ENDEAVOUR AND ACHIEVE

The Mombasa Polytechnic HIV/AIDS POLICY

Not all are infected but all are affected

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FOREWARD

It is an honour for me to write a forward to this important document – The Mombasa Polytechnic HIV/AIDS Policy.

The AIDS Pandemic has really emerged as one of the greatest killerdiseases the world over. Since the start of the pandemic, some millions of people have died. The disease has the highest toll among the 15-49 age bracket, which coincide with the economically useful ages in the human life-cycle. In effect, many lives are lost amongst those who would be actively engaged in economically productive activities like farming, office work, mining, working in factories, running government institutions etc. This has continued to create high levels of poverty among the world communities when parents and breadwinners leave behind hopeless and helpless dependants with no reliable sources of livelihood and social support.

It is worth noting that a great percentage of the HIV/AIDS prevalence is in the Sub-Saharan Region of Africa where Kenya is situated. There has however been noteworthy efforts by various governments, non-governmental and community-based organizations to combat this pandemic in the countries of the sub-region. National policies on HIV/AIDS, National strategies to deal with the situation and appropriate policies and programmes have been developed and implemented in various parts of Africa. These have been interpreted and translated at institutional level.

The efforts to combat HIV/AIDS have been met with various challenges. Among them are the socio-cultural and economic barriers. The greatest hurdle has been the high levels of ignorance,

stigmatization and denial among the communities, especially those rooted in their diverse cultural beliefs. Even among institutions of higher learning, there has existed an evasive attitude towards the pandemic sometimes resulting in little or no support from top-management towards HIV/AIDS programmes, no policy on HIV/AIDS in the institutions and no efforts to collaborate with other agencies on the issue.

The tertiary institutions however stand a very good chance to assist in the fight against the pandemic. These are institutions which handle a large number of the bright young people in society who are opinion-formers in their own rights and to whom society looks up to new ideas in society. The student turnover in such institutions is very high and since they are drawn from various communities and social classes, they pose the greatest opportunity, if guided well, in the fight against HIV/AIDS pandemic. The students in these institutions are sexually active and find themselves with a lot of freedom unlike in secondary schools where they were restricted. Furthermore, these are individuals who are flexible, out to acquire new skills, knowledge and attitudes for life. These are the reasons for turning to these institutions in the fight against HIV/AIDS.

The Mombasa Polytechnic, being a tertiary institution in the Coast Province of Kenya, thus recognizes that AIDS is both a health and developmental issue which concerns the entire Polytechnic community and the Kenyan Society as a whole. The Polytechnic thus strives to engage and collaborate with society in playing an active role in mitigating the effects of HIV/AIDS among its staff, students, parents/guardians and the Kenyan society as a whole.

The Polytechnic aims to achieve this by integrating HIV/AIDS activities in the Polytechnic functions and programmes including teaching, research and community service.

The Mombasa Polytechnic HIV/AIDS policy clearly articulates the various rights and responsibilities of staff and students. It is a responsibility for all of us to read and internalize the Policy and, more important, take our responsibility and commitment to implement it in entirety for the management and mitigation of HIV/AIDS both in the Polytechnic and in Kenya as a nation.

"Three people die every five minutes from AIDS in Kenya. What are you doing about it?" (Ministry of Health, The Daily Nation Newspaper of April 4, 2003 page 30) If this trend continues unabated there will come a time when Kenya will have only very old people.

Let us join hands and act now to save our posterity.

K. Kbech
Chief Principal

ACKNOWLEDGEMENT

The AIDS epidemic is a threat to mankind's future existence. Many institutions are confronted by the disease and do not know how to handle it and its other related facets. They do not have clear policy guidelines on how to deal with HIV/AIDS and other related issues.

The Mombasa Polytechnic is no exception and has risen to the challenge and made a deliberate effort to come up with an HIV/AIDS Policy which is in line with the Kenya National HIV/AIDS Strategic Plan.

This policy is a product of various individuals and groups who have made positive contributions towards its formulation. We are highly indebted in particular, to the Working Group on Higher Education of the Association for the Development of Education in Africa (WGHE/ADEA) for the material and moral support/advise in formulating the policy. We are especially grateful to M/S Georgia De Silva and more so Mrs. Alice Sena Lamptey who came in person to initiate the policy formulation process. The HIV/AIDS Policy Formulation Co-ordinating Team of: Mr. K. Koech – Principal, Mr. Juma Mdigo – Deputy Principal, Mr. A. M. Gekonge – Registrar, Mrs. H. M. Salim – Head of Business Studies Department/Patron Peer Educators Club and Mr. J. M. Kilungu Lecturer – Business Studies, for their visionary leadership in the policy formulation exercise.

We are also highly indebted to the Board of Governors employees, Heads of Departments, Lecturers, Peer Educators Club, Students and parents for their contributions without which the policy document would not have been realized.

Lastly, we are highly indebted to the valuable contributions and support from the Mombasa Polytechnic Board of Governors for giving the impetus necessary for the formulation process.

We sincerely hope that the whole Mombasa Polytechnic Community will support the implementation of this policy.

EXECUTIVE SUMMARY

A. BACKGROUND

OVERVIEW OF THE HIV/AIDS SITUATION IN THE COUNTRY

HIV/AIDS was first diagnosed in Kenya in 1984. Since then, the lives of infected individuals, their families, and communities, the companies and agencies they work for, and the society as a whole are all affected by the HIV/AIDS pandemic.

By June 2000, it was estimated that 1.5 million people in Kenya had died of AIDS according to a report by the National Aids Control Council of Kenya. Cumulative deaths due to HIV/AIDS in Kenya were forecasted to rise to 2.6 million by the end of 2005, if no interventions are introduced. The main modes of Transmission of HIV are sexual contact (90%), mother-to-child transmission (9%) and contact with blood (1%).

The National AIDS Control Council (NACC) of Kenya estimates that the national adult prevalence rose from 5.3 percent in 1990 to 13.1 percent in 1999. The national adult prevalence in Kenya shows signs of stabilizing below 14 percent and eventually declining if effective interventions are effectively implemented. The prevalence is generally higher in urban areas, with an average of 16-17% than in rural areas, which have an average of 11-12%. However, this data is collected from urban areas mainly where there is ready access to hospital facilities.

Table: NATIONAL SEROPREVALENCE TRENDS IN KENYA (1990-1999)

	NATIONAL HIV POPULATION				URBAN ADULTS		RURAL ADULTS	
	'000'			%	'000'	%	'000'	%
Year	Children	Adults	Total	Prevalence	Population	Prevalence	Population	Prevalence
1990	32	510	542	5.3	140	9.0	370	4.6
1991	40	660	700	6.6	180	10.8	480	5.8
1992	48	820	868	7.4	220	12.8	600	6.9
1993	56	970	1026	7.8	250	13.7	720	8.0
1994	64	1140	1204	9.0	290	14.8	850	9.1
1995	70	1290	1360	11.0	320	15.7	970	10.0
1996	76	1450	1526	11.9	350	16.3	1100	10.8
1997	81	1580	1661	12.8	380	16.8	1200	11.4
1998	84	1710	1794	13.9	410	17.2	1300	11.8
1999	89	1840	1929	13.1	440	17.5	1400	12.2

Source: National AIDS Control Council, 2000.

Available data from AIDS surveillance units which are not well distributed geographically throughout Kenya, shows that 80-90% of infections are in the 15-49 year age group and 5-10% occur in children less than 5 years of age. Most AIDS related deaths occur between the ages of 25-35 for men and between 20-30 for women. Assuming an average incubation period of nine to ten years, these deaths suggest that most infections occur in the teens and early 20s. This also suggests that young women are more vulnerable to infections than men of their own age group.

A close look at the Kenya National HIV/AIDS Strategic Plan (Kenya Government, 2000) reveals the following interventions

as the priority areas in the education sector (in which the Mombasa Polytechnic is classified):

- Prevention and advocacy
- Enhanced community care for HIV/AIDS patients to avoid children being kept out of school to take care of sick relatives.
- Affirmative action by local community leaders, Government, NGOs and local authorities in terms of school bursary funds etc,
- Better parenting of teenage children through inculcating good moral values,
- Affirmative action to increase girl child education.
- Using teachers as role models to sensitise school going children and the wider community on the dangers posed by HIV/AIDS pandemic,
- Counselling and senitisation of the teaching fraternity, from college to the practicing teachers,
- Better succession management in the education sector,
- Introduce family life education in schools to ensure and sustainability of the strategic plan in the context of the education sectors,
- Enhanced resource mobilization to cater for the wider school curricular through the MTEF budgetary process and development partners,
- Research, and development of Information, Education and Communication (IEC) and AIDS curriculum in learning institutions.

One of the Key priority areas of the NACC strategic plan is the promotion of behaviour change among priority groups including the youth and adolescents in school and out ofschool, women and girls of which the Polytechnic handles a great number.The key objective being to reduce the HIV/AIDS prevalence by 10% annually to reach a target programme of 20-30% reduction in Kenya by 2005. This will be achieved through promotion of safer sexual behaviour and promotion of safer non-sexual behaviour practices by the year 2004. The main strategies set out to achieve these are:

- Teaching of HIV/AIDS in schools and colleges,
- Strengthening advocacy and social mobilization activities in all sectors and at all levels,
- Enhancing community participation and partnership through decentralization;
- Capacity building of targeted groups;
- Integrating HIV/AIDS related information into all service delivery posts of all sectors including schools and colleges; and strengthening condom programming initiatives including social marketing activities

B. **AIMS**

It is in the light of the above interventions and strategies that the Mombasa Polytechnic as an educational institution intends to make a contribution. We aim to formulate an institutional HIV/AIDS policy to guide all HIV/AIDS related activities and decisions within the institution.

We also aim at publishing and distributing HIV/AIDS awareness-related literature (magazine) within the institution and its environments as an educational and awareness creation strategy.

C. **OBJECTIVES**

(1) To develop an institutional HIV/AIDS Policy for use in the Mombasa Polytechnic

(2) To promote HIV/AIDS education and training in the Mombasa Polytechnic and its environments,

(3) To reduce the HIV/AIDS prevalence through promotion of safer sexual behaviour and safer non-sexual practices in the Polytechnic community.

(4) To promote changes in attitude towards HIV/AIDS and the people living with HIV/AIDS for greater social interaction and reduction of HIV/AIDS stigmatization.

(5) To encourage greater participation by the community in HIV/AIDS programmes and activities.

D. **METHODOLOGY**

To achieve the above aims and objectives, we intend to use the following activities:

(1) Develop an institutional HIV/AIDS policy

(2) Form a Technical Committee to oversee the HIV/AIDS programmes of the Polytechnic.

(3) Publish and distribute an AIDS Awareness magazine and other literature to the Polytechnic and surrounding community. (Free of charge)

(4) Organize seminars and workshops on HIV/AIDS for various segments of the Polytechnic community.

(5) Organise Drama and other related shows on HIV/AIDS internally and externally.

(6) Produce and show video tapes on AIDS to the Polytechnic and outside community.

(7) Liaise with other heads of educational establishments (schools and colleges) on HIV/AIDS

(8) Constantly and appropriately review the Polytechnic HIV/AIDS Policy and programs in line with development in the National AIDS Policy.

(9) Creat the opportunity for members of the polytechnic coommunity living with HIV/AIDS to voluntarily declare their status without fear of stigmatization and /or discrimination.

1.0 CONTEXT

1.1 INTRODUCTION

The HIV/AIDS Pandemic and the Education Sector in Kenya.

According to the National AIDS Control Council, the HIV/AIDS epidemic affects the education sector, to which the Mombasa Polytechnic belongs, in at least three ways;

- Supply and effectiveness of experienced teachers is reduced by HIV/AIDS related illness and death
- Children are kept out of school/college if they are needed at home to care for sick family members or to work in the fields to support the family and
- Children may drop out of school/college if the families cannot afford school/college fees due to reduced household income as a result of an HIV/AIDS death or increased hospital/ medication bill due to HIV/AIDS illness.

A problem facing the education sector in Kenya is that teenage children and the youth are especially susceptible to HIV infection. This poses a special challenge to educational institutions like Mombasa Polytechnic to educate its population to protect themselves. Kenya has a high literacy rate of 76 per cent for males and 67 per cent for females. With the newly introduced free primary education, figures are bound to rise. However, despite the advantages of high literacy levels nationally, the pandemic is threatening the enrolment and completion rates of students in institutions like the Mombasa Polytechnic.

Notwithstanding the above, the education sector has the infrastructure, and the human resources, which can be used as a vehicle to promote preventive behaviour and create enabling environments. The problem has been that the educational institutions have operated with some loosely defined implicit policies on the HIV/AIDS pandemic. Other institutions do not seem to have a trace of those policies at all and have assumed that the HIV/AIDS responsibilities belong to the government or the health sector or some NGO.

`It is in light of these circumstances that the Administration of the Mombasa Polytechnic in collaboration with WGHE /ADEA, has identified a dire need for a policy document on HIV/AIDS to help in the design, implementation and control of HIV/AIDS activities in the institution. This policy has been drafted by a committee on HIV/AIDS set up by the Polytechnic Administration. The Policy statements include the ideas and opinions of sampled members of various representative groups in the Polytechnic including the Board of Governors, members of teaching staff, members of non-teaching staff, students and parents/guardians.

It is inevitable that the HIV/AIDS pandemic will have a profound effect on student recruitment, enrolment and completion as well as staff recruitment and performance, both directly and indirectly. Accordingly, this policy is intended to provide an institutional response to both the national, as well as personal challenges that the HIV/AIDS pandemic poses. It is our belief that the Mombasa Polytechnic has the potential to influence behaviour formation and behaviour change among its youth.

1.2 THE MOMBASA POLYTECHNIC STRATEGY IN THE KENYA NATIONAL HIV/AIDS STRATEGIC FRAMEWORK

The Mombasa Polytechnic HIV/AIDS Policy supports the Kenya National HIV/AIDS Strategic Plan of October 2000. The Policy is also influenced by the Federation of Kenya Employers (F.K.E) Suggested Workplace Policy Guidelines on HIV/AIDS Prevention and Management.

The Mombasa Polytechnic recognizes that there is an undeniable link between human rights and public health in the context of HIV/AIDS. This has been demonstrated in studies which have shown that HIV prevention and care programmes with coercive or punitive features (Fear Appeal) result in reduced participation and increased alienation of those at risk of infection. This further prevents people from seeking HIV-related counseling, testing, treatment and support because of the fear of discrimination, lack of confidentiality and other negative consequences. The protection and promotion of human rights are thus necessary both to the protection of the inherent dignity of persons affected by HIV/AIDS and to the achievement of public health goals of reducing vulnerability to HIV infection, lessening the adverse impact of HIV/AIDS on those affected and empowering individuals and communities to respond to HIV/AIDS more positively.

1.3 THE MOMBASA POLYTECHNIC RESPONSE

The population of the Mombasa Polytechnic community is made up of individuals who are in the most susceptible HIV/AIDS age bracket (18-28 on average for students, and 18-45 on average for the staff). Most of these individuals admitted are sexually active and in the case of the students in particular sexual act even increases over their course of study at the Polytechnic. Thus it has become imperative that the Polytechnic develops a response to the HIV/AIDS pandemic for the following reasons:

(a) The Polytechnic plays a key role in the training and development of human resources in the Coast Region of Kenya. Thus it has a responsibility to build and sustain high-level program and research capacity required to fight all factors such as HIV/AIDS which may impact negatively on human resource training and development in the region.

(b) The location/position of Mombasa Polytechnic along the East African coast and industrial tourism zone of Kenya is strategically important for it to serve as focal point for disseminating HIV/AIDS prevention information in the area.

(c) Leadership; through this policy the Polytechnic will provide leadership in teaching, research, and community engagement on HIV/AIDS and its impact.

(d) By reaching the student/worker population with information on HIV/AIDS the Polytechnic reaches out to Kenyans in all parts of the country since the student population is drawn from all over Kenya and some other African countries.

2.0 PREAMBLE

The Mombasa Polytechnic as a key tertiary institution among others in Kenya recognizes the devastating impact the HIV/AIDS pandemic is wrecking on life and development in the nation.

As an institution made up of people from all walks of life Mombasa Polytechnic recognizes the negative effects HIV/AIDS stigma and discrimination could introduce into its population and therefore accepts to promote a human rights based approach to fighting the disease within its territory.

The youthful nature of the majority of the population of the Polytechnic and their being sexually active with increasing intensity as they progress through their years of study and the relationship of the sexuality factor to the spread of HIV/AIDS is also dully recognized.

Accepting its role and function as an institution that must be constantly engaged with society and its development therefore the Mombasa Polytechnic is committed to playing its full part in collaboration with other regional, national and international partners in mitigating the impact of HIV/AIDS on its internal constituency of staff and students and the Kenya society at large.

In this vein the Polytechnic will aim at achieving total engagement of all its relevant functions integrating HIV/AIDS into teaching, research and community service.

3.0 POLICY COMPONENTS

This policy has four principal components:

1. Rights and responsibilities of employees and students affected and infected by HIV/AIDS;
2. Integration of HIV/AIDS into the Polytechnic programmes/ activities.
3. Provision of Preventive, Care and Support services in the Polytechnic,
4. Implementation and Review of the Policy.

3.1.0 Rights and Responsibilities of employees and students affected and infected by HIV/AIDS

3.1.1 Rights of employees

1. Staff members infected with HIV/AIDS are entitled to the same rights, benefits and opportunities as other members of the Polytechnic community.

2. No employee or applicant for employment at the Polytechnic shall be required to undergo an HIV test, or to disclose his/her HIV/AIDS status.

3. No member of staff in the Polytechnic shall be denied to sign an employment contract or to renew an employment contract on the basis of his/her HIV/AIDS status.

4. An employee who wishes to know his/her HIV/AIDS status is entitled to seek for voluntary counseling and testing.

5. HIV/AIDS status shall not be used as a criterion in selection for staff training, promotion and other human resource development opportunities.

6. The Administration of the Polytechnic shall, upon recommendation of relevant medical authorities allow any member living with HIV/AIDS to continue in employment as long as his/her physical condition shall permit him/her to perform the essential functions of the job.

7. Employment shall not be terminated on grounds of HIV/AIDS status. HIV Status shall not be used as a basis for retrenchment, retirement or termination of employment on the basis of ill health, unless a recognized medical practitioner advises that the affected member of staff is no longer physically or mentally capable to continue his/her work.

8. Where a member of staff living with HIV/AIDS is finding it difficult to perform because of his/her deteriorating health condition, the Administration shall give serious consideration to provide alternative assignments, flexible work scheduling, job sharing, leave of absence to access medical care in accordance with government Policy on employment.

9. The HIV/AIDS status of employees shall not be disclosed to any other party (including the spouse or parents) without the informed consent of the employee concerned.

10. HIV/AIDS status shall not be reflected in the personal files of employees.

11. In case the Administration is informed about the positive HIV/AIDS status of an employee, the Administration shall treat employee's sero-positive status with absolute confidence and ensure that only authorized officers will have access to that information.

12. Employees have a right to a supportive and safe working environment in which persons with HIV/AIDS are accepted and not stigmatized.

13. Employees have a right to know of the possible risks of occupational exposure to HIV/AIDS in their working environment and its surroundings.

14. Employees have a right to access all such educational materials and information that will equip them with scientific and epidemiological evidence so as to assure them that people with HIV/AIDS infection do not pose any risk of transmission of the virus to other members.

15. No employee shall be required, except where information is needed to assist in treatment, to declare his/her HIV/AIDS status to the Administration, and non-disclosure of an employee's HIV/AIDS status shall not be a cause for disciplinary action.

16. The Polytechnic will endeavour to provide a safe working environment in which the exposure to HIV/AIDS is minimized, and also provide the necessary protective devices.

3.1.2 Rights of Students

1. No student applicant at the Polytechnic shall be required to undergo an HIV test or to disclose his/her HIV status prior to admission.

2. No student at the Polytechnic shall be required to undergo an HIV test, or disclose his/her HIV/AIDS status. Any student who wishes to know his/her HIV/AIDS status shall seek for Voluntary Counseling and Testing (VCT) from a VCT centre.

3. The HIV/AIDS status shall not be a criterion in granting students admissions, registrations, granting of loans, bursaries, scholarships or clearing prospective student leaders to vie for posts in their union.

4. The Administration shall not use HIV/AIDS status in determining admission to the polytechnic hostels or processing of meal-cards.

5. No student shall be discontinued from the Polytechnic on the grounds of their HIV/AIDS status, unless the student is no longer physically or mentally fit to continue with his/her studies.

6. The results of voluntary HIV test conducted at the Polytechnic medical center will remain confidential between the student and the person authorized to give the results.

7. The HIV/AIDS status of a student shall not be disclosed to any other party (including parent/guardian or sponsor) without the informed consent of the student concerned.

8. Polytechnic students have a right to a supportive and safe learning, playing and working environment in which persons with HIV/AIDS are accepted and not stigmatized.

9. Students have a right to a safe learning environment in which exposure to HIV is minimized, through appropriate counseling and where necessary, provision of protective devices.

3.1.3 Responsibilities of Staff and Students

1. Everyone in the Polytechnic has an individual responsibility to protect himself/herself against HIV infection.
2. Members of the Polytechnic community with HIV/AIDS have a special obligation to ensure that they behave in such a way as to pose no threat of infection to any other person.
3. The Polytechnic medical staff and science professionals have an obligation to choose professional paths that eliminate the risk of transmission to their patients, colleagues or other members.
4. Unless medically justified, no staff or students may use HIV/AIDS as a reason for lateness, absenteeism, failing to perform work, to complete assignments, to attend lectures or field trips or write examinations.
5. The Mombasa Polytechnic community has a responsibilty not to stigmatize those that are infected, rather they should endeavour to give them love.

3.2.0 INTEGRATION OF HIV/AIDS INTO THE POLYTECHNIC PROGRAMMES

3.2.1 Teaching

The Mombasa Polytechnic will support and encourage efforts by academic departments to incorporate aspects of HIV/AIDS and human rights into curricula, where possible.

The polytechnic will also offer several short courses on HIV/AIDS for all its staff and student representatives. Such courses will focus on HIV/AIDS in the workplace, including protection, performance management and legal issues. Short courses/seminars on a variety of subjects will also be offered to the Polytechnic community through appropriate departments, clubs or societies.

3.2.2 Research

The Mombasa Polytechnic will collaborate with other learning institutions and public health authorities in HIV/AIDS related research.

The Polytechnic will use its research for Policy review, teaching, community service and endeavour to influence developments related to the prevention and the search for cure of HIV/AIDS. The HIV/AIDS co-ordination committee will request for research project proposals related to HIV/AIDS from the various academic departments and will also assist in securing financing of such proposals.

3.2.3 Community Service

The Polytechnic commits itself to collaborate with the community in training and research on HIV/AIDS. It is essential that there is full community participation in the HIV/AIDS programme and that there is good flow of support between the Polytechnic and various communities and community structures. The Polytechnic will share its experience and best practice with NGOs, CBOs, and any other interested parties. This will include such activities as community visits, drama and video shows, community sensitization and educational campaign designed to promote prevention and management of HIV/AIDS.

3.3.0 PROVISION OF PREVENTIVE, CARE AND SUPPORT SERVICES AT THE POLYTECHNIC

3.3.1 Awareness and Prevention Measures

The Mombasa Polytechnic has a duty to educate and inform its members about HIV/AIDS. Appropriate information on all aspects of prevention and care will be made accessible to staff and students. The following strategies will also be employed to prevent the spread of HIV/AIDS in the Polytechnic:

- Encouraging responsible sexual behaviour including Abstinence from sex, mutual faithfulness/reduction in multiple sexual partnerships, and consistent and correct use of condoms.
- Providing HIV/AIDS materials through an HIV/AIDS resource center.
- Distributing literature on HIV/AIDS including pamphlets, magazines, posters, leaflets etc.
- Sponsoring educational activities such as dramas, discussions, debates, Video shows, film shows, guest visits etc. on HIV/AIDS.
- Organising training of HIV/AIDS Education Programme animators to co-ordinate AIDS education in the Polytechnic.

- Organising training of Peer Educators from amongst the staff and students to sensitize their colleagues and students respectively on the nature and prevention of HIV/AIDS.
- Organising HIV/AIDS awareness promotional campaigns.
- Increasing the awareness of sexually transmitted diseases (STDs) and their prevention and treatment.
- Acting against sexual harassment both in class and at work.
- Making condoms available throughout the Polytechnic departments and in Students Centres.

3.3.2 Counselling, Care and Support

Staff and students will have access to voluntary and confidential counselling services on HIV/AIDS at the Polytechnic in accordance with WHO Guidelines on Counselling. The Polytechnic will explore the possibility and establishment of a fully fledged Guidance & Counselling Office to carry out the counselling services including HIV/AIDS and STDs counselling and management. Referral services and advice for students and staff will be provided where necessary. The Polytechnic will also explore the possibility of and provision of home-based care, including nursing care, PLWHAS counselling, and training of care providers.

4.0 POLICY IMPLEMENTATION AND REVIEW

The overall responsibility for Co-ordinating implementation of this HIV/AIDS Policy lies with the Senior Management and the HIV/AIDS co-ordinating team..

This includes the Chief Principal, Deputy Principal, Registrar, Dean of Students and Heads of Departments. These will be assisted by the HIV/AIDS Co-ordinating Committee, representatives of the Mombasa Polytechnic Peer Educators Club and representatives of the Students Union.

The Co-ordinator of the Mombasa Polytechnic HIV/AIDS Committee will be responsible for Policy co-ordination and oversight. The Officer will chair the Implementation committee, comprising of staff and students and will report directly to the Chief Principal.

The functions of the Implementation Committee include:

- Disseminating and coordinating the HIV/AIDS Policy throughout the Polytechnic.
- Disseminating information and coordinating the HIV/AIDS activities throughout the Polytechnic. These include pamphlets, video films, drama, debates etc.
- Organizing regular consultative meetings with the Polytechnic Community about matters related to HIV/AIDS.
- Collaborating with the Government and NGOs which run HIV/AIDS Programmes.
- Collaborating with the community and other tertiary institutions and stakeholders.

- Organising training of Peer Educators from amongst staff and students to sensitize their colleagues on HIV/AIDS
- Establishing and implementing a system of policy monitoring and evaluation.

The Polytechnic will establish an appropriate budget line for the implementation of this policy. A strategic workplan will guide the implementation of this policy. This policy will be subjected to regular review and appraisal in response to emerging changing trends in society.

APPENDIX I

What is Voluntary Counselling and Testing?

Voluntary Counselling and Testing (VCT) is Counselling and Testing for the virus that causes AIDS (HIV). VCT is Voluntary. Therefore no one should be forced to do it. Counselling is an essential part of VCT before and after being tested for HIV.

Who can ask for VCT?

VCT is for people who want to know whether one is infected or not infected with the virus that causes AIDS. Clients can test as couples if they so wish, especially those preparing to get married, re-uniting or separating for a period.

Anyone aged 18 or over can use VCT services. However, individuals who are below the age of 18 and married, have children or are sexually active are considered as mature minors and can use VCT services.

Confidentiality

VCT services are confidential. This means the Health Worker does not need to know your name and will not tell anyone else your result. Instead you are given a number which is unique to you alone. All service providers have been trained to keep confidentiality.

The Process of Testing for HIV

Before blood is taken from you, your counselor will discuss with you, your risk of infection, the meaning of the different HIV results and how you can live longer if you have HIV. A small blood sample will be taken by a finger prick and tested. You can learn of your results within an hour's time, or even less, depending on the Test method used.

Benefits of knowing your HIV status.

If you are infected, you can:-

- Get ongoing counselling and information on how to keep healthy
- Get TB Preventive Therapy
- Receive early treatment for infections such as TB
- Protect your unborn child from getting infected with the virus
- Protect your partner from getting infected
- Make decisions regarding marriage and having children
- Prepare your family to receive the information that you are infected

If you are not infected, you can

- Stop worrying that you may be infected
- Become empowered on how to protect yourself from getting infected
- Make informed plans for marriage and having children (if your partner is also tested)

What other support services are available?

Ask for more information from the counselor about medical treatment, nutrition, family planning, legal issues, children care, HIV prevention, peer support etc.

APPENDIX II

WHO COUNSELLING GUIDELINES FOR HIV TESTING

COUNSELLING BEFORE HIV TESTING OR SCREENING

Undergoing a test for HIV infection is likely to be an important step in a person's life, and should always be accomplished by pre-test and post-test counselling.

THE AIM OF PRE-TEST COUNSELLING

Counselling before the test should provide individuals who are considering being tested with information on the technical aspects of screening and the possible personal, medical, social, psychological, and legal implications of being diagnosed as either HIV-positive or HIV-negative. The information should be given in a manner that is easy to understand and should be up to date. Testing should be discussed as a positive act that is linked to changes in risk behaviour.

A decision to be tested should be an informed decision. Informed consent implies awareness of the possible implications of a test result. In some countries, the law requires explicit informed consent before testing can take place: in others, implicit consent is assumed whenever people seek health care. There must be a clear understanding of the policy on consent in every instance, and anyone considering being tested should understand the limits and potential consequences of testing.

Testing for HIV infection should be organised in a way that minimizes the possibility of disclosure of information or of discrimination. In screening, the rights of the individual must also be recognized and respected. Counselling should actively endorse and encourage those rights, both for those being tested and for those with access to the records and results. Confidentiality should be ensured in every instance.

ISSUES IN PRE-TEST COUNSELLING

Pre-test counseling should focus on two main topics: first, the client's personal history and risk of being or having been exposed to HIV; secondly, assessment of the client's understanding of HIV/AIDS and previous experience in dealing with crisis situations.

ASSESSMENT OF RISK

In assessing the likelihood that the person has been exposed to HIV, the following aspects of his or her life since about 1990 should be taken into account:

- Frequency and type of sexual behaviour: specific sexual practices, in particular, high risk practices such as vaginal and anal intercourse without use of condoms, unprotected sexual relations with prostitutes;
- Being part of a group with known high prevalence of HIV infection or with known high-risk life-styles, for example, users of injecting drugs, male and female prostitutes and their clients, prisoners, and homosexual and bisexual men;

- Having received blood transfusion, organ transplant or blood or body product;
- Having been exposed to possibly non-sterile invasive procedure, such as tattooing and scarification.

ASSESSMENT OF PSYCHOSOCIAL FACTORS AND KNOWLEDGE

The following questions should be asked in assessing the need for HIV testing:

- Why is the test being requested?
- What particular behaviour or symptoms are of concern to the client?
- What does the client know about the test and its uses?
- Has the client considered what to do or how he/she would react if the result is positive, or it is in negative?
- What are the client's beliefs and knowledge about HIV transmission and its relationship to risk behaviour?
- Who could provide (and is currently providing) emotional and social support (family, friends, others)?
- Has the client sought testing before and, if so, when, from whom, for what reason, and with what result?

The initial counselling should include a discussion and assessment of the client's understanding of (a) the meaning and potential consequences of a positive or a negative result, and (b) how a change in behaviour can reduce the likelihood of infection or transmission to others.

Pre-test counselling should include a careful consideration of the person's ability to cope with the diagnosis and the change that may need to be made in response to it. It should also encourage the person being counseled to consider why he or she wishes to be tested and what purpose the test will serve. When asking about personal history, it is important to remember that the client:

- May be too anxious to absorb fully what the counsellor says;
- May have unrealistic expectations about the test; and
- May not realize why questions are being asked about private behaviour and therefore be reluctant to answer.

During pre-test counseling, it is also important that the client be told that current testing procedures are not infallible. Both false-positive and false-negative results occur occasionally, although supplementary (confirmatory) test are very reliable if an initial test is positive. These facts must be clearly explained, together with information about the "window" period during which the test may be unable to assess the true infection status of the person.

IF TESTING IS NOT AVAILABLE

There may be locations where reliable facilities for testing are not readily available. Where this is so, every effort should be made to emphasize prevention counselling, especially the need for changes in behaviour among people who have engaged in high-risk activities, and the reinforcement of appropriate behavioural changes.

COUNSELLING AFTER HIV TESTING OR SCREENING

Counselling after testing will depend on the outcome of the test, which may be a negative result, or an equivocal result.

COUNSELLING AFTER A NEGATIVE RESULT

It is very important to discuss carefully the meaning of a negative result (whether this was anticipated or not). The news of being uninfected is likely to produce a feeling of relief or euphoria, but the following points should be emphasized:

- Following a possible exposure to HIV, there is a "window" period during which a negative test result cannot be considered reliable. This means that, in most cases, at least three months must have elapsed from the time of possible exposure before a negative test can be considered to mean that infection did not occur. A negative test result carries greater certainty if at least six months have elapsed since the last possible exposure.
- Further exposure to HIV infection can be prevented only by avoiding high-risk behaviour. Safer sex and avoidance of needle-sharing must be fully explained in a way that is understood and permits appropriate choices to be made.
- Other information on control and avoidance of HIV infection, including the development of positive health behaviour, should be provided. It may be necessary to repeat explanations and for the counsellor and the person being counselled to practice methods of negotiating with others in order to assist the client in introducing and maintaining new behaviour.

COUNSELLING AFTER A POSITIVE RESULT

People diagnosed as having HIV infection or disease should be told as soon as possible. The first discussion should be private and confidential, and then the client should be given time to absorb the news. After a period of preliminary adjustment, the client should be given clear, factual explanation of what the news means. This is the time for acknowledging the shock of the diagnosis and for offering and providing support.

It is also the time for encouraging hope for achievable solutions to the personal and practical problems that may result. Where resources are available, it may also be justifiable to talk of possible treatments for some symptoms of HIV infection and about the efficacy of anti-viral treatments.

How the news of HIV infection is accepted or incorporated often depends on the following:

1. The person's physical health at the time. People who are ill may have delayed reaction. Their true response may appear only when they have grown physically stronger.

2. How well prepared the person was for the news. People who are completely unprepared may react very differently from those who were prepared and perhaps expecting the result. However, even those who are well prepared may experience the reactions described in the following pages.

3. How well supported the person is in the community and how easily he or she can call on friends. Factors such as job satisfaction, family life and cohesion, and opportunities for recreation and sexual contact may be make a difference in the way a person responds. The reaction to the news of HIV infection may be much worse in people who are socially isolated and have little money, poor work prospects, little family support, and inadequate housing.

4. The person's pre-test personality and psychological condition. Where psychological distress existed before the test result was known, the reactions may be either more or less complicated and require different management strategies than those found in persons without such difficulties. Post-result management should take count of the person's psychological and/or psychiatric history, particularly as the stress of living with HIV may act as a catalyst for the reappearance of earlier disturbance.

   In some cases, news of infection can bring out previously unresolved fears and problems. These can often complicate the process of acceptance and adjustment and will need to be handled sensitively, carefully, and soon as possible.

5. The cultural and spiritual values attached to AIDS, illness, and death. In some communities with a strong belief in life after death, or with a fatalistic attitude towards life, personal knowledge of HIV infection may be received more calmly than in others. On the other hand, there may be communities in which AIDS is seen as evidence of antisocial or blasphemous behaviour and is thus associated with feelings of guilt and rejection.

Counselling and support are most needd when reactions to the news of HIV infection and disease appear. Some reactions may initially be very intense. It is important to remember that such responses are usually normal reactions to life-threatening news and as such should be anticipated.

PSYCHOLOGICAL ISSUES

The psychological issues faced by most people with HIV infection or diseases revolve around uncertainty and adjustment.

With HIV infection, uncertainty emerges with regard to hopes and expectations about life in general, but it may focus on family and job. An even more fundamental uncertainty may concern the quality of life and life span, the effect of treatment, and the response of society. All these are relatively unpredictable in terms of their long-term outcome. They need to be discussed openly and frankly, but care should always be taken to encourage hope and positive outlook.

In response to uncertainty, the person with HIV must make a variety of adjustments. Even the apparent absence of a response may, in itself, be an adjustment through denial. People start to adjust to news of their infection or disease from the time they are first told. Their day-to-day lives will reflect the tension that causes other psychosocial issues to assume more or less prominence and intensity from time to time.

FEAR

People with HIV infection or disease have many fears. The fear of dying and, particularly, the fear of isolation and pain. Fear may be based on the experiences of loved ones, friends or colleagues who have been ill with, or died of AIDS related causes. It may also be due to not knowing enough about what is involved and how the problems can be handled. As with most psychological concerns, fear and the pressures such fear creates can often be managed by bringing them clearly and sensitively into the open. They should be discussed in the context of managing the difficulties, including with the help of friends and family or with the counselor.

LOSS

People with HIV-related disease experience feelings of loss about their lives and ambitions, their physical attractiveness and potency, sexual relationships, status in the community, financial stability, and independence. As the need for care increases, a sense of loss of privacy and control over life will also be experienced. Perhaps the most common loss that is felt is the loss of confidence. Confidence can be undermined by many aspects of life with HIV, including fear for the future, anxiety about the coping abilities of loved ones and caregivers, by the negative and/or stigmatizing actions of others. For many people, recognition of HIV infection will be the first occasion that forces them to acknowledge their own mortality and physical vulnerability.

GRIEF

People with HIV infection often have profound feelings of grief about the losses they have experienced or are anticipating. They may also suffer the grief that is projected on to them by close family members, lovers, and friends. Often these same people are supporting and taking care of them on a day-to-day basis, and watching their health decline.

GUILT

A diagnosis of HIV infection often provokes a feeling of guilt over the possibility of having infected others, or over the behaviour that may have resulted in the infection. There is also guilt about the sadness the illness will cause loved ones and families, especially children. Previous events that may have caused pain or sadness to others and remain unresolved will often be remembered at this time and may cause even greater feelings of guilt.

DEPRESSION

Depression may arise for a number of reasons. The absence of a cure and the resulting feeling of powerlessness, the loss of personal control that may be associated with frequent medical examinations, and the knowledge that a virus has taken over one's body are all important factors. Similarly, knowing others or about others who have died or are ill with HIV-related disease, and experiencing such things as the loss of potential for procreating and for long-term planning may contribute to depression.

DENIAL

Some people may respond to news of their infection or disease by denying it. For some people, initial denial can be a constructive way of handling the shock of diagnosis. However, if it persists, denial can become counter-productive, since people may refuse to accept the social responsibilities that go with being HIV positive.

ANXIETY

Anxiety can quickly become a fixture in the life of the person with HIV, reflecting the chronic uncertainty associated with the infection. Many of the reasons for anxiety reflect the issues discussed above and concern the following:

- prognosis in the short and long term
- risk of infection with other diseases
- risk of infecting others with HIV
- social, occupational, domestic, and sexual hostility and rejection
- abandonment, isolation, and physical pain
- fear of dying in pain or without dignity
- inability to alter circumstances and consequences of HIV infection
- how to ensure the best possible health in the future
- ability of loved ones and family to cope
- loss of privacy and concern over confidentiality
- future social and sexual unacceptability
- declining ability to function efficiently
- loss of physical and financial independence.

ANGER

Some people become outwardly angry because they feel they have been unlucky to catch the infection. They often feel that they have been, or information about them has been badly or insensitively managed. Anger can sometimes be directed inwardly in the form of self-blame for acquiring HIV, or in the form of self-destructive (suicidal) behaviour.

SUICIDAL ACTIVITY OR THINKING

People who are HIV infected have a significantly increased risk of suicide. Suicide may be seen as a way of avoiding pain and discomfort or of lessening the shame and grief of loved ones. Suicide may be active (i.e deliberate self injury resulting in death) or passive (i.e concealing or disregarding the onset of a possibly fatal complication of HIV infection or disease).

SELF-ESTEEM

Self-esteem is often threatened early in the process of living with HIV. Rejection by colleagues, acquaintances, and loved ones can quickly lead to loss of confidence and social identity, and thus to reduce feelings of self-worth. This can be compounded by the physical impact of HIV-related diseases that cause, for example, facial disfigurement, physical wasting, and loss of strength or bodily control.

HYPOCHONDRIA AND OBSESSIVE STATES

Preoccupation with health and even the smallest physical changes or sensations can result in hypochondria. This may be transient and limited to the time immediately after the diagnosis, or it may persist in people who find difficulty in adjusting to the disease.

SPIRITUAL CONCERNS

Concern about impending death, loneliness, and loss of control may give rise to interest in spiritual matters and a search for religious support. Expressions of sin, guilt, forgiveness, reconciliation, and acceptance may appear in the context of religious and spiritual discussions.

Many of these and other concerns will appear or become more pronounced when a diagnosis of HIV is made. The appearance of new infections, cancers and periods of severe fatigue all have significant emotional and psychological impact. The effect is likely to be even greater if the person with AIDS has been rejected by family or friends and has withdrawn from normal social relationships.

OTHER COUNSELLING ISSUES

HIV infection often highlights other issues critical to quality of life.

SOCIAL ISSUES

Environmental and social pressures, such as loss of income, discrimination, social stigma (if the diagnosis becomes commonly known), relationship changes, and changing requirements for sexual expression, may contribute to post-diagnosis psychosocial problems. The patient's perception of the level and adequacy of social support is of vital concern and may become a source of pressure or frustration.

MEDICAL MANAGEMENT

The type of counseling support usually required and requested is often influenced by the person's experiences with other forms of health care related to the infection. Where the patient or loved ones feel that medical management has been insensitive or has been conducted without sufficient regard for privacy, counseling may be all the more necessary in order to persuade the patient to comply with recommended treatment programmes.

Counselling may also involve helping the person gain access to appropriate medical care and greater participation in decisions about treatment. If there is any evidence of neurological disease, day-to-day management of the patient may be complicated, and special emphasis will have to be given to counseling of family, loved ones and care-givers.

At this stage, counselors may need to co-ordinate a range of health and social services. Many people with HIV will also seek care from traditional or complementary healers: this may first be revealed in the context of supportive counseling. Where this is the case, counseling can help patients talk about their perceived needs and their satisfaction with these caregivers.

COUNSELLING AFTER AN EQUIVOCAL TEST RESULT

If the result of the HIV test is equivocal, the counselor has particular responsibilities to provide information. In particular, there are two main issues to cover:

1. The person should be given a clear explanation of what such a test result means. The first test most commonly used on all samples is the enzyme-lined immunosorbent assay (ELISA). The ELISA has levels of sensitivity and specificity approaching 99.5%, meaning that a non-reactive result with this technique can be regarded as a definite indicator that the person is not infected, except for test during the "window period". However, a reactive result suggests the possibility of HIV infection. The usual procedure in that case is to perform a second test using the ELISA; if the second ELISA test is also positive, supplementary testing is required, for example using the Western blot test. The results of such supplementary testing may be positive (indicating no infection), or indeterminate (giving an equivocal result). Where the result of supplementary testing is indeterminate (which may be the case in up to 10% of samples in some areas), the reason may be one of the following:

the test is cross-reacting with a non-HIV protein (usually, the protein reaction is simulating the reaction associated with p24 core protein).

- There has been insufficient time for full sero-conversion to occur since the person was exposed to HIV.

When presented with an indeterminate result, the options are to:

- Use other methods to try to achieve a reliable result. Combinations of laboratory techniques may be needed to exclude false-positive results.
- Refrain from further testing for the moment. If the result is indeterminate and further testing is not possible, the person cannot realiably be considered HIV-infected. The counselor should advise the person to come for repeat testing in three months. It is important to remember that the risk of finding a false-positive result in the ELISA is higher in areas with a low level of HIV infection than where the background rates of HIV infection are high. Thus, in places where there are many people with AIDS in the community, it is more likely that a reactive or positive resulting the ELISA is accurate.

2. Prevention and support while waiting for an unequivocal result. The period of uncertainty following an equivocal test result may be three months or longer. It is important for counselors to stress essential messages related to prevention of transmission, regarding sexual activity, drug use, donation of body fluids or tissues, and breast-feeding. Just as importantly, however, the uncertainties associated with this period may lead to acute and sever psychosocial difficulties, and the counselor must be prepared to assess and man age such issues or to make appropriate referrals, if possible.

SELF-HELP GROUPS

In some places, the counselor can call on peer-support or self-help groups, part of a growing network of non-governmental AIDS Service Organizations (ASOs). These can provide a type of personal care and peer-based psychosocial support that may not be available elsewhere. If no such groups exist, the counselor may be able to encourage clients to form one.

Where this is not possible, the counselor may be able to put clients in touch with each other on an individual basis, at the discretion of the counselor and with the express consent of the individuals and on a confidential basis. Matters that are often best dealt with through self-help groups, but which need to be raised by the counsellor in any event, include the following:

1. Learning to live with HIV infection. Self-help groups are often in a good position to address this because many of the people involved may have already gone through the process. They can describe the medical and psychological problems they have experienced and the interventions they have found most useful.

2. Helping care-givers and loved ones handle the pressures of living with sick or distressed people on a daily basis, especially where this involves managing bleeding, vomiting, incontinence, disposal of dressings, etc., and advice regarding sexual relations.

3. Reducing stress and avoiding conflict. The need to overcome anxiety, depression and other possible challenges to sustained health has to be handled on a practical, "I did this..." basis.

4. Deciding how best to talk about HIV/AIDS. Fears of disclosing a diagnosis of HIV or AIDS to loved ones, family, friends, and colleagues need to be examined and solutions sought, including what to say, to whom, when, and how.

5. Dealing with feelings of loneliness, depression, and powerlessness. Self-help or peer support groups can provide help and mutual support. Advice from people who have themselves gone through such feelings may be more meaningful than advice provided on a second-hand or theoretical basis.

6. Managing the implications of adopting and maintaining safer sex behaviour. Peer support groups can organize discussions and training that can be far more relevant than advise provided through formal health care programmes, peer commitment to safer sex also helps make these practices socially acceptable, attractive and thus sustainable.

The essence of peer-support group activity is a feeling of group cohesion, a sharing of experiences and mutually supportive activities. At times, such groups may need help in getting started and in maintaining regular activities. They will all look to the counselor for help in identifying medical services and caregivers. Providing legal advice and, in some cases, financial support may also become issues in establishing such groups and giving them operational legitimacy.

APPENDIX III

FACTORS HAMPERING THE FIGHT AGAINST HIV/AIDS IN KENYA

- The culture of denial.
- Ignorance about the causes of AIDS amongst the general population with some attributing HIV/AIDS to witchcraft or to curses arising from breaches of some communal taboos by the victims of HIV/AIDS.
- Enforced idleness amongst the unemployed youth who lack appropriate recreational facilities.
- Lack of access to medical treatment because of grinding poverty amongst the populace.
- Unaffordable anti-retroviral drugs.
- Lack of commitment by some employers to assist their employees to cope with the ravages of HIV/AIDS.
- The tendency amongst employees not to reveal their sero-positive status for fear of either losing their jobs or rejection by their work colleagues.
- Resistance by some religious group to sex education in schools without which the youth may engage in unsafe and unprotected sex out of ignorance.
- Sharing cramped living quarters in urban areas.
- Non-availability of drugs in Government hospitals.
- Opposition by some religious groups to condom distribution who are stressing reliance on abstinence on moral grounds.
- General moral laxity amongst the youth.

- Exposure of youth to pornography and to uncensored sex films.
- Inadequate/lack of parental advice on sex.
- Lack of vigorous and sustained public campaign on HIV/AIDS by a broad section of leadership in the country.
- Traditional cleansing rituals involving sex undergone by some living spouses of AIDS victims.
- Wife inheritance in certain communities.
- Revenge/don't care attitude by some infected people "why should I die alone?"

THE IMPACT OF HIV/AIDS ON ENTERPRISES

The impact of HIV/AIDS on enterprises includes:-

- Loss of human capital, especially skilled and high-level professionals.
- Loss of production capacity as a result of HIV/AIDS related absenteeism.
- High staff turnover.
- High training and replacement costs.
- High employee healthcare costs.
- Decreased agricultural production and increased food insecurity. High social security and employee welfare costs.

SYMPTOMS OF HIV INFECTION

The early symptoms tend to be similar to those of a common illness but are persistent, more severe and are of a longer duration often upto one month. They include:

- Fever;
- Mental changes (dementia) e.g. memory loss, poor concentration etc;
- Unexplained weight loss;
- Chronic cough;
- Persistent or intermittent diarrhoea;
- Severe recurrent skin rashes;
- Severe infection of the mouth and pharynx;
- Swollen glands in the neck, armpit or groin.

Where the above symptoms persist for more than two weeks, medical evaluation is recommended at the earliest opportunity.

TRANSMISSION OF HIV INFECTION

The AIDS virus tends to concentrate its attacks on the body fluids, especially the **BLOOD**, **SEMEN** and **VAGINAL SECRETIONS**. It has however, been established that transmission takes place in three ways;-

- Through sexual intercourse – most common mode.
- Through Blood e.g. transfusion, non-sterile injection, equipment, organ/tissue transplant etc.
- Prenatal transmission i.e from infected mother to infant, and Breast-feeding of babies by HIV-positive mothers.

NOTE: According to medical sources, there is **No evidence to suggest that AIDS can be transmitted by casual person-to-person contact** (eg. Bodily searches, hand-shakes, hugs/embraces, etc), or through insect bites, food, water, toilets, swimming pools, shared eating and drinking utensils or such items as office furniture, telephones or second-hand clothing.

PREVENTIVE/CONTROL MEASURES AGAINST HIV INFECTION

Prevention/control against HIV infection is largely dependent on individual effort and will, and easy access to available information, education and counselling services is very important.

The most commonly quoted measures are as follows:-

- Abstinence or celibacy (no sex at all).
- Avoidance of multiple sex partners – (the more the partners, the higher the risk) or total fidelity to one's spouse popularly known as "zero grazing".
- Practising safer sex through proper use of condoms (though not fool-proof).
- Avoidance of unnatural sex acts.
- Ensuring the use of sterilized needles and syringes or any other equipment used e.g. in ear-piercing, hair-dressing, acupuncture, circumcision, dental devices etc.
- Attending only clinic/health centers having sterilizing facilities.
- Avoidance of having children by those who are HIV positive.

APPENDIX IV

SOME KEY POINTS TO NOTE ABOUT HIV/AIDS STIGMA AND DISCRIMINATION

Stigma is a ***process***, not a thing.

Involves:

- Identification of 'undesirable differences' among people and societies.
- Creation of 'spoiled identities' – Defines the person as 'other'.
- Processes of distancing and devaluation –
  - Reinforcement of existing social and structural inequalities
  - Promoting processes of personal and societal
- HIV-related stigma reinforces prejudice against already marginalized groups of people and individuals, persons living with HIV/AIDS (PLWHAs), women, commercial sex workers and their families etc. When PLWHAs internalize stigma it perpetuates their invincibility in society altogether.

Reasons for stigma vary: e.g., fear of contagion and death, prejudice against already stigmatized groups, social norms about "bad" behaviours.

Stigma is harmful because it

- Can lead to feelings of shame and guilt
- Can cause individuals to become isolated

- Can cause others to do things, or omit to do things, that harm or deny services or entitlements to others.

Those stigmatized against:

PLWHAs or those at risk of HIV may be reluctant to

- Use condoms (assumes risk, infection, and/or infidelity)
- Seek an HIV test or care for sickness
- Acknowledge to themselves (denial) or others they are living with the disease.

Stigmatizers:

- Family, care-givers, providers may be reluctant to give care
- Neighbours may be violent if disclosed, or HIV suspected (e.g. stop breast-feeding)
- Women may be thrown out of the home

Social context of stigma:

- Policy may deny access to care/treatment or permit property-grabbing
- Schools, workplace may be reluctant to permit attendance.

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