The Management of HIV/AIDS in the Workplace Made Easy

By Dr Cleopas Sibanda
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About the author

Dr Cleopas Sibanda is a qualified medical doctor and an Occupational Health Specialist with the benefit of several years of experience in Southern African countries in the field of Medicine and Surgery, Occupational Safety and Health (OSH), Labour and Social Security.

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Over the years Dr Sibanda has traveled a lot to many international conferences of organisations such as the International Labour Organisation (ILO), the International Social Security Association (ISSA) and the International Commission on Occupational Health (ICOH) on Occupational Safety and Health (OSH) business. He has also participated in the drafting of many international OSH instruments.

It is therefore hoped that all this experience, as shared through the aegis of this book, will find good use, meaning and positive interpretation in the field of HIV/AIDS, and OSH in general in the world of work.

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Introduction and foreword

This book is meant for use by Governments, Employers and Employees and their representative organisations as they try to deal with the scourge of HIV/AIDS in the workplace.

It is a simple do it yourself guide that emphasizes on the basic facts and principles of HIV/AIDS management, more specifically in the workplace. As such its starts off by engaging the reader in a discussion about the basic factual attributes of HIV/AIDS, these being the fact that AIDS is caused by HIV infection, that HIV infection is mostly sexually transmitted, that AIDS kills, that AIDS is incurable, that HIV infection is preventable and that AIDS, like any other infectious disease, is generally associated with poverty.

After establishing these basic facts, the book then goes on to deal concisely but comprehensively with the issues of the management of HIV/AIDS in the workplace. It places emphasis on legal provisions, international conventions and recommendation, world best practices and many other novel ways of tackling the HIV/AIDS pandemic in the world of work in a sustainable way.

The recommendations given herein are very smart and practical in an easy to understand and use sort of way. It is hoped that readers and users will find this material very useful as they try to implement their own HIV/AIDS Programmes in the World of Work, either at national, enterprise or organizational level.

It also proffers rather new, interesting and thought provoking opinions on how best to approach the management of HIV/AIDS in the Workplace with regards to workers rights and representation at the workplace in the addendum at the very end of the book by challenging the status quo. Other interesting and rather novel ways of looking at issues which this book also provokes are the concept of human basic sexual instincts, the relevance of abstinence and virginity in HIV/AIDS prevention, HIV/AIDS voluntary counseling and testing (VCT) and the unknown sexual habits of HIV/AIDS clients who know their status. To say that these issues have been handled in this book in a thought provoking manner is definitely an understatement.

All in all, this book is a very good buy that should be found on the desks and bookshelves of all serious practitioners and stakeholders in the field of HIV/AIDS in the Workplace and also Occupational Safety and Health in general.

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Chapter 1  The World is in trouble with HIV/AIDS

Shocking HIV/AIDS Statistics

Ladies and gentlemen, here are some shocking statistics concerning HIV/AIDS in this world! According to a 2007 Demographic and Health Survey Report Document of one Southern African country, as we speak, forty-two point six percent, yes, you read it right, forty-two point six percent of all pregnant women are carriers of the HIV virus that causes AIDS in that country! A whooping 42.6% good people! But that is not all.

Between age groups 15 to 19yrs, 10.1% of women are HIV positive, while 1.9% of men are HIV positive. From 20 to 24yrs of age inclusive, 38.4% of women are HIV positive, while 12.4% of men are, and from 25 to 29yrs of age inclusive, a whooping 49.2% of women are HIV positive, as are 27.8% of the men! From 30 to 34yrs of age 45.2% of women are HIV positive, while 43.7% of men are also infected, and from 35 to 39yrs of age, 37.7% of the women are HIV positive, while 44.9% of men are similarly infected. From 40 to 44yrs of age, 27.9% of the women are HIV positive, while 40.7% of the men are, and from 45 to 49yrs of age, 21.4% of the women are HIV positive, while 27.9% of the men are also HIV positive. From 50 to 54yrs of age, 24.3% of the women are HIV positive, while 28.3% of the men are also HIV positive, and from 55 to 59yrs of age, 9.6% of the women are HIV positive, while 17.4% of the men are also HIV positive. Finally, above 60yrs of age, 7% of the women are HIV positive, while 13.3% of the men are also HIV positive. If these shocking statistics do not scare someone, then that person must be made of steel! This is for real, ladies and gentlemen, and it is just sobering. The whole world is in trouble, serious trouble, with HIV/AIDS! The biggest problem seems to be the fact that the most and worst affected people in this scenario are the working class, those between 15 and 60 years of age! Imagine what these shocking statistics mean for the constant spread of HIV/AIDS throughout the whole world!

HIV/AIDS is a Global problem

There are those countries that may think that their own statistics are better, so they do not really need to worry about statistics from a tiny poor Southern African country. But as we all know, HIV/AIDS knows no national boundaries. No one is safe really. HIV/AIDS infection may not be as highly transmissible as “Swine Flu” (H1N1), but it surely will not remain contained in any one of the worst affected poor countries of this world forever, especially at such high prevalence rates. HIV/AIDS is in fact a global problem, and it must be tackled as such at all levels of society by all the concerned stakeholders, which translates to just about everybody. Individual companies, local authorities, municipalities, countries and the regional and international community must all play their respective roles in trying to contain this scourge.

This book focuses on HIV/AIDS in the world of work because of the socio-economic implications that this scourge poses for workers, employers, governments, national, regional and the global community at large. However, it must always be remembered that the ramifications of the effects of HIV/AIDS are in fact more far reaching than just the socioeconomic impact.

Appreciating the HIV/AIDS pandemic

Many people have not yet appreciated what the HIV/AIDS pandemic really means to them as individuals, members of families, societies, or countries. Perhaps we need to pause and think about it for a while. Imagine if 42.6% of all pregnant women in one country are HIV positive, or if 49.2% of all women aged between 25 and 29 years of age are also HIV positive as has been depicted above. What does this really mean for that particular country and also for the rest of the world? It may mean that almost half of the
marriageable age women in that country are HIV positive, and they may transmit the virus to their husbands leading to similar percentages in males. It also means that unless there are vigorous antenatal programmes for the prevention of mother to child HIV/AIDS transmission in utero, then almost a quarter to half of the children born in this scenario may be HIV/AIDS infected at birth.

What will the demographic and health outlook be in this scenario in ten to fifteen years time? We know that it takes about seven to ten years to develop the signs and symptoms of HIV/AIDS from the time of the initial HIV/AIDS infection, and we also know that within the next seven to eight years death from the disease is almost certain in the absence of palliative anti-retroviral therapy.

What needs to be done now?

What it means is that anti-retroviral therapy has got to be intensified in this scenario and it is everyone’s business to make sure that this happens and not only the business of the poor and affected countries. HIV/AIDS does not respect country boundaries. Neither does it select according to tribe, race, religion, tradition or culture. The whole world is in it as one global village on this one. Governments, Employers and Employees have all got to play their respective roles in solving the challenges posed by HIV/AIDS. While it may be very important that in worst case scenarios like the one described above, a lot of urgent effort has got to be directed towards the prevention of mother to child HIV transmission and anti-retroviral therapy in general, the importance and necessity of preventive and protective measures should never be neglected.

This terrifyingly alarming situation could have been avoided a long time ago with the effective implementation of the appropriate HIV/AIDS preventive programmes, but the situation can still be prevented from getting worse than it already is at the moment or can even be reversed by vigorously implementing the same preventive programmes right now. Concentration on therapy alone will ultimately not help much. It may lead to the burnout syndrome when all effort may seem to be wasted on a hopeless case scenario and we then tend to give up. The consequences of burnout will be disastrous!

Risky sexual behaviour

Unprotected sex

Allowing HIV/AIDS predisposing sexual behaviour to continue unabated will not serve the situation. The 42.6% HIV positive pregnant women mentioned above definitely indulge in dangerous HIV/AIDS predisposing sexual behaviour; otherwise they would not be pregnant or HIV positive. For a start, they definitely had unprotected sex, which is why and how they got pregnant in the first place. Unprotected sex is really risky sexual behaviour as will be demonstrated in the next chapters. It may lead to unwanted pregnancy and or HIV infection. The good news is that it can also be prevented completely, even in this worst case scenario.

Multiple concurrent sexual partners

Another form of risky sexual behaviour that the unfortunate 42.6% pregnant women mentioned above, and also the other entire HIV positive population in the quoted Demographic and Health Survey may have participated in is the practice of having multiple concurrent sexual partners with whom they indulged in unprotected sex. For example, who made all these 42.6% women pregnant in the first place? Without quoting figures, the fact is that some of these women were made pregnant by their boyfriends and not by their husbands or the people that they call their real husbands. Others were made pregnant by other
people's husbands. And yet still others, even though they may be happily married as they will always say, were made pregnant by other women's husbands or other women's boyfriends, and so on and so forth! It is all so very complicated, but then this is the fact of the troubled world that we are living in today which has put us in trouble with HIV/AIDS! However, having multiple concurrent sexual partners with whom one has unprotected sex can still be avoided even in the worst case scenario and the opportunity to act in this regard, and to institute preventive measures should not be passed on simply because the situation looks alarmingly hopeless. It is never too late to try.

**Perverted sexual orientation and the genesis of HIV/AIDS**

Another form of risky and dangerous predisposing sexual behaviour which has become very rampant in today's world is perverted sexual orientation. There have been many theories about where exactly HIV/AIDS came from and how exactly it ended up as a disease of human beings. A lot of unproven hypotheses and theories have been put forward by everyone who has cared to let their imagination run wild. Some people have said that HIV/AIDS was created in certain laboratories of the world as a biological weapon in an attempt to get rid of a certain race or tribe of people, and then got accidentally released into the general population in an experiment that went wrong.

Other people have said that it came from Siamese Monkeys in the wild jungles of this world, promoted by gluttonous meat loving gormandizers who want to eat anything and everything, while others have said that it is a curse from God for the too many unspeakable sins that we had started to indulge in as human beings. The fact is that no one really knows where HIV/AIDS came from, but when everyone has become an HIV/AIDS theorist, some of the really very weird sexual behaviours that we then indulge in as human beings in the name of various self abrogated freedoms and human rights leave many people not knowing exactly what to believe in or what not to believe in.

People say that they have got the right to produce and to watch pornography, but when that pornography involves people having weird sex with each other or even with animals other than human beings, or any other thing that moves, one may never know the difference between what is really natural and what is not natural about human sex and sexuality. This then may just provide the appropriate feeding ground for the ever so alert HIV/AIDS theorists who will then confuse us even more with their crude theories of the genesis of HIV/AIDS. Risky sexual perversion, or at least the spread of such ideas, can surely be prevented in the fight against HIV/AIDS.

**False assurance and false hope**

If we do not focus on prevention, now that there is palliative anti-retroviral therapy, imagine what may still happen in the most affected countries or in any other country for that matter in the years to come because of rampant HIV/AIDS? A lot of mothers and fathers, young man and young women, boys and girls, and children will develop full blown AIDS everywhere! Health services will be stretched to breaking point even with HIV/AIDS anti-retroviral palliative therapy.

**HIV/AIDS is a leading underlying cause of hospital admissions**

HIV/AIDS is already the leading underlying cause of admissions in all age groups in most infectious diseases hospitals in the developing world! The situation may slowly develop to be exactly the same in the so called developed countries many years from now if people there do not focus on eliminating HIV/AIDS from the developing countries, or from any part of the world for that matter, in unison and as one global village, through the adoption of good, sound and effective preventive measures.
HIV/AIDS, poverty and the global economic meltdown

As more and more people get infected and affected by HIV/AIDS, family and individual incomes will increasingly be channeled towards medical expenses, perhaps to the detriment of the provision of food, shelter, education, transport and everything else. Government expenditure will follow suit. Then there will be abject poverty, more global economic meltdown, more unemployment, malnutrition, destitution, illiteracy and more disease everywhere! A lot of families will eventually lose bread winners after costly, spirited, but futile battles waged against HIV/AIDS by using anti-retroviral palliative therapy in a failed attempt to make these valuable bread winners recover from the disease, HIV/AIDS.

Since HIV/AIDS is in fact actually a syndrome, a complex of diseases, the cost of its treatment is not exclusively confined only just to the cost of the palliative antiretroviral drugs and administering them. It also includes the cost of treatment for tuberculosis, pneumonia, meningitis and all the other opportunistic infectious diseases that are predisposed by HIV/AIDS viral infection, plus the socio-economic cost of illness to the individual concerned, his family, the company they work for, and their country as well. These costs are tremendous. And then there will be more poverty and more HIV/AIDS, and more poverty and more HIV/AIDS and on and on and on! It is a vicious circle.

There is no doubt that this world is in trouble with HIV/AIDS. HIV/AIDS is causing and is going to cause a lot of socio-economic problems for many countries and the whole world at large. Governments, Employers and Employees must therefore come together to prevent and fight this scourge, right now more than ever before.
Chapter 2  The pros and cons of it all – AIDS is caused by HIV infection

The HIV/AIDS business needs individual solutions

Hopefully by now the reader may have accepted the fact that this whole world is in trouble with HIV/AIDS. It is also hoped that by now the reader feels fired up to do something positive about this HIV/AIDS challenge primarily at the individual level, but also as a member of the family, the workforce or society at large.

Everyone has a duty to fight HIV/AIDS

One does not have to feel powerless to act against HIV/AIDS at the individual level because, in fact, we can only defeat and stop HIV/AIDS at the individual level when we as individuals, prevent ourselves from getting infected in the first place, and first and foremost, thereby playing our rightful and correct role in improving national HIV/AIDS statistics. Society alone cannot act without individual action. Society is just an extension of the individual. Everything that happens in any given society is done by individuals, this including acquiring and spreading HIV/AIDS! Think about it.

Some people may think that it is the Government that must do something or everything about HIV/AIDS, but then it is not the Government that gets infected by the HIV virus or that suffers from AIDS and then dies. It is us the individual people, you and me. Even in Government as in society in general, the decision to do or not do something positive about HIV/AIDS or anything else for that matter, as a Government or as a society, is made by individual members of that Government or that society and not by the Government institution itself. Either way, it still comes down to individuals. So in reality the solution to the challenge of HIV/AIDS, or any other challenge for that matter, can only come from individuals, by individuals, and for individuals! This is the democratic way of accomplishing the HIV/AIDS business.

How the HIV/AIDS challenge is discussed in this book

Anyway, we now intend to go into the meat of this discussion about AIDS/HIV in the workplace. But before we zero in onto the workplace, we need to first know and understand everything about HIV/AIDS parse so that when we talk about it at the workplace level, we at least have a strong knowledge background from which to base our confrontation with it. That way we then may have a better chance to succeed. As such, for the next few chapters, we shall be talking about the five or so basic facts about HIV/AIDS. Some of these basic facts are that: 1. HIV/AIDS is caused by HIV viral infection. 2. HIV/AIDS is mostly sexually transmitted. 3. HIV/AIDS has no cure. 4. HIV/AIDS kills, and finally 5. HIV/AIDS is preventable. We shall dissect all these basic facts one by one until we all are in the clear. When one looks at these basic facts, they sound and seem clear enough to anyone, but not many people are actually aware of what these basic facts really mean, and this ignorance affects their daily sexual and other behaviours which quite often predispose them to the risk of HIV/AIDS.

HIV/AIDS is caused by HIV infection

Let us now start with the first basic fact, the fact that HIV/AIDS is caused by infection with the Human Immune Deficiency Virus (HIV). How many of us really know this and what it means, and how many of us actually believe it? Ladies and gentlemen, believe it or not, but the fact that HIV/AIDS is caused by the HIV virus has already been proved and demonstrated by science and technology, so we shall not labour to demonstrate how this fact was arrived at in this book. If we do that here and now, which we honestly can
do, we are afraid that we shall loose you our targeted shop floor reader in some scientific and technological jargon, and that you shall get bored, and then we shall loose you again, but this time to HIV/AIDS.

We certainly do not want to loose you that way or in any other way for that matter. Let it just be known, and be restated here and now, that the Acquired Immune Deficiency Syndrome (AIDS) is actually caused by HIV viral infection, and that a virus is a tiny, tiny micro-organism that is very invisible to the naked eye, and that infects the CD4 cell human T-lymphocytes that are found in our blood, and leading to Acquired Immune Deficiency Syndrome or AIDS for short. Finish.

What do some people believe is the cause of HIV/AIDS?

Here and now we are just going to discuss what some people may believe, and what the readers may also have been made to believe, by tradition, culture, practice or precedent, to be the cause of HIV/AIDS. These beliefs may unfortunately not necessarily be based on the truth about HIV/AIDS, but they may have led many to behave in the ways that they did, which predisposed them to the risk of HIV/AIDS. At the end of this chapter hopefully readers will believe in the basic truth about the causation of HIV/AIDS, this being the fact that AIDS is caused by underlying HIV infection. It is also hoped that we shall have by then demystified all the other supposed untrue causes of AIDS in the minds of the readers so that they can behave correctly and accordingly as individuals in the fight against HIV/AIDS.

The people’s beliefs are true in their consequences

One Psychiatry teacher at a Medical School where he was teaching clinical psychology once said this statement to his students which he went on to explain as we shall also try to explain now because of its relevance to the beliefs of people with regards to the causes of HIV/AIDS. He said that “The truth does not matter. What matters is what people believe in, and if this is the truth, then so much the better for the resultant behavioural consequences. The people’s beliefs are true in their consequences.” That may sound a bit confusing or does it not? Perhaps not at all, and we shall explain why here and now. As you may be aware, people do not do the things that they do just because of the facts or the truth that is put before them about these things. They behave in the way that they do most importantly because they believe in the facts or the truth that has been put before them and not just because it is true or a fact. This means that the fact may be out there for all to see, irrevocably proven by science, technology and everything else, but the people must first of all believe in this fact, in this truth, before they can behave in accordance with its dictates. If people do not believe in a certain fact or a certain truth, they cannot surely be expected to behave according to it or in accordance with its dictates.

People’s behaviour is governed by what they believe in

People, at any one given time, behave according to whatever they believe to be true and not necessarily according to the truth, because what they may believe to be a fact or the truth may, unfortunately, actually not be a fact or true. If their beliefs are coincidentally based on the truth or on facts, then we can only expect that the actions or the consequences of actions based on those beliefs will be so much better than if the beliefs were not based on the truth or on facts. This is the crux of the matter here, ladies and gentlemen. The people’s beliefs are true in their consequences!

As an example, if someone is attacked by malaria and becomes very sick and starts to hallucinate, and himself or his relatives who may come to help him at that particular point in time believe that he or she is being attacked by evil spirits or ghosts do you think that they will take this poor fellow to the nearest
hospital for the treatment of malaria in the first instance? This is highly unlikely. Rather, they will most probably rash him to the nearest prophet, preacher man, priest, pastor or even magician for exorcism of the evil spirits that they so believe are attacking him. What then will be the consequences of such actions based on such beliefs? Disastrous of course!

**Beliefs in themselves are neither true nor false, but their basis can be true or false**

Because the beliefs in this malaria case are based on a premise that is false or not true, (Please watch out that we are deliberately not using the terms wrong or right, correct or incorrect in this case. This is because beliefs cannot be judged or faulted in that way. We shall explain this later), the consequences here will most probably be gruesome. This poor fellow will most probably die of malaria whiles still being exercised of demons or evil spirits. These are the true consequences of his beliefs. Who then is to blame for what might happen if and when this unfortunate patient dies? Do we blame him or her, the victim, for his own death because of his beliefs that were not based on the truth, or do we blame the exorcists for fanning those beliefs? Do we blame the medical profession or the Government for not educating the people properly healthwise? Do we blame the society that made him believe in evil spirits?

If this person had gone to hospital instead, he would most probably have survived and stopped hallucinating after getting the appropriate malaria treatment, but he did not do that primarily because of his beliefs. He believed, or at least those around him and could help him did so, that he was possessed by evil spirits, and consequently behaved inappropriately for his perceived type of illness and therefore ended up dying of malaria, a curable disease. This is very unfortunate. Malaria is a simple, treatable and curable disease. It is not like HIV/AIDS which is not curable. And yet everywhere in this world year in and year out, thousands of people die from malaria, sometimes with capable, accessible and affordable health facilities just a stone throw away. One really wonders why, but then we have got to realize that it is all about beliefs sometimes!

**People cannot be faulted for their beliefs**

Before we go any further, let us establish the fact that people cannot in fact be faulted for their beliefs, whether they are based on the truth or not, even on matters to do with HIV/AIDS, because they are usually not entirely willfully and knowingly responsible for holding such beliefs in the first place. That is why we must always be very careful and guard ourselves against being too fast to condemn or blame other people, and/or their beliefs, in any particular matter, as being correct or incorrect, wrong or right, true or false.

When we say that a belief is true or false, we are not necessarily talking about the belief itself, but about the facts or the premise on which that belief is based. The belief itself cannot be said to be false because the believer should definitely, and in fact, at least truly believe in it for it to ever be called a belief in the first place, so it cannot be a false belief. As an example, the client with malaria sited above truly and not falsely believed that they were possessed by evil spirits, which is why and how they ended up at the exorcist’s door steps and not in hospital. They truly held that belief.

People are not wrong or right for believing in what they believe in, even if the belief might not be based on facts or the truth. This is because people are not entirely responsible for their own beliefs. In fact they are just victims of circumstance in this regard. Surprised? Do not worry because we shall clear your surprise in this regard shortly, and perhaps help you to become a better person in the way that you look at other people and particularly HIV/AIDS victims.
How do people end up believing in what they believe in?

There are very many reasons why people end up believing in what they believe in, most of which they cannot do anything about or even help themselves out of. The most basic example here concerns our own children. Almost everything that our children believe in comes from us their parents and or from other responsible adult people. What is good and what is bad, what is right and what is wrong, the religion to follow, whether ghosts and witches exist or not, what is HIV/AIDS, what causes it, how it can be prevented, and so forth and so on, all comes from the adults.

No child will wake up one morning suddenly knowing all these things from the blues or of its own accord. Children learn to believe in all these things from their parents, and also from other adults, or from other children who will have learnt about it from their parents or from other adults as well. They learn to believe in this way hook, line and sinker. If the parents and other adults in society hold certain beliefs, HIV/AIDS included, so will the children too. That is a given.

Can we then justifiably fault the children for believing in the things that are not true or not based on facts or the truth under such circumstances? How can the children know and believe in the truth for sure when, because of their being children, completely under the spell of their adult parents, relatives or other adult people in the community, all they have got at their disposal is what these adults believe in and teach them to believe in, directly or indirectly, which may, unfortunately, not be based on facts or the truth? No, we cannot blame the children.

People cannot be blamed for holding beliefs that are based on false premises

It will be unreasonable and perhaps cruel as well, to blame the children for holding onto false beliefs under these circumstances. We really ought to agree with this philosophy here, ladies and gentlemen. In the same vein, the adults too may hold certain beliefs which may not be based on facts or the truth due to circumstance completely out of, and beyond their own control. They too may not be blamed for holding false beliefs about anything, HIV/AIDS included. People's beliefs are shaped by their individual genetic constitutions, their individual experiences and the environment in which they live or have lived before. Genes give us the potential to be who we can possibly be, and we had no choice in picking our own genetic constitutions in the first place. God, Allah, or whoever one may want to believe, or has been made to believe, to be one's creator, did the choosing for you.

Genetics, experience and the environment contribute to people holding certain beliefs

Thus I have got in me the genes of a Black African man and I am therefore Black and African, someone has got in them the genes of a White European man and they are therefore White and European, while another person has got in them genes of an Oriental Asian man and are therefore Asian, and so on and so forth. Nobody ever chose or chooses the genes that they may end up with in this life, so it cannot be anybody's fault that one is black or white!

Because of these genes which we did not choose in the first place, we found ourselves in different parts or the world, such as in America, Africa, Europe, Asia, etc. These different habitats or living environments perhaps engendered onto us by our different genomes as Charles Darwin and his evolutionary theories would like us to believe, gave us different developmental experiences in real life, so much so that at any one given time, we were and perhaps still are all at very different stages or levels of human psychosocial growth and development. These different stages or levels of human psychosocial growth and
development encompass everything in our lives, from political, psychological, social, economic, religious, traditional and cultural growth and development, and so forth and so on, including our understanding of HIV/AIDS issues.

Thus our beliefs in all spheres of life are also at varying levels of psychosocial growth and development throughout the whole world today. This again we did not choose. We did not make a conscious choice as we could not possibly have told God to give us a certain genome, a certain place on earth and certain experiences that we went through or are going through right now, our own beliefs and experiences with HIV/AIDS included.

If today we end up being perceived to be at a certain lower psychosocial developmental level whereby we hold certain beliefs that are not based on facts or the truth about HIV/AIDS, or any other issue for that matter, then we surely cannot possibly be faulted for that. We can only be pitied and it can only be hoped that the generations that come after ours will at least be at a different and higher level of psychosocial development in this regard so that their beliefs on the same or similar issues could be said to be based on the truth, or as close to the truth as is possible, for the sake of the betterment of the consequences of behaviours based on those beliefs.

**It is difficult to teach old dogs new tricks as far as beliefs are concerned**

One cannot possibly or easily teach an old dog some new tricks. As far as beliefs are concerned, they evolve in society over a long period of time. It is not possible to find a society that switches from one fundamental traditional belief to the other overnight, HIV/AIDS included. The process of a societal paradigm shift is a slow, long and arduous one, and it takes the passage of generations.

This is why it is so very important for society to vigorously focus on the children, and the younger generation in the case of HIV/AIDS. But at the same time, we cannot really blame the older generation for holding the beliefs that they have held onto about HIV/AIDS, and neither can we give up hope about trying to align those beliefs with the truth or reality on the ground. We still should and must actually focus on every single member of society regardless of age in our fight against HIV/AIDS.

**The myths about HIV/AIDS**

So having established the pros and cons of beliefs, let us then now dissect some of the false premises on which certain beliefs about HIV/AIDS that some people may hold are based on, without blaming anybody for these beliefs. Blaming each other will not get us anywhere in our fight against HIV/AIDS.

**Religious myths about HIV/AIDS**

Let us start in Church of all places. A lot of religions that we know of believe that HIV/AIDS is a curse from God for the too many sins that we are now committing in this world. They site all the weird sins that science is supposedly committing from genetic engineering (the GMOs) to human cloning, through everything else that is weird and down to the lewd and perverted practices of bestiality as some of the things that have enraged God about human beings.

They say that for these reasons, the Mighty Creator then got very annoyed with us and sent HIV/AIDS down onto this now scotched earth in order to punish us, and in order to teach us a lesson about the sinning and waywardness of our God forbidden sexual behaviours. According to these religious people, and in accordance with this philosophy of theirs, we must all repent of our sexual sins and then turn to
God for salvation from HIV/AIDS. This, they contend, is the only way by which we may prevent HIV/AIDS and perhaps save the human race from perishing due to this disease.

**How do we get religious salvation from HIV/AIDS?**

The preacher man says first we must pray to God for the forgiveness of all our sins, and then we must accept only him as our Lord and saviour from HIV/AIDS and undertake to never go back to our sinning sexual ways again. And bingo, this entire HIV/AIDS thing will just somehow, simply and miraculously disappear from the so saved societies or communities, and sometimes even from our very own individual infected bodies! That sounds very plausible, and perhaps even possible to the believer, who then may go on to practice and act accordingly.

If you believe in this philosophy what are you most likely to do in order to combat HIV/AIDS at a personal level? If you are not infected already you are most likely to pray to God that he looks after you so that you never get infected at all. You will most probably try to walk on the straight and the narrow path all the way to heaven.

**Praying, religious faith and trust alone are not enough for the fight against HIV/AIDS**

Suppose you are married or you have got a boyfriend or girlfriend with whom you indulge in even the religiously blessed safe sex whereby there is sex only with your wife or wives but no condom is used; will your other sexual partner or partners be doing exactly the same thing too, the praying and walking straight in God's light, even if they may promise that they are doing exactly the same thing as you are doing and only with you, so there is no need for any extra protection like using a condom?

Can one be too sure of this even if one prays to God for it to happen that way, day in and day out? Is it enough to only pray for God’s guidance and blessings in the fight against HIV/AIDS? Can we not ourselves do something positive about it like using condoms all the time we have sex with anybody, including our very own wives or husbands, even if they may be as religious as we say we are, and even if we completely trust each other in matters to do with sex, in or outside marriage?

Does trust alone, in whatever way it may be conceived, come into it or become the end all and be all of our HIV/AIDS preventive efforts, if we indeed also really know and believe that HIV/AIDS is caused by infection with the HIV virus, a virus, which is mostly sexually transmitted and which can easily and definitely be prevented by using a condom each time we have sex regardless of, or even if we trust our sexual partner or partners, or trust and believe in God to save us from this HIV/AIDS? Can we just depend on our trust in the other person, or even in the good Almighty Lord himself alone in the case of HIV/AIDS being caused by the HIV virus, and it being preventable by condom use each time we have sex?

**Big Religions have discouraged condom use in the fight against HIV/AIDS**

Most religions, faiths or churches that we may know of have actually preached and or continue to preach against the use of the condom, imagine! They say that God is against such anti-creation, unnatural and unfaithful practices, so it is a sin to use condoms during sex. Do these people know and believe the fact that AIDS is in fact caused by HIV viral infection and not by the lack of religious faith; even if this may be a contributing factor but only in as far as the decadence in our sexual morals is concerned. Do they believe that because the HIV virus is real, it is a real particle and not a myth, and therefore its transmission can in fact be effectively prevented by using a condom? Apparently it would seem that these highly religious
people do not believe these basic facts about HIV/AIDS, because if they really honestly and in deed believed in these facts, then they would also be behaving appropriately in their Churches whereby they would stop preaching against the use of condoms to their congregations and begin to encourage condom use in the fight against HIV/AIDS, even silently. Their preaching against condom use has had, and continues to have disastrous consequences for the human race as far as HIV/AIDS is concerned.

Practical and reality based actions are also needed in order to fight HIV/AIDS effectively

We can also apply the same logic to the rampant belief of only just praying to God for relief from anything that we may feel we want to be relieved of which is routinely practiced in some other Churches or Religions. God helps those who help themselves they will always say whenever it suits them, but sometimes they may then just urge their followers to help themselves only with prayer! Will prayer alone take away the HIV virus that is already inside one’s body, or will it prevent one from getting infected by the HIV virus from one’s equally religious but infected partner if one does not use a condom every time one has sex, even if one prayed every hour on the hour twenty-four-seven? No, no ladies and gentlemen, prayer alone will not help in matters to do with HIV/AIDS because it is caused by something real, a virus. We must believe this in order for God to then give us the salvation that we so much seek from him. We must believe in the basic facts about HIV/AIDS and then act according to this belief and use condoms all the time we have sex so that by God’s grace we may be saved from the scourge of HIV/AIDS.

Please good people go to Church, pray hard, or even harder, but believe in the truth about this matter, the matter of HIV/AIDS and then act correctly and accordingly. As medical doctors will tell you, they have come across many a priest or a highly religious fellow who was not spared the scourge of HIV/AIDS simply because they did not use a condom during one sexual encounter, and not because they were sinning. But when you add sinning with sister Grace behind the pulpit into the whole mix, then you really have got an HIV/AIDS explosion. Recently some prostitutes came out into the open in one most HIV/AIDS affected Southern African country, and proclaimed through the press that some of their most ardent customers were the very man of the cloth! Did you here that? Now are these guys using condoms with these sisters of loose morals or not? What do you think as a believer? Could it be a case of preaching one thing and then doing the other? Is there any preacher man out there who is willing to reveal the truth about this matter to us please? We surely would like to know. All of us.

Everything comes from God

If we can go back to the religious argument of the scourge of HIV/AIDS being a curse from above, there is absolutely nothing that is not a curse from God himself because nothing can actually happen without God allowing it to happen. At least that is what most religions will also teach their followers. Therefore all the other diseases, the good things and the bad things, are all also a curse from above because without God allowing them to happen, and giving them a possibility and the chance to happen, then they would most probably never happen at all. This is a fact, believe it or not.

God helps those who help themselves

It's not only diseases that are a curse, but also droughts, cyclones, tsunamis, earthquakes, etc., etc. All of these are a curse from God. But praying and believing in God's miracles only and not taking active preventive and precautionary measures ourselves to protect ourselves from, and or to mitigate the consequences of these disasters, will not help us. Abdicating to God our duties and responsibilities to protect ourselves in this way will actually be very catastrophic for us and for humanity in general,
especially in the case of HIV/AIDS. One cannot honestly blame a storm or genuinely ask God to save his house from a storm when one builds his house in a storm prone environment without taking the necessary precautions to enable the house to withstand any storm, even a very small one, as far as is humanly possible. God helps those who help themselves. So let us all help ourselves with this HIV/AIDS thing which is caused by a virus that we know. We must therefore believe in the basic facts about HIV/AIDS and act or behave accordingly, while we also at the same time, and if we want, keep on praying to God to give us the strength to do just that.

Do not get this wrongly, ladies and gentlemen. We all believe in God and we all sometimes go to Church too. We have read the Bible and other religious books a lot and we, as human beings, see a lot of wisdom in religion. But, we must also believe in the truth, in reality, in what is that is. If there is any miracle that we must believe in, it is the miracle of reality. There is no other miracle that is greater than this, we must believe. It is not possible to appreciate reality without being struck by its awesome immensity, its diverse complexity, its being real, and its being there. Reality is a miracle in itself, but that is just about where all miracles begin and end!

**Get real and get protected from HIV/AIDS**

Let us all get real about HIV/AIDS and actually believe what we already know, which is that it is caused by a virus, a real particulate micro-organism that can be prevented by using a condom each time we have sex and then do exactly just that – use a condom each time we have sex!

The other beliefs based on false premises are much simpler to explain away than the religious beliefs. Some magicians, mystical and mythical traditional healers in our midst have got nothing under the sun which they cannot treat, even if they may not have the slightest idea as to what it is or what causes it. Their medicines which they usually do not know what they are exactly, in terms of chemical constituencies, are said to be able to treat or cure just about everything. They claim they can cure a myriad of diseases, including HIV/AIDS, even if God himself said that some of these diseases cannot, in fact, be treated or cured!

Now if anyone ever believes that, then they can believe in anything and perhaps we may not need to waste a lot of time and effort on them, but we must feel sorry for them really. These magician followers will visit the magicians no matter what we say against the practice, and they will be told what they want to hear, which is that HIV/AIDS is caused by something else and not the HIV virus, and that HIV/AIDS infection can be cured, which is obviously not true. They will then die of HIV/AIDS at the magician’s place like in the example of the hallucinating cerebral malaria case that was sighted at the beginning of this chapter. It is a pity really, because we cannot blame them for their erroneous beliefs either.

**Some magicians and traditional beliefs have harmed the fight against HIV/AIDS**

Had it not been for the fact that in many parts of the world, sometimes part of the magicians’ method of curing HIV/AIDS involves the rape of young or minor children, we would not waste our breaths on the magicians and their people. But long and behold, the forced rape and the subsequent HIV/AIDS infection of innocent minor children as part of the magician’s treatment of HIV/AIDS should make our hearts bleed with sorrow. We should never allow such a thing to happen, and therefore we as society should take stern measures to prevent such from happening. We must accept that some traditional and cultural beliefs and practices have not really helped the fight against HIV/AIDS. They have instead harmed it. Perhaps it is not enough to just imprison the rapist who was advised by a magician to rape a minor as part of magical HIV/AIDS treatment. The responsible magicians must also be imprisoned considering how
people come to believe in the things that they believe in. The incentive for divulgence of the responsible magician here could be a slight reduction in the rapists' own prison terms. In order to globally discourage this practice of blind medicine by magicians in general, which exactly is what it actually is, blind medicine, it is hereby suggest that any magician or faith healer that causes the death or the infection with HIV/AIDS of anybody during any kind of treatment or therapy, directly or indirectly, should be imprisoned for a very long time without parole. Our other beliefs in herbalists, sorcerers, and a myriad of other mystical, mythical and magical things with regards to HIV/AIDS should be strongly discouraged.

**Reality itself is a miracle and the truth is stranger than fiction**

Let us all teach our children about only one miracle, the miracle of reality. This business of believing in more miraculous miracles whether in Church or at the magician's place is not on, ladies and gentlemen. If we let our children believe in these miraculous miracles, then they are doomed as far as HIV/AIDS is concerned and so are we, because we would most probably not be preaching one thing to them and then doing the other behind closed doors, or would we really do such a thing as do as I say but not as I do, perhaps much like the preacher men whom prostitutes have publicly claimed frequent them in one of the most HIV/AIDS affected countries sighted above? Ladies and gentleman, we hope we have made our points clear in this chapter, so we can now move on to the next chapter to make yet another interesting point when we look at the fact that HIV/AIDS is mostly sexually transmitted and what this means to and for us in terms of sexual behaviour.
Chapter 3  HIV/AIDS infection is mostly sexually transmitted

From the previous two chapters we have now established that this world is in trouble with HIV/AIDS, and that HIV/AIDS is actually caused by the HIV virus. In this chapter we want to establish the fact that the HIV virus is mostly sexually transmitted and how this relates to HIV/AIDS prevention, sex and sexuality. Let us then just go into the facts straight away. The HIV virus is found in the blood and lymphatic systems and other body fluids of infected people, but its most common entry point, its main route of transmission is mostly sexual, both homosexual and heterosexual transmission. Some reports suggest that sexual transmission accounts for more than ninety percent of all new HIV infection today.

Blood, blood products and other body fluids can transmit HIV/AIDS infection

It should be noted that blood and blood products will also transmit HIV infection, but this route has since been nearly eliminated within the medical fraternity by rigorous screening of all blood and blood products. However, accidental transmission via contact with blood or blood products still happens both in medical practice and outside medical practice. There are reports of people who have gotten HIV infection when they were helping out in motor vehicle accident scenes without proper protective equipment or clothing such as rubber gloves, face masks and full body aprons. It is really unfortunate that such has actually happen when it could have been prevented by the proper use of personal protective equipment (PPE). Drug users who still share hypodermic needles are particularly at high risk of HIV/AIDS infection.

Today HIV/AIDS infection is mostly sexually transmitted

Let us go back to sexual transmission. The fact that HIV is mostly sexually transmitted is one of the biggest reasons why it is very difficult to eradicate the virus worldwide, especially in poor and developing countries. Some students at medical school somewhere in this world in the late eighties, saw one male colleague and friend of theirs staring blankly and gravely in front of him during a tea break session in a way that signified someone deep in thought. They approached him and enquired as to what was the matter, teasing him about wanting to commit suicide. What he said made them laugh but it was no laughing matter. Still looking very serious and staring straight ahead of him, he replied thus:

“This disease was put in the wrong place. We are all going to die.”

“What disease?” They asked.

“HIV/AIDS.” He replied and the other students burst out laughing, but not for a long time.

HIV/AIDS is no laughing matter. One by one the students went deep into thought as each one of them privately contemplated their own fate, vis-à-vis, HIV/AIDS and sex. Probably they had laughed then not at the substance of the matter but at the fact that their friend seemed to be deeply and thoughtfully disturbed by the idea that HIV/AIDS was put in the wrong place, as if he wanted to do something to change this situation.

They were probably simply laughing at their friend and not at what he had said. This is because they were all very scared, really scared of HIV/AIDS then, but besides that fear, they had probably not yet given a thought to the idea that it was, in fact, perhaps a very big tragedy that this disease was mostly a sexually transmitted infection. With the alarming statistics presented in the first chapter of this book, now one can see the tragedy quite clearly.
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Why is it a tragedy that HIV/AIDS is mostly sexually transmitted?

Lets us all agree here and now that sex is essential for life. Without sex there is no life. This is very true for all the sexually reproductive living things, human beings included. But then sex is the major way of transmitting HIV/AIDS, some people say up to 99%! Do you now see the tragedy, ladies and gentleman? Lets us now talk about the psychosocial dimensions and the bottom line of sex and sexuality in general and also of human sexual behaviour in particular in relationship to the sexual prevention of HIV/AIDS.

God created human beings to reproduce themselves sexually

When God created people and all the other living things, he put in them the capacity to reproduce spontaneously without him having to come back and create another living organism every time a new one has to be formed or reproduced. He had to make living things reproduce themselves otherwise he would have had no rest creating things every millisecond on the millisecond for the rest of forever. In other words God being the best and the most efficient protoplasmic engineer that he is, put a pre-programmed system in place for involuntary and spontaneous self-regeneration of all living things. This reproductive programme is spontaneous and almost autonomous in the sense that although it behaves according to his predetermined natural laws, rules, regulations and principles, it appears to run itself automatically and spontaneously and cannot be stopped easily if at all it can be stopped. For such a system to succeed there has got to be some nearly irresistible or actually irresistible urge or tendency for automatism or spontaneity geared towards self-regeneration or reproduction as it were and this seems to be actually the case with animal sexual reproduction.

Applying this logic to sex, one will find that although most human beings think that they can actually decide as to whether they want to have sex or not, with whom, when, how, why and so forth and so on, this might not necessarily be actually true if one looks at the sexual behavior and sexual habits of other sexually reproductive animals in this regard, since we are all God's creations, perhaps with the same or similar God given preprogrammed natural tendencies for self-regeneration through sexual reproduction.

The story of the sexual behaviour of the dog

Most animals obviously do not seem to have the luxury of choosing if they want to have sex or not, with whom, when, why and how. Take dogs for example. Male and female dogs do not always have sex every time they meet. Most of the time the male dog just sniffs the female dog's behind and proceeds as if there is no female around it if it is not yet the right time for them to have sex. But when it is the right time for sex, when the female dog goes naturally and by God's grace on heat as it shall surely do one day, all hell will break loose. Just one sniff and one lick, then the male dog goes totally crazy, completely bananas! It becomes very alert and very excited, wiggling its tail fast and furiously while at the same time literally whimpering excitedly as it runs around the female dog apparently confused and not knowing which part to touch next, or even what to do. It is a spectacle to watch.

The only one thing clearly on the male dog's mind at that particular point in time is definitely just sex and nothing else. Nothing under the sun will stop it from having it, not even the snarling threats or even the painful bites of the female dog itself, let alone the embarrassed and disapproving protestations of its owner. Just nothing! Also, it does not matter where the dogs are or what time of the day it is.

When the female dog is on heat it seems like everywhere, anywhere and anytime is time for sex, even right in front of their owners, or right in front of two honourable people who would rather not watch such a spectacle together because of embarrassment, like the mother-in-law and the son-in-law, or the father-in-law and the daughter-in-law. What an embarrassment it has been sometimes! All the so called very
faithful and trained dogs that one may have seen before and marveled at their loyalty to their trainers somehow seem to lose all their composure and the training when another dog on heat is present or passes by. You may have seen one very disappointed owner of such a trained dog who got himself severely bitten by his own very well trained, previously obedient and very faithful Doberman when he tried to restrain it from pursuing a bitch on heat. The guy would be thoroughly bitten by his own dog, ladies and gentleman, if ever he persists on restraining it when it is under the influence of basic sexual instincts. He will have to let it go and it shall surely go with the other dog that is on heat. It may come back home after a couple of hours or even of days, and only when the deed has been done!

Sexual drive is spontaneous and automatic..............eventually

This is the automatism and spontaneity about sex and sexual reproduction that God apparently put into the psyches of all the sexually reproductive living organisms in order for them to have the capacity for self-procreation whether they liked it or not. It seems like God made it in such a manner that at a certain point in time, whether we like it or not, there seems to be no going back on having sex with the other one! This sex quite often results in the creation of many other or another new living organism, in the process of sexual reproduction as we call it today. This happens with all animals, human beings included. Please pose a bit now and think deeply about what this means for the prevention of the sexual transmission of HIV/AIDS.

People think that they can control their own basic sexual instincts

Human beings actually think that they are far better than all the other animals in many if not all the aspects of sexual control. They think that they can control themselves to a very large extent in matters to do with sex and sexual reproduction. To some greater extent this is apparently true. Human beings seem to be able to decide on when they may have sex, with whom, where and how, and sometimes even why. One would think that because of this apparent capability our HIV/AIDS sexual prevention score will be very high, but as we all know, this is unfortunately not the case at all! The high prevalence rate of sexually transmitted HIV/AIDS worldwide betrays our near total failure in this regard. However, generally speaking, people do not usually have sex with their relatives, in public places, or just willy-nilly with anybody and at any time as it were, on heat or not on heat. They may also decide to have sex using condoms or any other form of protection or contraception if they choose. Somehow human beings feel that they are more in charge of their own sexual behaviours than most of these other animals. We have to concede that this is apparently true, and therefore to a larger extent we can still actually be able to help ourselves in the issue of the prevention of the sexual transmission of HIV/AIDS.

Sexual urge in human beings in largely self-controllable, but basic sexual instincts may not be that easy to control

But is it really true that human beings can control their sexual urge or drive? Maybe not very true if we consider the high prevalence rate of unwanted pregnancies, sexually transmitted diseases and HIV/AIDS among different groups of people. Apparently this assertion is not very true. Human beings do not have much magnificent control over their own sexual behaviour just like all the other animals if they really want to think about it in more rational terms than being egocentric. At a certain point in time human beings too seem to totally loose this perceived self-control just like all the other sexually reproductive animals. This point is called the point of no return. At the right time, at the right place, with the right person, under the right circumstances and with the right stimulus, it seems that man will have sex much in the same manner as our overwhelmed dog no matter what the consequences! That right time is at the point of no return.
It seems that at this point in time, we all just behave as good as, or is it as bad as, all the other sexually reproductive animals, whether we like it or not. If we in deed are all God's creations, all things living and none living, then perhaps we should rather not waste our time arguing with this fact. It is apparently basically true that now we have to reproduce each other sexually and rather involuntarily and automatically, just the way God planned it. This means a lot in the way we may then have to consider how best to prevent HIV/AIDS in view of the fact that it is mostly sexually transmitted. Think about it.

The medical students' cohort study

In fact, the author will be the one to know better because when he was a medical student at University in the mid to late eighties, a cohort study was conducted on them to see if they could fully control their own sexually activities at all times with regards to the use of condoms every time they had sex. The author was one of the guinea pigs if we may say that. As medical students, they all knew all there was to know about the basic facts concerning sex, condom use and sexually transmitted infection. These medical students knew about the sexually transmitted diseases and about the double protective effect of using condoms each and every time they would have sex. The condom protects one from both unwanted pregnancy and sexually transmitted infection. They really did not need any persuasion or convincing in this regard. Perhaps that is why they chose medical students for this experiment. Let us now let the author tell his story.

Condom use and human sexual behaviour studied

We were each given a box of one hundred condoms, to be refilled when necessary, and ordered to always keep at least three or more of the loose condoms in our purses and these purse to be always in our pockets and on our persons without fail all the time no matter where we were, what we were doing, or what we were putting on. We were also given anonymous forms which we had to religiously, truthfully and correctly fill in at the end of each week giving details about how many times we had had sex during the previous week, how many times we were able to use the condom and how many times we failed to use the condom and why we thought we failed to use it. The research project went on for fifty-two weeks. There were more than a couple of hundreds of us, both males and females, and the dropout rate was negligible. Female students were very few though.

Highly sexed up medical students and HIV/AIDS

Now for the results! These were very interesting. As young people, most of us were between twenty and thirty years of age, you can bet that there was a lot of sex everywhere! Yes there was a lot of sex, I can confirm that. It looks like we just loved sex or was it also because we were young and we were involved in this experiment where we had to show that we did something by weekly filling up the sexual record score cards (forms) that were given to us? It was hard to tell why we were so highly sexed up. On average, each one of us had sex six times every week! Here we are talking about the actual number of times one had sex or the actual so called rounds as it were and not the sex sessions or occasions on which one had sex. Of course, the occasions were fewer than the rounds because on average it was three rounds per session or per occasion, which means that we had sex on one or two occasions per week, which in fact could be normal for young newly independent university undergraduate students anywhere in the world.

There was nobody who did not have sex at least once and at least on one occasion per month throughout the experimental one year period. All of us had sex at least once a month. Granted, there seemed to have been some nymphomaniacs among us too. One guy beat us all. He had sex every single day under the sun! The author shall keep his score to himself but it was not too bad at all. Ladies and gentleman, we
were only young men and women, so please forgive us! Apparently we could not just help ourselves when it came to having sex.

Perhaps the reader may want to pose now and reflect on what this highly sexed behaviour of young adults may mean with regards to the transmission of HIV/AIDS in view of the fact that it is mostly sexually transmitted. Just how many people could be having sex right now as you are reading this throughout the world? What about in your own country? So how many people could be exposing themselves to the risk of HIV/AIDS right now? Think about it. The more interesting statistics in this research project is in relationship to human sexual control, the consistent and proper use of condoms, and sexually transmitted infection, including HIV/AIDS and this is what we want to share with you now.

All students failed to 100% consistently use condoms!

Imagine that not any one of us managed to have sex one hundred percent consistently using the condom at all times during the fifty-two week period under review even if we had the damn things with us right in our very own pockets and at all times too! Not even one of us managed to do that! In fact, all of us had sex at least once, but actually several times, and on one or more occasions without using the condom! We are talking about informed, educated, motivated and knowledgeable medical students here, ladies and gentlemen! If such people could behave like this where human sexual behaviour control is concerned and in the face of HIV/AIDS, how about the common people off the streets? What does this mean about their innate capacity to control their own sexual behaviours as a preventive tool or measure against HIV/AIDS? Think about it.

There was sex with multiple partners

Anyway let us go back to our results. To make matters worse, we also each had sex with several different partners throughout the whole year! In fact the minimum number of partners one had sex with in the fifty-two weeks of the study was three, either concurrently or consecutively! This is very depressing but interesting. As far as HIV/AIDS prevention is concerned we are always preaching about not having sex or unprotected sex with multiple concurrent partners.

Granted, having unprotected sex with anybody, even just one person is very risky and it is therefore not advisable at all, but, for interest sake, which is riskier, having protected sex with multiple concurrent partners or having the same with multiple consecutive partners in one year? Is there any difference between the relative risks to HIV/AIDS exposure of someone having “protected” sex with say three concurrent partners in one year and the other person doing the same but this time with three consecutive sexual partners during the same period, assuming the condom protection failure rate to be equal in both cases? What does this mean for the sexual transmission of HIV/AIDS? Please think about it very carefully before answering, especially considering the fact that all the students in this experiment had unprotected sex at least once or more during the one year period. Both of these cases could also fail to use condoms at least once, but even once can be one too many where HIV/AIDS is concerned.

There was a 90% condom user rate

Perhaps thankfully, most of the times that the students had sex they did it with the condom. Their condom user rate was just above ninety percent, which we were told was significantly higher than that in the general population which was then estimated to be at around thirty percent. We did very well you could say, especially since the prevalence of HIV/AIDS back then was less than 1%, but as far as HIV/AIDS is concerned now, with prevalence rate among such a group as quoted in chapter 1 being 49.2%, perhaps
it was not good enough to save us from HIV/AIDS considering other parameters like promiscuity and the fact that we all did it without a condom at least a few but several times throughout the whole year. Perhaps we should all have managed to do it with the condom all the time considering the fact that we were young, knowledgeable, medical students and we always had the condoms in our pockets all the time. But hey, this is the reality of human sexual behaviour, ladies and gentlemen. There is always something called a failure rate in every and any man-made situation. Just imagine what this means for the sexual spread of HIV/AIDS in an alarmingly high prevalence rate environment such as the one depicted at the beginning of chapter 1? Can we really be safe from sexually transmitted HIV/AIDS? Again please stop and ponder.

Reasons students gave for sometimes failing to use condoms

The most interesting part of the project was the reasons given for doing it without using a condom on those occasions that one did it without using this gadget. Truth is stranger than fiction, ladies and gentlemen! Imagine that with several condoms right there with you in the purse in your pocket you proceed to have sex without putting on even just one condom in this day and age of HIV/AIDS! That is almost unbelievable but it happens, as it has happened before. That is why we have got so much HIV/AIDS in this world today!

Reasons given for failing to use the condom sound spurious but they are real

The most common reason proffered for not using a condom even when one had it with them in the pocket right there and then was that it was too late to put it on at that time, and the meaning of too late was given as no longer possible! Probably meaning that one had already done it without putting on the condom in the first place anyway! The other more common reasons in the top five were that; 2, it was the first time having sex with this partner (girlfriend) and from experience one would not have been given the sex if one wasted time trying to put on the condom because the new partner would have been "sober" again about what was just about to happen and then most probably perhaps refuse to cooperate.

It was adjudged to be better to strike the iron while it was still hot under these circumstances. 3, the partner (girl) had refused to have sex before when they were just about to do it when the guy had pulled out a condom in an attempt to put it on, which unfortunately seemed to interrupt the flow of things and made the other partner change her mind; 4, plain and simple drunkenness; and finally 5, the other partner (girl) refused saying that she was not a prostitute! There were many other highly creative reasons as well like that this was my regular partner or that this was my only partner at that time and so forth and so on, but these were less frequent maybe because as young students we were more afraid of making somebody's daughter pregnant and becoming parents prematurely, or getting matrially committed to anyone too early more than anything else, so mostly we did not want to keep permanent partners, and therefore we had a few more than one sexual partner.

The possibility of sexual behaviour change or modification

These were the top five reasons given for not using a condom at any one particular time during the study period. Readers must realize that the condom's constant availability was most assured and not even a single person sighted its unavailability as the reason why they did not use it. That was out of question because we ensured that we always had them right in our pockets as ordered right at the beginning of the study. Now we must all agree that HIV/AIDS, or no HIV/AIDS, with or without a condom, sex shall be had no matter what, if the conditions are right! This is the point that we must appreciate in our quest to fight HIV/AIDS and them advise or behave accordingly. But we must also look at the reasons given by the
students as to why they sometimes failed to use the condom and wonder what these reasons and the resultant failure rate thereof will be in our general populations considering factors such as poverty, the low rate of literacy, lack of knowledge, religion, tradition and culture, but most importantly, the generation gap in as far as the sexual transmission and prevention of HIV/AIDS is concerned. It is just possible that at the end we may be in a position to completely understand why the fact that HIV/AIDS is mostly sexually transmitted can be quite a big challenge.

Paradoxical female results

As a consolation to the fairer sex, it may be noted that the few female students fared much better than boys in our study, but then we are talking about university girls here, and not only university girls, but medical students for that matter. One wonders what the results would have been if we were talking about our fairer ladies of the night or just plain and simple township girls in a highly impoverished environment. But then all of the student girls also had sex without condoms at one time or the other throughout this experiment! It is just only that their data was slightly better than that of the boys.

With this in mind, why is it then that according to the statistics presented in chapter 1, and even any other statistics generally, women seem to show higher prevalence rates of HIV/AIDS in general? Could it be that in real life out there and not in medical school, women actually have more sex than man? This could just be possible, ladies and gentlemen, and the reasons for this could be more interesting in as far as the prevention of the sexual transmission of HIV/AIDS is concerned. Please take note and find out. Why are women more vulnerable to HIV/AIDS?

The sturdy sample was small

Anyway, eventually, the lecturers said that at a few hundreds, the sample was small, but, nevertheless, it gave them some interesting inferences. What the author can tell you now is that it is just about twenty years after this study was conducted and some people who were suspected to be the most sexed up ones amongst the group, and who were also suspected to be the ones who did it without condoms most of the time, are now no longer with us. They died of HIV/AIDS several years after graduation! Perhaps this small research data was not from such a small sample after all!

The psychosocial dimensions and the bottom line of sex and HIV/AIDS

For this reason one feels that it may be relevant here to draw some practical examples from this study. One would also suggest that if there was anyone who could sponsor a similar research project to be carried out today in one of the most HIV/AIDS affected countries, we could have interesting results from which we may be able to gain a lot of insight into how we may prevent HIV/AIDS in view of the fact that it is mostly sexually transmitted. Anyway, let us look at these results philosophically and in relationship to the psychology and sociology of sex and sexuality, and the theory of automatism and spontaneity, and God's natural way of ensuring the self propagation of species or reproduction with regards to the prevention of the sexual transmission of HIV/AIDS. Now, let us ask this question again. How much self-control does Man have over his sexual desires and the sexual activities thereof, after all?

Man apparently has by and large greater self-control of his sexual desires and activities than all the other animals and most of the time, this we must agree. But at certain times, places, environments, occasions, and so forth and so on, this self-control seems to be lost, and man just behaves as good as dogs and all the other animals on this earth. Put even what you may think is the dullest boy or man in a room with a woman, close the door and turn off the lights, and you will here the woman screaming!
One blind singer from one Southern African country, who is unfortunately now late, once sang that sex is the most sobering thing on earth ever and that even a madman gets very sober and very normal, if only for a moment, when he is having sex. Perhaps we would now like to change this observation and say that sex is the craziest thing ever on this planet; even the most sober man or woman goes crazy when he or she thinks of or is having sex! What a paradox!

Imagine medical students failing to use condoms consistently for just one year, all of them in the survey sighted above! What of the majority of them saying that the main reason why they did not use the condom at any one particular time was that it was too late? Too late to want to survive in this day of HIV/AIDS! Is that not crazy? When has it ever been too late to be safe except when having sex! Maybe the real meaning of too late here was that "I just could not be bothered," but to be a bit fair to the students, let us say that perhaps it meant that it was way past the point of no return in terms of sexual arousal so much so that stopping to put on the condom was well-nigh impossible. This we seem to have amply demonstrated in this chapter that it actually happens, and it has actually happened everywhere. It is the biggest poser in our fight against HIV/AIDS and its sexual transmission.

What is the point?

The point that we are trying to make here again and again is the fact that it seems that whether we like it or not, we may have to have sex at a certain point in time in our lives as ordained by God and perhaps for involuntary sexual reproductive purposes. That is one point.

Always have condoms on you

The next point is that it is better for us to keep condoms somewhere on our persons all the time so that when that time comes, we may be able to use them. For this to become general practice in our lives and societies, not only should we de-stigmatize HIV/AIDS, but condom use as well. (See later chapters)

Do not fail to use the available condoms

The third point is the fact that there will always be something called a failure rate in any given system and that this rate is never going to be zero. When we look at the medical students' ninety percent condom user rate espoused above, that is very high indeed even if we have not emphasized on this fact up to now because we did not want to sound as if it was an achievement considering the other parameters like the fact that they all managed to have sex without using a condom at least once during the one year study period. One wishes for the same or an even better condom user rate to be achieved in the general population of any one given country, but especially in the most HIV/AIDS affected countries of this world. That will be the day when the fight against HIV/AIDS will have been won!

Granted, we cannot all use condoms successfully all the time and at all times because at some point and in time we will have to make babies, and also there is this failure rate. When we want to have babies, one would strongly recommend that we both get tested for HIV/AIDS, and when we both test negative, we then go ahead to make our baby or babies but then quickly revert back to using condoms again as soon as the other one successfully gets pregnant and or the baby is out.

There is absolutely no good reason for failing to use the available condom

The fourth point is that yes, there is absolutely no good enough excuse for not using condoms in the face of this rampant HIV/AIDS pandemic, not even the one that this is my wife or husband, or that this is my one and only steady partner. No, nothing.
Always use the condom to prevent HIV/AIDS

The fifth and final point here is that we must always use the condom. If we believe that HIV/AIDS is caused by the HIV virus, and that the HIV virus is mostly sexually transmitted, then the most logical way to prevent it would be to either not have sex at all, which we have seen and amply demonstrated in this chapter that it is perhaps not reasonably or practically possible at some point in time; or to use a condom all the time that we have sex, which as we have seen here that with the right amount of education, knowledge and preparedness, as in the case of the medical students, it is about ninety percent achievable.

Always aim high

Let us perhaps aim to make the consistent use of condoms 100% achievable, so that when and if we fail, as we shall surely always do at some point in time as has been demonstrated on several occasions in this chapter alone, then we may fall somewhere in the upper passing mark of the HIV/AIDS sexual transmission prevention performance scale. This perhaps could in fact be our sixth and final point. For now, let us rest our case. We shall take it up in the next chapter where we shall talk about the fact that HIV/AIDS infection has no cure yet. Yes, HIV/AIDS infection has no cure yet, despite all that you may have heard about, or know of the so called antiretroviral drugs!
Chapter 4  

HIV/AIDS has no cure

Antiretroviral drugs do not cure HIV/AIDS

It is hoped that many readers have not yet been thrown off the cart so far as they read this book, and that they are all still reading the book as they journey through the complicated and perilous valley of HIV/AIDS in an effort to understand more about it and how it can be successfully prevented in general and also in the workplace in particular. As was said before in earlier chapters of this book, we shall definitely zero in on the workplace eventually, but so far it has been and will be about improving on our background general knowledge of the HIV/AIDS subject. There is no way we can get to understand the pros and cons of dealing with HIV/AIDS at or in the workplace if we do not understand all the issues surrounding the subject in general.

In the last chapter, we dealt with the issue of HIV/AIDS being mostly sexually transmitted. In this chapter, we want to deal with the rather surprising issue that HIV/AIDS infection, in fact, has got no cure yet. Many people find this fact hard to believe. If the widespread use of antiretroviral drugs has lead so many people to believe that there was now a cure for HIV/AIDS so much so that they did not need to take any preventive or protective measures when having sex, any more than they would want to prevent infection by gonorrhea or syphilis, or just to prevent pregnancy, then perhaps it is about time that the whole world revisited its messages to the people about HIV/AIDS and the so called antiretroviral drugs.

Misconception about HIV/AIDS cure is not good for the fight against the disease

Those poor and most affected countries of this world that are still steeped in mystical, mythical, traditional, religious and or cultural disbelief about the causations, transmissibility and curability of HIV/AIDS, and that are still very rich in other counter mystical, mystical, traditional, religious and or cultural beliefs and practices, may really be at a very high risk of having all their people eventually wiped out by the HIV/AIDS pandemic if this grave misconception about the use and efficacy of anti-retroviral drugs is not corrected very quickly and now.

Granted, anti-retroviral drugs have brought about a lot of relief for the HIV/AIDS sufferers, but to assert that HIV/AIDS is now no longer a terminal illness but treated just like any other chronic illness such as Diabetes Mellitus, Asthma or High Blood Pressure (The famous BP) as has been heard even some medical practitioners asserting, is in fact taking the presumed potency of these so called antiretroviral drugs too far, and perhaps highly misleading. It should be discouraged, especially in the face of rampant HIV/AIDS.

How antiretroviral drugs work

Without confusing readers with the mechanisms of action of these drugs, may it be told here that it is a fact that these drugs help a lot in prolonging the lives of HIV/AIDS patients, but they do not eliminate the HIV virus from the body systems completely, so they cannot and do not cure HIV/AIDS, and therefore no such claims should be made by anyone. Anti-retroviral drugs just reduce the viral load in the body by slowing down viral reproduction and prolonging the lifespan of infected CD4 cells, thereby somehow delaying the development of full blown AIDS which will eventually still develop anyway, because of various reasons, regardless of whether or not one still is on these drugs as religiously as they can ever be. This is just about the only good thing that the anti-retroviral drugs do. They only palliatively improve the quality of life of HIV/AIDS patients.
Because of their non-selectivity in action, these antiretroviral agents have terrible side effects. Generally most of them slow down the body's normal metabolic processes. In so doing they actually suppress the body's immune system as well. That is why they cannot be taken prophylactically, and or for continuous long periods of time by those whose immunity has not yet gone down drastically. That is also why post exposure prophylaxis is done only for a given short period of time. In a person with a normal CD4 cell count and with or without HIV/AIDS, antiretroviral drugs will definitely lower their CD4 cell count, together with all the other blood cells and general cellular growth and replacement, and consequently make the person taking them more susceptible to infections or the development of full-blown HIV/AIDS.

But in a person already down with HIV/AIDS, and whose CD4 cell count is now lower than a given optimal level, then, because the antiretroviral drugs' immunosuppressive effects are far less than those of the HIV virus itself, that is to say they suppress the growth of the body cells at a much slower rate than the rate at which they slow down HIV viral reproduction inside the CD4 Cells, they then end up suppressing the re-production of the HIV virus more than the continued existence or the regeneration of new CD4 cells, with the result that the viral load progressively becomes less and less while the number of CD4 cells in the blood becomes more and more, hence their efficacy.

**Antiretroviral therapy (ARVT) is palliative therapy**

Please note that although the viral load may be reduced by these antiretroviral drugs to undetectable levels in the blood, this is not the same thing as saying the patient has been cured of HIV infection. The virus will just be temporarily no longer detectable in the client's blood anymore, and that is all we can say. As to how long this state of affairs will last depends on the client, the types of antiretroviral drugs that they are taking, and how they are taking them, but so far as is known in the medical fraternity, this has not, and will possibly and most probably not last forever, so HIV infection is in fact, practically still incurable, and the contrary cannot, and perhaps must never be said for now.

**Antiretroviral drugs have got nasty side effects sometimes**

Please note that sometimes when antiretroviral drugs are given to a person whose CD4 cell count has gone down below a given very low level, and who can no longer show an active immunological reaction, then they may actually in fact expedite the demise of such a person instead of helping them out because of their toxicity or side effects. This actually happens with many diseases sometimes. At a certain point in time, it may actually be too late to institute any drug therapy. There are many people who have reported that their debilitated relative died just a few days or a few weeks after starting on the appropriate, say, TB therapy, because of this phenomenon. This paradoxical phenomenon always poses a very difficult decision for the doctors when they may have to choose between to start treatment or not to start treatment at a certain very late stage of the disease.
HIV/AIDS is not just as good (or as bad) a chronic illness as any other

Just to re-emphasize, it should be noted that suppression of viral replication and therefore viral reproduction is not the same thing as complete shut down of the same process. The doses at which these substances (antiretroviral drugs) should be given in order for them to completely shut down viral replication are such that the human cells, together with the human being, will die first before this is achieved! So the only alternative is to give the anti-retroviral drugs at lower none lethal levels in order to maintain a tolerable balance between efficacy and toxicity while improving the quality and prolonging the lives of those infected by the virus.

This definitely does not make HIV/AIDS just as good a chronic illness as any other. For a start, diabetes, asthma and high blood pressure are not transmissible in the same way as HIV/AIDS. If one has sexual contact or any other form of contact with a diabetic for example, one will not get the diabetes as in the case of HIV/AIDS. It will be interesting to study the infectivity of people on antiretroviral therapy if this can ever be done at all, because they will definitely still be infective even while still on treatment.

The other side effects of the anti-retroviral drugs include alopecia (loss of hair), general body malaise and generally not feeling well, but if one were already down with HIV/AIDS, the disease itself would perhaps have given one the same or similar signs and symptoms in a much worse and more severe form so much so that one would definitely appear to be recovering when they take the antiretroviral drugs.

The prognosis of HIV/AIDS is still bad

That is perhaps all there is to say about antiretroviral drugs and their usefulness in the fight against HIV/AIDS. Let us not then go out there getting ourselves infected or infecting other people saying just because there are anti-retroviral drugs anyway! As you may have now seen and understood, these drugs do not cure HIV/AIDS. Many people who have been properly diagnosed to have HIV/AIDS have gone on to die of the same disease despite them taking antiretroviral drugs. So ladies and gentlemen the, fact still remains that there is no cure for HIV/AIDS, so do not be fooled by anyone or anybody, faith healers, traditional healers, and magicians included.

HIV/AIDS prevention is our best hope so far

Finally, if there in deed is no cure yet for HIV/AIDS, then perhaps our only hope for survival is to try and prevent it at all costs, or as far as is practically possible. Apparently, we have got to go back to basics again. We have got to advocate for the widespread use of the condom as a matter of routine in our societies with all our hearts, all our minds and all our souls, but most importantly, with all our purses too, both as keepers of the condoms and the money that is needed to buy them. In the next chapter we shall be looking at the fact that HIV/AIDS KILLS and dissecting it as we have done with all the other previous topics so far. It may appear to be simple, but let us find out if this is in fact the case.
Chapter 5  HIV/AIDS Kills

Everyone is afraid to die

Now that you know the following facts about HIV/AIDS: that the world is in trouble with HIV/AIDS, that HIV/AIDS is caused by HIV infection, that HIV/AIDS infection is mostly sexually transmitted, and that there is no cure for HIV/AIDS, let us deal with the fact that AIDS kills.

The reason why most people are afraid of HIV/AIDS is that it is a disease that eventually causes the death of the one suffering from it. It kills. It is a terminal illness so to speak. This is about the only fact on HIV/AIDS that everyone seems to know, to understand, to agree with completely and to be afraid of, very, very afraid of in deed. Even the faith healers and the magicians seem to know this fact and they are also very afraid to die of HIV/AIDS. At least that is a good start for our fight against HIV/AIDS on the psychosocial frontline. However we seem to still have few sticking points even here though.

With the advent of the life prolonging antiretroviral drugs which were discussed in the previous chapter, many people may argue against the use of the word terminal illness with reference to HIV/AIDS, but may it please be noted that the term terminal illness as applied here does not necessarily denote that the patient is just about to die from the illness, but it simply means that the disease or illness is eventually fatal. It is a prognostic rather than a diagnostic term. The diagnosis of imminent death is something else entirely different.

Being HIV/AIDS positive does not mean that one is about to die of AIDS

Being diagnosed with HIV/AIDS today does not mean that you are going to be dead tomorrow, but HIV/AIDS is in fact eventually fatal despite the available treatment. This is the sad fact of this disease for now. What then do we do about this fact? There are a lot of people who could not face this fact and ended up committing suicide after being diagnosed to be HIV/AIDS infected, which is very unfortunate in deed. To people who may think like those who killed themselves, please note that death, from whatever cause, is guaranteed in this life anyway, so there is no need to hasten its arrival. It will be better to make the most of the good life that God has given to you and every minute of it counts like in a basket ball game. Why not just try to enjoy life while it lasts since it never lasts forever anyway? Please do not commit suicide no matter what.

HIV/AIDS positive people must use condoms even more vigorously for their own good

Although HIV/AIDS is a fatal disease, if one were diagnosed to be suffering from it today one should try to put more years back into their life by being optimistic about it instead of being pessimistic. For a start one should try not to get more HIV/AIDS infection by sticking to protective measures even more vigorously than before. Therefore one should then always use a condom as religiously as they can ever do, especially 100%. The thing about HIV/AIDS is that the condition develops faster and deteriorates even more with each new HIV re-infection on top of the already existing one. This is because apart from just increasing the viral load, HIV re-infection may introduce new drug resistant strains of the virus into an already precarious situation which then become even more precarious and may tip the balance into the development of full-blown AIDS.

So the attitude that since I am already infected then I do not need to use a condom anymore is in fact self defeating. You will just die faster if you do that. The same fate will meet those who may become vengeful
and want to spread it before they die. Hopefully there are not many people who will have this attitude to vengefully spread AIDS, but if there are any, then perhaps they should spend the rest of their lives behind bars, or somewhere in complete isolation because they are a menace to society.

**It is an international criminal offence to willfully spread HIV/AIDS**

It is very cruel and a criminal offence to willfully and knowingly infect someone with the HIV virus worldwide. However, frequently, too frequently one would say, we are always assaulted with cases of people who have willfully infected others with HIV/AIDS, especially minor children. This is so very unfair.

**HIV/AIDS related terminology has confused the fact that HIV/AIDS kills**

Going back to the fact that HIV/AIDS kills, many people have managed to dodge this fact expertly, especially when they are explaining their illness to relatives, or when they are relating the cause of death of a close relative. This is because on the one hand we make a distinction between HIV infection and AIDS, and say that being diagnosed as HIV positive, that being a carrier of the virus that causes AIDS, does not necessarily mean that one is already suffering from the disease AIDS at that time, which in fact is very true. On the other hand, we also try to make a distinction between AIDS and its complications, the opportunistic diseases that complicate HIV/AIDS, or the eventual mechanisms of dying from HIV/AIDS, by saying things like someone died of HIV/AIDS related TB, HIV/AIDS related diarrhea and so forth and so on.

**Doctors can help out with the confusion created by HIV/AIDS related terminology**

This makes people only want to talk about the related illness and not the underlying HIV/AIDS when they explain their illness or that of a close relative to other people or relatives. Even some doctor sometimes find it hard to put down a clear cut diagnosis of HIV/AIDS on the client's outpatients card or on the notification of the cause of death certificate with the result that someone once, perhaps accurately, remarked that although we all know that HIV/AIDS kills, and although we also know of many people who have died of HIV/AIDS, it seems that in hospitals no one dies of HIV/AIDS if we go by what some doctors write on these documents.

Some doctors in some parts of the world also routinely and extensively use the HIV/AIDS related language so much so that one may be inclined to think that HIV/AIDS as a stand alone disease no longer exists but has now been replaced by a lot of HIV/AIDS related diseases. If that is the case, then we may perhaps excuse those who still insist that HIV/AIDS does not kill, but other HIV/AIDS related diseases like TB do. Perhaps the medical profession needs to get its proper HIV/AIDS terminology back on track in this regard. That is all we can say about this small but consequentially big terminological misunderstanding. HIV/AIDS kills.
Chapter 6  HIV/AIDS infection is preventable

We have surely come a long way together, ladies and gentlemen. We now are aware of the following facts with regards to HIV/AIDS so far; that the world is in serious trouble with HIV/AIDS, that HIV/AIDS is in fact caused by HIV infection, that HIV infection is mostly sexually transmitted, that HIV/AIDS has no cure, and that HIV/AIDS kills. In this chapter we are dealing with the fact that HIV/AIDS is preventable, completely preventable ladies and gentlemen, so perhaps we can still make it as the human race. Perhaps we can still survive the HIV/AIDS storm.

How is HIV/AIDS preventable?

Most of the HIV/AIDS organizations, most media adverts, religious messengers and many other HIV/AIDS campaigners will tell you about the ABC of HIV/AIDS prevention. They will tell you that the pathway to preventing HIV/AIDS is abstinence, being faithful to one uninfected partner, and using condoms each time you have sex, hence the acronym “ABC”. To this list we may like to also add poverty alleviation, and then we will discuss the merits and demerits of each of these items later. Get ready to rock and roll ladies and gentlemen, because believe me it is not entirely as simple as it looks or as you may think it is. It is not really as simple as this ABC here.

Abstinence, virginity and HIV/AIDS prevention

Let us start with the first one; abstinence. How far feasible is it to abstain from sex? Can we realistically abstain from sex as an HIV/AIDS preventive measure? Please refer back to Chapter 3 again where we talked about the pros and cons of the inevitability of sex in sexually reproductive animals, human beings included. We do not need to go into any further detail about that again here.

Now after revisiting Chapter 3, how much practical attention will a teenage son or daughter who daydreams about sex and has wet dreams because of it almost everyday, pay to his or her parents when they tell him to abstain from sex until he or she gets married, at that moment when, as so often happens with our modern children these days, they are in a private secluded place with their equally hot lover, and due to the passionate kissing, touching and caressing, they have reached the point of no return?

Perhaps not much attention can be paid to, or in fact has been paid to this message of abstinence at that particular point in time. This is because the message of abstinence seems to militate against nature at that time. It is unnatural for sexually reproductive animals to abstain, especially when on heat, so, and as with all things unnatural, abstinence shall fall at that particular point in time.

This could actually be a fact considering the results of the medical students’ story narrated in chapter 3. With this in mind perhaps the gospel of abstinence actually needs to be qualified for it to gain a measure of credibility, and for it to be accepted as a real and practical alternative and or additional way of preventing HIV/AIDS which in fact it actually is.

Virginity is good to have but good behavior is better defense against HIV/AIDS

Abstinence as a virtue has been preached about in homes, at schools, at Churches, and in fact everywhere since time immemorial, way before even HIV/AIDS came into being. Marrying a virgin has been and still is a highly exalted practice in most religions, traditions and cultures of this world. Virginity was and perhaps still is viewed as denoting a good character or personality in the virgin individual. But really, does being a virgin actually mean that one is of good character? This theory of the link between
virginity and good character has now been so thoroughly discredited so much so that linking it to abstinence and HIV/AIDS prevention may not buy anyone any more votes.

Every woman on this earth is born a virgin, and incidentally so is every man. They then go on to loose the virginity at some point in time, some earlier than others, and others later than some, and for various reasons, good and bad, we never can easily tell which, but they were all born virgins in the first place. Marrying a virgin does not guarantee that he or she will not do it on the side later on in the marriage as has frequently happened to many unfortunate husbands and wives, if doing so was within his or her character at birth. We all know of renowned prostitutes who were still virgins at thirty, and also of some other prostitutes who lost it at fourteen years of age. We also know of promiscuous people who were virgins at marriage and non-promiscuous people who were not virgins when they got married.

Abstain from sex, but also always use a condom (Abstain from unprotected sex!)

The linking of virginity-good character-abstinence-HIV/AIDS prevention together may not win many hearts, especially the previously heartbroken ones. We need to rephrase this linkage very well. It is not like there is no good will in this linkage. Yes, it is there, and lots of it too, but so far the way it has been put across has frequently been a let down. Perhaps we may tell our children to try to delay having sex and exposing themselves to the risk of HIV/AIDS as long as they possibly can, and not to have indiscriminate sex at all, whether it be premature sex, sex before marriage, sex on the side, or any other kind of improper sex, and let us also tell them at the same time that should they fail to abstain like this for whatever reason, then they should never ever fail to use a condom no matter what because they will contract HIV/AIDS and die of it.

This altered message could provide a more plausible linkage between virginity-abstinence-HIV/AIDS. Note that we have in fact completely cut out the bit about good character linkage. Many people who continued to stay with highly promiscuous people in marriage simply because they were virgins when they married them in church, and therefore viewed them as of good character, have gone on to die of HIV/AIDS! So, in short, abstinence, yes, but very qualified abstinence and not just abstinence parse. That is the message about HIV/AIDS prevention that we may get out there in relationship to this matter.

Being faithful to one uninfected sexual partner is a virtue that we should all aspire for

Let us now turn onto the other so called pillar of HIV/AIDS prevention, the pillar of faithfulness to one uninfected sexual partner. How far feasible is this as well, considering what we have seen in chapter 3 of this book? There are in fact three aspects to the story here. The first aspect is that of being HIV negative yourself in the first place, which premises prior HIV testing, then the second aspect is that of an uninfected partner, which also premises prior HIV testing of the partner, and finally, the third aspect is that of the two of you being faithful to each other all the time. We shall dissect these aspects separately and try to understand and appreciate what they mean and whether or not they are feasible.

Voluntary counseling and testing (VCT) for HIV/AIDS, a rethink may be needed

The aspect of voluntary HIV testing is a dicey one. There are not that significantly many couples who jointly present themselves for VCT and then go on to share the results with the view of trying to be faithful to one uninfected partner in this world, especially in the worst affected communities. In such circumstances people are petrified of VCT because of the very high likelihood of coming out HIV positive. However, there is something else about VCT which we need to examine more closely. In medicine, there
are basically only three reasons why medical investigations and or tests may be acceptably, rationally, ethically and professionally conducted on any client whatsoever. These are for diagnostic purposes, for treatment purposes and finally for research purposes and perhaps nothing else. What is the reason for VCT and is it acceptable, rational, ethical and professional? This is the big question, and apparently no one has ever asked it in our frenzied pursuit of VCT programmes all these years. The reality of this oversight could be bad for us as the reader may find out below.

The exact sexual behavior of HIV/AIDS positive people who know their status is not known. Has anyone in the medical profession ever bothered with studying the sexual behaviour of people who have had voluntary HIV/AIDS counseling and testing, both the ones who tested positive and the others who tested negative in order to see if it benefits them and or the society in which they live to have this kind of test done on them? What exactly is the sexual behaviour of a healthy looking HIV positive person who is aware of his HIV/AIDS status? Is it responsible sexual behavior whereby he or she will use a condom each time they have sex, or is it that of vengeful irresponsibility whereby they may never bother to use the condom or warn the other partner about their HIV/AIDS positive status? Do we really know the answers to these very crucial questions in relationship to VCT and HIV/AIDS prevention? Could we possibly not be precipitating and encouraging the spread of HIV/AIDS through VCT all these years? Let us see. If one is HIV positive but they do not know it yet, are they not most likely to be more open to HIV/AIDS preventive messages, sexual behaviours changes and preventive practices than the person who knows that they are already HIV positive anyway? There are a few shocking bad examples.

The shocking behaviour of some HIV/AIDS positive people who knew their status

In a hospital in one West African country not so many years ago, a healthy looking nurse who knew her HIV positive status, reportedly went on to vengefully have unprotected sex with hundreds of men, doctors included, whose names she religiously kept in a diary to be read out at her burial. You do not want to know how many people fainted at this girl’s funeral, and not because of grieving for her, but because of grieving for themselves. In another worst affected Southern African country, one HIV positive woman who knew her status confessed in church and it came out in the public press that she slept with more than thirty one men from the same church without using condoms. And yet another one, in the same press, went on to have three children with three different men when she knew that she was HIV positive. Two of the children were born with HIV infection and they had now developed full-blown AIDS and she was publicly asking for assistance to look after them. All this is not fiction. It actually happened. Could this not be just the very tip of an ice burg? Wither VCT?

And more HIV/AIDS positive people behavioural horrors

The author has got the personal and horrendous experience of saving a widowed man from the throes of death due to HIV/AIDS by putting him on appropriate anti-retroviral drugs only to see him marrying another young wife and actually making her pregnant when he appeared to have well recovered from the disease a couple of years later. Could this unfortunate young woman have been told of the HIV/AIDS status of this man? Most probably she was never told. The biggest question here and now becomes that from these few examples, is this not the way that HIV positive people who are aware of their status generally behave despite our expectations to the contrary? This is very serious.
What exactly is the sexual behaviour of HIV/AIDS positive people who know their status?

There are in fact many such examples of dangerous antisocial behaviors by HIV positive people who are aware of their status that we all may know of, but this could just be the tip of an iceberg. Real research is needed to ascertain the actual sexual behaviour of voluntarily tested HIV positive people or even people who have been put on anti-retroviral drugs and appear to have recovered from the disease. We may find out that all this euphoria about voluntary HIV testing has been thoroughly misplaced. It will be very unfortunate in deed. The possible results of proper research on this matter could be frightening.

Anyway, one would expect any sane person who has voluntarily tested HIV positive to try to live positively and completely refrain from spreading the infection at all costs and not just to try not to do so. This could have been the logic behind the promotion of VCT in the first place, although such logic has never fitted in with the three basic reasons for conducting medical investigations or tests as given above.

Some VCT HIV/AIDS positive clients are really positive

But to be really fair to VCT, a lot more people in this world have actually come out in the open to declare their positive HIV status, promising to now have turned over a new leaf and that they will now be as straight as ever can be and they will always use a condom, will never pass on the virus, and all the other good things that any promoter of VCT would like to hear. These good reformed people are publicly clearly the overwhelming majority compared to the avengers, although this would be expected. More nice guys are expected to come out publicly than the bad guys.

Unfortunately, these nice guys, or now seemingly nice guys, are still a tiny, tiny fraction of the number of people who have actually tested positive at VCT Centres throughout the world. Thus we may have to admit that our lack of knowledge of the real sexual behaviours of HIV positive people who know their status still remains exposed. Perhaps we should do something about this and very quickly too it seems.

What do we do now about VCT?

From the little we now can say we know personal restraint by HIV positive people who are aware of their status may or may not to be their natural code of conduct after all! What do we say now about VCT in view of these ambiguous revelations? Would it not be better if we had continued with the scenario whereby everybody assumed that they were HIV negative and treated everybody else as if they were HIV positive? Maybe, just maybe, such a scenario serves our purposes of preventing HIV/AIDS through modified sexual behaviours and practices much better than VCT?

So, perhaps the idea of being faithful to one uninfected sexual partner, in so far as it encompasses, and or, demands and or premises the need for voluntary HIV counseling and testing may not at all sound so appealing for precisely the reasons of the uncertainty of individual sexual behaviour and practices post HIV test results, especially if, and when those results come back positive. Maybe we just need to be faithful to our partners and cut out the uninfected bit. Maybe. Serious thinking is needed here.

Just being faithful to one partner

Coming now to the question of just being faithful to one partner, with or without voluntary HIV testing, this also is a very dicey issue too. Bearing in mind what we have conceded to be the inevitability of sex in sexually reproductive people and the reality of the point of no return and our own various and varied sexual relationship experiences, how far can any one of us vouch for their own chastity or faithfulness at
any one given point and time in their whole life? May all those people who want to say that they have never been unfaithful, not even once, and not even a little bit, throughout their lives, either with girlfriends, wives, husbands or in whatever other kind of relationships please put their hands up? This case is rested.

So under these circumstances, one would again recommend that rather than completely trust only in our faithfulness to each other, which we cannot even guarantee for ourselves, perhaps, as far as the successful prevention of HIV/AIDS is concerned, we must also conjunctively use the condom each time we have sex no matter what or with who. The message should perhaps therefore be that be faithful, but also always use a condom at the same time.

**Always use a condom when having sex**

The condom should be the most effective method of preventing HIV/AIDS at the individual level, but only if properly and consistently used without fail. The only problem with the condom is failure to use it consistently and correctly, which unfortunately is very rampant, as we have seen in Chapter 3.

Failing to use the condom even once is one too many. It may actually result in exposure to HIV/AIDS. If a society in which even the most ardent users of the condom like the medical students quoted in chapter 3, with a user rate of 90%, will all (100%) fail to use the condom at least once in a period of just one year, then the hopes of making the condom the be all and end all of HIV/AIDS prevention in the larger, more complicated, more difficult, and more vulnerable community become very bleak.

It means that the condom alone is not enough to control or prevent HIV/AIDS at community level, even if it might be the best thing we have got at the individual level. This is the reason why in one of the next chapters we shall discuss the fact that HIV/AIDS is a disease of poverty.

However, the fact still remains that if there is just one thing that one can and should actually do as an individual about HIV/AIDS prevention, that thing is to always use a condom each time one has sex, no matter what or with who, tested or not tested. That is the message.
Chapter 7  There is stigma attached to HIV/AIDS and condoms

What is stigma?

Stigma is defined as “feelings of disapproval that society has about particular things, illnesses or ways of behaving.” It is a fact that there is some kind of social stigma attached to HIV/AIDS and condoms, much to the detriment of our fight against this disease and our quest to promote wide spread condom use in every and all communities of the world.

Social stigma is some deep seated disapproval of something that sits firmly at the epicenter of the society’s beliefs, traditions, cultures, norms, values and practices so much so that it cannot easily or quickly be uprooted, except slowly, tactfully and insidiously by very, very gentle persuasion or coercion over a long period of time as society shifts its own paradigm in an evolutionary process.

Anything sexual is stigmatized

Anything to do with sex, no matter what it is, seems to have some sort of social stigma attached to it in most, if not all traditions, cultures, religions, norms, values and practices of most societies of this world. Even if all of us are definitely products of some sexually activity at some point in time, we just do not seem to be able to openly talk about sex, or even to want it to be talked about, because of this social stigma that is attached to sex.

De-stigmatization of the condom is essential for the fight against HIV/AIDS

If society is going to win in its fight against HIV/AIDS and in its fight to also promote the wide spread use of the preventive and protective condom at the same time, then perhaps one of the most crucial battles in this fight has got to be that of the de-stigmatization of condoms and HIV/AIDS. People have got to start to routinely pick up and use condoms everywhere from high school to adult life, from the church to the most sacred traditional place, and from everywhere to everywhere, in much the same way as one goes shopping for and picks up groceries. That can happen and should in fact happen if we hope and want to stop HIV/AIDS dead in its tracks.

How do we go about waging this war then? Gentle persuasion is the answer. Gentle, resolute, efficient and effective persuasion. It must be noted that as much as stigmatization is not an individual but societal issue, so also is de-stigmatization. De-stigmatization cannot be easily achieved by the individual acting alone at the individual level. The task is too heavy for one person acting in isolation and therefore may not be achievable. It must be approached and implemented at the level of society because that is were the stigma is.

Many people have no problems using condoms as individuals. They routinely buy them and use them, but they do not want to be seen buying the condoms or sometimes even to be known that they use condoms. This is the social stigma attached to condoms. What this stigma then does is to discourage widespread and effective use of the gadget so much so that it then adversely affects the fight against HIV/AIDS which actually is the case here. It is therefore in society’s interests to fight stigmatization.

How society can fight stigmatization

It is obvious that our traditional, religious and cultural beliefs, values, norms and practices have got to shift towards natural acceptance of the condom and HIV/AIDS as part of normal life for these two issues not to be frowned upon or stigmatized. Condoms and HIV/AIDS may not be a normal part of life, they may
not be the way how things (sex) should normally be done or should normally be like, but they are surely part of our normal life now and so we must now accept this fact and behave accordingly. If this acceptance does not materialize, stigmatization will continue. What is critically important here is this societal paradigm shift that must be done as condoms and HIV/AIDS are de-stigmatized.

Education and knowledge about stigma

How is this paradigm shift going to be achieved? It is simple, but complicated. The routine is simple but the practice is complicated. We must start at the beginning. People have got to be educated, they have got to be given the basic knowledge and facts about condoms and HIV/AIDS as we are doing right here and now, so that they know all the facts and correctly too. That is the simple part and it has already been done successfully to a large extent throughout the world. It is about the only thing that we have successfully done about de-stigmatizing condoms and HIV/AIDS. Apparently everyone is now aware of the fact that this stigma does exist, but other than that, nothing more. So people just talk and ask for HIV/AIDS and condoms not to be stigmatized. How this can or should be done they do not say.

The hardest part is actually doing something about it. Unfortunately and as expected, not much has been done in our societies to de-stigmatize condoms and HIV/AIDS in spite of our daily preaching about the need to des-stigmatize these issues. We just talk and do not do anything about it maybe because it is difficult to do something, or maybe because we actually do not know what to do and or how to do it, maybe because of all of these reasons. Just telling people to de-stigmatize condoms or HIV/AIDS or to change the way they feel about it, will not achieve much or even anything at all. Stigma is a societal feeling, an attitude in society and cannot be talked away, especially to individuals. It has got to be driven away. This is the first and foremost thing that we must accept about stigma: that it is a societal attitude that has got to be driven away and replaced by acceptance.

Driving away the HIV/AIDS and condoms stigma

The responsibility to drive away stigma, the hardest part of the whole process, lies, first and foremost, not directly with individual members of society, but squarely with the societal leadership, individually, collectively and severally. The religious, traditional, cultural and government leadership has got the moral responsibility and obligation to drive away the social stigma about HIV/AIDS and condom. They have got to set down and implement laws and regulations, norms, values and practices, examples and precedents that drive away stigmatization. Such laws and regulations must include the mandatory health education on matters of HIV/AIDS and condoms in all schools, colleges, universities, at public gatherings, in churches and in all workplaces, plus the mandatory provision of condoms in all these places as well. That is the only way by which society can achieve a paradigm shift. That is the only way by which society can slowly change its values, beliefs, norms and practices. And that is the only way to drive out stigma. We have got to accept this fact that society's leadership has got a very crucial role to play in any de-stigmatization process. The leadership has got the duty and responsibility to make the first paradigm shift in the society and that is very hard in deed. In fact it is the hardest part of the whole process.

Resistance to change

There will be resistance, make no mistake about it. The biggest resistance will be in our own heads and the heads of our societal leadership. Nothing ever changes without a change of mind. Someone, somewhere has got to change his mind about something first before any changes can take place. Our societal leadership has got to change its mind first and then go on to enact laws, rules and regulations
that make it compulsory, and not optional, for there to be condoms everywhere in public places, in schools, in churches, everywhere where many people may be gathered for whatever reason, as the very first step towards de-stigmatization. They must also make similar laws for HIV/AIDS such as the ones recommended for the workplace in this book in the chapter on the Code of Conduct on HIV/AIDS and Employment, and also in general, for the societal acceptance of HIV/AIDS as part of our normal life now.

**Effecting the process of de-stigmatization**

After the appropriate laws, rules, regulations, codes of conduct or any other piece of enabling legislation have been passed, hopefully with the full co-operation and participation of the affected members of society, they must now be effectively and efficiently implemented as we de-stigmatize. This is the second hardest part of the whole process of de-stigmatization because there shall be immense resistance from everywhere. There shall be resistance and reluctance from the leadership and the administrators to enforce the new laws of the land for fear of the safety of their own leadership positions should they be adjudged to be too enthusiastic to move onto still taboo territory by their own followers despite what the new laws may now be saying. There shall also be resistance from all the other members of society for fear of not knowing what the other members will feel about it yet. Naturally, no one wants to be the first one to break the ice. This is called group inertia. It can be overcome though.

**Breaking the ice of stigma**

As usual and in any given society, there are always a fair number of people who will voluntarily take up leadership positions, the daring ones. In the presence of the enabling legal environment, such people will always more easily and readily come up because they are always there in every organisation, Public Health Inspectorate, Occupational Safety and Health (OSH) Inspectorate and the police force included. These dare devils will come out to enforce the laws of the land, the laws of the church or the laws of tradition and culture. And then this stigma will begin to be driven away from society, but not before another fort of resistance has been overcome.

This fort of resistance is the resistance of the individual members of society and it is the last and least difficult task, but it is still very difficult to accomplish all the same. It is less difficult in the sense that once the leadership makes the first move to break the ice in enforcing the law, a few individual members of society can always be made an example of and them naturally everyone else will fall in line, but its also very difficult in the sense that usually many, many examples have got to be set before everyone else falls in line. With everyone else falling in line, then that's it, stigma will be no more.
Chapter 8  HIV/AIDS is a disease of poverty

We are just a few steps away from understanding all the basic facts about HIV/AIDS now. We really have come a long way indeed. Remember we started off examining the fact that the global community is in real trouble with HIV/AIDS, and then we moved on to the basic facts about the disease itself. These facts included that AIDS is actually caused by HIV infection, that HIV infection is mostly sexually transmitted, that HIV/AIDS is incurable, that HIV/AIDS kills, that HIV/AIDS is preventable, and finally that there is social stigma attached to condoms and HIV/AIDS. In this chapter, we want to deal with the fact that HIV/AIDS is a disease of poverty.

HIV/AIDS is not caused by poverty

Please do not get the wrong message here. We are not saying that HIV/AIDS is directly caused by poverty. We already have said that it is directly caused by HIV viral infection in chapter 2, so we would not contradict ourselves here. When we say that AIDS is a disease of poverty, we are just stating what is generally known about all the infectious diseases, HIV/AIDS included. What is known, agreed upon, and universally accepted is the fact that most infectious diseases are generally and strongly associated with poverty, so much so that they have been called diseases of poverty.

The statistical analyses of the incidence and prevalence of infectious diseases have found poverty to be a ubiquitous positive confounder in all these cases regardless of all the other demographic variables. As such, the attributable risk due to poverty is statistically significant, and can thus be taken on its own merit. What this means is that poverty reduction alone can and in fact does play a very significant role in reducing the incidence and prevalence of infectious diseases, HIV/AIDS included.

Poverty reduction leads to improved infectious diseases statistics

One may remember that the incidence and prevalence, and hence the risk of infectious diseases such as TB and infective diarrhea drastically went down during the industrial revolution solely due to the drastic improvements in the standards of living of the people. There were no antimicrobials at that point in time. Antibiotic treatment for infectious diseases is actually a recent thing whose widespread use only came about in the mid-twentieth century well after disease trends had already started to gone down due to improved standards of living alone. Improvements in the standards of living of the larger part of the general population can be equated to poverty reduction. Many studies have been done in a lot of different places and countries and have shown that poverty plays a very significant role in the predisposition or exposure of people in any community to a particular infectious health risk, HIV/AIDS included.

A graphic example of the link between infectious diseases and poverty

One unfortunate Southern African was recently gripped by a devastating cholera outbreak that killed more than 4000 people after infecting over 100 000 others, a thing that had not happened in recent memory in that country. This cholera outbreak happened against the backdrop of crippling poverty and unemployment that hit the country over a period of a decade in which the country really hit very hard times, experiencing rampant hyperinflation, with the last known official inflation figures being put at a staggering 230 million percent, perhaps a world record.

Prior to this cholera outbreak and because of the supersonic inflation, poverty had practically gone riotously ballistic in this country. Prices of commodities skyrocketed by the hour every hour while incomes similarly shrunk and eventually evaporated in the opposite direction. Unemployment reached the unbelievable level of 96%. Every citizen became a self-employed dealer, buying and selling anything and
everything that could be bought or sold. Hunger and poverty became the order of the day. The public health system and public facilities broke down completely and there were rivers of sewage everywhere. Water from the taps dried up and electricity became a luxury.

By the time cholera broke out, it had long been expected to do so. People were surprised not by the outbreak of the disease but by the fact that it had taken so long to do so. This is because most people knew that because of the abject poverty that had afflicted the country, all the other diseases of poverty, cholera included, were going to break out anytime. There was no accompanying immediately recognizable dramatic outbreak of HIV/AIDS, but eventually this albatross may catch up with this country one day.

HIV/AIDS as one of the diseases of poverty may not breakout as dramatically as cholera does, but it will surely break out one day, perhaps long after people have forgotten about the acute poverty predisposing episode. Of course, cholera takes a few hours to three days to show its ugly face and a similar time frame to kill its victims thereafter unlike HIV/AIDS which takes seven to fifteen years to do the same. However, both are still diseases of poverty.

What is poverty?

Poverty is the socioeconomic state of affairs in which an individual, a family, a group of people, or a community are not able to adequately provide for their most basic human needs without outside assistance. The most basic human needs were described by Abraham Maslow in what is now called the Abraham Maslow's hierarchy of needs. These basic needs include Food, Health, Shelter, Education and Transport. Winston Churchill, the former British Prime Minister during World War II reportedly once said that Governments are put in place by God so that they can look after the basic human needs of the majority 80% poor of their society. The minority 20% rich can look after themselves and they do not need a Government. Anyone who wants to rule forever must therefore prioritize the needs of the poor people of his community. This sounds like wise advice for all the political leadership of this world.

Now that we know what poverty is, let us analyze why it is so much associated with infectious diseases to the extent that it is universally accepted that these diseases may actually be called diseases of poverty and yet it is not the direct cause of these diseases by itself. Of course, infectious diseases are caused by infection with micro-organisms such as bacteria, viruses, fungi, protozoa, and not by infection with poverty! Poverty causes these diseases in as far as it predisposes people to the risk of contracting the disease or the infection. That is the whole point, and that is why infectious diseases are called diseases of poverty.

How poverty predispose people and communities to infectious diseases:

People need food to survive

The key to good health is not only the adequate availability of food, but good balanced and nutritious food as well. Food is one of the most basic human needs and where there is no capacity to get adequate food there is under nutrition, a form of malnutrition. Under-nutrition makes the body less able to develop effective immunity or the ability to fight or defend itself against infections. In such a scenario it is obvious that infectious diseases may now take root and this is in fact part of what actually happens in impoverished situations. The other thing that may also happen is that lack of food may lead people to engage in antisocial behavior in their quest to try and secure some food for themselves and their families and prevent starvation. Such antisocial behavior may comprise theft for example, or even prostitution. In
the case of HIV/AIDS, prostitution is the problematic antisocial behavior that predisposes people to this infection. Add this to the already diminished immunological capacity due to under-nutrition and then we have got a real recipe for disaster on our hands.

**Poverty promotes prostitution and HIV/AIDS**

In impoverished environments, the definition of prostitution goes well beyond the explicit sex trade, the direct exchange of sex for money. It also includes the liberalized attitude of conscious or subconscious sexual permissiveness that then permeates through the whole fabric of society whereby implicit sexual relationships for monetary gains become a normal thing which is no longer frowned upon by society. This liberal attitude tends to de-stigmatize prostitution! In this situation, everyone, from juveniles, college students, university students, young adults, adults, housewives and the elderly, then become vulnerable to prostitution and HIV/AIDS. This may explain a lot of the alarming HIV/AIDS data that was presented in chapter one. Go back there and have a look. Just see how every age group is alarmingly and heavily affected by HIV!

**Food is a basic human need**

In the impoverished food squeezed environment, the man who can provide the much needed and not so readily available money to buy food become also as vulnerable to HIV/AIDS as those to whom they provide this money in return for sexual favours. That is why in poor countries, the prevalence of HIV/AIDS is higher in employed sexually active men than it is in similar unemployed men.

**Health is a basic human right and need**

The next most basic element of human needs that we should now look at is health itself. Without food one definitely cannot be healthy, but without good health one may not also be able to look for, work for or have any food. If someone is sick and they have no money to afford treatment, assuming the treatment to be both available and accessible in the first place, then one may not be able to look for the money that they need in order for them to restore their good state of health. It becomes a vicious circle. The easiest example in this scenario is the case of the sick lion. A sick lion cannot hunt or compete for food and will eventually die of hunger. Even where someone may have already been working initially then they fall sick, if they are absent from work for a long period of time, or even forever, then they may definitely lose their job, which at that time may be their only source of income and survival. HIV/AIDS patients have been frequently affected by this problem and they have found themselves in even more dire circumstances. Death from HIV/AIDS then usually becomes almost assured, unavoidable and very quick too.

**Health education is very important for HIV/AIDS prevention**

Good health services will not only provide the much needed and necessary treatment in the event of illness, but will also provide the much needed health education and hygiene advice which is essential for disease prevention. The definition of good health itself goes far beyond the simple absence of infirmity or disease. It also encompasses the state of one's physical, social and mental well-being. The availability, accessibility and affordability of good health services are almost vital where HIV/AIDS is concerned.

**Shelter is a basic human right and need too**

Then the other element of the most basic human needs is shelter. Shelter encompasses things like accommodation, housing and clothing. These are the things that protect or provide shelter to people. They make people feel protected from the ravages of nature such as the weather. Good shelter also
protects people from other antisocial human beings like murderers, thieves, rapists and robbers by providing the necessary security. In this modern world, provision of shelter is a difficult and expensive business for everyone including the Government, but more so for the individual or individual families. The sub-prime mortgage bonds that precipitated the global economic meltdown amply illustrate this point.

For something to eat and a roof under one's head a man will do anything, and so will a woman too. In impoverished societies the men with the means can afford to marry as many wives as they may please as long as they can provide them with shelter and everything else. They can also have girlfriends on the side too. In one African country these side girlfriends are called “Small Houses” perhaps only to amply emphasize on the need for shelter. Multiple concurrent sexual partners and HIV/AIDS are the obvious results in this situation.

**Education is also a basic human right and need**

Now let us turn to education as one of the most basic human needs. Education has been defined in philosophical terms as the possession of the capacity and or ability to survive on one's own in any given environment without depending on anybody or anyone. Education therefore premises a certain amount of wisdom about life in general and survival in particular. It is the thing that allows people to be able to make and take sound, good and principled choices in life. There is really no doubt that the basis of education is learning or being taught. We were all once taught, formally and or informally, about all the things that we now say we know or are educated about today. This formal and or informal learning process we have called education, by which we premise that we are busy teaching each other and or our children things that actually work in real life. We honestly hope that this is in fact the case. The availability, accessibility and affordability of education in schools and colleges, universities and vocational technical training institutions, in-house at work and everywhere else, is an essential prerequisite for a society's socioeconomic development. There is no doubt about that.

**It is difficult to provide HIV/AIDS health education to uneducated people**

As far as HIV/AIDS are concerned just imagine how easy or difficult it is to teach people about the pros and cons of this disease if they have got very little or no formal academic education at all, and if they do not know or believe in the germ theory of infectious diseases, if they cannot understand what a virus is or cannot believe that there is in fact any such thing as a virus, if they will not understand the language used in the first place, even if that language is vernacular. It is very difficult to teach such people anything, let alone about HIV/AIDS.

Lack of formal education, the kind of education that is in fact the process of learning, the one that we are certified to have done in schools and colleges, universities and any other learning institutions, is a great hindrance to professional education and training, not only for the job market but also for the purposes of survival in life in general. Ignorance about the basic facts concerning HIV/AIDS which have so far been discussed in this book has actually killed a lot of people. So where poverty abounds and people cannot go to school, cannot get educated, HIV/AIDS bounds too. There is no wonder.

**Transport is a basic human need**

Finally, let us examine the most basic human need of transport. Locomotion or movement is a basic natural characteristic of all living animals, human beings included. Movement makes it possible for people to survive. They move from place to place looking for food, health services, shelter, education,
employment and money. Without transport (and communication) there cannot be any socioeconomic activity or indeed any activity of any kind at all because the word activity itself premises the presence of movement. Where the general poor 80% majority cannot afford transport costs then there will also be great poverty and HIV/AIDS. It is not a coincidence that most women would prefer a man with the famous three "Cs", these being Car, Cash and Career. Please take note that the car (transport) comes first in these 3Cs.

Many people with wheels, let alone good posh ones too, exchange wives, women and girlfriends like confetti, more especially in an environment where most people cannot afford to drive where there is no public transport or where transport costs are generally unaffordable by the majority poor. Statistics also show that HIV/AIDS prevalence in poor societies is higher in males who drive than in similar males who do not drive.

**Alleviating poverty is as good as preventing HIV/AIDS**

So at the end of it all we must agree that poverty predisposes people to HIV/AIDS and therefore HIV/AIDS can be referred to as a disease of poverty! We must also agree then that at community level, perhaps the best method of preventing HIV/AIDS is poverty reduction and not condom use, but both approaches must be used concurrently because at the level of the individual, the condom is probably the best form of protection against HIV/AIDS available so far.
Chapter 9  HIV/AIDS Programme Management in the Workplace

Now we can go into the discussion about HIV/AIDS at the workplace proper. We now have got enough background information about HIV/AIDS to enable us to understand the reasons why we have got to do what is recommended in the following few chapters which deal with the HIV/AIDS challenge specifically as it pertains to the workplace. In this chapter we discuss the management of HIV/AIDS programmes in the workplace. Hopefully we are still together.

Occupational Safety and Health (OSH) Committees

Ideally in every work place and work environment there should be in place an Occupational Health and Safety Committee (OSH Committee) comprised of equal numbers of workers and management representatives that has got real decision making powers and whose mandate is not only to advise on the company’s rules, regulations and codes of conduct with regards to OSH issues but also to look at the company’s vitality and social welfare programs in general under which will also be HIV/AIDS. As with all issues relating to OSH, top level management commitment and involvement is vital and paramount right from the beginning, otherwise there will be no success.

These OSH Committees are recommended regardless of whether there is enabling legislation or not. It is recommended that the best practice is for companies and organizations to take it upon themselves to provide world class services to their stakeholders at all times and everywhere in the world regardless of there being any local legal requirements to do so or not. This is just part of being good corporate citizens. On the other hand it is also recommended for Governments of the world to put into place with full consultation and participation of all the stakeholders, especially the tripartite partners, OSH and other social security laws that will help to prevent and or to alleviate the suffering of unfortunate employees in the event that there may be companies or organizations that may not be inclined to be good and or caring employers of their own accord.

The principles of risk management

In managing the risk of HIV/AIDS in the workplace, the OSH Committee needs to apply the principles of risk management as with all other OSH issues pertaining to occupational health risks. First of all they will need a Company HIV/AIDS Policy Document in much the same way a country may need a similar law. In this policy document, the company must clearly state, among others, the following commitments and undertakings of the tripartite partners, i.e., the employer and the employees themselves:

The Company HIV/AIDS Policy

1. That the Company does not and shall not discriminate employees according to their HIV/AIDS status in its recruitment, promotion, continuous education and training, medical insurance or any other company policy for that matter.
2. That following from number 1 above, there shall therefore not be a requirement for any pre-employment, pre-placement, pre-promotion, pre-training, or any other pre-whatever testing for HIV/AIDS as a pre-requisite for anything in the company.
3. That the company undertakes to and shall provide and or facilitate the provision of HIV/AIDS related health education to all its employees at least once a year during working time and at no cost to the employees. (This will be in addition to the hopefully on going OSH education that should be continuously taking place in the company almost everyday, the so called “Safety and Health Talks,” which should happen at every work station at the beginning of every shift.)
4. That the company shall not undertake or engage in any human resources administration practices that may predispose its employees and their families to a higher risk of HIV/AIDS than already exists in the general population. (Examples of such predisposing high risk practices are the continued and or prolonged separation of spouses or loved ones due to the unavailability of appropriate family accommodation close to the workplace, or due to prolonged working periods away from home, the lack of transport for those working late at night, general underpayment of workers, and the lack of a vitality programme and or recreational facilities.)

5. That the company shall provide condoms free of charge for all its employees in all its public utilities and buildings at all times, especially in the public toilets at all its premises.

6. That HIV/AIDS shall be handled and treated as any other disease and not as a special case in matters of human resources administration concerned with such issues as sick leave, medical insurance, life insurance, health related disability, early retirement on grounds of ill-health, and any other health related issues, practices and procedures.

7. That the company shall, in conjunction with the workers, do all that it can in order to promote good health (vitality), including HIV/AIDS prevention, among all its employees at all times regardless of where they may be working within the company.

8. That individual employees are duty bound and responsible for their own health and the health of their colleagues at work, and their spouses and children at home, issues of HIV/AIDS included. It is the duty and responsibility of the employees, either at work or at home, to look after their own health, and not to expose other people to health risks, and also to notify the employer of any impending health risks and ask for the assistance of the employer to help and to enable them to eliminate or minimize the risk as far as is practicable whenever they think that they may need such help and or that the employer may be able to assist them in this regard.

9. That the company shall abide by all the relevant legislation prescribed by the Government dealing with the issues of employee health and safety in the workplace, including HIV/AIDS.

10. That the company in its practices shall always abide by the Universal Declaration of Human Rights and the Patients' Charter in dealing with issues related to HIV/AIDS among its employees, their families and their dependents.

The Company HIV/AIDS Policy must be implemented

After such a Company HIV/AIDS Policy Document has been written, deliberated on, agreed upon, adopted at the highest management level, and then disseminated to all the stakeholders, the next step is to come up with a plan of action and the activities that will give effect or meaning to this policy. In other words the policy has now got to be implemented. A good company policy, even on anything for that matter, which is then not implemented, is as bad as having no policy at all. It could actually even be worse because a quick check with the Christian Bible shows that the verse that says that those who deliberately and knowingly transgress shall not be forgiven is still there in this holy book.

Implementing the Company HIV/AIDS Policy

The implementation stage of the Company HIV/AIDS Policy is also just as involving a process as the policy drafting phase itself. Each one of the above points, 1 to 10, in the policy statement needs to be translated into concrete action. This means that the meaning of each of these points must be clearly understood by everyone concerned and then translated into activities that are again written down, deliberated upon, agreed on, adopted and similarly disseminated to everyone in the company with the same top level management involvement and commitment as with the initial drafting of the policy document.
Company HIV/AIDS Programme Action Plan

This second stage in the implementation of the Company HIV/AIDS Programme involves the drawing up of the Company HIV/AIDS Programme Action Plan Document. In this programme action plan, the policy statements above become the broad targets, objectives or key result areas to be attained over a given period of time. Some will be long term targets, while others will be short term objectives. Results must then be set for these targets or objectives. These results or goals must be smart goals. This means that they must be specific, measurable, attainable, realistic and timed.

Along side each result or target goal there must be a well defined and again smart activity or series of activities by which that result may be achieved. Periodically, at the end of a given and agreed period of time, a programme implementation status report or progress review report must be produced, reviewed accordingly and another revised plan of action must then be produced and again implemented.

A Standard Company HIV/AIDS in the workplace Programme Plan of Action

For each activity there must be a responsible or lead person or department or function allocated to it otherwise it may not be done or accomplished. The process of continuous review then goes on and on until the programme is completely in place, is running and becomes self-sustainable. The table below is a good example of a Standard Company HIV/AIDS Programme Action Plan emanating from the Company HIV/AIDS Policy Statement above.

Company HIV/AIDS Programme Action Plan (Work Plan)

<table>
<thead>
<tr>
<th>Broad Target</th>
<th>Long term objective</th>
<th>Short term objective</th>
<th>Results or target goals</th>
<th>Activities</th>
<th>Status Report</th>
<th>Lead person or Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>No discrimination according to HIV/AIDS status.</td>
<td>To be an equitable employer.</td>
<td>To eliminate discrimination according to HIV status at employment, promotion, training by the 30(^{th}) of December 2009.</td>
<td>Human Resource Medical Examination Forms that outlaw the requirement for HIV testing during pre-employment or pre-promotion and pre-training medical examinations.</td>
<td>Production of Human Resources Medical Examination Forms that do not only exclude HIV testing, but also specifically prohibit it.</td>
<td>Consultant Occupational Health Medical Specialist engaged on the 1(^{st}) of August 2009. Results (Medical Forms) expected by 31(^{st}) October 2009.</td>
<td>Human Resources Manager, HR Dept.</td>
</tr>
</tbody>
</table>

From the above table it goes without saying that the Programme Action Plan (PAP) actually also provides for the action itself (i.e. activity) and the same flow chart or table can also be used for reviewing the programme periodically.

Further recommendations

After drawing up and agreeing on this PAP, a commencement date and review dates are then set for the whole programme, preferably again at the highest management level and with the lead persons and departments being appropriately appointed and notified. It would also be better for accountability’s sake if the contents or provisions of this PAP document become part of the annual performance appraisals of the responsible persons and their departments.
Expert advice needed

Ideally the company should come up with its HIV/AIDS Policy Document and its HIV/AIDS Programme Action Plan Document with the expert assistance of an external consultant, preferably an Occupational Health Medical Specialist. It is only logical that if one really wants to do something properly it is better to do it professionally and correctly right from the start.
Chapter 10  Theoretical basis of managing the HIV/AIDS Risk in the Workplace

Let us now discuss the principles of risk management briefly as they relate to managing the HIV/AIDS Risk in the workplace. The hierarchy of risk management goes something like this: First and foremost, there is the prevention of the risk by risk elimination, if this is not completely adequate then there is prevention of the risk by engineering control methods, then by management control methods, and finally if this is still inadequate, there is risk prevention by protection methods or the use of personal protective equipment (PPE), or condoms in the case of HIV/AIDS.

Risk elimination

Ideally and as far as is practically possible, the risk must be completely eliminated altogether in the first instance. Where this can actually be done then it must be done as the first and only option. Since we sometimes cannot realistically and or practically be able to directly, specifically and completely eliminate the risk of HIV/AIDS and or the risk of the sexual activity that predisposes employees to the risk of HIV/AIDS in the workplace, this then becomes not entirely realistic or attainable as an objective, goal or target result. Attempted elimination of the risk must then be linked to the next hierarchy of risk management.

However, from the example of a Company HIV/AIDS Policy given in Chapter 9, it can be noted that in fact some Human Resources Administration conditions and practices within the company that may predispose certain groups and individual employees to the risk of HIV/AIDS can in fact actually and realistically be eliminated from the work environment. This should be done as a matter of priority.

Such conditions and practices include the none availability of condoms in public utilities, general underpayment of employees, lack of transport for staff who start or finish work late at night, prolonged absence from home and loved ones due to long periods of working out of station, lack of appropriate accommodation for the employees and their families and many other adverse conditions of service and or practices that do not auger well for the prevention of HIV/AIDS.

Administrative control measures

You may note that the elimination of adverse or HIV/AIDS promoting practices or conditions is in fact also an administrative or management control measure. However with proper administrative or management control methods, the management puts in place measures that will ensure that the people who may be exposed to the risk are first and foremost, not only well educated about all aspects of the risk, but are also well trained and experienced for the task, and well equipped to handle both the task and the risk. They are then given specific authorities or work permits and working procedures to follow when they are handling the task and the risk.

Administrative or management risk control measures in the case of HIV/AIDS will include such things as appropriate health and HIV/AIDS education, assigning only trained and experienced professionals to undertake tasks that are adjudged to be too risky, for example only nurses and doctors are allowed to put up drips or intravenous lines in hospitals and nobody else, and finally, providing the operators with the necessary personal protective equipment such as rubber gloves and face masks, and then ensuring that they actually use this equipment correctly and at all times when handling the risk.
The use of personal protective equipment (PPE)

The last resort in our hierarchy of risk control measures is risk prevention by protection or the use of PPE. Those who are familiar with the subject of Occupational Safety and Health (OSH) in the workplace may know that the use of personal protective equipment (PPE) is always the last resort. Condoms are just another form of PPE.

PPE cannot be used alone but should always be used in conjunction with all the other risk control methods. This observation is very important to note because there are those employers whose only contribution to the fight against HIV/AIDS in the workplace is to provide their employees with condoms and more condoms. Yes, it is good to provide employees with condoms, but much more than just that can and should actually be done.

As we have discussed elsewhere in this book, at the individual level, the use of the condom is probably the best available method of protecting oneself from the risk of HIV/AIDS. But at the community level, available statistics do not support this because of the very low condom user rates and the very high condom failure rates in most communities. Therefore condoms should never be used alone in any community. The best method of preventing HIV/AIDS at community level, as you may already have seen from this book is poverty reduction!

Poverty reduction is not the sole responsibility of Government alone as many people may like to think that it is. Employers too can and should actually play a very important role in reducing poverty in societies in which they operate or do business. Remember we said that in poverty afflicted environments the majority of people will not be able to adequately afford food, shelter, health, education and transport without outside help. In order to play their rightful part in poverty reduction, employers may start off by ensuring that they do not grossly underpay their employees to begin with. They may even also make some of the basic human needs stated above directly available to their employees and their families where this is possible. Employees too should play their own part in poverty alleviation. They must try to get involved in other income generating projects, no matter how small, outside of work, more especially if the other spouse is not formally employed. With the income from work they can start a small business, even door to door salesmanship, as a supplement to the family income.
Chapter 11  Practical HIV/AIDS Risk Management in the Workplace

Risk assessment

First, a risk assessment process has got to be carried out, and the risk has got to be quantified and qualified in terms of frequency or likelihood of happening and severity or seriousness of the consequences thereof. A value judgment must then be made as to the priority rating of the risk in terms of the urgency of the envisaged risk preventive actions which must be taken.

Very high priority risks are those risks that have got a very high likelihood of happening plus very serious consequences should they happen. Very low priority risks are those risks with a very low likelihood of happening plus negligible consequences should they happen. In between these two extremes there is a whole range and mixture of risk ratings. A value judgment must be made of each of the given ratings. Very high priority risks must be acted upon immediately while very low priority risks may be acted on later. All risks must be dealt with eventually. This process of dealing with risks, preventing or minimizing them is called risk management.

The HIV/AIDS risk is high priority risk

So far, we have long established that the risk of HIV/AIDS is very high in the whole world, but particularly in certain poor African countries. All workplaces are therefore also at high risk from the same HIV/AIDS. It is therefore imperative that this risk must be managed. This is the whole reason why this book was written in the first place.

Principles of risk control must be followed when managing the HIV/AIDS risk in the workplace

The principles of risk control have still got to be followed even here. First and foremost, we must adhere to the hierarchy of risk control measures. We must try to use the risk elimination control measure first, failure of which we may then resort to engineering control measures, then administrative control measures and finally personal protective control measures only as a last resort, and in that order. From the start, we must always remember that these risk control measures are not mutually exclusive as they may, and in deed should or must in most cases be employed concurrently.

Eliminating the HIV/AIDS risk in the Workplace

Can we possibly eliminate the risk of HIV/AIDS in the workplace? Oh, yes we can! Where the work is health or medically related, and exposes workers to the risk of HIV infection directly, say, through contamination with infected blood or blood products, or any other body tissue samples, especially at handling as in the case of nurses, doctors, phlebotomists, laboratory technologist, first aiders and many other health workers, it is imperative to try to eliminate this risk by avoiding altogether those procedures, practices or operation techniques that will expose these workers to the risk of HIV/AIDS. If the substitute techniques so adopted leave no chance at all for the possibility of HIV/AIDS infection, then the risk will have thus been effectively and successfully eliminated.

HIV/AIDS risk engineering control measures

It is not always possible to eliminate risk in the workplace. Engineering control measures must then be considered and be put into place whereby the risk is completely isolated from the workers by building it out or encasing it in, so that it never comes into contact with the employees.
Unfortunately, it is not possible to encase (quarantine) HIV/AIDS patients in the health profession so as to protect the general public or health workers from the risk of HIV/AIDS by engineering control methods. The isolation or the quarantining of HIV/AIDS infected people in the name of public protection is an unacceptable breach of the fundamental Individual Human Rights of these people, a serious breach of the United Nations Universal Declaration of Human Rights of 1948, and of the Patients’ Charter, and so it cannot even be an option in this civilized world. What we can only engineer out are the operation techniques in medical practice as has been already discussed under HIV/AIDS risk elimination above.

**HIV/AIDS risk administrative control measures**

The third level of risk control measures is putting into place administrative or management control measures that will minimize the exposure to the said risk for the affected employees. There are in fact many administrative or management control measures that can be employed in this regard. First and foremost, management has got to ensure that the employees are not only well informed, but are also well educated about the risk at hand. Knowledge is power, or so they say, therefore one would expect a knowledgeable employee to behave in a much better way in order to avoid exposure to risk than the one who does not know anything at all about the risk.

**HIV/AIDS risk information in the workplace (Risk education)**

The employees must be informed about the presence of the HIV/AIDS risk in the workplace, the pros and cons of exposure to the risk and the consequences thereof, but most importantly they must also be taught about how to recognize the risk and how best to avoid exposure, both for themselves and for others, colleagues, family and the general public included.

This risk education process is apart from the general health education about HIV/AIDS. It is specifically focused on the exact HIV/AIDS risk which the employee may be exposed to in his or her own particular working environment. For example, the HIV/AIDS risk faced by medical practitioners in the course of their work is different from the HIV/AIDS risk faced by hotel workers. The former are faced with a medical HIV/AIDS health risk while the latter are faced with a social HIV/AIDS health risk. Specific approaches to HIV/AIDS risk management and information systems are therefore essentially different for these two groups of workers as it pertains to their two different working environments.

The specific content of HIV/AIDS risk information given may be thus different for different categories of workers but what is not different is the fact of the need for this information to be given to the employees before they can start working. This is the reason why in the proposed company HIV/AIDS policy or national HIV/AIDS legislation that were suggested in the previous chapter, it was pointed out that it is a must to undertake to educate employees about HIV/AIDS at the workplace as a matter of policy, more so for workplaces that may expose employees to this risk directly or indirectly.

**HIV/AIDS health education in general**

This kind of health education has already been dealt with elsewhere in this book. We shall only proffer a specific suggestion here. General HIV/AIDS health education must actually be provided to all employees regardless of whether or not they are exposed to any HIV/AIDS risk in the workplace to cover for the HIV/AIDS social risk to which every member of society is exposed. This kind of education should be provided by the company to all its employees including directors, at least once a year, during working hours, and at no cost to the employee. There must be a record of attendance for each and every employee and this record must be kept in the employee’s personal file while the employee keeps a copy.
Most importantly this HIV/AIDS health education must be administered by a competent and experienced professional in order to avoid disastrous misconceptions whereby certain deleterious myths about HIV/AIDS may be perpetuated as was discussed in earlier chapters.

Administrative HIV/AIDS risk control by exposure control measures or methods

The next facet of management control measures that may be used to reduce health risk in the workplace is what is called the exposure control method. Here, management will put in place work permit procedures that will, say, only allow well trained and experienced professionals or workers to perform certain duties, tasks or functions that may be deemed to be too risky, or are likely to expose them to the said risk if they were not careful or trained, even though engineering control measures might already be in place.

The work permits will also clearly spell out the operation procedures to be followed by the permitted worker as he or she goes about performing the risky task, including the maximum length of time that they may be allowed to be exposed to the risk in that process, plus the duty of the permit issuing officer to ascertain that all the requirements of the so issued work permit are fulfilled before, during and after it has been issued.

Permitting only trained people to do certain risky tasks and also making sure that they obtain a work permit before they can do so will ensure that at least workers with the least likelihood of inadvertent risk exposure may come into contact or deal with the said risk. The possibility of ill-prepared workers being exposed to and consequently being affected by the risk is thus minimized by this administrative or management control measure called the exposure control method.

As far as the risk of HIV/AIDS is concerned, this means that only properly trained people should be allowed to handle tasks which may expose them to the risk. Thus, in a hospital situation, only trained phlebotomists, nurses and doctors may be allowed to take blood from clients and no one else, and so on and so forth. It will be very unfair and perhaps cruel to send someone to perform a risky task that they were not at all prepared or trained to handle in the first place. That is a sure way of getting them exposed instantaneously to the said risk obviously with disastrous consequences.

The case of workers who work with the public

In non-medical institutions where exposure to the risk of HIV/AIDS may be from social contacts such as in the hotel and tourism industry, it is also very unkind to send workers to work in these institutions or environments before teaching and training them about the possibility of exposure to the HIV/AIDS risk from their social contacts with clients in the course of their daily work since they deal with different kinds of people on a daily basis.

Exposure to the risk of HIV/AIDS in such situations is in fact a work related issue and therefore must be dealt with as such. There are many other industries that also expose workers to the risk of HIV/AIDS through social contacts while at work and which thus need to tool up their employees in a similar manner to that suggested here for the hotel and catering industry. For example, the sales and marketing profession, the teaching profession, politicians (Parliamentarians), the entertainment profession, or even the health profession in general, and many others. It means therefore that the management control measure that ensures that only HIV/AIDS educated and trained workers may be sent out there where they may be exposed to the HIV/AIDS risk through social contacts while at work must be implemented in all such establishments! This is food for thought.
We have already extensively dealt with the use of PPE such as condoms and gloves in the previous chapters. We must re-emphasize here that since this is the last resort in the hierarchy of risk control measures, PPE should never be used solely on its own, no matter how protective it may be. Providing employees with condoms only will not do much for the fight against HIV/AIDS.

**There is no acceptable HIV/AIDS risk**

The concept of acceptable risk is very difficult to apply to HIV/AIDS. This concept premises that after all the possible risk control measures have been implemented there will always be some residual risk that cannot be dealt with no matter what we can do due obviously to our limited abilities in any given situation. This residual risk must be acceptable when certain value judgments are applied to it. Usually this means that it must be generally agreed that the chance of the risk affecting anyone under these circumstances is no longer high but now very, very low or negligible, but it can still happen. With risks that are found only in the workplace, this acceptable risk mark is reached when the employer ensures that the employee is no longer exposed to this risk at work at rates that are greater than those to which the general population is already normally exposed. It means that the working environment should eventually be the same as the general normal environment. It should pose no more risk than the other. However, although it is recommended that the employer should undertake not to expose his workers to a risk that is higher than that to which the general population is already exposed under normal circumstances, in abnormal circumstances like the very high prevalence rates of HIV/AIDS sighted in chapter 1, this philosophy cannot be applied, unfortunately. The only acceptable HIV/AIDS risk is no HIV/AIDS risk. So as far as HIV/AIDS is concerned we may only talk about unacceptable risk and not acceptable risk.

**Unacceptable HIV/AIDS risk**

An example of unacceptable HIV/AIDS risk is the practice of employing people in jobs that permanently keep them away from their spouses or frequently take them away from the same. This is tantamount to exposing them to an HIV/AIDS risk that is higher than that in the normal population even as abnormally high as it may be (see HIV statistics in Chapter 1) because they may naturally seek the consort of other partners during this period. Employers should try as much as is possible to keep spouses together all the time. Late night workers who are not provided with transport will also become exposed to the risk of HIV/AIDS which is greater than that of the general population especially if they are women because they may be raped at night on their way home, or even be forced by circumstances beyond their control to go into relationships of convenience with people with motor vehicles so as to get transport back home late at night if the employer does not provide the same. Labour laws should actually try to look at transport provision for late night workers as a way of combating HIV/AIDS at the workplace.

**HIV/AIDS risk mitigation**

The final risk control measure that should always be catered for is the management of the consequences of the risk itself when all our control measures have failed to stop the risk from happening and it has happened or is happening. This is called risk mitigation or disaster management. HIV/AIDS is actually a declared national disaster in many highly affected countries. In the case of HIV/AIDS, we will be looking at the management of people or employees who have been diagnosed as now being infected with or suffering from HIV/AIDS. What does that entail in terms of treatment, job placement, skills transfer, training, sick leave, invalidity, early medical retirement or premature death? There needs to be a well developed company policy that deals with these issues and this policy must always be able to take the special needs of these people without negative discrimination in any way whatsoever. Positive discrimination in this case is not bad at all.
Chapter 12  The Theory of HIV/AIDS Programme Management Planning

Probably there will be nothing or very little that can be accomplished in any programme if there is no clear-cut sequential and logical programme management plan right at the beginning. At the beginning of every programme one must have a concrete programme management plan which they must try to follow both in letter and in spirit. So here we present what we believe could be a good, practical and realistic HIV/AIDS in the Workplace Programme Management Plan that can be adapted for use at both the national and enterprise levels.


A standard programme has got to have specific programme goals or outcomes that are measurable, achievable, realistic and timed. There must also be similar objectives or outputs bearing in mind the differences between goals or outcomes and objectives or outputs in the first place. Goals or outcomes are the broad targets of any programme or project, while objectives or outputs are the smaller and cumulative target results that must be achieved first before the bigger and broader target can be realized. For each objective or output, there must be an activity or a series of activities that must be undertaken in order to attain or achieve it, and there must also be a lead person assigned to each activity to make sure that the activity or activities are actually carried out in the first place, properly and on time too. Below are listed some of the activities that an HIV/AIDS in the Workplace Programme Management Plan may consist of depending on the type of organisation concerned:

1. Adoption of the Company’s HIV/AIDS in the Workplace Policy Document produced by a consultant engaged by the Human Resources Manager, and produced in consultation with the Workers Committee within four weeks time.

2. Adoption of the Company’s HIV/AIDS and Employment Code of Conduct Document produced by a consultant engaged by the Human Resources Manager and produced in consultation with the Workers Committee within four weeks time after the production and adoption of the Policy Statement Document sighted above.

Company HIV/AIDS policy versus HIV/AIDS and Employment Code of Conduct

It should be noted that there is a big and significant difference between a Policy Statement and a Code of Conduct. Perhaps we should pause here for a moment and explain. A Policy Statement, no matter how elaborate and fancy it may be, is just but a statement of intent. It is a mission statement full of visions, values and aspirations that an organisation may want to portray itself as typifying, and the way it wants itself to be seen in the public eye, with regards to the way it purports to want to deal with certain issues, HIV/AIDS included. It is a statement of the way the company or organisation says it intends to do business, and not the way it actually does business for now. A policy statement is usually futuristic grand standing and posturing. Sometimes it also grandstands about the present. Unless if this policy statement, as important as it is on its own, and in its own right, is then translated into actually doing things, it may remain just a statement of intent, a pipe dream and nothing else.

For example, a policy statement that forcefully says that there shall not be any gender discrimination in the company’s recruitment policy does not in fact say much or anything at all about how gender discrimination may or will actually be prevented at recruitment in the same organisation or company. This is very important to note.
Because of this lack of specifics, one may find out that in fact job recruitment interview forms of the same company will ask prospective employees to fill in their sex or gender, which many then be used, consciously or subconsciously, to discriminate against them on gender basis at selection for interviews whereby one may find that more males may then be called for job interviews than their females counterparts even though there may have actually been an equal number of male and female applicants, or even more female than male applicants to begin with. If gender discrimination was already and truly outlawed by way of the company policy as contained in the policy statement document, why then would it be necessary or required of an applicant to state his or her sex or gender on a job interview application form? This becomes a self-contradiction of sorts and it happens.

An Employment Code of Conduct

On the other hand, an Employment Code of Conduct operationalising this same policy will have in its provisions a clause that specifically outlaws the question that requires applicants to fill in their sex or gender in the pre-job interview application forms. When this is done, then the company can say that it does not, and not will not, condone gender discrimination in its recruitment policy with a certain measurable and patent visible degree of genuineness. A Code of Conduct therefore puts into effect and in certain and specific terms, the provisions of a policy statement. This difference is very important and must be noted.

In the case of HIV/AIDS, a Company Policy Statement may say that the company shall not discriminate against employees according to their HIV/AIDS status in its recruitment, training, and or promotion procedures, but unless this will actually be done is clearly spelt out in the company HIV/AIDS and Employment Code of Conduct, it may still remain a pipe dream, with employees being discriminated against in every sense of the word and in very subtle and discrete ways too.

In order to operationalise such a policy statement, the Company’s HIV/AIDS and Employment Code of Conduct must then specifically go on to say and ensure that pre-employment, pre-training, pre-promotion and any other mandatory company medical examinations, tests or investigations done by, for, and or, on behalf of the company, shall not include any HIV/AIDS testing and or any past medical history questions relating to HIV/AIDS specifically and or in any way whatsoever. It is one thing to ask a client for his or her past medical history in general, and it quite another thing altogether to ask the same client specifically if he or she has ever been tested for HIV/AIDS in the past, and or the results thereof, and or to ask if he or she has ever suffered or been treated of HIV/AIDS.

It is these discriminatory, specific and probing questions and or tests that the Code of Conduct will seek to outlaw, and because they will be outlawed in very clear and specific terms, there is no doubt about them having been breached or not if and when that question ever arises. Why would one’s HIV status be enquired about or tested for, and why would past medical HIV/AIDS history be asked for if this information is not necessarily going to be used against them in any way whatsoever in the first place. The difference between a policy statement and a code of conduct may be equated to the difference between an ILO Convention and its accompanying Resolution with the policy statement being the Convention and the code of conduct being the Recommendation.
Perhaps now that we are fully aware of the intrinsic differences between a policy statement and a code of conduct, we may continue with the standard provisions of a Company HIV/AIDS Programme Management Plan:

3. Alignment of all the company’s Human Resources Administration Procedures and Practices, Medical Examination Forms, and any other forms that may be filled in by, for and or conducted on behalf of the company on employees, and or prospective employees, with the provisions of the Company HIV/AIDS and Employment Code of Conduct, and this to be done by the consultant engaged by the Human Resources Manager and in consultation with the Workers Committee within four weeks after the adoption of the said Code of Conduct.

It should be noted that Human Resources Administration (HRA) is a very broad concept. Where HIV/AIDS is concerned, HRA Procedures and Practices (HRAPP) to be aligned with the Company’s HIV/AIDS and Employment Code of Conduct must not only include the obvious prohibition of HIV/AIDS related medical tests and or medical history questions, but must also include such frequently left out things as pre-placement HIV/AIDS health education for all the employees who may, due to their vulnerability to exposure because of direct contact with blood, blood products, body fluids and body tissues, and also because of increased social contact in the course of their daily duties at work, they may actually be at higher risk of contracting the disease than the general public, or any other employees within the same company.

Such employees may include those employed in the medical profession and the health services in general, the hotel and catering industry, sales and marketing industry, the entertainment industry and many other social industries as was clearly pointed out in the previous chapter. These employees need to be armed or tooled with the relevant HIV/AIDS knowledge base that will make them better able to respond and perhaps eliminate or prevent HIV/AIDS exposure during the course of their daily work.

In addition to HIV/AIDS health education and the necessary protective working tools like gloves, these employees must also be voluntarily and freely supplied with the necessary condoms for HIV/AIDS prevention on the social scene, but of course not to use during working hours. Sending them into the HIV/AIDS battlefield without the necessary knowledge, tools and combat gear and or ammunition will only make them cannon fodder for the disease.

Another aspect of the HRAPPs that must be rationalized is the permanent and or prolonged separation of spouses from one another due to different working environment or location postings or shifts. These must be avoided as far as is practically possible because it exposes both spouses to increased risk of HIV/AIDS as was argued elsewhere in this book. Any other HRAPPs must be closely examined with the view of ensuring that the company does not engage in HRA activities that may or can actually expose its employees to a higher risk of HIV/AIDS than is already in existence in the general population. Let us now continue with the standard provisions of a Company HIV/AIDS Programme Management Plan:

4. Appointment by the Human Resources Manager, and within four weeks after the adoption of the Company HIV/AIDS Policy Statement Document, of a Wellness or Vitality Co-ordinator to oversee the Company Wellness or Vitality Programme which will, among other things, necessarily include all issues dealing with HIV/AIDS in the Workplace, prioritizing health education, disease prevention, protection, rehabilitation and treatment.
5. Production and presentation of the Company Wellness or Vitality Programme Action Plan Document and Annual Budget, including HIV/AIDS in the Workplace activities and the specific budget thereof too by the Wellness/Vitality Co-ordinator, and with the participation of the Workers Committee, and its approval by Management at the highest level within four weeks of his or her appointment.

These activities and budget must include items such as the procurement of condoms for free distribution to employees and other stakeholders within the company facilities, the procurement of other necessary personal protective equipment like gloves where needed, and the provision of HIV/AIDS health education to all the company employees at least once a year by consultant HIV/AIDS health education specialists.

6. The production of quarterly and annual reports by the Wellness/Vitality Co-ordinator and their presentation to both management and the Workers Committee for review, evaluation and recommendations.

7. Continuous improvement of the whole HIV/AIDS Programme by all the stakeholders through constructive tripartite and bipartite social dialogue, criticism and suggestions at any time during the implementation stage, and at specific planned meetings like the quarterly and or annual programme review meetings.

These seven points, ladies and gentlemen, are basically a concise example of the standard provisions of good Company HIV/AIDS Programme Management Plan. These standard provisions can actually be implemented at national, organisation or enterprise levels just with the necessary changes in terminology but being basically the same.

At national level

At national level while the Policy Statement may remain as a Policy Statement, the Employment Code of Conduct must be made into a mandatory and specific piece of legislation such as an Act or regulation.

At enterprise level

At Enterprise level, this mandatory piece of national legislation must make it compulsory for companies and organisations that employ a certain number of people to draw up and register with the legal authorities their own Company HIV/AIDS Policy Statements and their own Company HIV/AIDS and Employment Codes of Conduct which must all be aligned and not contrary, to the legal provisions. It must also be made compulsory by the proposed national legislation herein for companies or organisations to submit to the legal authorities their annual HIV/AIDS Programme Management Plans which should include the appropriate budgets thereof.

Workers representation in the Company HIV/AIDS in the Workplace Programme

Please note that we have continuously referred to the Workers Committee in this chapter when we talked about tripartite or bipartite social partners' consultation instead of referring to the Occupational Safety and Health (OSH) Committee, HIV/AIDS Committee, Wellness Committee, or any other committee for that matter, which may be there at the workplace.

This is because of the emerging concept of one workers representative committee at the workplace which we also now subscribe to wholeheartedly. Just like the re-emergence of the one UN (United
Nations) concept, it is actually not desirable and therefore no longer recommended at least by the author and those who share the same opinion, for the sake of cohesion and progress, to have a multiplicity of worker representative organisations or bodies for just one workplace. Just one is enough.

The Workers Committee, being the oldest worker representative organisation in the workplace, should thus reclaim its spot as the sole legitimate worker representative organisation at the workplace. If this concept gains ground and is accepted of course the trade unionist will be very happy. This suggestion is dealt with more extensively as an addendum in chapter 15 of this book under continuous improvement.
Chapter 13  HIV/AIDS Policy and Employment Code of Conduct side by side

Taking on from where we left in the previous chapter, we want to examine in detail the recommended standard provisions of a good HIV/AIDS Policy Statement Document and a good HIV/AIDS and Employment Code of Conduct Document side by side, just to clarify issues further.

We have already explained the difference between these two documents in the said previous chapter so we may not go into the same detail here again. What we are going to do in this chapter is to enumerate the standard provisions of a good HIV/AIDS Policy Statement and then expand them into the concrete specifications of a good HIV/AIDS and Employment Code of Conduct point by point.

Here goes:

1. A good Company HIV/AIDS Policy Statement must start by stating that “The Company shall appoint a Wellness or Vitality Coordinator with full responsibilities, accountabilities and authority to coordinate, as situationally appropriate, the company’s response to the HIV/AIDS pandemic at the workplace.”

Without a specifically appointed responsible person, or when HIV/AIDS is left to be a side responsibility of an already overburdened, unwilling and perhaps incapable manager or employee, then very little, or nothing can or will actually be accomplished on the ground. The Company HIV/AIDS Policy Statement may thus remain as just that; a very good, ambitious, high sounding statement, but simply just a statement and nothing else. This is the biggest let down of many company HIV/AIDS endeavours and it must be corrected once and for all times by appointing a specific person to the job. The Company HIV/AIDS and Employment Code of Conduct will then go on to enumerate some of the duties, responsibilities and powers of the said person as follows:

   a. The Company Wellness/Vitality Coordinator shall report at the highest management level.

   b. The person shall coordinate the company’s wellness programme by playing a planning, controlling, advisory, consultative and organizing role, and also by ensuring compliance with national legislation, company rules, regulations and codes of conduct concerned with HIV/AIDS in particular, and the well-being of employees as a whole in general.

   c. There shall be a specific annual budget for this function planned, controlled, and accounted for by this cadre and with the relevant approvals, checks and balances.

2. The next thing a good Company HIV/AIDS Policy Statement may want to make is that “The company shall comply with all the basic national legal requirements in relationship to HIV/AIDS in the workplace as a bare minimum, but shall also try to comply with international, WHO, ILO and any other standards and world best practices in dealing with HIV/AIDS in the workplace.” Then the Company HIV/AIDS and Employment Code of Conduct may specify the minimum legal and other standards which the company must adhere to as follows:
a. The Employment and Industrial Relations Act.

b. The Workmen's Compensation Act.

c. The Occupational Safety and Health Act.

d. The HIV/AIDS and Employment Act or the HIV/AIDS and Employment Code of Conduct or regulations


i. The United Nations Universal Declaration of Human Rights of 1948. (Human Rights, Representation Rights, gender equality, right to life, right to decent work, etc)

j. The Patients' Charter (Right to dignified health care, privacy, confidentiality, etc)

k. Any other relevant and appropriate national, regional and international standards.

3. A good Company HIV/AIDS Policy Statement may also start by recognizing HIV/AIDS as a Workplace issue by simply stating that “We take and recognise HIV/AIDS as a Workplace issue.” It sounds good, but what exactly does this mean? Under this declaration that HIV/AIDS is a workplace issue, the HIV/AIDS and Employment Code of Conduct may then categorically and clearly expand this declaration and point out the following specific issues and concerns:

a. That HIV/AIDS can infect and or affect workers at the workplace, and that HIV/AIDS infected and or affected workers can also affect the workplace.

b. That commensurate with 3a above, the company shall therefore put into practice Human Resources Administration Procedures and Practices that will prevent and protect workers and other clients from being infected and or affected by HIV/AIDS while at work and also prevent and protect the workplace from being affected by HIV/AIDS as a matter of course.

4. Another statement of a good company HIV/AIDS Policy is that “The Company shall not discriminate people according to their true or perceived HIV status in its recruitment, promotion, job training, education, insurance and any other company procedures and practices for that matter.”

This also sounds very good, but it still begs the question as to what exactly does this mean, and can the company be pinned down to anything in the case of a perceived or real breach of this statement by the same company? This again is where the Company HIV/AIDS and Employment Code of Conduct comes handy. Under this all consuming statement, the code of conduct may then specify the following provisions and in no uncertain terms too:
a. There shall not be any requirement for HIV/AIDS testing, past medical history questions related to previous HIV/AIDS testing, HIV/AIDS treatment or any other HIV/AIDS specific probing questions during the mandatory pre-employment, pre-training, pre-promotion, pre-insurance and periodic medical examinations either done by, for or on behalf of the company. (NB: Medical doctors are always capable of clinically diagnosing clients who may not be medically fit for employment, training or insurance purposes by the use of standard routine clinical medical examination techniques, procedures, medical tests and other investigations without necessarily or specifically testing for HIV/AIDS)

b. There shall not be any stigmatization or tolerance of the same, whatsoever, of people living with or perceived to be living with HIV/AIDS in the Company Human Resources Administration Procedures and Practices and, also in the company's inter-personal relationships code of conduct or practice for employees while at work.

c. There shall be no discrimination of employees on the grounds of their perceived and or real HIV/AIDS status in the company's paid sick leave, medical insurance and treatment, life insurance, occupational accident injury and diseases disability benefit insurance, social security benefits, early retirement on grounds of ill-health, invalidity and or death benefits, and or any other health, morbidity and or mortality related policies, procedures and practices.

d. There shall not be any discrimination of any kind based on perceived and or real HIV/AIDS status in the way the company deals with its clients and the public at large and also in its activities as a corporate citizen in general.

5. The fifth provision of a good Company HIV/AIDS Policy could be that “The Company shall provide HIV/AIDS Health Education for all its employees while at work and at no cost to the employees themselves both in terms of time and money.”

This really sounds good too, but again does not really mean anything in terms of exactly what shall be done. In this case, the Company HIV/AIDS and Employment Code of Conduct may elucidate the issues with the following specific provisions:

a. Each and every one of the employees, including managers and up to the Chief Executive Officer themselves, shall attend at least one HIV/AIDS Health Education training course, seminar, workshop, lecture or teach-in per annum, during working hours, and at the company's expense. The course shall last at least for two hours, and shall be conducted by paid credible HIV/AIDS Health Education Specialists or Consultants. Employees shall be appropriately certified to have duly attended such a course, lecture, and seminar or training accordingly, which certificate shall be kept in the employees personal files.

b. All employees who can be directly or indirectly exposed to the risk of HIV/AIDS while at work shall similarly as in (a) above, undergo special, specific, and relevant HIV/AIDS Risk Education and Training, and shall be certified to have undergone the same, prior to commencement of duties (i.e. during induction), and yearly thereafter, in order to make them fully aware of the occupational HIV/AIDS health
hazard and risk facing them at work and how best they can prevent it and protect themselves and others from it.

c. The HIV/AIDS Health Education so provided to employees shall consist of the basic facts about HIV/AIDS, these being the fact that AIDS is caused by HIV infection, that HIV is mostly sexually transmitted, that AIDS is incurable, that AIDS kills, and that HIV/AIDS is preventable, in addition to the relevant exposure method risks that they may face in the course of their daily work, and in life in general, and how to prevent and protect themselves from these risks of exposure, including the appropriate and proper use of personal protective equipment and materials like condoms and gloves. It shall also encompass new developments in relationship to the HIV/AIDS risk or the disease itself, including available palliative antiretroviral therapy.

d. All employees shall also be educated about and trained on their general rights as employees, responsibilities and duties as enshrined in the national legal framework and other provisions with regards to HIV/AIDS in the workplace, and then encouraged and or assisted to exercise these rights as appropriate by all the competent authorities starting with the Employer, Employer Representative Organizations, the Government and Workers Representative Organizations, and moving on to other players in the field of HIV/AIDS such as social welfare and non-governmental organizations and so on and so forth.

6. The other provision that a good Company HIV/AIDS Policy Statement may make is that “The Company shall prevent and protect its workers from the risk of HIV/AIDS in the workplace and shall not, therefore, expose them to such a risk as may become higher than that which the general population may already be facing at that time or any other time thereafter, or knowingly expose HIV/AIDS susceptible employees to the risk of infection and or the risk of the development of full-blown AIDS.” To operationalise this provision, the Company HIV/AIDS and Employment Code of Conduct may then make the following categorical and specific provisions:

a. The company shall manage the HIV/AIDS risk in the workplace according to standard and sound principles of risk control measures that emphasize on risk elimination, engineering control, administrative exposure control and risk protection in that order, but always using a combination of the best possible available methods at any one time.

b. There shall only be unacceptable HIV/AIDS risk and no acceptable HIV/AIDS risk in the company workplaces.

c. The company shall provide all directly HIV/AIDS exposed workers in the workplace with the necessary and appropriate personal protective equipment and clothing and make it compulsory for them to use it properly and at all times that they may be exposed to the risk in the course of their assigned duties.

d. The company shall provide all employees with condoms, both male and female varieties as appropriate, which they may voluntarily acquire from within the company premises public utilities or facilities, and with due preservation of their own self-respect, human dignity, tradition and culture.
e. In its Human Resources Administration Procedures and Practices (HRAPPs) the company shall not engage in activities that may expose its employees to an HIV/AIDS risk that becomes higher than already exists in the general population by, for example, paying them sub-economic wages or salaries, assigning them duties that take them away from their homes and their spouses for prolonged periods of time, assigning them duties in socially isolated environments for prolonged periods of time, putting them in single-sex working and or living conditions, or conditions that are disproportionately male or female dominated, and not providing them with transport to and from work when they are on abnormal or night shifts.

f. The employer shall provide, as far as is practically possible, a healthy working environment for the worker, one that is reasonably free of or protected from occupational health risks, HIV/AIDS included, and with the assistance, advice, cooperation and full participation of the concerned employee or his or her representative, and also that of the representatives of the legal authorities.

g. The employer shall not knowingly expose susceptible employees to the risk of HIV/AIDS and shall therefore not assign immunosuppressed workers or already HIV/AIDS infected workers to perform tasks that may further expose them to the risk of development into full-blown HIV/AIDS, bearing in mind that it is the duty and responsibility of the concerned worker to voluntarily disclose this information to the employer and not the duty or responsibility of the employer to find out this information on his own.

7. The seventh provision of a good Company HIV/AIDS Policy Statement may be that "The company shall try to assist and encourage employees affected by HIV/AIDS to access support, care and treatment as they may need from time to time, and as far as it can possibly do at any one given time, and from time to time, and through the available, accessible and affordable company, government, donor and or any other resources at its disposal." The Company HIV/AIDS and Employment Code of Conduct may then expound and specify as follows:

a. Whenever needed or called upon to do so, the company shall provide HIV/AIDS affected employees with the necessary paid time off in order for them to access the needed medical advice, care, support and treatment, and where it can possibly do so, especially with the assistance of the Government and or other donors, the company may provide for these services itself and or from within its own premises.

b. The company shall not discriminate against HIV/AIDS infected and or affected employees in its medical services, medical aid and life cover insurance policies and or practices, and any other medical assistance or leverage that the company may offer to and for the benefit of all its employees from time to time.

c. HIV/AIDS infected and or affected employees shall be treated in pretty much the same way as any other employees with chronic illnesses or diseases may be treated, both by law and precedent. Positive discrimination (favours) for HIV/AIDS affected employees is not prohibited but is in fact encouraged especially where it is reasonably and practically possible. It is a privilege and not a right.
d. The company shall make peer education and counseling services available throughout the company for all its employees who may need them through the appropriate selection, education, training and incentivisation of peer educators and voluntary counselors from within the ranks of the company's own employees.

8. The last provision of a good Company HIV/AIDS Policy Statement may be that "The Company shall continue to engage, dialogue, collaborate and co-operate with all its social partners, these to include other employers and employer representative organisations, employees and employee representative organisations, the Government and government representatives, non-governmental agencies and any other relevant and interested donor organisations, in its endeavour to provide for a holistic management of its HIV/AIDS in the Workplace Programme in accordance with the laws of the land, the available, accessible and affordable resources, and the world best practices at that time, at any other given time, and from time to time." The Company HIV/AIDS and Employment Code of Conduct may then elaborate on the relevant social partners as follows:

a. The Government and its representatives (Specifying Ministries and Departments)

b. Employer Representative Organizations (Specify)

c. Employees Representative Organisations (Specify)

d. The International Labour Organisation. (ILO)

e. The World Health Organisation. (WHO)

f. The United Nations and all its agencies.

g. The donor community.

h. Regional, international, inter-governmental and any other organisations.

The detailed information given in this chapter is in fact a practical basis for a comprehensive and holistic national, organizational or enterprise level based Standard HIV/AIDS Policy Statement, and the enabling Standard HIV/AIDS and Employment Code of Conduct, both of which may be used to give rise to a good and operational Company HIV/AIDS Management Programme and Plan of Action with reasonable expectations of success. It is recommended that companies must produce these two documents first and foremost before they can have an HIV/AIDS Programme and Programme Management Plan of Action based on the provisions of these two policy documents. The rest, as they say, is clear.
Chapter 14  Monitoring, Evaluation and Review of HIV/AIDS in the Workplace Programmes

Company HIV/AIDS in the Workplace Programmes must be accomplished and managed according to a well defined and budgeted for workplan that is designed to achieve results, outputs, objectives, goals and outcomes as provided for in the Company HIV/AIDS Policy Statement Document, the Company HIV/AIDS and Employment Code of Conduct Document and national legislation, and this as a bare minimum requirement. The programme must also try to meet the provisions of the world best practices, and it must show continuous improvement all the time. This, ideally, is how any programme must be implemented.

Is the Company HIV/AIDS in the Workplace Programme on track?

How do we know that we are going in the right direction as far as programme implementation is concerned? This is where programme monitoring, evaluation and review comes in. At all times, and also at given specific times during the programme implementation process, such as quarterly, half yearly, yearly, or mid-term, we must stop and ask ourselves if we are doing the right things for the programme and under the circumstances, in order to achieve the desired specific targeted results and on time too. In other words, we must ask ourselves if we are on target.

There should be no change of goal posts

Honest answers to these questions will enable us to refocus, redirect and or redouble our efforts in order to achieve our desired initial goals or objectives. One thing that is not recommended though, at this juncture, and in this kind of exercise, is the habit of changing goal posts all the time. We should not be too keen to shift the goal posts to another different position simply because we have gone off course, or have been too slow to achieve the desired results, or we are just too proud to admit that we are failing. With our main targets, goals, or outcomes in mind, we must review our progress with the Programme towards these desired end results. We may re-adjust or change our short-term objectives, outputs or result targets as the situation may demand, but we may not easily or frequently change our main goals, outcomes or targets. If we keep on changing our main objectives, we run the risk of ending up where we never intended to with our Programme or project in the first place.

How exactly do we go about doing a programme monitoring, evaluation and review process?

First, we need to have our programme implementation plan at hand. The programme implementation plan will inform us as to what was or is supposed to have happened or to be happening at any one given time, how it is supposed to be done, why it is supposed to be done, by whom, when, at what cost and where it is supposed to be done. So at any one given time during the programme or project implementation process, we can stop and compare this programme or project implementation plan with actual progress on the ground. We will then analyze the similarities and differences between what was supposed to be happening and what has actually happened or is actually happening on the ground and then find out the reasons for these differences and attempt to correct the situation by trying to align what is actually happening on the ground with what was supposed to be happening as closely as is practically possible, always bearing in mind that sometimes our own ambitions may have to give in to reality and not the other way round. There is just no way will reality have to suit our own wishes.
If the project or programme implementation plan was drawn up based on specific, measurable, achievable, realistic and timed (SMART) short-term objectives or goals, then usually there is not much goal post shifting that may happen or that may be necessary. However, if we were over-ambitious or had a lot of oversight, we may have to tone down our ambitions in line with reality. With each programme review process, we must be able to draw up a modified new programme or project implementation plan to which we must then re-commit ourselves and our efforts anew, this time, hopefully all the more cleverer and wiser than before. So, in this way, the cycle of project planning, project implementation and project review and continuous improvement will continue until we have achieved the desired end results. This is as true for implementing HIV/AIDS in the workplace projects or programmes as it is for any other project or programme.

**Programme conformity with the stated goals and objectives is very important**

In the programme planning, implementation, review and continuous improvement cycle, we must be wary of a few important things. We must be wary of conformity. This is to say that we must always make sure that the process conforms to our HIV/AIDS Policy Statements, our HIV/AIDS and Employment Code of Conduct, national legislation and any other relevant world best practices in that particular field. In order to achieve this conformity, we must always do some follow-through thinking whereby at the review stage we do not only review the programme implementation plans in terms of how far they have gone on or how successful we have been in implementing them, but we must also review them in terms of how far they conform to our stated mission statements, visions and values. In short, how far they conform to our Company HIV/AIDS Policy Statements.

It will not auger well for our image as a company, as an organization or as a Government, if our HIV/AIDS in the Workplace project or programme implementation process does not conform to our stated Policy Statements, legal provisions, or Employment Codes of Conduct. If this happens, we may then rightly be accused of double standards or double speak where we say one thing but then go on to do the other.

**Independent programme evaluation is sometimes necessary**

To assist us to do a more objective HIV/AIDS in the Workplace project or programme monitoring, evaluation and review process, we may need to engage the services of well trained, experienced and knowledgeable professional consultants in the field in which we are running our programme. Although this may cost us some money, if we had planned properly at the very beginning, this will also be in our HIV/AIDS in the Workplace project or programme management budget plans. The advantage of having an independent professional consultant periodically evaluating our project or programme for us is that no matter how objective we may try to be in assessing our own selves (self assessment), the element of subjectivity and self justification is always there and we cannot run away from it. There is always a natural and excusable tendency when one is appraising oneself, to be lenient towards oneself, and this may not auger very well for the successful implementation of any project or any programme for that matter. Sometimes we need to be told the brutal truth about our own failures or sloppishness by some other people so that we may pull up our socks and move forward more resolutely than before in implementing a project or programme.

**Periodic programme reports must be produced**

Another way of doing a project or programme monitoring, evaluation and review process is the production and submission of periodic project or programme reports to the sponsors, to higher authority, or to independent evaluators as well.
The reports so submitted must be very comprehensive and all encompassing and must be a true reflection of what is actually happening on the ground. They must not be cooked up stories which are a far cry from what is really and actually happening in the programme or project. The beauty about the periodic project or programme reports is that the evaluator can always check randomly and unannounced to verify the veracity or truthfulness of the reports as they purport to represent or portray the obtaining situation on the ground.

Telling outright lies is very unprofessional and a big embarrassment if and when found out as is always the case anyway. One also risks abrupt termination of the project or programme and loss of sponsorship if one misrepresents the truth in a report. This should never be done no matter what. It is better to lose sponsorship while telling the truth than to lose it because of telling lies. Those who lose sponsorship in the latter fashion may not get any other sponsorship again or in the near future if ever they get any such or other similar sponsorships ever again.

Some important definitions

Let us go back to looking at what programme monitoring, evaluation and review entail one by one so that we may understand the whole process wholesomely once and for all times sake.

Programme Monitoring

Project or programme monitoring entails the process of following up on the implementation process and comparing the actual stage presently reached in the project implementation process with the projected time frames as provided for in the previously adopted implementation plan document. Project or programme monitoring is therefore essentially just a follow up process checking on time. It tries to check if things have been happening and or have happened on time in the project or programme implementation process.

Programme Evaluation

Project or programme evaluation on the other hand, is the process whereby the evaluator tries to explain logically, truthfully and meaningfully the reasons why the project or programme is still at that particular stage at that very point in time, instead of being at the desired or planned for stage in its implementation process. This is the hard part of the whole process of project monitoring, evaluation and review because there are always seemingly very good reasons that are proffered as to why the project or programme is delayed or failing, and these reasons, usually by design, consciously or subconsciously, always have very little or nothing to do with the intrinsic deficiencies of the project or programme implementing team, supervisor or manager.

Accept the results of a project or programme review process

When the project or programme is not going on very well, or even well at all, it is very difficult to admit to anyone, let alone oneself, of the truth about one’s own failures or failings. However, if there is going to be any progress at all in the future of the project or programme, then one needs to swallow one’s pride and accept that they are failing or have failed to implement the project or programme in the way it was planned for. The cause of that failure may be the fact of the personage of the project implementer or implementers themselves, among other things, but this fact is naturally very hard to accept.

However, until and unless we accept the real and true causes stumbling our project or programme and then take the appropriate steps to correct them, we may never taste success in any project or programme
whatevsoever, HIV/AIDS in the Workplace Programmes included. Blaming all other people, other things and everything else except our very own selves when a project or programme is failing or has failed will not and has never gotten anybody anywhere at all. If anything, it has always hindered progress by providing a detrimental thought blockage towards reinventing ourselves or successful solutions to problems at hand, and also even to future problems.

The blame game is not necessary before, during or after project or programme review

Somehow, Governments seem to run away with the trophy if we consider the number of people or organisations that are most likely to refuse to accept the blame or to blame themselves for failure in the case of faltering projects and or programmes. There is apparently always some external force, some terrorist saboteurs, some neocolonialists or some such other imperialist forces to blame for the failures of governments to implement their own national development programmes and never themselves. As demonstrated before, it is only natural to try to shift the blame onto somebody else, but this is not recommended or acceptable at all.

In private companies, programme or project evaluators are usually able to pin point the cause of failure down to the responsible and accountable person, and this person usually suffers the inevitable consequences of failing to deliver. However, dismissal is not always the correct option in these circumstances. Sometimes it is better to retain a reasonable, trained and experienced person who has made just one or even a few mistakes that lead to project failure, than to get a totally new person altogether because experience, even the experience of failing, will always count for the better eventually. However, repeated failure, especially in circumstances where the integrity, qualifications and training of the concerned person may be called into question, may not be acceptable.

Programme Review

Anyway, after an honest project or programme evaluation has been done, the next step is to review the project or programme implementation strategy or plan. This entails drawing up a new or revised programme implementation plan document that takes into consideration the present state and stage of the project development, the causes of this state of affairs and the solutions thereof, and any other considerations that are necessary to move the whole process forward in order to catch up with the initial project implementation plans or even to do better. This process of reviewing a project implementation plan also needs a lot of honesty and being even more realistic than before. Where the initial project implementation plans have been adjudged to be over-ambitious or even unrealistic in the evaluation process, toned down project implementation mini-targets and time frames should be made in this review process. If unrealistic goals, targets and time frames continue to feature in a project review document, then perhaps the project evaluation process will not have been done correctly. Anyway, eventually there should be a revised, more realistic, straight forward and easier to implement project implementation plan document. This document now becomes the new project implementation plan document in use.

Old records and documents must be retained

However, the old document is not thrown away. It, together with the project monitoring and review reports, is kept for future reference as the project goes on so that there may not be a repetition of the same previous mistakes that were once made in the project implementation process all over again at any one time in future or as the project gets implemented. It is just possible that there might be a change of guard as far as the project or programme, and especially the programme, implementation team is concerned,
well before the desired target results have been achieved, and new guys have to be roped in to continue with the work, but then they may befall into the same pit or pits which the older guys fell into unless if they had some historical documents like the old project implementation plans to warn and guide them.

Many times project implementers throw away these old documents because of pride and fear that they may expose themselves and their previous failures to others in the future, but any seasoned evaluator would know that the solid experience that we so much cherish and value in the so called fundis actually comes from such failures that were wisely and appropriately corrected as the project or programme went on. Success is not measured only by the number of achievements one has made, but also by the number of times one has picked oneself up and succeeded from a position of failure. Not many people have always succeeded the first time around that they set about to accomplish a given new task, and this is only normal, so we should not be ashamed of failure.
Chapter 15  Continuous improvement of HIV/AIDS in the Workplace Programmes

As we conclude the discussion on the management of HIV/AIDS in the workplace, let us now look at the concept of continuous improvement in the implementation of HIV/AIDS project or programme management plans. Continuous improvement is a very important concept in as far as it tries to guarantee that we should always look at doing the things that we do today in an even much better way and for even much better results tomorrow.

There cannot be improvement without change

Yes, we could be very satisfied with the way things are happening or being done today and there might not be any apparent need for us to do the very same things in any better way or to achieve any better results today than yesterday, but such an attitude towards continuous improvement would not lead to any meaningful or sustainable growth and development. Imagine if motor vehicle or locomotive manufacturers had been totally satisfied with their invention of the automobile to the extent that they saw no need to continuously improve its designs, mechanisms of function and performance levels from when they first invented it! Where will we be today in the automotive industry?

We will probably still be stuck with those old, cumbersome, painfully slow and noisy contraptions that took the whole of five hours just to cover a distance of one hundred kilometers! At that time when the automobile was first invented, contemporary folks thought that this amazing machine was pretty fast and very ingenious too considering the fact that they mostly travelled on foot, on horse backs or in horse drawn carts and stage courts at that time.

In fact, one English King is supposed to have complained that the train was moving too fast when he and his wife took a ride in the locomotive for the very first time in their lives and yet it was doing only twenty miles per hour! Continuous improvement in the technology of automobiles has ensured that the product kept on improving for the better in all aspects of its performance from looks to output.

Today we have a fantastic range of beautiful, high quality and good performance automobiles, thanks to the concept of continuous improvement. We can apply the same concept of continuous improvement to any other system such as the telecommunications industry, the computer industry and so forth and so on and it will continue to hold water all the time. We can also apply this concept to HIV/AIDS programmes and programme implementation with the same results.

Some people have argued that systems that are already running and functioning smoothly need not to be disturbed, so it is advisable to let things be and not to interfere with them. This may be true in certain circumstances but only if the end results of trying to improve the performance or function of a programme or system ends up not improving these things but instead worsening them. In that case, that is definitely not continuous improvement. We are talking about real improvement here and not the worsening of things, so that argument does not perhaps hold any water.

Change is not necessarily the same thing as improvement

Inadvertent worsening of an otherwise smoothly running programme or system in an ill-conceived bid to improve it has always created failures out of an otherwise successful programme or system much to the great embarrassment of many people. Such activities and actions are not advisable at all. What usually
happens is that in an ill-advised bid to contribute to an already running and otherwise successfully and efficiently operating programme or system, some people may seek to show that they are part of the success story by unnecessarily and wrongly trying to “improve” things that they have absolutely no idea about, even against the advice of the experts. This unwarranted and rather unbecoming behaviour or attitude has always lead to embarrassing decelerations and sometimes outright programme or system failures.

This “I did it” disease usually afflicts the bosses in many projects or programmes when they seek to take credit for themselves in situations that they were little involved in right from the start, especially when things have turned out to be good and or are succeeding, even if they may have been very skeptical and or down right unsupportive of their subordinates right at the very beginning of it all. It is always nice to share in the success of a project, but sometimes the best way to do it is not to interfere in any way at all. Cheering the workers on or just being there for them could be a much better option than inadvertent programme derailment.

Sometimes there is really no need for improvement or change

When we seek to continuously improve the programme implementation process, even the experienced professionals themselves may also need to be cautioned about unwanted, ill-conceived and perhaps uncalled for improvement attempts. As has already been said before, it is always not necessary to be seen to be continuously improving things, more so when, with all the present and modern technology being applied already, there might be absolutely no way of really improving things.

Systems improvement must come with a sum total improvement in the performance of the whole system and not just improvement in a small part which may not add any value to the whole system. Sometimes we fall into the trap of celebrating improvements in one part of a big project, programme or system which actually results in the slowing down or lessening of the total performance or quality of the project, programme or system and this cannot be said to be continuous improvement no matter how smart or appealing the partial improvement may actually be.

This trap of overall meaningless or detrimental smart programme improvements is a trap that usually catches the expert programme implementers. Their zeal to achieve the best in the best way possible always seems to get the better of them, and sometimes with disastrous results. It is the same self-actualization trap that many a great achiever has fallen into.

New developments always necessitate systems changes

As far as HIV/AIDS in the Workplace programmes are concerned, it is very possible that because this is a new field which is still under exploration, new discoveries, developments and inventions may come about which the programme may need to take on board and incorporate accordingly. This may just be a change and not necessarily an improvement, but it could also be a genuine improvement.

For example, as it is many countries have not yet enacted any specific HIV/AIDS and Employment Acts or any similar legislation. Many organisations or companies operating in these countries are just doing what they think is the best that they can do for and with their employees under these circumstances. After the passage of any HIV/AIDS and Employment legislation by Government in any particular country, companies and organisations will now have the legal obligation to align their HIV/AIDS in the workplace programmes and activities with the new legal provisions. This will necessitate a programme review process with the view of taking on board the new legal requirements. This must always be done as a
matter of priority. The unfortunate thing about legal requirements, however, is the fact that sometimes if these legal provisions were not well thought out at the beginning, especially where they lack the advice of experienced professionals in the field; they may not actually result in continuous improvement in the project implementation process. Sometimes they take away the quality and good performance of any already running and well organized programme or system.

**Legal changes need to be approached very carefully**

Governments are better advised to seek the services of experienced and trained experts before they put together any legislation. The advice here also goes further to include the fact that contrary to what most people believe, legal minds or lawyers are not always the best minds to draw up any or every piece of legislation other than that which deals with the way the law itself is administered (Jurisdiction and Jurisprudence). The best people to draw up the raw legal provisions in any field are the professional practitioners in that field themselves. The lawyers will come in to put the provisions in appropriate legal language but always in consultation with the professional experts in that field who will have drafted the legal provisions in the first place, so that the said legal provisions may eventually mean what the professionals intended them to mean legally and not something else completely different.

The failure to deliver on sound legal provisions is the scourge of many governments. Many Governments have rushed to enact ill-conceived and ill-thought out pieces of legislation drafted by completely wrong people in an attempt to satisfy a given sector of the local or international community that may be perceived as demanding enactment of such legislation as a precondition for something, especially financial assistance or aid, or just so that they may look good in the eyes of onlookers, followers or voters. The results have been that these poorly thought out legal provisions have failed to serve their purpose and in many cases they have not really improved things at all but have actually gone on to worsen them, which is not right. This is food for thought for many governments as far as legal provisions are concerned.

**Changes to conform to international standards**

International organisations such as the ILO or the WHO may come up with new conventions or recommendations for dealing with HIV/AIDS in general or at the workplace in particular and these developments must also the catered for in the already on going HIV/AIDS programmes. An HIV/AIDS vaccine may be discovered one day and perhaps preventive efforts may be shifted towards vaccination if this is adjudged to be more superior to all other preventive methods that may be available or recommended at that particular point and time.

**Addendum: The case for one Workers Representative Body in the workplace**

As a form of continuous improvement in the way workers' issues are handled or dealt with at the workplace, especially where HIV/AIDS and Employment issues are concerned, and more especially because of these issues, and the way they have been dealt with in this publication, the author feels very much persuaded to proffer an opinion in relationship to Workers Representative Bodies in the workplace and also to suggest improvements in this regard.

**The status quo with regards to workers representative bodies in the workplace**

The accepted modus operandi in companies and organisations at the moment or even at the level of the ILO, is the recommendation that there be Occupational Safety and Health (OSH) Committees in the
workplace that are composed of equal numbers of management and employee representatives, and that are tasked with overseeing the implementation of the company or organization OSH policies and programmes. Currently there is also a recommendation of similarly constituted HIV/AIDS or Wellness Committees at the workplace to oversee the company HIV/AIDS or Wellness Policy and Programme implementation.

On the other hand, there has always been the legal provisions, conventions and recommendations, even at the level of the ILO, that in every workplace employing a given number of employees, there be a freely and democratically elected Workers Committee that is put in place and mandated directly by workers themselves and of their own free will and accord, to negotiate with the employer or his representatives (Management) on the workers' behalf, on all issues to do with the workers' rights and conditions of service, including OSH, HIV/AIDS, and any other conditions of service either already in place or still to come. The Workers Committees have thus grown to be very powerful organisations in every workplace since 1919 when the ILO was formed. Their formation has become second nature to workers in very workplace in this world.

The immense powers of Workers Committees

At national level, Workers Committees have coalesced according to industry, and at the recommendation of powerful organisations such as the ILO, to form very powerful industrial workers trade unions that can bring down any industry if they fail to negotiate or agree on any industry wide conditions of service for the concerned workers. Also and again at national level, and once more also again at the recommendation of the ILO, these Industrial Workers Trade Unions have coalesced into mighty powerful National Federations of Labour, or National Federations of Trade Unions that have got the capacity to actually bring down the whole country to its knees economically or even politically if there happens to be failure of communication or disagreement with employers in general or even with Government, or both, as far as the global administration of labour issues are concerned in the country.

Internationally, the ILO is the only major United Nations organ that demands that the tripartite social partners, that is to say the Workers, the Employers and the Government, are equitably represented in all its structures and in all country or international delegations that may attend any of its conferences, seminars or workshops worldwide, and it also always implements its projects, programmes or any other activities with the full participation of these identified tripartite social partners. As such, ILO conventions, recommendations and or declarations, clearly define who exactly these tripartite social partners are in any given country or given situation.

Workers Committees are clearly well defined and very well supported everywhere

As far as workers organisations are concerned, the ILO defines and recognizes national federations of workers unions, industry based workers unions, down to enterprise or company based Workers Committees, and has even got very clear and well respected guidelines as to how these organisations may be constituted and how they may operate within themselves and in conjunction with the other social partners. As a result, there is no other workers representative committee that is as old as, more understood, better cherished and more trusted than the Workers Committee in any given workplace. Most employees place all their faith in their Workers Committees!
Workers Committees are well respected

Employers have come to accept and respect the independence, position and power of the Workers Committees as far as they represent workers or employees in their collective bargaining or negotiations for their all inclusive general conditions of service. They dare not unnecessarily or arbitrarily antagonize the Workers Committee! Through Workers Committees, employees have thus gained the status of equal partners in the workplace.

Similarly, National Trade Unions and Trade Union Federations have also gained the same mutual respect in industry, and also with their Governments and Employers Federations. Consultation with workers through their legitimate representative bodies is now the order of the day almost everywhere, much to the betterment of the workers own conditions of service or even their socioeconomic status.

Governments the world over have frequently passed many laws in favour of and at the instigation of the workers through their Trade Unions. Of course, internationally, we have already said that the ILO has given all workers of this world a very strong voice, powerful and decisive.

Some workers concerns were removed from the direct jurisdiction of Workers Committees in the workplace.

It is very good for Worker Representative Bodies to be very powerful, at all organizational levels. This is all so very good overally and in general, but the problem comes when certain workers concerns in the workplace like OSH or HIV/AIDS and others, which basically also touch on workers general conditions of service, are apportioned to an OSH or HIV/AIDS committee whose workers representative members are not always or necessarily also Workers Committee members. These so called technical committees are sometimes not that democratically constituted in the eyes of the workers, as opposed to the workers committees, with the result that they are deemed not to truly represent the workers or even their wishes.

Other workplace committees are not trusted by workers or respected by management

Technical committees are not the most naturally trusted workers representative bodies in the workplace and this is a fact, especially in the developing world. To make matters worse, these technical committees are usually not accorded the same status as the Workers Committees by the management. They usually cannot make any binding decisions, just being relegated to advisory bodies whose advice is seldom taken on board or implemented, in total contrast to the Workers Committees that always make serious decisions with the full mandate of the law and of the workers who they represent, and their decisions stick like glue even legally.

Management usually respects and implements the outcomes of their deliberations with their workers committees in much the same way that law abiding Governments will respect and implement the judgments of the judiciary in their own country, while on the other hand the recommendations of technical committees such as the HIV/AIDS or Wellness Committees do not get the same or similar treatment. Whether we like it or not we have to accept that this has lead to the erosion of the power and credibility of technical committees, if they ever had any such power or credibility in the first place, in as far as they should represent workers rights in the workplace.
Technical Committees are not mandatorily represented at the ILO

Technical Committees are usually not mandatorily represented in ILO delegations to the annual Geneva Conference, even if such technical issues as OSH or HIV/AIDS are there on the agenda for that particular year, neither are they usually represented in the executive committees of National Federations of Trade Unions, or even in the executive committees of National Trade Unions, let alone on the executive committees of the Workers Committees themselves at the workplace.

The contribution of technical committees to the welfare of the workers is lost right at the very beginning of their conception, at the workplace itself! Yet somehow, we continue to advocate for, sometimes even by means of unenforced or unenforceable legislation, the creation of these none functional or none effective institutions in the workplace almost everyday, perhaps in a gesture of pseudo-self-accomplishment, or the veneer of appearing to be doing something positive about workers OSH or HIV/AIDS or Wellness rights or needs. What really is the point of all this? Think about it.

Management sometimes ducks technical issues affecting workers rights

At Workers Committee meetings with management, OSH and HIV/AIDS or Wellness/Vitality issues are usually expertly ducked by management with reference that their discussion belongs to the said technical committees where management knows very well that there is no obligation for them to act even if they may receive the appropriate recommendation, unless, of course, if the issues somehow end up on the agenda of workers committee. There is also no danger of any strike action based on these issues if they remain with the technical committee. Usually management will only act on OSH, HIV/AIDS, and any other related technical committee issues if and when they have become Workers Committee issues. This unfortunately is a fact in most cases, especially in the developing world. Even Governments do not usually and easily listen to expert advice unless and until Trade Unions come into the picture.

Multiple workers representative bodies in one workplace may not be systems improvement

The question that begs for a well considered and honest answer then becomes that is there really any need at all for there to be any such technical committees as the OSH, HIV/AIDS or Wellness Committees, or any other technical committee for that matter, also representing workers’ conditions of service issues in the same workplace where there is already a very powerful, very well networked, employer feared and respected, government and internationally recognized institution such as the Workers Committee that has got an all inclusive agenda, mandated to it by law, custom, precedent and practice, to democratically represent the wishes of the workers in very workplace?

How effective have these so called technical committees been in articulating workers rights and needs and in achieving the desired results? If the truth may be told the author thinks that they have not been very effective, more especially in the developing world, where some governments do not respect and or support the existence of even the traditional labour unions.

It may be the right time for positive changes in worker representative systems approach

Perhaps it is high time that the ILO revises its stance on this multiplicity of worker representative organisations in one workplace with the view of rationalizing, streamlining, or mainstreaming them into just one organisation, such as the Workers Committee only, in the same spirit and framework as the
emerging concept of the one UN system of approaching United Nations development assistance at international and national levels.

It is the author's understanding that this one UN mentality entails a situation whereby all the United Nations organisations or organs operating in any one given country will not only let each other know about what each and every one of them is actually doing at any one given time, but will also try to avoid duplicity and encroachment onto each others' territories of operation by channeling whatever development assistance they may envisage to render in the country, through the programmes, projects and activities of the most relevant UN body in that particular field and not necessarily through their own activities, programmes or projects.

**Improved workers focus at the workplace is needed to fight HIV/AIDS**

The one UN System is a very sound way of improving focus, efficiency and effectiveness by the United Nations as a one whole, and at country level. The same may also be extended to Workers Representative bodies in the workplace, bearing in mind the fact that Workers Committees are the oldest, most democratically elected, most representative, most accepted and most legally recognized worker representative organisations in the workplace. Any other worker representative organisation at the workplace, OSH and HIV/AIDS/Wellness Committees included, if at all necessary, should work through or within the aegis of the Workers Committees.

We may have to accept the fact that perhaps this multiplicity of worker representative organisations in one workplace has really served no purpose at all, or has even actually retarded growth and development in the realm of the holistic realization of workers' rights in the world of work for all these years, and it is just about the right time that we put it aside in favour of the orthodox and tried and tested way of doing business with the workers on the shop floor, which is the democratic, free and fair representation and expression of their own freedoms, rights and responsibilities at work - the Workers Committee platform!

**Nothing changes without a change of mind**

The author is really persuaded that this is perhaps the most reasonable way to go now if matters such as HIV/AIDS in the Workplace can ever be tackled properly and effectively; after all, many issues pertaining to HIV/AIDS in the workplace are really conditions of service and workers rights issues! Of course, the Workers Committees and Trade Unions will be very pleased to have all their powers in the workplace back with them once more instead of being apportioned to some other controversially appointed technically committees in the first instance, but that is beside the point. This is just a suggestion for continuous improvement in the way we approach labour issues in the workplace, and from the perspective of workers representation. As a parting shot, please always bear in mind that the first and the most imperative thing that needs to be accomplished or that needs to be done in any successful or improved change process is to change our own minds!

**CMS**
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