LET'S WORK ON TB AND HIV

International Labour Organization

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Resource Manual

for Peer Educators of Enterprises on **TB and HIV/AIDS** Workplace Programmes

USAID FROM THE AMERICAN PEOPLE

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NACO National AIDS Control Organisation India's Voice against AIDS Ministry of Health & Family Welfare, Government of India www.naco.gov.in

The Union International Union Against Tuberculosis and Lung Disease Health solutions for the poor

CHALLENGE TB

Resource Manual

for Peer Educators of Enterprises on **TB and HIV/AIDS** Workplace Programmes

First published 2019

A Resource Manual for Peer Educators of Enterprises on TB and HIV/AIDS Workplace Programmes

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Dated the 6th June, 2019

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Message

Government of India is fully committed to ending TB by 2025; and ending AIDS as a public health threat by 2030. The Revised National TB Control Programme as well as National AIDS Control Programme envisage working with different ministries, the private sector, employers' and unions.

To address social determinants of health the programme is partnering with various line Ministries for an accelerated response towards Ending TB. I appreciate the leadership provided by the Ministry of Labour and Employment in developing a National Policy Framework on TB and HIV and the world of work in India which provides the framework within which workplace policy and programmes on TB and HIV/AIDS should be implemented. I am also pleased to see that the ILO has already mobilized Indian Employers to sign a joint statement of commitment to work on TB and HIV/AIDS.

The world of work needs policy framework, training and communication tools and it is good to note that the ILO is working on this. The advocacy videos developed by the ILO have already been used in the media campaign of the national TB and HIV programmes.

*In this context, I am extremely pleased to see this manual - **Resource Manual for Peer educators of Enterprises on TB and HIV/AIDS Workplace Programmes** - prepared by the ILO. This manual will go a long way in helping enterprises in their work on HIV and TB.*

*As both HIV and TB affect workers in the prime of their productive lives, we need to expand our efforts in reaching out to workers. We must make all efforts to **detect early and treat early**- both TB as well as HIV.*

I hope enterprises will make good use of this manual and Ministry of Health & Family Welfare (MoHFW) stands committed to working with the Ministry of Labour and Employment (MoLE), enterprises, unions and the ILO in scaling up TB and HIV/AIDS work place initiatives in India.

(Sanjeeva Kumar)

The Union
International Union Against Tuberculosis and Lung Disease
Health solutions for the poor
Union Internationale Contre la Tuberculose et les Maladies Respiratoires
Unión Internacional Contra la Tuberculosis y Enfermedades Respiratorias

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MESSAGE

Ending TB in India is key to ending the global TB epidemic. Embedded in The Union's overarching goal to fight TB globally, USAID funded-Challenge TB project aims to expedite it by engagement with an array of stakeholders to implement a 'Call to Action' for TB Free India.

Towards this end, workplace initiatives have a crucial role to play by not only reaching out to more than 1 million missing TB cases in India but also by promoting a platform for equitable access to health for workers.

The Union is pleased to engage with the ILO, which has been dedicated to the development of a sound policy environment. Bolstered by ILO's capacity development and multi-pronged communications tools, this manual will help to bridge the gap between management and workers, by creating a cadre of peer educators to disseminate knowledge on TB and HIV/AIDS.

The Union will continue to work with the ILO and governments and hope that ILO will continue to offer its technical assistance to enterprises to help them develop their workplace policy and programme on TB and HIV control in India.

I am confident that enterprises, governments and all the stakeholders will find this training manual and communication tools extremely valuable to build a strong foundation and inclusive environment for TB and HIV/AIDS prevention programmes.

Leave no one behind in the fight against TB.

Dr Syed Imran Farooq
Country Director - Challenge TB
The Union South-East Asia
International Union Against Tuberculosis and Lung Disease

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Message

Tuberculosis and HIV/AIDS continue to be two of India's serious public health challenges. India has the highest burden of TB and the third largest number of people living with HIV globally.

Both TB and HIV/AIDS affect people in the prime of their working lives. By detecting early for TB and HIV, and by facilitating treatment of those who get infected, we can keep our workers healthy and productive.

However, experience has shown that TB and HIV/AIDS are not about just treatment. We need to end discrimination and create an enabling environment for people to detect early and adhere to treatment.

Employers' support means a lot to workers living with TB and HIV/AIDS, as has been demonstrated in the case studies globally as well as in India. The lessons is clear – having a secured employment and assurance that people will not face discrimination – contributes immensely to treatment adherence.

I congratulate the Ministry of Labour and Employment, GOI, and Indian employers on their leadership in addressing TB and HIV/AIDS. The National Policy Framework on TB and HIV/AIDS in the world of work; and the Indian Employers' Statement of Commitment on TB and HIV/AIDS approved recently, are important milestones. These policy statements prove that India is strengthening a multi-sectoral response to TB and HIV, and the world of work actors are fully engaged.

ILO stands committed to offering its support to the Ministry of Labour and Employment, Ministry of Health, and employers' and workers' organizations in strengthening the world of work response to TB and HIV/AIDS.

ILO has supported the national HIV/AIDS response since 2001, and has developed useful training and advocacy tools. This manual is another important contribution to enhance awareness about TB and HIV/AIDS among workers.

I trust this will further strengthen the workplace response.

Dagmar Walter
Director

PREFACE

Tuberculosis remains the leading cause of death among people living with HIV, accounting for around one in three AIDS-related deaths. In 2017, there were an estimated 10 million cases of tuberculosis disease globally, including 900,000 (9%) among people living with HIV, according to the WHO. Therefore, there is a need to approach the epidemics of TB and HIV/AIDS in tandem. Addressing one without the other is not going to help.

India stands committed to the goal of 'achieving a rapid decline in the burden of TB, morbidity, and mortality while working towards the elimination of TB' by 2025; and to the goal of 'ending the AIDS epidemic as a public health threat' by 2030. The Revised National TB Control Programme as well as the National AIDS Control Programme, being run by the Ministry of Health envisage a multi-sectoral response with the engagement of the private sector/ employers, enterprises, and trade unions in achieving these goals.

Majority of those affected by TB and HIV/AIDS are in the most productive age group. The ILO in India is engaged in strengthening the TB and HIV/AIDS policy and programme in the world of work in collaboration with the Ministry of Labour and Employment (MOLE), National AIDS Control Organization (NACO), Central TB Division, Employers' and Workers' Organizations, enterprises, UNAIDS, WHO and development partners. A National Policy Framework on TB and HIV in the world of work has been developed which provides overarching policy guidelines. Indian employers have also come forward and signed a joint statement of commitment to TB and HIV/AIDS.

I am pleased to present this **"Resource Manual for Peer educators of Enterprises on TB and HIV/AIDS Workplace Programmes."**

The purpose of the manual is to institutionalize a robust TB and HIV/AIDS workplace policy and programme within enterprises and create a cadre of peer educators who could create awareness amongst workers, work towards ending stigma and discrimination and promote early diagnosis and treatment for TB as well as HIV-related illnesses.

I acknowledge the collaboration and financial support we received from "The Union" under the USAID Challenge TB project, which helped us develop this manual. I hope enterprises and other relevant stakeholders will find this manual useful.

S. M. Baqar
National Project Coordinator,
TB, HIV and AIDS in the World of Work
International Labour Organization
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Special thanks are extended to Central TB Division and National AIDS Control Organization under the Ministry of Health and Family Welfare, Government of India, for their contributions and participation leading to the finalization of this manual.

We would like to acknowledge the contribution of Dr. Pooja Tripathi in redrafting sections, compiling user-friendly resource materials and finalizing the manual after pretesting it in a training programme.

Sincere appreciation is also extended to Ms. Anuradha Sahni, who provided administrative support in finalizing the manual.

We also thank Mr. Syed Mohammad Afsar, Senior Technical Specialist, ILO Gender, Equality, Diversity and ILOAIDS, Geneva, and Ms. Divya Verma, National Professional Officer (Programme), ILO DWT for South Asia and Country Office for India, for their constant guidance and valuable contribution in finalizing this manual.

CONTENTS

ACRONYMS

ACF	Active Case Finding
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
BCC	Behaviour Change Communication
CSR	Corporate Social Responsibility
CXR	Chest X-ray
DBT	Direct benefit transfer
DOTS	Directly Observed Treatment Short Course
DR-TB	Drug Resistant TB
DST	Drug Susceptibility Testing
DTC	District Tuberculosis Centre
ELISA	Enzyme-Linked Immunosorbent Assay
GoI	Government of India
ICTC	Integrated Counselling and Testing Centres
ILO	International Labour Organization
HIV	Human Immunodeficiency Virus
MDR-TB	Multi-Drug Resistant TB
MoHFW	Ministry of Health and Family Welfare
MSM	Men Who Have Sex with Men
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NSP	National Strategic Plans
PLHIV	People Living with HIV
PWID	People Who Inject Drugs
RNTCP	Revised National TB Control Programme
SACS	State AIDS Control Societies
STDs	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection
TB	Tuberculosis
The Union	International Union Against Tuberculosis and Lung Disease
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
XDR-TB	Extensively drug-resistant TB

BACKGROUND

Despite the unparalleled efforts taken by the public sector, private enterprises and non-governmental organizations to manage the epidemics of TB and HIV/AIDS, over the past few decades, TB is still the leading infection cause of adult mortality in the world and caused an estimated 1.4 to 1.7 million deaths in 2017[1] while, HIV related deaths ranged between 670, 000 – 1.3 million.[2]

Worldwide, almost 2 billion (one-third of the population) people are infected with TB, while approximately 8.4 million new cases appear every year[3]. While, 36.9 million people are living with HIV/AIDS, with 1.8 million of newly infected cases globally[4]. The burden of TB in India continues to be the highest in the world, with an estimated incidence of 2.7 million new cases in 2017[5]. On the other hand, while the estimated number of HIV/AIDS cases in India has declined marginally with 2.1 million cases in 2017, the country has the third largest HIV epidemic in the world[6]. A substantial amount of evidence and literature highlights the higher prevalence of TB cases among the HIV endemic population. To illustrate, while the risk of developing TB in non-HIV infected patients is 5 to 10%, people living with HIV/AIDS are 20-30 times more likely to develop active TB than person without[7]. Furthermore, the double burden of HIV and TB does not only increase the probability of deaths but also augment the spread of TB at a faster rate.

However, the majority of the people infected with TB remain either undiagnosed, untreated, or unreported by the current health care system. India alone accounts for more than a million missing cases that are not notified every year.[8] Even patients who are identified having TB are either diagnosed or treated at a very later stage. Conversely, 79% of people living with HIV were aware of their status in India of whom; however, only 56% were on antiretroviral treatment (ART)[9]. Nevertheless, the emergence of multi-drug resistant TB (MDR-TB) has aggravated the situation as an individual infected with not only MDR-TB patients are potentially at a higher risk of mortality but also risk spreading this form of the disease to others. Although, the treatment for MDR-TB is available; the diagnosis and treatment are not only costlier but also longer than the ordinary (drug-susceptible) TB.

TB and HIV/AIDS affect adults mostly in their chief productive years of life and once infected such an individual owing to the disease-led inability has to confront the loss of productivity at not only the workplace but also within the households. Loss of employment, reduced household income, and detrimental socioeconomic impact are significant disease sequelae for both TB and HIV/AIDS. To demonstrate, on an average, an individual infected with TB loses three to four months of his work time annually, which accounts for a loss of 20-30% of the household income. A TB related mortality leads to near about 15 years of income-loss to the family.[10] The tragic loss of life, continuous suffering, and poverty need to be addressed by the engagement of all the stakeholders while identifying the TB cases in its early course of infection and reaching the unreached.

Accordingly, the engagement of enterprises is vital in preventing and controlling the epidemic of TB and HIV/AIDS as these diseases not only have a direct impact on the health and well-being of the employees but also on productivity, labor turnover, loss of skills, increase in expenditure on employees' replacement and training, health care and social security. In the case of TB, the risk of disease transmission increases manifold at workplaces as the workers spend considerable time in close proximities with each other, in confined and sometimes in poorly ventilated rooms. Moreover, certain occupations such as mining, constructions, healthcare, and those working in poor conditions in the informal sector are more predisposed to acquiring active TB disease. According to a recent WHO estimate, out of 8.4 million infected TB patients globally, the majority

are potential wage earners, whose ill health contributes to 30% decline in average productivity and disappearance of US $ 12 billion from the global economy every year.[11]

On the other hand, an HIV-positive worker could face a plethora of problems ranging from isolation at work due to widespread myths about the transmission of the disease to overt discrimination leading to loss of employment. Consequently, such behavior at the workplace could not only discourage other workers from being tested for HIV but also lead to disruption of the production cycle due to stigma inherent to the disease. Enterprises could act as an integral platform to increase the awareness about the disease among the workers and in turn, could contribute to control and destigmatization of the disease.

Despite the barriers linked to work-related concerns such as loss of wages, stigma, discrimination, and inaccessibility to health facilities outside the work hours, TB and HIV are preventable and treatable. However, they continue to have catastrophic consequences for individuals, enterprises, communities, and national economies. Recognizing their impact on an individual's well-being, productivity, and community, there is a need for enterprises to have interventions and strategies aiming at improving the health of the workforce.

RATIONALE

Economically productive age group is hit hardest by TB and HIV/AIDS, compounded by the related mortality and morbidity of these two diseases. As a result, not only these two diseases could compel an individual or a household to poverty, increase in unpaid care in TB/HIV-affected household, but also cause significant loss of productive workforce for any nation. Therefore, it becomes imperative for the enterprises and formal/informal businesses to integrate TB and HIV/AIDS to workplace training component.

Throughout the world, there is a considerable amount of resources available on workplace policies, manuals, and guidelines for integrating TB and HIV/AIDS control activities in the corporate sector. The WHO and ILO jointly developed the first guideline for Workplace TB Control in 2003. Subsequently, a new guideline to improve access to healthcare services, along with prevention, treatment, and management of TB/HIV was released in 2010 which emphasized the necessity of multi-pronged involvement of non-government counterparts of health service provision instead of overreliance on government health infrastructure.

Accordingly, engagement with private enterprises, employers, community groups, and other non-government organizations could ensure improvement in the availability and accessibility of TB and HIV/AIDS management and care. The enterprises could contribute by sharing the responsibility of raising awareness by providing training to the employees on the prevention and management of these two diseases. Moreover, they can also formulate effective workplace policies to safeguard the rights of those infected with TB and HIV/AIDS. This training module should be used as a guiding tool and benchmark to achieve these goals.

Workplace TB and HIV/AIDS control activities and policies could offer both the enterprises and community substantial benefits in the following ways:

- Act as an access point to a large number of vulnerable workers at the same place, and such point-intervention like training can impact a larger populace with lesser resources;
- Providing the opportunity to create awareness and educate the masses and therefore, leading to early diagnosis and adherence to treatment as employees tend to remain in the same location for a more extended period and thus can be encouraged to seek support and guidance when required;

- Help in reducing stigma and discrimination associated with TB and HIV/AIDS, by improving knowledge and ensuring that people infected with these diseases can continue their jobs and are entitled to all the benefits;
- Support in reaching the unreached and tapping the population that has reduced access to the public health system or not reported through it.

TARGET AUDIENCE

This training can be provided to:

- All prospective employers and employees under all forms of arrangements, contracts, and industries;
- Both formal and informal sector functionaries and support staff;
- Those undergoing training, including interns or engagement of any worker with the organization.

DURATION OF TRAINING

The training is offered for two days, with a total of 11 hours session time, generally comprising 7 hours per day.

GOAL AND OBJECTIVES OF TRAINING

The proposed training aims to build the capacity of a cadre of peer educators who can impart knowledge of TB and HIV/AIDS through this manual to their fellow workers. Not only it will help workers and enterprises to gain understanding on TB and HIV/AIDS and discerning the importance of TB/HIV as a workplace issue and therefore, recognize the scope of adapting the existing workplace policies to have an inclusive approach to prevent, treat and manage these two diseases.

The main objectives of the training will be as follows:

- To enhance the knowledge of the participants about TB, HIV/AIDS, MDR-TB and the association between TB and HIV;
- To enable the participants, recognize TB and HIV/AIDS as issues for the world of work by learning key approaches to workplace policies and programmes for prevention, treatment, care and support in reference to TB and HIV/AIDS;
- To empower the participants, recognize their role in implementing TB and HIV/AIDS programmes at their workplace by providing them with the necessary skills and tools to facilitate their work as peer educators.

TRAINING AGENDA

Session Number & Time	Session	Session Objectives	Methodology
Day 1			
9:00 – 9:30 AM	**Registration**		
Session 1.1 9:30 – 10:00 AM	Opening session: Introduction of participants	▪ To create a participatory environment for learning and sharing.	Exercise for Ice-breaking. Facilitation by the resource person
Session 1.2 10:00 – 10:30 AM	Expectation from the workshop and Pre-test questionnaire	▪ To gather expectations of the participants and assess the knowledge/attitudes on the issues; and discuss the objectives of the workshop.	1. Exercise: Writing the expectations on slips of paper and sorting them topic-wise and presenting the workshop agenda by the resource person; 2. Pre-test Questionnaire
Session 1.3 10:30 – 11:30 AM	Inauguration	Suggested speakers: ▪ National or State TB/ AIDS officials /ILO ▪ Address by a TB survivor/ Person Living with HIV/ AIDS ▪ Enterprise management	
11:30 – 11:45 AM	**Coffee/Tea Break**		
Session 2 11:45 – 1:15 PM	TB and HIV/AIDS scenario in India & the national response	▪ To discuss the extent of the problem; ▪ To familiarize the participants with the national responses to TB and HIV/AIDS.	Interactive presentation and facilitation by resource person
1:15 – 2:00 PM	**Lunch Break**		
Session 3 2:00 – 4:00 PM	Basics of TB and HIV/AIDS	▪ To enhance the knowledge level of the participants on TB and HIV/AIDS.	Quiz and discussion. Facilitation by resource person.
4.00 – 4.30 PM	**Coffee/Tea Break**		
Session 4 4:30 – 5:30 PM	Combatting stigma and discrimination associated with TB and HIV/AIDS in the world of work	▪ To provide an understanding of reasons for stigma and discrimination; ▪ To share elements of national policy framework on TB and HIV/AIDS in the World of work.	Game, discussion, Interface with a TB survivor or a person living with HIV/AIDS. Facilitation by resource person.

Session Number & Time	Session	Session Objectives	Methodology
Day 2			
Session 5 9:00 – 10:00 AM	Recap of Day 1	▪ To review the previous day's sessions and revisit key learning in terms of knowledge on TB and HIV/AIDS.	▪ Recap by participants; ▪ Review and facilitation by resource person.
Session 6 10:00 – 11:00 AM	Elements of workplace programme for TB and HIV/AIDS	▪ To enable participants, understand key elements of the workplace policy and programmes on TB and HIV/AIDS.	Interactive discussion; Case study. Facilitation by resource person.
11:00 – 11.30 AM	**Coffee/Tea Break**		
Session 7 11:30 – 1:00 PM	Behaviour Change Communication	▪ To familiarize the participants to the concept/process of behaviour change in the context of TB and HIV/AIDS workplace programme, ▪ To orient the participants to the Inter-personal skills in order to enhance the effectiveness of health education sessions at the workplace.	Interactive presentation, film, discussion; Role plays; Facilitation by resource person.
1:00 – 2:00 PM	**Lunch Break**		
Session 8 2:00 – 3:30 PM	Practice session for participants	▪ To enable the participants, apply their knowledge and skills in creating awareness on TB and HIV/AIDS in their workplace.	Group assignments and presentations. Facilitation by resource person.
3:00 – 3:30 PM	**Coffee/Tea Break**		
Session 9 3:30 – 4:30 PM	Facilitating early detection and treatment for TB and HIV/AIDS at workplaces	▪ To share strategies on voluntary counselling and testing and detection for TB and HIV; ▪ To share strategies on treatment adherence at workplaces and building partnerships with national/state TB and HIV programmes.	Facilitation by resource person.
Session 10 4:30 – 5:30 PM	Valedictory	▪ Participants feedback/ Post-test questionnaire ▪ Future steps after training ▪ Vote of thanks	Facilitation by resource person. Closing remarks by the management

SESSION PLANS

Session 1

OPENING SESSIONS - BUILDING THE WORKSHOP ENVIRONMENT

Duration: 1 hour

Session Objective:

- To create a participatory environment for learning and sharing;
- To gather expectations of the participants and assess the knowledge/attitudes on the issues; and discuss the objectives of the workshop.

By the end of the session, the participants will be able to:

- Introduce themselves to the group;
- List their expectations from the training;
- List and agree on some ground rules for the training;
- Familiarize themselves with the goal and objectives of the training;
- Respond to pre-test knowledge assessment as per their current understanding.

Methodology:

- Ice-breaking exercise
- Gathering expectations of participants and listing them on a flip chart
- Setting ground rules through discussion
- Administering the pre-test questionnaire
- Opening statements by the management and resource persons

Material Required:

- Flip chart/Chart paper
- Pre-test questionnaire
- Whiteboard markers
- Any other material required for the ice-breaking exercise in case a new activity is decided

NOTE FOR FACILITATOR

Activity 1: Ice-breaking

Think of any game/exercise to break the ice and allow for participants to know each other better.

Suggested Exercise:

Encourage participants to move around and form a pair by looking for a person with a birthday closest to theirs. Once they find their pairs, they can be given 5 minutes to know each other on the following points:

- Their partner's name and work they do;
- What does he/she like most about their work;
- Why does he/she want to become a peer educator.

Then ask the pairs to introduce each other.

[Any other technique of pairing or making groups can also be thought out. If the time is less, they can also be asked to know and share their partner's expectations from the workshop. This can then take care of the next activity as well.]

Activity 2: Gathering Expectations

Suggested Exercise:

- Go around the table and ask each participant to express one expectation with which they have come for this workshop;
- Write on a flip chart with some space in between so that similar expectations can be clubbed together when repeated;
- Once the participants are done, use this opportunity to briefly present the agenda and match the sessions with the expectations;
- If there are some expectations beyond the scope of the workshop, it should be specifically told to the participants. If the resource person is confident of handling the expectations, he/she can decide to allow for some time on that after the completion of training schedule;
- Emphasize on the importance of active involvement of each participant in every session.

Activity 3: Setting Training Ground Rules

It is important to set some norms right from the beginning. The best way to begin is from expectations which have one common point- Expectation to learn. This calls for collective action and ensures a cordial workshop environment to facilitate learning.

The facilitator can write on a separate flip chart and display it in the training hall. Norms suggested in Box 1 can be used as guiding points for the group to agree.

BOX 1–TRAINING GROUND RULES

- Punctuality:
  - Adhere to the start and end time for each day and the sessions
  - Maintain the timeliness of tea/lunch breaks
- Mobile phones to be on silent mode during the sessions
- Participants to ask questions during the session
- Maintain respect for each other
- Active participation by all participants
- One person to speak at a time
- Give opportunity to others to speak

Emphasize: ***These are the skills they will need as peer educators!***

Activity 4: Administering the Pre-Test Questionnaire

[A pre and post-test questionnaire is provided in the resource materials. Sufficient copies should be made for the participants while preparing for the training programme.]

- Introduce the session by telling the participants that before the workshop begins, it will be good to assess what all participants know about TB and HIV/AIDS as it will help the facilitators to assess the current level of individual's knowledge and therefore, will act as signpost to focus on particular topics;
- Similar test (post-test) will be administered towards the end of the training. Therefore, the effectiveness and quality of the sessions delivered can be measured by the improvement in participants' knowledge at the end of the workshop;
- Distribute a copy to each participant at the beginning of the training and ask them to fill it;
- Ask the participants to put the date and name on the answer sheet, however, do inform them that writing their names is not mandatory.

Activity 5: Video

- For the inauguration session, while waiting for the key speakers to arrive, present the following videos to orient the participants for the upcoming sessions.
- Click on the link below to show the videos:

Link to the Video:
https://youtu.be/1BjeAogBewI

Session 2

TB AND HIV/AIDS SCENARIO IN INDIA & THE NATIONAL RESPONSE

Duration: 1 hour and 30 minutes

Session Objective:

- To discuss the extent of the problem of TB and HIV/AIDS;
- To familiarize the participants with the national responses towards the two epidemics.

By the end of the session, the participants will:

- Understand the magnitude of the TB and HIV/AIDS issues globally and in India;
- Be familiar with the main components of India's response to TB and HIV/AIDS;
- Recognize the key HIV/AIDS affected population in India;
- Understand the concept of Targeted interventions;
- Know about the HIV/AIDS Act, 2017.

Methodology:

- Exercise: Missing word or number game
- Discussion

Materials required:

- Paper slips with missing numbers and words (for Missing Word or Number Game)
- Computer/Laptop
- LCD Projector
- Links to the video films

NOTE FOR FACILITATOR

Activity 1: Missing Word or Number Game

- Start the session by distributing Cards/Paper slips to participants;
- Prepare cards in such a way that most crucial word or number concerning TB and HIV/AIDS scenario should be missing in the statement so that participants may think over it;
- Complete the exercise by involving each participant

Activity 2: Interactive PowerPoint Presentation on TB and HIV/AIDS Scenario in India & The National Response

- Discuss TB and HIV/AIDS scenario by using PowerPoint presentation;
- PowerPoint should also cover:
    - Present a comparative data (Global vs. National);
    - Annual burden of TB MDR-TB, HIV/AIDS, TB-HIV co-infection;
    - Key population vulnerable to TB and HIV/AIDS;
    - Components of national strategic plan, highlighting the focus on multi-sectoral response and the role of the private sector;
    - The presentation should be short, not more than 15 slides to allow time for interaction.

Activity 3: ILO's "Let's work on it"

- Show the video prepared by ILO- "Let's work on it" by clicking on the link below: https://www.ilo.org/newdelhi/info/public/vid/WCMS_615969/lang-- en/index.htm
- After the video, discuss main issues raised in the film:
    - TB statistics (death in a minute);
    - Doctor's remark on treatment compliance and availability of services;
    - TB survivor's message on necessity of treatment compliance;
    - MDR-TB patient's message on family support;
    - Various forms of stigma associated with TB.

Emphasize: that TB statistics changes as a result of surveillance. So, keep updating national and global scenario from:

- https://www.who.int/
- https://tbcindia.gov.in/

Session 3

BASICS OF TB AND HIV/AIDS

Duration: 2 hours

Session Objective:

- To enhance the knowledge level of the participants on TB and HIV/AIDS.

By the end of the session, the participants will:

- Know the transmission, symptoms, diagnosis, prevention, and treatment of TB and HIV/AIDS;
- Understand the basic concepts on: population vulnerable to TB, MDR-TB and ways to prevent it; Pulmonary-TB and Extra-pulmonary TB; the window period;
- Recognize the connection between HIV and other sexually transmitted diseases;
- Recognize the impact of TB and HIV/AIDS on the workplace;
- Appreciate the role can workplace play in preventing the spread of TB infection
- Understand their role as a peer educator for prevention of TB and HIV/AIDS at workplace.

Methodology:

- Card game
- Discussion
- Presentation

Materials required:

- A set of Card game
- Computer/Laptop
- LCD Projector
- PowerPoint Presentation

NOTE FOR FACILITATOR

Activity 1: Card Game on the Basics of TB and HIV/AIDS

- It is a pack of 20 cards of questions and 20 cards of answers on topics pertaining to TB, Drug-resistance TB and HIV/AIDS;
- Questions cover a range of topic on the two diseases with a particular focus on the transmission, symptoms, diagnosis, prevention, and treatment of TB, MDR-TB, and HIV/AIDS at workplace.

Tips:

- 'Q' printed on the top left corner of the card indicates a question card;
- 'A' printed on the top left corner of the card indicates an answer card;
- The number of the question and the answer card is mentioned at the bottom-right corner of the card;
- Use the 'cut here' line to divide each page into a question card and an answer card;
- The first card provides directions to use the card game.

Steps to Conduct the Card Game:

- Depending upon the number of participants, select an equal number of questions and answer cards;
- Distribute the cards so that each participant receives either a question or an answer card;
- For example:
    - If the number of participants is 30, select only 30 cards: 15 questions and 15 answers for the first round;
    - Once the first round is over, take the rest of the cards and complete 40 cards.
- With the help of the answers provided, ensure that the questions are thoroughly discussed.

Session 4

COMBATTING STIGMA AND DISCRIMINATION ASSOCIATED WITH TB AND HIV/AIDS IN THE WORLD OF WORK

Duration: 1 hour

Session Objective:

- To provide an understanding on reasons for stigma and discrimination;
- To share elements of national policy framework on TB and HIV/AIDS in the World of work.

By the end of the session, the participants will:

- Learn the common myths surrounding TB and HIV/AIDS and the truth behind them;
- Understand stigma and discrimination associated with TB and HIV/AIDS;
- Learn the impact of stigma;
- Understand the measures that can be taken to reduce it.

Methodology:

- Games
- Interface with a TB survivor or a person living with HIV/AIDS or video produced by the ILO if it is not possible to get a person.
- Discussion

Materials required:

- Paper slips with three statements
- Flip chart
- Marker pens
- Computer/Laptop
- LCD Projector
- Power Point Presentation
- Links to the video film

NOTE FOR FACILITATOR

Activity 1: Two Lies and A Truth Game

- Distribute card or paper slips to participants with three statements (two incorrect and one correct statement);
- Ask each participant to read the three statements;
- Ask them to find out which one of the three statements they think is correct and why;
- If there is a disagreement, then discuss and tell them why a particular answer is correct;
- In this way all wrong perceptions and myths associated with TB and HIV/AIDS will be dispelled.

Activity 2: Interface with a TB Survivor or a Person living with HIV

- Invite a TB survivor or a person living with HIV/AIDS;
- Request them to share their story;
- This should be a moderated exercise with the aim to gain some insight from this person's experience;
- The experience sharing should include:
    - What did they feel when they were diagnosed?
    - Would they like to share any discrimination that they faced, particularly at work;
    - How was the treatment initiated;
    - Support received from the family and the society;
    - Feelings about their recovery;
    - Challenges they have been facing during the course of the disease;
    - Their main message to the leaders of world of work.

Activity 2b: Video - Story of Dipti (a TB Survivor)

This activity should be conducted only if an interface with a TB survivor or a person living with HIV/AIDS is not possible.

- Show the video by clicking on the following link:
  https://www.youtube.com/watch?v=hvaormVq0vE
- After the video, discuss the main issues raised in the film:
    - Dipti's message on necessity of treatment compliance;
    - Her message on family support;
    - The challenges that she faced during her journey of recovery from TB.

Activity 3: Word Association Game

- This game is based on the MODE model, points suggested in Box 2 can be used as guiding points for the group to understand the concept.
- Explain to the participants that they will see four random words on the flip chart.
- On seeing the words, the participants have to say the first word(s) that come to the mind when they think of the word written on the flip chart.
- On a flip chart, write the word 'Boss' and ask the participants to say the first word(s) that came to their mind.
- Ensure that at least half the participants share their thoughts.
- Display only word at a time;

- Repeat the process with the following words:
  - 'Alcohol and Cigarettes'
  - 'Mother'
  - 'Sex worker'
- Explain to the participants that this model can be applied to the interventions required to reduce the stigma associated with HIV and AIDS.

BOX 2–MODE MODEL

(Motivation and Opportunity as Determinants of the attitude-behavior relation)

Attitude:

- Individual's negative or positive association to a given object.
- One's attitude towards any object is the product of the memory between the object and the individual's evaluation of it, whether negative or positive.
- The association between the object and its evaluation varies and can be either strong or weak.

MODE Model:

- According to this model, our behavior is driven by our attitudes, particularly a strong one. Strong attitudes lead people's behavior toward positive or socially acceptable things or outcomes.
- Some of these social behaviors are automatic, i.e., spontaneous, while other behaviors are deliberative.
- The deliberative behaviors evaluate the costs and benefits of an attitude-relevant behavior.
- In other words, depending on a given situation, we can override our negative attitude towards a certain object and change our behavior if we have the opportunity in terms of time, and ability to overcome the effect of that attitude.
- The MODE model can be applied to the interventions required to reduce the stigma associated with HIV and AIDS.
- Hence, by changing the behavior that is expressed towards HIV and AIDS, even if the attitude does not change immediately, could result in gradual change in the attitudes causing the stigma.

Activity 4: Interactive Power Point Presentation on the Negative Impact of Myths and Stigma

- Discuss the negative impact of the myths and stigma surrounding TB and HIV/AIDS on:
  - Disclosure of the disease or HIV status;
  - Diagnosis and counselling;
  - Access to care.

Day 2
Session 5

RECAP OF DAY 1

Duration: 1 hour

Session Objective:

- To review the previous day's sessions and revisit key learning in terms of knowledge on TB and HIV/AIDS.

By the end of the session, the participants will be able to:

- Recapitulate the key messages and learning from the sessions covered on the day 1.

Methodology:

- Recap by participants;
- Review and facilitation by resource person.

Materials required:

- Flip charts
- Marker pens

Suggested Exercise:

- Welcome the learners on the second day of the workshop;
- Start the session with a recap of key points discussed on day one;
- Ask each participant to recall important learning, message, data or information that they liked most;
- Allocate approximately 2-3 minutes to each person;
- If a participant gives a wrong message or forgets any key information, ask other participants to volunteer;
- Clarify doubts if any, from previous day's sessions.

Session 6

ELEMENTS OF WORKPLACE PROGRAMME FOR TB AND HIV/AIDS

Duration: 1 hour

Session Objective:

- To enable participants, understand key elements of the workplace policy and programmes on TB and HIV/AIDS.

By the end of the session, the participants will:

- Understand the role of the workplace in TB and HIV/AIDS prevention;
- Know the steps in the development of a workplace programme.

Methodology:

- Interactive presentation
- Film
- Case study
- Discussion

Materials required:

- Computer/Laptop
- LCD Projector
- PowerPoint Presentation
- Links to the video film
- Copy of Case study

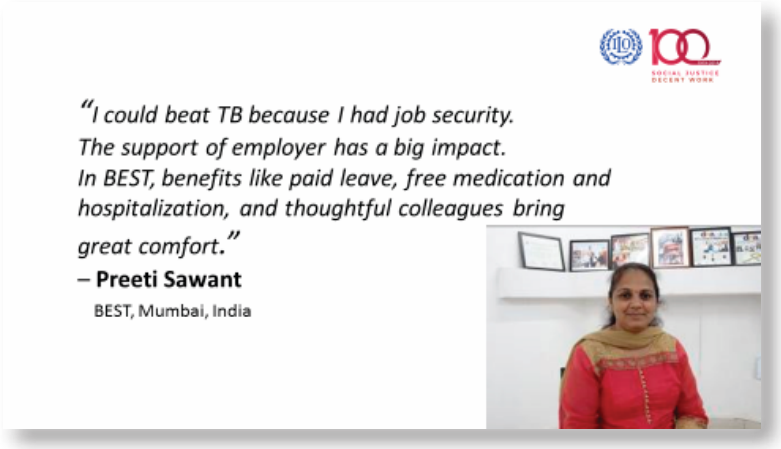
NOTE FOR FACILITATOR

Activity 1: Interactive PowerPoint Presentation on 'Why should workplaces discuss TB and HIV'

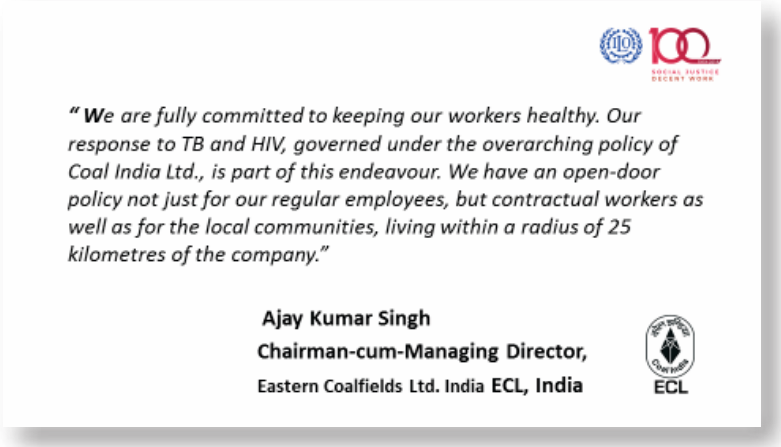
- Start the session with the PowerPoint presentation "Why should workplaces discuss TB and HIV."
- After taking participants' responses, discuss the effect on productivity due to these illnesses and other crucial statistics to make them realize the importance of TB and the need for multi-stakeholder intervention.
- Gradually steer the discussion to the 'Role of the workplace' in TB and HIV/AIDS prevention.
- Capture participant's response on early diagnosis, treatment adherence, and reducing stigma and discrimination associated with TB and HIV/AIDS.
- Build a consensus among participants on the role of workplaces and the need for multi-stakeholder engagement for TB and HIV/AIDS.

Activity 2: Case Study

Present the photograph and statement of a survivor (Preeti Sawant from BEST Mumbai) to highlight the role of an organization in the successful treatment of MDR-TB.



Similarly, present a positive statement or pledge from the chairman of a workplace to emphasize the commitment of top leadership in TB prevention (Chairman cum Managing Director, ECL).



- Discuss the significance of the engagement of people living with TB and HIV/AIDS as the best advocates and crucial in dispelling the myths prevalent in the society about TB and HIV/AIDS.
- Discuss necessary steps to be taken to develop a workplace policy and programme: formation of a committee, appointment of a nodal person, training, and awareness programmes.
- Discuss the **Elements of Workplace Policy:**
    - Recognition of TB and HIV as workplace issues
    - Non-discrimination
    - Healthy work environment
    - Social dialogue
    - Gender equality
    - Confidentiality
    - Continuation of employment and reasonable accommodation
    - Prevention
    - Treatment, care and support.

The policy should be developed through an internal committee, involving workers and their representatives; and should encompass the following principles:

The purpose of a policy is to ensure a consistent and equitable approach to the implementation and integration of TB prevention, treatment and care activities with related HIV workplace programmes among employees, their families as well as the communities in which the business is situated.

Benefits of a Workplace Policy on TB and HIV:

- Supports early detection and treatment of employees and keeps them healthy and productive;
- Supports employees affected by HIV and TB to understand what support and care they will receive, assures non-discrimination, their employment protection status, so that they are more likely to come forward for appropriate treatment;
- Measures consistency with appropriate national policies and legislation;
- Makes an explicit commitment to corporate action;
- Establishes and protects the rights of those affected;
- States a standard of behaviour for all employees (whether infected or not);
- Provides guidance to supervisors, managers, unions, human resource and occupational health professionals;
- Helps to control the spread of TB and HIV;
- Assists an enterprise in planning for TB and HIV care and control.

Activity 3: Drawing on Session 2 to Highlight the Role and Importance of Workplace

- Recall session 2 on TB and HIV/AIDS scenario in India and draw out responses on the role and importance of the workplace in:
    - Active case finding;
    - Effect on productivity;
    - Care and treatment;

- Contractual workers/migrants associated with the workplaces;
- Corporate Social Responsibility (CSR) initiatives;
- Community surrounding workplace;
- Hospitals and clinics associated with the workplace;
- The social commitment of the workplace;
- In meeting the national priority of ending TB by 2025 and Ending AIDS as a public threat by 2030.

"Our company is fully committed to ending AIDS through a comprehensive programme that covers employees, truckers and communities along the highways in collaboration with the ILO. Take an HIV test today. You have the full support of the company."

D.P. Agarwal,
Chairman, Transport Corporation of India

"Early HIV testing is a game changer to ending AIDS as early detection leads to early and effective treatment. So, take the HIV test, live a healthy life, and continue to be a good performer at work."

Dr. Ajay Kumar Gupta,
Director Health Service Department of Health & Family Welfare,
Govt. of Himachal Pradesh, India

"Early diagnosis of HIV helped me to initiate treatment on time. I am leading a healthy life since 1997 and working perfectly well. So, my message to all is take the HIV test early to stay healthy and productive!"

Daxa Patel, President,
National Coalition of People Living with HIV in India (NCPI+)

Session 7

BEHAVIOUR CHANGE COMMUNICATION

Duration: 1 hour and 30 minutes

Session Objective:

- To familiarize the participants to the concept/process of behaviour change in the context of TB and HIV/AIDS workplace programme;
- To orient the participants to the Interpersonal skills to enhance the effectiveness of health education sessions at the workplace.

By the end of the session, the participants will:

- Learn the main concepts of BCC;
- Acquire basic communication and training skills;
- Role of Interpersonal Communication (IPC).

Methodology:

- Interactive presentation
- Film
- Role play
- Discussion

Materials required:

- Computer/Laptop
- LCD Projector
- PowerPoint Presentation
- White board or Flip charts
- Marker pens

NOTE FOR FACILITATOR

Activity 1: Interactive PowerPoint Presentation on 'Behaviour Change Communication (BCC)'

- Start the session with a brief PowerPoint presentation on 'Behaviour Change Communication (BCC);'
- Use the presentation as an introduction to the components of BCC;
- After the initial discussion on BCC, gradually lead the discussion towards the role of a Peer educator in BCC;
- Ask the participants' opinion on the characteristics of a good peer educator.

Activity 2: Basic Communication and Training Skills

- Ask the participants to think of someone who they consider to be an excellent communicator and ask them to remember the qualities in the person;
- Invite participants to mention the qualities of an excellent communicator;
- Write the responses as they are mentioned on a board or flip chart;
- Categorize the responses if possible under skills and attitudes;
- Highlight the importance of the right attitude for becoming an excellent communicator.

Activity 3: Role play

- Inform the participants that two role plays will be conducted;
- The first role play will be based in a formal setting and the other in an informal setting;
- **For Formal Setting:** Peer educator will deliver a session based on transmission, symptoms, and diagnosis of TB, MDR-TB, and HIV/AIDS in 15 minutes in an interactive way using a card game or another preferred method;
- **For Informal Setting:** Peer educator will talk about TB and HIV/AIDS their consequences, prevention, and treatment services with a group of co-workers assembled casually during their free time or a coffee break;
- After the completion of the role play, ask the participants to compare the qualities of an excellent communicator listed in the previous (Activity 2) with the role plays conducted.
- Facilitate the discussion and summarize the following tips of verbal and non-verbal communication:
    - Keep language simple (the language that target audience understand);
    - Avoid using technical jargons;
    - Make the communication interactive;
    - Take regular feedback from the audience;
    - Maintain eye contact;
    - Listen well;
    - Be observant;
    - Show respect to participants;
    - Be honest;

- Shows genuine concern;
- Be careful of the volume and tone of your voice;
- Encourage questions

Activity 4: Interpersonal Communication (IPC)

- Discuss the essential characteristics of IPC with the group. Stress that IPC is effective in both formal and informal sessions and peer educators must endeavour to be adept at IPC.
- Summarize the discussion and highlight the key points:
  - Initiate rapport building with people is very important. This helps in understanding the target audience and relating the subject to their context.
  - Access the group's needs and create interest on the subject;
  - Timing is very crucial. When to begin and when to conclude the session is critical;
  - Create a conducive environment;
  - Introduce the matter properly, provide appropriate information based on the needs of the group;
  - Give relevant examples as much as possible;
  - Involve your audience; communication should be two-way;
  - Address questions and allow room for seeking clarifications;
  - Use appropriate communication tools (audio-visual aids);
  - Take feedback and summarize the key messages at the end of the session;
  - Highlight the action points.

Session 8

PRACTICE SESSION FOR PARTICIPANTS

Duration: 1 hour and 30 minutes

Session Objective:

- To enable the participants, apply their knowledge and skills in creating awareness on TB and HIV/AIDS in their workplace.

Methodology:

- Group assignments
- Interactive presentation
- Role plays
- Discussion

Materials required:

- Computer/Laptop
- LCD Projector
- PowerPoint Presentation

NOTE FOR FACILITATOR

- Randomly allocate participants into three-four equal groups;
- Each group spends 10 minutes for going over the card game on questions and answers.

Group Planning and Delivering of Practice Sessions:

- Participants will work together to plan and then deliver a training session in the allocated time;
- Allot 30 minutes to each group; 10 minutes for brainstorming and 20 minutes for presenting the session;
- Inform the group to select two people among themselves to deliver the session;
- Advise the groups to highlight only the critical points of the sessions so that they can complete their presentation in the allocated time;

Group Feedback Discussion: After both the groups have completed their presentation, ask them to self-critique their performance and welcome constructive feedback from the observers.

- During the last 15 minutes of this session, provide feedback on the following points:
    - The objectives of the session were clearly presented;
    - Participation and interaction were encouraged by the presenters;
    - Their approach towards answering observers' questions;
    - Speech: articulation, the intonation of speech, appropriateness of words;
    - Use of hand gestures, and overall body language.

- Ensure all participants understand the total amount of time allocated to each group;
- Emphasize that it will not be possible to present all the facts and the points that were presented during the sessions;
- The practice sessions will mostly focus on the style of presentation, participant engagement, and interaction;
- Interrupting a practice session and correcting the technical content of the presentation by the observers should be discouraged.

Session 9

FACILITATING EARLY DETECTION AND TREATMENT FOR TB AND HIV/AIDS AT WORKPLACES

Duration: 1 hour and 30 minutes

Session Objective:

- To share strategies on voluntary counselling and testing and detection for TB and HIV/AIDS;
- To share strategies on treatment adherence at workplaces and building partnerships with national/state TB and HIV/AIDS programmes.

By the end of the session, the participants will:

- Realize the need of the intervention and benefits of VCT@WORK and the provision of linkages at workplace for TB and HIV/AIDS;
- Recognize the main barriers to TB and HIV/AIDS treatment adherence;
- Know the main measures to overcome these barriers.

Methodology:

- Videos
- Group assignments
- Interactive presentation
- Role plays
- Discussion

Materials required:

- Computer/Laptop
- LCD Projector
- PowerPoint Presentation

"We have received a very positive response from employees on voluntary counselling and HIV testing. We stand committed to expanding VCT@WORK. It is good for the employees, and it is good for the company."

Dr. Manju Khandeparker,
Dy. Chief Medical Officer,
Mormugao Port Trust, Goa, India

NOTE FOR FACILITATOR

Activity 1: Interactive PowerPoint Presentation on "Voluntary Counselling and Testing for workers–VCT@WORK"

- Start the session with the PowerPoint presentation "Voluntary Counselling and Testing for workers- VCT@WORK;"
- After capturing participants' responses, discuss the need of the intervention and benefits of having such facility or linkages at workplace for TB and HIV/AIDS;
- Encourage the participants to share their experiences with testing and detection for TB and HIV.

Activity 2: Strategies to Enable Treatment Adherence at Workplaces and Building Partnerships with National/State TB and HIV/AIDS Programmes

- Draw on from the discussion in Session 6 on Elements of workplace programme to TB and HIV/AIDS, and brainstorm on the 'barriers to TB and HIV treatment adherence,' by focusing on barriers related to:
- Health System Factors:
    - Accessibility to a public/private health facility
    - Interaction with health personnel
    - Challenges in receiving the DOTS therapy
- Knowledge and Attitude towards TB and HIV/AIDS:
    - Education and information about the diseases
    - Awareness of the duration of the treatment regimen
    - Beliefs about TB and co-infection
    - Stigma (fear of social avoidance, loss of employment and social support)
- Drug Regimen Factors:
    - Pill burden
        - perceived fear that high number of pills will cause potential damage to the body;
        - perceived fear that too many drugs will not be tolerated well by the body;
    - Side effects of the drugs
    - Perception of "felt better"
- After capturing participants' responses, discuss the measures that can be taken at the workplace to strengthen the treatment adherence through:
    - Health information sessions;
    - Demystification of commonly held beliefs;
    - Reduction in stigma;
    - Flexible timing and closer distance of the site providing the treatment;
    - Wage-loss compensation;
    - Conduct periodic TB screening, and Active Case Finding (ACF) campaigns

- Development of partnerships between the companies and hospitals;
- Integration of TB and VCT@WORK services at the workplace.

- The participant-led discussion should draw on the key messages delivered from all the previous sessions to ensure all the barriers and interventions to tackle them are discussed and fully acknowledged by the participants.
- Emphasize the problem of "missing" TB and HIV cases every year by reminding the participants that:
  - India has more than a million "missing" TB cases every year - not notified, undiagnosed, or inadequately diagnosed and treated in the private sector;
  - In India only 79% of all people living with HIV (PLHIV) know their status, of which only 56% are on treatment;
- Stress on the negative impact of 'missing cases' on the individual, community, and society collectively.

RESOURCE MATERIAL

ANSWER KEY PRE/POST-TRAINING TEST QUIZ

Q. 1 Tuberculosis (TB) is caused by?
- **a) Bacteria**
- b) Virus
- c) Parasites
- d) All of the above

Q. 2. How do you get TB?
- a) Through sexual contact
- **b) Through the air**
- c) Through blood
- d) Through polluted water
- e) B and C

Q. 3. TB can be transmitted by sharing plates/cups with an infected person.
- a) True
- **b) False**

Q. 4. Who can develop TB out of the following? (Can tick multiple response)
- **a) Smoke cigarettes**
- b) Use chewable tobacco
- c) Consume liquor but do not smoke
- d) Do not smoke, consume liquor or chew tobacco
- e) Very poor
- f) All of the above
- g) None of the above

Q. 5. You should get tested for TB only if you have cough as a symptom?
- a) True
- **b) False**

Q. 6. TB can infect a person only once in a lifetime, once treated you become immune to TB?
- a) True
- **b) False**

Q. 7. HIV/AIDS is caused by?
- a) Bacteria
- **b) Virus**
- c) Parasites
- d) All of the above

Q. 8. How is HIV transmitted? (Can tick multiple response)
- a) Unprotected sex with an infected person
- b) Transfusion of infected blood or blood products
- c) Sharing of needles contaminated with infected blood
- d) From infected mother to her baby
- **e) All of the above**

Q. 9. Can a person become infected if he or she uses the same toilets as someone who is HIV-positive?
- a) Yes
- **b) No**

Q. 10. Can a person become infected with HIV from a mosquito bite?
- a) Yes
- **b) No**

Q. 11. A person suffering from Sexually transmitted infection (STI) has a high chance of HIV/AIDS exposure?

a) True
b) False

Q. 12. There is no treatment for HIV/AIDS?

a) True
b) False

Q. 13. Once diagnosed, a person with HIV/AIDS only has a few years to live?

a) True
b) False

Q. 14. Would you be comfortable to work alongside a co-worker who is HIV-positive or has TB?

a) Yes
b) No

Q. 15. If one of your co-workers is diagnosed with HIV/AIDS or TB, in your opinion should they be allowed at work?

a) Yes
b) No

Q. 16. Is there any link between HIV and TB?

a) Yes
b) No

Session 2

TB AND HIV/AIDS SCENARIO IN INDIA & THE NATIONAL RESPONSE

BURDEN OF TB IN INDIA

- Globally, one-third of the population is infected with TB;
- According to the 2017 estimates, the incidence rate of TB in India (new cases per lakh population per year) was 204;
- The burden of TB in India continues to be the highest in the world, with an estimated 27 lakh people developed TB in 2017;
- Out of these 27 lakh cases of TB, only 17 lakh cases were notified ('Missing Cases')
- India is the country with the highest burden of both TB and MDR-TB;
- MDR-TB -prevalence in new cases is around 3.6% and 17% in previously treated cases;
- In 2017, TB caused an estimated 1.6 million (16 Lakh) deaths across the world, out of which 4.5 lakh people who died due were from India;
- But these deaths can be prevented, and with timely and proper care and treatment, TB patients can be cured, and the battle against TB can be won.

NATIONAL RESPONSE TO TB

- In India, TB control initiatives are carried under the government's Revised National TB Control Programme (RNTCP). Since its inception, the program has gone through several strategic changes and improvement in quality and access across the country.
- The programme provides quality diagnostic and treatment services at no user fee in the government health facilities.
- The programme is managed by the Central TB Division of Directorate General Health Services (MoHFW) at the national level. State TB Cell is the nodal agency at the state level, followed by District Tuberculosis Centre (DTC) for TB control in the district.
- Directly Observed Treatment Short Course (DOTS) strategy is the mainstay of RNTCP and ensures treatment, management, and compliance.
- RNTCP is responsible for carrying out the five-year TB National Strategic Plans (NSP) released by the Government of India (GoI) to set out strategies and interventions needed to eliminate TB in India;
- **Notifiable Disease:** To ensure proper and timely diagnosis, standardized TB care and management, and reduce TB transmission and fight emergence of drug-resistant TB (DR-TB), GoI has declared TB as a notifiable disease. Therefore, health care providers (clinical establishment run by the government/ Private clinics/ NGOs/Local practitioners) shall notify every TB case to local health/municipal authorities every month.
- NSP 2017-25 has envisaged TB free India with zero deaths, disease, and poverty due to TB and is based on the four strategic pillars of "Detect – Treat – Prevent – Build."
- These four strategic pillars encompass several multifaceted measures. Ranging from early identification at the first point-of-care (public and private sector), universal testing for DR-TB, integrating highly sensitive diagnostic tests through rapid molecular testing for the laboratory confirmation of TB and DR-TB, to patient-centric approach to improving adherence monitoring.

- Strengthening the private provider engagement approaches is one of the overarching thrust areas and ensures that free of cost diagnostic tests and drugs are provided to TB patients seeking treatment from the private health sector.
- **Policy Framework to address Tuberculosis, TB related co-morbidities and HIV in the World of Work in India:** The GoI has developed the policy framework to provide guidelines to all stakeholders in the world of work to facilitate an enabling environment to prevent new infections, early case detection, access to free treatment and treatment adherence towards TB and its co-morbidities, including HIV (More information available in Relevant Policy Document on Page 38).
- **Nikshya Poshak Yozana:**
    - Is a Direct benefit transfer (DBT) scheme launched by the GoI, through which Rs. 500/- per month is provided for nutritional support to each notified TB patient for the duration of their TB treatment.

BURDEN OF HIV/AIDS IN INDIA

- Worldwide, 36.9 million (369 Lakh) people are living with HIV/AIDS, with 1.8 million (18 Lakh) of newly infected cases in 2017;
- India has the third largest HIV epidemic in the world, with 2.1 million (21 Lakh) cases at the end of 2017;
- In 2017, around 88,000 new HIV infections were estimated in India;
- In India only 79% of all people living with HIV (PLHIV) know their status, of which only 56% are on treatment;
- A large number of people with HIV do not get tested or access treatment until the later stages of the disease;
- The prevalence of HIV is higher than the national average among the key population affected with HIV/AIDS;
- **Key affected populations:** in India are Commercial Sex Workers, Men who have sex with men (MSM), People who inject drugs (PWID), Transgender people, Migrant workers, Truck drivers;
- **Bridge Populations:** Migrant workers and truck drivers are categorized as 'bridge populations,' as they form links between urban and rural areas, and between groups that are at high- and low risk of HIV transmission;
- It has been reported that 75% of women testing positive in India have a husband who is a migrant labourer;
- PLHIV are 20-30 times more likely to develop active TB than a person without;
- TB infection also makes the progression of HIV infection to AIDS faster.

NATIONAL RESPONSE TO HIV/AIDS

- National AIDS Control Organisation (NACO) is the apex level body within the Ministry of Health & Family Welfare, GOI, which plans and coordinates the national response to HIV/AIDS;
- State AIDS Control Societies (SACS) are the nodal agencies at the state level who receive support from NACO and work in collaboration with different agencies;
- Resources for the national programme are mobilized from GOI, World Bank, Bilateral/donor agencies, and the UN agencies;

- The first phase of the National AIDS Control Programme (NACP) began in 1992, continued till 1999;
- At present, India is in Phase IV of NACP (2012-2017, extended to 2018);
- A key component of the NACP-IV is the prevention of new HIV infections by reaching 80% of key affected populations with targeted interventions;
- **Targeted Interventions:** are based on the strategy that prevention of HIV transmission among key affected populations will also lower HIV transmission among the general population;
- **Diagnosis:** Testing for HIV can be done free of cost at Integrated Counselling and Testing Centres (ICTC). ICTC also provide necessary information on the modes of HIV transmission and promoting behavioural changes; and help establish the link with HIV/AIDS prevention, treatment, and care services.
- **Treatment:** People detected as HIV-positive at ICTCs can receive life-long free treatment and care at Anti-Retroviral Therapy (ART) Centres.
- **HIV/AIDS Act:** The GoI has implemented HIV/AIDS (Prevention and Control) Act[12] 2017. The act aims to protect the rights of PLHIV by prohibiting discrimination against them. Denial, termination, discontinuation or unfair treatment concerning employment, educational establishments, health care services, residing or renting property, standing for public or private office, and provision of insurance of any person diagnosed with HIV/AIDS is prohibited.

Missing Word or Number Game

I.

1. Globally, in 2017, 10 million (1 Crore) people fell ill from TB, which is 27,400 people every day.
2. Globally in 2017, 1.6 million (16 Lakh) people died from TB, that's over 4,400 people every day.
3. TB is the leading killer of people living with HIV.
4. India is the country with the highest burden of both TB and MDR-TB.
5. In 2017, 27 lakh people developed TB in India.
6. Out of these 27 lakh cases of TB, only 17 lakh cases were reported.
7. Health care providers (clinical establishment run by the government/ Private clinics/ NGOs/Local practitioners) shall notify every TB case to local health/municipal authorities every month.

II.

8. TB treatment should be done through the DOTS strategy.
9. People affected with TB lost 3-4 months of work time annually, and 20-30% of the household earnings.
10. No country has ever eliminated TB.
11. India has the third largest HIV epidemic in the world, with 2.1 million (21 Lakh) cases at the end of 2017.
12. In 2017, around 88,000 new HIV infections were estimated in India.
13. In India only 79% of all people living with HIV (PLHIV) know their status, of which 56% are on treatment.
14. People detected as HIV-positive can receive life-long treatment at Anti-Retroviral Therapy (ART) Centres for free.

POLICY FRAMEWORK TO ADDRESS TUBERCULOSIS, TB RELATED CO-MORBIDITIES AND HIV IN THE WORLD OF WORK IN INDIA 2019

Contents

Acronyms

AFB	Acid-Fast Bacilli
HIV	Human Immunodeficiency Virus
ILO	International Labour Organization
MDR	Multi-Drug Resistant
MoHFW	Ministry of Health and Family Welfare
MoLE	Ministry of Labour and Employment
NSC	National Steering Committee
NTP	National Tuberculosis Program
OI	Opportunistic Infection
RNTCP	Revised National Tuberculosis Control Program
TB	Tuberculosis
WHO	World Health Organization
XDR	Extensively Drug Resistance
NACO	National AIDS Control Organization

Standard Definitions:

Worker refers to any persons working under any form or arrangement.

Workplace refers to any place in which workers perform their activity.

Stigma means the social mark that, when associated with a person, usually causes marginalization, or presents an obstacle to the full enjoyment of social life by the person infected or affected by HIV and/or TB.

Discrimination is the expressed behaviour towards a worker based on the individual's perceived HIV and/or TB status, including discrimination on the ground of sexual orientation.

Reasonable accommodation is any modification or adjustment to a job or to the workplace that is reasonably practicable and enables a person living with HIV or AIDS and/or TB to have access to, or participate or advance in, employment.

Vulnerability refers to socio-economic disempowerment, cultural context and work situations that make workers more susceptible to the risk of infection (HIV/TB) and situations which put children at greater risk of being involved in child labour.

Tuberculosis and its co-morbidities: Tuberculosis (TB) includes Multi-Drug Resistant (MDR) and Extensively Drug Resistant (XDR). The co-morbidities include tobacco, alcohol and HIV.

Scope of the Policy Framework

This policy framework covers all workers working under all forms or arrangements, and all workplaces covering formal as well as workers engaged in informal economy.

Goal and objectives of the policy framework

The overall goal of this policy framework is to provide an operational framework to all stakeholders in the world of work towards the goal of eliminating tuberculosis (TB) by 2025, by facilitating an enabling environment to prevent new infections, early case detection, access to free treatment and treatment adherence towards TB and its co- morbidities, including HIV.

The policy framework builds on the 'National Policy on HIV/AIDS and the world of work' and provides guidance to world of work actors – governments, employers/private sector and workers' organizations, civil society organizations and all relevant partners.

The **objectives** of the policy framework are to provide a set of guidelines to address the TB in the world of work and within the framework of the policy "Prevention of HIV/AIDS in the world of work". This framework will cover the following key areas:

- To promote awareness on TB prevention, screening and treatment across workplace in India.
- To advocate for and facilitate an environment that minimizes and prevents TB transmission at workplaces across India.
- To support and ensure early and free diagnosis of TB across workplaces in India.
- To facilitate and ensure access to free TB drugs and adherence for the entire workforce across India.
- To ensure care and support services for the workforce, post the completion of treatment.
- To address TB and HIV co-infection in the world of work.
- To advocate and facilitate a stigma free environment for accessing TB associated services at the workplace in India.

Background

India accounts for 27.4 Lakh of the 100 Lakh new tuberculosis cases globally, according to the WHO Global TB report 2018 India is a signatory to the WHO's 'The End TB Strategy' that calls for a world free of tuberculosis, with measurable aims of a 50% and 75% reduction in incidence and deaths, respectively by 2025, and corresponding reductions of 90% and 95% by 2035. To meet these targets, India is adopting newer strategies. India is also one of the high HIV burden countries.

Across the globe emergence of Multi-Drug Resistant (MDR) and Extensively Drug Resistance (XDR) TB is proving to be a challenge. World Health Organization (WHO) has quoted, if a country having 300 cases per one lakh population as annual overall TB incidence rate, out of this, 60 cases per year are expected among a workforce of 20,000 (WHO-ILO, 2003). It has been estimated, that a person with infectious diseases could infect about 20 different individuals during their lifetime (Qazi Shafayetul Islam, 2015). A workplace having 20,000 employees could be considered for establishing a Directly Observed Treatment, Short-course (DOTS) programme in collaboration with National Tuberculosis Programme (NTP) (WHO-ILO, 2003).

All workplaces may not be at increased risk for TB; there are certain workplace settings with increased TB risk as have been suggested by WHO and International Labour Organization (ILO) (Table 1)

Table 1: Workplace settings with increased TB Risk (WHO-ILO, 2003)

Work Place Setting	Cause of Increased Occupational Risk
Oil and Gas Industries and Plantations	Cramped living quarters and potentially poor health conditions
Mining Industry	Silicosis and Cramped living quarters
Prisons	Exposure of Prisoners and Prison employees to prisoners with TB in often cramped conditions
Health Centers/ Hospitals	Can be contracted with other infected individuals
Businesses with large Migrant Force	Poverty, Poor sanitation and living conditions, birth in countries with high TB infection rates

The national stakeholders' consultation informed that there are few industries which need to be considered for TB workplace intervention, such as beedi making industry, brick-kilns, stone crushing industry, textile (jute/cotton) industry and transport workers. Hence, the framework should provide scope for identification and inclusion of new workplaces for TB intervention.

Globally, there have been several strategies implemented in different workplace settings, resulting in increased case detection and treatment outcome. In Bangladesh, workplace intervention for TB has been implemented in a garment industry in collaboration with the national TB program. As a result, there was a 100% success rate in treatment and it has further recommended for education, screening and treatment at workplace (A.N. Zafar Ullah, 2012). There have been systematic studies among health care providers (HCPs)/ health care settings (Anja Schablon, 2009) (José Torres CostaEmail author, 2010), while it is limited in other workplaces.

India has been reported with 18.28 Lakh cases in 2017, with 35,950 multi-drug resistant (MDR) TB and 2666 reported in 2017. India is estimated to be the second highest HIV-TB cases globally (CTD-DGHS-MoHFW, TB-India 2018. Revised National TB Control Programme-Annual Status Report, 2018) and emergence of MDR and XDR TB is reported. TB is a notifiable disease since 2012. The Indian government has been continuously making its effort in addressing the spread of Tuberculosis through establishing hospitals, clinics, making BCG vaccination as national policy, conducting National Sample Survey, establishing research institutions and National Tuberculosis Program. In addition, Government of India has engaged Non-Government Organization (NGO) to facilitate its efforts to control TB in the country (Jain, 2011). India's National Health Policy 2017 calls for more active case detection, supplemented by preventive and promotive action in the workplace and in the living conditions. The increased drug resistance, access to free drugs and ensuring adherence, and containing transmission of resistant strains are the challenges in India.

Further, the national strategic plan for TB elimination 2017-2025 (RNTCP, 2017) and RNTCP Technical and Operational guidelines for India 2016 (CTB-DGHS-MoHFW, RNTCP-Technical and Operational Guidelines for TB control in India - 2016), recommends symptom screening and periodical health camps in, "settings like transit camps, night shelter, old age home, orphanages and de-addiction centres that may have ill ventilated and unsanitary environment". The National Strategic Plan further states the need for establishing surveillance system at workplaces and in

migrant sites. India's National Tuberculosis Program had laid down the following criteria for high suspicion of active TB cases as mentioned in Box 1.

- Symptoms suggestive of TB infection,
  - Presumptive Pulmonary TB refers to a person with any of the symptoms and signs suggestive of TB including: -
  - Cough for > 2 weeks
  - Blood in sputum or hemoptysis
  - Fever > 2 weeks
  - Significant weight loss
  - Any pulmonary abnormality in chest radiograph

Note: *In addition, contacts of microbiologically confirmed TB patients, PLHIV, Diabetics, Malnourished, cancer patients, patients on immuno-suppressants or steroids should be regularly screened for sign and symptoms of TB*

Box 1: Criteria for High Suspicion Active TB Cases
(CTB-DGHS-MoHFW, National Startegic Plan for Tuberculosis Elimination 2017-2025, 2017)

Key Guiding Principles of the TB policy framework at the workplace
The following principles have been adapted from various workplace policy documents and these principles will guide the workplace strategies and interventions.

The need to address TB and HIV co-infection:

- Tuberculosis remains the leading cause of death among people living with HIV, accounting for around one in three AIDS-related deaths.
- In 2017, there were an estimated 10 million cases of tuberculosis disease globally, including 9% among people living with HIV.

In 2017, TB caused an estimated 1.3 million deaths (range, 1.2-1.4 million) among HIV-negative people and there were an additional 300 000 deaths from TB (range, 266 000-335 000) among HIV-positive people.)

- **Recognition that workplaces can play a vital role in elimination of TB:** It has been amply demonstrated that TB can negatively impact work productivity in industrial set-ups through increased absenteeism and turnover of staff due to TB- associated morbidity and mortality. Most workers spend most of their waking hours at their places of work. In some situations, the workplace may also be where workers live. The need therefore to introduce access to TB control services may be stronger in this setting than in any other.
- **Non-discrimination:** A non-discriminatory environment enables the uptake of screening and treatment by employees and, hence, ensure a healthy workforce. There should be no discrimination against the workers on the basis TB infection because this will inhibit efforts aimed at promoting TB prevention.
- **Rights-based and gender equality:** TB is a disease of poverty and inequality. A number of factors related to human rights and gender can hinder the effectiveness, accessibility and sustainability of TB programs and services. Gender-related barriers to TB services may take many forms, affecting both men and women. Overall, men face higher risk of developing TB

than women and there are more TB deaths among men. Men are also more vulnerable to TB due to gender-specific occupations. In many places, men are more likely to have jobs, such as mining or blasting, with exposure to particulates. Men may be more likely to migrate for work, which may cause interruptions in TB treatment. Men may also be more likely to smoke or use drugs in many societies, both independent risk factors for TB. On the other hand, women may have less access to TB treatment and prevention services than men, and in some settings, have been less likely to undergo sputum smear examinations. Therefore, more equal gender relations and empowerment of women are vital to successfully prevent the spread of TB infection and enable women to cope with TB.

- **Safe and healthy work environment:** The work environment should be healthy and safe for all workers in order to prevent infection of TB, in accordance with the provisions of international standards. A safe and healthy work environment will keep the workforce healthier and ensure productivity without any delay or discontinuation.
- **Case finding and Diagnosis:** Early identification of workers and their families with a high probability of having active TB (presumptive TB) is the most important activity of the case finding strategy in a workplace. Screening for TB should be voluntary and confidentiality should be ensured. Periodic screening should be extended for an informed voluntary uptake as this will ensure early detection of cases and minimize the period of treatment and further ensuring a disease-free environment.
- **Continuation of employment relationship:** Irrespective of the disease status, the employer should continue to provide employment to the individuals, which will help them to adhere to the treatment and prevent further transmission. There should be psychosocial support for employees who have TB, such as free treatment and services, identical salary during treatment or compensation for loss of income, free transport to health facilities, food support or other motivations to continue treatment. Appropriate provisions of leave and suitable changes in the work will encourage an employee to complete the treatment.
- **Prevention:** TB infection is preventable. Prevention should be the primary focus and prevention strategies should be focus on behaviour change, knowledge, treatment and the creation of a non-discriminatory environment. Workplace prevention interventions should be continuously studied for their effectiveness and should be financed preferably in public-private partnership mode.
- **Treatment, Care and Support:** Solidarity, care and support should guide the response to TB in the world of work. All workers including contractual workers are entitled to affordable health services. There should be no discrimination against them and their dependents in access to and receipt of the benefits.

Methodology

This policy framework was developed on the basis of reviewing the literatures including policy documents, guidelines, strategy documents, technical reports, annual reports and peer-reviewed articles. Based on the review of these literatures, the policy and programmatic gaps, challenges, needs, opportunities and recommendations have been extracted.

The first draft was reviewed by the experts at ILO and based on their expert comments and suggestions the policy framework was further revised. The revised framework was presented in a one-day national consultative meeting with national level experts, Employer and worker's organizations, government, development partners and industries. Based on the inputs provided by the experts during the national consultation the policy framework was further revised and finalized.

Implementation

To facilitate implementation of workplace policy and guidelines for TB control, there is a need to engage different stakeholders. The word 'stakeholder' has been defined as a "group or person with an interest, involvement or investment in something" or "people who will be affected by a project or who can influence it, but who is not directly involved in doing the work" (John Griffiths, 2008). This engagement of the stakeholders could be appropriately instigated for the effective outcome of the programme. The engagement of various stakeholders depends upon different reasons and interests which needs to be identified and addressed appropriately. For TB workplace interventions, the stakeholders could be broadly categorized into the following categories.

Government (MOLE and MOHFW)

The Ministry of Labour and Employment (MoLE) and Ministry of Health and Family Welfare (MoHFW) should take lead in providing workplace policy guidelines on TB. This coherence between the ministries is needed due to government's decision to bring TB and HIV prevention programmes together and MoLE has already formulated the national policy on HIV/AIDS in the world of work in 2009.

- The MoLE should share TB workplace policy framework with employers and workers organizations as this would ensure a healthy workforce besides contribution to the national response on TB.
- MoLE should also guide employer and worker's organizations to extend and adapt their
- TB prevention programmes to the needs of informal workers.
- The MoLE and MoH should ensure periodic review and ensure that the challenges are addressed without hampering the implementation of the workplace intervention for TB.
- Employers' organizations
- Employers should consult with workers and their representatives to issue guidelines to their members to develop and implement appropriate programmes on early detection, prevention and care & treatment of TB and protect all workers from discrimination related to TB.
- Employers and their organizations in consultation with workers and their representatives, should initiate and support programmes at their workplaces to create a pool of resource persons trained on TB.
- Employers should take all measures to risk reduction and management of TB that includes proper ventilation at workplaces, less cramped workplace settings and periodic checkups and regular awareness camps especially in those workplaces where there are high chances of TB infection.
- Employers in consultation with workers and their representatives should take measures to reasonably accommodate workers with TB related illnesses. These could include rearrangement of working time, opportunities for rest breaks, time off for medical appointments, flexible sick leaves and return-to work arrangement.
- In the sprite of good corporate citizenship, employers and their organizations, should where appropriate, encourage fellow employers to contribute to the prevention of TB in the workplaces.

National TB Programme (NTP)/ Government:

- TB workplace interventions should be very well defined in the national strategic plan to eliminate TB
- There should be endorsement of the role of employers and worker's organizations for implementing workplace interventions.
- National strategic program should guide to initiate new programme on TB prevention and up-gradation of facilities and programme for effective response ensuring establishment of appropriate infrastructure facilities for linking and treatment services, wherever required.
- Ensuring TB prevention and control programmes in all government settings.
- Worker organizations in consultation with employers should take all measures to risk reduction and management of TB that includes proper ventilation at workplaces, less cramped workplace settings and periodic checkups and regular awareness camps especially in those workplaces where there are high chances of TB infection.
- Worker organizations in consultation with employers and their representatives should take measures to reasonably accommodate workers with TB related illnesses. These could include rearrangement of working time, opportunities for rest breaks, time off for medical appointments, flexible sick leaves and return-to work arrangement.

National AIDS Control Organization (NACO):

- Implementation of memorandum of understanding (MoU) signed between NACO and MOLE to strengthen workplace program of HIV and TB will pave the way for a robust world of work response for prevention of the TB.
- NACO's HIV workplace intervention provides an easy entry for TB interventions at the workplace as well.

Workers' organizations (e.g. trade unions):

- Workers and their representatives should consult with employers to issue guidelines to their members to develop and implement appropriate programmmes on early detection, prevention and care & treatment of TB and protect all workers from discrimination related to TB.
- Workers and their organizations should use existing union structures and facilities to provide information on TB in the workplace, and develop educational material and activities appropriate for workers and their families, including regularly updated information on worker's rights and benefits.
- Workers and their organizations should work with employers to develop appropriate strategies to minimize the impact of TB on workers and their productivity.
- Ensuring that the TB control program is in line with national policies and guidelines.

Non-Governmental Organizations (national and international):

- Promotion of health services in equity across all levels of employees.
- Promoting and ensuring capacity of the government and healthcare providers.
- Developing and advocating for evidence-based strategies and cross-country learnings for strengthening government responses.

Social organizations:

- Social organizations should be engaged for facilitating resources for welfare of the world of work.
- Social organizations should be engaged for volunteerism in implementing workplace interventions and awareness on TB, importance of early detection and treatment adherence.
- Organizations like Rotary International and Lions Club should be considered as potential stakeholders, as these organizations show interest in serving the interest of the nation.

Community representatives:

- Engagement of community (infected and treated for TB) will help in creating a stigma and discrimination free environment.
- Engagement of community ensures stigma free environment in the world of work.
- Engagement of community helps in spreading the message on the importance of early detection and treatment adherence.
- Engagement of community provides positive approach towards treatment of TB as a disease.

Private practitioners (PPs):

- Majority of patients initially seek care from private providers before they turn to public institutions. Therefore, RNTCP should try to capitalize on ability of this sector to reach patients who would not, or are unable to, access public services
- Treatment regimens under RNTCP are efficacious and cost-effective compared to the regimens prescribed by PPs. By involving the PPs in RNTCP
- Participation of PPs in RNTCP would also help reduce the financial burden on the poor, arising due to cost of drugs in particular. Economic evaluations undertaken on two public-private mix (PPM) DOTS sites in Hyderabad and New Delhi revealed that the cost per patient cured to the society was slightly lower in PPM DOTS compared to public sector DOTS
- The government infrastructure by itself cannot possibly deliver care to all patients because it would mean a substantial increase in infrastructure and personnel in public system.

Mechanism to review implementation of the policy framework

In 2009 Ministry of Labor & Employment (MOLE) had formulated a policy on Prevention of HIV/AIDS in the world of work in India. A National Steering Committee (NSC) was formed by the ministry with representatives from employers' and workers' organizations, institutions of the MOLE, NACO, ILO and People Living with HIV/AIDS (PLHIV) for effective implementation of the policy. In 2017, the NSC was expanded to include the Central TB Division, Ministry of Health. The TB workplace policy framework could also be implemented in an integrated manner and governed by the same NSC to ensure smooth implementation without creation of multiple structure. Considering the growing changes in health care provisions and the TB situation in the country, the TB workplace policy framework could be revisited on appropriate time interval.

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Session 3

BASICS OF TB AND HIV/AIDS

FAQ ON THE BASICS OF TB AND HIV/AIDS

1. How are TB and HIV/AIDS different from other illnesses?

- Both affect people at the most productive age (15-49 years);
- Both can be prevented;
- Both may go undetected for years;
- Even though treatment exists, stigma and discrimination associated with TB and HIV/AIDS remain a major challenge.
    - We all need to know about TB and HIV/AIDS as anyone can get them;
    - Everyone can play a role in prevention and treatment effectiveness for HIV and TB

2. What is TB and how does it spread?

- Tuberculosis (TB) is caused by bacteria that most often affects the lungs;
- TB is one of the top 10 causes of death worldwide;
- TB spreads from person to person through the air. When people with TB cough, sneeze, or spit, they propel the TB germs into the air;
- The amount of time, the environment, and body's immune system all contribute to whether a person gets infected or not; and in most cases, body is able to fight off the TB bacteria.
    - People with compromised immune systems, such as people living with HIV, malnutrition or diabetes, or people who use tobacco, have a much higher risk of falling ill.

3. What is the difference between Latent TB infection and Active TB disease?

- **Latent TB:** About one-quarter of the world's population and 40% of Indians have Latent TB infection, which means TB lives but doesn't grow in the body;
    - The person is not sick, has no symptoms and can't infect others but can advance to TB disease;
    - Has a normal chest x-ray and a negative sputum smear.
- **Active TB Disease:** TB is active, and the person is sick with symptoms and can spread TB to others or could die if not treated.
    - Latent TB can be reactivated into active TB disease; people infected with TB bacteria have a 10% risk of falling ill with active TB disease in their lifetime;
    - The vast majority of TB cases can be cured when medicines are provided and taken correctly;

- India has more than a million "missing" TB cases every year - not notified, undiagnosed, or inadequately diagnosed and treated in the private sector.

4. How soon after exposure do TB symptoms appear?

- Most persons infected with TB bacteria never develop TB disease because of their strong immune system;
- If TB disease does develop, it can occur 2 to 3 months after infection or even years later;
- The chances of TB infection developing into TB disease lessen with the passage of time.

5. What are the most common symptoms of TB?

- TB affects:
  - Lungs- **Pulmonary TB** (most common site of infection)
  - Organs other than the lungs- **Extra-pulmonary TB** ('outside lungs')
- The most common symptoms of Pulmonary-TB are:
  - Cough for more than two weeks
  - Weight loss
  - Weakness or fatigue
  - Loss of appetite
  - Fever
  - Night Sweats
- Symptoms of Extra-pulmonary TB depend on the site of the affected organ.
  - When a person develops active TB (disease), the symptoms may be mild for months. This can lead to delays in seeking care and results in the transmission of the bacteria to others.
  - People ill with TB can infect up to 10-15 other people through close contact over the year.
  - People living with HIV who are infected with TB
    - may not experience any symptoms OR
    - develop symptoms late and are less likely to present with coughing.

6. What is Extra-pulmonary TB?

- Extra-pulmonary TB affects other parts of body outside lungs, such as lymph nodes, pleura, bones and joints, meninges of the brain, intestine, genitourinary tract, etc.;
- In general, it is more difficult to diagnose Extra-pulmonary TB;
- Diagnosis may often require invasive procedures to obtain diagnostic specimen and more sophisticated laboratory techniques than sputum microscopy.

7. Who is at risk of contracting TB?

People at risk of contracting TB can be divided into three broad groups.

Clinically	Socially	Geographically
People living with HIV	Have had recent contact with an infectious patient	Urban Slums
Undernutrition or Malnourished	Migrants	Hard to reach areas
Co-morbidities like: o Diabetes Mellitus, o Malignancies, and on long term immunosuppressant therapy (Cancer medications or Steroids) o Patients on dialysis	People living in Congregated settings - night shelters, De-addiction centres, Old age homes	Indigenous and tribal populations
Substance abuse including o Smokers o Alcoholics o Illicit drug users	Occupations with risk of developing TB	
	Have been or who are in prison	
Health Care Workers		
Household & Workplace Contacts		
Patients with past history of TB		
Antenatal mothers attending ante-natal clinics		
Children		
Elderly		

8. How is TB diagnosed?

There are several tests available to diagnose TB and depend on the type of TB suspected.

- **Sputum Smear:**
  - Samples of sputum coughed can be tested to see if TB germs are present;
  - The sputum is examined under a microscope; visible TB germs indicate an active TB infection (Pulmonary TB) in the lungs and throat;
- **Chest X-ray:**
  - A chest X-ray can identify damage to the lungs caused by Pulmonary TB;
  - The chest x-ray can be normal in latent TB and Extra-pulmonary TB.
- **GeneXpert test:**
  - Most advanced test for diagnosing TB as well as testing for resistance;
  - Recommended test in key populations such as children, PLHIV as well as Extra-pulmonary TB.
    - A negative sputum smear (TB bacteria not visible) or normal chest x-ray does not mean that the person DOES NOT have active TB infection. A culture test can be used to confirm this.

9. What is DR-TB and why it is a cause of concern?

- A person with active TB disease has drug-resistant TB (DR-TB) if the TB bacteria that the person is infected with will not respond to, and are therefore resistant to, at least one of the main TB drugs;
- If bacteria are resistant to certain TB drugs, this means that the drugs don't work. Other drugs then need to be taken by the person if they are to be cured of TB.
- There are two main types of DR-TB:

1. Multi-drug resistant TB (MDR-TB):

- It means that the TB bacteria that a person is infected with are resistant to two of the essential TB drugs;
- India is the country with the highest burden of both TB and MDR-TB in the world.

2. Extensively drug-resistant TB (XDR-TB):

- It is a form of TB which is resistant to at least 4 of the core anti-TB drugs.

10. How does a person get MDR-TB or XDR-TB?

There are two main ways that a person can get MDR-TB or XDR-TB:

1. Mismanagement of TB treatment:

- Improper or incorrect use of anti-TB drugs:
- If the treatment regimen is not based on the recommended treatment schedule (wrong medication, or the wrong dose, or for too short a period)
    - Or if the patient had undiagnosed XDR-TB

2. Person-to-person transmission:

- A person can also get MDR-TB if they get TB bacteria from another person who already has MDR-TB;
    - Premature treatment interruption can cause drug resistance, which can then be transmitted, especially in crowded settings such as a workplace, prisons, and hospitals.

11. Can Drug-resistant TB (DR-TB) be diagnosed and treated?

YES, a person can go through drug susceptibility testing (DST).

- Drug susceptibility testing means testing to find out if a person has got drug- resistant TB.
    - Treatment for MDR-TB and XDR-TB are available; however, both take substantially longer to treat than ordinary (drug-susceptible) TB.

12. Is TB curable?

YES.

- It can also be cured in people living with HIV;
- DOTS is the internationally recommended strategy to control TB. It is important that people with the disease are identified as early as possible so that they can start treatment promptly;

- People in contact with TB patients can also be traced for investigation for TB and measures can be taken to minimize the risk to others;
- It is however important to state that some strains of bacteria have now acquired resistance to one or more of the antibiotics commonly used to treat them; known as drug-resistant strains. There are more expensive medicines capable of treating drug- resistant forms of TB.

13. What is DOTS?

- DOTS or Directly Observed Treatment Short course is the internationally recognized strategy for TB control;
- It has been recognized as highly efficient and cost-effective;
- The five components of DOTS are:
    - Political commitment with increased and sustained financing;
    - Case detection through quality-assured bacteriology;
    - Standardized treatment with supervision and patient support;
    - An effective drug supply and management system;
    - Monitoring and evaluation system and impact measurement.

14. What is the treatment of TB and MDR-TB?

- TB treatment usually involves the patient with TB taking a combination of different TB drugs;
- TB bacteria die very slowly, and so the drugs must be taken for several months;
- Duration of TB treatment ranges from 6 to 27 months depending upon the type of TB;
- TB Patients should be properly counselled by doctors/counsellors about treatment compliance and other risk factors.
    - Even when a patient starts to feel better once they start TB treatment, they can still have bacteria alive in their body. So, the person needs to keep taking the drugs until all the bacteria are dead;
    - TB diagnostics and treatment are available free in district hospitals or specialized TB clinics;
    - Government of India has allocated Rs 500/month as nutritional support to notified TB patients taking treatment from government facilities.

15. How can we ensure treatment adherence?

- Poor adherence to TB treatment could lead to poorer clinical outcomes, emergence of drug resistance, increased duration of infectivity and consequent onward transmission of infection;
- A checklist for the successful promotion of adherence to treatment includes the following:
    - Service and medication are offered free of charge and have guaranteed supply;
    - Directly observed treatment in the workplace should be in a private room to preserve confidentiality and comfort;
    - The TB treatment supporter who directly observes treatment must be acceptable to the patient;
    - The TB treatment supporter must be well trained and supervised;
    - The DOTS appointment is organized so as not to disrupt the patient's daily routine.

16. What should be done to prevent TB from spreading?

- TB education is necessary for both people with TB and the general public;
- People with TB need to know how to take their TB drugs properly. They also need to know how to make sure that they do not pass TB on to other people;
- The public needs to know the basic information about TB for several reasons including reduction of stigma still associated with TB;
- Active case finding (ACF):
    - The following three TB risk groups should be systematically screened for active TB:
        - Household contacts and other close contacts;
        - People living with HIV should be systematically screened for active TB at each visit to a health facility.
        - Current and former workers in workplaces with silica exposure should be systematically screened for active TB.
            - TB is the most common presenting illness among people living with HIV, including among those taking antiretroviral treatment, and it is the major cause of HIV-related deaths.
            - The presence of TB and HIV infection together also increases the number of people infected by each infectious person.

17. Why TB is declared a notifiable disease?

Government of India declared TB a notifiable disease in 2012 to ensure:

- Proper and timely TB diagnosis;
- Standardized TB care and management;
- Reduce TB transmission and fight emergence of drug resistant TB;
- Therefore, health care providers (clinical establishment run by the government/ Private clinics/ NGOs/Local practitioners) shall notify every TB case to local health/municipal authorities every month.

18. What is HIV and how does it affect us?

HIV stands for:

H= Human

I = Immuno-deficiency

V= Virus

- HIV, after entering the human body, gradually destroys the immune system, i.e., the ability to fight infections/diseases;
- As it is a human virus. It is found only in human beings.
    - There are no immediate and specific symptoms of HIV infection, generally;
    - HIV infection does not mean that a person has AIDS.

19. What is AIDS?

AIDS stands for:

A = Acquired
I = Immune
D = Deficiency
S = Syndrome

- AIDS is the most advanced stage of HIV infection which can take from 2 to 15 years to develop depending on the individual's immunity;
- With Anti-Retroviral Treatment (ART), this duration can be further increased. However, it is a life- long treatment; and treatment adherence is a crucial issue.
    - People living with HIV can live a long healthy and productive life; Having a job/ employment supports treatment adherence.

20. How is HIV transmitted?

HIV can be transmitted through:

- Unprotected sex with an infected person;
- Transfusion of infected blood or blood products;
- Sharing of infected needles or syringes;
- Infected mother to her child – during pregnancy, during birth, or after delivery through breast milk.
    - HIV spreads through these routes because HIV is found in high concentration in blood, semen, vaginal secretions, and breast milk.

21. In what ways HIV is not transmitted?

One cannot get HIV by:

- Shaking hands with an infected person;
- Drinking water or eating food from the same utensils used by an infected person;
- Hugging, touching or kissing;
- Caring and looking after people with HIV or AIDS;
- Getting bitten by an infected person;
- Use of the same toilets as AIDS patients or people with HIV;
- Sharing telephones, computers, machines and other office equipment;
- Sneezing and coughing;
- Getting bitten by a mosquito that has already bitten an infected person.

22. How can we prevent ourselves/others from getting the HIV infection through the sexual route?

- The most common mode of HIV transmission (as well as other STD transmission) is through unprotected (without a condom) sexual intercourse or through sexual contact with an infected person.

- It could be homosexual or heterosexual contact;
- Almost 85% of the People Living with HIV/AIDS in India are reported to have been infected through sexual mode of transmission.
- But we can prevent ourselves/others from getting the HIV infection through the sexual route by using the ABC approach:
    - Abstinence
    - Being mutually faithful to one partner
    - Condom use- correctly and consistently

23. Is there a connection between HIV and other sexually transmitted diseases?

YES.

- Having a sexually transmitted disease (STD) can increase a person's risk of becoming infected with HIV, whether the STD causes open sores or breaks in the skin (e.g., syphilis, herpes, chancroid) or does not cause breaks in the skin (e.g., chlamydia, gonorrhoea);
- If the STD infection causes irritation of the skin, breaks or sores may make it easier for HIV to enter the body during sexual contact;
- Even when the STD causes no breaks or open sores, the infection can stimulate an immune response in the genital area that can make HIV transmission more likely.
- In addition, if an HIV-infected person also is infected with another STD, that person is three to five times more likely than other HIV-infected persons to transmit HIV through sexual contact.

24. How does a mother transmit HIV to her unborn child?

- An HIV-infected mother can infect the child in her womb through her blood;
- The baby is more at risk if the mother has been recently infected or is in an advanced stage of AIDS;
- Transmission can also occur at the time of birth when the baby is passing through the mother's genital tract;
- Transmission can also occur through breast milk.

25. Can we prevent transmission of HIV from infected Mother to Child?

YES.

- Use of ART anti-retroviral therapy (ART) to the mother during pregnancy and at the onset of labour and to the baby soon after the birth reduces the risk of infection.

26. How can a person find out his/her HIV status?

- The HIV status of a person can be known through a blood test;
- The most commonly available test is ELISA (Enzyme-Linked Immunosorbent Assay) and the Western Blot, a confirmatory test is usually done after ELISA;
- The testing facilities are available both in private and government hospitals in India at Integrated voluntary, confidential counselling, and testing Centers (ICTC).
    - Remember: You don't have to be sick to take an HIV test;
    - Taking an HIV test shows you have a healthy lifestyle.

27. What is Window period in the context of HIV Testing?

- Our immune system produces antibodies to fight any infection. The window period is the time taken by the human body to produce antibodies in the quantity that can be detected through a blood test;
- It takes about 3-12 weeks (or up to 6 months in some cases) after HIV infection to form antibodies in detectable quantity;
- In simple terms, the window period is the period in which a person is infected, but his/her test result does not show it.
    - During the window period, the HIV status does not show in the test, but the person can infect others;
    - It is important to test regularly for HIV.

28. Why is TB and HIV co-infection dangerous?

- TB and HIV co-infection is when people have both HIV infection, and either latent or active TB disease;
- When someone has both HIV and TB each disease speeds up the progress of the other;
- People living with HIV (PLHIV) get TB infection faster due to their compromised immune system;
- TB infection progresses faster from latent to active TB disease in PLHIV;
- TB is the most common presenting illness among people living with HIV, including among those taking antiretroviral treatment, and it is the major cause of HIV-related deaths;
- In 2017, 32% of AIDS deaths were from TB;
- In India, 58% of all people with HIV-associated TB did not reach care according to reported data;
- A person with HIV infection is more likely to develop TB outside the lungs. The symptoms may not be typical, delaying the diagnosis and treatment of TB disease;
- People with TB and HIV infection may not respond to TB skin tests and their chest x- rays may look normal even if they have the TB disease;
- PLHIV face the threat of drug-resistant TB. If diagnosis is delayed there is increased risk of mortality from multidrug-resistant and extensively drug-resistant TB;
- TB infection also makes the progression of HIV infection to AIDS faster.

29. Is there a vaccine for TB and HIV prevention?

- The protection offered by the BCG vaccine against Pulmonary TB in adults is variable;
- Since most transmission originates from adult cases of Pulmonary TB, the BCG vaccine is generally used to protect children, rather than to interrupt transmission among adults;
- The BCG vaccine has been shown to provide children with excellent protection against the more severe and widespread forms of TB;
- There is no vaccine for HIV prevention yet; though research is going on to find an effective one.
    - Knowledge about TB and HIV /AIDS is essential. Both can be prevented by knowing about them and spreading awareness;
    - Early detection and treatment are the keys to effective prevention;
    - Reducing stigma and discrimination is an effective prevention strategy for both diseases.

30. Should I isolate myself, so that I don't infect anyone else?

NO. Latent TB and HIV infection do not spread from person to person.

- Since there are no immediate and specific symptoms of HIV infection, everyone needs to take the HIV test. If HIV-positive, one can start the treatment early to stay healthy;
- Getting rid of TB is a community effort, and it is not a person's fault if others get infected.

Active TB patients' need to do the following:

- Follow cough etiquette:
  - While coughing, they should cover their mouth and nose with a tissue;
  - The used tissue should be disposed of in a bin;
  - If tissue is not available, then the person is advised to cough or sneeze into their upper sleeve or elbow;
  - They should not cough into their hands. Hands should be washed after coughing.
- Making sure you finish the entire treatment will also reduce the risk of transmission, because at some point during the treatment, the bacteria in you will be inactive so you cannot transmit the bacteria to others;
- Keeping windows and doors open to increase ventilation are other ways to help prevent the spread of TB.
    - Isolation does not help anyone. Nevertheless, we all must promote early detection and treatment for TB and HIV/AIDS;
    - Keep working. Employers' and co-workers support can be vital in helping a person with TB, and HIV/AIDS live a healthy, productive, and dignified life.

31. What is the impact of TB and HIV/AIDS on the workplace?

- The impact of TB and HIV on the workplace may include any of the following:
  - Loss of skills and experience;
  - Disruption of workflow;
  - Reduction of productivity;
  - Increase in direct cost (treatment and care);
  - Increase in indirect cost (replacement and retraining of workers);
  - Increase in absenteeism;
  - Reduction in profits and investment;
- The impact of TB and HIV on the workplace is significant. TB and HIV/AIDS workplace programmes thus make business sense as they contribute towards reducing the impact and sustaining the profitability of businesses.

32. Why should we work on TB and HIV/AIDS together in our workplace?

- Both affect people in the prime of their working life;
- TB remains one of the leading causes of hospitalization and deaths amongst people living with HIV;
- People living with HIV on treatment remain at increased risk of TB disease.

- Ending TB and AIDS by 2030 is a global commitment under sustainable Development Goal 3;
- India stands committed to the goal of 'ending TB by 2025' and 'ending the AIDS epidemic as a public health threat' by 2030;
- A multi-sectoral response and partnerships with the private sector/ employers, enterprises and trade unions are crucial for the control of TB and HIV/AIDS; and is an essential strategy of the National TB control Programme and National AIDS Control Programme.

33. What role can workplace play in preventing the spread of TB infection?

The workplaces can play a significant role by:

- Having a workplace policy assuring non-discrimination, continuity of employment and access to prevention, treatment, care, and support services;
- Organizing education and counselling sessions through peer educators;
- Promoting early diagnosis; quality treatment and supporting treatment adherence
- Developing partnership with service providers of the national AIDS and TB control programmes.

- Follow the National Policy Framework on TB and HIV in the World of Work
- Follow the Indian Employers Commitment on TB and HIV in the world of Work

34. What is my role as a peer educator for prevention of TB and HIV/AIDS at my workplace?

- Regularly update my knowledge and educate my co-workers about TB and HIV/AIDS through formal as well as informal sessions;
- Use communication materials posters, billboards at strategic points as well as social media to create awareness;
- Get to know the service providers offering testing and treatment close to my workplace;
- Refer workers to access services after my sessions;
- Be the bridge between the management and workers to ensure that the workplace implements a policy of non-discrimination and offers full support to workers living with TB and HIV/AIDS;
- Generate periodic reports for the management and TB and HIV/AIDS Workplace committee as agreed in the work plan.

TWO LIES AND A TRUTH GAME ANSWER KEY

1.
- TB is a hereditary disease (it runs in the family).
- **You cannot get TB by sharing utensils or food.**
- TB can spread through sexual contact with an infected TB person.

2.
- All TB patients are infectious.
- Tuberculosis is incurable.
- **TB can be cured by proper medical treatment.**

3.
- You can get HIV by using the same toilets as used by a HIV-positive person.
- You can get HIV by sharing office equipment with a HIV-positive person.
- **You can get HIV by using an unsterilized needles, syringes or lancets.**

4.
- **I cannot get infected with HIV by hugging or shaking hands with a HIV-positive person.**
- I'm straight and don't use IV drugs. I won't get HIV.
- I don't need to worry about getting HIV. Drugs will keep me well.

5.
- HIV is a death sentence.
- People with HIV look sick.
- **People living with HIV may not look sick, feel sick, or even know they have acquired HIV.**

6.
- **Non-smokers can get TB.**
- TB infects only those who smoke excessively.
- TB infects only those who smoke beedi and consume chewable tobacco.

7.
- TB affects those who are poor and do not take nutritious diet.
- **Anyone can get TB, be it a rich or poor, healthy-looking or thin.**
- I exercise and do Yoga regularly, have a strong immunity so cannot contract TB.

8.
- If a couple has HIV, they do not need to protect themselves.
- **I can have a baby even if I'm HIV-positive.**
- I could tell if my partner was HIV-positive.

9.
- It is OK to stop taking HIV or TB drugs if I'm feeling better.
- **I should not stop the treatment of HIV or TB, even if I'm having strong side-effects.**
- It is OK to stop taking HIV or TB drugs for a few days if I'm having strong side-effects.

10.
- I had BCG vaccination, so I'm protected from TB.
- I do not have any more cough, so my TB is cured, and I should not take the medicine anymore.
- **It is possible to catch TB more than once.**

UNDERSTANDING STIGMA

Conflating the characteristics or traits exhibited by individual members of a group, caste, religion, gender, occupation, and ethnicity to all its members result in stereotypes. Compounded by lack of knowledge, awareness, and information, gradually stereotyping leads to the formation of prejudices. These beliefs, preconceived attitude, or judgment towards someone or something are unjustified, baseless, and are formed in advance through a nonconscious process of our minds.

Prejudices, when enacted, become discrimination, and involve unequal and unjust treatment directed towards an individual due to their affiliation to a group, caste, religion, gender, occupation, nationality, and ethnicity. Often people have been discriminated on the grounds of their sex, weight, color, socioeconomic status, education, marital status, speech, disability, and disease, and so on.

Stigma depicts the 'situation of the individual who is disqualified from full social acceptance'[13] due to the pervasive stereotyping, and prejudices in our society. It can be defined as "the shame or disgrace attached to something regarded as socially unacceptable."[14]

TB and HIV/AIDS are highly stigmatized diseases, and patients with infection are discriminated and socially ostracized. Other health conditions that face stigma are Mental disorders, Leprosy, Physical or Mental impairments leading to disabilities, Sexually- transmitted diseases, and certain skin diseases.

TYPES OF STIGMA

Stigma can be categorized into four types:

Public stigma: Is people's perception and behavioural response to someone with perceived stigma. These perceptions and actions enacted because of them reinforce the status of stigma faced by an individual or group of people who are affected by the disease. For instance, a society's values towards sexuality, gender, substance abuse, and the disease itself shape people's beliefs. Stereotypes about PLHIV and their association with specific sexual orientation or preference as faced by men who have sex with men (MSM) is one such example.

Stigma by-association: Negative attitude towards a person who is not a part of the stigmatized group, caste, religion, occupation, and ethnicity per se but is associated with a person who is facing the stigma. Family members, caregivers, and friends of a PLHIV also experience shame and often face social avoidance.

Institutional stigma: Is systematic perpetuation of a stigmatized health condition by public and private institutions and society's cultural ideology. For example, PLHIV often face the loss of employment, denial of social and healthcare services, and loss of housing.

Self-stigma: Stigma faced by an individual at the society-level, social avoidance of their family members and friends, and at the hand of cultural institutions, have severe consequences both for the individual who is stigmatized and for the society altogether. For instance, a person could avoid getting tested for HIV because of the associated stigma towards PLHIV. Due to the fear of disclosure, a person could avoid disclosing their HIV status with their family members or colleagues out of the perceived shame associated with HIV/AIDS or avoid treatment entirely. Moreover, an HIV-positive person often internalizes the negative labels associated with the disease, which could not only lead to a reduction of self-esteem and self-efficacy but also affect the individual's overall wellbeing by creating a sense of hopelessness and despair.

IMPACT OF STIGMA

- Leads to delayed or refusal of testing and counselling seeking behavior towards HIV/AIDS;
- Decreases chances of disclosure of seropositive status because of the perceived risks associated with disclosure, such as:
    - fear of rejection by family and friends;
    - fear of loss of employment;
    - fear of getting improper or no treatment.
- **Access to care:** once diagnosed, a PLHIV can either delay care and treatment or not adhere to the medications. This avoidance of care could lead to withdrawal and isolation of the individual.
    - Refusal to provide care and treatment or providing poor quality of care to PLHIV worsens their health-seeking behavior.

COMBATTING STIGMA

- Social impact: Stigma associated with HIV/AIDS could lead to loss of income and livelihood, loss of the marriage and childbearing options, withdrawal of caregiving in the home, loss of social benefits and insurance, and loss of reputation.
- Increase awareness by disseminating information on transmission, risk reduction behaviors, prevention, and treatment of HIV/AIDS to reach a variety of audience, at all levels of the organization, by using various mediums of communication (posters, information booklet, workshops, and training).
- Develop a support system at the workplace for people to share their concerns about any disease and offer coping skills to individuals with TB and HIV/AIDS.
- Promote an open and friendly environment by conducting experience-sharing meetings with workers affected by TB and HIV/AIDS. Such interaction will not only provide information on the disease through audience interaction but also will help in humanizing the challenges faced by PLHIV and help dispel myths surrounding TB and HIV/AIDS.

NATIONAL POLICY ON HIV/AIDS AND THE WORLD OF WORK

Launched by the Indian Ministry of Labour and Employment in 2009, the policy is a guiding tool for employers and workers in the public and private sectors and provides strategies for 'collaboration and implementation to protect the Indian working population from HIV infection and mitigate its social and economic impact.'[15] The policy also proposes a set of measures to combat stigma and discrimination towards people infected and affected by HIV/AIDS through the following interventions:[16]

- Develop and implement non-discriminatory workplace policies;
- Integrate HIV/AIDS services in other health related services;
- Adapt flexibility and reasonable accommodation (adjust assigned work, as practically as possible) for PLHIV;
- Involve PLHIV in planning and implementation;
- Ensure continued employment and benefits to PLHIV.

"HIV status is not a barrier to employment. With treatment that is available now, people remain healthy and productive. Companies need to commit to ending discrimination and encourage employees to take the HIV test early. I do the same in my company."

Rohit Relan,
President, All Indian Organization of Employers & Managing Director, Bharat Seats Limited, India

"All tension was gone when I was told that I don't have the HIV infection. I received counselling and good information. An early diagnosis enables us to stay healthy by taking treatment on time."

Sanjay Ganjhu,
Worker at Central Coalfields Limited, Ranchi, India

"Prevention of HIV/AIDS in the world of work is one of the strategic priorities of National AIDS Control Programme in India. Efforts are being made by NACO in collaboration with ILO India office to engage various stakeholders at all possible level for bringing awareness among workers and to promote VCT@WORK in the world of work. Industries of public and private sectors, employers' organizations and trade unions are sensitized to join hands to bring down new infection amongst workers."

Sanjeeva Kumar,
Additional Secretary & Director General, NACO & RNTCP, Govt. of India

Session 5

ELEMENTS OF WORKPLACE PROGRAMME FOR TB AND HIV/AIDS

TB AND HIV/AIDS AN ISSUE FOR THE WORLD OF WORK

- TB and HIV/AIDS affect:
  - Workers and their families
  - Employers/Enterprises
  - Government and National economies
- Both the diseases hit hardest at the most productive 15-49 age group;
- Loss of employment, denial of educational opportunities to children, denial of social and healthcare services, and loss of housing are some of the devastating repercussions of both the diseases;
- TB and HIV/AIDS-related illnesses and death mean:
  - Increase in absenteeism due to illness and bereavement;
  - Increase in labour turnover due to illness and death;
  - Fall in production due to absenteeism, labour turnover, loss of skills/experience;
  - Increase in expenditure on employees' replacement and training, health care and social security cost, reduction in profit levels.

The workplace provides an ideal venue for initiating effective programmes of prevention and care related to TB and HIV/AIDS because:

- It provides the platform and opportunity to reach a large number of people;
- Workers are influential in their communities, and through them, awareness of TB and HIV/AIDS can reach the communities as well.

THREE-LAYERED STRATEGY AT THE WORKPLACE

1. Policy development
2. Prevention programme
3. Care and support

1. Developing Workplace Policy on TB and HIV/AIDS:

A sound policy statement, developed through a consultative process, serves as the foundation on which a strong TB and HIV/AIDS prevention programme can be built at a workplace.

How does policy help?

A well-written HIV Policy clearly defines the position of the company concerning TB and HIV/AIDS;

- It gives direction to managers as to how to manage and to employees on how to seek assistance to handle the crisis of HIV/AIDS at the workplace;
- A non-discriminatory policy at the workplace helps in creating an atmosphere of trust and confidence among employees;

- Without a policy in the workplace, it is difficult to manage TB and HIV/AIDS problems in the workplace.
- Experiences reveal that TB and HIV/AIDS prevention programmes become more effective in the presence of a policy assuring non-discrimination of workers.

The process of developing a Policy on TB and HIV/AIDS:

- Convene a meeting with key people, representatives from senior management, the welfare department, Trade unions, Human resources department, Medical department, workers affected with TB and PLHIV;
- Discuss the TB and HIV/AIDS issue and share perspectives, generate dialogue on the issues that would be part of the Policy;
- Have a look at the TB and HIV/AIDS workplace Policies from other enterprises/companies;
- Develop a draft and finalize the written Policy with consensus;
- The Policy needs to be reviewed from time to time to make necessary changes;
- Policy dissemination needs to be part of TB and HIV/AIDS work plan of the company
- Workers need to be made aware of the existence and contents of the Policy for its effective implementation;
- Effective dissemination of Policy helps in building trust and gaining the confidence of employees.

2. Care and Support:

While the policy framework should form the basis for a non-discriminatory environment, some of the services that can be created are:

- Provision of counselling for infected workers;
- Counselling of workers' families and co-workers, with the consent of the worker;
- Medical support as per the enterprise norms;
- Provision for compassionate leave and work adjustment can be created;
- Referral linkages with the nearby voluntary counselling and testing centre, agencies working on the care and support programmes can be made;

3. Public-Private Partnerships (PPP) in TB and HIV/AIDS Prevention:

- Companies get into PPP for different reasons like strategic investment or CSR:
- Different models have emerged:
    - intervention funded jointly with companies and international organizations;
    - interventions financed by companies, implemented by NGO with technical assistance from government/ international organization;
    - interventions funded jointly by corporate;
- Confidence from a successful workplace programme triggers PPP and vice-versa;
- Workplace programmes provide a good entry point;
- Companies having their medical set up are more likely to set up testing, counselling, and treatment centres.
- Great potential to expand HIV counselling, testing, and treatment to contractual workers and migrant labourers.

International Labour Organization

1919·2019

BEST in India experiences benefits of a comprehensive response to TB and HIV

The Brihanmumbai Electric Supply and Transport (BEST), a statutory undertaking of Mumbai Municipal Corporation, India, is the lifeline of the megapolis' road public transportation service, reaching out to three million commuters daily. BEST also supplies electricity to over a million consumers in the city. Its comprehensive TB and HIV workplace programme is among the most effective employer-driven health interventions in the country. Having over ten years of technical partnership with the ILO, the company is experiencing several benefits of such a response.

"To reduce TB related morbidity and mortality among its employees, the Brihanmumbai Electric Supply & Transport Undertaking ensures effective measures for early detection and diagnosis and appropriate treatment for an adequate duration with special extra-ordinary benefits. This has helped BEST in achieving WHO's target of 95 per cent cure rate and 100 per cent reduction in treatment of cases lost to follow up. These measures have also played a crucial role in reducing absenteeism on account of sickness as well as the expenditure towards the treatment of TB cases."

Surendra Kumar Bagde
General Manager, BEST

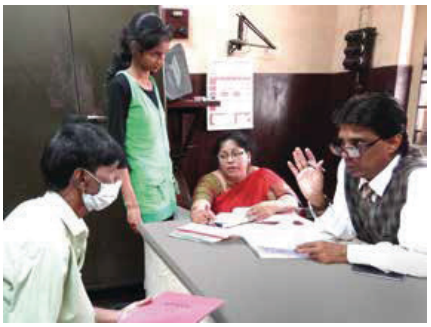
BEST has over 40,000 employees, (39,326 men and 1,139 women). It also employs 840 casual labourers on a contractual basis. A socially-conscious employer, BEST has put in place numerous welfare policies and schemes for its employees. As part of its CSR activities, BEST regularly undertakes social awareness campaigns.

TB and HIV response of BEST is part of the company's focus on health and well-being of employees, their families and communities.

BEST developed its HIV and AIDS Workplace Policy in 2005 during the first phase of the ILO project in India. The policy was revised in 2011, and again in 2015. Regular awareness activities, promotion of confidential Voluntary Counselling and Testing, and partnerships with the Maharashtra State AIDS Control Society and the Municipal Corporation of Greater Mumbai for free HIV testing and treatment, have brought good results.

There has been a marked reduction in new HIV cases. In the last four years, there has been a significant reduction in absenteeism due to HIV. Thanks to effective treatment, HIV-positive employees are living a healthy and productive life.

LET'S WORK ON TB AND HIV



Tackling TB by setting standards of care

BEST addresses TB as per national TB programme guidelines. The programme is executed through **26 in-house depot dispensaries;** a team of depot medical officers, pharmacists, medical attendants, on-call specialist consultants; and the Mumbai Central Bus Depot Dispensary and Investigation Centre.

TB **treatment is free** and facilities are available in-house or at a DOTS centre near home. Those fighting the HIV-TB co-infection can avail of single window service at the Mumbai Central Depot Dispensary and Investigation Centre. This is done under a memorandum of understanding signed in 2012 with the Brihanmumbai Municipal Corporation (BMC) and the Mumbai District TB Cell.

The empanelled hospitals of BEST provide hospitalization to patients either free of cost or at a subsidized rate. In case of payment, BEST provides an advance once its medical officer in-charge has visited the patient at the facility for assessment.

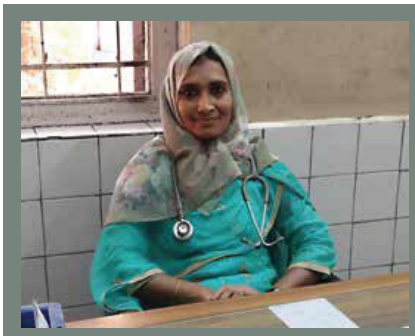
Facilitating treatment adherence

A monthly **three-tier follow-up system** has been devised to ensure that cases lost to follow-up are identified early and remedial action is taken. The first follow-up is at the DOTS centre, the second at the depot dispensary and the final one at the Mumbai Central Bus Depot Dispensary and Investigation Centre, where the patient has a consult with the pulmonologist.

To manage the difficult side-effects of TB medication, which has a significant bearing on treatment adherence, consultations from specialists like a pulmonologist, cardiologist and ophthalmologist are available.

Continuous medical education is organized periodically for medical officers, pharmacists and technicians with the assistance of the Mumbai District TB Cell.

Counselling plays an important part in optimum treatment outcome and adherence. Sessions are held not only at the time of commencement of treatment but througout the course of the treatment. If required, the spouse and other family members are asked to be part of the process.



"For TB treatment and care, BEST has mounted a comprehensive response so that employees readily come forward and seek treatment and regain full health at the soonest, without fearing loss of job or bearing the financial burden of the disease. Free treatment and paid leave provide huge mental relief to the patient and their family members."

– Dr Sadiya Ansari,
Medical Officer,
Mumbai Central Bus Depot
Dispensary & Investigation Centre

To ensure that employees are motivated to seek and complete TB treatment, and colleagues are supportive, BEST has made several policy decisions. Employees are sanctioned leave with pay for up to one year. Depending on the years of service,

there is also leave without pay for up to three years, which ensures job security. Furthermore, in case an employee develops physical disability post treatment (as may be in the case of TB of the spine or brain), s/he is entitled to a reasonable accommodation under which a suitable alternate assignment is offered maintaining the salary of the employee. There is an in-house Disability Board that deliberates on such cases.

Focus on prevention

Awareness is created through peer educators, counsellors, and display of communication materials shared by the Mumbai District TB Cell and the ILO in buses, bus shelters, electricity poles, depots and dispensaries, as well as at staff quarters.

The medical department has **identified five main triggers** of secondary immuno deficiency among BEST employees around which the TB prevention strategies are based. These are: stress, protein energy malnutrition, tobacco addiction, diabetes and HIV. Regular awareness and recreational activities are organized by the BEST Arts & Sports Club whilst yoga and stress manage- ment camps are held in collaboration with KEM Hospital. **High-protein diet** is available at concessional rates at the depot, workshop and mobile canteens run by BEST. The company has also set up an in-house drug de-addiction centre. These initiatives, apart from diabetes control programme and a spirited implementation of the HIV Workplace Policy, make the prevention strategy at BEST.

Key results

The TB programme has produced good results over the last few years:

- 100 per cent treatment adherence has been achieved.
- Hospitalization cases have reduced by 95 per cent.
- Number of deaths due to TB has reduced by 90 per cent.
- Over the last three years, BEST has continuously shown a cure rate of 95 per cent.
- The average sickness absenteeism due to TB in 2012 was over one year, it has now reduced to six to eight months.
- Support to TB patients and persons living with HIV and other chronic illnesses through special leave as well as the policy of providing reasonable accommodation under the company's focus on health and well-being of employees.

"When a TB patient faces the triple whammy of extreme physical illness,mental distress, and a financial burden, the support of his/her employer has a big impact.

In BEST, benefits like paid leave, free medication and hospitalization, and thoughtful colleagues bring great comfort."

– Preeti Sawant, employee

Strengths of the intervention

- A senior management committed to ensuring the health and well-being of the workforce.
- The presence of dedicated medical personnel and infrastructure.
- Focus on prevention, quality treatment and treatment adherence to address the twin epidemics of TB and HIV.
- A supportive and stigma-free work environment that encourages workers to come forward for treatment and ensures adherence.

- Engagement of workers' unions that build the confidence of employees.

Key lessons

- Integrating TB response with other health initiatives paves the way for a far-reaching impact.
- Management support to workplace-based social/health interventions ensures sustainability in the long run.
- Employee-centric policies, which promise job security, offer reasonable accommodation, and contribute to a destigmatized workspace, encourage workers to seek timely counselling and treatment.
- Effective linkages with the national, state and local TB frameworks and action plans for collaboration – technical and treatment – allows for the development and provisioning of effective treatment opportunities.
- Sensitive, caring co-workers greatly lend to creating a stress-free work atmosphere, which enables sick employees to deal positively with their illness and get back on the job fast and fully fit.
- Access to treatment at workplace presents a seamless opportunity to tackle the disease.
- Astute advocacy strategies and peer education play a vital role in arming employees with the knowledge to not only safeguard themselves but also enjoy a productive life as a result of opportune diagnosis and treatment.

Next steps

- TB survivors who are enjoying an active life post treatment will be given centre-stage as 'brand ambassadors'. Sharing stories and experiences on a public forum will transform them into ideal role models for TB response.
- The Medical Department is working on a proposal to extend extra-ordinary paid leave from 12 to 18 months for MDR- and XDR-TB patients due to the lengthy duration and difficult nature of treatment. Alternately, there are discussions on capping leave with pay depending upon the type of TB diagnosed.

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International Labour Organization

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Reaching out to miners with TB and HIV programmes: Eastern Coalfields Ltd. India

Eastern Coalfields Limited (ECL) is a subsidiary of Coal India Limited (CIL) India, a state- owned coal mining company which is the largest producer of coal in the world. ECL operates in the coal belt of Durgapur-Asansol in West Bengal. It is one of the leading public sector companies in India engaged in protecting miners from TB and HIV in collaboration with the national TB and HIV programmes and the ILO.

"When it comes to combating infectious diseases and associated risks in the work environment, a workplace intervention acts as the keystone. At ECL, we are fully committed to keeping our workers healthy. Our response to TB and HIV, governed under the overarching policy of Coal India Ltd., is part of this endeavour. We have an open-door policy not just for our regular employees, but also for contractual workers as well as for the local communities, living within a radius of 25 kilometres of the company."

Subrata Chakravarty,
Director-Technical, ECL

ECL currently has a total workforce of over 64,000. In addition, the company engages a large number of contractual workers. Believing in an integrated health care and wellness response, the company provides healthcare to employees, their dependants and contractual workers, focussing on HIV, TB as well as hypertension and diabetes through dedicated in-house programmes.

ECL's corporate social responsibility initiatives are directed towards the economically vulnerable, land evictees and Project Affected People (PAPs) staying within a 25-kilometer radius of ECL. Projects include construction of toilets, provision of drinking water facility in private and government schools as well as in gram panchayats in the area; livelihood enhancement and women's empowerment; construction and repairs of roads, water tanks, school buildings; support to the differently-abled through the Asansol Braille Academy, a unit of Asansol Prevention of Blindness Society; regular health camps and medical activities for the community; creation of solid waste management and organic waste management systems, among others.

Since 2008, ECL has successfully implemented the HIV and AIDS workplace policy and programme in collaboration with the ILO. The ILO has trained a cadre of master trainers and peer educators in the company who conduct regular

LET'S WORK ON TB AND HIV

awareness programmes for miners in the collieries and promote voluntary counselling and testing for HIV. In collaboration with the National AIDS Control Organization and the West Bengal State AIDS Control Society the company has set up a model Integrated Counselling and Testing Centre (ICTC) at Central Hospital, Kalla. The centre has an open-door policy not just for regular ECL workers, but contractual workers as well as for the local communities. Workers who are tested positive are referred to the Bardhaman Medical College for Antiretroviral therapy (ART) and other related services. The management's involvement, through the effective dissemination of policy and presence at important events, has played a key role in the success of the HIV programme.

Getting grips on tuberculosis

Miners are especially at the risk of TB since they usually work in cramped, underground mines, where ventilation is compromised and temperatures are extreme. Additionally, prolonged exposure to chemicals and coal dust also weaken their lungs considerably.

The company provides quality diagnostic and treatment services for TB to all the employees through a well-established medical set-up: two Central Hospitals – one each at Sanctoria and Kalla; seven Area Hospitals catering to around 12-14 collieries; and 114 operational dispensaries at the colliery level.

ECL follows the Revised National Tuberculosis Control Programme (RNTCP) guidelines to treat indoor patients and refers the outdoor patients to the District TB Cell. There is a budgetary provision for delivering comprehensive medical services. For specialized TB tests not available at ECL, patients are referred to the empanelled tertiary care hospitals. Medical reimbursements are given to employees who have purchased medicines privately.

Detection

Initial as well as Periodic Medical Examination of employees, which includes a chest X-ray and sputum exam, are conducted at the time of induction and on a periodic basis, respectively.

ECL provides free quality diagnostics and treatment to all those who come in with symptoms of TB. Although X-ray and pathology facilities are available at the Area Hospitals, too, for an ultimate diagnosis, patients visit the Central Hospitals. If they are coming from a faraway colliery – for instance, at Central Hospital, Kalla, patients come from as far as Pandaveswar, which is 50 kilometres away - then they are admitted for the duration that they are undergoing the tests.

Notification

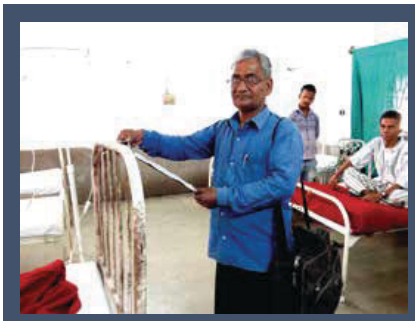
Diagnosed TB cases are referred to the District TB Cell. The notification happens from the DOTS centre near the patient's home, from where his/her medication is administered. For patients admitted at the TB ward in the Central Hospitals, the doctor in-charge contacts the zonal TB Home Visitor (TBHV), appointedby the District TB Officer (DTO), and coordinates notification and medication.

Treatment adherence

While DOTS medication is monitored by the TB Home Visitor, who supplies medicines at the patients' doorstep and updates the treatment card, he is also instructed to direct the outdoor ECL patient to go back to the Central Hospital for the follow up. Additionally, it's mandatory for all patients who are positively diagnosed at ECL to come back in six months for a re-examination.

To ensure that employees are motivated to seek and finish treatment, ECL provides special leave with half-pay. Initially, it is given for six months, extendable up to another six months.Those who apply for special leave have to visit the doctor every month for leave extension.

In case an employee develops physical disability (as in the case of TB of the spine or brain or any other chronic illness), the employee is entitled to alternate employment as part of the policy on providing reasonable accommodation. The Job Suitability Board, which comprises the Chief of Medical Services, specialist doctors, and members of the personnel department looks into such cases. A confidential report is prepared after inquiry and on the basis of its recommendation, the personnel department takes appropriate action on providing reasonable accommodation to the concerned employee.



"As ECL employees, patients receive several benefits that are essential to combat the disease. Competent salaries, free housing and medical care, special leave – for a working person these make all the difference as they are free of financial burdens and job insecurity and can concentrate on recovery."

– Ashok Mahato,
TB Home Visitor

Strengths of the response

- Management's commitment to the overall health and well-being of the employees and the policy of covering communities under CSR.
- Partnerships with the District TB Cell and the State AIDS Control Society.
- Collaborations with the ILO for institutionalizing a rights-based workplace programme for HIV and TB; training of master trainers and peer educators; and facilitating partnerships with national HIV and TB programmes.
- Focus on creating a nondiscriminatory environment for TB as well as HIV, which encourages workers to come forward to seek diagnosis and treatment.
- Presence of a committed cadre of medical staff and medical infrastructure.
- The policy of reasonable accommodation aids employees in seeking treatment.

Key lessons

- An integrated response to TB and HIV is essential.
- Workplace programmes driven by management commitment and a rights-based policy are sustainable.
- Employers' support in the form of providing job security, benefits such as special leave; the provision of reasonable accommodation; and focus on a stigma- and discrimination-free workplace make it easier for workers to come forward to seek counselling/testing and treatment.
- The supportive and caring attitude of co-workers greatly contributes

to treatment completion and on-time recommencement of duty. For a working professional, this becomes a great motivator to overcome the illness fully before re-joining.

- The availability of medicine, diagnostics and treatment facilities at the workplace makes treatment more approachable.

- Linkages with the government's TB and HIV programme are essential to ensure quality of services and broaden the reach of the interventions.

Next steps

- ECL is gearing up to sign a memorandum of understanding with the Paschim Bardhaman District TB Cell to certify the company's dispensaries and hospitals as linked DOTS centres. This will enable workers to pick up their medication from within the ECL set-up and will allow the medical staff to closely monitor the treatment compliance.

- The company is planning to strengthen its prevention activities by organizing colliery-based events and integrating HIV and TB training into its Vocational Training Centres.

- Despite excellent treatment facilities, adherence is a major issue, driven by rampant alcoholism in the collieries. ECL is considering conducting periodic de-addiction camps as well as setting up de-addiction centres with trained doctors and para-medical staff in the long-term.

"I had help from staffers as well as from the company in terms of benefits like free treatment and paid leave. The doctors were agreeable to giving me short breaks to rest. For a worker suffering from TB, such backing at the workplace is paramount."

– Tapan Adhikary (left), an employee

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RELEVANT POLICY DOCUMENT

Statement of Commitment of Indian Employers' Organizations on addressing TB and HIV in the world of work

We, the employers' organisations of India, recognize that:

- Tuberculosis (TB) and HIV/AIDS have emerged as a major threat to the world of work. More than 90 percent of TB and HIV infections in India have been reported from the most productive age group of 15-49 years.
- Most TB and HIV deaths in India occur among young adults in the economically productive age group, with high economic and social costs.
- TB and HIV/AIDS can adversely affect employees and pose a serious threat to enterprise performance due to increased absenteeism, disruption of operations and increased expenditure on employee treatment, replacement and associated costs.

- Development of workplace policy and programmes dealing with TB and HIV/AIDS is the rights thing to do. It protects workers and it also makes business sense.
- Businesses are key institutions in contributing to the development of the national social fabric. Businesses cannot separate their interest from those of the societies in which they function. Businesses are directly exposed to societal dynamics and need to contribute in addressing the need of people who are directly or indirectly affected by TB and HIV/AIDS.
- Ending TB and AIDS by 2030 is a global commitment under sustainable Development Goal 3, which calls for wide-ranging partnerships beyond the health sector.
- India stands committed to the goal of **'achieving a rapid decline in burden of TB, morbidity and mortality while working towards elimination of TB in India by 2025'** and to the goal of **'ending the AIDS epidemic as a public health threat by 2030'.** The National TB control programme as well as the National AIDS Control programme, being run by the Ministry of Health envisage a multi-sectoral response with the engagement of the private sector/employers, enterprises and trade unions in achieving these goals.

Therefore, we commit to provide leadership and take concrete steps to collectively advocate for greater response to TB and HIV/AIDS from the world of work in partnership with the Indian government at central and state level, trade unions, ILO, UNAIDS, WHO, international agencies and other relevant stakeholders, including the informal economy actors.

We endorse the guidelines provided by the National HIV and TB policies; the National Policy on HIV and AIDS and the world of work; and the draft National Policy Framework on TB and HIV/AIDS in the world of work.

We encourage our member companies to effectively use these guidelines in developing policy and programmes on TB and HIV/AIDS at their workplaces.

We pledge to undertake sincere efforts to develop our response following the key principles which are:

- **Recognition of TB and HIV/AIDS as workplace issues**

TB and HIV/AIDS are workplace issues, not only because they affect the workforce, but also because the workplace can play a vital role in limiting the spread and effects of the epidemics.

- **Non-discrimination**

There should be no discrimination or stigmatization of employees – on the basis of TB and on real or perceived HIV status and /or because of the sexual orientation of an employee.

- **Gender equality**

More equal gender relations and the empowerment of women are vital to successfully preventing the spread of HIV and TB and enabling women to cope with TB and HIV/AIDS.

- **Healthy work environment**

The work environment should be healthy and safe, and adapted to the state of health and capabilities of employees.

- **Social dialogue**

A successful TB and HIV/AIDS workplace policy and programme requires cooperation and trust between employers, employees, and governments.

- **Confidentiality**

Access to personal data relating to a worker's HIV and TB status should be bound by the rules of confidentiality.

- **Continuing the employment relationship**

TB and HIV infection should not be the causes for termination of employment. Persons with TB and HIV-related illnesses should be able to work for as long as medically fit to work.

- **Prevention**

Both HIV and TB are preventable. Prevention should be the primary focus and prevention strategies should be focus on behaviour change, knowledge, treatment and the creation of a non-discriminatory environment.

Treatment, Care and support

All employees are entitled to health services and to benefits from statutory and occupational schemes. Government of India provides free treatment for HIV/AIDS (Anti-Retroviral Treatment) as well as for TB. Employers' support is key in ensuring treatment adherence, both for TB as well as for HIV and AIDS. Social protection should also be extended to people living with HIV and TB patients.

On our part, we commit ourselves to the following:

- Collaborate with the national TB and AIDS control programmes and facilitate partnership with our members to strengthen the multi-sectoral response to TB and HIV/AIDS in India.
- Undertake advocacy with our member enterprises in partnership with national programmes, all relevant development partners, the International Labour Organization, WHO and UNAIDS. Wherever possible, TB and HIV/AIDS will be included in the agenda of our meetings.
- Facilitate technical support – policy advice, training, communication and advocacy, building partnership with the health sector- for our member companies and other affiliates to help them start/strengthen their response to TB and HIV/AIDS in their workplaces.
- Collaborate with trade unions, civil society organizations, other Indian apex/state bodies of trade and industry associations, networks of People Living with HIV and TB, and other relevant partners.
- Facilitate technical support for our members from relevant agencies should they wish to integrate TB and HIV/AIDS in their welfare and/or Corporate Social Responsibility initiatives.
- Develop and disseminate best practices on TB and HIV/AIDS workplace programmes.
- Set up an annual award to recognize the enterprises that provide exemplary leadership and implement result-oriented TB and HIV/AIDS programmes. We shall seek partnership with national programme and international organizations such as the ILO to develop a sound criterion for such an award, which will form the basis for selection of enterprises for the award.
- Participate in key national/state level committees on TB and HIV/AIDS in India and at the international level to present our views and generate support for expanding the workplace interventions in India.
- Undertake collaborative efforts in preparing and submitting proposals for workplace initiatives to national and international funding agencies, including the Global Fund on HIV/AIDS, Tuberculosis and Malaria. We will seek technical help from ILO, UNAIDS, NACO and other relevant agencies in this regard.
- Advocate for increase domestic funding for TB and HIV in India; including efforts in mobilizing resources form the private sector.
- Create an internal focal point in our organizations for TB and HIV/AIDS and develop a mechanism to plan and review our yearly activities on TB and HIV/AIDS.

Signed by AIOE, ASSOCHAM, CII, EFI, FICCI, LUB, SCOPE

A GUIDANCE NOTE FOR ENTERPRISES:

1. Formulating a TB and HIV workplace policy

A TB and HIV workplace policy is necessary as it provides the framework for direct action at the workplace and demonstrates the support and commitment of management. It should be developed in a participatory manner with the active involvement of senior management and representatives of workers. This process enhances trust, transparency, accountability, ownership, commitment as well as sustainability of the workplace programme.

Following the guidelines of the national policies and taking inspiration from the ILO Recommendation on HIV and AIDS and the world of work (No.200); and the ILO's guidelines Tuberculosis: Guidelines for Workplace control activities, enterprises can develop their policy.

The workplace TB and HIV policy should be integrated in a broader policy (e.g. health, wellness or occupational safety and health policy) or agreement, or an exclusive statement of commitment.

The policy should be developed through an internal committee, involving workers and their representatives; and should encompass the following principles:

- recognition of TB and HIV as workplace issues
- Non-discrimination
- Healthy work environment
- social dialogue
- gender equality
- confidentiality
- continuation of employment and reasonable accommodation
- prevention
- treatment, care and support.

For all employees, when medical records are kept in the company, provision needs to be made for adequate data processing measures. These measures should be governed by rules of confidentiality consistent with the ILO code of practice on the protection of workers' personal data, 1997, and other relevant international data protection standards. The transfer of important medical information with the employee at exit (e.g. past TB/HIV treatment experience) should be consistent with these rules and should be done in a fully confidential manner.

The purpose of a policy is to ensure a consistent and equitable approach to the implementation and integration of TB prevention, treatment and care activities with related HIV workplace programmes among employees, their families as well as the communities in which the business is situated.

Benefits of a workplace policy on TB and HIV

- Supports early detection and treatment of employees and keeps them healthy and productive
- Supports employees affected by HIV and TB to understand what support and care they will receive, assures non-discrimination, their employment protection status, so that they are more likely to come forward for appropriate treatment;
- ensures consistency with appropriate national policies and legislation;
- makes an explicit commitment to corporate action;
- establishes and protects the rights of those affected;
- states a standard of behaviour for all employees (whether infected or not);

- provides guidance to supervisors, managers, unions, human resource and occupational health professionals;
- helps to control the spread of TB and HIV; and;
- assists an enterprise in planning for TB and HIV care and control.

2. Management commitment:

- Commitment by the management to provide sustainable resources and staff time for TB and HIV prevention, treatment and care in the workplace.
- Development and implementation of clear workplace policy on TB and HIV.
- Implementation of administrative and environmental infection control measures to minimize the risk of transmission of infection in the workplace.

3. Behaviour Change Communication

Awareness and educational campaigns to create awareness on HIV and TB, address negative attitudes towards people with TB and HIV and increase awareness among the employees about TB and TB/ HIV co-infections;

4. Early detection

Promotion of voluntary counselling and testing for HIV and detection of TB. This requires partnership with the nearby health facilities or strengthening health facilities within the enterprises, if they exist. Ensuring access to good quality diagnostic services, particularly sputum smear microscopy to ensure early detection of infectious cases, thereby preventing the further spread of TB.

5. Treatment and treatment adherence

Systems should be in place for providing anti-retroviral treatment (ART) for those who turn out to be HIV positive, with due respect for confidentiality and non-discrimination. For TB patients, Direct observation of standardized short course chemotherapy by a healthcare worker or treatment supporter to ensure a cure and prevent the emergence of drug resistance should be arranged. Partnership with the nearest ART centres and DOTS programme of health department need to be ensured.

Employers support can be key in ensuring treatment adherence. Counselling, leave provision, nutrition, and psychosocial support for employees who have TB and HIV need to be ensured.

Efforts should also be made to link up with the government social protection schemes so that employees, particularly the contractual workers may avail the benefits.

6. Monitoring and evaluation

- Systematic monitoring and standardized reporting on implementation of policy and programme through internal committees
- Assessment of the impact on awareness, testing and treatment measures.

Session 6

BEHAVIOUR CHANGE COMMUNICATION

BEHAVIOUR CHANGE COMMUNICATION

The process of influencing individuals' behavior changes through effective communication.

Why are we talking about Behaviour Change Communication (BCC)?

- Because knowledge and awareness do not always translate into safe sexual behavior.

Theory of Behaviour Change Process:

An individual goes through the following stages, before changing their behaviour:

- Unaware
- Aware
- Concerned
- Knowledgeable
- Motivation to change
- Trial and assessment
- Sustained behavior changes

BCC Encompasses:

- Increasing risk perception;
- Encouraging personal commitment to change;
- Enhancing skills to make changes;
- Creating an enabling environment.

Strategic Segmentation of Audience:

- Clients
- Service Providers
- Opinion-makers

BEHAVIOR CHANGE IN WORKPLACE PROGRAMMES

What do we attempt to change?

I. Behavior change in Managers (government, employers, unions):

- Develop workplace policy and Programme, if you don't have one;
- Develop and implement a plan (appoint nodal person, set up a TB and HIV/AIDS committee, allocate budget);
- Allow staff time for TB/HIV education and training;
- Ensure refresher training for peer educators to keep them motivated and address high drop-out rate.

II. Behavior change in Workers:

- Participate in awareness programmes and know about STI, TB, and HIV/AIDS;
- Understand and reduce risky behaviors, if any;
- Develop non-discriminatory behaviors towards PLHIV or co-workers;
- Use condoms for protection;
- Take treatment for STI;
- Know your HIV status - Visit a Counselling and Testing Centre;
- Share your knowledge with family/friends - Play a role in HIV prevention efforts.

Key Components of BCC Plan:

- Research to understand existing knowledge, practices, attitude, and behaviors;
- Development and use of audience-specific communication materials;
- Training of service providers;
- Interpersonal communication;
- Use of different media channels;
- Special events/programmes;
- Monitoring and evaluation to track progress.

BCC IN TB AND HIV/AIDS PROGRAMME

BCC is an essential component in the HIV Programme because:

- BCC provides information and knowledge crucial to control the epidemics of TB and HIV/AIDS;
- HIV spread depends on the personal behaviors of individuals, those behaviors can be addressed through effective BCC;
- BCC promotes and supports the uptake of services;
- Strengthens skills of the individual to make necessary changes;
- Develops a supportive environment;
- BCC promotes and supports the uptake of other services such as STD treatment, Condom use, Counselling and Testing, ART, and other referral services.

Some of the Approaches of BCC:

- Interpersonal Communication (one to one and small group informal discussions) sessions conducted by health educators, peer educators, etc. is the most effective method;
- Use of local media - street theatre, folklore, etc.
- Application of IEC materials.

INTERPERSONAL COMMUNICATION (IPC)

To make the IPC session effective, the peer educator/ health worker should follow the points below:

- Should update the information from time to time on HIV/AIDS and STDs services available;
- Understand the target audience and their needs for information, and services and customizes the session as per the target audience' needs;
- Demonstrate respect for the audience and create a friendly atmosphere;
- Deal with each topic wholly and separately, do not give too much information or too little information;
- Get the attention of the audience;
- Create a participatory atmosphere so that the audience can ask questions and seek clarifications;
- Take feedback;
- Address key concerns and questions;
- Use appropriate IEC materials;
- Leave behind your contact details in case someone from the group would like to contact after the session in private.

Efficacy of sessions depends on:

- The attitude of the service provider (Non-judgmental, unbiased);
- Use of language (non-technical and straightforward);
- Timing (when to start, when to finish);
- Rapport building;
- Dealing with the noise (external and internal);
- Involvement of the target audience;
- Proper use of materials;
- Effective listening and observation;
- Call for action and take feedback.

Session 7

FACILITATING EARLY DETECTION AND TREATMENT FOR TB AND HIV/AIDS AT WORKPLACES

To accelerate the movement to end the global AIDS epidemic, one of the principal components of the 90-90-90 treatment targets set by UNAIDS to be achieved by 2020, is to ensure that 90% of all people living with HIV are aware of their HIV status. Towards this end, the voluntary, confidential counselling and HIV testing for workers[17] (VCT@WORK) initiative is part of the ILO's efforts to take an active and rights-based approach to reach women and men workers, their families and communities by promoting voluntary, confidential HIV counselling and testing for workers. The initiative is grounded on the principle of overcoming the stigma and discrimination towards HIV/AIDS at the workplace.

By fostering strong partnerships with key players engaged in HIV testing initiatives, and establishing extensive referral links with other service providers, the initiative has improved not only the accessibility, and coverage of HIV testing services, but also has helped to alleviate the stigma and discrimination surrounding the disease at workplace.

In a similar vein, the strategies adopted by this initiative have been expanded to early detection of TB through the public-private engagement approach advocated by the National Strategic Plans (NSP - 2017-25) for control and prevention of TB. Instituting referral networks through the workplace will ensure early diagnosis and treatment initiation for workers affected by active TB disease.

"VCT@WORK is a path-breaking campaign. Be part of this to protect employees as well as future generations from HIV."

Radha Shyam Mahapatra,
Director Personnel, Central Coalfields Ltd., Ranchi, India

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