplace, which included workers and some community members, have helped change their practices. Workers said they noticed lower death rates among employees. Employees also observed that there has been an improvement in workers' productivity because of medical intervention provided by the company, such as free medication for both employees and their dependants.

The most visible impact for employees of companies' workplace programmes is raising awareness of HIV and AIDS. As one employee suggested; "Knowledge is power." This includes knowledge about HIV transmission and prevention and services available, including VCT and PMTCT.

Non-Permanent Employees

Monthly, non-permanent workers are paid an average of 65 percent of what regular workers are paid in these three agricultural firms. About 17 percent of overall benefits to employers of HIV programmes to seasonal workers derived from reduced medical costs for one company. The HIV programme for non-permanent workers paid for itself. For the other two companies, the programme produced net benefits. Over the three companies, benefits averaged 32 USD for each seasonal employee.

Although non-permanent workers are eligible for, and benefit from, most existing aspects of workplace programmes, at present they are not specifically targeted in prevention campaigns, particularly behaviour change and social change communications, and furthermore many say they are unable to access workplace HIV activities.

In most cases temporary workers are aware of HIV-related information being provided by the company, although they are not well informed about where to get tested for HIV, and many are unsure as to whether their company has a workplace HIV policy.

Most respondents had heard of HIV, could name at least one correct mode of transmission, gave correct answers for what HIV is (a disease, a virus) and showed few misconceptions about HIV transmission. However, this overall knowledge has not led people to employ standard prevention techniques or to adopt risk-lowering behaviour. Respondents show low levels of condom use combined with relatively high levels of multiple concurrent sexual partnerships. Levels of transactional sex were also high, with nearly a third of respondents at both sites stating that they had participated in such relationships. In the farms, there were high levels of stigma surrounding working with people living with HIV.

Recommendations

Replacement labour may be less skilled, have less knowledge, and be more distracted, less committed, more overworked, and less focused than original labourers. The major cost of HIV and AIDS for some industries, then, might well be the loss of markets in the region or country.

Given the overwhelming evidence of this study that HIV and AIDS is a major cost and can be mitigated, it is a major recommendation of this study that companies should look upon HIV as a strategic issue, design ways to keep track of costs, benefits and counts, and look upon these figures as central to company planning in the medium term.

The 2007 DHS survey should be extensively analyzed to establish a baseline for industries and the national workforce. Given that the impact of HIV for companies is only partially captured by a company based examination, industry-based analysis is needed.

From the employees and community members' perspectives, there is room for improvement. For instance, in the further implementation of the HIV workplace programmes, the language and visualisation of prevention messages must reach the illiterate and non-English speaking members of the communities, resulting in increased access to HIV related health care and services. For workplace programmes to be effective, they need to be multi-sectoral, comprehensive, focused, and community driven

While most people appreciate the work of the companies regarding HIV, some employees feel that the companies are not doing enough to help families that are affected with HIV. Community members expressed the need to translate the brochures' information about HIV from English to the local languages, which will help those who cannot read and understand English to have access to HIV information.

Besides the need for more information about HIV in general, the research found that several community members are not sure of the effects of ARVs, even though they can receive them gratis. The communities need more information about the effects and efficacy of ARVs before people began taking them.

The question of treatment and care for non-permanent workers remains largely unresolved. Companies feel they cannot provide treatment to mobile workers, as it would be unethical to begin treatment if it cannot be continued when the contract is over. Yet, the study reveals that even modest incorporation of such workers in workplace programmes provides benefits to both companies and temporary workers.

A more holistic approach to prevention programmes for non-permanent workers is required. Through implementing broader workplace programmes – for example including the wider community and addressing the environmental vulnerability factors of non-permanent workers – existing programmes can be made more effective.

5.3 Private sector's response to the AIDS epidemic in Africa. WHO. 2003.

Region: South Africa

Scope:

The costs to business that arise from HIV/AIDS in the workforce have been documented. For some firms, they are substantial, increasing labour costs by more than 6%. Wide variation exists among firms in the absolute magnitude of the costs and the relative importance of direct (out of pocket) and indirect (productivity) costs, particularly in the costs associated with retirement, death, and disability benefits.

Companies that decide to manage these costs have different strategies. This paper discusses the strategy called the "burden shift". It addresses not the absolute magnitude of the burden, but its allocation among various levels and sectors of society. Our interest is in private sector actions that result in employers bearing less of the burden of AIDS, whether

those actions are directed at AIDS or are taken for other reasons and affect the AIDS burden coincidentally.

We hypothesize that the systematic shifting of this burden is a rational and predictable response by business and an important social and economic phenomenon to which a deliberate public policy response is needed.

Methodology

The paper describes and analyses burden-shifting practices, both deliberate and inadvertent. Our data are primarily from South Africa —Africa's largest economy and the country whose private sector accounts for the largest share of employment. After presenting anecdotal and survey evidence and a firm-level analysis of burden-shifting practices, we discuss the implications of the burden shift for businesses, governments, and households.

Findings

Common practices that transfer the burden to households and government include pre-employment screening, reductions in employee benefits, restructured employment contracts, outsourcing of low skilled jobs, selective retrenchments, and changes in production technologies. Between 1997 and 1999 more than two-thirds of large South African employers reduced the level of health care benefits or increased employee contributions. Most firms also have replaced defined-benefit retirement funds, which expose the firm to large annual costs but provide long-term support for families, with defined- contribution funds, which eliminate risks to the firm but provide little for families of younger workers who die of AIDS. Contracting out previously permanent jobs is also shielding firms from benefit and turnover costs, effectively shifting the responsibility to care for affected workers and their families to households, nongovernmental organizations, and the government. Many of these changes are responses to globalization that would have occurred in the absence of AIDS, but they are devastating for the households of employees with HIV/AIDS.

Recommendations

Given the importance of developing realistic national strategies to manage the epidemic and the discrepancy between public pledges of action against AIDS and private measures that shift the burden of AIDS, we see a need for action at three levels.

First, each country must decide how it wants the burden of HIV/AIDS to be allocated. The burden is huge, and in the end the largest share will almost inevitably fall on individuals and households. The private sector has a clear incentive, and some ability, to shift the burden unless governments take action to prevent it. Deliberate decisions on social policy must be made, and enforced, if the ultimate allocation of the burden is to be socially desirable.

Second, researchers and international organizations should begin to develop a set of strategies and tools that help countries achieve the balance they desire. This effort can draw on extensive experience in other fields to regulate business practices and balance private sector interests with the public good. Such a balance is difficult to achieve but certainly not

impossible. Successful examples include environmental regulations that phased out leaded gasoline in a way that protected children's health, while minimizing the cost to business; and antitrust legislation that ensures competitive pricing for consumers, while guaranteeing a level playing field for businesses.

Finally, the trend we have described in this paper should be monitored and analysed. We have presented a hypothesis, with some preliminary supporting evidence drawn largely from a single country in the region. Before policy-makers can develop response strategies, they need a better understanding of baseline conditions. Systematic data collection and ongoing monitoring of levels of benefits, hiring practices, and employment structures are needed to understand the nature and magnitude of the trend, determine where and for what types of industries or employers it is most important, and evaluate the impacts of policy changes. Using experience from other fields and other countries, as well as information generated by monitoring and analysis, we can encourage both governments and businesses to recognize and bear their fair share of the burden and to do their best to support the households who will bear the rest.

5.4 Perception of Indian employers about HIV/AIDS in the world of work. ILO/AIDS. 2002

Region: India

Scope

The main objective of the study is to capture the perceptions of Indian employers about the HIV/AIDS in the world of work. This is meant to determine the key parameters that could be used to undertake appropriate advocacy/intervention strategies in the world of work vis-à-vis HIV/AIDS. The study aims to present the employers' view on HIV/AIDS in the world of work, specifically of the private sector.

Methodology

This is a research study of a larger scale that involved survey of 1,058 firms in the private sector during April- June 2002 in 21 States and 71 districts all over India. The study depended on the interviews of employers. No special emphasis was given to industrial sectors and geographical areas where higher incidence of HIV/AIDS is reported.

Respondents in the sample mainly consist of 51.4 per cent owners, 20.4 per cent CEOs, and 12 per cent HR heads and 16.2 senior level functionaries designated by the management for the interview. In fishing, plantation and trade, respondents are mostly owners. Only 4.3 per cent of respondents are women. Of the total (46) female respondents, 34.8 per cent are owners, 26.1 per cent CEOs and 21.7 per cent HR leaders.

The sample included 53.6 per cent formal and 46.4 per cent informal segments of industry. It is found that as the investment size increases the size of informal segment decreases. The final sample covered around two-thirds tiny and small industry and one-third medium and large industry.

The firms under study cover a total of 160,947 workers. Around one-third of total workers are from the category of short-term and contract workers (51,854). They include casual labour, temporary employees and trainees. While men are found more among the regular category, women are more in the category of short-term and contract workers. In the occupational category, men are more found in the skilled segment (73,446) while women are least employed in the managerial segment (2,175). The strength of seasonal workers (7,871) is found higher than that of the migrant workers (5,560) in the sample of total workers. However, more firms employ migrant workers. While 110 firms employ migrant workers, only 102 firms employ seasonal workers. Total migrant workers constitute around 3.5 per cent of the workforce in the sample, and male migrant workers (3,868) constitute 69.6 per cent of the total migrant workers.

Findings

Health and social security status of firms

- Only 9.5 per cent of firms claim to have health policy.
- 8.6 per cent firms provide some direct or indirect facilities for family planning, condom promotion or for both. While 4.2 per cent of firms conduct some classes or programs for sex education of staff, 1.1 per cent provide STD clinics for its staff. It is significant that 4.7 per cent of establishments give AIDS counselling. Fifteen firms (1.4 per cent) are common among those providing sex education and AIDS counselling. Only four firms (0.4 per cent) provide all these four facilities.
- 22.6 per cent (239) of firms provide some benefits to the families of employees who die of sickness.
- Except maternity benefits, no other special facilities are given to women workers.

Awareness level of employers

- The overall general awareness level about HIV/AIDS is found high, as 52.5 to 73.8 per cent of employers identified at least one correct answer as the source of HIV.
- Risky/unprotected sexual intercourse has been taken least seriously by construction sector (88.5 per cent) followed by mechanized fishing (92 per cent) and trade (92.3 per cent).
- The attitude of employers toward recruitment of HIV-affected persons is negative, as 67.1 per cent of them are not ready to employ HIV positive persons. However, majority (55.3 per cent) was ready to allow them continue with the employment. Though a good majority (71.6 per cent) was ready to offer treatment, most of them were not clear on who would foot the bill.
- IT sector showed greatest readiness to recruit and it came highest in non-discrimination, while the sector of construction stood lowest-ranked in both the issues. At the same time IT showed least interest in offering treatment. Finance and real estate stood highest in the scale of comparison with regard to issues of allowing the HIV affected to continue in job and offering treatment. Mechanized fishing showed least interest in allowing the infected to continue in job.
- In non-discrimination, allowing continuation in job, and offering treatment, formal sector stood in forefront, while informal sector fared better in showing readiness to recruit the HIV infected. Tiny industry stood at the lowest rung in matters of non-discrimination and treatment.

- When the possible reaction of co-workers was assessed from the perception of employers, it was found most of them gave negative opinions. 24.2 to 36.5 per cent of employers felt that co-workers will refuse to work, neglect or avoid the worker, or will protest. Only 12.9 per cent thought that workers will support the HIV affected co-workers.

Impact of HIV/AIDS on industry

- The threat of opportunistic infection is very visible over and above the impending threat of HIV to the industry. The total workers infected with STD, opportunistic and related diseases are 265 in 70 firms (6.6 per cent). Of them, TB infected alone is 144. Hepatitis affected 83, hepatitis B two, and STD 36 workers. Firms with disease-affected persons are found in almost all the major States and all sectors in the sample. Tiny, small, medium and large industries are all affected, medium industry leading over other sectors. As far as higher incidence is concerned, manufacturing sector is mostly affected, followed by construction and trade.
- Hotel, mechanized fishing, manufacturing, trade, and finance & real estate are the sectors that suffered the impact of HIV/AIDS. By nature of industry, the impact in terms of all factors reported has affected the formal industry. In terms of size, every industry irrespective of size is affected by HIV/AIDS.
- Regarding policy, only 5 respondents (0.5 per cent of total firms) have said that they have HIV policy at enterprise level.
- Some firms follow certain steps with the objective of preventing HIV among their staff. Some of the steps are: aids awareness camps and classes, character monitoring, discussion and distribution of available information, education of workers, encouraging workers to discuss the issue, medical steps like giving Hepatitis B shot, sex education, etc.

Expectation of employers with regard to nature, level and implementing agencies of policy

- 47.1 per cent of the respondents want to make use of the existing health facilities and thus link the HIV policy with a general integrated health policy. Majority of the respondents (48.4 per cent) treats HIV as special case that needs more attention and wants to keep it independent of the existing health policy.
- While 86.7 per cent of employers went in favour of implementing the policy at government level, 42.7 per cent opted at enterprise level and 44.3 per cent at the level of employers' association. That means, a minimum of 42.7 per cent of employers are ready to bear responsibility at enterprise level, and 44.3 per cent want co-operation from employers' association. At the same time, 86.7 per cent of them expect active intervention from the side of government.

Recommendations

- The survey reiterated the need for an HIV/AIDS policy at workplace. ILO could work with the Government, employers and trade unions to evolve a comprehensive policy on HIV/AIDS in the world of work and suggest model policies at the enterprise level.
- The three major policy elements supported by most of the employers are 'education and awareness programs,' 'sex education and condom promotion,' 'counselling and treatment.' Therefore, it is very important to arrive at measures directly or indirectly linked to the above three policy elements.

- Employers preferred simultaneous action at the levels of government, employers' association, and enterprises. This reflects clear willingness of employers to have an HIV/AIDS policy in the world of work, though they expect active support of government. They expect also the support of NGOs, private sponsors, media and trade unions. Majority of respondents prefers government as the implementing agency with regard to education and awareness programs, sex education and condom promotion, and counselling and treatment. NGOs, private sponsors and media are the other important agencies suggested. Lobbying is needed to persuade Government to take initiative.
- Stronger opinion has emerged with regard to the interlinkage of a new HIV/AIDS policy in the world of work with the existing health policy. A national comprehensive policy is needed in this context.
- The relatively high level of awareness found among employers with regard to HIV and AIDS has to be utilized to develop a realistic assessment of HIV/AIDS and to devise proactive steps. The focus of the translation of awareness shall intend (1) to evolve preventive measures, (2) to persuade employers to acknowledge the rights of HIV positive workers, and (3) to enable the employers to assess the impact of HIV/AIDS at enterprise level and evolve necessary measures with the cooperation of the workers.
- Measures should be initiated against discriminatory practices.
- Best practices have to be documented and disseminated for emulation and learning.
- Fishing sector needs special measures, as it emerged as the sector with low awareness levels on various counts and also as the sector more affected with HIV and other diseases. Discrimination of HIV-affected co-worker is also reported from this sector. Both the workers and employers need crash measures of sensitization and also health and social security measures.

5.5 Care and Treatment to Extend the Working Lives of HIV-Positive Employees: Calculating the Benefits to Business, *South African Journal of Science* (July 2000)

Region: South Africa

Scope

In this paper, we look at the potential benefits to South African businesses of investing in treatment and care initiatives that are likely to extend the working lives of HIV+ employees. The humanitarian and ethical arguments for companies to provide treatment and care to employees are clear and compelling, but a strong financial case for investing in treatment and care has not yet been made. The purpose of this paper is to describe an approach to analyzing the benefits of interventions that extend the working lives of employees and to demonstrate such an analysis using published data on the costs of HIV/AIDS to companies.

Methodology

The data for the analysis come from published analyses of the costs of HIV/AIDS to businesses in Africa. In this literature, the direct (out-of-pocket) costs analyzed typically include pension and provident fund contributions, service gratuities, death or funeral benefits, health clinic use, recruitment, and training. Indirect (productivity) costs typically include absenteeism and reduced performance.

Findings

By retaining skilled and experienced employees for an additional year or years, the company:

- Buys time for drug prices to fall and for medical and social science researchers to develop new ways to treat HIV/AIDS
- Reduces the time managers and supervisors must spend coping with employee deaths and high turnover rates
- Reduces the impact on the morale, motivation, concentration of the rest of its workforce of having colleagues fall sick and die
- Creates more time to implement strategies to cope with the epidemic, such as training replacement employees, shifting to less labour- intensive technologies, and managing the loss of overall workforce skill, experience, institutional memory, and cohesion that HIV/AIDS is causing.

While not all of these benefits apply to all employers in South Africa, every organization likely has an opportunity to obtain some of them. This includes both large, formal-sector firms and small and medium sized enterprises, government agencies, universities, and NGOs.

Recommendations

If organizations are to be persuaded to make larger investments in care and treatment, there is

an urgent need for further research and communication on several key issues, including:

- the effectiveness and cost of treatment and care interventions that can be implemented through the workplace, as well as at health facilities and in communities
- the costs to companies, in present value terms, of new HIV infections at each level of the workforce under different assumptions about life expectancy and discount rates
- the administrative feasibility of providing available care and treatment interventions to large numbers of employees in various kinds of companies and organizations.

While we still have a great deal to learn about the issues identified above, the analysis in this paper should provide strong encouragement to businesses, government, and other employers to think seriously about investing further in treatment and care of HIV-positive employees.

5.6 Patterns of disclosure and antiretroviral treatment adherence in a South African mining workplace programme and implications for HIV prevention, African Journal of AIDS Research, 15 Dec 2011

Region: South Africa

Scope

Social and psychological barriers to the disclosure of one's seropositive HIV status to significant others and poor adherence to taking medications pose significant challenges to

the scaling-up of access to antiretroviral treatment (ART) in the workplace. Such barriers are predictive of sub-optimal treatment outcomes and bedevil HIV-prevention interventions at a societal level. Against this background, this article explores the lived experiences of 19 HIV-positive male participants, between the ages of 33 and 57 years, who were enrolled in an ART programme managed at an occupational health clinic at a mining company in South Africa. The majority of these mineworkers had been aware of their HIV status for between 5 and 7 years. The study explored psychological and relational factors, as aspects of these participants lived experiences, which had a bearing on their adherence to their ART regimen and the disclosure choices that they made regarding their HIV status.

Methodology

The research was conducted at one of the larger sites of a multinational mining company operating in South Africa. At the time of the study, the employee population at the site comprised approximately 380 permanent employees and 70 contract employees.

At the time of the study, 104 HIV-seropositive patients had been registered on the clinic's HIV-treatment programme. Of this patient cohort, 40 individuals were on pre-HAART and 38 on HAART, with the balance being either deceased or out of contact with the clinic. In December 2009, 19 HIV-positive participants were recruited from the occupational health clinic at the site, using a non-probability sampling technique. Interviews with the participants occurred between January and May 2010.

Findings

This study highlights the psychological and the relational aspects of everyday living shown to have significantly impacted ARV-adherence behaviours in a sample of HIV-positive mineworkers. Primary variables impacting negatively on ART adherence included psychological factors related to knowing one's HIV status, a perceived loss of control over one's health and quality of life, the pressure to accept the overwhelming responsibility of being labelled HIV-positive, fear of social stigma and marginalisation, and difficulties with disclosure and its implications. Medication adherence was also negatively impacted by personal difficulties in coping, which arose irrespective of whether or not a participant had disclosed his HIV status to people with whom he lived or to non-family members.

Recommendations

The following recommendations are offered in order to improve ART adherence among mineworkers in resource limited settings. These recommendations rely on a combination of educational, psychological and relational strategies in order to maximise long-term treatment adherence. First, in terms of education and counselling, it is important that individuals receive counselling to prepare them for an ART regimen. Furthermore, it is pivotal that there is constant and effective communication between the client and healthcare provider. During adherence counselling, a positive link needs to be made between knowing and accepting one's HIV-positive status and the benefit of increasing the quality of one's life through treatment. Healthcare professionals need to provide procedural information about adherent behaviour and make the positive link between ART and a long, healthy life. Furthermore, educating individuals on the relationship between adherent behaviour and HIV-risk reduction enables the responsibility for treatment adherence and HIV-prevention to be shared between the healthcare provider and the client. As regards

HIV-prevention, testing and treatment, lifestyle-adjustment approaches need to be incorporated as part of employee wellness programmes. Such a holistic approach is critical in closing the demonstrated gap between HIV prevention, testing and treatment in workplace programmes.

In terms of psychological and relational factors, interventions should privilege an emphasis on acceptance of one's HIV-positive status in order to promote treatment-adherent behaviour. Second, disclosing to a healthcare provider as a first step to illness management needs to be encouraged. Third, as part of this process, there is a need to build the client's self-efficacy in managing their illness. Disclosing to a trusted family member/s may serve as an important source of social support. Counselling also needs to be provided for family members who are affected by HIV. In this regard, a couples' counselling programme for both sero-concordant and sero-discordant couples is essential to any HIV-related illness-management programme.

Lastly, and most importantly, this study echoes the findings of previous studies regarding the discourse of silence surrounding HIV and AIDS on a broad community level. Secrecy and silence about one's seropositive HIV status and HIV-treatment-taking are major barriers to a person's self-actualisation and may be expressed in non-adherent behaviour. Simoni, Montgomery, Martin, New, Demas & Rana (2006) make a case for the integration of biomedical interventions with client-focused educational and behavioural strategies, which should be reinforced by directing attention to larger structural issues, such as increasing access to care and reducing stigma, to effectively confront the challenges of HIV prevention and treatment.

5.7 HIV/AIDS services through the workplace: a survey in four sub-Saharan African countries, USAID. 2008.

Region: Ethiopia, Kenya, Namibia, and Zambia

Scope

For over a decade, many businesses have experienced increased costs and reduced productivity as a result of HIV/AIDS. Many companies are responding to the HIV/AIDS crisis through investment in prevention programs, especially in employee education and condom distribution. A smaller, but increasing number have supported a range of care and treatment services for employees and their families. However, not enough is known about the factors that influence the choices companies make in HIV/AIDS service provision and the range of approaches taken to increase access to services.

To address this knowledge gap, the Private Sector Partnerships-One project (PSP-One) conducted a survey of companies in Ethiopia, Kenya, Namibia, and Zambia in 2006-2007.

Methodology

PSP-One selected the sample based on a list of companies that donor agencies had previously worked with related to HIV/AIDS issues. Human resources personnel or health clinicians from 121 companies participated in the survey via an online, self-administered questionnaire, or phone interviews. The data were then analyzed using univariate and bivariate analyses. Additional qualitative data were collected through key informant interviews with company personnel from four companies in each of the study countries.

Findings

Survey results show that companies that do not deliver or finance HIV/AIDS services on site primarily refer their employees to government facilities for HIV/AIDS services. More than half of companies with onsite clinics obtain HIV tests, drugs to treat opportunistic infection (OI) and tuberculosis (TB), and male condoms from the government. Cumulatively, 69 percent of companies offer voluntary counselling and testing services on site, finance these services, or use both mechanisms. OI and TB services follow closely behind, at 68 and 60 percent respectively. Prevention of mother-to-child transmission services and home-based care are not as commonly delivered on site or financed for employees. Forty-two percent of companies facilitate access to ART through onsite clinics or offsite financing. Results differ between services offered by large, multinational companies and those offered by small and medium enterprises, and qualitative data analysis focuses on the motivations for and challenges of HIV/AIDS service provision by both small and large companies.

Recommendations

Referrals often are used as a mechanism for facilitating access to services, especially among small companies and non-multinational ones. When companies cannot offer HIV/AIDS services, they should encourage human resources or clinical staff to be knowledgeable about services in the area that employees may access. Future research also should identify why referrals are made to certain entities over others, how these referral entities work with companies to better meet the HIV/AIDS needs of employees, and what actions employees take when they receive a company referral for each type of HIV/AIDS service.

Most mechanisms that facilitate HIV/AIDS access are chosen either because of employee demand or in light of available company resources and need for cost-savings. Though this survey does find that companies commonly cite services being available for free from the government as a primary reason for not offering HIV/AIDS services in general, the survey does not probe that motivation for each individual service. Future studies should look to determine the basis for companies' decisions to offer particular HIV/AIDS services. Such rigorous exploration of motivations can help companies and governments to coordinate the types of services offered at each entity to better meet the HIV/AIDS needs of employees and the general population.

As stated in this paper's definition of "access," this research does not consider uptake of services, so questions remain about employees' behaviour related to HIV/AIDS services. Future research might identify if patients utilize the services to which they have been referred. Nor does this research cover private practitioners' role in workplace HIV/AIDS services and whether they have proper training to deliver services, consistent supply chain access, and patient reporting requirements like the public sector. Other related issues for future research not studied here include HIV/AIDS-service satisfaction and quality, which

could influence where employees seek HIV/AIDS services, and the extension of services to dependents and the community.

This study offers several useful contributions to better understanding the role of sub-Saharan African companies in providing HIV/AIDS services. Because the majority of the literature about workplace HIV/AIDS services examines companies in Southern Africa, particularly South Africa, this study deliberately focused on other African countries. The challenges to service provision identified by the surveyed companies in Ethiopia, Kenya, Namibia, and Zambia are relevant to companies in countries without a strong private insurance system and without the presence of multinational companies with strong corporate social responsibility policies on HIV/AIDS service provision and the active involvement of shareholders on the issue.

This study cuts across countries and quantifies the range of service provision types and mechanisms used by companies in sub-Saharan Africa that are diverse—in terms of size, industry, and national origin. Much of the existing literature explores motivations for why companies offer HIV/AIDS services but there has been little attempt to systematically quantify which services are actually being offered, and how companies actually finance those services. The study also explores some motivators for offering workplace services and assesses why certain services and financing mechanisms are used predominantly by large companies. Thus, these findings can help missions and organizations looking to collaborate with or provide relevant technical assistance to small or large companies wishing to expand their HIV/AIDS service provision.

Looking ahead, further research can specifically examine the challenges for HIV/AIDS service provision in smaller companies in low-income countries. Increased donor funding and resource flows for HIV/AIDS services in high-prevalence countries may affect the provision of workplace services, and should be investigated. This research supports the ability of all companies, both large and small and with or without ample resources, to effectively provide workplace HIV/AIDS services for the benefit of both the company and its employees.

ANNEXES:

a. THEMES AND SECTORS COVERED BY REGION:

Southeast Asia (Cambodia, Indonesia, Malaysia, Myanmar, Philippines, Singapore, Thailand and Viet Nam) Mandatory on HIV testing of migrant workers.

India: Men and women migrant construction workers.

India: Assessment of Implementation of HIV/ AIDS workplace policies.

India: Prevention of HIV/ Aids in the word of work. Knowledge, Attitude, Behaviour, Practices, Hospitals, Medical and paramedical staff.

India: Socio economic impact of HIV/ AIDS on PLHIV and their families.

India: Economic impact of HIV/AIDS on PLHIV accessing Antiretroviral Treatment: Indentify costs, stigma and discrimination.

India: Economic impact of HIV/AIDS in the mining sector.

India: Perception of employers about HIV/AIDS in the world of work.

Jordan: Policy and practice on workplace HIV /AIDS.

China: Improving reproductive health among young female migrants should be a core priority for enterprises, government and the health sector.

China: Discrimination against people living with HIV within healthcare settings.

China: HIV/AIDS related employment discrimination.

Malawi: Economic empowerment of workers, women and cross border officials operating along the transport corridors by providing business-related services as well as HIV prevention programmes to reduce risky sexual behaviours.

Mali: Barrier to voluntary HIV testing and counselling. Campaign and education programmes to address HIV in the context of other health risk.

Tanzania: The cooperative movement, which is comprised of member-based organizations, has developed some innovative programs to address the plight of the orphan and vulnerable children.

Malawi, Tanzania, and Uganda: Economic and social costs of HIV/ AIDS On CSOs in Africa.

South Africa: Migration, urban live hoods and informal workplace.

South Africa: Gender and HIV.

South Africa: Mining sector policy, protecting the rights of workers.

South Africa: Employers perceptions of HIV/AIDS and company programmes.

South Africa: Sexual risk behaviour on the spread of HIV.

South Africa: Domestic violence, health and HIV.

Sub-Saharan Africa: Workplace, HIV related behaviour change.

East and southern Africa: Zambia and Zimbabwe: Stigma and discrimination for HIV positive teachers.

Kenya, Zambia: Employment discrimination and HIV stigma.

Kenya, Lesotho: Cooperative model for the delivery of home based care services for PLHIV. (Partnership prevention, treatment and support services).

Kenya: Stigma and discrimination, educate, support and advocacy for teachers HIV rights. (Kenya network of positive teachers (KENEPOTE).

Zambia: Cost benefit analysis of HIV workplace programmes.

Swaziland: Positive living in Social Economy, improve treatment and care, gender stigma and discrimination.

Botswana: Policy and programme to improve health and welfare of PHLIV and their families

Senegal: Behaviour Change and communication programmes.

Guinée: (KABP) behaviour change and stigma and discrimination.

Ghana: National response on reducing stigma and discrimination.

Ukraine: HIV in the workplace from the point of view of its gender-related aspects.

Ukraine: Prevention at workplace in the health system, stigma and discrimination.

22 Countries Ports: (Australia: Barbados: Belgium: Benin: Brazil: Colombia: Honduras: Ghana: Guatemala: India: Kenya: Mexico: New Zealand: Nigeria: Norway: Panama: Philippines: South Africa: Sweden: Sri Lanka: Tanzania: Togo) Advocacy and campaign, education for tackling fear and stigma.

5 Counties Civil aviation sector: (Argentina, Bulgaria, Ethiopia, India and Jordan) national response to HIV, stigma and discrimination, promote behaviour change.

United States: Barriers to employment, co- morbid problems

9 countries in 4 regions: Kenya, Nigeria and Zambia (sub- Saharan Africa), Estonia and Poland (Eastern Europe), Malaysia and the Philippines (Asia-Pacific,) and Argentina and Mexico (South America). PLHIV Stigma Index.

Netherlands, Share-Net: New model on human resource management.

b. SECTORS COVERED

Transport sector (Port and port workers; Civil aviation sector)

Health sector (Medical, Nursing, paramedical staff)

Cooperatives

Informal workplaces

Mining sector

Agricultural sector

Education sector

Civil Society Organisations

NGOs

United Nations System

c. TARGET GROUPS:

Gender, Youth, Children, Families, Migrants, Sex workers, Employers federations, Trade Unions, Medical Staff.

d. PROGRAMS:

Economic empowerment; Education trainings; Promote behaviour change; Capacity building; Dialogue between sectors; Prevention; Awareness programs; Sex education and condom promotion; Counselling and treatment; Gender equality.

E. References

a. Vulnerability Studies

1. Approaches to Gender and Sexuality: Responding to HIV. International HIV/AIDS Alliance. 2011
2. Domestic Violence, Health and HIV. (TLAC) Tshwaranang Legal Advocacy center. 2009
3. Esther S.Wigers. Gendered vulnerability to aids and its research implications. Wageningen University. 2007.p.45
4. Gender Aspects of HIV/AIDS in the World of Work in Ukraine. ILO/AIDS. 2011
5. Gender based violence and HIV. USAID. 2010
6. HIV prevention Capacity Building. AED Center on AIDS & Community Health, CDC. 2005
7. Opportunity in Crisis: Preventing HIV from early adolescence to young adulthood. ILO/AIDS. 2011
8. Rapid assessment among migrant workers in the construction sector on HIV risk and vulnerability in Raigad district, Maharashtra, India. ILO/AIDS. 2008
9. Reproductive Health and Gender Awareness in Shenzhen's Migrant Population. ILO/AIDS. 2011
10. South African HIV/AIDS programming overlooks migration, urban livelihoods, and informal workplaces. African Journal of AIDS Research.2011
11. Study on mandatory HIV testing for employment of migrant workers in eight countries of Southeast Asia. ILO/AIDS. 2006
12. The epidemic in this country has the face of a woman: Gender and HIV/AIDS in South Africa. African Journal of AIDS Research. 2011
13. The role of economic empowerment in reducing HIV risk and vulnerability among girls and young women along selected hotspots of the transport corridors of Malawi. ILO/AIDS. 2011
14. Women's health, HIV/AIDS and the workplace in South Africa. African Journal of AIDS Research. 2011

b. Stigma and Discrimination studies

15. AIDS CARE Perceived barriers to employment among persons living with HIV/AIDS. 2004
16. Combating HIV stigma in health care settings: What works? International Center for research on Women. 2009. (AWISA)
17. Discrimination against people living with HIV within healthcare settings in China. ILO/AIDS. 2010
18. Employment discrimination and HIV stigma: survey results from civil society organizations and people living with HIV in Africa. African Journal of AIDS research. 2011 (Kenya, Zambia)
19. HIV and AIDS related employment discrimination in China. ILO/AIDS. 2011
20. Report, HIV in civil aviation sector. ITF. 2010
21. Rising to the challenge- USAID Health policy initiative in Kenya. USAID. 2009. (AWISA)
22. Stigma and discrimination at work. GNP+. 2012
23. Study report on HIV, ports and port workers. ITF. 2011
24. Supporting HIV positive teachers in ESA. UN Plus. 2006

25. The reality of HIV and AIDS related Stigma and Discrimination in Southern Africa. SAFAIDS. 2003. (AWISA)
26. Women, Girls and HIV and AIDS: Education, Women's Economic Empowerment and Workplace Violence. ILO/AIDS. 2010

c. Impact studies

27. A Study on the Economic Impact of HIV/AIDS on People Living With HIV (PLHIV) Accessing Anti Retroviral Treatment (ART) Centres in New Delhi. ILO/AIDS. 2010
28. Cross-Country Study of the ILO/USDOL HIV/AIDS Workplace Education Program. ILO/AIDS. 2008
29. Impact Assessment of ILO/USDOL HIV/AIDS Workplace Education Project. ILO/AIDS. 2000
30. Impact Study of HIV and AIDS on the United Nations System. UN Cares. 2007
31. Impact of HIV/AIDS on poverty, inequality and economic growth. International Development Research Center. 2006. (AWISA)
32. International Labour Organization, HIV/AIDS and work: global estimates, impact on children and youth, and response. 2006
33. Managing HIV/ AIDS in the workplace. Stop AIDS Now. 2006
34. Managing HIV/AIDS in the work place. Ethiopia. Stop AIDS Now. 2009
35. Multisectoral Impact of the HIV/AIDS epidemic. Kaiser Family Foundation. 2007. (AWISA)
36. Prevention of HIV/AIDS in the world of work: A tripartite response: Knowledge, Attitude, Behaviour and Practices (KABP) Study of Medical (Nursing) and Para-medical personnel of ESIC hospitals on HIV/AIDS/STI and TB. ILO/AIDS. 2010
37. Socio-Economic impact of HIV/AIDS on people living with HIV/AIDS and their families. India. ILO/AIDS. 2003
38. Study Report on Economic Impact of HIV/AIDS on Singareni Collieries Company Limited (SCCL). India. ILO/AIDS. 2010
39. Survey on HIV/AIDS among its affiliates. Understand the impact of HIV/AIDS in different transport sector. ITF. 2007
40. The cooperative model for the delivery of home based care services for people living with HIV. ILO/AIDS. 2011
41. The second national-HIV Communication survey. Health Department (South Africa), USAID/PEPFAR & CDC. 2011

d. Cost Benefit

42. AIDS CARE Perceived barriers to employment among persons living with HIV/AIDS. 2004
43. AIDS Care, HIV/AIDS, income loss and economic survival in Botswana. 2006
44. Cost Benefit Analysis of HIV Workplace Programmes in Zambia. Stop AIDS Now. 2007
45. Care and treatment to extend the working lives of HIV-Positive employees. South African Journal of Science. 2000 (AWISA)
46. Perception of Indian employers about HIV/AIDS in the world of work. ILO/AIDS. 2002
47. Private sector's response to the AIDS epidemic in Africa. WHO. 2003 (AWISA)
48. The AIDS Accountability Workplace Scorecard. AIDS Accountability International. 2011. (AWISA)
49. HIV/AIDS services through the workplace. USAID. 2008. (AWISA)

50. HIV/AIDS in the Workplace. International Finance Cooperation. 2002. (AWISA)

Internet:

- <http://awisa-network.net>
- www.avert.org