

**Gender sensitive best practices
on mitigating the impact of HIV/AIDS in the world of
work**

Draft background paper,
Inter-regional tripartite meeting on
best practices in workplace policies and programmes on
HIV/AIDS

Geneva, 15-17 December 2003

Helen Watchirs
Australian National University

September 2003

TABLE OF CONTENTS

Executive Summary

1. Introduction

2. Best Practice

3. Gender Sensitive Approaches

4. Effective Approaches

5. Case Studies

(A) Vulnerable Employment Sectors

(i) Sex Workers

Case Study 1 - Sonagachi

(ii) Mine Workers

Case Study 2 – Lesedi

(B) Union Initiatives

Case Study 3 – Mobile Male Construction Workers in Vietnam

(C) Worker Driven Initiatives

Case Study 4 – PHILACOR

(D) Employer Activities

Case Study 5 – Youth Career Development

(E) Community Organizations Initiatives

Case Study 6 -International AIDS Organisation

(D) Gender Sensitive Tools

Case Study 7 – Stepping Stones

6. Conclusion

1. Introduction

Of the 42 million people living with HIV infection, nearly half are women – in sub-Saharan Africa 58% of the 29.2 million people infected are women.¹ In South Africa twice as many young women are infected than young men, reflecting women's economic dependence on older men and social subordination in terms of lower access to education, health care, land, credit and other resources. Stigmatization, discrimination and lack of privacy associated with the epidemic continue to negatively affect workers' human rights, and gender issues are a key component that needs to be addressed. Repercussions are deep with widening gaps of gender inequality driving the epidemic in many countries, and exacerbating existing problems that adversely affect women more than men, such as poverty, illiteracy, refugees and child labor. Men too are vulnerable to infection by values that increase their risk behavior, such as peer pressure to have many female partners, and avoid responsibility for HIV prevention and care issues and practices.

The term gender used in this paper means culturally specific constructs that define socially acceptable male and female roles. They determine the extent of information and knowledge that partners have about sexual acts, and are critical to understand if changes in behavior are to be achieved, such as use of safer sex measures to prevent HIV transmission. The term sex only refers to biological difference between men and women.

The two main framework concepts used in this paper are vulnerability and impact. Vulnerability highlights gender equality and non-discrimination (including special measures favoring women) issues that can have prevention outcomes by reversing the spread of the epidemic. Impact focuses on mitigating the gendered effects and accommodating the social and care needs of workers living with HIV/AIDS. Some programs that improve women's access to economic resources in informal settings (which is the subject of a separate Best Practice paper in this ILO series), such as

micro-finance and social protection schemes, reduce both vulnerability to and impact of HIV – for example the Ugandan Foundation for Credit and Community Assistance which provides rural women with credit and savings products through village banking.²

2. Best practice

The term best practice used in this paper refers to effective programs and policies that have been tested in the real world of work and are replicable in other settings with appropriate and relevant local adjustments. They reflect ILO and general human rights standards and specifically recognize gender dimensions to varying degrees. Some case studies attempt to be comprehensive in having goals aimed at both mitigation and prevention, but their achievement may be less than intended, however nonetheless significant in demonstrating how to implement them in a workplace. Documenting evidence-based best practice is a practical means of sharing their strengths and learning from their weaknesses that can be applied in other settings.

The case studies are not absolute or prescriptive models and should not be read in a misleading way, that is, they are not necessarily common practices, but this does not detract from their usefulness. What is striking in the available documentation is that much more work has been done in the formal sector focusing on male employees, with some positive care and support benefits for partners and families. Programs in women-dominated sectors are more rare, except for those targeting the sex industry, and even then some appear to be focused on protecting males from nearby worksites, potentially risking the promotion of viewing women as ‘reservoirs of infection’.

Best practice case studies were selected because the interventions, on the available documentation, reflect the values and principles of the *ILO Code of Practice on HIV/AIDS and the World of Work* (see Appendix for summary of relevant standards that incorporate gender perspectives). Additional factors that were considered were the relevance, effectiveness, efficiency and ethical soundness of the interventions.

Most cases studies have been evaluated and these results have been incorporated where they are available.

3. Gender sensitive approaches

ILO's Manual on *Implementing the ILO Code of Practice on HIV/AIDS and the World of Work* recognizes that specific facets of gender inequality in the workplace are in respect of: hiring standards; training; lesser pay for equal work; segregation of women in certain industries; access to productive resources, eg credit; participation in economic decision-making; promotion; and unemployment.³ It has a module on the gender dimensions of the epidemic that is aimed providing technical assistance to develop policies and programs for men and women workers. It covers issues such as how gender inequality drives the epidemic, masculinity, gender violence and sexual harassment, recognition of sex work as an industry, and enforcing gender equality in the workplace under general ILO Conventions.

The features of gender sensitive programs have been used in selecting case studies include:

- identifying broad social and individual determinants of HIV vulnerability;
- building decision-making and negotiation skills on sexual relations;
- explaining the facts of HIV transmission as well as discussing individual risk of specific sexual practices, preferences and orientation;
- recognizing contextual vulnerability issues and having interventions that help create conditions to reduce vulnerability;
- motivating through a rights-based approach;
- helping women and men overcome gender-based power imbalances;
- exploring risks and providing treatment for STIs (sexually transmitted infections) and RTIs (reproductive tract infections);
- assisting people make informed and independent reproductive choices; and
- exploring gender-based violence and offering services for survivors.

This checklist is based on the International Planned Parenthood Federation's HIV/Gender Continuum that enables rapid self-assessment of HIV prevention programs and services ranging from non-gender sensitivity, to somewhat and ideal gender-sensitivity. Some gender-sensitive approaches can be very simple in conveying the message that both men and women need to be involved in HIV/AIDS programs. For example the HIV/AIDS Employers' campaign in Cameroon uses posters depicting both male and female executives wearing a red AIDS ribbon as a tie.⁴ Similarly, companies in the Kenyan Tea Growers' Association appoint peer leaders on workplace AIDS Committees in positions as 'Mama Condom' and 'Baba Condom', who fellow workers can approach for advice on condoms, counseling and voluntary testing onsite.⁵

4. Effective approaches

A unifying factor in most case studies is the understanding that information about HIV is necessary, but not sufficient, to change behavior, as measured quantitatively by bio-medical indicators such as HIV prevalence or use of condoms. Sustainability of programs are often linked to whether they are single-session or long-term, and if they have broad-base support, that is if they involve tripartite-plus partners, management, unions, workers, health carers, government, donors and community groups, including HIV/AIDS, human rights and women's groups. A critical first step is knowledge of employee culture, particularly in the gender dimension, in respect of the prevalence of factors such as HIV and STI prevalence, sexual and other violence, and drug and alcohol problems, in order to make programs relevant and effective.⁶

Peer education is a central characteristic of many successful HIV education programs and recognizes that peer membership shapes and limits sexual identities, so it is vital to address this as well as individual contexts to promote empowered identities with changed sexual risk-taking behavior. Peer education is not always gender sensitive. It is important that groups do not reproduce the same gender dynamics that need to be changed, such as bullying by dominant male decision-makers. Also female educators

can be used ineffectively in male-dominated workplaces with little influence on collective behavioral norms, because they lack the legitimacy or recognition as peers. The most successful approach appears to be to use facilitators and peers of homogenous sexes. For example, a peer education program of young female factory workers in Thailand overcame initial concerns of workers that too much knowledge about sex would damage their reputation. The peer education program provided information about HIV, dispelled the association of HIV-infection solely with commercial sex work, encouraged discussion of gender roles that were obstacles to safer sex, and offered training in negotiating condom use in romantic relationships.⁷

5. Case Studies

This section sets out seven gender-sensitive case studies in selected employment sectors and analyses interventions by stakeholders, including unions, employers and communities, as well as intervention tools that were developed in workplaces or are adaptable for use in workplaces.

(A) VULNERABLE EMPLOYMENT SECTORS

(i) Sex workers

Most documentation of gender sensitive HIV prevention programs focus on sex work, which is contradictory given the potential for exploitative working conditions for women. The driving force for some programs often appears to be the high HIV and STI prevalence of female sex workers and need to prevent them infecting male formal sector workers, rather than general women's empowerment, although this is often recognized as a necessary precondition for increasing condom use. Unity rather than competition in independent workers is essential to counter client resistance to condoms. Because peer education of sex workers has been a focus of prevention programs, there is a wealth of studies compared to other areas of work, but the one most often cited as successful is Sonagachi in India, because of the large social capital it mobilized for HIV prevention. The gender empowerment project with sex

workers has proved to be sustainable for over a decade because of its foundation in the community and has inspired many similar projects in West Bengal and the world.

1. Case Study - Sonagachi (India)

Dates: The project started in 1992 is and still ongoing

Aim:

The aim of the Sonagachi project is to prevent and treat HIV and STI infection among sex workers, their clients and partners by increasing condom use through an enabling environment with an appropriate gender perspective.

Problem:

In 1992 over 90% of sex workers in the Sonagachi area had never used condoms, and had little knowledge of HIV/AIDS issues.

Context:

Baseline surveys were conducted in 1992 of sexual practices and STI and HIV prevalence (see below under Outcomes). These studies also indicated that 85% of participants were illiterate. The area targeted by the project houses about 370 brothels with approximately 4000 sex workers servicing over 20,000 men daily.

Stakeholders:

The All India Institute of Hygiene and Public Health led the project in consultation with the National AIDS Control Organization, and with sponsorship from WHO and other donors, such as NORAD (Norway), DFID (UK) and HORIZONS (USAID).

The two NGO partners are the Health and Eco-Defence Society and the Human Development and Research Institute. As the project progressed broader community groups became involved in 1994, such as a woman's organization (Sramajibi) and a community legal group (Socio-legal Aids Research and Training Centre). Sex workers manage the project through the Durbar Mahila Smanwaya Committee

(DMSC), which was formed in 1995 – it represents mainly female, but also some male and transsexual (estimated to be 250), sex workers.⁸ Partners of sex workers (‘babus’) have also formed a committee and collective to work with the DMSC, especially in protecting workers and clients from violence. Police required training in order to be supportive of the project, and prevent violence rather than continuing counter-productive raids that emphasize the illegality of the industry (if not conducted ‘within a room’) and further marginalizes workers.

Intervention:

The project targeted STI and HIV control through providing accessible health services, and peer education to promote collective safer sex norms and condom use by workers and clients. The core community empowerment approach of the project is self-described as ‘reliance, respect and recognition’. The program is not merely a medical intervention involving the provision of improved and free health services (general and sexual), but also addresses wider gender issues that had socioeconomic impacts. The project’s Health Service Centres provide non-judgmental care to workers and families in the day, and service clients in the evenings, and have grown in number over time. Peer educators are paid a small salary, wear uniforms and trained in HIV information and communication over a six-week period. They utilize flip-charts that require little literacy and enable them to explain basic sexual health and safer sex issues to their peers. The peer educators are also provided with general skills in literacy (taught by daughters of sex workers) and legal rights. In 2000 there were 200 peer educators (some of them volunteers), and their duties include daily outreach work in brothels and other sites to encourage workers to attend free health clinics, and distributing condoms (some free and some for sale).⁹ Peer educators have an Advisory Board and a grievance committee to resolve conflicts. Meetings are regularly convened of larger groups of sex workers and clients to provide information and education, such as videos, slides and drama performances about HIV and STI prevention and prostitution in general. The monitoring by a stakeholder Committee of entry into the profession provides opportunities for sexual health education, as well as screening of under-age workers.

In 1995 the Usha Multipurpose Cooperative Society was established to provide economic and social assistance, as this informal work sector does not generally provide social protections. The Cooperative consists of savings and loans scheme for women, social marketing of condoms, and childcare programs for children of current younger sex workers run by older former sex workers. Such support for families decreases the social isolation of workers. In 1998 a Positive Hotline was established by sex workers to provide counseling and support for any HIV positive person and is assisted by professional volunteers.

Outcomes:

Evaluations of the project found a decrease in genital ulcers and STIs (gonorrhea decreased from 13.2% in 1992 to 3.9% in 1993 and recent syphilis decreased from 25% in 1992, 15 % in 1995 to 12% in 1998), and increases in condom usage by sex workers, from 2.7% (1992) to 81% (1995).¹⁰ Surveys conducted by sex workers of clients' regular use of condoms show a rise from 2.7% in 1993 to 69% in 1995, and a further increase to 90.3% in 1998. This increase in condom use is despite continuing initial client reluctance to use condoms, as there are no client focused interventions, but which is countered by a united rather than competitive front of sex workers. In 1998 HIV prevalence of workers at Sonagachi plateaued at 5.5%, which was a slight increase from 1992, but not as exponential an increase in sex workers in other areas of India (up to 55%). In 1999 the Cooperative sold 730,656 condoms. It is estimated that the reduction in STIs has resulted in a saving of 30-50 rupees for DALYS (disability adjusted life years).

Lessons Learned:

The sustainability of the project in increasing condom use, avoiding escalating HIV rates, and lowering STI infections has been attributed to its responsiveness to sex worker and client needs, and ability to mobilize and unite this community to act on its own behalf by gradually enabling it to take responsibility for the intervention. Building the capacity of sex workers as professionals, and avoiding a rescue or

rehabilitation approach to the sex industry was a key factor in the project's acceptance by the community, who were regarded as partner change agents rather than passive beneficiaries. Providing for holistic needs of workers by addressing quality of life issues was more empowering than only targeting their sexual health requirements. Similarly, acceptance of the needs of clients, such as access to health care, rather than judgmental attitudes is important to the success of the project. Traditional individual behavior change techniques were viewed as inadequate to enable adoption of collective safe sex norms and practices because of worker's existing class, gender and social inequalities. Genuine representation and participation of the community in planning and implementing the project was essential to engender trust and sustainability. Increased and more open professionalism of workers enhances self-esteem and the ability to be assertive and negotiate with clients and officials, such as law enforcement officers. The ability to refuse sex work without condoms was associated with empowerment of workers to resist human rights abuses in many facets of their lives, such as violence, discrimination, and extortion by third parties such as 'loan sharks'.

Budget: US\$90,000 per annum

Contact: Dr Mrinal. Kanti Dutta
sonagachi@sify.com

(ii) Mine workers

The social context of workers' identities shapes their sexual risk-taking behavior as well as their responses to intervention programs, particularly when concentrated in gender groupings (such as the construction of 'machismo' masculinity), for example male miners separated from their families become fatalistic about exposure to daily work hazards and tend to minimize long-term risks that do not immediately threaten their survival, such as HIV.¹¹ Mining companies, such as the Anglo American Corporation in South Africa have extended their gender sensitivity to include social uplift and micro-finance schemes for women in the community as an alternative to

sex work, by providing income from bread or brick making, and pre-cast fencing.¹² Similar programs for mining communities have been set up in other countries, such as Irian Jaya, Indonesia.¹³ The most gender sensitive intervention that would be effective in the long-term is to allow mine workers to bring their families with them, or to at least enable regular visits by families to their worker husbands/fathers (or vice versa).

A recent study criticizes the ineffectiveness of some programs focusing on sex worker communities in mining towns, because they do not sufficiently address local vectors, such as what people believe and practice about the spread and prevention of HIV/AIDS, for example the need for skin-to-skin contact in living situations lacking intimacy and privacy.¹⁴ A related study of community-led peer education documents the required cooperation by male managers to access a deprived, violent, competitive and chaotic sex worker community with an estimated 68% HIV prevalence, attached to mining towns in South Africa, and the necessity to demarcate ‘women’s business’ in which they have no leadership interest.¹⁵ It found that the objective of increasing condom use was equally important to all workers: HIV positive workers could protect their clients and partners, as well as themselves from STIs and HIV (re-)infection; and HIV negative workers would be protected from both STI and HIV infection.¹⁶ The projects attempted to promote collaborative stakeholder partnerships but did not meet expectations in addressing broader structural contexts and sexual determinants for a number of complex reasons, including different perceptions of the role of stakeholders, and the lack of trust and full engagement by mine management and unions. There was also criticism of the focus on sex workers rather than miner clients, who held superior economic and social power in negotiating sexual encounters, and lack of bridging social capital between these two groups.

The Lesedi project was less ambitious than these projects, as it is mainly a shorter-term biomedical intervention, and it had the advantage of being broadly and strongly supported by mine management and workers’ unions, as well as involving local communities of women sex workers.

2. Case Study - the Lesedi project (South Africa)

Dates:

1996 and still ongoing.

Aim

The project aims to reduce the high prevalence of STIs (a co-factor for HIV infection) in migrant mine workers separated from their families, and women in the local community who depend on them through their work in the sex industry. Mine managers wished to reduce the direct medical costs of workers' ill-health as well as more substantial indirect costs of decreased productivity, disability, premature death, and worker retraining. Lesedi, means 'we have seen the light'.

Problem:

Previous projects had facilitated miner's access to sexual health information, condoms and STI treatment, but there had not been enough impact on individual behavioral change.. Women in the surrounding community who interacted with the miners had poor access to preventative and curative STI services, as well as general health services.

Context:

The project was established in the community of Virginia, close to the Harmony Gold Mining Company site. It is a residential community servicing 4,000 miners based in three single sex hostels.

Stakeholders:

Family Health International (AIDSCAP) and management of the Harmony Gold Mining Company led the intervention with the support of the National Union of Mineworker's and health authorities, including the South African Institute for Medical Research. Other funders have also been involved in later stages of the project, including the European Union. The local community has embraced the

program, overcoming initial skepticism of free diagnosis and treatment of approximately 400 female sex workers servicing the male mine workers.

Intervention:

The project developed from basic sexual health education of workers, medical care and provision of condoms by mine medical stations and personnel areas that did not impact enough on workers' STI and HIV rates. It extended the program to women in the community by setting up mobile clinics providing periodic presumptive treatment with monthly antibiotics because of the high prevalence of asymptomatic STIs, rather than relying on syndromatic management (that is based on patient symptoms, which are not always present, and clinical diagnosis using laboratory results). However, STI rates of attendees were continuously measured to justify the initial decision that participants were in need of treatment (when baseline data showed a STI prevalence of over 50%) and the risk of antibiotic resistance. The clinics also provide condoms and information about STIs and HIV. Health departments have been involved in funding and evaluating the project, and were able to assist in removing regulatory constraints on nursing prescription practices in the clinics.

The project initially employed two outreach workers to promote clinic attendance by attending meeting places frequented by sex workers, such as bars, and distributing referral cards. Later six female clients were trained as peer educators, who regularly met with workers individually and in groups, which was important in building community involvement and trust. Harmony has now committed to provide a fixed site for the clinic as well as two mobile clinics serviced by three full-time nurses. The program was been expanded to now serve 100,000 miners and 4-5,000 women in the nearby areas of Welkom (Lechabile project), Westonaria-Randfontein (WRAP project) and Evander (Powerbelt project) and other mining companies, Goldfields Ltd and Joel Mine. The project has a planning committee that meets regularly, and adequate financial records are maintained to ensure accountability and control. Process indicators were used in the intervention to measure the number of peer educator referrals and clinic attendances.

Outcomes:

Evaluations of the project have shown that there was a decrease in the number of sexual partners, women's STIs have reduced by 85%, men's STIs have reduced by 43% and genital ulcers have reduced by 78% (as revealed by routine annual medical examinations in the mine clinics). Figures for change in reported condom using behavior increased from 15% to 70% of mine workers and from 3% to 60% of sex workers. Computer models estimate that 40 female and 195 male HIV infections have been averted (46% less than what was expected without the program).¹⁷ The estimated direct saving of US\$539,630 to the mining company is very substantial.¹⁸

Lessons Learned:

The project demonstrated the limited effectiveness of interventions that focused only on the workplace in areas of high HIV prevalence, and highlighted the benefit of recognizing and addressing health problems in local communities. The use of presumptive STI treatment of sex workers is unorthodox, but from the evaluation results, they appear to be effective, mostly because the intervention has been implemented in cooperation with the mine workers' union, the community and other stakeholders. Promotion and availability of condoms are essential components of the project to counter the risk of monthly medical visits having a negative impact on prevention, because participants might believe that they could engage in high-risk behavior since the STI presumptive treatment drugs protected them. The project carefully weighed the ethics of providing presumptive treatment in a high prevalence area with inadequate access to medical services – the decline in STIs was much quicker and greater than was achieved by existing efforts to educate individuals to change their behavior. The effectiveness of the project needs to be continuously monitored, as the justification for using presumptive treatment may be diminished when prevalence has leveled. It is important to conduct situational analyses in the mines and surrounding community at different stages of the project for evaluation purposes, and to justify the mine management's decision to have a cost-effective intervention that went beyond the workplace.

Budget: US\$53,760 pa of which 39% was expended by Harmony on salaries plus incentives, 54% for supplies (STD drugs and 20,800 condoms) and 7% to rent a trailer to use as a mobile clinic. There were also social costs of US\$72,500 pa contributed by stakeholders – general health services provided at the mobile clinic by the Department of Health, condoms donated by Population Services International (which provided half of the supply required), and the time spent by other staff, such as the Harmony medical manager, administrator, technical assistance consultant and participants.¹⁹

Contact: Dr Tony de Coito
tdecoito@harmony.co.za

(B) UNION INITIATIVES

Many unions have general HIV programs, but only several focus on gender or related issues, such as the International Confederation of Free Trade Union, which has developed a Framework of Action Towards Involving Workers in Fighting HIV/AIDS in the Workplace that recognizes the need to overcome sexism and abuse of women by integrating gender components in all trade union programs and technical cooperation projects.²⁰ The International Union of Foodworkers has developed a model agreement based on its research of sexual exploitation of women, especially girls, in tourism. The National Union of Workers in the Hotel, Restaurant and Allied Industries in the Philippines has included a clause from this model in its collective agreements with hotels, including issues such as employee reporting and refusing requests for child prostitution, with duties of management support in the case of customer disputes. The Conservation, Hotels, Domestic and Allied Workers Union in Tanzania has been active in raising awareness and withdrawing child labor, and reducing the vulnerability of children to HIV/AIDS and sexual exploitation.²¹

The following case study concerns a union leading an effective intervention to reach mobile male construction workers with appropriate stakeholders – it highlights the benefits of using a gender sensitive peer education, compared to another, approach.

3. Case Study - Mobile male construction workers in Vietnam

Dates: 1994-5

Aim:

The project aims to access highly mobile male workers in the construction industry who are difficult to reach, by providing them with effective HIV/AIDS education.

Problem:

Mobile workers who travel from site to site are vulnerable to HIV/AIDS because they are separated from home communities and had higher levels of alcohol abuse and unprotected sex with sex workers (known as ‘eating cakes and paying money’).

Context:

In Ho Chi Minh City, Vietnam, HIV prevalence is low but new HIV-infections are increasing in the general population. One quarter of the city’s workforce is comprised of migrant workers, including the construction industry, truckers, traders and domestic workers. Health authorities wished to know whether it was feasible to scale up existing visiting health communicators projects to this population.

Stakeholders:

The project was initiated by the Ho Chi Minh City Labor Union in collaboration with the College of Social Sciences and Humanities at the Ho Chi Minh City National University and the Ho Chi Minh City AIDS Committee, and with support from the Horizons Program, the Population Council/Vietnam and the Ford Foundation.

Intervention:

The project targeted mobile, predominantly male, workers from the construction industry in twelve city building sites using two approaches at half of each site. The first arm was not successful, nor sustainable, as it used volunteer visiting health communicators (VHCs) who were primarily young female student social workers and left the program when their studies were completed. They had one-on-one education sessions off-site with workers once or twice a week, as they were not allowed on site for safety reasons. The union directed this program and construction management was not actively involved in its out-of-work-hours sessions. The second arm of the project used trained peer educators who worked on site and interacted with peers during work breaks or after work. One peer educator for every twenty workers was trained – initially for four days, then with refresher courses four and eight months later. The issues covered included promoting preventive behaviors such as abstinence, reducing the number of sexual partners, using condoms and being treated for STIs. These peer educators overcame their initial sensitivity to discussing sexual issues, and after six months overtook the comfort levels of VHCs. Their knowledge of HIV/AIDS issues similarly increased over six months, but to a level equal to the VHCs. They worked informally as counselors one-on-one, as well as in groups using participatory education approaches, including role-plays, games, drama and songs. New sites were added to the study when construction work was completed at a site.

Outcomes:

The program was evaluated by comparing baseline interviews with 1,244 workers, then follow up surveys of 1,256 workers at six months and 574 workers at twelve months after the intervention. Of the respondents, 85% were male and 15% female, usually working in separate sites. The peer education program was more successful than the voluntary program and was ultimately more affordable per worker reached – they spent longer amounts of time with workers, and distributed more condoms (reaching 78% of workers) than VHCs. Peer education messages were diffused into the larger workforce, including workers who were not direct participants, indicating the dialogue about HIV/AIDS issues had increased in the workplace. The evaluation of the program found that it increased HIV and STI knowledge, and professed

adoption of risk reduction values, such as it being acceptable for women to ask a man to use a condom and being able to refuse visits to sex workers when invited by colleagues.

Lessons Learned:

The peer education program was cheaper and more effective than using visiting health communicators. It had a broader reach than the voluntary program because peers communicated better among fellow workers, sharing private issues as friends, with further information dissemination reaching workers who were not direct participants, as well as receiving greater management support and work time for their activities. Management appreciated the systematic approach by the union to the program, and who were prepared to be flexible and address concerns about the resources required and its cost effectiveness.²²

Budget: unknown

Contact: bao@popcouncil.org.vn or philip@popcouncil.th.com

(C) WORKER DEMAND DRIVEN INITIATIVES

Not only management and unions drive HIV/AIDS measures – workers themselves can pressure stakeholders to provide them with gender sensitive HIV/AIDS education and information programs.

4. Case Study - PHILACOR

Dates: 1996 and ongoing

Aim

To provide male workers with appropriate HIV/AIDS education by communicating messages that were relevant to their needs.

Problem:

Young sexually active male employees lacked knowledge about HIV/AIDS issues.

Context:

PHILACOR Corporation is a fridge and freezer manufacturer in the Philippines employing 1,500 workers, 96% of them male and half of who are single. The average age is 27 years.

Stakeholders:

The Philippine Appliance Corporation commenced a HIV/AIDS communications program in response to worker demand and invited local HIV/AIDS NGOs, such as the Remedios AIDS Foundation Inc. and PLWHAs to collaborate with workers, management and the relevant union.

Intervention:

Stakeholders developed new information and education materials, which contained appropriate messages that were relevant to workers and six peer educators were trained for two weeks by the NGOs and the Department of Health. These peer educators gave seminars on HIV/AIDS issues at meetings attended by their fellow workers, and HIV/AIDS issues are mainstreamed into existing programs such as first aid, new staff orientation and worker reorientation. The company has a quarterly newsletter that includes article on HIV/AIDS advocacy issues in English and the local language. The PHILCORP HIV/AIDS policy developed by management and the union includes issues relating to employment, discrimination, reasonable accommodation, and workplace education, and is based on respect for the rights and dignity of PLWHAs and lack of discrimination on the basis of health status, gender and sexual orientation. The program and the policy were consistent with the National Workplace Policy on Sexually Transmitted Diseases and HIV/AIDS developed by the Department of Labour and Employment.

Outcomes:

The program combined special HIV seminars and mainstreamed training, by incorporating HIV issues into existing staff programs, such as orientation and first aid. PHILACOR's HIV/AIDS policy covers issues of discrimination, reasonable accommodation and employment rights, and has been approved by management and unions. An in-house evaluation found that 90% of employees had accurate knowledge about HIV transmission.²³

Lessons Learned:

HIV/AIDS prevention and education peer program that are targeted with gender appropriate messages and materials, are simplified by having a homogenous employee profile.

Budget: unknown

Contact: Dr Efren T. Llarena
ederick@philacor1.mozcom.com

(D) EMPLOYER INITIATIVES

Employers have been active in the HIV/AIDS and several multinational companies, such as Heineken and De Beers have established free or highly subsidized (up to 90%) anti-retroviral treatment programs for workers and their spouses.²⁴

Documentation of some HIV projects in the formal workplace do not focus on gender issues, usually because they are in male dominated industries, but contain some elements of a gender aware HIV program. For example, Odebrecht, a Brazilian construction and engineering firm working in Angola provides health specialists for women staff and women in the community at two sites, holding women's discussion groups and training and ARVs for pregnant women to prevent mother-to-child transmission.²⁵

The hotel industry has been innovative in addressing gender and workplace issues, particularly in HIV/AIDS prevention work. UNAIDS and the International Hotel and

Restaurant Association have issued a Guide for the Hospitality Industry that contains examples of hotel HIV/AIDS policies.²⁶ The World Tourism Organization is also promoting initiatives against child prostitution and industry associations have adopted codes and policies. An innovative prevention program was piloted in Thailand led by Pan Pacific Hotels and has been adopted in a number of other countries.

5. Case Study -Youth Career Development Programme

Dates: Started in 1995 and still ongoing.

Aim

The program is aimed at vulnerable and disadvantaged young women in rural areas as an intervention to divert them from the sex industry where they are at high risk of exploitation and HIV-infection by providing participants with alternative career opportunities in the hospitality industry.

Problem:

The Thai government estimates that 20-40,000 girls under the age of 18 years are engaged in the commercial sex industry. In northern Thailand poverty and social attitudes facilitates the recruitment of a large number of young women into the commercial sex industry, either by limited career choices, coercion or being sold by their families.

Context:

UNICEF conducted a situational analysis before designing the project to explore the social, economic and cultural factors driving the recruitment of young women in the sex industry, which informed the selection of geographic areas and target groups, such as hill tribes.

Stakeholders:

In Thailand the public-private partnership program involves a number of leading hotels led by Pan Pacific Hotels and UNICEF. In 2002 100 young women were recruited by the 19 hotels involved (including Shangri-La, Regent, Grand Hyatt, Novotel, Pathumwan Princess, Crowne Plaza, Sheraton, Sukothai, Merchant Court, Marriott, Le Royal Meridian, Intercontinental, Westin Banyan Tree and the Peninsula). A total of 500 young women have participated in the program (only one boy was included in the first intake). The program is endorsed by the International Hotel and Restaurant Association. The International Business Leaders Forum has supported the program since 1999 and has funding from the UK Department for international Development (DFID) to globally expand the program. The program has been or is in the process of being extended to other countries, including the Philippines, Bangladesh, Indonesia, Palau, Jamaica and South Africa.

Intervention:

Young women from the age of 17 years are recruited mainly from welfare schools, as the target group is those most at risk of working in the sex industry if they are not assisted (although girls who have an existing association with the sex industry are excluded). The five-month hospitality training program provides transportation to Bangkok, meals, accommodation (provided by the Girl Guides Association) and uniforms. Technical areas include housekeeping, laundry, food and beverage services. Girls are provided with supplementary informal life skills training sessions organized by UNICEF and held fortnightly by hotel staff, business training institutes and NGOs on issues such as sexual harassment, workplace safety, sexual health, HIV/AIDS, human rights, children's rights and urban survival skills.

Outcomes:

The programme has been effective in preventing young people from entering the sex industry by raising their skills and self-esteem, and finding them employment in hotels and restaurants. Of those who have graduated from the program, 60% are currently employed in the hospitality industry and 24% are continuing their education (half of that group being students at university).²⁷ Similar programs have been

developed in Thailand for diverting young women from sex work by vocational training in non-exploitative areas as assistant health workers, secretaries (with computer skills), sewing and gem cutting.²⁸

Lessons Learned:

The program is sustainable and has been replicated because it mobilizes the private sector's existing resources and builds partnerships between stakeholders in other sectors such as government, NGOs and funding agencies. It is envisaged as an empowerment tool for young women at risk of sexual exploitation by providing living conditions and a curriculum that are responsive to their needs, and is not merely a vocational training program in a non-traditional setting. Although it has only reached a relatively small number of vulnerable women, the program demonstrates that they respond positively and responsibly to opportunities for long-term social and economic security.²⁹

Budget: unknown

Contact: info@youthcareer.org or ampha@panpac.com

(E) COMMUNITY ORGANIZATIONS INITIATIVES

HIV/AIDS organizations and other NGOs can be models of HIV workplace policies and practices, and in some cases they promote gender sensitivity, such as the Health Economics and HIV/AIDS Research Division (HEARD) and the Southern African Training Programme, which has produced a gender mainstreaming tool for integrating gender issues in policy formulation and program planning, implementation and evaluation cycles.³⁰ Community organizations, such as women's groups may be able to provide technical assistance for workplace programs – for example, the National Council of Negro Women in the USA has a HIV/AIDS Training and Technical Assistance Project that provides training to minority community-based organizations and collaborates with public health agencies in the

effective delivery of prevention services targeting African American women. The International AIDS Alliance has been a global leader in developing workplace and medical benefit policies that are gender sensitive.

6. Case Study -The International AIDS Alliance

Dates: 2002-2003

Aim:

The purpose of the program is to develop workplace and medical benefit policies, including access to treatment, for staff of mixed sexes working in a HIV/AIDS NGO.

Problem:

Some of these staff employed by HIV/AIDS NGOs are HIV positive and need accommodation of their health status, in order to be manage their chronic condition and continue working optimally. Experience suggests that workers, because of their economic and social vulnerability, may not readily attempt to access early treatment plans unless workplace stigma and discrimination are also addressed in a gender sensitive manner.

Context:

Most people in developing countries cannot afford access to anti-retroviral treatment because private medical care is too expensive and access through employer-sponsored health care is the only realistic option. However, many medical insurance policies specifically exclude chronic illnesses. AIDS service organizations often have affirmative action policies for recruiting, retaining and keeping PLHWA staff healthy. However, they usually have limited budgets, so equity in access by workers to health plans is important to weigh against the financial stability of the organization.

Stakeholders:

The International AIDS Alliance (IAA) is an NGO that has a Secretariat based in the United Kingdom, which supports HIV/AIDS communities in developing countries. It has member NGOs in developing countries, including KHANA in Cambodia, which it works in collaboration with as partners – this means that they have access to technical assistance and resources, such as the Canadian HIV/AIDS Legal Network.

Intervention:

The International AIDS Alliance has drafted a tool to assist three (of a total of seventeen) linking organizations in Cambodia, Senegal and Burkino Faso develop HIV workplace and medical benefits policies using participatory workshops and based on the ILO Code. Positive discrimination measures may be included to recruit PLWHAs, such as waiving general waiting periods under workplace health insurance policies. Staff benefits are also equitable, being of the same level in developing countries as headquarters in the United Kingdom under a template policy developed in 2001. A particular difficulty is defining dependents and it was decided by KHANA that confidential registers of eligible spouses, children parents, and other dependents for medical benefits needed to be established. This is consistent with workplace policies requiring staff to sign confidentiality agreements to prevent the unauthorized disclosure of HIV-related information of colleagues who may wish to be open about their HIV status at work. Otherwise staff would be reluctant to reveal their own or partner's HIV status when in need of care. The workplace policy also has prevention aspects, such as providing free and discrete access to male and female condoms, as well as gender sensitive and voluntary HIV testing and counseling, and STI diagnosis and treatment. It provides for protocols to be established for staff to access post-exposure prophylaxis by gender sensitive services where they have been exposed to the risk of HIV infection at work or elsewhere, for example through accidents or sexual assault. Benefits paid under health insurance schemes are required to be confidential and gender sensitive.³¹

The workplace policy adopted by KHANA in Cambodia requires HIV/AIDS information and training to be gender sensitive, and the section on gender states:

‘The organization acknowledges that HIV/AIDS impacts on male and female staff differently. This includes recognition that women normally undertake the major part of caring for those with AIDS-related illnesses, and that pregnant women with HIV have additional special needs. Any staff and family assistance arrangements will be designed to accommodate these differing impacts, and as appropriate to redress gender inequalities, for example by encouraging and supporting men as carers.’³²

This policy is operationalised in making reasonable accommodation measures equally applicable to both sexes, such as compassionate leave, flexible working hours, part-time work, extended sick leave, transfer to lighter duties and return-to-work arrangements. In Senegal and Burkino Faso where HIV prevalence is much greater than Cambodia this gender aspect of the policy was supplemented by reference to preventing mother-to-child transmission.

Outcomes:

The project is very recent and is being evaluated at the end of 2003.

Lessons Learned:

Policies need to be tailored to meet local situations (following a situation and response analysis of local access to care that costed all necessary components), particularly in relation to gender issues, such as definitions of confidentially registered dependents eligible for medical benefits. It is essential to balance sustainability and social justice in these workplace and medical benefits policies.

Budget: unknown.

Contact: Tilly Sellers

tsellers@aidsalliance.org

(F) Tools

There are number of gender sensitive tools that have been designed to address HIV issues, some of them specifically in the workplace context. The Royal Tropical

Institute (Belgium), the South African AIDS Information Dissemination Service and WHO developed a checklist entitled ‘How Gender Sensitive is Your Work?’ It is designed for use by researchers, policy-makers, program implementers and health carers, but could be adapted for many workplaces. UNIFEM, UNAIDS and UNFPA developed a *Gender, HIV and Human Rights Training Manual* in 2000.³³ UNIFEM have also developed a booklet, *CEDAW and the Gender Dimensions of the HIV/AIDS Pandemic* that uses the general framework of the Convention on the Elimination of Discrimination Against Women to structure a rights-based approach to the epidemic.³⁴ UNAIDS have developed a Gender Sensitivity Checklist covering policy and program development, implementation and organizational structure.³⁵ The UNAIDS’ *Gender and AIDS Almanac* is a resource aimed at development practitioners and policy makers, that could be usefully disseminated in some work settings, as it explores the relationship between gender and the HIV epidemic in general societal and specific contexts such as prevention and care. The Nordic Institute for Women’s Studies and Gender Research developed a manual on *Gendering Prevention Practices* that attempts to reach a deeper engagement with gender issues shaping sexual norms than traditional AIDS awareness program, by addressing heterosexual risk behaviors in small participatory learning groups.³⁶

Communication tools such as humor and comics can be useful to target gender sensitive messages to workers. The Faculty of Education in the University of Chiang Mai developed comic books to be used by peer educators targeting young female factory workers in Thailand. They simply address prevention issues that can be difficult for women to discuss, such as condoms, which research had revealed was perceived as ‘men’s business’. One humorous comic gives practical examples of what girls can actually say to negotiate safer sex, using the characters of a young factory worker called Jon Di and the Brother Protector Condom, who has been created by the Spirit of Good Health and materializes into a young man when five young women are saved from AIDS. The Heterosexual Men’s Project run by Family Planning in New South Wales Australia used humor to challenge some aspects of male culture that were obstacles to safer sex among building workers, who were difficult to reach with

traditional workplace education campaigns. It produced beer coasters and toilet stickers to place in workplaces and the community that attempted to facilitate discussion of condoms between men and women by providing icebreakers, such as queries about condom size (hinting at corresponding penis size).³⁷

A common feature of successful programs is enabling the separation of male and female workers in prevention programs, but allowing space for collaboration at strategic points. Some programs have noted that women-led projects can challenge male authority, which may lead to resentment and attempts to discredit them.³⁸ There is also the risk that peer groups will simply reflect wider community norms regarding gender roles, that is, men dominating discussion with women being intimidated into silence. Stepping Stones is a successful HIV/AIDS communications tool that has been successfully used in a variety of settings, including workers, to address gender issues.

7. Case Study - Stepping Stones

Dates: tool developed in 1995 and use is ongoing

Aim:

Stepping Stones is aimed at changing private sexual behavior by being appropriate to personal vulnerabilities and situations, as opposed to high profile media campaigns, which merely bring public attention to HIV issues. It builds on research demonstrating the mismatch between knowledge and sexual practices, and that peers are a main source of information about sexual matters.

Context:

The Stepping Stones project was developed in Uganda in 1995 as a community mobilization tool where HIV prevalence among the adult population was 8.3%.³⁹ The approach as set out in a Manual has been used in over one hundred countries (including Myanmar, the Gambia, Zimbabwe, Malawi, Mozambique and South Africa). Traditional prevention messages (for example Abstain, Be Faithful, use

Condoms) are impractical in the context of cultures where fertility is highly valued. They have little traction in societies where it is the cultural norm for men to have multiple sexual partners, and it is culturally unacceptable for wives to discuss these matters with their husbands, making one-sided monogamy a strong risk factor for HIV-infection in many countries.

Stakeholders:

ActionAid started the Stepping Stones project as part of the Strategies for Hope series in Uganda and developed a 240-page manual and video that is now used by over 2,000 organizations in various contexts, including Horizons (USAID), DFID (UK) and the Medical Research Council (SA). Financial support for the development of the manual and video were provided by OXFAM, Charity Projects, Redd Barna (Uganda), Swiss Development Cooperation, UNDP and WHO.

Intervention:

Stepping Stones is an education empowerment program addressing HIV and gender issues that enables dialogue between small groups of men and women in many venues, including workplaces, for example soldiers, trainee teachers and their partners in Uganda. It works through a progression of four key themes of learning, sharing, caring and changing over eighteen sessions of 2-3 hours (totaling 60 hours). It includes issues of cooperation and communication, relationships, HIV and safer sex, gender roles and planning for the future. It uses participatory, non-formal learning methods that make it enjoyable as well as empowering for participants, such as songs, games and role plays – literacy is only required of facilitators, but not participants. Full plenary sessions are held to share and compare peer discussion. Stepping Stones recognizes that programs involving only one partner of a relationship can be ineffective, and educating men about sexual and reproductive health enables them to be more supportive of their partners, as well as meeting their own sexual needs. It is a powerful tool for motivating and mobilizing men that requires preparatory work in a community through participatory needs assessments and discussion with influential community leaders, many of who are men. For example in

the Gambia the Stepping Stones program was presented as an infertility prevention program (because STIs are a major determinant), rather than a family planning one which would not have been acceptable to the community.

Outcomes:

Evaluations are not available for workplace contexts, but in countries such as the Gambia have shown that more effective and sustained behavior change, particularly knowledge, attitudes, and condom uptake, as well as increased dialogue and equity within partnerships.⁴⁰ A USAID study set out changes in attitudes by agreement with key questions asked of participants before and after a Stepping Stones intervention: ‘A real man must have many women’ (47% decreased to 19%); ‘Some women deserve to be beaten’ (49% decreased to 20%); ‘A condom is needed even if a woman is using contraception’ (48% increased to 94%); and ‘Someone at home or a close friend could have HIV without knowing it’ (39% increased to 75%).⁴¹ An evaluation of a program in Uganda showed improvements in several areas: less wife-beating, more mutual respect and sense of well-being, greater ability to discuss sexual matters within families, improved self-esteem, increased condom use, more desire for economic self-sufficient, and improved community care and support for HIV-positive people.⁴² One commentator noted: ‘I have seen conservative, authoritarian men of the armed forces (Uganda) mellow down to pleasant smiling change agents within a period of seven days in Stepping Stones training programs.’⁴³

Lessons Learned:

Stepping Stones has found it essential to engage communities if behavior changes are to be sustained – participants use the tool to develop locally appropriate solutions to HIV vulnerability that involve gender issues. For example in Cambodia the Manual was adapted to focus on women’s lack of assertiveness and self-esteem, and men’s lack of responsibility towards sexual problems. The project found it necessary to separate groups (usually into four, each with a facilitator) according to gender and age to enable members to speak as a group in order to overcome gender and age barriers –

‘men and women each need private time and space with their peers to explore their own needs and concerns about relationships and sexual health’.⁴⁴

Budget: unknown. The Handbook is sold or distributed free to community groups in developing countries by Action Aid (in several languages), and the time of facilitators and participants would need to be costed.

Contact: Linnea Renton

LRenton@actionaid.org.uk

6. Conclusion

There are a number of interventions that have been attempted around the world, either explicitly or implicitly addressing gender issues. They range from: empowerment of women by building more equal communities that interact with men (eg Sonagachi); transforming gender roles and relationships within existing communities by improving access to information, education and skills (eg Stepping Stones); gender sensitive approaches that meet the different needs of women and men in particular areas, such as differential burdens of care and access to treatment (eg International AIDS Alliance); and gender-neutral approaches - that is not worsening the situation with regard to harmful gender norms, but tolerating it with prevention programs that diagnose and treat sexually transmitted diseases that are co-factors in HIV-infection (eg targeting men in male dominated industries such as mining and construction industries where men migrate to mainly single sex communities serviced by local women engaging in survival sex). There are also programs targeting women in industries where they are predominant, such as garment factory workers, and diversion programs to prevent young women from entering the sex industry.⁴⁵

These approaches are not exclusive and some interventions may use a combination of them. The minimum level is to provide peer education, which is simplified in homogenous workplaces, to promote new collective gender identities with changed

sexual risk-taking behavior and responsibility for HIV/AIDS prevention and care. Involving both partners of a relationship is ideal to facilitate behavior change, but may be more difficult in the employment context because only one may be present. However, in vulnerable single sex male communities dual programs have been successful where they also appropriately focus on nearby sex worker communities.

The scarce documentation of interventions in informal sectors with predominantly female workers (except in the sex industry), compared to male dominated formal industries is of concern because it implies that there are not enough effective programs.⁴⁶ Many tools set out in this paper are useful to facilitate and measure the extent of gender sensitivity in workplaces and their application can be a first step in remedying the vulnerability and impact aspects of the epidemic. A large feature of their sustainability is the extent of the mobilization of tripartite-plus partners, including employers, unions, workers, NGOs donors, and government authorities – which particular sector leads the program is not as important as building support between all affected stakeholders. Being responsive to workers' and communities' holistic needs is important – health promotion in the HIV/AIDS area needs to address broader gender contexts that are determinants of vulnerability, such as building the capacity of individual men and women to negotiate and make non-coerced decisions about sexual relations.

APPENDIX: General HIV, Labor, Human Rights and Gender Standards

The four main aims of the *ILO Code of Practice on HIV/AIDS and the World of Work* (2001) all have gender dimensions – prevention, mitigation, care and support, and eliminating stigma and discrimination. The Code recognizes that women are more likely to become infected and are more often adversely affected by the epidemic, due to biological, socio-cultural and economic reasons. Refusing unsafe sex or negotiating safer sex is not a realistic option for some women, which has led to the development of female-controlled technologies, such as the female condom and microbicides. Structural inequalities in the status of women intensify the impact of HIV, including the concentration of women in the informal sector, which does not have social security or other occupations health benefits.

Therefore equalizing gender relations and empowering women are key HIV prevention measures. Implementing general rights under ILO Conventions and human rights treaties, such as equal pay for equal work between men and women, are important to address vulnerability issues (eg through use of mainstreaming gender audits).⁴⁷ HIV interventions, such as workplace information and education programs need to be gender sensitive to be effective by targeting both men and women to address different types and degrees of risk – either separately, or together if appropriate. Unequal power relationships need to be addressed in the workplace, including sexual harassment, and in the community, such as sexual and general violence.⁴⁸

Raising women's and men's rights and responsibilities awareness and understanding is critical in this process, so that they can be acted upon to protect themselves. Some important rights are gender neutral in the workplace such as the Code's prohibition on HIV-testing for recruitment, employment and insurance purposes, but access to voluntary testing requires gender-sensitive pre and post-test counseling. The Code highlights the need for employee and family assistance programs that recognize the additional burdens on women, such as caring for ill family members, pregnancy and

girl orphans who are forced to leave school early in order to support the family, and may be vulnerable to sexual exploitation in underage commercial sex work or informal sector domestic work.

The UNGASS Declaration of Commitment notes the disproportionate impact of the epidemic on women, and stresses that equality and empowerment are fundamental elements to reduce vulnerability. It reaffirms States Parties' commitments made at the Beijing and Cairo Conferences and their five-year reviews,⁴⁹ and sets the following benchmarks to be reached by 2003-5:

- addressing gender dimensions of the epidemic and including the full participation of PLWHAs, particularly women (article 37);
- challenging gender stereotypes and attitudes and gender inequalities, including the involvement of men in prevention (article 47);
- developing and accelerating national strategies promoting the advancement of women and their full enjoyment of all human rights, sharing responsibility of men and women to ensure safe sex, and empowering women to have control over and make decisions about their sexuality and protect themselves from HIV infection (article 59);
- implementing measures to increase women's capacity to protect themselves through provision of gender-sensitive health care and services (article 60);
- eliminating discrimination against women, including violence and harmful traditional and customary practices, trafficking and sexual exploitation (articles 61-2);
- developing and implementing national strategies that incorporate HIV/AIDS awareness, prevention, care and treatment into programs responding to emergency situations, and recognizing the increased risks to populations, in particular women (article 75);
- reducing mother-to-child transmission by increasing access to antenatal care, information, counseling, testing, prevention and treatment (article 54); and
- reviewing the social and economic impact of the epidemic, especially women in their role as caregivers (article 68).

Although not explicitly mentioned in the Declaration, it is consistent with the *International Guidelines on HIV/AIDS and Human Rights*, specifically Guideline 5 on protective laws and Guideline 8 on women and other vulnerable groups.⁵⁰

Gender sensitivity is lacking both generally, and specifically in relation to HIV, in workplaces, particularly in informal sectors. Ethical Codes of Conduct in social auditing of industries such as horticulture address gender issues, but usually in respect of overt issues such as working conditions and wage rates, rather than structural issues that force women, although being the majority of employees, to be disproportionately concentrated in vulnerable positions (that is casual, temporary or seasonal), and lack access to training because of their socially subordinate roles.⁵¹

ENDNOTES

- ¹ UNAIDS, *AIDS Epidemic Update* (2002).
- ² A. McDonagh, *Microfinance Strategies for HIV/AIDS Mitigation and Prevention in Sub-Saharan Africa*, ILO Working Paper No. 25 (2001).
- ³ ILO, *Implementing the ILO Code of Practice on HIV/AIDS and the World of Work*, Module 5 (2002).
- ⁴ ILO, *Implementing the ILO Code of Practice on HIV/AIDS and the World of Work: An Education and Training Manual* (2002).
- ⁵ UNAIDS, *Report on the Global HIV/AIDS Epidemic* (2002) p109.
- ⁶ UNAIDS, *Summary of Best Practices*, Issue 2 (2000).
- ⁷ An evaluation found that peer leaders improved their HIV knowledge, including perceived vulnerability to infection, and enabling skills. Workers involved in the program were given certificates on its completion and reported that it enabled them to discuss HIV more openly with others without fear of judgment of their morality - K. Cash, J. Sanguansermisri, W. Bussayawong and P. Chuamanochan, *AIDS Prevention Through Peer Education for Northern Thai Single Migratory Factory Workers*, International Center for Research on Women, Women and AIDS Research Program, Report-in-Brief (1997).
- ⁸ *Ibid.*
- ⁹ *Female Sex Worker HIV Prevention Projects: Lessons Learnt from Papua New Guinea, India and Bangladesh*, UNAIDS Case Study (2000).
- ¹⁰ S. Singh and S. Chowdhury, *A Dream, A Pledge, A Fulfillment: Five Years; Stint at Sonagachi 1992-97*, All India Institute for Hygiene and Public Health, Calcutta.
- ¹¹ C. Campbell, 'Migrancy, Masculine Identities and AIDS: The Psychosocial Context of HIV Transmission on the South African Gold Fields' (1997) 45(2) *Social Science Medicine* 272-284
- ¹² UNAIDS and the Prince of Wales Business Leaders Forum, *The Business Response to HIV/AIDS: Innovation and Partnership* (1997).
- ¹³ Family Health International/USAID, *Workplace HIV/AIDS Programs: An Action Guide for Managers*
- ¹⁴ C. Campbell, *Letting Them Die: Why HIV/AIDS Prevention Programs Fail* (2003).
- ¹⁵ C. Campbell and Z. Mzaidume, 'Grassroots Participation, Peer Education, and HIV Prevention by Sex Workers in South Africa' (2001) 91 (12) *American Journal of Public Health* 1978-87.
- ¹⁶ *Ibid.*
- ¹⁷ UNAIDS, *The Lesedi Project: HIV Prevention in Mining Communities*, Best Practice Digest (2001).
- ¹⁸ G. George, *Company Practices: Company Actions on HIV/AIDS in the Durban Metropolitan Area*, HEARD, supported by DFID and the Durban Chamber of Commerce and Industry (2002).
- ¹⁹ Synergy Project, *Keeping Up with the Movement: Preventing HIV Transmission in Migrant Work Settings* (2003).
- ²⁰ ICFTU, *AIDS: The Fear Syndrome* (2000).
- ²¹ B. Rau, *Combating Child Labor and HIV/AIDS in Sub-Saharan Africa*, ILO, International Programme on the Elimination of Child Labor, Paper No. 1 (2002).
- ²² Horizons Report, *Operations Research on HIV/AIDS: HIV/AIDS Workplace Programs – Mobilizing Managers, Crafting Policies, Educating Workers*, Population Council (June 2003).
- ²³ UNAIDS, *Summary Booklet of Best Practices*, Issue 1 (1999) and *The Private Sector Responds to the Epidemic: Debswana – A Global Benchmark*, UNAIDS Case Study (2002).
- ²⁴ UNAIDS and International Organisation of Employers, *Employers' Handbook on HIV/AIDS: A Guide for Action* (2002).
- ²⁵ *Ibid.*
- ²⁶ UNAIDS and International Hotel and Restaurant Association, *The Challenges of HIV/AIDS in the Workplace: A Guide for the Hospitality Industry* (1999).
- ²⁷ UNAIDS, *Summary Booklet of Best Practices*, Issue 1 (1999)
- ²⁸ UNAIDS, *Reducing Girls' Vulnerability to HIV/AIDS: The Thai Approach*, Best Practice Case Study (1999).
- ²⁹ UNICEF, *Asia-Pacific Answers: Good Practices in Combating Commercial Sexual Exploitation of Children and Youth* (2001)

-
- ³⁰ Health Economics and HIV/AIDS Research Division (HEARD) *The Impact of HIV/AIDS on Civil Society: Assessing and Mitigating Impacts – Tools and Models for NGOs and CBOs* (2002) and Southern African Training Programme, *Mainstreaming Gender in the Response to AIDS in Southern Africa: A Guide for the Integration of Gender Issues into the Work of AIDS Service Organizations* (2001).
- ³¹ The KHANA medical policy enables payment of 90% of medical cost claims up to a maximum of US\$400 pa per staff member, with the Executive Director having a discretion to extend this amount by a further \$200 for chronic illnesses, and beyond this amount by a decision of the Board of Trustees.
- ³² International HIV/AIDS Alliance, *Developing HIV/Workplace and Medical Benefits Policies with Partners in Cambodia, Burkino Faso and Senegal* (2003).
- ³³ The Manual has been field tested in eight countries and contains training modules for workshops to be facilitated over several days, including human rights and development issues using a gender framework
- ³⁴ It looks at issues of rights to health (including reproductive health - article 12), non-discriminatory participation in public and political life, education and work (articles 7, 10 and 11), equality rights in relation to legal capacity, financial matters and marital and family relations (articles 13, 15 and 16), suppressing trafficking and sexual exploitation of women (article 6), removing social and cultural patterns of male and female conduct that are based on stereotypes or prejudices (article 5), and barriers to health identified by the CEDAW Committee, including violence against women and female genital mutilation
- ³⁵ UNAIDS, *Resources Packet on Gender and AIDS* (2002).
- ³⁶ J. Lewis, *Gendering Prevention Practices: A Practical Guide to Working with Gender in Sexual Safety and HIV/AIDS Awareness Education*, NIKK (2003) and UNAIDS, *Resource Pack on Gender and AIDS: Best Practices/Programmes that Work* (2002). The Living For Tomorrow Project was piloted in Estonia in 1998. Some of the exercises include gender mapping, identifying valued gender characteristics and sexual expectations, imaging equality, visualizing realities and change, and discussing a questionnaire about gender traditions as HIV risks. Lessons learned from the project were to include male as well as female facilitators, as sex education has traditionally been a female preserve in Baltic States. Also the concept of gender needed to be locally relevant, and distinguished from former Soviet ideologies of equality and negative stereotypes of Western feminism
- ³⁷ *Facing the Challenges of HIV, AIDS, STDs: A Gender-based Response*, Royal Tropical Institute (Netherlands), Southern Africa AIDS Information and Dissemination Service and WHO (1995)
- ³⁸ C. Campbell and Y. Mzaidume, 'How Can HIV be Prevented in South Africa? A Social Perspective' (2002) 324 *British Medical Journal* 229-232.
- ³⁹ N. Kaleeba et al, *Open Secret: People Facing up to AIDS in Uganda*, Strategies for Hope Series 15, Action Aid (2000).
- ⁴⁰ K. Paine et al, '“Before We Were Sleeping, Now We are Awake” Preliminary Evaluation of the Stepping Stones Sexual Health Programme in the Gambia' (2002) *African Journal of AIDS Research*..
- ⁴¹ RFA Sub-group Program Implementation Subcommittee, Interagency Gender Working Group, *Guide for Incorporating Gender Considerations in USAIDS's Family Planning and Reproductive Health RFAs and RFPs* (2000)/.
- ⁴² G. Gordon and A. Welbourn, *Stepping Stones and Men: A Desk-based Review of Stepping Stones Workshops on Men*, Inter-Agency Gender Working Group (2002) and A. Welbourn, *Gender, Sex and HIV: How to Address Issues that No-one Wants to Hear About* UNESCO (2000).
- ⁴³ Stepping Stones Feedback website: www.steppingstonesfeedback.org.
- ⁴⁴ ActionAid, briefing, *Safe Crossing: The Stepping Stones Approach to Involving Men in the Prevention of Violence and HIV Transmission* (2000)
- ⁴⁵ G.R. Gupta, 'Gender Sexuality and HIV/AIDS: The What, the Why and the How' (2000) Plenary Address to the XIIIth International Aids Conference, Durban, South Africa.
- ⁴⁶ M. Heywood, *HIV/AIDS and the World of Work in South Africa: Much Ado About Nothing*, A Report to ILO (2000).
- ⁴⁷ ILO, *Gender Equality Tool: First Gender Audit* (2002)
- ⁴⁸ *Gender-based Violence and HIV/AIDS in South Africa: Organizational Responses*, Centre for AIDS Development, Research and Evaluation (2003).

⁴⁹ International Conference on Population and Development (1994) and Fourth World Conference on Women (1995)

⁵⁰ The *International Guidelines on HIV/AIDS and Human Rights*, Office of the high Commissioner for Human Rights and UNAIDS (1998).

⁵¹ S. Barrientos, C. Dolan and A. Tallontire, *Gender and Ethical Trade: A Mapping of the Issues in African Horticulture*, Natural Resources Institute Working Paper (2001).