Reducing Stigma and Discrimination Related to HIV and AIDS
Training for Health Care Workers

PILOT TRAINER’S MANUAL
BASED ON

Reducing Stigma and Discrimination Related to HIV and AIDS.
Training for Health Care Workers
(EngenderHealth, 2004)

May 2009
Kyiv
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INTRODUCTION

Background
Stigma and discrimination related to HIV and AIDS are a persistent problem in many health care facilities around the world, particularly in those countries hardest hit by the epidemic. Stigma and discrimination result in poor quality of care for those who are infected or ill (or suspected of being infected), frighten away potential clients in need of HIV-related and other services from seeking care, and undermine prevention efforts by limiting access and service utilization.

Stigma and discrimination in health facilities have numerous causes, including lack of knowledge among staff about the modes and risk of HIV transmission, and judgmental attitudes and assumptions about the sexual lives of people living with HIV. Another significant cause of stigma and discrimination is health workers’ fears of becoming infected during the course of their work. In the absence of assurance that they will be protected from the virus, and without access to drugs for postexposure prophylaxis, health workers may engage in behavior that can prevent HIV-positive and other vulnerable individuals from receiving lifesaving care and support.

Health workers’ negative attitudes and behaviors are also driven by beliefs and myths about HIV and AIDS, lack of knowledge and skills in HIV and AIDS clinical management and counseling, lack of drugs and supplies, limited knowledge of modes and risks of HIV transmission in health care settings, and an over-estimation of me risk of HIV infection following occupational exposure.

Training Approach and Content
To reduce stigma and discrimination in health care settings, we need to address health care workers fears about getting infected on the job, and their need to protect themselves through standard precautions. This manual uses participatory training methodologies to modify health care workers’ attitudes while giving them practical knowledge and tools to both assure client rights and meet their own needs for a safe work environment. The training covers the following:

Values clarification about HIV and AIDS
Stigma and discrimination towards people believed or known to be HIV-positive
Clients’ rights to dignify, comfort, privacy, confidentiality, and safety
Clients’ right to receive services free from discrimination
Basic information about HIV transmission
Health care staffs need for safety from injury and infection on the job
Standard precaution practices for infection prevention
Post-exposure care, including post-exposure prophylaxis

This manual contains current information and protocols for preventing and managing occupational exposure to HIV. Please note that the term standard precautions is used throughout this document Standard precautions help protect both clients and healthcare staff from exposure not only to blood, but also to other body fluids that can transmit infection. This term encompasses the commonly used term universal precautions, which refers to practices performed to protect health care staff from exposure to bloodborne microorganisms.

Who are Trainers?
This training is facilitated by a team of two trainers, one of them is an NGO representative and the other – physician of the local AIDS Center. Thus, during stigma sessions, the NGO
representative is the leading trainer, while physician of the local AIDS Center takes the lead in the sessions on HIV transmission, use of prevention means and post-exposure prophylaxis.

**Who is Target Audience?**

This training was designed for medical doctors and nurses. Trainings for doctors and nursing staff should, whenever possible, preferably be facilitated separately, since doing so will help medical nurses feel more comfortable in the training. The group should consist of no more than 25 individuals.

**How Long Is the Training?**

This is a one-day training and it lasts 6 hours.
The questionnaire below is used for pre-training evaluation. Participants should complete the questionnaire individually before the training starts.

**Instructions:** Read each statement and choose the answer that best reflects your attitudes, values, and comfort level related to HIV and AIDS and working with people who are living with HIV or AIDS.

**I believe...**
I believe that people who are infected with HIV should not be treated in the same areas as other patients in order to protect the larger population from infection.

- strongly agree
- agree
- disagree
- strongly disagree

I believe that people infected with HIV are responsible for getting infected.

- strongly agree
- agree
- disagree
- strongly disagree

I believe that HIV-positive patients are the biggest threat to my safety at my place of work.

- strongly agree
- agree
- disagree
- strongly disagree

I believe most HIV-positive health care workers get infected at work.

- strongly agree
- agree
- disagree
- strongly disagree

**I feel...**
I feel that providing health services to people infected with HIV is a waste of resources since they are going to die soon anyway.

- strongly agree
- agree
- disagree
- strongly disagree

I feel that I am at high risk of becoming infected with HIV working in the health facility.

- strongly agree
- agree
- disagree
- strongly disagree

I feel that clients who have sexual relations with people of the same sex have a right to access the highest quality of health services in my facility.

- strongly agree
- agree
- disagree
- strongly disagree

I feel that clients who are sex workers have a right to access the highest quality of health services in my facility.

- strongly agree
- agree
- disagree
- strongly disagree

**I am comfortable...**
I am comfortable providing health services to clients who are HIV-positive.

- strongly agree
- agree
- disagree
- strongly disagree

I am comfortable performing surgical or invasive procedure on clients whose HIV status is unknown.

- strongly agree
- agree
- disagree
- strongly disagree

I am comfortable sharing the bathroom with a colleague who is infected with HIV.

- strongly agree
- agree
- disagree
- strongly disagree
I am comfortable assisting or being assisted by a colleague who is infected with HIV

**Strongly agree**  **Agree**  **Disagree**  **Strongly disagree**

**I avoid...**

I avoid touching clients for fear of becoming infected with HIV

**Strongly agree**  **Agree**  **Disagree**  **Strongly disagree**

I avoid touching clients’ clothing and belongings for fear of becoming infected with HIV

**Strongly agree**  **Agree**  **Disagree**  **Strongly disagree**

I avoid performing ANY task at work without wearing latex gloves.

**Strongly agree**  **Agree**  **Disagree**  **Strongly disagree**

Withholding health services from a client believed or known to be HIV-positive is a violation of me client s human rights.

**True**  **False**

When mere are shortages of needles and syringes, it is acceptable to rinse me syringes in disinfectant solution and to reuse them as long as new needles are used.

**True**  **False**

The risk of HIV transmission following needlestick or sharps injuries is very small, approximately 1 in 300.

**True**  **False**

The risk of HIV transmission following a splash of blood or body fluids to non-intact skin or mucus membranes is very small, approximately 1 in 1,000.

**True**  **False**

Standard precautions are designed to protect only health care workers from clients who may be infected with HIV or hepatitis.

**True**  **False**

Standard precautions are also applicable when providing home-based care.

**True**  **False**

Needlestick and sharps injuries can be prevented.

**True**  **False**

It is appropriate to test clients who look like they are HIV-positive or clients preparing for surgery, to ensure that staff take precautions during surgery to prevent HIV transmission.

**True**  **False**

A pregnant staff member who is accidentally injured by a needlestick or a sharp instrument cannot receive post-exposure prophylaxis due to me risk of damage to me fetus by antiretroviral drugs.

**True**  **False**

A health worker who knows mat he/ she is HIV-positive can continue to work safely in service delivery as long as they avoid activities mat present a risk of transmission to clients.

**True**  **False**
To prevent transmission of HIV and other bloodborne infections in the health care setting, staff should wear latex gloves for every client contact, including taking vital signs.

True          False

To prevent stigma and discrimination in the health care setting, staff must treat all clients with respect and in a welcoming manner, provide privacy and confidentiality, and avoid creating segregated areas for clients who are known or believed to be HIV-positive.

True          False

If a healthcare worker has a recent cut on her/his hand, the risk of HIV transmission following contact with a client’s blood is higher than if the skin of the hand is intact.

True          False

Exposure risk procedures are invasive procedures where there is a risk of injury to the healthcare worker that may result in exposure of the client’s open tissue to the blood of the worker.

True          False
Session 1. Introduction. Introduction of participants, expectations, agenda overview, time limits

- **Objectives:**
  1. Articulate training participants’ expectations.
  2. Overview training objectives.
  3. Overview training agenda.

- **Time**
  20 minutes

- **Materials**
  - Flipchart paper
  - Markers
  - Tape
  - Pens and paper for participants
  - One copy of the agenda for each participant (annex 1)

- **Steps**
  1. Welcome participants
  2. Have participants introduce themselves and express at least one expectation that they have for the training. Write down all the expectations on flipchart paper as they are mentioned.
  3. Review the training objectives and the specific training activities, being sure to highlight which objectives and activities address participants’ expectations.
  4. Review the training agenda.

- **Handouts**
  - Agenda of Training on PLHIV stigma prevention in healthcare settings (annex 1)
Annex 1

Agenda
Training on PLHIV stigma prevention in healthcare settings

Goal:
The goal of this training module is to change healthcare providers’ attitudes toward people living with HIV (PLHIV) to be more supportive and to reduce stigma within the healthcare setting.

Training objectives:
- Improve knowledge about HIV disease (including transmission risk and post-exposure prophylaxis, universal precautions and, WHO 4 clinical stages of HIV disease);
- Improve understanding about stigma and discrimination, and their impact on PLHIV and service delivery.

Specific training activities:
- Define key concepts related to stigma and discrimination, and explore HIV-related stigma;
- Understand the implications of stigma on health care services to PLHIV and those believed to be HIV-positive;
- Assist participants to explore their own thoughts, beliefs, attitudes and behaviors about HIV to realize how they can impact their professional life;
- Provide an overview of clients’ rights and health care staff’s needs, specifically related to HIV safety for the client/patient and health care providers.
- Introduce participants to the principles and practices of universal precautions to avoid HIV, viruses of hepatitis and causative agents of other disease transmission (to and from patient and provider and HIV post-exposure prophylaxis) in healthcare settings.

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| 09.50 – 10.10 | Registration.  
               Pre-training evaluation questionnaire.                     |
| 10.10 – 10.30 | **Session 1. Introduction. Introduction of participants, expectations, agenda overview, time limits.** |
|             | **Objectives:**  
               3. Articulate training participants’ expectations.  
               4. Overview training objectives.  
               3. Overview training agenda. |
| 10.30 – 11.30 | **Session 2. Thoughts, beliefs, attitudes and behaviors about HIV disease**  
               Discussion, interactive game |
|             | **Objectives:**  
               1. Learn more about the participants’ attitude toward several potentially sensitive HIV issues.  
               2. Recognize their own thoughts, beliefs, attitudes and behaviors about HIV and realize how they can impact their professional life.  
               3. Discuss clients’ rights and health care staff’s needs, specifically those, related to HIV safety. |
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| 11.45 – 13.00| **Session 3. HIV related stigma, stigmatization and discrimination. Impact of stigmatization on the quality of life.**  
Discussion, PowerPoint Presentations (PPT)  
**Objectives:**  
1. Define stigma and discrimination.  
2. Explore how and why stigma is related to PLHIV.  
3. Explore stigmatizing language.  
4. Analyze the impact of HIV-related stigma on medical services provided to PLHIV and those believed to be PLHIV.  
5. Present the findings of the PLWH-related stigma survey among medical care providers, run under USAID|Health Policy Initiative, to the training participants.  
6. Discuss how HIV-related fears can affect the quality of client services. |
| 13.00 – 14.00| Lunch                                                                   |
| 14.00 – 15.30| **Session 4. HIV transmission overview: understanding personal and professional risk**  
Interactive game, PPT, discussion  
**Objectives:**  
1. Explore the risk of HIV transmission at different behavior models.  
2. Debunk HIV transmission myths.  
3. Identify the 4 stages of HIV disease as defined by WHO.  
4. Discuss most frequent HIV and virus hepatitis transmission risk factors to patient and provider in healthcare setting. |
| 15.30 – 15.45| Coffee-break                                                            |
| 15.45 – 17.00| **Session 5. HIV precautions at workplace for patient and provider and post-exposure prophylaxis.**  
PPT, discussion  
**Objectives:**  
1. Discuss the attitude of heath care staff toward professional HIV transmission risk.  
2. Introduce participants to the principles and practices of universal precautions to avoid HIV, hepatitis and other disease transmission (to and from patient and provider and HIV post-exposure prophylaxis) in healthcare settings.  
3. Overview the professional ways of HIV prevention in healthcare settings and post-exposure prophylaxis. |
| 17.00 – 17.30| **Session 6. Closing-up. Post-training evaluation questionnaire.**  
**Objectives:**  
1. Training participants’ feedback.  
2. Completing post-training evaluation questionnaire by training participants.  
3. Discussion of follow-up and next steps after the training. |
Session 2. Thoughts, beliefs, attitudes and behaviors about HIV disease
Discussion, interactive game

- **Objectives:**
  1. Learn more about the participants’ attitude toward several potentially sensitive HIV issues.
  2. Recognize their own thoughts, beliefs, attitudes and behaviors about HIV and realize how they can impact their professional life.
  3. Discuss clients’ rights and health care staff’s needs, specifically those, related to HIV safety.

- **Time**
  1 hour

- **Materials**
  - Flipchart paper
  - Markers
  - Tape
  - Pens and paper for participants
  - Prepare two pieces of flipchart paper by writing “Agree” on one of them and “Disagree” on the other. Post the “Agree” and “Disagree” signs on opposite sides of the room. If the training facility does not have enough space for participants to move freely during this activity, there is an option of using color stickers, where green color, for instance, will stand for agreement and blue color for disagreement.
  - A list of value statements (annex 2).

- **Steps**
  1. Explain that this exercise will help us understand viewpoints that are different from our own, and to consider how these attitudes and beliefs about HIV and AIDS might affect the way we treat clients. State that there are no “right or “wrong” answers and that we are all entitled to our own opinions.
  2. Ask participants to gather in the center of the open area. Direct their attention to the "Agree" and "Disagree" signs.
  3. Explain that you will be reading a series of value statements. After you read a statement aloud, the participants will decide whether they agree or disagree with the statement, or if they are unsure of their response. Those who agree will move and stand by the "Agree" sign. Those who disagree will move and stand by the "Disagree" sign. Those who are unsure will remain in the middle of the room, let participants know that if they hear something that causes them to change their opinion during the course of the activity, they may move from one area of the room to another.
  4. Read a statement out loud. Ask participants to move to the appropriate area of the room, according to their opinion. Invite comments from one or two participants from each location ("Agree", "Disagree," and "Unsure"), to explain why they have chosen to stand where they are.
  5. The facilitator remains neutral, by not offering interpretations for the statement that would influence participant responses. However, he or she can share factual information to clarify matters, as needed. After hearing a representative from each position, give participants the option of switching positions if they wish. When participants move, ask them what prompted their decision to change position.
  6. Repeat this process until you have posed all the statements that you wish the group to consider.
7. Ask the participants to return to their seats for a group discussion. Facilitate a discussion to explore differences of opinions and values more deeply based on the following questions.

**Key Discussion Questions**
- How can you explain the differences between individuals in this group?
- If you were an HIV-positive client at your facility, would you have a different opinion about these issues?
- Why is exploring these issues important?
- How can we keep our own values from influencing our work in a negative way?

**Training Tips**
- During this exercise, it is important to emphasize that there are no "right or "wrong" answers.
- In addition, the facilitator should remain neutral throughout the exercise and maintain a balance among the different viewpoints expressed.
- In order to explore a range of issues, you may need to limit discussion of each statement to comments from one or two participants representing each position.

8. **Summarize** the session by reviewing with participants the key points elicited from the discussion exercises.
Annex 2

Belief Statements

***DO NOT DISTRIBUTE TO PARTICIPANTS***

It is okay to isolate HIV-positive patients in a separate ward.
Patients who are HIV-positive should be treated the same as other patients.
Since there is little we can do for a patient with AIDS, it is better to spend time and limited resources
on patients with treatable illnesses.
Clients who are thought to be at high risk for HIV should be treated the same as other clients.
It is okay to reveal the HIV status of a patient to their spouse or close relatives.
A provider should be much more careful of needlestick injuries or other potential exposure
with a client who is a sex worker than with a monogamous married woman.
Health care staff should routinely be tested for HIV as a means to prevent staff from infecting clients.
Health care staff should have the right to refuse to provide services if materials they need to apply standard precautions are not available.
An HIV-positive woman should not have a baby.
People who get HIV through sex deserve it because of their behavior.
People who get HIV through injecting illegal drugs deserve it because of their behavior.
If provider is afraid of getting HIV from a patient, he or she should have the option not to see that patient.
If HIV testing is available, providers have a right to test their clients for HIV so they know the HIV status of the clients they treat.
A surgeon has the right to test a patient for HIV without their consent prior to surgery.
An HIV-positive health care provider should not be allowed to treat patients.
Clients have a right to know if a health provider is infected with HIV.
Providers who work at facilities where sex workers receive care are at higher risk for getting exposed to HIV on the job, than those providers who work at facilities that do not see sex workers.
It is best to treat HIV patients at a separate facility, rather than in the same facility as other patients.
Regnant women thought to be at risk for HIV should be tested for HIV whether or not they agree to it.
Women with HIV who get pregnant should be encouraged to terminate their pregnancy.

Discussion, PowerPoint Presentations

- **Objectives:**

  1. Define stigma and discrimination.
  2. Explore how and why stigma is related to PLHIV.
  3. Explore stigmatizing language.
  4. Analyze the impact of HIV related stigma on medical services provided to PLHIV and those believed to be PLHIV.
  5. Present the findings of the HIV related stigma survey among medical care providers, run under USAID Health Policy Initiative, to the training participants.
  6. Discuss how HIV-related fears can affect the quality of client services.

- **Time**
  1 hour 15 minutes

- **Materials**
  - Flipchart paper
  - Markers
  - Tape
  - Copies of PowerPoint presentation for each participant (Annex 3)

- **Steps**
  1. Ask participants two questions:
     - *What are PLHIV afraid of when seeking help in healthcare settings?*
     - *What are medical staff afraid of when providing care to PLHIV?*
   
   First, one of the questions should be asked with all responses written down on the flipchart, and after that the second question is also asked followed by documentation of all responses. If participants are not active enough, then each of them may be suggested an option of writing down their responses on stickers, which then can be placed on the flipchart. This should be followed by a discussion related to the fact that sometimes medical staff is afraid of getting infected while working with HIV-positive clients and their anxiety may cause stigma and discrimination of these clients, which, in their turn, are among PLHIV fears preventing them from seeking help in medical settings.
  2. Ask the participants to brainstorm the definitions of stigma and discrimination. Write the responses on the flipchart. Summarize the brainstorm.

**Training Tips**

During the presentation, try to maximum involve participants in discussion of the presented material, giving examples and providing feedback.

When providing definition of “stigma”, refer to the results of the brainstorm and personal experience of participants related to any stigma, for instance, being fresher on the course, red-haired, four-eyes, fatso, etc. This will enhance better understanding by participants of both the essence of this phenomenon and feelings of people having anxiety of being stigmatized when seeking or receiving assistance.

While discussing the last slide, encourage the group to provide as many comments as possible to the question on knowledge required to reduce the anxiety which is the cause of
stigmatization.

4. **Summarize** the session by reviewing with participants the key points elicited from the discussion and the presentation.

- **Handouts**
  - PowerPoint presentation “HIV Related Stigma, Stigmatization and Discrimination” (annex 3)
  - A conceptual framework and basis for action. HIV/AIDS stigma and discrimination. UNAIDS (annex 4)
  - Stigma and Discrimination. Fact Sheet. UNAIDS (annex 5)
Annex 3

PowerPoint presentation “HIV Stigma, Stigmatization and Discrimination”

HIV Related Stigma, Stigmatization and Discrimination

Training for Health Care Workers

Presentation Plan

1. Origin of the word “stigma”
2. Definition of stigma
3. Types of stigma
4. External and internal stigma
5. Discrimination
6. PLHIV discrimination cause and effect
7. Fear as a reason for PLHIV stigmatization
When Did Stigma Appear?

The Greeks used the word “stigma” to refer to bodily signs exposing something unusual or bad in the moral status of the signifier.

The signs were cut or burnt into the body and advertised that the bearer was a slave, a criminal or a traitor – a blemished person, ritually polluted, to be avoided, especially in public places.

Nowadays, the term is widely used in something like the original literal sense but is applied more to indicate the humiliating status of an individual as such.

What Is Stigma? (1)

Stigma is an attribute that is deeply discrediting within a particular social interaction.

(E.Goffman, 1963).
What Is Stigma? (2)

Stigma is a definite and negatively perceived by society feature that determines the status of its signifier and relevant behavior in social interactions.

Stigma is a socially constructed phenomenon, which leads to depreciation of a human being and affects the stigmatized individual.

Verbal Stigma Manifestations

In everyday life we use special stigmatizing language, without thinking much of its origin. Below are some examples:

- Cripple
- Idiot
- Moron
- AIDSy
- Fool
- Mongol
- Con
- Schizoid
- Freak
- Country bumpkin
- Joe Schmo
Stigma Types

• **Human body defects** — various physical deformities

• **“Blemishes of character”** — perceived as weak will: criminality, drug use, homosexuality, unemployment, suicidal attempts and even radical politics, etc.

• **Tribal stigma** of race, nation and religion — beliefs that are transmitted through lineages and equally contaminate all members of a family

  (E.Goffman)

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Stigma-Provoking Diseases

Diseases potentially subjected to intensive stigmatization have some common features:

• people affected by the disease are often blamed for their condition;
• disease is progressive and incurable;
• disease is poorly understood by people in the general population;
• symptoms can hardly be hidden or even can not be hidden at all.

  (E.Goffman and other)
External and internal stigma

External stigma is intolerable attitude of social environment to people. It may be manifested through domination, oppression, use of force and control, aggression, categoricity, accusation, punishment, condemnation, exclusion, contempt, offence, avoidance.

Internal stigma occurs when people internalize external reactions upon themselves. It relates primarily to feelings of shame, fear, anxiety, depression, inferiority complex, personal fault and PLHIV fear of being stigmatized and discriminated.

Double Stigma

• Merger of two or more stigmas.
• HIV related stigma oftentimes tops the already existing stigmas associated with such marginalized populations as MSM or FSW, and such types of behavior as injecting drugs or having sex with casual partners.
Stigmatization and Discrimination

- Stigmatization is a negative attitude in social interaction based on an attribute regarded discrediting within a particular person by the society.

- Stigmatization leads to discrimination, which in its turn leads to internal stigma, which encourages and reinforces stigmatization, making thus the vicious circle.

What is Discrimination?

Discrimination is intentional limitation of rights of part of people, selected social groups or individuals based on a specific attribute (race, age, gender, nationality, religion, sexual orientation, health status, job, etc.)
Discrimination Levels

- **Policy level** (government structures)
- **Social level** (private and civil society organizations, institutions and other society settings)
- **Personal/Interpersonal level** (individuals)

Reasons for PLHIV Stigmatization in Society

- Fear of infection = fear of death
  (this fear is raised by lack of knowledge/information)
- Prejudice against pre-stigmatized groups
- Social norms regarding “wrong” behavior
Fear of Stigmatization Affects Intention Of

- going through HIV testing
- disclosing status to other people
- seeking or providing care and support
- starting treatment; developing treatment adherence

2007 HPI S&D Survey Among medical care provider: Main Findings

- Majority of medical providers stated it is appropriate to disclose the status to other medical staff who deal with PLHIV patients, relatives and AIDS Centers
- Excessive preventive measures are popular among medical staff (like 2 pair of gloves, 2 masks) when PLHIV is on a doctor’s visit
- More than 1/3 of medical providers would feel ashamed if they would find out if they had HIV
- About 1/3 of respondents think that PLHIV should be treated separately, in separate locations
- Respondents do not believe IDUs, SW, MSM are like other group of people (i.e. teachers, salespersons, military, hairdressers, government officials)
- Majority of respondents stated medical providers are infected at the work place
Fear: Cause and Effect of Stigmatization

“Fear infects just like rhinitis and always turns singularity into multiplicity”

(Johann Wolfgang von Goethe)

Fear of potential infection is one of ten major fears.

Fear of disease is strengthened by unawareness of both true causes of disease and its development forecasts.

FEAR

“When unawareness starts growing fears then shouldn’t we grow aware to stop those fears?”

(Lucius Annaeus Seneca)
What should we be aware of?

What should we be aware of?

What should we be aware of?

What should we be aware of?
A conceptual framework and basis for action:
HIV/AIDS stigma and discrimination
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A conceptual framework and basis for action

HIV/AIDS stigma and discrimination

June 2002
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I. BACKGROUND AND RATIONALE

The World AIDS Campaign for the years 2002–2003 will focus on stigma, discrimination and human rights. The main objective of the campaign is to prevent, reduce and ultimately eliminate HIV/AIDS-related stigma and discrimination, wherever it occurs and in all its forms.

Stigma and discrimination associated with HIV and AIDS are the greatest barriers to preventing further infections, providing adequate care, support and treatment and alleviating impact. HIV/AIDS-related stigma and discrimination are universal, occurring in every country and region of the world. They are triggered by many forces, including lack of understanding of the disease, myths about how HIV is transmitted, prejudice, lack of treatment, irresponsible media reporting on the epidemic, the fact that AIDS is incurable, social fears about sexuality, fears relating to illness and death, and fears about illicit drugs and injecting drug use.

The Declaration of Commitment, adopted by the United Nations General Assembly Special Session on HIV/AIDS in June 2001, highlights global consensus on the importance of tackling the stigma and discrimination triggered by HIV/AIDS. All over the world, the shame and stigma associated with the epidemic have silenced open discussion, both of its causes and of appropriate responses. This has caused those infected with HIV and affected by the disease to feel guilty and ashamed, unable to express their views and fearful that they will not be taken seriously. And they have led politicians and policy-makers in numerous countries to deny that there is a problem, and that urgent action needs to be taken.

The stigma and discrimination associated with HIV/AIDS have many other effects. In particular, they have powerful psychological consequences for how people with HIV/AIDS come to see themselves, leading, in some cases, to depression, lack of self-worth and despair. They also undermine prevention by making people afraid to find out whether or not they are infected, for fear of the reactions of others. They cause those at risk of infection and some of those affected to continue practising unsafe sex in the belief that behaving differently would raise suspicion about their HIV-positive status. And they cause people with HIV/AIDS erroneously to be seen as some kind of ‘problem’, rather than part of the solution to containing and managing the epidemic.

In countries all over the world, there are well-documented cases of people with HIV/AIDS being stigmatized, discriminated against and denied access to services on the grounds of their serostatus. At work, in education, in health care and in the community, people may lack the education to understand that HIV/AIDS cannot be transmitted through everyday contact, and they may not know that infection can be avoided by the adoption of relatively simple precautions. This lack of awareness can lead people to stigmatize and discriminate against those infected, or presumed to be infected, with HIV/AIDS. Gender-based stigma and discrimination require special mention. The power relations that underscore gender relations and that tightly intersect with discrimination against women mean that women are unable to say “No” to unwanted or unprotected sex. This provides a highly combustible fuel for the epidemic.

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1 See, for example, the recent report developed and published by Panos: [http://www.panos.org.uk/aids/stigma_countries_study.htm](http://www.panos.org.uk/aids/stigma_countries_study.htm) But see also UNAIDS (2000) HIV and AIDS-related Stigmatization, Discrimination and Denial: Forms, Contexts and Determinants. Research studies from Uganda and India. Geneva, UNAIDS.
I. BACKGROUND

The impact of HIV/AIDS-related stigma and discrimination does not end here. It also affects the capacity of societies to respond constructively to the devastation caused by the epidemic. Despite the catastrophe, silence prevails and action is slowed because of stigma and denial and, ultimately, because of people’s fears about being open. In 1999, for example, an estimated 860,000 children lost their teachers to AIDS in sub-Saharan Africa. In Zambia, teacher deaths caused by AIDS are equivalent to about half the total number of new teachers the country manages to train annually. A similar situation prevails among many other groups of government workers. This catastrophe calls for more to be done. Part of the response lies in addressing the existing widespread stigma and discrimination.

United Nations Declaration of Commitment on HIV/AIDS

‘Stigma, silence, discrimination and denial, as well as lack of confidentiality, undermine prevention, care and treatment efforts and increase the impact of the epidemic on individuals, families, communities and nations’ (Paragraph 13).

‘By [the year] 2003, [nations should] ensure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS that address the epidemic in forthright terms; confront stigma, silence and denial; address gender-and age-based dimensions of the epidemic; [and] eliminate discrimination and marginalization’ (Paragraph 37).

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

HIV/AIDS-related stigma does not arise out of the blue, nor is it something dreamed up in the minds of individuals. Instead, like responses to diseases such as leprosy, cholera and polio in the past, it plays to deep-rooted social fears and anxieties. Understanding more about these issues, and the social norms they reinforce, is essential to adequately responding to HIV/AIDS-related stigma and discrimination. Otherwise, we run the risk of developing programmes and interventions that are not comprehensive, thus achieving little impact.

3 http://www.unaids.org/whatsnew/others/un_special/Declaration2706_en.htm
II. SOME STARTING POINTS

Concern about HIV/AIDS-related stigma and discrimination is not new. It is now widely recognized that there are three phases to the AIDS epidemic in any society. The first of these is the epidemic of HIV infection. This enters a community silently and unnoticed. Next follows the epidemic of AIDS, which appears when HIV triggers life-threatening infections. Finally, there is the third epidemic—the epidemic of stigma, discrimination, blame and collective denial—that makes it so difficult to effectively tackle the first two. HIV/AIDS-related stigmatization and discrimination make prevention difficult by forcing the epidemic out of sight and underground.

“HIV/AIDS-related stigma comes from the powerful combination of shame and fear—shame because the sex or drug injecting that transmit HIV are surrounded by taboo and moral judgement, and fear because AIDS is relatively new, and considered deadly. Responding to AIDS with blame, or abuse towards people living with AIDS, simply forces the epidemic underground, creating the ideal conditions for HIV to spread. The only way of making progress against the epidemic is to replace shame with solidarity, and fear with hope.”

Statement by Peter Piot to Plenary of the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance, Durban South Africa, 5 September 2001

But what action is needed and what must be the priorities? Four issues are clear:

Firstly, we need clear thinking about what stigma and discrimination are, where they come from, particularly the social and cultural drivers that fuel them, and what they do.

Secondly, we need to appreciate their links to broader existing inequalities and injustices and denial of individuals’ realization of human rights and fundamental freedoms.

Thirdly, we need to focus the World AIDS Campaign to stimulate a better understanding of the complex stigma- and discrimination-related issues that precipitate the epidemic.

Fourthly, it is critical to set objectives for results. We need to identify opportunities for action across each and every one of the key fields identified in the UNGASS Declaration of Commitment—namely prevention; care, support and treatment;

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4 As far back as 1985, the author and activist Cindy Patton was writing about HIV/AIDS-related stigma and discrimination in *Sex and Germs: The Politics of AIDS*. Here, she pointed to their links to fear of germs and disease, to fear of death, and to deep-seated worries about sex and sexuality. A couple of years later, Susan Sontag addressed similar concerns in *AIDS and its Metaphors*, highlighting parallels between the social response to HIV/AIDS and earlier societal anxieties about leprosy, tuberculosis and cancer.


6 [http://www.unaids.org/whatsnew/speeches/eng/piot040901racism.htm](http://www.unaids.org/whatsnew/speeches/eng/piot040901racism.htm)
III. WHAT IS STIGMA?

advancement of HIV/AIDS-related human rights; reduction of vulnerability; alleviation of social and economic impact, including that on children orphaned or made vulnerable by HIV/AIDS; HIV/AIDS-related research; and addressing HIV/AIDS in regions affected by conflict and disaster.

It goes without saying that our thinking and action should be rooted in the universal nature of human rights standards, principles and norms. Around the world, numerous instances of HIV/AIDS-related stigma and discrimination can be identified. Equally important is the identification of the ways in which violation of human rights and the stigma and discrimination that are embedded in these violations exacerbate the spread of HIV.

There are already many examples of the initial efforts to eliminate these forms of stigma and discrimination. Sometimes these efforts succeed and sometimes they are less successful. But wherever they occur, they are worthy of attention, not only for their potential to help us better understand the social response to HIV/AIDS, but also because they act as beacons to future success.

III. WHAT IS STIGMA?

Stigma has ancient roots. It has been described as a quality that ‘significantly discredits’ an individual in the eyes of others. It also has important consequences for the way in which individuals come to see themselves.

Importantly, stigmatization is a process. The qualities to which stigma adheres (e.g. the colour of the skin, the way someone talks, the things that they do) can be quite arbitrary. Within a particular culture or setting, certain attributes are seized upon and defined by others as discreditable or unworthy. Stigmatization therefore describes a process of devaluation rather than a thing.

Much HIV/AIDS-related stigma builds upon and reinforces earlier negative thoughts. People with HIV/AIDS are often believed to have deserved what has happened by doing something wrong. Often these ‘wrongdoings’ are linked to sex or to illegal and socially-frowned-upon activities, such as injecting drug use. Men who become infected may be seen as homosexual, bisexual or as having had sex with prostitutes. Women with HIV/AIDS are viewed as having been ‘promiscuous’ or as having been sex workers. The family and community often perpetuate stigma and discrimination, partly through fear, partly through ignorance, and partly because it is convenient to blame those who have been affected first.

It is also necessary, when analysing the roots and results of stigma, to demonstrate how different groups experience stigma and, most particularly, how men and women are differentially affected by it.

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7 The origins of the word can be traced to classical Greece where outcast groups were branded, or physically marked, as a permanent measure of their status.

8 Drawing on his research with individuals who had experienced stigmatization, including people with mental illness, physical deformities or socially ‘deviant’ behaviours, the US sociologist Erving Goffman has argued that the stigmatized individual is a person with a ‘spoiled identity’ who is ‘rendered unworthy’ in the eyes of others.
The real battle against AIDS in Africa is being played out in the families and villages of Africa, where the authority of government rarely extends. This sort of discrimination is intensely personal, and it takes many forms: schoolchildren ostracizing other children on the playground, or in-laws boycotting the widow of a son who has died from the disease. Images of HIV/AIDS in the media and television, which suggest that it is a ‘woman’s disease’, a ‘junkies’ disease, a ‘Black disease’, an ‘American disease’ or a ‘gay plague’, also create HIV/AIDS-related stigma and discrimination and reinforce these stereotypes and beliefs. Although images associated with HIV/AIDS vary, they are patterned so as to ensure that HIV/AIDS-related stigma plays into, and reinforces, existing social inequalities. These include gender inequalities; inequalities that deny sex workers their dignity and rights; inequalities based on race and ethnicity; and inequalities linked to sexuality in general, and homosexuality and transgendered status, in particular.

Like many other sexually transmitted infections, HIV/AIDS was first perceived as a disease of ‘outsiders’. In the early 1980s, for example, and among gay and other homosexually active men in Europe and Australia, it was seen as being closely linked with the United States of America. In the eyes of some African and Asian leaders, HIV/AIDS has been viewed as a disease of the West, linked to the weakness of family structures, liberal social values and moral decline. With the passage of time, and for diverse reasons, in most countries of the world, AIDS has come to be associated with sub-Saharan Africa.

Racism and xenophobia are evident, not only with respect to the presumed ‘origins’ of HIV/AIDS, but also with respect to the stigmatization and discrimination that have followed in the wake of the epidemic. The racist assumptions of many early AIDS-related discourses were clear in startling statements about ‘African sexuality’ that were typical during the early years of the epidemic. But xenophobia and racism have not only imbued dominant images and cultural constructions of the epidemic, they have also been reproduced within it. Thus, people with HIV/AIDS from racial and ethnic minorities are often seen not as individuals living in contexts of marginalization and inequality but as the causes of their own misfortune. This kind of approach can be seen in responses all over the world, and undoubtedly underpins indifference to the plight of some of the most heavily affected communities.

Self-stigmatization, or the shame that people living with HIV/AIDS experience when they internalize the negative responses and reactions of others, is also evident. Self-stigmatization can lead to depression, withdrawal and feelings of worthlessness. It silences and saps the strength of already-weakened individuals and communities, and causes people to blame themselves.

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9: http://www.yaids.org/network/otrs/vol1iss4.htm
10: Most notably, syphilis in 15th and 16th century Europe
12: These often evoked images of sex between humans and animals, or of exotic cultural practices such as the eating of raw or inadequately cooked green monkey flesh
themselves for their predicament. It has links to what some writers have called ‘felt’, as opposed to enacted, stigma, in that it affects primarily an individual’s or community’s feelings and sense of pride.

It is silence, exclusion and isolation that limit our ability to provide the care and services needed by people living with HIV. It is the silence, exclusion and isolation of our leaders that prevent us from developing and marketing effective HIV prevention efforts.13

Stigma is linked to power and domination throughout society as a whole. It plays a key role in producing and reproducing relations of power. Ultimately, stigma creates, and is reinforced by, social inequality. It has its origins deep within the structure of society as a whole, and in the norms and values that govern much of everyday life. It causes some groups to be devalued and ashamed, and others to feel that they are superior. For example, long-standing ideologies of gender have resulted in women being blamed for the transmission of sexually transmitted infections or HIV. This has influenced the ways in which families and communities react to the seropositivity of women. Many women are blamed for the illnesses from which they and their husbands suffer.

IV. DISCRIMINATION

Stigma is harmful, both in itself, since it can lead to feelings of shame, guilt and isolation of people living with HIV, and also because negative thoughts often lead individuals to do things, or omit to do things, that harm others or deny them services or entitlements. Hospital or prison staff, for example, may deny health services to a person living with HIV/AIDS. Or employers may terminate a worker’s employment on the grounds of his or her actual or presumed HIV-positive status. Families and communities may reject and ostracize those living, or believed to be living, with HIV/AIDS. Such acts constitute discrimination based on presumed or actual HIV-positive status and violate human rights.

Discrimination occurs when a distinction is made against a person that results in his or her being treated unfairly and unjustly on the basis of their belonging, or being perceived to belong, to a particular group.

Because of the stigma associated with HIV/AIDS, and the discrimination that may follow from this, the rights of people living with HIV/AIDS and their families are frequently violated. This violation of rights increases the negative impact of the epidemic. At the level of the individual, for example, it causes undue anxiety and distress—factors that are known

13 http://www.nhrural.org/pagefile/aidsbook.html
in themselves to contribute to ill-health. At the level of the family and community, it causes people to feel ashamed, to conceal their links with the epidemic, and to withdraw from participation in more positive social responses. And at the level of society as a whole, discrimination against people with HIV/AIDS reinforces the mistaken belief that such action is acceptable and that those infected with HIV/AIDS should be ostracized and blamed.

Around the world, there have been numerous instances of such HIV/AIDS-related discrimination. People with (or believed to have) HIV/AIDS have been:

- segregated in schools and hospitals, including under cruel and degrading conditions. Cases of degrading treatment have often been reported in prisons where inmates are often mandatorily confined, often without their basic needs being met, including access to medical care;¹⁴
- refused employment. An airline cabin attendant in South Africa was denied employment based on his HIV-positive status. Fortunately, he was able to successfully challenge this discriminatory action in court;¹⁵
- denied the right to marry. For example, the Supreme Court in India ruled that a person living with HIV/AIDS has no right to marry and found a family.¹⁶ Further, some jurisdictions require mandatory HIV testing before granting marriage licenses;
- required, when returning to their national country, to submit themselves to a HIV test. Individuals have been denied the right to return to their country on suspicion of being HIV-positive. Others have been denied visas or entry permission;¹⁷
- rejected by their communities. All over the world, people with HIV/AIDS have been banished by their communities. Throughout Central and Southern Africa and in South Asia, a woman diagnosed with HIV/AIDS may be sent back to her family or village of origin, once her serostatus becomes known;¹⁸ and
- killed because of their seropositive status. In December 1999, a young community volunteer, Ms Gugu Dlamini, was stoned and beaten to death by neighbours in her township near Durban, South Africa after she had spoken out openly on World AIDS Day about her HIV infection.

Each example above offers an illustration of individual and social stigma being acted upon and, as a result, discrimination taking place.


¹⁵ A settlement offer was made by South African Airlines, and the matter was dealt with out of court. The offer included SAA unconditionally admitting that the exclusion of Mr ‘A’ based on his HIV-positive status was unjustified and that SAA would pay Mr ‘A’ the sum of 100 000 South African Rand as compensation and redress. Additionally, SAA would pay all legal costs. See also [http://www.hri.ca/partners/alp/press/presss1.shtml](http://www.hri.ca/partners/alp/press/presss1.shtml)

¹⁶ Judgement given by the Supreme Court in Mr X vs. Hospital Y Authority [reported in (1998) 8 SCC 296]. Considering that, at present, there is no cure for AIDS, in effect the decision in Mr X implies that the Petitioner’s fundamental right to marry was completely infringed, and he could never marry.

¹⁷ See [http://travel.state.gov/HIVtestingreqs.html](http://travel.state.gov/HIVtestingreqs.html) for a list developed by the US Department of State that highlights about 60 countries that require HIV tests, and conditions that are applied; see also Carlier J-Y, The free movement of persons living with HIV/AIDS: EU HIV/AIDS Programme in Developing Countries, European Commission, Luxembourg, 1999; Deutsche AIDS Hilfe and AIDS Info Doca Schweiz, Quick Reference, Travel and residence regulations for people with HIV and AIDS, Third edition, Berlin, December 2001. The text is accessible at [www.aidsnet.ch/immigration/d](http://www.aidsnet.ch/immigration/d) (German) and at [www.aidsnet.ch/immigration/f](http://www.aidsnet.ch/immigration/f) (French); Swiss Federal Department of Foreign Affairs (http://www.hivnet.ch) and [http://travel.state.gov/HIVtestingreqs.html](http://travel.state.gov/HIVtestingreqs.html)

¹⁸ See [http://www.panos.org.uk/aids/stigma_countries_study.htm](http://www.panos.org.uk/aids/stigma_countries_study.htm) and also UNAIDS (2000) HIV and AIDS-related stigmatization, discrimination and denial: forms, contexts and determinants. Research studies from Uganda and India. Geneva, UNAIDS
V.

HUMAN RIGHTS

As noted, HIV/AIDS-related stigma often leads to HIV/AIDS discrimination. This, in turn, leads to the violation of the human rights of people living with HIV/AIDS, of their families and even of those presumed to be infected, such as family members or other associates.

Freedom from discrimination is a fundamental human right founded on principles of natural justice that are universal and perpetual. Human rights inhere in individuals because they are human, and they apply to all people everywhere. The principle of non-discrimination is central to the human rights thinking and practice. The core international human rights instruments prohibit discrimination based on race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

The United Nations Commission on Human Rights, in its resolutions\(^\text{19}\), has declared that the term ‘or other status’ in the various international human rights instruments should be interpreted to cover health status, including HIV/AIDS. The United Nations Commission on Human Rights has further confirmed that discrimination on the basis of HIV/AIDS status (actual or presumed) is prohibited by existing human rights standards.

**Discrimination against people living with HIV/AIDS, or those thought to be infected, is therefore a clear violation of their human rights.**

But why is it important to recognize the links between stigma, discrimination and human rights violations? There are several reasons:

- Firstly, because stigma, discrimination and human rights violations are interrelated. They create, reinforce and legitimize each other. They form a vicious circle.
- Secondly, since freedom from discrimination is a human right, there are already existing frameworks for responsibility and accountability of action. Human rights derive from the relationship between the individual and the State. They arise from the legal obligation of States to regulate the relationships between their citizens. Thus, States are responsible and accountable, not only for directly or indirectly violating rights, but also for ensuring that individuals can realize their rights as fully as possible. States have the obligation to respect, protect and fulfil human rights.

In relation to discrimination, the obligation to *respect* requires States not to directly or indirectly discriminate in law, policy or practice. The obligation to *protect* requires States to take measures that prevent third parties from discriminating\(^\text{20}\), and the obligation to *fulfil* requires States to adopt appropriate legislative, budgetary, judicial and other measures to ensure that strategies, policies and programmes are developed to address the discrimination and to ensure redress to those who have been discriminated against. The existence of


\(^{20}\) For example, the adoption of legislation to ensure equal access to health care and health-related services provided by third parties, to control the marketing of medicines and medical equipment, and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct.
HIV/AIDS-related discrimination is a litmus test for the lack of respect, protection and fulfillment of human rights.

A human rights framework provides avenues for people who suffer discrimination on the basis of their actual or presumed HIV-positive status to have recourse through procedural, institutional and monitoring mechanisms. Since HIV/AIDS-related discrimination constitutes a violation of human rights, persons who discriminate are accountable by law and redress can be provided, where appropriate.

Procedural, institutional and other monitoring mechanisms exist to ensure accountability at national, regional and international levels. At national level, these include courts of law, national human rights commissions, ombudsmen, law commissions and other administrative tribunals. For example, the National Human Rights Commissions of South Africa, Ghana and India and the Ombudsman of Costa Rica have undertaken various activities to promote and protect HIV/AIDS-related rights in their countries.

Beyond legal redress, there are many other ways of tackling HIV/AIDS-related stigma and discrimination. Public information campaigns, for example, have an important role to play in helping people understand the unfairness and unjustness of stigmatization and discrimination. They can also change individual and social attitudes. Participatory education can help individuals place themselves in the position of someone who has suffered discrimination and thereby appreciate the injustice of discriminatory actions. Through grass-roots activism, advocacy and involvement in the development and implementation of policy, the actions of people living with and affected by HIV/AIDS can be a radical force for change, breaking down the barriers to the full realization of human rights.

It is important, during and beyond this campaign, to ensure that all forms of discrimination that fuel the epidemic are equally addressed and action taken. The campaign must move beyond the documentation or flagging of the issue to creating positive role models and encouraging positive action.

VI. KEY STAKEHOLDERS

As tools for tackling HIV/AIDS-related stigma and discrimination, policy and legal reform will have a limited impact unless supported by the values and expectations of a society as a whole. Widespread and enduring changes in social attitudes are required if we are to make headway against HIV/AIDS-related stigma and discrimination.

Bringing about such change requires mobilizing many different stakeholders, including people living with and affected by HIV/AIDS; partners, friends and families; religious and traditional leaders; legal and civil rights groups; nongovernmental and community-based organizations; the business community and workers’ organizations; doctors, politicians, nurses and health-care workers; teachers, youth leaders, women leaders and community workers; and the police and the military. Additionally, links need to be made with broader struggles that address underlying economic, social, cultural and political inequalities—for example, gender inequality, the rights of the child, the rights of minorities, and the rights of refugees and other people displaced as a result of persecution or violent conflict.
Central to this effort must be action to transform social attitudes and values. Given the fact that the roots of much HIV/AIDS-related stigma and discrimination lie in existing injustices and inequalities, in order to tackle such stigma and discrimination, these injustices and inequalities must be addressed. But how can this be achieved?

VII. SUCCESSFUL ACTIONS AND RESPONSES

Documented efforts to challenge HIV/AIDS-related stigma and discrimination remain relatively rare. Research is urgently needed to identify the most effective ways of tackling stigma and discrimination across a range of contexts. Also needed are examples of programmatic success. What follows is a stocktaking of selected successful actions and responses. Further case studies will be made available throughout the course of the World AIDS Campaign.

Countering stigma

While a recent review\(^{21}\) concluded that 'relatively few interventions to reduce AIDS stigma have been conducted (or at least rigorously evaluated, documented and published) in developing countries', research undertaken also indicates that local communities have been exploring ways of reducing levels of stigma through:

- the dissemination of information;
- coping-skills acquisition;
- counselling approaches;
- programmes promoting greater involvement with people living with HIV/AIDS; and
- monitoring violations of human rights and creating a supportive legal environment to enable people to challenge discrimination.

In Israel\(^{22}\) and in Jamaica\(^{23}\) more positive attitudes towards people living with HIV/AIDS have been promoted through peer education, lectures, pamphlets or workshops, although the effects of such behavioural change remain undocumented.

Combining information-based approaches with counselling has been shown to increase disclosure among people living with HIV/AIDS, and has triggered improved community attitudes compared with baseline measures in countries such as Uganda\(^{24}\) and Zimbabwe\(^{25}\).

In Uganda, the work of The AIDS Support Organisation (TASO) and other community-based groups has been central to encouraging greater openness about the epi-

\(^{21}\) See [http://www.popcouncil.org/pdfs/horizons/litrvwstigdisc.pdf](http://www.popcouncil.org/pdfs/horizons/litrvwstigdisc.pdf) The discussion of stigma-reduction measures that follows draws heavily upon this review


emic and in providing support and care to individuals, families and communities living with HIV/AIDS.

Zambia was one of the first African countries to implement HIV home-care services, and the Ndola Catholic Diocese Home-Based Care Programme has been internationally recognized for the high quality of its work. Thanks to strong community participation and the motivation of the programme’s volunteers, over 70% of those in need of HIV/AIDS-related care are being reached. Consequently, perhaps, negative attitudes towards HIV/AIDS reportedly lessened and local people have been empowered with the knowledge, skills and self-confidence they need to cope with the impact of the epidemic.

In Phayao Province in the north-east of Thailand, multisectoral work bringing together a range of governmental and nongovernmental organizations was key to reducing new infections in this badly-affected area in the late 1990s, and in promoting good-quality home- and community-based care. A people-oriented approach facilitated greater openness about the epidemic, and the promotion of a ‘care not scare’ approach reportedly stimulated greater social cohesion and support.

In the United Republic of Tanzania, teachers and health workers implemented a two-to-three-month programme of AIDS-related information, small group discussions, and role-play to improve primary-school-age children’s knowledge, attitudes and practices. Follow-up 12 months later showed that attitudes towards people living with HIV/AIDS had significantly improved.

In the United States of America, an early study used information and coping-skills development to resolve negative feelings among physical therapy students and increase their willingness to treat people living with HIV/AIDS.

Contact with HIV-infected or -affected groups has been used in several studies and programmes. The belief here is that a more personal relationship with people living with HIV/AIDS (either through face-to-face conversations or by hearing a testimonial from infected or affected individuals) will demystify and dispel misinformation, generating empathy, which, in turn, reduces stigma and prejudice. Such work shows mixed results, with some studies reporting reductions in negative attitudes, and others not.

26 Kaleeba N et al. (2000) Open Secret: People facing up to HIV and AIDS in Uganda. St Albans, TALC
Tackling discrimination

With respect to measures to counter discrimination, a more programmatic approach has frequently been adopted. This has involved a variety of actors coming together to counter the negative consequences of HIV/AIDS-related stigma as it impacts upon lives and communities.

In India, for example, the Lawyers’ Collective in Mumbai has successfully defended workers who have been discriminated against and lost their jobs on account of their HIV-positive status. The Collective has also raised public awareness about HIV/AIDS through public rallies and mobilizes public opinion against stigma and discrimination. One of its most significant achievements to date has been the upholding of the ‘suppression of identity’ clause. This allows a person with HIV/AIDS to file his or her case under a pseudonym.32

In Thailand, the Thai Business Coalition, which comprises around 125 businesses, including multinational companies, has developed training courses and a manual to support good workplace policy and practice. Documented effects of this work include HIV-positive employees reporting increased levels of acceptance and support, human resources personnel requesting technical assistance in the development of non-discriminatory policies, and staff volunteering to participate in the work of HIV/AIDS NGOs and/or specific HIV/AIDS projects.33

The Brazilian subsidiary of Unilever has reinforced the company’s internationally adopted HIV/AIDS response with an HIV/AIDS programme focused not just on employees, but also on their families and the community. The company used one of its brands—the AXE deodorant—to identify a campaign promoting greater awareness and acceptance among 14–25-year-old men. The company subsequently used the platform of the Brazilian Business Council for HIV/AIDS to share their experience and materials with other companies.34

In India, work is under way in New Delhi to establish HIV-patient-friendly hospitals. The goal is to make services more attuned to the needs of people with HIV/AIDS. Among the measures being taken is policy development on matters such as pre- and post-test counselling, confidentiality and the importance of informed consent. Efforts are also being made to extend staff education and training, and to strengthen the application of universal precautions in patient care.35

In South Africa, the Centre for the Study of AIDS at the University of Pretoria has been active in challenging racist and prejudiced attitudes among staff and students. The Centre has also introduced HIV/AIDS-related concerns into elements of the higher education curriculum, including in subjects such as law, agriculture and engineering. This has led to greater understanding of the issues, de-stigmatizing and enhancing discussion of HIV/AIDS-related concerns.36 Also in South Africa, the AIDS Law Project at the

32 http://www.hri.ca/partners/lc/about/cases.shtml
35 http://www.pepcouncil.org/horizons/projects.html
36 http://www.csa.za.org/
University of Witwatersrand has challenged HIV/AIDS-related discrimination in the highest-level courts, on issues such as unfair dismissal and discrimination in prisons.\(^{37}\)

Lack of access to antiretroviral treatment is a key issue that enhances or advances HIV/AIDS-related stigma and discrimination in many countries. The perceived ‘untreatability’ of AIDS is a key factor contributing to the stigmatization of many of those affected. As long as HIV/AIDS continues to be equated with serious illness and death, public attitudes towards the epidemic seem likely to be slow to change. For this reason, as well as on grounds of equity and justice, efforts are being made to extend the availability of antiretroviral drugs.

In Costa Rica, for example, where official resistance to antiretroviral therapy was initially premised on the assumption that it was too expensive to provide, a small group of people living with AIDS—the Patient Coalition—negotiated for a year with the government. Frustrated, the group appealed to the Supreme Court in 1997 and won its support, forcing the government to begin offering antiretroviral drugs to people with HIV/AIDS. Today, a substantial number of Costa Ricans with AIDS receive combination therapy.\(^{38}\) Just as importantly, the increasing visibility of people with HIV/AIDS in this country and in other Central American republics is helping to significantly enhance awareness and challenge negative stereotypes and attitudes.\(^{39}\)

In Venezuela, Acción Ciudadana Contra el Sida (ACCSI) filed a suit on behalf of 11 people with HIV/AIDS who claimed they were not receiving proper medical attention, and their rights to non-discrimination, health, equality, access to science and technology and access to social security, as guaranteed by the National Constitution, the American Convention on Human Rights, and other conventions signed and ratified by Venezuela, were thereby being infringed. In May 1997, the court upheld the lawsuit, and ordered the Social Security System to provide treatments (including protease inhibitors) on a regular basis at no cost. Numerous other lawsuits have subsequently been successful, including those filed against the Ministry of Defence and the Ministry of Health.\(^{40}\)

In Brazil, the government, pushed by a strong activist movement, has instituted free HIV/AIDS treatment for everyone infected. Today, almost all people in Brazil have access to treatment, and mortality from AIDS has been substantially reduced. Aggressive policies combining parallel licensing and successful negotiations with pharmaceutical companies for sharp price reductions have contributed to the success. But there have been social consequences, as well. Brazil’s response to HIV/AIDS has been recognized as one of the most successful globally and, while HIV/AIDS-related social solidarity cannot be solely attributed to the availability of treatment drugs, the widespread availability of such drugs has reportedly lessened negative responses to the epidemic.\(^{41}\)

But even in countries with well-developed treatment-access programmes, the risk of discontinuation and interruption of treatment availability continues to be a concern. In Argentina, and in the wake of the serious economic problems currently confronting the country, the vulnerability of the antiretroviral-treatment-access programme has been highlighted. Here, as in other countries, there is serious concern that the distribution of medications may be in jeopardy because of the broader political and economic situation.\(^{42}\)


\(^{39}\) [http://www.aguabuena.org/ingles/articulos.html](http://www.aguabuena.org/ingles/articulos.html)

\(^{40}\) [http://www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol5no42000/carrascodurban.htm](http://www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol5no42000/carrascodurban.htm)


\(^{42}\) Personal communication, V. Terto Jr, ABIA, Rio de Janeiro, Brazil.
VIII. SOME STRATEGIES FOR SUCCESS

Issues of access to treatments for HIV and AIDS are, of course, complex, and the relationship between the implementation of access programmes and combating HIV/AIDS-related stigma and discrimination requires further investigation. But it is also important to remember that, whatever their cause, inequalities in access to treatment drugs determined by, *inter alia*, price are not only unjust, they can be changed, as clearly illustrated by the joint UNAIDS/WHO Accelerating Access to HIV/AIDS Care, Support and Treatment initiative. 43

VIII. SOME STRATEGIES FOR SUCCESS

Too often, in the past, stigma reduction has been likened to a model of enlightenment, in which those who know best intervene to correct the bad thoughts and actions of others. This approach sees the minds of those who are being educated as vessels waiting to be filled with the good ideas of intervention specialists and communications experts instead of empowering communities through a participatory process that unleashes their knowledge and experiences.

What are the key features of successful approaches? Successful approaches must be honest and relevant to the lives of individuals affected. Further, they should aim to develop accurate understanding of the epidemic, its nature and its causes. They should also seek to address the root causes of anxiety and insecurity—fear of contagion, sexuality, illness and death. And, finally, they should safeguard the dignity of individuals and respect human rights in the process and outcomes.

Given the intimate link between HIV/AIDS-related stigma, discrimination and human rights violations, *multi-pronged interventions are needed* to address each of these issues. Stigma, discrimination and human rights can be used as entry points for successful work. Thus, action must be taken to *prevent* stigma and *challenge* discrimination when it occurs, and *monitor and redress* human rights violations.

Far more successful are efforts to unleash the power of ‘resistance’ on the part of stigmatized populations and communities, so as to enable them to fully enjoy the human rights to which they, like all others, are entitled. Ultimately, it is the power of community to challenge and to ‘take charge’ that, in many countries, has made the greatest headway against the epidemic. This is illustrated in the work of organizations such as TASO in Uganda, which has done much to bring HIV/AIDS out into the open, de-stigmatizing the epidemic in the process. 44

The importance of this kind of work has been well documented, especially in countries such as Brazil, where ‘popular education’ has been used as the basis from which to develop programmes aimed at consciousness-raising, empowerment and community mobilization. One of the key lessons to be learned from such work is the importance of tackling stigma and discrimination, not only in relation to HIV/AIDS, but also in relation to the other forms of inequality and exclusion that disempower those most vulnerable to infection.

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In São Paulo, Brazil, for example, research has shown that, in order to implement HIV/AIDS prevention programmes for inner-city youth, it is first necessary to confront issues of poverty and economic marginalization, the stigma and racism associated with being a migrant (often from the poor north-eastern region of the country), and the unequal gender-based power relations and norms in Brazilian culture. By focusing not only on HIV/AIDS, but also on these other issues, Brazilian health promotion workers, like those in other parts of Latin America, have demonstrated the potential of what might be described as a kind of ‘community pedagogy’ as the foundation for a more effective response to HIV/AIDS.\(^46\)

What could be some successful approaches?

Continuing advocacy is needed for social change in response to HIV/AIDS-related stigmatization and discrimination. The role of people with HIV/AIDS and of religious and political leaders in such a process cannot be underestimated.

* Empowerment of people living with, and affected by, HIV/AIDS.

Community mobilization, advocacy and social change must take place alongside interventions to change the broader context in which individuals and communities live.\(^47\) Local ‘ownership’ of HIV/AIDS, such as that fostered as part of building an AIDS-competent community,\(^48\) is essential to a successful response.

* Action is needed to tackle the gender, racial and sexual inequalities and stereotypes upon which HIV/AIDS-related stigma and discrimination so often feed. In particular, efforts should be made to counter prejudice and misunderstanding and to protect the human rights of sex workers, men who have sex with men and other minorities who are discriminated against.

* Promote life-skills education and counselling to help HIV-infected and affected children cope with stigma.

* Ensure that comprehensive care and services, including voluntary counselling and testing (VCT), and follow-up care are available to enable individuals to learn their serostatus and provide support to enable them to disclose their status to other family members.

Raise awareness so that families and communities can access interventions (e.g. prevention of mother-to-child transmission and care and support services) as they become available, or hold authorities accountable if such services are not available.

* Legal protection for people living with HIV and AIDS is a powerful way of redressing, and thereby mitigating, the unequal power relations, the social inequality and the exclusion that lie at the heart of HIV/AIDS-related stigmatization and discrimination. Such protection should be promoted, together with appropriate reporting and enforcement mechanisms.

Greater support is needed for community legal aid centres and/or legal services to tackle instances of discrimination and the abuse of human rights. Basing such services in existing AIDS service organizations, or organizations of people living with

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HIV/AIDS, may be one way of helping develop trust among those who have experienced discrimination, especially where such organizations are already valued and respected by the community.

Training and support for existing legal aid institutions in developing their approach to human rights and HIV/AIDS are needed, alongside the creation of lawyers’ collectives specializing in HIV/AIDS-related concerns. Training and supporting members of associations of people living with HIV/AIDS are also important, so that these associations can provide in-house paralegal counselling and advice.

The workplace provides an excellent opportunity to set standards that protect human rights and to establish a supportive environment for those living with HIV and AIDS. The ILO Code of Practice on HIV/AIDS and the World of Work provides basic principles to guide policy development, as well as guidelines for practical programming. A workplace policy on HIV/AIDS is a powerful instrument with which to combat discrimination and encourage solidarity through education and awareness-raising.

Within the health-care setting, ensure that codes of ethics and professional conduct for health-care services are in place and are enforced, and that their application to HIV/AIDS is taught within professional training curricula. Offer sufficient forms of redress should violations of professional ethics occur.

Encourage practical HIV-related training for all health-care workers to promote better understanding, to promote confidentiality and to reduce unfounded anxiety. The use of universal precautions will not only allay staff anxieties but will also help protect the identities and rights of infected patients.

Concrete action needs to be taken to ensure greater access to, and uptake of, treatment drugs. Helping people to understand that it is possible to live with HIV/AIDS, and to recognize that treatment advance promises real hope for the future, is an important step in dissipating fear and anxiety about the epidemic in the workplace and in the community.

Ensure that HIV/AIDS-related subjects, including counselling skills, are included in the pre- and in-service training of religious leaders.

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49 For example: Alter Law in the Philippines and the Lawyers Collective HIV/AIDS Unit in Mumbai, India. These are groups of lawyers specializing in HIV/AIDS-related cases and offering free legal service in this area.

50 The ILO Code of Practice on HIV/AIDS and the World of Work is being used in a number of countries as the basis for the revision of employment laws and other instruments in order to establish the rights of, and guide conduct towards, workers living with HIV or AIDS.
IX. CONCLUSION

If effective responses to HIV/AIDS-related stigma and discrimination are to be promoted, work has to occur simultaneously on several fronts: communication and education to encourage better understanding; action and intervention to establish a more equitable policy context; and legal challenge, where necessary, to bring to account governments, employers, institutions and individuals. The fundamental objective, however, is to strive for action based on this understanding—action that will promote more egalitarian and gender-progressive role models, and that will help guide the manner in which we live and interact with one another.
Stigma and Discrimination

All over the world, the AIDS epidemic is having a profound impact, bringing out both the best and the worst in people. It triggers the best when individuals group together in solidarity to combat government, community and individual denial, and to offer support and care to people living with HIV and AIDS. It brings out the worst when individuals are stigmatized and ostracized by their loved ones, their family and their communities, and discriminated against individually as well as institutionally.

An overview of HIV/AIDS-related stigma and discrimination

- Stigma and discrimination around HIV and AIDS continue to fuel the global AIDS epidemic. ‘Live and let live’, the World AIDS Campaign for 2003, explores how both individuals and organizations can help reduce stigma and discrimination.
- The campaign is working to tackle stigma and discrimination in a number of settings including: education, faith based organizations, health care settings, legal systems, the media, parliamentarians and the workplace.

What is HIV/AIDS-related stigma and discrimination?

- HIV/AIDS-related stigma can be described as a ‘process of devaluation’ of people either living with or associated with HIV/AIDS. This stigma often stems from the underlying stigmatisation of sex and intravenous drug use – two of the primary routes of HIV infection.
- Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status. Stigma and discrimination breach fundamental human rights and can occur at a number of different levels including: political, economic, social, psychological and institutional.
- When stigma exists people often prefer to ignore their real or possible HIV status. This can lead to the risk of faster disease progression for themselves and also to the risk of them spreading HIV to others.

The nature of stigma and discrimination

- HIV/AIDS-related stigma builds upon, and reinforces, existing prejudices. It also plays into, and strengthens, existing social inequalities - especially those of gender, sexuality and race.
- HIV/AIDS-related stigma and discrimination play a key role in producing and reproducing relations of power and control. They cause some groups to be devalued and others to feel that they are superior. Ultimately, stigma creates and is reinforced by social inequality.

Stigma, discrimination and human rights

- Prejudiced and stigmatizing thoughts frequently lead people to do, or not do, something that denies services or entitlements to another person. For example, they may prevent
health services being used by a person living with HIV/AIDS, or terminate their employment on the grounds of their HIV status. This is discrimination.

- Discrimination occurs when a distinction is made against a person that results in their being treated unfairly and unjustly on the basis of their belonging, or being perceived to belong, to a particular group.

Tackling stigma and discrimination as a rights issue

- The human rights framework provides access to existing procedural, institutional and other monitoring mechanisms for enforcing the rights of people living with HIV and AIDS, and for countering and redressing discriminatory action.
- Appropriate reporting and enforcement mechanisms ranging from legal aid services to hotlines for reporting acts of discrimination and violence can provide powerful and rapid means of mitigating the worst affects of HIV/AIDS-related discrimination.

The wider impact

- Stigma and discrimination can lead to depression, lack of self-worth and despair for people living with HIV. But people living with the disease are not the only ones at risk from this fear and prejudice.
- Negative attitudes about HIV also create a climate in which people become more afraid of the stigma and discrimination associated with the disease than of the disease itself. When fear and discrimination prevail, people may choose to ignore the possibility that they may already be, or could become, HIV-positive – even if they know they have taken risks. And people may decide not to take actions to protect themselves for fear that in doing so they are associating themselves with HIV and having been ‘at risk’. All of this helps to create an environment in which the disease can more easily spread.

- The World AIDS Campaign seeks to break the cycle of stigma and discrimination by:
  - Highlighting the harm of stigma and discrimination
  - Promoting the benefits of tackling stigma and discrimination
  - Using education to challenge ignorance, fear and denial
  - Promoting hope and the contribution of people living with HIV and AIDS
- One of the most effective ways to break the cycle of stigma and discrimination is through ensuring people living with HIV can contribute to society. The best way to do this is to provide treatment to keep people healthier longer.
- The World Health Organization (WHO) and UNAIDS are spearheading a bold initiative to roll out antiretroviral treatment to 3 million people, in areas of most need, by the end of 2005. In addition a growing number of countries are setting up national comprehensive prevention and care programmes. These initiatives can help lift the pall of suspicion and secrecy that accompanies the epidemic.

- Only by confronting stigma and discrimination will the fight against HIV/AIDS be won.

Live and let live. Help us fight fear, shame, ignorance and injustice worldwide.

For more information, please contact Andy Seale, UNAIDS, Geneva, (+41 22) 791 4765 or Dominique De Santis, UNAIDS, Geneva, (+41 22) 791 4509. You may also visit our website, www.unaids.org, for more information about the programme.
**Session 4. HIV transmission overview: understanding personal and professional risk**

Interactive game, PPT, discussion

- **Objectives:**
  1. Explore the risk of HIV transmission at different behavior models.
  2. Debunk HIV transmission myths.
  3. Identify the 4 stages of HIV disease as defined by WHO (August 2006).
  4. Discuss most frequent HIV and hepatitis related transmission risk factors to patient and provider in healthcare settings.

- **Time**
  1 hour 30 minutes

- **Materials**
  - Flipchart paper
  - Markers
  - Tape
  - Prepare four cards using letter-sized colored cards or paper, with the following titles:
    o High risk
    o Medium risk
    o Low risk
    o No risk
  - Prepare behavior and myth cards (annex 6) using letter-sized cards or paper, with one behavior or myth per card or piece of paper.
  - PowerPoint presentation on HIV pathogenesis, copied for all training participants (annex 7)

- **Steps**
  1. Distribute all of the cards with behaviors and myths to the participants, trying to ensure that each participant has the same number of cards.
  2. Ask participants to individually read their cards and place them on the floor, where facilitators place the cards titled with stages of risk. Each card should be allotted under the category which, in participant’s opinion, matches the probability and associated risk of HIV infection under the circumstances of the situation described in the card.
  3. Once all cards are placed, discuss jointly with participants the location of cards, supporting the discussion with explanations why some cards should fall under one category and not another. In case some cards were placed wrong, move them to the relevant risk category and explain in detail the reason for doing so. Encourage participants to explain their opinions and correct any mistakes or ambiguities.

**Key Discussion Questions**

Do you disagree with the placement of any cards? Where should they go instead and why?

Are you confused by the placement of any cards? Why is a particular card placed where it is along the continuum?

Which cards did you find most difficult to place along the continuum?

Which cards can be categorized as myths? Are there other myths about HIV transmission that you have heard about in your community? Where do these myths come from and how can we dispel them?
4. Conclude and summarize the discussion.
5. Make PowerPoint presentation on HIV pathogenesis.
6. **Summarize** the session by reviewing with participants the key points elicited from the discussion and the presentation.

- **Handouts**
  PowerPoint presentation on HIV pathogenesis (annex 7)
Annex 6

Behavior and myth cards

Abstinence
Masturbation
Sexual stimulation of another’s genitals using hands
Sex with a monogamous, uninfected partner
Oral sex on a man (fellatio) with a condom
Oral sex on a man (fellatio) without a condom
Oral sex on a woman (cunnilingus)
Vaginal sex with a condom
Vaginal sex without a condom
Vaginal sex with multiple partners always using a condom
Anal sex with a condom
Anal sex without a condom
Massage
Having unprotected sex with your partner or spouse
Hugging a person with HIV
Vaginal sex with withdrawal prior to ejaculation
Re-using sharp instruments to cut me skin
Be-using injection needles or syringes between clients
Sitting on a public toilet seat
Getting bitten by a mosquito
Breastfeeding from an HIV-positive mother
Receiving a blood transfusion
Helping someone with a nosebleed
Sharing eating utensils with an HIV-positive person
Donating blood
Getting pierced
Shaking hands with an HIV-positive person
Labor and delivery (risk to child, mother is HIV-positive)
Sharing needles to inject drugs
Going to the dentist
Performing a pelvic exam during delivery without gloves
Performing a delivery without gloves
Recapping a used needle
Cleaning up a blood spill wearing latex gloves
Cleaning up a blood spill without wearing latex gloves
Performing a cesarean section delivery wearing latex gloves
Traditional circumcision (male)
Getting a clients blood on your hands
Getting a clients blood on your hand (which has a recent cut on it)
Getting a clients blood on your hand (which has a rash on it)
Getting a clients blood on your hand which has a torn cuticle
Getting blood from a client splashed in your eye
Getting blood from a client splashed into your mouth
Sticking yourself with a used needle in the lab
Taking a blood pressure without gloves
Taking temperature without gloves
Performing an abdominal exam without gloves
Performing an antenatal abdominal exam without gloves
HIV Pathogenesis

Training for Health Care Workers

Presentation Plan

1. HIV transmission
2. HIV pathogenesis in humans
4. Virus resistance to environment
5. HAART impact on HIV
HIV Transmission (1)

Ways of transmission:
- Sexual
- Blood transfusion
- Mother-to-child

Risk of sexual transmission increases in the following cases:
- Penetrating sexual contact, injuries during sexual contact
- Serum conversion (high viral load)
- Advanced stage of disease (low CD4 count & high viral load)
- Sexually transmitted co-infections and co-morbidities (genital herpes, ulcerations, pathological excretions)

HIV Transmission (2)

Risk of mother-to-child transmission comprises:
- 15-25% in different countries
- 35-40% in developing countries (breastfeeding)
- Reduces by 50% and more under PMTCT
- Reduces under ART (under HAART – reduces to 1%)
HIV Infection Risk Factors

• Sexual relations with casual partners

• Any genital erosion
  – Syphilis, Herpes Simplex Virus

• Any sexually transmitted disease

• Insufficient safe sex practices (for instance, use of condoms)

• High viral load in partners (HIV RNA)

HIV Structure
HIV Pathogenesis in Humans (1)

- Infection occurs due to close contact with blood and other biological fluids containing the virus in quantity sufficient for infecting (sperm, vaginal secretion, breast milk)
- Mucosal dendritic cells facilitate the penetration of virus into the human body
- Virus instantly hits activated CD4 lymphocytes next to the infection entry and is carried by them into regional lymph nodes
- After that, HIV consumes the human body via blood and lymph flows

HIV Pathogenesis in Humans (2)

- Virus is detected in blood and lymph nodes; in latent form, it harbors in long-surviving lymphocytes, which makes its complete removal impossible
- Permanent impairment of lymphatic system occurs within 48 hours
- Physical contact with infected blood or other biological fluid requires immediate prophylaxis (optimally, right after the contact)
- Some groups of patients with depressed immune system may have rapid disease development. Infants and people with defective immune system belong to such groups
WHO Clinical Staging of HIV/AIDS for Adults and Adolescents, 2006 (1)

**CLINICAL STAGE**

**Asymptomatic. Persistent generalized lymphadenopathy**

**CLINICAL STAGE**


**CLINICAL STAGE**

CLINICAL STAGE V


HIV Development Features

Variability of clinical manifestations of HIV is determined both by viral factors and patient’s health.

Average interval between the moment of infection and the development of opportunistic infections in humans receiving no treatment comprises 8-10 years.
### Virus Resistance To Environment

HIV is highly unstable in external environment

The temperature of 22°C kills HIV in 4 days.

HIV is inactive after being treated with:
- 0.5% solution of sodium hydrochloride,
- 70% alcohol for 10 minutes;
- bleach cleaners;
- alcohol, acetone, ether.

On the surface of intact skin, HIV is destroyed by human protective enzymes and bacteria.

HIV dies quickly at the temperature of 57°C and almost instantly at boiling temperature.

### HAART Impact on HIV

**Effective and timely ARV treatment:**
- maximum depresses replication of HIV in humans;
- revives immune system and reduces viral load;
- reduces risk of HIV transmission;
- reduces HIV transmission to healthy population;
- increases expectancy and quality of life of HIV-positive people.
Session 5. HIV precautions at workplace for patient and provider and post-exposure prophylaxis.
PPT, discussion

- **Objectives:**
  1. Discuss the attitude of health care staff toward professional HIV transmission risk.
  2. Introduce participants to the principles and practices of universal precautions to avoid HIV, hepatitis and other disease transmission (to and from patient and provider and HIV post-exposure prophylaxis) in healthcare settings.
  3. Overview the professional ways of HIV prevention in healthcare settings and post-exposure prophylaxis.

- **Time**
  1 hour 15 minutes

- **Materials**
  - Flipchart paper
  - Markers
  - Tape
  - PowerPoint presentation “HIV protection at workplace and post-exposure prophylaxis”, copied for all training participants (annex 8).
  - Post-Exposure Prophylaxis for HIV: Clinical Protocol for the WHO European Region, copied for all training participants.

- **Steps**
  1. Explain to all participants that the objective of this session will be achieved through discussion of the PowerPoint presentation “HIV protection at workplace and post-exposure prophylaxis”, developed based on the Clinical Protocol for the WHO European Region.
  2. Make the PowerPoint presentation “HIV protection at workplace and post-exposure prophylaxis” (annex 8).

**Training Tips**
During the presentation, try to maximum involve participants in the discussion of the presented material, giving examples and providing feedback.

  3. Summarize the session by reviewing with participants the key points elicited from the discussion and the presentation.

- **Handouts**
  - PowerPoint presentation “HIV protection at workplace and post-exposure prophylaxis” (annex 8)
  - Post-Exposure Prophylaxis for HIV Infection: Clinical Protocol for the WHO European Region (annex 9).
HIV protection at workplace and post-exposure prophylaxis

Training for Health Care Workers

Presentation Plan

1. Universal precautions
2. Risk of HIV infection at workplace
3. Post-exposure prophylaxis
Presentation Goal and Objectives

• **Goal:**
  present universal precautions and learn recommendations on HIV post-exposure prophylaxis (PEP)

• **Objectives:**
  – be able to assess a risk of HIV transmission when performing professional duties;
  – identify indications for post-exposure prophylaxis;
  – introduction of PEP protocol.

Universal Precautions Embrace (1):

*Contacts associated with the risk of infection:*

  – Percutaneous contact (e.g. a needle stick or a sharps injury);
  – Contact of mucous membranes or non-intact skin with biological material;
  – Contact of intact skin with blood, body tissues or fluids over a long period of time (several minutes or more) or on a large area.
### Universal Precautions Embrace (2):

- **Blood and other body fluids, exposure to which may cause HIV infection:**
  - sperm
  - vaginal discharge
  - any fluids containing visible blood
  - cultures and culture media with HIV

- **Body fluids with unidentified degree of HIV infection risk:**
  - synovial fluid
  - cerebrospinal fluid
  - pleural fluid
  - peritoneal fluid
  - pericardial fluid
  - amniotic fluid

### Universal Precautions Embrace (3):

- any tissues or human body organs (except for intact skin) removed (during lifetime or autopsy)
- tissues and organs of test animals with blood-borne infections

- any body fluids that are hard to identify
- any cuts of unknown origin
Individual Protection Means

- latex gloves
- gowns, laboratory overalls
- face screens, masks, eye shields

Universal Precautions Do NOT Embrace:

- Lacrimal fluid
- Nasal discharge
- Saliva (except for dental situation where there is a high risk of blood getting in saliva)
- Sweat
- Sputum
- Vomit mass (not containing blood)
- Urine
- Feces
Recommendations For Administrative Staff

- Reduce the number of invasive interventions
- Enforce the implementation of effective guidelines and recommendations in the work of an institution
- Train medical staff to apply universal precautions
- Provide the staff with protective and other requisite means and equipment

Occupational Risk of HIV Infection

- percutaneous contact with HIV-infected blood – 0.3% (3/1000) (from 0.2% to 0.5%)
- exposure of mucous membranes to blood – 0.09% (9/10 000) (from 0.006% to 0.5%)
- contact with intact skin – risk not identified
- contact with other body fluids – risk not identified
Indications For Post-Exposure Prophylaxis

- Skin injury caused by a sharp object, contaminated with blood, fluid containing visible blood or other potentially contagious materials
- A bite by an HIV positive patient, who has a visible source of bleeding in the mouth
- Exposure of mucous membranes of the mouth, nose and eyes to blood, fluids containing blood or other potentially contagious material
- Exposure of injured skin to blood, fluids containing blood or other potentially contagious material (e.g. open wound, chafe, windburns or areas affected by dermatitis)

Universal Precautions

- Simpler and cheaper than post-exposure prophylaxis
- It is necessary to take precautions that can protect against HIV infection, e.g.: gloves
- Preventive means should be available
- Staff should be systematically trained
- Accident logs should be monitored to understand and bridge gaps in HIV prevention (e.g. needles should have caps)
HIV Prevention #1

- The most important prevention mean that is often overlooked is **YOU**:
  - Be concentrated
  - Be prepared and alert
  - Pay attention
  - Do not talk when holding a needle. All attention should focus on this potentially dangerous weapon

Actions To Be Taken In Case Of Occupational Exposure

- First aid: rinse contaminated skin (injured or intact) with water and soap; rinse mucous membranes with water. Do not press the area of a needle stick to avoid accidental bleeding
- Assess the risk of HIV infection
- Do PEP if the risk of HIV infection is high
PEP (1)

• An accident should be assessed for a potential risk of HIV infection
• Potential risk:
  – Is the source of the accident HIV positive? Or HIV status is unknown?
  – Time from the moment of the accident: PEP must be started <72 hours and the earlier the better. Minutes matter!
  – Other known risk factors in case of percutaneous contact:
    • Blood remaining on the needle
    • Large hollow bore
    • Needle that was in the vein – in contrast to intramuscular or subcutaneous injection
    • Deep penetrating needle stick
    • High viral load of the source (early seroconversion, late stages of HIV, OI or failed ART, high viral load detected)

PEP (2)

• Clinical assessment and initial HIV testing of a healthcare worker, who had an accident, should be provided only upon informed consent.
  – This may be a barrier to PEP
  – Stigma and fear are most likely to compel the staff not to consent to be tested. As a result, staff do not report accidents at all
  – All healthcare workers must be regularly trained on accidents management and should have access to confidential testing
PEP (3)

- Training to reduce the risk of accidents should be provided to all healthcare workers once or twice a year, as well as to all newly hired staff.

- An accident should be discussed with the healthcare worker, who had it, without accusations or judgements, the sequence of the events preceding the accident should be discussed too.

- An accident report should be prepared, but the healthcare worker must be sure that it will not be used against him/her by the institution’s administration.

PEP – ART (1)

Depending on the risk of infection and testing results, the following actions must be taken in case of an accident:

1. If the testing result of a potential source of infection is negative or the testing result of the worker, who had an accident, is positive

   RV prophylaxis is not provided. Positive worker needs HIV care
2. If the testing result is negative for the worker, and positive for the patient

Risk is measured and if PEP is applicable, then:
- The worker is referred for counseling;
- A 4-week ARV prophylaxis is provided, during which possible side-effects are monitored;
- During 4 weeks of PEP, on a weekly basis, meetings are held with the worker;
- Repeat HIV testing is done 1, 3 and 6 months after the exposure.

**PEP – ART (1)**

Risk of HIV infection in case of accidents:
- In case of a needle stick, if it is a large bore, if the needle was in the vein or it was a deep penetration
- In case of small needle stick after an intramuscular, subcutaneous injection or not deep, bloodless penetration

High risk  
Low risk  

Clinical approach is necessary, and all details of the accident are very important
PEP – ART (2)

• If the status of the source-patient is impossible to determine:
  – Perceive the source as HIV high risk (e.g. if the source is an IDU)
  – Perceive the source as HIV low risk, e.g. in a clinic for diabetes patients in case of a stick with an insulin needle

• Determine the VHB immune status of the worker and if necessary perform vaccination

• If possible, test the healthcare worker and the source for VHC

PEP – ART (3)

• Provide thorough counseling to the healthcare worker who had an accident
• Provide counseling without blaming the worker
• Discuss safe behavior practices to prevent future accidents
• Explain:
  – The meaning of testing results
  – If PEP is prescribed, provide counseling on possible side effects, drug interactions and adherence
  – The need for notifying about the accident all sexual partners, and use condoms for 6 months after the accident
Prevention After Unsafe Sex

- Risk of infection during sexual intercourse:
  - 0.1–3.0% for a passive partner during anal sex;
  - 0.1% – 0.2% for a female during vaginal sex;
  - 0.03% – 0.09% for a male during vaginal sex;
  - In case of low viral load the risk of infection is lower.

- No prophylaxis is recommended after casual sex

- In case of condom breakage, if the pair is discordant, prophylaxis is provided

- Sexual abuse victims should receive same prophylaxis as healthcare workers

PEP: Recommendations

- PEP should start as soon as possible, it is best to start it during the first 2 hours after exposure, but not later than 72 hours after exposure

- HAART

- When a scheme is chosen, one should consider what ARV the source patient is receiving, and possible cross-resistance to various drugs
PEP:
Indications For Prophylactic ART

. HIV exposure at workplace

B. Other contacts:
   – One-time high risk exposure during the last 72 hours
   – Sexual intercourse with an HIV positive person or a partner from a high risk group

PEP:
Protocol. ARV (1)

. Start in the first hours after exposure (not later than the first 72 hours).

. Prescribe a three-component ART course for 4 weeks:

• Two drugs – a combination of Zidovudine and Lamivudine:
  – Zidovudine - 300 mg, internally, every 12 hours
  – Lamivudine - 150 mg, internally, every 12 hours

• Third drug - Protease Inhibitor:
  – Lopinavir/Ritonavir – 400/100 mg, internally, every 12 hours (first choice drug)
  – Alternative PI, less desirable:
    Sakvinavir/Ritonavir – 1000/100 mg, internally, twice per 24 hours
PEP: Protocol. ARV (2)

• If the source patient is on ART (especially second line therapy), an individual approach that considers cross resistance is required

• Ideally, counseling by a specialist in infections, involved in PLHIV treatment, care and support

PEP: Protocol. ARV (3)

• Confirmed risk:
  – Liver toxicity of Nevirapine in those who received PEP. Therefore, NVP is contraindicated during PEP.

• NRTI can be prescribed in the following cases:
  – Resistance to protease inhibitors
  – If the infection source is resistant to ARV and other drugs, but is susceptible to NRTI.
PEP:
Protocol. ARV (4)

Do laboratory testing to determine contraindications for ARV and baseline indicators for further assessment of therapy side-effects:

- Pregnancy test
- CBC with leukogram and number of thrombocytes
- Biochemical indicators of liver functions
  - GPT
  - GOT
  - ALP
  - Total bilirubin

National PEP Protocols

- Meet WHO protocols
- HAART with PI is optimal
- Due to a shortage of ARV drugs, during PEP the 2000 national recommendations are used.
  - AZT – 800-1000 mg. daily – 3-4 weeks not later than 24-36 hours after exposure
- Registration of contacts and requisite forms
13 Post-exposure Prophylaxis for HIV Infection

Clinical Protocol for the WHO European Region
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I. Policy issues

Following exposure to HTV, there are currently only two known means to reduce the risk of developing HIV infection: post-exposure prophylaxis (PEP) and interventions to prevent mother-to-child transmission (see Protocol 10, *Prevention of HIV transmission from HIV-infected mothers to their infants*).

- PEP policy should be part of a comprehensive national HIV/AIDS policy and also include any occupational health and post sexual assault services policies.
- PEP services should be integrated into existing health services and provided as part of a comprehensive standard precautions package that reduces workplace exposure to infectious hazards.
- Eligibility for and access to PEP should be equitable, without discrimination on grounds of age, gender, sexual orientation, citizenship, occupation or incarceration.
  - Decisions about whether to provide PEP should be based on clinical consideration of risk factors.
  - PEP services should be provided after:
    - occupational exposure to HTV infection or potential HIV infection;
    - accidental non-occupational exposure to HIV infection or potential HIV infection, including nosocomial exposure.
- The human rights and confidentiality of people accessing PEP should be respected.
- In the context of exposure and/or the provision of PEP, informed consent needs to be obtained for HIV testing and counselling in accordance with both client and provider initiated counselling and testing guidelines. (See Annexes 1 and 2 for examples of informed consent forms.)
- In special situations where the individual has limited or no capacity to consent to an HIV test (such as a child or an unconscious or mentally ill adult), a legal guardian, custodian or other person designated in advance by the patient may be able to provide consent, depending on national or regional legislation.
II. Background and general considerations

PEP is a medical response given to prevent the transmission of pathogens after potential exposure. PEP for HIV refers to a set of comprehensive services to prevent HIV infection in exposed individuals. These services include, first aid care, counselling and risk assessment, HIV testing based on informed consent, and depending on risk assessment, the provision of short term (28 days) antiretroviral (ARV) drugs, with follow up and support.

1. Occupational exposure to HIV

1.1. Definition
According to the ILO/WHO guidelines for occupational PEP, “an occupational exposure is defined as a percutaneous, mucous membrane or non-intact skin exposure to blood or body fluids that occurs during the course of an individual’s employment. This applies to health care workers (HCW) and to non-health workers.” (1) An occupational exposure may place a worker\(^1\) at risk of HIV infection through injuries such as those involving a potentially contaminated needle or sharp instrument or chapped, abraded skin or contact with mucous membranes.

1.2. Risk for transmission
The risks for occupational transmission of HIV vary with the type and severity of exposure (2, 3).
\- The average risk for HIV transmission after a percutaneous exposure to HIV-infected blood has been estimated to be approximately 0.23% (95% confidence interval (CI) = 0.00-0.46%) (3).
\- The average risk after a mucous membrane exposure is estimated to be approximately 0.09% (CI = 0.006-0.5%) (4).
\- Factors associated with an increased likelihood of transmission include:
  - deep (intramuscular) injury
  - injury caused by a device that enters a blood vessel
  - injury with a hollow-bore needle
  - a source patient with a high viral load (VL).
\- Episodes of HIV transmission have also been documented after non-intact skin exposure. Although the average risk for transmission by this route has not been precisely quantified, it is estimated to be much less than the risk for mucous membrane exposures.
\- The risk for transmission after exposure to HIV-infected fluids or tissues other than blood has not been quantified either, but it is considered probably lower than for blood exposure.

1.3. Potentially infectious body fluids (5)
\- Blood and visibly bloody body fluids are considered as potentially infectious.
\- The risks of HIV transmission from cerebrospinal, synovial, pleural, peritoneal, pericardial and amniotic fluids are unknown.
\- Semen and vaginal secretions have not been implicated in occupational transmission from patients to health care providers.
\- Faeces, nasal secretions, saliva, sputum, sweat, tears, urine and vomitus are not considered potentially infectious unless they contain visible blood.

\(^1\) Besides health care providers (physicians, dental personnel, nurses, laboratory and autopsy personnel, nursing assistants, medical technicians, pharmacists, medical students et al.), others at risk of workplace exposure include police, fire and ambulance personnel.

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1.4. Factors affecting the risk for HIV transmission after an occupational exposure

Epidemiological and laboratory studies suggest that multiple factors might affect the risk for HIV transmission after an occupational exposure (2, 3).

- For percutaneous exposure to HIV, increased risk for HIV infection is associated with exposure to blood from the source person, as indicated by:
  - a device (e.g. a needle) visibly contaminated with blood; or
  - a procedure that involved a needle being placed directly in a vein or artery or in a deep injury.
- High viral load in the source person is also a condition that may increase the risk of HIV transmission.

2. Non-occupational exposure

Due to ethical considerations, it is not possible to make prospective randomized controlled studies to evaluate the efficacy of PEP in preventing HIV after non occupational exposure. Neither are there data from studies or case reports providing definitive evidence of the efficacy of PEP after sexual, injecting drug or other non-occupational exposures to HIV. However, several related data sets from occupational exposure, mother-to-child transmission and animal studies support the biological plausibility of its effectiveness (6-10).

2.1. Definition

Non-occupational exposure is any direct mucosal, percutaneous or intravenous contact with potentially infectious body fluids that occurs outside perinatal or occupational situations (11):

Non-occupational exposure is considered to be all accidental and sporadic incidents in which contact with blood or other body fluids (semen, vaginal secretions, etc.) that pose a potential risk for HIV infection occurred. Non-occupational exposure includes unprotected sexual exposure, sexual exposure involving a broken or slipped condom, injecting drug users (IDUs) sharing equipment, accidental needlestick injuries, bite wounds, mucosal exposure, etc.

Non-occupational exposure also includes nosocomial exposure. Accidental exposure to HIV originating in a health care facility includes cases where a patient is exposed by a health care worker (HCW) or another patient (12). Three scenarios can result in a patient being exposed to HIV nosocomially (13):

- an HTV-infected HCW who does not know his/her HIV status performing an exposure-prone procedure;
- an HTV-infected HCW performing a non-exposure-prone procedure (and when there is e.g. a spontaneous nosebleed or a physical assault on the HCW); or
- the event that an invasive device or product contaminated with HIV by use on one patient is accidentally reused on another patient.

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2 Percutaneous non-occupational exposure includes but is not limited to accidental or criminal sticks with needles contaminated with blood or other bodily fluids.

3 Exposure-prone procedures are those in which there is a risk that injury to the HCW could result in exposure of the patient to the blood of the HCW, including some common procedures found in surgery, obstetrics, gynaecology, midwifery and dentistry (13). HCWs who know that they are HIV infected, should not be involved in such procedures
2.2. Risk for transmission

The estimated per-act transmission risk from unprotected exposure to a person known to be HIV-infected is low. It varies depending on the type of exposure.

<table>
<thead>
<tr>
<th>Exposure route</th>
<th>Risk per 10 000 exposures to an infected source</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood transfusion (3)</td>
<td>9 250</td>
<td>92.5</td>
</tr>
<tr>
<td>Mother-to-child transmission (15)</td>
<td>1 500-3 000</td>
<td>15-30</td>
</tr>
<tr>
<td>Needle-sharing injecting drug use (3)</td>
<td>80</td>
<td>0.80</td>
</tr>
<tr>
<td>Receptive anal intercourse (16, 17)</td>
<td>50</td>
<td>0.50</td>
</tr>
<tr>
<td>Percutaneous needle-stick (18)</td>
<td>30</td>
<td>0.30</td>
</tr>
<tr>
<td>Mucosal membrane exposure (19)</td>
<td>10</td>
<td>0.10</td>
</tr>
<tr>
<td>Receptive penile-vaginal intercourse (16, 17, 20-24)</td>
<td>1-15</td>
<td>1.01-0.15</td>
</tr>
<tr>
<td>Insertive anal intercourse (16, 17)</td>
<td>6.5</td>
<td>0.065</td>
</tr>
<tr>
<td>Insertive penile-vaginal intercourse (16, 17)</td>
<td>1-15</td>
<td>0.01-0.15</td>
</tr>
<tr>
<td>Receptive oral intercourse (17)</td>
<td>1</td>
<td>0.01</td>
</tr>
<tr>
<td>Insertive oral intercourse (17)</td>
<td>0.5</td>
<td>0.005</td>
</tr>
</tbody>
</table>

* Estimates of risk for transmission from sexual exposure assume no condom use. Source: adapted from Roland et al. (14).
III. Evaluation of the exposure, exposure source and exposed person

1. Evaluation of exposure
An exposure incident should be evaluated for the potential of HIV transmission based on the type of body substance involved, the transmission route and the severity of the exposure. The following factors should be considered in evaluating the risk of transmission:

• the type of exposure:
  ◦ percutaneous injury
  ◦ mucous membrane exposure
  ◦ open wound exposure;

• the type and quantity of fluid/tissue:
  ◦ blood;
  ◦ a fluid that contains blood;
  ◦ a potentially infectious fluid (e.g. seminal, vaginal, cerebrospinal, synovial, pleural, peritoneal, pericardial or amniotic fluid) or tissue;
  ◦ concentrated virus (direct contact); and

• the recency of exposure.

2. Evaluation of the exposure source
When feasible, the person whose blood or body fluid is the source of potential exposure should be evaluated for HIV.

• If an exposure source is known and available, testing the source person for HIV is recommended as soon as possible, or testing the suspected exposure material (blood, tissue, etc) if the person is unavailable.

• Procedures that should be strictly followed for testing the source person include:
  ◦ obtaining informed consent (see suggested form in Annex 1)
  ◦ pre- and post-test counselling
  ◦ referral if positive for appropriate post-test counselling, care and treatment.

• A rapid HIV-antibody test is preferred in situations where enzyme-linked immunosorbent assay (ELISA) tests cannot be completed within 24-48 hours.

• Two positive ELISA or rapid HIV-antibody tests are considered to be highly suggestive of infection, whereas a negative result is an excellent indicator of the absence of HIV antibody.

• In no way should administration of PEP for the exposed person be delayed while waiting for test results.

• The routine use of direct virus assays (e.g. an HIV p24 antigen enzyme immunoassay (EIA) or HIV RNA tests) to detect infection among exposure sources is usually not recommended because:
  ◦ the infrequency of occupational seroconversion and the increased costs of these tests do not warrant routine use in this context; and
  ◦ the relatively high rate of false-positive results for these tests in this context can lead to unnecessary anxiety or treatment.

• The exposure source should also be tested for hepatitis viruses (HCV and HBV).

• Information to consider when evaluating an exposure source includes:
  ◦ previous HIV test results; and
  ◦ clinical symptoms (e.g. acute syndrome suggestive of primary HIV infection and history of possible HIV exposure within the last three months) or personal history suggesting possible exposure to HIV; and
  ◦ history of treatment, duration, its success or failure, type of regime and adherence.
• If the exposure source is unknown, cannot be tested or refuses to be tested, the risk of HIV transmission should be assessed epidemiologically, if possible. Relevant information includes:
  o type of exposure
  o prevalence of HIV in the population where the source material originates.
• If the source person is known to have HIV infection, the following information is also useful to know in determining an appropriate PEP regimen:
  o clinical stage of the HIV infection;
  o CD4 cell count;
  o viral load, as a high plasma viral load increases the risk of transmission in all cases (27);
  o antiretroviral treatment history;
  o genotypic or phenotypic viral resistance results (if available);
  o in a case of sexual exposure, the existence of genito-oral ulcers or other sexually transmitted infections (STIs), and whether menstruation or other bleeding occurred at the time (24); and
  o in the case of an accidental needle-stick exposure, whether fresh blood was present and whether it was a deep injury or intravenous injection (all increase the risk of HIV transmission) (6).
• If this information is not immediately available, initiation of PEP, if indicated, should not be delayed. Appropriate changes in the PEP regimen can be made if new information emerges after PEP has been started.
• If the source person’s results are HIV seronegative at post-exposure evaluation and presents no clinical evidence of AIDS or HIV infection, no further testing of the source is indicated. The likelihood of the source person being in the “window period” of HIV infection with no symptoms of acute retroviral syndrome is extremely small.

3. Evaluation of the exposed person
Evaluation of exposed persons (regardless if it is occupational or non-occupational) has to be done as soon as possible and within hours after an exposure. The following evaluations are recommended:
• an HIV serological baseline test to establish infection status at the time of exposure, with pre- and post-test counselling and based on informed consent (see Annex 2);
• direct virus assays for any exposed person who has an illness compatible with an acute retroviral syndrome, regardless of the time elapsed since exposure;
• evaluation of circumstances, medical conditions and medications that might influence drug selection for PEP (e.g. pregnancy or breastfeeding);

It is useful to perform the following baseline tests if resources are available:
• baseline laboratory testing to monitor for adverse reactions:
  o complete blood count (CBC) with differential and platelets
  o liver function tests (LFTs) (asparate aminotransferase (AST), alanine aminotransferase (ALT), bilirubin) ° urea or serum creatinine; and
• baseline serological tests for hepatitis (HCV antibodies and hepatitis surface antigen (HBsAg)).

3.1. Additional considerations for non-occupationally exposed people
In addition, those seeking care after potential non-occupational exposure to HIV should also be evaluated for the following information:
• frequency of exposures to HIV;
• history of specific sexual, drug-injecting or other behaviours that might have heightened the risk for acquiring HIV infection;
• if an accidental needle-stick exposure, whether there was fresh blood and whether it was a deep injury or intravenous injection (6); and

if a sexual exposure:
- condom use
- presence of STIs (as determined by testing)
- need for emergency contraception or pregnancy testing (for females)
- presence of sexual assault, by one or more persons
- whether menstruation or other bleeding was present at time of exposure.
IV. Clinical management of people incidentally exposed to HIV

1. First aid

For a potential exposure to HIV, “first aid” refers to the actions that should be taken immediately afterwards. The aim of first aid is to reduce contact time with the source person’s body fluids (including blood) and tissues, and to clean and decontaminate the exposure site to reduce the risk of infection (28).

If the skin is broken following an injury with a used needle or other sharp instrument, take the following steps.

- Wash the injury immediately, using soap.
- Encourage the puncture wound to bleed freely under running water for several minutes or until bleeding ceases.
- If running water is not available, clean site with a gel or hand cleaning solution.
- Do not use any strong solutions, such as alcohol, bleach or iodine, as they may irritate the wound and make the injury worse.
- Do not squeeze or rub the injury site.
- Do not suck a puncture wound.

After a splash of blood or body fluids, do the following:

- for a splash on unbroken skin:
  - wash the area immediately;
  - if running water is not available, clean the area with a gel or hand rub solution;
  - do not use any strong solutions, such as alcohol, bleach or iodine, as they may irritate the affected area;
  - use mild disinfectants, such as Chlorhexidine gluconate 2-4%;
  - do not rub or scrub area;
  - use a dressing.

- for a splash in the eye:
  - irrigate the exposed eye immediately with water or normal saline. Sit in a chair, tilt the head back and have a colleague gently pour water or normal saline over the eye, gently pulling the eyelids up and down to make sure the eye is cleaned thoroughly;
  - if wearing contact lenses, leave them in place while irrigating, as they form a barrier over the eye and will help protect it; once the eye has been cleaned, remove the contact lenses and clean them in the normal manner, which will make them safe to wear again;
  - do not use soap or disinfectant on the eye.

- for a splash in the mouth:
  - spit the fluid out immediately;
  - rinse the mouth thoroughly, using water or saline, and spit out again. Repeat this process several times.

- do not use soap or disinfectant in the mouth.

2. Counselling an exposed person

After the evaluation, health care workers should provide counselling on risk-reduction behaviour to the exposed person regardless of how the individual was exposed, and of whether or not antiretro-viral (ARV) drugs will be recommended for PEP, as such, counselling can reduce the risk of future exposures (29, 30).
It should be made clear during the counselling session that PEP is not mandatory. An informed consent form (see Annex 2) should be signed if the exposed person opts for PEP. In addition to the information outlined on the informed consent form, the exposed people should be counselled on:

- avoiding pregnancy and seeking safe alternatives to breastfeeding;
- avoiding blood, tissue or sperm donation;
- using condoms for sexual intercourse up to the sixth month test confirming that the exposed person remains seronegative;
- standard precaution measures for those at risk of workplace exposure; and
- the need for clinical and serological follow-up.

As stated on the consent form, there is a strong need for adherence to PEP regimens, for further information on adherence refer to Protocol 1, *Patient evaluation and antiretroviral treatment for adults and adolescents*, for information on adherence issues.

Psychological support should be an integral part of counselling and include appropriate referrals as needed.

Counselling on risk-reduction behaviour after non-occupational exposure should also focus, where indicated, on:

- safer injecting practices, with referral to harm-reduction programmes and drug-dependence treatment services;
- STI treatment, with referral to appropriate services; and
- contraception and condom use.

Furthermore, counselling on sexual abuse should be provided, where needed, with appropriate referrals, such as legal services.

**3. No indication for ARV use for PEP purposes**

Some situations do not require initiation of AEVs for prophylaxis purposes. They include (26):

- if the exposed person has previously tested positive for HIV (this needs to be documented);
- if exposure is chronic (occurring regularly versus occurring occasionally⁴), e.g. between serodiscordant sex partners who rarely use condoms or IDUs who share injecting equipment;
- if the exposure does not pose a risk of transmission, e.g.:
  - exposure of intact skin to potentially infectious body fluids;
  - sexual intercourse with proper condom use during which the condom remained intact;
  - exposure to non-infectious body fluids (such as faeces, saliva, urine, sweat) with no blood contamination; or
  - exposure to body fluids from a person known to be FIV-seronegative, unless identified as at high risk for recent infection within the "window period"; and
- if the exposure was more than 72 hours previous (however, consider referring for counselling, testing and clinical follow-up).

Note that the final decision for prescribing or not prescribing PEP should be made on the basis of risk evaluation, the patient-physician relationship, bearing in mind that PEP should never be considered a primary prevention strategy (11).

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⁴ People who are occasionally or episodically exposed to HIV, such as sexually assaulted sex workers who otherwise use condoms, episodically abused children, medical waste workers with repeated sharps injuries, et al should be considered for PEP based on previously described evaluation (see section III of this document).
4. **Time of initiation and duration of PEP**

PEP should be initiated within hours of exposure - ideally within 2 hours and not later than 72 hours after exposure and should not be delayed while waiting for tests results.

The optimal duration of PEP is unknown. Data show that four weeks of ZDV has appeared protective in occupational and animal studies. PEP should be administered for four weeks if tolerated (9, 31-33).

5. **Considerations in choosing an ARV regimen for PEP**

The only PEP efficacy data are from a retrospective case control study (6) on a zidovudine monotherapy, taken as prophylaxis measure. The model in the study indicates reducing risk of HIV acquisition by approximately 81% in health care workers after percutaneous exposure.

No evidence indicates that a three-ARV combination is more effective than a two-ARV combination, or two-ARV combination is more effective than three-ARV combination. Some data suggest that there is significant toxicity associated with three-ARV regimens, while two-ARV combinations are generally well tolerated (29, 34). Offering a two-drug regimen is a viable option, primarily because the benefit of completing a full course of this regimen exceeds the potential benefit of adding a third agent and risking non-completion (35).

For the vast majority of exposure cases, whether occupational or non-occupational, and whether due to percutaneous injuries or to contact with mucous membrane or non-intact skin, the regimen with two ARVs considered to be sufficient. However, suspected or proven drug resistance in a source person might guide a decision to prescribe a three ARV drug regimen.

If a question exists concerning whether to use a two-drug or three-drug regimen, start the two-drug regimen immediately rather than delay administering PEP.

6. **Antiretroviral regimens and drugs for PEP**

6.1. **Two ARV drug regimens**

The two-drug ARV regimen (see Table 2) consists of two nucleoside or nucleotide reverse transcriptase inhibitors (NRTIs).

<table>
<thead>
<tr>
<th>Preferred</th>
<th>ZDV + 3TC(^a) (or FTC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternatives</td>
<td>TDF + FTC(^b) (or 3TC)</td>
</tr>
<tr>
<td></td>
<td>or d4T + 3TC</td>
</tr>
</tbody>
</table>

The combination ZDV + 3TC is available as a fixed-dose combination (FDC) (Combivir), one tablet twice daily (BID). The combination TDF + FTC is available as an FDC (Truvada), one tablet once daily (OD).

6.2. **Three ARV drug regimens**

Expanded ARV regimens (see Table 3) are combinations of three ARVs (two NRTIs + one protease inhibitor (PI)). They are recommended for exposures that pose an increased risk of transmission or that involve a source in whom antiretroviral drug resistance is likely (see section 5).
**TABLE 3.** THREE-DRUG ARV REGIMENS

<table>
<thead>
<tr>
<th>Preferred</th>
<th>ZDV + 3TC&lt;sup&gt;a&lt;/sup&gt; + LPV/r</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternatives</td>
<td>ZDV + 3TC&lt;sup&gt;a&lt;/sup&gt; + SQV/r or ATV/r or FPV/r or TDF + FTC&lt;sup&gt;b&lt;/sup&gt; + SQV/r or ATV/r or FPV/r or d4t + 3TC + SQV/r or ATV/r or FPV/r</td>
</tr>
</tbody>
</table>

<sup>a</sup>The combination of ZDV + 3TC is available as an FDC (Combivir), one tablet BID.

<sup>b</sup>The combination of TDF + FTC is available as an FDC (Truvada), one tablet OD.

6.3. ARV dosages

- **ZDV:** 300 mg per os (PO), BID with food 3TC:
  - 150 mg PO, BID or 300 mg PO, OD FTC: 200 mg, PO, OD TDF: 300 mg, PO, OD d4T: 30 mg PO, BID
- **LPV/r:** 400 mg/100 mg PO, BID with food
- **SQV/r:** 1000 mg/100 mg PO, BID ATV/r: 300 mg/100 mg PO, OD FPV/r: 700 mg/100 mg PO, BID

In cases involving children who need PEP, dosages should be adjusted accordingly (please refer to Protocol 11, *Paediatric HIV/AIDS treatment and care*). For further details regarding essential information about ARVs please refer to Protocol 1, *Patient evaluation and antiretroviral treatment for adults and adolescents*, Annex 4.

6.4. ARVs not recommended for PEP

Some ARVs are not recommended for use in PEP, primarily because of a higher risk for potentially serious life-threatening events: abacavir (ABC), the combination of didanosine (ddI) and d4T, and NVP (36, 37). Amprenavir (APV) should not be given to pregnant or lactating women (38-40). In addition, EFV is not recommended because of low genetic barrier.

An exceptional use of efavirenz (EFV) may be considered when:
- the exposed person cannot tolerate available boosted PIs;
- the source is known to be infected with drug-resistant HIV that is sensitive to EFV.

7. Follow-up of exposed persons

People who have been potentially exposed to HIV, whether occupationally or non-occupationally, should receive follow-up treatment.
- Counselling, post-exposure testing and medical evaluation should be provided to all exposed people, regardless of whether they receive PEP or not.
- If taking ARVs patients should be followed up for adherence and possible side-effects of ARVs (e.g. nausea or diarrhoea) should be managed symptomatically without changing the regimen. For more information, please refer to Protocol 1, *Patient evaluation and antiretroviral treatment for adults and adolescents*. 

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After baseline testing at the time of exposure, follow-up testing using enzyme immunoassay should be performed at 6 weeks, 12 weeks, and 6 months after exposure, even if PEP is declined. Direct virus assays may be performed on any exposed person who has an illness compatible with an acute retroviral syndrome, regardless of the interval since exposure. For those who become infected with HCV after exposure to a source coinfected with HIV and HCV, extended HIV follow-up (for 12 months) is recommended (41). If an exposed person seroconverts after PEP, he or she should be referred for HIV treatment and care services. Psychological support should be provided and referrals suggested as appropriate, including needle and syringe exchange for IDUs. If the exposure is due to rape, it is important to arrange for counselling and support. The victim also needs to be provided with information regarding STIs, pregnancy and legal matters. If the exposed person is a child or adolescent, or if the exposure is due to rape, it may be worthwhile to cooperate with other specialists, e.g. a paediatrician or a rape counsellor. Health care providers caring for people exposed to HIV should report these cases to their health departments regardless of whether or not PEP has been prescribed, and a national PEP registry should be maintained. (See the proposed occupational exposure report in Annex 3 and the proposed non-occupational exposure report in Annex 4)
V. Prevention of occupational and nosocomial exposure

After occupational exposure, it is recommended to evaluate work place safety measures and strengthen standard precautions measures.

The importance of primary prevention in any setting where HIV can be transmitted should be reinforced in every programme that provides PEP. Health care workers (HCW) and other exposed workers should receive appropriate information on PEP availability and the reference centres. It is important to underline that PEP is not ever likely to be 100% effective, and thus it should always be integrated into a larger HIV exposure prevention strategy based on standard precaution principles. Quality control and evaluation of safety conditions at work should be re-evaluated after exposure.

Provided that the procedures for preventing occupational transmission of bloodborne viruses are adhered to at all times, most clinical procedures pose no risk of transmission of HIV from an infected HCW to a patient (42).

1. Standard precautions

Standard precautions are infection control measures that reduce the risk of transmission of blood-borne pathogens through exposure to the blood or other body fluids of patients and health care providers. As it is not possible to identify everyone who may be infected with a bloodborne pathogen, protecting HCWs and patients against HIV and hepatitis viruses should be based on the concept that all patients and HCWs are assumed to be infected with bloodborne diseases.

The application of standard precautions requires that all blood and other body fluids should be regarded as potentially infectious and appropriate protective action taken. To help protect HCWs and patients from bloodborne infections, including HIV, WHO advises that standard infection control precautions be used, as follows.

- Wash hands with soap and water before and after procedures.
- Use protective barriers such as gloves, gowns, aprons, masks and goggles for direct contact with blood and other body fluids.
- Disinfect instruments and other potentially contaminated equipment.
- Handle soiled linen properly (see next section).
- Using new, single-use injecting equipment for all injections is highly recommended.
- Sterilizable injections should only be considered if single-use equipment is not available and if their sterility can be documented with time, steam and temperature indicators.
- Discard contaminated sharps immediately without recapping in puncture- and liquid-proof containers that are closed, sealed and destroyed before completely full.
- Document the quality of sterilization for all medical equipment used in percutaneous procedures (45).

Please see Annex 5 for a checklist of standard precautions for HCWs.

2. Reducing occupational exposure in health care settings

2.1. Basic preventive measures and workplace practices

In addition to standard precautions, workplace practices should be instituted and followed to reduce exposure to bloodborne pathogens and other infectious materials. Avoid accidental injuries.

---

5 The overall risk of an infected HCW transmitting HIV to a patient is low. Worldwide, only two possible reports of such transmission have been reported, both during exposure-prone procedures (43, 44)
and exposure routes that can transmit bloodborne infections. The following guidelines should be adhered to:

- Institute procedures to ensure and monitor compliance with safety measures.
- Only allow health care professionals to perform a duty involving exposure to body fluids if they have undergone training and education in infection control and preventive measures, including the correct methods for cleaning up accidental spills of blood and other body fluids.
- Avoid splashing, spraying, splattering and generating droplets of blood or other potentially infectious materials.
- Clean all equipment and environment surfaces immediately after contact with blood or other potentially infectious materials.
- Place potentially infectious specimens in properly labelled containers that will prevent leakage during collection, handling, processing, storage, transport and shipping. Use a secondary container if the primary container becomes contaminated or punctured.
- **Hand-washing is essential.**
  - Wash hands and any other exposed skin with soap and water before and after procedures, including after removal of gloves and other personal protective equipment or attire.
  - Following the contact of body areas with blood, other potentially infectious materials or contaminated surfaces, wash hands and flush mucous membranes with water immediately or as soon as feasible.
  - Use soap and *running* water. If running water is not available, use an appropriate antiseptic hand cleanser and clean towels or antiseptic towelettes, followed by regular hand-washing as soon as feasible.
  - If minimal skin lesions are already present on hands (e.g. cuts), they need to be properly addressed before using gloves. Bear in mind that glove use requires consideration of additional safety precautions (see Annex 5).
- **Proper handling of soiled linen is essential.**
  - Soiled linen should be handled as little as possible.
  - Gloves and leak-proof bags should be used if necessary.
  - Bags and containers of soiled linen should be labelled.
  - Soiled linen should be cleaned and laundered outside patient areas, using detergent and hot water.
- Place all regulated waste in closable, leak-proof containers.

In addition, health care workers must observe the following restrictions:

- Do not eat, drink, smoke, apply cosmetics, apply lip balm or handle contact lenses in work areas where occupational exposure to bloodborne pathogens is likely.
- Do not keep food and drink in refrigerators or other locations where blood or other potentially infectious materials are present.
- Never use the mouth to pipette or suction blood or other potentially infectious materials.
- Never use hands to pick up broken glassware that may be contaminated.
- Do not bend, recap, break or remove contaminated needles or other contaminated sharps.
- Never use hands to reach into, open, empty or clean reusable sharps containers (46).

### 2.2. Protective material and equipment

Protective equipment and controls should be instituted in all health care settings. To prevent transmission of bloodborne pathogens, the following precautions should be taken:

- **Protective equipment and clothes** should be made available to and worn by all workers who come into contact with blood or body fluids, including:
  - gloves
  - liquid-resistant gowns
  - face and eye protection.
• **Safety measures for needles and syringes include the following.**
  o Use new, single-use, self-sheathing needles or other new disposable injecting equipment for all injections.
  o Only consider sterilizable injections if single-use equipment is not available and if the sterility can be documented with time, steam and temperature indicators.
  o Use needleless intravenous (IV) access systems.
  o Use a mechanical device that protects the hand or a safe one-handed technique if needle recapping or removal is absolutely necessary.
  o In general, containers for sharps should be wall-mounted when not in use to avoid accidents that may occur from patients (especially children) playing with or trying to open them.
• **Safety measures for other sharps include the following.**
  o Discard contaminated sharps immediately and without recapping in puncture- and liquid-proof containers that are closed, sealed and destroyed before completely full.
  o Position sharps disposal containers so that they are easily accessible and maintained upright throughout use.
  o Replace sharps disposal containers regularly and do not allow them to overfill.
  o Before moving a container of contaminated sharps, close it completely. Place it in a secondary container if leakage is possible.
• **Safety measures for dental instruments, devices and equipment include the following (47).**
  o Follow normal heat-sterilization procedures for surgical instruments, periodontal sealers, scalpel blades, surgical dental burs, dental mouth mirrors, amalgam condensers, reusable dental impression trays and dental handpieces.
  o If disinfecting instruments or other equipment that is heat-sensitive, use high-potency disinfectant.
  o Devices connected to the dental water system that enter a patient’s mouth (e.g. handpieces, ultrasonic sealers, air abrasion devices and air/water syringe tips) should operate for a minimum of 20-30 seconds after each patient to discharge water and air and flush out any patient material.
  o Where possible, use dental units that prevent retraction of oral fluids.
  o Components that are permanently attached to dental unit waterlines (e.g. the handles and dental unit attachments of saliva ejectors, high-speed air evacuators and air/water syringe tips) should be covered with impervious barriers that are changed after each use.
• **Appropriate first-aid equipment should always be readily available for dealing with spilled body fluids, and staff should be trained to institute safety precautions following any accident.**
• **Containers appropriate for waste disposal should always be available - as should guidelines for such disposal.**

2.3. **Technological controls**
Technological controls can help isolate and remove bloodborne pathogens from the workplace.
• **Document the quality of the sterilization for all medical equipment used for percutaneous procedures.**
  • Disinfect instruments and other contaminated equipment.
• **Before servicing or shipping, decontaminate any equipment that is contaminated with blood or other potentially infectious materials. If decontamination is impossible, attach a label that states which portions of the equipment remain contaminated.**
• **Set up quality control charts to monitor standard precautions in technical procedures and instrument use.**
2.4 Personal protective equipment and its use

If the potential for occupational exposure still remains after an HCW uses up to date technological controls and standard work practice precautions, the employer must also provide personal protective equipment (PPE). This equipment must be provided in a readily accessible location and at no cost to the HCW.

- Gloves include special gloves if an HCW is allergic to conventional medical gloves.
  - Single-use gloves should not be reused, nor should reusable gloves that show signs of deterioration.
  - Petroleum-based lubricants should not be used, as they can eat through latex rubber.

- Gowns/laboratory coats should be used.
  - Outer garments should be worn in occupational exposure situations.
  - Surgical caps/hoods and shoe covers/boots should be worn only if potential gross contamination of the head or feet is anticipated.

- Face shields/masks/eye protection should be used.
  - Chin-length face shields or masks should be worn in combination with eye protection devices and side shields whenever splashes, spray, spatter or droplets of blood or other potentially infectious materials may be generated.
  - Regular eye-glasses do not provide sufficient protection against bloodborne contaminants.

Personal protective equipment must not permit blood or other potentially infectious materials to pass through to or reach work clothes, street clothes, undergarments, skin, eyes, mouth or other mucous membranes under normal conditions of use during the time in which the protective equipment will be used. Heavy gloves and protective clothing and appropriate training should be provided for all cleaners and waste disposal handlers.

If a protective garment is penetrated by blood or another potentially infectious material, it should be removed as soon as possible. Wash the affected area with soap and water. Remove all PPE prior to leaving the work area and place it in a designated receptacle. Employers are responsible for cleaning, laundering, repairing, replacing and disposal of used PPE.
VI. Suggested minimum data to be collected at the clinical level

Based on the proposed occupational and non-occupational reporting forms (Annexes 3 and 4), the clinical level should aggregate the detailed information about patients requiring PEP, receiving PEP and outcomes (patients who become infected or not).
Annex 1. Informed consent form for source person

(Informed consent to perform an HIV test and authorization for release of HIV-related information for purposes of providing post-exposure care to a person accidentally exposed occupationally or non-occupationally*)

A person has been exposed to your blood or a body fluid in a manner that may pose a risk for the transmission of a bloodborne infection. Many individuals may not know whether they have a bloodborne infection because people can carry these viruses without having any symptoms. We are therefore asking for your consent to test for the presence of human immunodeficiency virus (HIV). You will also be tested for hepatitis B virus (HBV) and hepatitis C virus (HCV). HIV testing is voluntary and requires your consent in writing; consent can be withdrawn for the test at any time. Your blood will be tested by a rapid or enzyme immunoassay serological test. The test result will be used to help determine whether the exposed person is actually at risk for HIV and requires treatment for that exposure.

We will inform you of the test results, helping you understand their implications as well as assisting you in accessing any services you may need.

**Meaning of HIV test results**
You also are being asked to authorize the release of confidential HIV-related information related to this request to the health professional, named below, who is treating the exposed person. This release is necessary to provide appropriate care and to counsel the exposed person about his or her risk of becoming infected and possibly infecting others. Confidential HIV-related information can only be given to persons you allow to have it by signing a release. These individuals are prohibited by law from subsequently disclosing these test results or your identity.

Name of exposed person’s health care provider to whom HIV test result will be disclosed:

Prior to executing this consent, you will be counselled about the implications of HIV testing and your confidentiality protections under the law.

**I understand the purpose for which I am being asked to submit a specimen for HIV testing. My questions about the HIV test were answered. I agree to be tested for HIV, and I authorize the release of this information to the health care provider for the exposed person. This release is effective for one year after the date listed below.**

Name of person to be tested Date

Signature of the person to be tested, or of the person consenting if different from the person to be tested

I provided pretest counselling. I answered the above individual’s questions about the test and offered him/her an unsigned copy of this form.

Signature __________________________ Title __________________________

Facility/provider __________________________

* This form is recommended only for cases of accidental non-intentional exposure. Incases of intentional exposure (e.g. a needle-stick or non-consensual sex), the issue of consent to be tested for HIV and the release of information about an individual’s HIV status is regulated by national laws.*
Annex 2. Informed consent form for exposed person

Name__________________________________________________ Record number _______________________

I understand that I have had an exposure which may be a risk for HIV transmission.

I have been given the following information about post-exposure prophylaxis (PEP):
• the risk of HIV transmission with and without PEP for the specific exposure;
• the benefits of HIV testing (now, at 6 weeks, at 12 weeks and at 6 months);
• the benefits and risks of taking PEP;
• the use of PEP during pregnancy;
• that PEP is not guaranteed to prevent HIV transmission;
• the importance of receiving post test counselling;
• other recommended blood tests;
• the importance of using methods that will prevent HIV transmission (e.g. using condoms, not sharing needles and not breastfeeding) for the next six months;
• the prohibition against donating blood, semen or tissues for the next six months;
• the usual duration of PEP (four weeks) and my ability to stop at any time (though this will reduce its effectiveness);
• the importance of treatment adherence (taking the correct dose of medications at the right time);
• possible side-effects of and drug interactions with the PEP medications; and
• (for HCWs): the safe work practices that are necessary to observe for the next six months.

I have understood this information and have been given the opportunity to ask questions and have received satisfactory answers.
   I voluntarily consent to post-exposure prophylaxis (PEP).
   I decline post-exposure prophylaxis (PEP).

Name__________________________________________________

Date ___________________ Signature _____________________________________________

I confirm that I have explained information about PEP as above.

Name__________________________________________________ Signature _____________________________________________

Position _____________________________________________ Date _______________________

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### Annex 3. Proposed occupational exposure report (confidential)

<table>
<thead>
<tr>
<th>Name (last, first, middle)</th>
<th>Address (work)</th>
<th>Address (home)</th>
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</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Birth date</th>
<th>Sex</th>
<th>Position</th>
<th>Years in practice</th>
<th>Telephone no</th>
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<table>
<thead>
<tr>
<th>Date/time of exposure</th>
<th>Location exposure occurred</th>
<th>Activity at time of exposure</th>
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</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Date/time of consultation</th>
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</table>

<table>
<thead>
<tr>
<th>Nature of injury (e.g. cut, splash or needle-stick, including bore of needle)</th>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Details of the procedure being performed, including where and how the exposure occurred</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Details of the exposure, including the type and amount of fluid or material and the severity of the exposure</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Reporting officer/procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Details about exposure source</th>
<th>Details about exposed person</th>
</tr>
</thead>
<tbody>
<tr>
<td>The source material contained:</td>
<td>Infected with:</td>
</tr>
<tr>
<td>HBV:</td>
<td>HBV:</td>
</tr>
<tr>
<td>HCV:</td>
<td>HCV:</td>
</tr>
<tr>
<td>HIV:</td>
<td>HIV:</td>
</tr>
<tr>
<td>Whether the source is HIV-infected:</td>
<td>Concomitant diseases:</td>
</tr>
<tr>
<td>Clinical disease stage:</td>
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<tr>
<td>Viral load:</td>
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</tbody>
</table>

96
<table>
<thead>
<tr>
<th>Post-exposure management:</th>
<th>CBC with differential</th>
<th>Serum liver enzymes</th>
<th>Signs and symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1 consultation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Week 2 consultation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Week 3 consultation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Week 4 consultation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV antibody test results</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 month:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3 months:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>6 months:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Signature/stamp</td>
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<td></td>
<td>Date</td>
</tr>
</tbody>
</table>
Annex 4. Proposed non-occupational exposure report (confidential)

<table>
<thead>
<tr>
<th>Name (last, first, middle)</th>
<th>Address (work)</th>
<th>Address (home)</th>
<th>Birth date</th>
<th>Sex</th>
<th>Telephone no.</th>
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</table>

**Date/time of exposure**

**Date/time of consultation**

**Other possible exposures**
- Last month:
- Last six months:

**Nature of exposure (for example injection, sexual contact)**

**Risks of exposure**

**Details of exposure, including the type and amount of fluid or material and the severity of exposure**
- Related to sexual exposure
- Related to injection exposure

**Details about exposure source**

- Source material contained:
  - HBV:
  - HCV:
  - HIV:
- Whether source is HIV-infected:
- Clinical disease stage:
- Viral load:
- History of antiretroviral treatment:
- Antiretroviral resistance (if known):
- Pretest counselling provided:

**Details about exposed person**

- Infected with:
  - HBV:
  - HCV:
  - HIV:
- Concomitant diseases:
- Hepatitis vaccination:
- Vaccine-response status:
- Pretest counselling provided:
<table>
<thead>
<tr>
<th>Test results:</th>
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<tbody>
<tr>
<td>HBV:</td>
</tr>
<tr>
<td>HCV:</td>
</tr>
<tr>
<td>HIV:</td>
</tr>
<tr>
<td>Post-test counselling provided:</td>
</tr>
<tr>
<td>Referral:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Test results:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBV:</td>
</tr>
<tr>
<td>HCV:</td>
</tr>
<tr>
<td>HIV:</td>
</tr>
<tr>
<td>Post-test counselling provided:</td>
</tr>
<tr>
<td>Referral:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PEP commenced (date):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informed consent obtained:</td>
</tr>
<tr>
<td>yes</td>
</tr>
<tr>
<td>no</td>
</tr>
</tbody>
</table>

| ARV regimen administered for PEP: |

<table>
<thead>
<tr>
<th>Post-exposure management:</th>
<th>CBC with differential</th>
<th>Serum liver enzymes</th>
<th>Signs and symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1 consultation</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Week 2 consultation</td>
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<td></td>
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<tr>
<td>Week 3 consultation</td>
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<tr>
<td>Week 4 consultation</td>
<td></td>
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<table>
<thead>
<tr>
<th>HIV antibody test results</th>
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</thead>
<tbody>
<tr>
<td>1 month:</td>
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<tr>
<td>3 months:</td>
</tr>
<tr>
<td>6 months:</td>
</tr>
</tbody>
</table>

| Pregnancy test result (for female patients) |

<table>
<thead>
<tr>
<th>Signature/stamp</th>
<th>Date</th>
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</table>
Annex 5. Standard precautions – an aide memoire

Infection control standard precautions in health care

<table>
<thead>
<tr>
<th>Background</th>
<th>Checklist</th>
</tr>
</thead>
</table>
| **Standard precautions are meant to reduce the risk of transmission of bloodborne and other pathogens from both recognized and unrecognized sources.** | **Health policy**  
Promote a safety climate.  
Develop policies which facilitate the implementation of infection control measures. |
| They are the basic level of infection control precautions which are to be used, as a minimum, in the care of all patients. | **Hand hygiene**  
Perform hand hygiene by means of hand rubbing or hand washing (see overleaf for detailed indications).  
Hands should always be washed with soap and water if hands are visibly soiled, or exposure to spore-forming organisms is proven or strongly suspected, or after using the restroom. For other indications, if resources permit, perform hand rubbing with an alcohol-based preparation.  
Ensure availability of hand-washing facilities with clean running water.  
Ensure availability of hand hygiene products (clean water, soap, single use clean towels, alcohol-based hand rub). Alcohol-based hand rubs should ideally be available at the point of care. |
| **Hand hygiene** is a major component of standard precautions and one of the most effective methods to prevent transmission of pathogens associated with health care. In addition to hand hygiene, the use of **personal protective equipment** should be guided by risk assessment and the extent of contact anticipated with blood and body fluids, or pathogens. | **Personal protective equipment (PPE)**  
ASSESS THE RISK of exposure to body substances or contaminated surfaces BEFORE any health-care activity. Make this a routine!  
Select PPE based on the assessment of risk: clean non-sterile gloves. clean, non-sterile fluid-resistant gown. mask and eye protection or a face shield. |
| In addition to practices carried out by health workers when providing care, all individuals (including patients and visitors) should comply with infection control practices in health-care settings. The control of spread of pathogens from the source is key to avoid transmission. Among source control measures, **respiratory hygiene/cough etiquette**, developed during the severe acute respiratory syndrome (SARS) outbreak, is now considered as part of standard precautions. | **Respiratory hygiene and cough etiquette**  
Education of health workers, patients and visitors.  
Use of source control measures.  
Hand hygiene after contact with respiratory secretions.  
Spatial separation of persons with acute febrile respiratory symptoms. |
| Worldwide escalation of the use of standard precautions would reduce unnecessary risks associated with health care. Promotion of an **institutional safety climate** helps to improve conformity with recommended measures and thus subsequent risk reduction. Provision of adequate staff and supplies, together with leadership and education of health workers, patients, and visitors, is critical for an enhanced safety climate in health-care settings. | |  
*6 The overall risk of an infected HCW transmitting HIV to a patient is low. Worldwide, only two possible reports of such transmission have been reported, both during exposure-prone procedures (43, 44). Source: WHO (48).*
Infection control standard precautions in health care

**Key Elements at a Glance**

1. **Hand hygiene**
   
   **Summary technique:**
   - Hand washing (40-60 sec): wet hands and apply soap; rub all surfaces; rinse hands and dry thoroughly with a single use towel; use towel to turn off faucet.
   - Hand rubbing (20-30 sec): apply enough product to cover all areas of the hands; rub hands until dry.

   **Summary indications:**
   - Before and after any direct patient contact and between patients, whether or not gloves are worn.
   - Immediately after gloves are removed.
   - Before handling an invasive device.
   - After touching blood, body fluids, secretions, excretions, non-intact skin, and contaminated items, even if gloves are worn.
   - During patient care, when moving from a contaminated to a clean body site of the patient.
   - After contact with inanimate objects in the immediate vicinity of the patient.

2. **Gloves**
   
   Wear when touching blood, body fluids, secretions, excretions, mucous membranes, nonintact skin.
   
   Change between tasks and procedures on the same patient after contact with potentially infectious material.
   
   Remove after use, before touching non-contaminated items and surfaces, and before going to another patient.
   
   Perform hand hygiene immediately after removal.

3. **Facial protection (eyes, nose, and mouth)**
   
   Wear a surgical or procedure mask and eye protection (face shield, goggles) to protect mucous membranes of the eyes, nose, and mouth during activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions.

4. **Gown**
   
   Wear to protect skin and prevent soiling of clothing during activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions.
   
   Remove soiled gown as soon as possible, and perform hand hygiene.

5. **Prevention of needle stick injuries**

   **Use care when:**
   - handling needles, scalpels, and other sharp instruments or devices
   - cleaning used instruments
   - disposing of used needles.

6. **Respiratory hygiene and cough etiquette**

   Persons with respiratory symptoms should apply source control measures:
   - cover their nose and mouth when coughing/sneezing with tissue or mask, dispose of used tissues and masks, and perform hand hygiene after contact with respiratory secretions.

   **Health care facilities should:**
   - place acute febrile respiratory symptomatic patients at least 1 metre (3 feet) away from others in common waiting areas, if possible.
   - post visual alerts at the entrance to health-care facilities instructing persons with respiratory symptoms to practise respiratory hygiene/cough etiquette.
   - consider making hand hygiene resources, tissues and masks available in common areas and areas used for the evaluation of patients with respiratory illnesses.

7. **Environmental cleaning**

   Use adequate procedures for the routine cleaning and disinfection of environmental and other frequently touched surfaces.

8. **Linens**

   Handle, transport, and process used linen in a manner which:
   - prevents skin and mucous membrane exposures and contamination of clothing.
   - avoids transfer of pathogens to other patients and or the environment.

9. **Waste disposal**

   Ensure safe waste management.
   
   Treat waste contaminated with blood, body fluids, secretions and excretions as clinical waste, in accordance with local regulations.
   
   Human tissues and laboratory waste that is directly associated with specimen processing should also be treated as clinical waste.
   
   Discard single use items properly.

10. **Patient care equipment**

    Handle equipment soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of pathogens to other patients or the environment.
    
    Clean, disinfect, and reprocess reusable equipment appropriately before use with another patient.

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1 For more details, see: WHO guidelines on hand hygiene in health care: [http://www.who.int/patientsafety/information_centre/ghhad_download7en/index.html](http://www.who.int/patientsafety/information_centre/ghhad_download7en/index.html).

2 The SIGN Alliance: [http://www.who.int/injection_safety/sign/en/]. *Source: WHO (48)*
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25. Busch MP, Satten GA. Time course of viremia and antibody seroconversion following human immunodeficiency virus exposure. The American Journal of Medicine, 1997, 102(Suppl. 5B):117-124.


30. Martin JN et al. Post-exposure prophylaxis (PEP) for sexual exposure to HIV does not lead to increases in high risk behavior: the San Francisco PEP Project. 8th Conference on Retroviruses and Opportunistic Infections, Chicago, 4-8 February 2001.


- Objectives:
  1. Training participants’ feedback.
  2. Completing post-testing evaluation questionnaire by training participants.
  3. Discussion of follow-up and next steps after the training.

- Time
  30 minutes

- Materials
  - One copy of the blank post-test for each participant (annex 10)

- Steps
  1. Focus on the fact that the training is coming to an end and ask participants to share their opinions on the future use of knowledge they received.
  2. Refresh participants memory on the subjects covered by the training and ask them to share their thoughts and opinions as to its relevance.
  3. Hand out the post-test questionnaire forms to participants (annex 10).
  4. Wrap-up the training in a formal manner.
Instructions: Read each statement and choose the answer that best reflects your attitudes, values, and comfort level related to HIV and AIDS and working with people who are living with HIV or AIDS.

I believe...
I believe that people who are infected with HIV should not be treated in the same areas as other patients in order to protect the larger population from infection.
   strongly agree   agree   disagree   strongly disagree

I believe that people infected with HIV are responsible for getting infected.
   strongly agree   agree   disagree   strongly disagree

I believe that HIV-positive patients are the biggest threat to my safety at my place of work
   strongly agree   agree   disagree   strongly disagree

I believe most HIV-positive health care workers get infected at work.
   strongly agree   agree   disagree   strongly disagree

I feel...
I feel that providing health services to people infected with HIV is a waste of resources since they are going to die soon anyway.
   strongly agree   agree   disagree   strongly disagree

I feel that I am at high risk of becoming infected with HIV working in the health facility.
   strongly agree   agree   disagree   strongly disagree

I feel that clients who have sexual relations with people of the same sex have a right to access the highest quality of health services in my facility.
   strongly agree   agree   disagree   strongly disagree

I feel that clients who are sex workers have a right to access the highest quality of health services in my facility.
   strongly agree   agree   disagree   strongly disagree

I am comfortable...
I am comfortable providing health services to clients who are HIV-positive.
   strongly agree   agree   disagree   strongly disagree

I am comfortable performing surgical or invasive procedure on clients whose HIV status is unknown.
   strongly agree   agree   disagree   strongly disagree

I am comfortable sharing the bathroom with a colleague who is infected with HIV
   strongly agree   agree   disagree   strongly disagree

I am comfortable assisting or being assisted by a colleague who is infected with HIV
   strongly agree   agree   disagree   strongly disagree

I avoid...
I avoid touching clients for fear of becoming infected with HIV
   strongly agree   agree   disagree   strongly disagree
I avoid touching clients’ clothing and belongings for fear of becoming infected with HIV

| strongly agree | agree | disagree | strongly disagree |

I avoid performing ANY task at work without wearing latex gloves.

| strongly agree | agree | disagree | strongly disagree |

Withholding health services from a client believed or known to be HIV-positive is a violation of the client’s human rights.

True False

When there are shortages of needles and syringes, it is acceptable to rinse the syringes in disinfectant solution and to reuse them as long as new needles are used.

True False

The risk of HIV transmission following needlestick or sharps injuries is very small, approximately 1 in 300.

True False

The risk of HIV transmission following a splash of blood or body fluids to non-intact skin or mucus membranes is very small, approximately 1 in 1,000.

True False

Standard precautions are designed to protect only health care workers from clients who may be infected with HIV or hepatitis.

True False

Standard precautions are also applicable when providing home-based care.

True False

Needlestick and sharps injuries can be prevented.

True False

It is appropriate to test clients who look like they are HIV-positive or clients preparing for surgery, to ensure that staff take precautions during surgery to prevent HIV transmission.

True False

A pregnant staff member who is accidentally injured by a needlestick or a sharp instrument cannot receive post-exposure prophylaxis due to the risk of damage to the fetus by antiretroviral drugs.

True False

A health worker who knows he/she is HIV-positive can continue to work safely in service delivery as long as they avoid activities that present a risk of transmission to clients.

True False

To prevent transmission of HIV and other bloodborne infections in the health care setting, the staff should wear latex gloves for every client contact, including taking vital signs.

True False

To prevent stigma and discrimination in the health care setting, staff must treat all clients with respect and in a welcoming manner, provide privacy and confidentiality, and avoid creating segregated areas for clients who are known or believed to be HIV-positive.

True False
If a healthcare worker has a recent cut on her/his hand, the risk of HIV transmission following contact with a client's blood is higher than if her/his skin is intact.

**True** **False**

Exposure risk procedures are invasive procedures where there is a risk of injury to the health care worker that may result in exposure of the client's open tissue to the blood of the worker.

**True** **False**

The risk of domestic violence related to HIV testing or disclosure of test results should be explored during pre- and post-HIV test counseling.