

DAY 4

© Universal precautions

© Mother-to-child transmission

© Stigma

Day 4 examines the two remaining transmission routes: the blood route and the mother-to-child route. Universal precautions and occupational exposure are discussed, and issues around mother-to-child transmission are debated. The main focus is on prevention, but aspects of care are also introduced. The day concludes with a session on stigma, which further links prevention and care, and thus provides a bridge to Day 5.

Learning objectives

By the end of Day 4, participants will be able to:

- © Understand the risks of HIV transmission in health care settings and through traditional practices
- © Describe universal precautions
- © Have an awareness of the management of occupational and rape-related exposure, including post-exposure prophylaxis
- © Describe mother-to-child transmission
- © Analyze options for preventing mother-to-child transmission
- © Explain the meaning of stigma, prejudice and discrimination
- © Analyze causes of stigma
- © Propose approaches for reducing stigma

Resource materials



Manual:

- ⊗ International Rescue Committee. (2003) Protecting the Future: HIV Prevention, Care and Support among Displaced and War-Affected Populations. Chapters 11, 12 & 13.

Handouts:

- ⊗ Course notes: Universal precautions.
- ⊗ Course notes: Management of occupational exposure.

Additional resources:

- ⊗ EngenderHealth. (2001) Infection Prevention Online Course www.engenderhealth.org/ip/about/ip.pdf
- ⊗ Centers for Disease Control and Prevention. (2001) Updated US Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Post-exposure Prophylaxis. MMWR 2001; 50 (No. RR-11). www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a1.htm
- ⊗ UNAIDS. (2001) Counseling and voluntary testing for pregnant women in high HIV prevalence countries. www.unaids.org/html/pub/publications/irc-pub01/jc245-couns_test_en_pdf.pdf
- ⊗ WHO/UNICEF/UNAIDS. (1998) HIV and infant feeding: a guide for health care managers and supervisors. www.unaids.org/html/pub/publications/irc-pub03/jc180-hiv-infantfeeding-2_en_pdf.pdf
- ⊗ Understanding and challenging HIV stigma – a toolkit for action. (2003) Facilitator's guide. The CHANGE project. www.changeproject.org/technical/hivaids/stigma.html
- ⊗ WHO/UNHCR. (2002) Clinical Management of Survivors of Rape – A guide to the development of protocols for use in refugee and internally displaced person situations. www.who.int/reproductive-health/publications/rhr_02_8/clinical_management.pdf
- ⊗ Asia Pacific Network of People Living with HIV/AIDS. (2004) AIDS-related Discrimination in Asia. www.gnpplus.net/regions/files/AIDS-asia.pdf
- ⊗ Engender Health. (2004) Reducing Stigma and Discrimination Related to HIV and AIDS: Training for Health Care Workers, Trainer's Manual and Participant's Handbook. www.engenderhealth.org/res/offc/hiv/stigma/



PowerPoint:

- 4.2b Blood route facts
- 4.2c Implementing universal precautions
- 4.2d Accidental exposure
- 4.2f Managing accidental exposure
- 4.3a MTCT
- 4.4b Illustrating stigma
- 4.4e Fighting stigma
- Teaching aids Day 4



Audio-visual:

Make the following to use with presentations and on wall display:

- ⊙ Audio: CD Track 07 and 08
- ⊙ Video: Mother-to-child transmission
- ⊙ Video: A fighting spirit



Posters:

- ⊙ Blood route (Show with PowerPoint 4.2b)
- ⊙ Universal precautions: (Make from text 4.2b)
 - Make poster of 7 points (Make from text 4.2f)
- ⊙ Managing occupational exposure (Make from text: 4.2f)
- ⊙ MTCT/PMTCT (Make from text: 4.3a & b)
- ⊙ PMTCT poster by Kenya participants (Show as introduction to debate 4.3e)
- ⊙ "What is stigma?" (Show with 4.4a)
- ⊙ Stigma quotations (Make from text: 4.4d)

Miscellaneous materials

- ⊙ PEP kit

DAY 4 - Session plan

Time	Topic	Materials
30 min	4.1 Introduction	
	4.1a Presentation: Introducing the blood route and the mother-to-child route	HIV/AIDS tree
	4.2 Universal precautions	
35 min	4.2a Activity: Developing awareness of HIV transmission through the blood route	Case studies
15 min	4.2b Presentation: Blood route facts	PowerPoint; Posters: Blood route, Universal precautions
40 min	4.2c Activity: Challenges & solutions to implementing universal precautions	Flipchart; PowerPoint
30 min	Break	
10 min	4.2d Presentation: Accidental exposure	PowerPoint
15 min	4.2e Activity: Management of accidental exposure	Flipchart
20 min	4.2f Presentation: Management of occupational exposure	PowerPoint; Poster: managing occupational exposure; PEP kit
	4.3 Mother-to-Child Transmission	
20 min	4.3a Presentation: What is MTCT?	Audio CD; PowerPoint; Poster: MTCT/PMTCT
20 min	4.3b Presentation: How can MTCT be prevented?	Poster: PMTCT; HIV/AIDS tree
45 min	4.3c Activity: Examine issues relevant to PMTCT	Video: Mother-to-Child
45 min	Lunch	
30 min	4.3d Activity: Identifying challenges to PMTCT	Flipchart
30 min	4.3e Activity: Debating PMTCT	PowerPoint poster: PMTCT by Kenya participants
	4.4 Stigma	
10 min	4.4a Activity: What is stigma?	Flipchart; Poster: What is stigma?
10 min	4.4b Presentation: Illustrating stigma	PowerPoint photo; flipchart
20 min	4.4c Activity: Examining why HIV/AIDS is stigmatized	Flipcharts
	4.4d Activity: Examining the consequences of stigma	Flipcharts; Posters: stigma, prejudice and discrimination quotations
15 min	Break	
20 min	4.4c&d Activity: Feedback	HIV/AIDS tree
15 min	4.4e Presentation: Addressing stigma	PowerPoint; Audio CD
30 min	4.4f Activity: Tribute to a man who fought stigma	Video: A Fighting Spirit
5 min	4.4g Activity: Personal commitment	
20 min	4.5 Conclusion	

4.1 Introduction



- ⦿ Brief overview of previous day with review of wall displays. Feedback on pre- and post-tests and evaluations
- ⦿ Select host team for the day
- ⦿ Pre-test
- ⦿ Overview of the day

4.1a **PRESENTATION:** *Introducing the blood route and mother-to-child route*



Presentation – 2 minutes.

Materials: refer to HIV/AIDS tree

On Day 1, we identified three HIV transmission routes:

- ⦿ sex
- ⦿ blood
- ⦿ mother-to-child transmission

On Day 3, we focused on the sex route, examining three aspects of prevention: STIs, VCT and condoms. We emphasized that prevention and care are linked. Today we focus on the blood route and the MTCT route, looking at interventions involving prevention and care. We also address stigma, which has important implications for both prevention and care.

4.2 Universal precautions



Activity

4.2a *Developing awareness of HIV transmission through the blood route*



Small groups.

Preparation – 15 minutes. Feedback – 20 minutes.

Materials: Case studies written on flipchart sheets; Flipcharts

“But why?” exercise:

Facilitator...

...introduces:

Case studies: (Facilitator should adapt case studies to local context.)

1. Blood transfusion

Jane is 20 years old and pregnant with her second child. She delivers the baby at home in her village, assisted by a traditional birth attendant. After the delivery, Jane has moderately severe vaginal bleeding. She is taken to the hospital where she receives a blood transfusion. At age 27, Jane dies after a long period of weight loss and weakness. *Why did Jane get HIV?*

2. Contaminated injection needles

Amina is a 5-year-old girl living in a refugee camp. She develops an abscess on her leg and her mother takes her to the camp clinic. The health worker drains the abscess and gives Amina an injection. At age 10, Amina dies from AIDS-related pneumonia. *Why did Amina get HIV?*



Activity 4.2a cont'd

3. Contaminated sharps in cultural practices

At age 12, Moi is circumcised during a traditional ceremony. When he is 16 years old, after repeated chest and skin infections, a doctor recommends an HIV test. The test is positive. Moi has never had a sexual partner. *Why did Moi get HIV?*

...concludes:

There are complex layers of factors underlying why people are infected with HIV through the blood route. As in the sex route, these factors can be grouped into the three vulnerability areas: behavioral, power and health services issues.

4.2b PRESENTATION: *Blood route facts*



Presentation – 15 minutes.

Materials: PowerPoint 4.2b: Blood route facts

Posters: Blood route (Example: PowerPoint: Teaching aids Day 4)

Universal precautions (Make from text)

The blood route

The HIV virus lives in the blood, therefore any blood-to-blood contact with a person who has HIV carries a potential risk of transmission. We know that HIV can also be found in urine, feces, semen, vaginal fluids, breast milk, saliva, tears and other fluids inside the body. However, blood is the only fluid that has been associated with transmission in health care settings.

HIV transmission through the blood route can occur through: (*Show blood route poster*)

1. Blood transfusions, blood product transfusions (e.g., clotting factor for hemophiliacs) or organ transplants.

Transfusion with infected blood or blood products carries an estimated risk of HIV infection of almost 100 percent.

Five to 10 percent of new infections worldwide are estimated to be the result of unsafe transfusions. WHO estimates that every year 13 million units of transfused blood are not screened for HIV or other infections. "...Despite all the technological marvels that humanity is experiencing, a reliable and safe blood supply is still out of reach for untold millions of people around the world..." (Gro Bruntland, WHO Director General, World Health Day, 2000)

2. Shared needles

Injecting drug users may share needles, or health workers may use the same needle on more than one patient. WHO estimates that each year up to 16 billion injections are given in developing and transitional countries. Ninety percent of these are given for curative purposes (i.e., not for immunization). Up to 96 percent of people seeking care from a primary health care provider receive an injection, of which over 70 percent are unnecessary or could be given as an oral formulation. WHO recently estimated that each year, the reuse of injection equipment may cause 20 million infections with hepatitis B virus and 250,000 infections with HIV worldwide.

3. Shared cutting instruments

Health care workers or traditional practitioners may use the same cutting instruments on different clients without proper sterilization. This risk is notable when procedures are done in quick succession, for example, during ceremonies for circumcision or female genital cutting.

4. Needle stick injury

A needle stick injury or occupational injury occurs when health care workers accidentally injure themselves with needles or other equipment used on a patient. The risk of a health care worker acquiring HIV after a needle stick injury from an HIV-positive person is less than 1 percent.

5. Contact of open sores with infected blood

This may occur if a health worker's skin has a sore or cut, providing an opening for infection to get into the body. No cases of transmission through intact skin have been documented.

6. Mucous membrane exposure

A splash of infected blood comes into contact with mucous membranes in eyes or mouth.

7. Sharing implements

Some implements may have traces of blood on them, e.g., toothbrushes, razor blades.

The first three situations carry high risks. The last four carry smaller but definite risks.

Although health care procedures are responsible for a small number of all infections, they represent a highly preventable source of HIV infection. Protection of health workers is essential, both for their own safety and to prevent any discrimination against HIV-positive patients. Health workers need to understand what does and does not constitute risk.

How can health workers protect themselves and their patients? By implementing universal precautions.

What are universal precautions? *(ask participants)*

Universal precautions are simple infection control measures that reduce the risk of transmission of infections through exposure to blood or body fluids.

Why are they called universal precautions? *(ask participants)*

1. All blood and body fluids from all people should be considered as infected with HIV or other infectious agents, regardless of the known or supposed status of the person.
2. HIV is not the only infection we must worry about. Other infections can also be transmitted through blood and other body fluids, e.g., hepatitis B and hepatitis C and syphilis through blood; shigella and other diarrheal disease pathogens through feces. The risk of developing hepatitis B infection after a needle stick injury can be as high as 20 to 30 percent. (Compare this with the less than 1 percent risk of acquiring HIV through a needle stick injury.) Hepatitis B has been shown to survive in dried blood at room temperature on environmental surfaces for up to one week. Thus, even if HIV did not exist, we must follow universal precautions.
3. Appropriate infection control practices are part of good quality and ETHICAL health care practice and should be followed when caring for *all* patients, in *all* places, at *all* times. This includes home care settings and traditional practices.

What do universal precautions consist of? *(Universal precautions poster)*

1. Safe blood transfusions
2. Safe injections
3. Safe surgical procedures
4. Safe technique
5. Safe processing of instruments
6. Safe environment
7. Post-exposure prophylaxis



Activity

4.2c Challenges and solutions in implementing universal precautions



Work in small groups, by organization.

Discussion – 20 minutes. Feedback – 20 minutes.

Materials: Flipchart sheets

PowerPoint 4.2c

Facilitator...

...introduces:

Read the summary of universal precautions given as a handout. Then:

1. Identify three challenges to implementing universal precautions in your setting (other than problems with supplies and logistics).
2. Suggest some simple, practical measures using existing resources that your organization could take as a first step to improving the situation (excluding improvements in logistics).

Handout: Summary of universal precautions:

1. Safe blood transfusions:

A: Provide safe blood

- ⊙ Screen all blood to be transfused.
- ⊙ Establish standardized procedures for blood transfusion.
- ⊙ Try to recruit low-risk donors.
- ⊙ Avoid payment of blood donors.
- ⊙ Screen donors using a checklist.
- ⊙ Try to establish a stored blood supply which then reduces the need to use potentially high-risk donors in an emergency.
- ⊙ Ensure appropriate supply of HIV tests and other screening tests.
- ⊙ Ensure staff members are trained in using HIV tests and other screening tests.
- ⊙ Ensure appropriate record keeping.
- ⊙ Establish quality control systems with monitoring and supervision.

B: Reduce the need for transfusion

- ⊙ Establish guidelines for blood transfusion to avoid unnecessary transfusions (Refer to p161 in "Protecting the Future").
- ⊙ Consider the use of volume expanders.
- ⊙ Prevent and treat anemia.
- ⊙ Train staff in transfusion guidelines and the use of plasma expanders.

C: Educate the public

- ⊙ Create a demand for appropriate quality services.
- ⊙ Educate to dispel misconceptions surrounding blood donation and work at instilling a culture of blood donation.

2 & 3. Safe injections and other procedures involving cutting or piercing skin:

- ⊙ Only give injections when absolutely necessary.
- ⊙ Always use new single-use disposable injection equipment (needles and syringes) and blades for each procedure.
- ⊙ If using reusable equipment, apply appropriate sterilization techniques.

4. Safe technique:

- ⊙ Wash hands before and after examining each patient.
- ⊙ Wash hands before and after any procedures.
- ⊙ Wash hands after handling any potentially contaminated item.
- ⊙ Wash hands after removing gloves.



Activity 4.2c cont'd

- ⊙ Limit skin contact with blood or other potentially contaminated material by wearing gloves.
- ⊙ Cover any sores with a waterproof dressing. Do not undertake procedures if you have a weeping rash.
- ⊙ Wear a gown or apron for procedures when there might be splashes of blood or body fluids.
- ⊙ Wear a mask and goggles for procedures where blood may splash, e.g., dentistry, surgical procedures and deliveries.
- ⊙ Use aseptic technique for procedures: do not touch a clean area with anything that has been in contact with a potentially contaminated area.

5. Safe processing of instruments/other equipment:

Cleaning, disinfecting and sterilizing are different processes carried out for different reasons. It is essential that health workers understand the differences. (The following reference provides an excellent overview that can be used to train staff on infection prevention: EngenderHealth. (2001) Infection Prevention Online Course.)

6. Safe environment:

- ⊙ Keep floors and other surfaces clean.
- ⊙ Manage soiled linen safely.
- ⊙ Dispose of all used sharps immediately in appropriate (puncture proof) containers. Do not walk around carrying a used needle or blade. Never put needles in with general waste. Do not re-cap needles, or remove them from the syringe after use.
- ⊙ Bury or incinerate sharps.
- ⊙ Burn or bury other medical waste (at least 20 meters away from water sources).

7. Post-exposure prophylaxis:

Discussed in next section.

...concludes (PowerPoint 4.2b cont):

It can be frustrating to try to maintain high standards when equipment and supplies are lacking. However, a lot can be done even when resources are limited, including in conflict-affected settings. Furthermore, many of the problems around universal precautions are related to behaviors of health staff rather than lack of supplies.

1. Establish standard procedures for infection prevention in health facilities: develop a procedure manual or file; develop wall charts to serve as reminders.
2. Train staff and ensure that procedures are understood.
3. Ensure that staff have the appropriate equipment and adequate supplies to implement precautions.
4. Supervise and support staff to ensure they implement the procedures.
5. Ensure staff have reasonable working hours and working conditions, because people who are stressed and tired may make mistakes or be tempted to cut corners.

Example from a conflict-affected setting:

The International Rescue Committee implemented a project in two hospitals in the Bas-Congo region of the Democratic Republic of Congo to reduce HIV transmission in health care settings. The project included:

- ⊙ Training of health care workers on universal precautions.
- ⊙ Provision of supplies to implement universal precautions.
- ⊙ Provision of supplies for syphilis, HIV and hepatitis B screening of blood for transfusion.
- ⊙ Training of laboratory personnel in the use and storage of supplies and equipment.
- ⊙ Conducting supervisory visits in collaboration with hospital administration to ensure implementation of universal precautions.

An important lesson learned from this project was the need for support from hospital administration which resulted in a higher level of accountability among staff to adhere to universal precautions.

4.2d **PRESENTATION:** *Accidental exposure*



Presentation – 10 minutes.

Materials: PowerPoint 4.2d: Accidental exposure

Health care workers can be exposed to HIV infection through contact with infected blood, body fluids or tissues.

Types of exposure in health care settings (occupational exposure):

- ⊙ percutaneous (penetrating the skin)
- ⊙ mucous membrane
- ⊙ non-intact skin
- ⊙ intact skin

All exposures do not carry the same risk for infection. Factors affecting risk:

1. Type of exposure to HIV-infected body fluid:

- ⊙ percutaneous: risk of infection about 0.3 percent
- ⊙ mucous membrane: risk of infection about 0.09 percent
- ⊙ non-intact skin: risk of infection not quantified but estimated to be less than for mucous membrane exposure
- ⊙ intact skin: no cases of infection documented

2. Exposure to blood carries a higher risk than exposure to other body fluids or tissues.

3. Risks are higher when a large amount of blood from the source person is involved, for example:

- ⊙ apparatus visibly contaminated with the patient's blood
- ⊙ procedure involved a needle being placed directly into a blood vessel
- ⊙ deep injury
- ⊙ hollow bore needles

4. Risks are also higher when the source person has end-stage HIV/AIDS, possibly because of high viral loads.

After an accidental exposure to potentially infected blood in an occupational setting, e.g., a needle stick injury, there are measures that can be taken to reduce the risk of acquiring HIV infection. Similar measures can also be taken in the event of exposure to HIV through rape.

The first step in managing accidental exposure, however, is prevention. Prevention of accidental exposure to HIV in health care settings involves the effective implementation of universal precautions. Staff should also be educated about prevention of sexual exposure and provided with condoms.



Activity

4.2e Management of accidental exposure – agency capacity



Plenary – 15 minutes.

Materials: Matrix on flipchart

Facilitator...

...introduces:

Ask each agency to enter answers on a matrix:

- a) Do all staff members receive health education on HIV/AIDS at your workplace?
- b) Are condoms available at your workplace?
- c) Does your organization have any policies or guidelines in place for management of accidental exposure? (needle stick injuries or related to sexual violence)
- d) Have you received any training or information on the management of accidental exposure, including post-exposure prophylaxis?

...concludes:

Many workplaces have by now introduced policies on accidental exposure, both for occupational exposure and for rape. If your organization has not done so yet, it is important for you to raise the issue with your supervisors.

4.2f PRESENTATION: Management of occupational exposure

Presentation – 20 minutes.



Materials: PowerPoint 4.2f: Managing accidental exposure

Poster: Managing occupational exposure (make from text)

PEP kit

Systemic infection does not occur immediately after the HIV virus enters the body. A brief period (possibly a few hours to a few days) exists before the infection becomes established, during which time antiretroviral therapy may modify or prevent viral replication. PEP is short-term ARV treatment to reduce the possibility of HIV infection after potential exposure. Similar ARV treatment is given for occupational and rape-related exposure, but the approach to patient management is clearly different. Comprehensive care of rape survivors is well described in the document: WHO/UNHCR (2002) Clinical Management of Survivors of Rape - A guide to the development of protocols for use in refugee and internally displaced person situations. (Refer to additional resources.)

This session will focus on the management of occupational exposure.

After an occupational exposure, a number of steps should be followed: (Make a poster "Managing occupational exposure" summarizing the points for the wall display.)

1. Immediate first aid:

- ⊙ Wash wounds and skin with soap and saline solution or water.
- ⊙ Flush mucous membranes with water.

2. Assess the risk associated with the exposure:

- ⊙ Type of fluid (e.g., blood, visibly bloody fluid, other body fluids) or tissue.
- ⊙ Type of exposure, e.g., percutaneous injury, mucous membrane or non-intact skin exposure, or human bites resulting in blood exposure.

3. Evaluate the source for likelihood of HIV infection:
 - ⊗ Assess the source patient using available information.
 - ⊗ Counsel the source patient and do HIV test if consent is obtained. Maintain confidentiality and ensure appropriate care and referral.
4. Provide counseling and clinical assessment for the exposed worker:
 - ⊗ Counsel on the implications of exposure.
 - ⊗ Counsel on the need for and implications of PEP.
 - ⊗ Obtain informed consent before proceeding with clinical examination and baseline HIV test.
 - ⊗ A thorough history must be taken concerning pregnancy, illnesses and medications that could affect decisions about drugs used for PEP.
5. Provide PEP when appropriate.
Details in next section.
6. Advise the exposed worker to use precautions to prevent secondary transmission during the follow-up period (i.e., abstain from sex or use condoms; do not donate blood).
7. Educate on risk reduction through review of the sequence of events leading to exposure.
8. Complete an exposure report.
9. Perform follow-up HIV testing for at least six months post exposure: at baseline, six weeks, three months and six months after the incident.
10. Provide counseling over the six-month period, regardless of whether or not the exposed worker has PEP.

Providing PEP

The exposed worker must be appropriately counseled prior to administering PEP. Antiretroviral drugs have potential adverse reactions. Because most occupational HIV exposures do not result in HIV infection, the potential toxicity of drugs must be carefully weighed against the risk of infection. The worker should also be aware that while administration of PEP is associated with a lower risk of HIV infection, treatment failure may occur. To date, information on percentages and circumstances of treatment failure of PEP is limited. It is important that the worker completes the full course of treatment. S/he should also be informed of potentially unpleasant side effects.

PEP should be started as soon as possible after the exposure – ideally within 2 to 4 hours. In some cases PEP has been given up to 2 weeks after the incident. However, it is believed to be more effective when given as soon as possible after exposure.

Combination therapy with two or three drugs is recommended for a minimum of 2 weeks and maximum of 4 weeks. WHO recommended regimens, in the absence of known resistance to zidovudine or lamivudine in the source patient, are:

Zidovudine 250-300mg twice a day

Lamivudine 150 mg twice a day

If a third drug is to be added:

Indinavir 800 mg 3 times a day or Efavirenz 600 mg once daily (not recommended for use in pregnant women.)

The exposed person taking PEP should be evaluated within 72 hours after exposure and monitored for drug toxicity for at least 2 weeks.

If the source person is already on ARVs, expert consultation should be sought.

In order for an organization to provide PEP appropriately, certain conditions should be in place:

(Ask participants)

- ⊙ Prevention - Implementation of universal precautions
- ⊙ Organizational protocols for management of occupational exposure
- ⊙ Training of staff on management of occupational exposure
- ⊙ Counseling capacity
- ⊙ Supplies, including HIV tests and PEP kits
- ⊙ Access to medical care (possibly specialist follow-up)

4.3 Mother-to-Child Transmission

4.3a PRESENTATION: *What is mother-to-child transmission?*



Presentation: 20 minutes.

Materials: Audio CD Track 07

PowerPoint 4.3a: MTCT

Poster display: MTCT

Introduce with CD - 5 minutes.

Since the beginning of the AIDS epidemic, over 5 million infants are estimated to have been infected with HIV. Ninety percent of these infections were acquired through the mother-to-child route. The remaining 10% were caused by sexual abuse, blood transfusion and other exposures to infected blood.

As the immune systems of young children are not yet fully developed, they usually develop AIDS much sooner than adults do. Many die within one to two years of birth. In Africa, half will have died by the age of five years.

Sometimes the term "parent-to-child transmission" (PTCT) is used, sometimes "mother-to-child transmission" (MTCT) and sometimes "vertical transmission". They all refer to the same process: the transmission of the virus from an HIV-infected mother to her baby. However, the term PTCT is used to emphasize the role and responsibility of both parents in the transmission process and avoids blaming the woman if the child is infected.

The HIV virus is transmitted from an HIV-positive mother to her baby in three possible ways:

- ⊙ during pregnancy
- ⊙ during labor and delivery
- ⊙ during breastfeeding

The rates of mother-to-child transmission have been found to vary under different circumstances, but on average 35 out of every 100 HIV-positive pregnant women will transmit the virus to their babies. Of these, about 7 will become infected during pregnancy, about 15 during labor and delivery and about 13 during breastfeeding (mostly during the early weeks). *(Diagram Protecting the Future p155)*

Therefore, it is important to realize that most babies (two-thirds) will not contract HIV from their HIV-positive mothers. The reasons one baby will become infected and another will not are not yet fully understood, but there are some factors that may increase the risk. We call these the biological risk factors associated with the MTCT route: *(HIV/AIDS tree)*

Make a wall display summarizing risk factors and interventions during pregnancy, delivery and breastfeeding, using a different color for each stage. *(See example in Teaching aids Day 4: MTCT wall display)*

Biological risk factors for MTCT

Factors associated with pregnancy:

- ⊗ Infection of the mother with the HIV virus during pregnancy. There are higher levels of virus in the blood (viral load) at the time of infection. (*Phases of HIV/AIDS poster*) The risk is also higher if the mother is pregnant when in an advanced stage of HIV/AIDS illness, when the viral load increases again.
- ⊗ The presence of some STIs, which may affect the placenta, making it easier for HIV to cross to the baby.
- ⊗ Malaria during pregnancy may also affect the placenta and facilitate transmission of HIV.
- ⊗ Poor nutritional and general health status of the mother.

Factors associated with delivery:

- ⊗ Obstetric procedures, such as amniocentesis, early rupture of membranes and episiotomy, increase the chance of the baby coming into contact with the mother's blood.
- ⊗ Blood transfusions.
- ⊗ Unsterile procedures (i.e., not observing universal precautions).

Factors associated with breastfeeding:

- ⊗ Infection of the mother with HIV during breastfeeding (high viral load).
- ⊗ Breast conditions (e.g., cracked nipples, mastitis, breast abscess).
- ⊗ Non-exclusive breastfeeding. Breast milk substitutes may result in damage to the lining of the baby's gastrointestinal tract, thus allowing an entry point for the virus when the baby receives breast milk. Mixed feeding (alternating breast milk with formula and/or other foods and fluids) appears to carry the highest risk.
- ⊗ Duration of breastfeeding (i.e., higher risk with longer duration).
- ⊗ Sores in the mouth of the baby (e.g., thrush) can provide an entry point for the virus.

4.3b PRESENTATION: *How can MTCT be prevented?*

Presentation – 20 minutes.

Materials: PMTCT wall display

The rate of transmission of HIV from mothers to babies can be reduced through a number of prevention methods.

Prevention of MTCT has two aims:

- ⊗ primary prevention: prevention of HIV infection in women
- ⊗ secondary prevention: prevention of transmission of the virus from an HIV-infected mother to her baby

The majority of HIV-positive women do not know that they are HIV positive:

- ⊗ they may not know about HIV
- ⊗ they may not know about antenatal VCT
- ⊗ they may not have access to antenatal VCT
- ⊗ they may prefer not to be tested for HIV, or
- ⊗ they may not be in a position to decide to get tested (e.g., when husbands or extended families make health care decisions)

Therefore, it is important to focus on and allocate resources to prevention strategies that **do not depend on testing during pregnancy**. These strategies include general measures that promote the health of all women. There are also a number of specific strategies aimed at women who are aware of their HIV-positive status.

General strategies:

Pregnancy:

- ⊗ Prevent unwanted pregnancies by increasing access to information and contraception.
- ⊗ Encourage couples when planning a pregnancy to consider VCT.
- ⊗ Discuss the option of postponing pregnancy in any woman with a chronic illness.

- ⊙ Prevent infection of the mother during pregnancy (primary prevention):
 - Provide condoms during pregnancy
 - Educate the community and help men to see their role in protecting their families
 - Treat STIs promptly
 - Practice universal precautions
 - Minimize blood transfusions

(Refer to AIDS tree: removing the sex and blood roots will automatically remove the MTCT root.)
- ⊙ Improve the health and nutrition of pregnant women, e.g., micronutrient supplementation.
- ⊙ Treat any infection during pregnancy promptly.
- ⊙ Use intermittent presumptive malaria treatment during pregnancy in malaria areas.

Delivery:

- ⊙ Avoid unnecessary obstetric interventions, especially artificial rupture of membranes, episiotomy and use of forceps.
- ⊙ Avoid unnecessary blood transfusions.
- ⊙ Implement universal precautions.

Breastfeeding:

- ⊙ Encourage breastfeeding mothers to use condoms.
- ⊙ Provide training for mothers and health care workers on appropriate breastfeeding practices to minimize breast problems.
- ⊙ Promote exclusive breastfeeding for all babies. The advantages of breastfeeding are well known; there are disadvantages associated with formula feeding and the introduction of other fluids and foods too early. Exclusive breastfeeding has been shown to reduce the risk of HIV transmission to babies. (This will be discussed in more detail later.)
- ⊙ Treat infant thrush.

Many of these activities may be components of existing health programs. However, recognition that they make an important contribution to the prevention of MTCT of HIV can help to justify investment of increased resources, and can also give health workers a sense that they can take positive steps to help reduce MTCT, even in the absence of antiretrovirals.

Specific strategies:

For women who have chosen to know their HIV status, a number of options may be available. However, it is important that women be given the choice to either opt in or opt out of VCT and PMTCT interventions. Mothers should be given full access to information, but should never be pressured into HIV testing or into joining a PMTCT program.

Pregnancy and delivery:

- ⊙ Antiretroviral therapy (ART)
 - ARVs work by lowering the viral load in the mother's blood and by preventing the HIV infection from becoming established in the newborn. Although some side effects have been observed, ARVs are generally safe, with the benefits of the drugs outweighing the risk of side effects. Two drugs are commonly used for PMTCT:

Zidovudine (AZT):

AZT tablets are taken twice a day by the mother from 36 weeks onward, and then more often when labor starts. This can reduce transmission to the baby by up to 50 percent. However, AZT is less feasible in developing countries because of high costs and the fact that many women may present for the first time only when they are in labor.

Nevirapine (NVP):

Nevirapine also reduces transmission by almost half. Here the mother takes a single dose orally at the onset of labor and a single dose of syrup is also given to the baby within 3 days after birth. Nevirapine costs about \$4 per mother and child pair, making it much more affordable than AZT. Nevirapine also has the advantage of being simple to use: the mother can be given a tablet to take at home when labor begins and there is a time space of three days to take the baby for treatment after birth.

Delivery:

- ⊙ Planned caesarean section before the onset of labor

This minimizes exposure of the baby to maternal blood and mucous and has been shown to reduce transmission by up to 66 percent. However, caesarean section is not feasible in many settings and also increases risks to the mother associated with surgery (e.g., anesthesia, bleeding, infection, etc.).

Breastfeeding:

- ⊙ Avoidance of breastfeeding

Breast milk substitutes (formula) or modified breast milk (wet nurse; heat-treated milk) may be used. If these are used, it is best to use them exclusively, i.e., not to alternate breastfeeding with substitute feeds.

- ⊙ Exclusive breastfeeding

The baby is given nothing but breast milk for 3 to 6 months, then abruptly weaned. This includes avoiding sips of water and other weaning foods traditionally given to babies.

There have been numerous studies assessing the effectiveness of various interventions to prevent MTCT. Results have varied considerably and research is ongoing. In industrialized countries, combinations of ART, caesarean section and replacement feeding have reduced MTCT rates to less than 4 percent.



Activity

4.3c *Mother-to-child – the story of two women and their babies*



Materials: Video: Mother-to-child – 45 minutes.

This video follows two HIV-positive pregnant women and their babies. It illustrates technical, social and emotional issues relevant to PMTCT. Some participants may find the video emotionally draining. Allow time for thought and spontaneous discussion afterwards.



Activity

4.3d *Identifying challenges to reducing MTCT*



Three groups.

Discussion – 10 minutes. Feedback – 20 minutes.

Materials: Flipchart

Facilitator...

...introduces:

Interventions to reduce MTCT using ARVs and breast milk substitutes have been very successful in some countries. However, implementation of these interventions is not simple and requires careful consideration. Conflict-affected settings pose further challenges. If such programs are introduced into the settings in which you work, identify some of the potentially challenging issues that need to be considered in relation to:

- ⊙ the mother
- ⊙ the baby
- ⊙ the health care system

Are there factors associated with the impacts of conflict and/or displacement that could affect PMTCT (either positively or negatively)?

Each group analyzes and discusses one topic. (Tip: Think about health, social and resource issues)



Activity 4.3d cont'd

...notes:

Mother:

If her HIV status becomes known, the mother may suffer the consequences of stigma. She may be blamed if she is found to be HIV-positive and seen as the one who brought HIV into the family. She may suffer violence and/or abandonment. Therefore, she may be reluctant to go for testing.

If she has a caesarian section, there are potential complications of anesthesia and surgery.

If she does not breastfeed:

- ⊙ Not breastfeeding may reduce uterine contractions post-delivery, with an increase in post-partum bleeding.
- ⊙ Not breastfeeding may reduce the mother's bonding experience with baby.
- ⊙ Breastfeeding delays return of fertility after pregnancy and without another method of contraception, she may soon become pregnant again. This is particularly important in relation to HIV-positive mothers, as another pregnancy very soon may negatively impact her health.
- ⊙ Not breastfeeding may be unacceptable in some cultures; the woman may feel she is a bad mother if she does not breastfeed, and others may criticize her.
- ⊙ Costs may be prohibitive. For example, free formula may not be available and water must be boiled resulting in fuel costs. The costs of the 22kg of formula required for the first six months is more than the annual income of many families.
- ⊙ There is an added burden of time and effort to prepare formula feeds.

If exclusive breastfeeding:

- ⊙ This may be difficult in some cultures, where traditionally other foods are introduced after a few weeks.
- ⊙ There is physiological stress on mothers who are malnourished or unwell.
- ⊙ It may not be practical for working mothers.

Baby:

- ⊙ Mother's milk is the best form of nutrition for newborns.
- ⊙ Breast milk protects against infections. Studies in Africa have indicated that children without HIV infection who receive replacement feeding have a 2.5 to 5 times greater risk of dying from any cause before the age of 12 months than breastfed children.
- ⊙ Formula feeds are associated with infection risks, e.g., unhygienic preparation, lack of clean water.
- ⊙ There is a risk that the baby may receive unsuitable foods, e.g., incorrect choice of formulas, incorrect dilution.
- ⊙ Not breastfeeding may impact bonding and result in reduced stimulation of the baby.

Health care system:

- ⊙ The health system must have the capacity to provide VCT and support services, ARVs and breast milk substitutes.
- ⊙ Issues include resources, technical capacity, organizational capacity and confidentiality.
- ⊙ Is it ethical to only provide treatment for babies, and not for mothers (and fathers)?
- ⊙ Even though services, including ARVs, may be available, women may choose not to use them.

Other issues:

- ⊙ Use of formula may impact on general promotion of breastfeeding.
- ⊙ HIV may be used as an excuse for unethical promotion of breast milk substitutes.
- ⊙ In conflict-affected settings, there is the possibility of flight or return to an area where formula or treatment are not available.
- ⊙ Ethics of provision of ARVs and formula to refugees when these options are not widely available to the host population.



Activity 4.3d cont'd

...concludes:

PMTCT is an important means for combating the spread of HIV. However, sufficient recognition should be given to the factors influencing any potential interventions. These factors must be researched in detail. In addition, medical aspects as well as social needs must be considered. The mother's needs as well as the baby's needs must be addressed. Risks and benefits must be carefully weighed. The balance of risk will vary in different settings. Weighing the risks has been difficult in resource-poor settings because little is known about safe, feasible and affordable alternatives to breastfeeding. In humanitarian settings exclusive breastfeeding for four to six months followed by early weaning is likely to be a much safer option overall for the baby than avoidance of all breastfeeding. However, UN guidelines recommend supporting the mother in her own choice based on information about risks and her personal, cultural, social and economic circumstances.



Activity

4.3e Debating PMTCT



Two groups.

Preparation - 15 minutes. Debate - 15 minutes.

Materials: Introduce with PMTCT poster: "PMTCT by Kenya participants" (In PowerPoint: Teaching aids Day 4)

Facilitator...

...introduces:

"...Put yourself in my position as an HIV-positive mother. I would do anything to stop my baby becoming infected, anything. And I have needs, too - I want to survive so that I can see my child grow up..." (HIV-positive activist, South Africa)

"...Of course I want to protect my baby, but I am afraid to find out my status. I suspect I am already infected. What can I do? I will have to breastfeed anyway, nothing can make any difference; so why should I find out? It will only cause pain and worry..." (Pregnant urban woman, Zimbabwe)

Debate:

Access to ARVs for PMTCT as well as breast milk substitutes should be provided and promoted by the government on a large scale throughout the country as soon as possible. One group argues for access and the other group argues against.

If participants are working in refugee settings:

Access to ARVs for PMTCT as well as breast milk substitutes should be made available for all refugees as soon as possible. One group argues for access and the other group argues against.

...concludes:

The factors impacting MTCT will vary from country to country and setting to setting. The decision to initiate a PMTCT program is complex and should be made in collaboration with relevant authorities and communities. This is not a decision a non governmental organization can make independently. Appropriate emphasis should be given to interventions that improve the health of *all* mothers and babies, regardless of HIV status.

• Example from a conflict-affected setting:

In Kakuma refugee camp in Kenya, the International Rescue Committee offers Nevirapine treatment to HIV-positive mothers and their infants. A recent report showed that over 2,700 pregnant women had accepted VCT. This represents 99 percent of antenatal care clients. Of those who tested positive, 80 percent accepted Nevirapine therapy.

PMTCT has also been introduced in other refugee settings, e.g., refugee camps in Tanzania.



Activity

4.4a *What is stigma?*



Plenary – 10 minutes.

Materials: Flipchart

Poster: What is stigma? (Make from text)

Facilitator...

...introduces:

What are the meanings of the words "prejudice," "discrimination" and "stigma"?

...notes:

Prejudice: intolerance, one-sidedness

Discrimination: set apart, separate, judge

Stigma: disgrace, shame, reproach, blemish, stain, spoiled identity

Ask participants: On Day 1 we identified some things that people say about PLWA and about refugees.

Do any of these represent stigma?

Almost all of the phrases will probably contain some degree of stigma.

Make poster for wall display "What is stigma?":

..."Stigma is prejudice and discrimination against a set of people who are regarded by others as being 'flawed, incapable, morally degenerate, or undesirable' and who are treated in a negative way. Prejudice is an attitude, while discrimination is overt behavior..." (Singhal, A & Rogers EM. (2003) *Combating AIDS*)

4.4b **PRESENTATION:** *Illustrating stigma*



Presentation – 10 minutes.

Flipchart; PowerPoint photo (4.4b Illustrating stigma)

Four examples of what stigma can do:

Read to participants, with accompanying PowerPoint photo:

- In 1996, Govend Singh, a 25-year-old migrant worker, left the village of Churher in the Indian state of Uttar Pradesh to find employment in Mumbai. Like many of his fellow migrant workers, he slept with commercial sex workers (CSWs). In 1999, when he began to feel tired and to lose weight, he went to Mumbai's Lash Deep Hospital for a checkup. He was HIV-positive. Govend Singh's fellow migrant workers, many of whom came from the same village, wrote home to their families that Govend had AIDS and that nobody should touch, talk with or see him. Too weak to work, when Govend returned to his village in April 2000, seeking shelter and care, he was shunned by his neighbors and family members, including his wife. Villagers dragged him into a pen where cattle and goats were kept. His captivity became a center of attraction for the villagers, who peeped into the enclosure, and teased him about his promiscuity. Twice a day they threw food into the enclosure. As Govend became weaker, he lay on the floor and was often stepped on by animals. On July 5th 2000, Govend was found dead in the enclosure. Since his death, his wife and two children have become social outcasts in the village. (Adapted from: Singhal, A & Rogers, EM. (2003) *Combating AIDS*.)

- ☉ On World Aids Day, December 1st, 1998, Gugu Dhlamini, a 36-year-old woman living in Durban, South Africa, disclosed her HIV status in a radio broadcast. A few days later she was stoned and stabbed to death by a gang of boys from her own neighborhood.
- ☉ *“My foster son, Michael, aged 8, was born HIV-positive and diagnosed with AIDS at the age of 8 months. I took him into our family home, in a small village in the south-west of England. At first, relations with the local school were wonderful and Michael thrived there. Only the head teacher and Michael’s personal class assistant knew of his illness. Then someone broke confidentiality and told a parent that Michael had AIDS. That parent, of course, told all the others. This caused such panic and hostility that we were forced to move out of the area. The risk is to Michael and us, his family. Mob rule is dangerous. Ignorance about HIV means that people are frightened. And frightened people do not behave rationally. We could well be driven out of our home yet again.”*
(‘Debbie’ speaking to the National AIDS Trust, UK, 2002 - UNAIDS Epidemic update 2003)
- ☉ *“There is a strong potential for stigmatization of the HIV victims in the camps. Wherever we have gone to sensitize, some refugees tell us to show them who is infected in the camp so that they can avoid contamination.”*
(UNHCR staff member. UNHCR news report on UNHCR website. December 3, 2003)

Four kinds of stigma were identified by PLWA at a workshop in Kenya: *(Write headings on flipchart and ask participants for their interpretation of each heading and for examples of stigma towards people living with HIV/AIDS in their contexts. Ask how conflict and displacement may impact stigma.)*

1. Self-stigmatization:

People feel they are being judged by others; they isolate themselves. There may be self-hatred, depression and playing the role of sick person. This has a negative impact on mental well-being and in turn on physical well-being.

2. Stigma from health care workers:

Unethical behavior: apathy in providing services, judgmental attitudes; breach of confidentiality; compulsory disclosure of HIV status; denial of treatment; sterilization without informed consent. For example, in Thailand 40 percent of a group of PLWA interviewed said their HIV status had been revealed to someone else without their consent. In a survey of 1,000 health workers in Nigeria, 10% admitted having refused to care for an HIV/AIDS patient or denied them admission to hospital and 20% felt that PLWA had behaved immorally and deserved their fate.

3. Representation and communication:

Careless language and unclear terminology used by the media, social leaders and society in general may result in misrepresentation of PLWA as people who are dying rather than living positively. For example, the negative term “AIDS victim” is frequently heard. Misconceptions are also presented about the behavior of PLWA, particularly their sexual behavior.

4. Social and work environments:

Hostility, violence, silence and denial about HIV/AIDS; exclusion of PLWA. People may lose jobs, be evicted from housing, denied loans and insurance. The children of PLWA may be ostracized at school and in the community.

PLWA in conflict-affected settings may experience all of the above. In addition, they may be stigmatized in similar ways because they are refugees, thus carrying a double burden. They may be blamed for bringing HIV into the host country and for being an additional burden on host country resources. Further examples of discrimination include possible mandatory HIV testing and denial of resettlement on the basis of HIV status.

Activities 4.4c and 4.4d are run concurrently in different groups.



Activity

4.4c Examining why HIV/AIDS is stigmatized



Work in small groups.

Discussion – 20 minutes. Feedback – 20 minutes, together with activity 4.4d.

Materials: Flipchart

Facilitator...

...introduces:

Why is HIV/AIDS stigmatized? i.e., Why are people with HIV/AIDS considered “undesirable”?

...notes:

- ⊙ HIV/AIDS is associated with subjects that are often taboo: sex, disease and death.
- ⊙ In the early stages of the epidemic, HIV/AIDS was associated with CSWs, men who have sex with men and injecting drug users. These groups were already stigmatized. When HIV was added, the prejudice increased.
- ⊙ HIV is associated with behavior regarded as immoral or “sinful,” such as premarital sex, extramarital sex and paying for sex.
- ⊙ HIV causes fear resulting from ignorance and misconceptions about ways of transmission. Fear may be irrational: prejudice and discrimination are emotional matters, not based on facts; the fact that HIV is incurable raises the level of fear.
- ⊙ People do not want to admit that an incurable disease acquired through “immoral” behavior could be spreading through their community – this labels their society as “bad.”



Activity

4.4d Understanding the consequences of stigma



Work in small groups.

Discussion – 20 minutes. Feedback 20 minutes, together with Activity 4.4c.

Materials: Flipchart

Posters: Stigma, prejudice and discrimination quotations

Facilitator...

...introduces:

Explain the following statement. How does stigma result in the points raised here?

Poster:

Stigma and discrimination: *“Together, they constitute one of the greatest barriers to preventing further infections, providing adequate care, support and treatment, and alleviating the epidemic’s impact...”* (UNAIDS, AIDS Epidemic Update 2003)

...notes:

- ⊙ People are afraid of being stigmatized. Stigma drives the problem underground, making it more difficult to address, because people are afraid to go for testing and afraid to seek care.
- ⊙ People may be afraid to take preventive measures, such as insisting on condom use, for fear that others will assume they are infected.
- ⊙ Because of stigma, it is difficult to speak openly, thus myths and misconceptions are easily perpetuated.
- ⊙ Because HIV is not talked about, it is easier for people to deny its existence.
- ⊙ Stigma can create a false sense of security among the general population that undermines prevention efforts. People associate HIV with groups that are already marginalized, such as CSWs, or men who have sex with men and therefore do not perceive themselves to be at risk.



Activity 4.4d cont'd

...concludes:

Make posters for wall display:

"Prejudice kills during life...such a death is worse than real death" (Herbert Daniel, HIV-positive Brazilian writer)

"AIDS attacks the body

Prejudice attacks the spirit

One is caused by a virus.

One is caused by ignorance.

Both can kill."

(Berer M and Ray S. Women and HIV/AIDS. In: Jackson H (2002) AIDS in Africa)

HIV/AIDS tree: prejudice, discrimination and stigma = water which helps the HIV/AIDS tree to grow

4.4e PRESENTATION: Addressing stigma



Presentation – 15 minutes.

Materials: PowerPoint 4.4e: Fighting stigma

Audio CD: Track 08

Fighting stigma

It is not easy to remove stigma. Three broad approaches can be taken:

- ⊙ Communication
- ⊙ Measures to protect PLWA against discrimination
- ⊙ Care of PLWA

These three approaches reinforce each other.

Communication

1. Addressing misconceptions:

Increase public awareness. Provide accurate information from respected sources. Get people talking about HIV/AIDS.

Create opportunities for them to address fears and misconceptions. Some ways of raising taboo subjects include:

- ⊙ Providing "safe spaces" for people to talk, e.g., telephone hotlines (anonymous, non-judgmental). In 2001 in Brazil, a telephone hotline received about 8,000 calls per day. Eighty percent of callers asked about HIV and 20 percent about STIs. In Thailand, people often talk to their barbers about personal matters, so barbers were trained to counsel on HIV/AIDS.
- ⊙ Involvement of religious leaders. Religious leaders have a lot of influence in many cultures. Many people go to religious leaders for advice. If they set an example and start talking about HIV, it is easier for their followers to do the same.
- ⊙ Using symbols: Symbols speak without using words. For example, the red ribbon has come to symbolize HIV/AIDS and support for those living with AIDS throughout the world.
- ⊙ Using humor, e.g., condom bus T-shirt.
- ⊙ Public figures supporting PLWA, e.g., Nelson Mandela.

2. Disclosure by PLWA:

- ⊙ Shows that anyone can be affected, e.g., ex-President Kenneth Kaunda of Zambia disclosed that his son died of AIDS.
- ⊙ Shows that PLWA are the same as everyone else; helps people to identify with them; gives HIV/AIDS "a human face", e.g., Nkosi Johnson, a young AIDS activist from South Africa; UWC student group.

(Audio: Track 08)

⊙ UNHCR arranged for a number of PLWA to visit a refugee camp: "...Dr. Dieudonne T.S. Yiweza, UNHCR's Regional HIV/AIDS Coordinator for Central Africa, explained his decision to organise the session. 'We thought that by having infected persons from outside visit the camp, skeptical refugees could realize that AIDS does exist, while at the same time we protect infected refugees from stigmatization.'" (From UNHCR news report on UNHCR website: For AIDS day, Dec 3, 2003.)

3. Remembering people who died of AIDS and acknowledging that they died of AIDS.

- ⊙ Memory boxes: these are cardboard boxes created by PLWA that are usually opened at their funeral by relatives and friends. They decorate the boxes with pictures of themselves with friends and family, and put personal items like clothing, diaries, letters, etc., inside, to help others remember them.
- ⊙ Grieving publicly: People grieve together and allow others to grieve with them, e.g., AIDS funerals, AIDS quilts, candle-light vigils.

4. Advocacy

(Ask participants what they understand by the term "advocacy.")

"Advocacy is a method and a process of influencing decision makers and public perceptions about an issue of concern, and mobilizing community action to achieve social change, including legislative and policy reform, to address the concern." (NGO Steering Committee. Code of Good Practice for NGOs Responding to HIV/AIDS – Unedited draft for consultation. March 15, 2004)

Groups of people, including PLWA, actively fight for the rights of PLWA, e.g., Phumla January. In South Africa a group called the Treatment Action Campaign (TAC) played a major role in pressuring the government into providing ARVs, using human rights protections in the constitution. (At the same time, it is very liberating for those affected to fight for the cause.)

Audio: 1.5 minutes

5. Personal commitment of politicians and other community leaders

- ⊙ President Museveni of Uganda made a point of mentioning HIV in his speeches during the time Uganda was working to reduce its HIV rate.

Measures to protect PLWA against discrimination

1. As part of their Declaration of Commitment on HIV/AIDS, drawn up at the United Nations General Assembly Special Session on HIV/AIDS in June 2001, Member States agreed to:

... "by 2003, enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by, people living with HIV/AIDS and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic (paragraph 58) " (UNAIDS AIDS Epidemic Update 2003)

e.g., Brazil became one of the first countries in the world to mandate universal and free access to HIV care.

2. Organizations must have workplace policies to promote non-discrimination and train their staff on adhering to them. Health staff in particular need training on issues such as confidentiality and informed consent to testing and treatment. (Ask participants what is in place in their organizations.)

3. PLWA need to know about their rights and should be supported to take action against discrimination. For example, human rights should be emphasized in BCC activities; complaint mechanisms should be in place at health facilities; PLWA should be assisted in accessing legal aid.

Care of PLWA

Treating opportunistic infections and using ART turns HIV/AIDS into a manageable chronic illness rather than a death sentence. Two communities in Haiti and Khayelitsha, South Africa where ARV programs were successfully introduced, reported reductions in stigma around HIV/AIDS. (This will be discussed in more detail on Day 5.)

To conclude this session, ask participants to stand up and stretch. Do some arm stretches together, ending with pointing both hands toward themselves. Then ask where the fight against stigma begins: **the fight against stigma and discrimination begins with us, here, today.**



Activity

4.4f *Tribute to a man who fought stigma*



Video – 30 minutes.
Video – A fighting spirit

Ask participants for their impressions.



Activity

4.4g *Making a personal commitment to fight stigma*

Individual. 5 minutes. No feedback.

Write down two things that you are going to do to fight stigma against HIV/AIDS and PLWA.

4.5 Conclusion



- ⊙ Overview of the day with link to Day 5
- ⊙ Suggested reading
- ⊙ Post-test
- ⊙ Daily evaluation