

HIV/AIDS PROGRAMME IN THE WORKING FOR WATER PROGRAMME

June 2005

Introduction

The Working for Water Programme like any other Government Expanded Public Works Programme (EPWP) is bound by the law to implement programme that have a socio economic impact on the communities where the bulk of employees come from. One of the key deliverables is the HIV/AIDS Programme. Within the organisation's various provincial offices the impact of AIDS has been felt at every level; office staff, project level and skilled staff have died. That is why the WfW Programme took the option of optimising HIV/AIDS deliverables above other social interventions – not to come first in comparison with other similar programmes but to sustain HIV infected individual know and unknown. It has been a very bumpy ride but the WfW Programme can boast of being somewhat counted among the pioneers in HIV/AIDS Workplace Policy and Programme development, Strategy and Implementation. Statistics of trained Peer Educators are growing each year. Because of the laws governing EPWP WfW has to have ongoing Peer Educator Training programmes. There are challenges to this, as the core business of the WfW Programme also demands as much if not more attention. We can actually say we have managed the balance.

Milestones

- ❑ In 1999 a proposal was presented to Management by WfW Social Development staff to develop a Strategy to accommodate HIV/AIDS as a component of the Social Development Deliverables. The proposal was approved and Management even worked with the key stakeholders then to commence with recruitment. Some may say they played the ace card by being specific in encouraging persons living with HIV or AIDS disease. That worked well for them and they did get a Person with HIV infection trained on; HIV/AIDS Workplace Model designed by UNDP for their GIPA¹ programme.
- ❑ 2000 saw the drafts that existed before turn into a living document accommodating the constraints that bound EPWP at that time. The recruitment and appointment of Social Development Coordinators and in some provincial/regional offices HIV Officers/Coordinators meant that there problem of capacity had been eliminated even before it became an issue as is common with HIV Programmes.
- ❑ In 2001 the WfW Programme worked on the number one delivery programme for HIV/AIDS; a Universal Precautions Programme. All regional Managers had an opportunity to address, workshop and approve the Universal Precautions Programme. Today there are posters in every region of basic information regarding Universal Precautions and the link with Health and Safety measures to prevent and/or reduce the risk of HIV contraction at work. This happened while the Draft Workplace HIV/AIDS document was still under scrutiny yet operational. The main issue was to create an environment of acceptance for the infected and affected and to create room for open discussion in how communities can get on board and take responsibility when WfW projects close.
- ❑ In 2002 the Programme fulfilled a dream by crating employment of people living with HIV/AIDS in the core business of the Working for Water Programme – control of invasive alien plants/species. These teams have each given first preference to people with the virus, followed closely by *people caring for children orphaned by HIV and then people who have lost loved ones to the disease*. The challenge was sustaining these people's services and it has paid off. These teams still exist and they have

¹ GIPA meaning Greater Involvement of People with AIDS

- caring and supportive Project Managers who work hand-in-hand with the community health care facility and HIV/AIDS Committee.
- ❑ In 2003 the WfW Programme expanded capacity in the National Office HIV/AIDS Component to accommodate issues of ill health since the Coordinator is living with HIV/AIDS. This once again was an ace. The expansion opened up other issues such as a consideration to combine the skills of the two HIV/AIDS Programme implementers – ***gender, food security and capacity building for Peer Educators*** so that they reduce the problems of job-hunting when they leave the programme. Partnerships were secured with DOTS² programmes; WIPAA³ and local health facilities. In this same year the Workplace HIV/AIDS Policy was reviewed and this time stakeholders from the regional offices were on board from the onset, management and senior management took time to advise and recommend during these proceedings. During this time the Social Development Research Coordinator was also one of the Champions in assisting the HIV/AIDS Component to measure its impact in a Rapid Appraisal that informed the SD Unit and good recommendations came out from that and now the work was intensifying. MANCO⁴ approved the Policy after it had been discussed in all regional offices with the key stakeholders and target groups. This was the year that WfW Staff, Management and partners Unicity HHIV/AIDS Committee went on a Campaign to promote VCT. Managers stood with staff at street corners passing out ***'goodie bags'*** stuffed with ***a leaflet on what World AIDS Day is about, the detailed use of Condoms including their origin, a female condom and 4 male condoms, a bumper sticker ' my friend with AIDS is still my friend' a set of 5 WfW branded pamphlets*** was part of the package – *basic Information about HIV, Positive Living, Universal Precautions, World AIDS Day, Voluntary Counselling and Testing*. To finish the event with bang, all managers went for HIV testing with full counselling in public! The theme for WfW that year was ***" I know my status... Do you know yours?"*** Thanks to the efforts and support of the HIV/AIDS Committee, a dream became a reality.
 - ❑ 2004 saw the birth of the Gender Programme from the SDU & AIDS Programme. As the World AIDS Day messages started to actually address the issue of gender especially women, the programme proposed a Gender programme not AIDS specific but embracing sexual harassment and other aspects. Thanks again to the appointment of a Transformation Officer the three programmes now talk to each other. The WfW HR unit paid a keen interest and created room for staff to access free care and support through the EAP⁵ Programme. The WfW Workplace Policy could not be launch due to logistics but as a living document it was translated into IsiXhosa, IsiZulu, SeTswana, TshiVenda, SeSotho and Afrikaans. This was also done with the branded WfW HIV/AIDS pamphlets. While editing was taking place regional stakeholders wasted not time but commenced with food security aspects with regional partners including contractors, project managers and stakeholders who have claim to the land used to plant food gardens. Regions also began a process of identifying role players in the struggle to access health care. While all this was happening, the SD Unit at National and Regional levels were busy working on Operational Plans, Standard Operational Plans, Action Plans that are region specific because not all regions have the same capacity so that there was transparency in terms of what each region's focus areas are in their Social Interventions – this then made room for Social Development to finally have Key Performance Indicators, to have statistics recorded with WaterWorks so that anyone at any time could be able to know who is doing what and at what stage of development is each focus area region by region.
 - ❑ 2005 came with all the above completed but more planning was done around step-by-step narratives on the SOPS. The Workplace HIV/AIDS Policy is now a document

² Directly Observed Treatment Short-course for TB

³ Women In Partnership Against AIDS – a component of Partnership Against AIDS

⁴ Management Committee

⁵ Employee Assistance Programme

with all the editions in place. In the plans of 2004 a proposal came from Regions to come up with a WfW specific HIV/AIDS Training manual that would ensure that the training is standardised and actually credible. That has given cause to the Coordinator to develop and create lesson plans for HIV/AIDS Training Manual predominantly meant for Peer Educators. When all the stakeholders have had the opportunity to edit the draft document it will then move on to the next step - accreditation.

Lessons learnt

1. It is a good strategy to have the input of people who are most knowledgeable about living with HIV/AIDS. The Working for Water Programme has found that to work in their favour as opposed to against.
2. The WfW HIV/AIDS Programme became the benchmark for the DWAF HIV/AIDS Programme and in 2002 the WfW HIV/AIDS Coordinator joined the DWAF AIDS Committee as one of its key informants. Today DWAF has a Workplace HIV/AIDS Committee Policy, Strategy and Line Function in place with all the relevant positions/vacancies worked within a budget.
3. The teams with HIV/AIDS related concerns are still thriving and have become healthier than teams where no one is known to be HIV infected.
4. The Universal Precautions Programme has developed so much that all new Project Managers and relevant staff are aware about its policies and requirements – it could at times be the only reference document in underresourced areas for maintaining basic hygiene practices especially at camps.
5. The WfW HR Unit has once again been a great support by creating yet another VCT⁶ Campaign in-house where workshops on AIDS information were conducted and testing was confidentially done at the workplace. 34 out of 50 staff member went for VCT- WELL DONE
6. To sustain a programme like a workplace HIV/AIDS Programme it is also wise to promote a healthy lifestyle without creating room for stigma and discrimination.

Challenges

- ✓ The WfW Programme has faced the worst challenge of losing skilled staff members to HIV/AIDS especially at regional level. This challenge can only mean that effective as we are as sector level, we still need to make a positive impact on staff by creating an environment where people feel free to discuss all health related issues not only HIV.
- ✓ Like other Departments, Government components, Corporate Companies and Organisations, there are a grey area when it comes to reasonable accommodation. One the one hand the employer wants to give support on the other hand the HIV positive individual fears loss of income. The area is problematic in that doctors are bound by law not to disclose the individual's HIV status of disease progression.
- ✓ As much as WfW can do there is also another aspect facing the programme – the first priority is the core business of the WfW Programme and this above all else demands attention as it is the reason for the existence of the AIDS Programme. We need also to know that as Control of Alien Invasive Plants is our primary delivery, we cannot be seen to take over other Departments' focus areas.
- ✓ Until delivery on HIV/AIDS is added to the job descriptions of all staff, it is still going to be difficult to get support in-house for the AIDS Programme.
- ✓ A challenge exists to create room for HIV positive individuals to be involved in decision-making forum that touch on HIV and Employment. This means a clear line function should be decided upon before recruitment and any people affected by these decision (people with HIV or AIDS) must be some of the informants to those decision if not part of them from the onset

⁶ Voluntary Counselling and Testing

Quick points on HIV/AIDS

The Disease progression is clinically described as follows:

Phase/Stage 1: Early HIV infection is characterised by very little illness possibly

For the first 3 – 6 months following the sero-conversion, when the condition changes from HIV negative to HIV Positive (1 – 2 weeks), these are the commonly recorded illnesses:

- Fever, headache
- Tiredness, malaise myalgia
- Rash
- Sore throat
- Muscle and joint pains
- Some swelling of the lymph glands
- Gastro-intestinal symptoms

Phase 2/Stage 2: Clinical latent or ' silent' infection – The Asymptomatic phase

This is period of good health spanning 3 to 7 years. At this stage the individual's blood test shows very if any damage to the white t-cell. Currently there is a test called viral load test that will show that there are HIV copies in that individual's body, no matter how few.

Phase 3/Stage 3: Minor HIV-related symptoms – minor symptomatic phase

This period lasts for 3 to 7 years before serious illness takes over which last for about 5 – 8 years. Doctors usually recommend Anti Retro Viral (ARV) treatment to reverse the onset of illness:

The following illnesses will plague the individual

- Chronic swelling of lymph glands – neck, maxilla and below the jaw
- Herpes Zoster
- Fevers
- Skin rashes
- Fungal nail infections
- Recurrent oral and vaginal thrush (Candidiasis)
- Recurrent upper respiratory problems

When the condition is not addressed then the stage progresses to HIV- related disease which means all the above illness come up on and off plus:

- Hairy leukoplakia
- Herpes simplex
- Herpes zoster (shingles) recurs
- Persistent fevers and skin infections
- Shrinking of previously swollen glands
- Persistent diarrhoea
- Weight loss of more that 10% of body mass
- Reactivation of previous TB

AIDS - The severe symptomatic phase:

This phase normally lasts for 18 months before the onset of death. All the symptoms or illnesses mentioned above plague the body added to them are:

- Kaposi's Sarcoma – skin cancer mostly prominent in AIDS patients.
- Memory loss and or concentration loss.
- Bouts or one of Cryptococcal Meningitis.
- Severe mental deterioration.
- Retinitis leading to partial of complete blindness
- Cyto Megalo Virus (*attacking digestive tract, eyesight, the brain and other organs*)

It is a fact that Poverty creates the conditions and environment that contributes to the spread of HIV.

