

# **World Council of Churches**

## **Towards a Policy on HIV/AIDS in the Workplace**

*Working Document*

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## I Preamble

The Book of Genesis shows us a God who looks back on every day of Creation and sees that it is good, and on the last day of creation examines all of creation and sees that it is very good (Gen 1:10, 12, 18, 21, 25, 31). The goodness of creation, according to our theology, becomes corrupted by sin, and thus disease and suffering enter into a “very good” creation. Jesus Christ comes to restore the wonder of creation, giving effect to His words, “I have come that you might have life, and have it in all its fullness” (Jn 10: 9-11). Sadly, in this age of HIV and AIDS many churches first responded to the global AIDS epidemic in a pre Jobian manner: “It is God’s punishment for sin” and today many churches are still responding in the same way. What determines whether a person is HIV-positive or not, is not whether that person has done the “lawful” or “unlawful”, but rather whether they have done the “safe” or the “unsafe”.

Today, we know that HIV infection is identifiable, preventable and manageable, and that with current medical know-how there is no reason why anyone should be dying of AIDS-related illnesses. Into this nightmare of the suffering and dying of the orphans and widows, and the threats experienced by the most vulnerable groups including prisoners and migrant workers, the words of Jesus speak again: “A new command I give you: Love one another. As I have loved you, so you must love one another.” (Jn 13: 34-36) The Christian community has done much across the globe to try and ease the pain and suffering of people living with HIV. A sad reality remains that in their reach of love, churches have most frequently reached out before reaching in.

Countless religious leaders have already died of AIDS-related illnesses, and even more frightening is the number of people in churches who had died in shame and many of shame. The stigma and discrimination around HIV and AIDS continues to drive the pandemic as they may prevent people from under going voluntary counselling and testing in order to learn their HIV status. Even if a person knows that they are HIV positive, and he or she knows that it is necessary to use a condom to protect his or her spouse; frequently he or she will not do so because the condom is associated with HIV and as a result questions may arise as to why it is now necessary to use a condom.

Some of the messages given to mitigate the spread of HIV have sadly added to the stigma. “ABC” is one such message.<sup>1</sup> Within the African Network of Religious Leaders Living with or personally affected by HIV and AIDS (ANERELA+), a new model has been developed, called **SAVE** (Safer practices, Available medications, Voluntary counselling and testing, and Empowerment through education). HIV and AIDS prevention will never be effective without a care component and the SAVE model combines both prevention and care components as well as providing messages

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<sup>1</sup> The way in which ABC has been presented and understood by most people is; firstly abstain, if you can’t abstain then be faithful, and if you can not be faithful then use a condom. This in no way takes any cognizance of a person’s HIV status. If you or your partner or prospective partner are living with HIV, and you have not been tested but have unprotected sexual intercourse, this puts the other person at risk of HIV infection. It is also true that while abstinence may be appropriate at some stages of life, faithfulness is always appropriate. In addition to this the use of a condom automatically falls into the category of being used by people who can not be faithful and do not want to abstain. This fuels stigma and keeps people from safer sexual practices.

to counter stigmatization. HIV is a virus not a moral issue. As such the response should be based on public health measures tempered by human rights principles.

**S** refers to safer practices covering all the different modes of HIV transmission. For examples, safe blood for blood transfusion, barrier methods for penetrative sexual intercourse, sterile needles and syringes for injecting, safer methods for scarification and adoption of universal medical precautions.

**A** refers to available medications. Anti-retroviral (ARV) therapy is by no means the only medical intervention needed by people living with HIV (PLHIV). Long before it may be necessary, or desirable, for a person to commence ARV therapy, medical needs concerning opportunistic infections and pathology tests arise. Treating opportunistic infections results in better quality of life, better health and longer term survival. Of vital importance to every person are good nutrition and an adequate supply of clean water, and this is doubly so for PLHIV.

**V** refers to voluntary counselling and testing, one intervention which may mitigate HIV-related stigma and increase the effectiveness of HIV prevention efforts. A person who knows his or her HIV status is in a better position to protect him or herself from infection or from infecting another, depending on the person's status. In addition, someone who is HIV-positive can be provided with information and support to live positively. People who are ignorant of their HIV status or who are not cared for can be sources of new HIV infections.

**E** refers to empowerment through education. It is not possible to make an informed decision without all the facts. Misinformation and mis-action are two of the greatest factors driving HIV- and AIDS-related stigma and discrimination. Correct information needs to be disseminated to all within churches so as to ensure that people respond to others through knowledge and from a perspective of Christ centred love. This will assist people to live positively – whatever their HIV status – and break down barriers which HIV has caused between people and within communities. Education also includes information on good nutrition, stress management and the need for physical exercise.

None of the models will be effective though if we cannot normalize the situation around HIV and AIDS.

Churches need to take the step and acknowledge that some people, in their employment or who work as volunteers, are not only living with HIV but dying from AIDS-related illnesses at a time where this is preventable. One of the ways in which HIV and AIDS can be normalized is for churches to adopt a Workplace Policy on HIV and AIDS, leading the field by example.

A gap has developed between churches and the society within which they live and operate. The Gospel imperative of love demands our reaching out to these communities. One of the roles of churches must be to promote and protect the health of those identifiable groups with at-risk behaviours which currently have high or increasing rates of HIV infection, or which public health information indicates are at greatest risk of and most vulnerable to new infection as indicated by such factors as the local history of the epidemic, poverty, sexual practices, drug-using behaviour,

livelihood, institutional location, disrupted social structures and population movements, forced or otherwise.

This workplace policy has been developed by the World Council of Churches in conjunction with African Network of Religious Leaders Living with or personally affected by HIV & AIDS (ANERELA+) and the Global Network of People living with HIV/AIDS (GNP+) to fill this gap, to help churches take the lead, and embrace and accept people living with HIV both within and outside churches. Nothing could more effectively deal with stigma and discrimination than church leaders and congregants living openly with their HIV status in the full knowledge that they are both accepted and supported by their church.

This workplace policy is in keeping with the on-going work of the WCC and with the statement adopted by the WCC Central Committee on the basis of the WCC Consultative Group on AIDS Study Process, September 1996, which outlined a series actions which churches could undertake in responding to the AIDS epidemic in the “Conclusion: what the churches can do”.<sup>2</sup>

## **II Epidemiological Situation<sup>3</sup>**

In 2005, there were close to five million new HIV infections worldwide, 3.2 million of these in sub-Saharan Africa alone. In the same year, 3 million people died of AIDS-related diseases; more than half a million were children. Today the total number of people living with HIV stands at 40.3 million, double the number in 1995. Despite progress made in a small but growing number of countries, the AIDS epidemic continues to outstrip global efforts to contain it. For regional epidemiological data *see Annex 1*.

## **III Rationale – Survival of Organizational Capacity**

The churches have a lot at stake if the response to HIV and AIDS is inadequate. This is not only because AIDS will kill more people this decade than all wars and disasters in the past 50 years, but also because it threatens the organizational capacity and very survival of churches in countries with high HIV prevalence. The collapse of churches would have implications for all aspects of the life of churches.

In acknowledgement of the devastating impact of AIDS, church leaders of Africa, and international and African ecumenical organizations developed a co-ordinated Plan of Action to respond to the AIDS epidemic in Africa, at a World Council of Churches (WCC) “Global Consultation on Ecumenical Responses to the Challenges of HIV/AIDS in Africa”, Nairobi, Kenya, 25-28 November 2001. The Plan of Action stated, “The Plan is part of the response, by these groups of partners, to the urgent challenge presented by the AIDS epidemic: a challenge to which all religious organizations have been struggling to respond, which is depopulating Africa faster than any calamity since the slave trade.”<sup>4</sup>

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<sup>2</sup> World Council of Churches Central Committee, Geneva, Switzerland 12-20 September 1996. Document No. 6.2B. The Impact of HIV/AIDS and the Churches' Response. A statement adopted by the WCC Central Committee on the basis of the WCC Consultative Group on AIDS Study Process, September 1996.

<sup>3</sup> UNAIDS, *Report on the Global AIDS epidemic*, 2005.

<sup>4</sup> The Ecumenical Response to HIV/AIDS in Africa, Plan of Action, developed at the “Global Consultation on Ecumenical Responses to the Challenges of HIV/AIDS in Africa”, Nairobi, Kenya, 25-28 November 2001.

## 1. Objectives

The World Council of Churches' HIV/AIDS Workplace Policy is intended to:

- Minimise the possibility of HIV infection for employees and volunteers and of churches as well as ordinands, and any of the aforementioned persons' spouses and dependents
- Assure ordination candidates that their HIV status will in no way influence their acceptance by churches as ordinands or influence whether or not the person will be ordained
- Assure a supportive work environment for employees, volunteers and ordinands living with or affected by HIV
- Assure that employees, volunteers and ordinands, and their spouses and dependents have access to care, support and treatment, including anti-retroviral therapy when necessary
- Manage and mitigate the impact of HIV on the life and work of churches
- Mitigate the impact of denial, stigma and discrimination in the workplace whether on the basis of real or perceived HIV status, or vulnerability to HIV infection

## 2. Definitions

**Acquired Immunodeficiency Syndrome (AIDS)** - is the late stage of the infection caused by the Human Immunodeficiency Virus (HIV). A person living with HIV can look and feel healthy for a long time before a AIDS diagnosis. However, HIV weakens the body's defence (immune) system until it can no longer fight off diseases and infections such as pneumonia, diarrhoea, tumours, cancers and other illnesses.

**Human Immunodeficiency Virus (HIV)** - this is the virus that may result in AIDS or Acquired Immunodeficiency Syndrome. HIV attacks the body's immune system – the system that fights against infections.

**Anti-Retroviral (ARV) Therapy** – drugs used in the treatment of HIV infection. They work against HIV infection itself by slowing down the reproduction of HIV in the body but are not a cure.

**Employee** is a person whose calling has been recognized and receives financial or other compensation for ministry exercised on a church's behalf, or lay people holding paid positions within churches.

**Volunteer** is a person who participates in the ministry of a church on a voluntary basis whether financially compensated or not.

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**Ordinand** is a person who a church has accepted as having a calling from God, and who that church is assisting with theological and other training in preparation for ordination.

**Spouse** is the married partner of the employee, volunteer or ordinand.

**Dependent** is defined as a person:

- Living in the country but not necessarily in the same residence as the employee, volunteer or ordinand and for whom the employee, volunteer or ordinand is responsible.

In addition:

- No distinction is to be drawn between adult and child dependants in terms of the coverage provided under the terms and conditions of this policy, and
- Up to a total of eight dependants, who must be registered by name with the church or faith-based organization, may be covered by the terms and conditions of this policy.

**HIV-related information** includes information that someone:

- may be living with HIV;
- has been asked to have an HIV test or been counselled about having a HIV test;
- is receiving or has received treatment or counselling which suggests he or she may be living with HIV;
- may have had experiences which puts him or her at risk of contracting HIV; or
- has a close association or relationship with someone living with HIV.

**HIV screening** means any measurement of potential or actual HIV infection, whether direct (HIV testing), indirect (assessment of risk-taking behaviour) or asking questions about tests already taken or about medication.

**Reasonable accommodation** means any modification or adjustment to their work or responsibilities that is reasonably practicable and will enable a person living with HIV to have access to, or participate or advance in employment.

**Post-exposure prophylaxis (PEP)** a type of antiviral therapy for HIV designed to reduce (but not eliminate) the possibility of infection with the virus after a known exposure.

**Universal blood precautions** are a simple standard of infection control practice used to minimize the risk of infection with blood-borne pathogens, including HIV and hepatitis. Universal precautions involve the use of protective barriers such as gloves, gowns, aprons, masks, or protective eyewear, which can reduce the risk of exposure of the person's skin or mucous membranes to potentially infective materials.

### **3. Responsibility for implementation**

Responsibility for implementation of this workplace policy rests with the highest decision making authority of churches/ Regional Ecumenical Organization (REO)/ faith based organization.

#### **4. Confidentiality**

4.1 Churches must encourage a supportive work environment in which employees, volunteers and ordinands can discuss HIV openly, including their own experience living with HIV. Where employees, volunteers and ordinands disclose that they or their spouse and/or dependents are living with HIV, the confidence will be respected. Disclosure under all circumstances will be treated as shared confidentiality between the parties, unless expressly stated to the contrary. If there is any doubt, the person living with HIV should be consulted before further disclosure takes place.

4.2 HIV-related information concerning prospective ordination candidates or employees or volunteers, or current employees or volunteers or any of the above mentioned people's spouses and/or dependents will be kept strictly confidential.

4.3 Employees and volunteers working for churches as well as ordinands shall sign a confidentiality agreement (Annex 2), and shall be informed that the unauthorised disclosure of HIV-related information is a disciplinary offence. It may also lead to legal proceedings against the person who disclosed the information and the church.

#### **5 Gender dimensions**

5.1 Churches acknowledge that HIV impacts on male and female employees, volunteers and ordinands differently in regard to physiological susceptibility to infection as well as reproductive health. It is also acknowledged that women normally undertake the major part of caring for those with AIDS-related illnesses, and that pregnant women with HIV have additional special needs.

5.2 Any assistance programmes will be designed to accommodate these differing impacts, and as appropriate to redress gender inequalities, for example by encouraging and supporting men as carers.

#### **6. Safer Practices (sexual or otherwise)**

6.1 The relevant church authority will provide employees, volunteers and ordinands with sensitive, accurate and up-to-date information to enable them to protect themselves from HIV and other sexually transmitted or blood borne infections as well as TB, malaria and sleeping sickness.

6.2 Where the blood supply is not secure, the relevant church authority will provide information to employees, volunteers and ordinands as to where safe blood can be obtained.

6.3 The relevant church authority will also provide information on where sterile needles and syringes can be obtained due to the fact that HIV transmission may occur through the use of non-sterile needles and syringes.

6.4 The relevant church authority will ensure all church vehicles are fully fitted with seat belts. Where available, seat belts must be worn by all employees, volunteers and ordinands when travelling on duty. The relevant church authority will also ensure that all vehicles are regularly and properly serviced and maintained.

6.5 Employees, volunteers and ordinands must wear helmets when travelling on duty by motorcycle.

## **7. Occupational or other exposure**

7.1 In the case of accidents involving the risk of exposure to human blood, universal precautions shall be used to ensure there is no risk of HIV transmission or other blood borne infections. This requires that in premises and vehicles, first aid kits are available.

7.2 The relevant church authority shall develop procedures for the immediate referral for counselling, assessment and medical treatment (including post-exposure prophylaxis, where appropriate) of employees, volunteers and ordinands as well as their spouses and dependents exposed to the risk of HIV infection (e.g. through an accident or sexual assault), whether in the workplace or elsewhere.

7.3 Reasonable paid time off will be provided for counselling following occupational or other exposure.

## **8. Available Medication (Opportunistic Infections, Pathology and Anti-retroviral (ARV) Therapy)**

8.1 The Gospel imperative to love should guide the AIDS response in churches including care, support and treatment for employees, volunteers and ordinands as well as their spouses and their dependents living with HIV. All employees, volunteers and ordinands as well as their spouses and their dependents irrespective of HIV status are entitled to affordable health services.

The compromised immune system resulting from HIV infection leaves people more susceptible to bacteria, parasitical, viral and other forms of infection. Churches need to take special care of the health needs of employees, volunteers and ordinands, and their spouses and dependents by providing access to medications to treat opportunistic infections, which results in better quality of life, better health and longer term survival.

Part of the successful treatment of opportunistic infections involves their timely diagnosis. Management of HIV infection requires the on-going monitoring of the person's immune response,<sup>5</sup> and when medically indicated, churches need to make

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- An annual CD4 cell count test if available locally
- Update of haemoglobin or hematocrit levels
- A pregnancy test for women
- Regular total white blood cell count and differential tests as necessary from the commencement of therapy.
- Serum alanine or aspartate aminotransferase level

anti-retroviral therapy available, including appropriate monitoring, to employees, volunteers and ordinands as well as to their spouses and their dependents.

8.2 People living with HIV, their families and friends need counselling and support along their journey of testing, diagnosis, living with and perhaps dying of AIDS. The experience of a HIV-positive person talking with someone else who is also HIV-positive – peer support – can be very helpful in drawing people out of their fear and isolation due to their HIV status, and expose them to ways of positive living. Churches should provide safe spaces for congregational-based PLWHA support groups. In addition, the partnership between churches and PLWHA networks is useful for linking people to support groups as well as peer education and support.

8.3 Of vital importance to every person are good nutrition and an adequate supply of clean water. For PLWHA these needs are amplified. In the event that these needs are met, many other interventions are delayed or not necessary. Churches must ensure the provision of advice, training and support about the increased energy and protein needs as well as foods that provide key micronutrients to employees, volunteers and ordinands as well as their spouses and their dependents living with HIV. Information on ensuring the safety of water must likewise be provided. This can be done in conjunction with PLWHA networks and other partners.

## **9. Voluntary Counselling and Testing**

9.1. Access to free, voluntary and confidential HIV counselling and testing (VCT) shall be made available to employees, volunteers and ordinands as well as to their spouses and dependents either by the relevant church authority or where this service is not made available will provide information as to where the services are available. Where these services are not provided free of charge churches will reimburse the costs of VCT.

9.2. The relevant church authority will nominate a person, ordained or lay, from whom employees, volunteers and ordinands can seek confidential advice, counselling and referral on HIV-related matters.

## **10. HIV Screening and Employment**

10.1 There is no obligation on prospective ordination candidates or employees or volunteers, or current employees or volunteers to inform the relevant church authority of their HIV status.

10.2 HIV status will in no way be taken into consideration for ordination, employment or placement within churches.

10.3 HIV screening will not be required either as a condition of employment or for continuation of employment.

## **11. Information and Training**

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- Serum creatinine and/or blood urea nitrogen
  - Serum Glucose

11.1 The relevant church authority will provide information and training on workplace issues raised by the HIV epidemic, on appropriate responses, and on the general needs of people living with HIV and their carers.

11.2 Such information and training will be gender sensitive, as well as sensitive to race, disability, and human sexuality.

11.3 Information will include the availability of local support organizations for people living with HIV, and other affected communities as well as people living with HIV networks working in partnership with churches.

11.4 As far as practicable, such information and training will be integrated into existing programmes and formative training for ordinands.

11.5 Training for employees, volunteers and ordinands on HIV will take place during paid working hours and attendance by all employees, volunteers and ordinands, including all within churches' hierarchy, will be considered as part of work obligations.

11.6 Such training will be open, where practicable, to the spouse and dependents of employees, volunteers and ordinands.

11.7 Relevant church authorities will be trained on the implementation of this policy.

## **12. Reasonable accommodation**

12.1 Churches will reasonably accommodate the special needs of employees, volunteers and ordinands living with, or directly affected by, HIV when and where practicable.

12.2 Reasonable accommodation may include flexible working hours and time off for counselling and medical appointments, extended sick leave, transfer to lighter duties, part-time work, and return-to-work arrangements.

## **13. Stigma and discrimination**

13.1. Churches acknowledge that denial, stigma and discrimination related to HIV is a sin and against the will of God. As such, churches will not discriminate on the basis of actual or perceived HIV status under any circumstances, including opportunities for placement and advancement.

13.2 Churches will put in place processes through which reconciliation between PLWHA and their churches can be effected.

13.3. Employees, volunteers or ordinands living with HIV will be treated no less favourably than employees, volunteers or ordinands with other serious illnesses.

13.4. The relevant church authority will undertake activities to address HIV- and AIDS-related stigma in churches, including through employee, volunteer and

ordinand training and the promotion of an open, accepting and supportive work environment for all who chose to disclose their HIV status.

13.5. Employees, volunteers and ordinands who discriminate against people living with HIV will be subjected to disciplinary procedures in the event that counselling efforts fail.

#### **14. Advocacy for universal access**

The failure to deliver ARV therapy to the millions of people who need it is a global health emergency. Some six million people in developing countries, who are HIV-positive, will require antiretroviral therapy by 2005. However, only some 440 000 people are currently being treated. In sub-Saharan Africa, where most of the people in need of treatment live, only 150,000 people are receiving ARVs.<sup>6</sup> Churches are well placed to be involved in advocacy work for access to treatments for all who need it.

#### **15. Travel, assignment and vaccination**

15.1 When arranging short-term travel to other countries for church employees, volunteers and ordinands, the relevant church authority will notify the individual of any legal restrictions on entry for people living with HIV.<sup>7</sup> If an employee, volunteer and ordinand cannot undertake short-term travel for this reason or any other HIV health-related reason, reasonable accommodation will be made to identify other tasks.

15.2 When arranging long-term travel or reassignment for employees the relevant church authority will notify the employee of any legal requirements for HIV screening.<sup>8</sup> When HIV screening is required, the relevant church authority will ensure referral to pre and post-test counselling for the employee, and will reimburse the cost for such counselling if it is not otherwise available free of charge.

15.3 If an employee is unable to take an assignment in a particular country because of that country's HIV-related requirements, the relevant church authority will take reasonable steps to find an alternative post.

15.4 The relevant church authority should find out what restrictions apply to people living with HIV entering the country. If there are restrictions, the relevant church authority should advocate with the government for these to be repealed.

#### **16. Termination of employment**

16.1 HIV infection is not a cause for termination of employment.

16.2 Employees, volunteers and ordinands with a HIV-related illness will continue in employment as long as they are medically fit for available, appropriate work.

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<sup>6</sup> WHO, Coverage and need for antiretroviral treatment, <http://www.who.int/3by5/coverage/en/>, cited 14 September 2004

<sup>7</sup> Entry and Residency Regulations For People Living with HIV/AIDS Information on 168 countries, online in English, French and German [www.aidsnet.ch/linkto/immigration/](http://www.aidsnet.ch/linkto/immigration/). In order to procure the most up to date information the embassy of the relevant country should be consulted.

<sup>8</sup> Entry and Residency Regulations For People Living with HIV/AIDS Information on 168 countries, online in English, French and German [www.aidsnet.ch/linkto/immigration/](http://www.aidsnet.ch/linkto/immigration/). In order to procure the most up to date information the embassy of the relevant country should be consulted.

16.3 In the case of termination of employment due to extended illness; employees, volunteers and ordinands living with HIV will be accorded the same benefits and conditions as apply to termination due to other serious illnesses.

### **17 Grievance and disciplinary procedures**

17.1 The relevant church authority will provide procedures that can be used by employees, volunteers and ordinands for work-related grievances, including failure by the church to implement any aspect of this policy.

17.2 Disciplinary proceedings may be commenced against any employee, volunteer or ordinand who violates this policy.

## Annex 1

### Regional Epidemiological Data<sup>9</sup>

#### HIV in sub-Saharan Africa

Sub-Saharan Africa has just over 10% of the world's population, but is home to more than 60% of all people living with HIV—25.8 million. In 2005, an estimated 3.2 million people in the region became newly infected, while 2.4 million adults and children died of AIDS.

Declines in adult national HIV prevalence appear to be underway in Kenya, Uganda and Zimbabwe. Each of those countries, however, remains saddled with a large, potentially ruinous epidemic. HIV prevalence remains exceptionally high in southern Africa and the epidemic is continuing to expand, notably in Mozambique and Swaziland. West and Central Africa show no signs of changing HIV infection levels, except for urban parts of Burkina Faso where prevalence appears to be declining.

In South Africa the epidemic has evolved at an astonishing speed. National adult HIV prevalence of less than 1% in 1990 soared to almost 25% within 10 years. New data from South Africa show that HIV prevalence among pregnant women has reached its highest levels to date: 29.5% of women attending antenatal clinics tested HIV-positive in 2004. AIDS in South Africa is taking a devastating toll on human lives. A recent study of death registration data has shown that deaths among people 15 years of age and older increased by 62% from 1997-2002.

Very high HIV prevalence—often exceeding 30% among pregnant women—is still being recorded in Botswana, Lesotho, Namibia and Swaziland and there is no clear evidence of a decline in HIV prevalence. In Swaziland HIV prevalence among pregnant women soared to 43% in 2004, up from 34% four years earlier. In 1992, prevalence had stood at 4%.

In Malawi the epidemic is diverse and has not yet exhausted its potential for growth. Prevalence among pregnant women ranged from just under 7% at a site in the central region to 33% at the southern tip of the country. Prevalence in rural communities is particularly high (up from 12.1% in 1999 to 14.5% in 2003) as is prevalence among pregnant women (20% among 20-24 year-olds).

In Zambia, national mean HIV prevalence among adult pregnant women has hovered at 18-20% since 1994 with rising prevalence trends seen among 15-19 year-old antenatal clinic attendees. Urban residents are twice as likely to be HIV-positive, compared with those in rural areas, with the highest infection levels clustered in cities and towns that straddle major transport routes.

#### HIV in Asia

In 2005, some 8.3 million people were living with HIV in Asia, including 1.1 million people who became newly infected in the past year. AIDS claimed some 520,000 lives in 2005. National HIV infection levels in Asia are low compared with some other continents, notably Africa. But the populations of many Asian nations are so

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<sup>9</sup> UNAIDS (2005). *AIDS Epidemic Update*. December 2005.  
<http://www.unaids.org/Epi2005/doc/download.html>

large that even low national HIV prevalence means large numbers of people are living with HIV. Injecting drug use is the strongest initial driver of HIV infection in Asia.

In China, HIV cases have been detected in all 31 provinces. The most serious HIV epidemics in China to date have been clustered among specific population groups (injecting drug users, sex workers, former plasma donors, and their partners) and in certain geographical areas, especially in the south and west of the country.

HIV prevalence of 18-56% was found in drug injectors in six cities in the southern provinces of Guangdong and Guangxi in 2002, while in Yunnan province just over 20% of injectors tested positive for HIV the following year. Paid sex probably accounts for a large part of the estimated 20% of HIV infections in China that are due to unprotected heterosexual contact. The potential overlap between paid sex and injecting drug use is likely to become the main driver of China's epidemic.

China has made slow progress in realizing the 2003 pledge to provide free antiretroviral treatment to all who need it; by June 2005, about 20,000 people were receiving the drugs in the 28 provinces and autonomous regions where antiretroviral treatment had been introduced.

Diverse epidemics are underway in India, where an estimated 5.1 million Indians were living with HIV in 2003. Although levels of HIV infection prevalence appear to have stabilized in some states (such as Tamil Nadu, Andhra Pradesh, Karnataka and Maharashtra), it is still increasing in at-risk population groups in several other states. As a result, overall HIV prevalence has continued to rise.

Transmitted mainly through unprotected sex in the south and injecting drug use in the north-east of India, HIV is spreading beyond urban areas. A significant proportion of new infections are occurring in women who are married and who have been infected by husbands who visited sex workers.

Surveys carried out in various parts of India in 2001 found that 30% of street-based sex workers did not know that condoms prevent HIV infection, and in some states fewer than half of all sex workers knew that condoms prevent HIV. Large proportions of sex workers (42% nationally) also thought they could tell whether a client had HIV on the basis of his physical appearance.

Indonesia is on the brink of a rapidly worsening AIDS epidemic mainly due to widespread injecting drug use. Over 70% of people who requested testing in Pontianak (on the island of Borneo) discovered that they were infected with HIV; three quarters of them were injecting drug users. Meanwhile, HIV prevalence as high as 48% has been found in drug injectors at rehabilitation centres in Jakarta.

In Viet Nam, where HIV already has spread to all 64 provinces and all cities, the number of people living with HIV has doubled since 2000 reaching an estimated 263,000 in 2005. HIV infection levels of 40% among drug injectors are not unusual.

The combination of high levels of risk behaviour and limited knowledge about AIDS among drug injectors and sex workers in Pakistan favours the rapid spread of HIV, and new data suggest that the country could be on the verge of serious HIV

epidemics. Already an explosive epidemic has been detected among injecting drug users in Karachi, 23% of whom were found to be HIV-infected in 2004. Knowledge of HIV among injectors (and sex workers) is extremely low. In Karachi, more than one quarter had never heard of AIDS and as many did not know that sharing injecting equipment could leave them infected with HIV. One in five sex workers cannot recognize a condom, three-quarters do not know that condoms prevent HIV and one-third have never heard of AIDS.

In Malaysia, approximately 52,000 people were living with HIV in 2004, the vast majority of them young men (aged 20-29 years), and three-quarters of them injecting drug users.

Thailand has been widely hailed as one of the success stories in the response to AIDS. By 2003, estimated national adult HIV prevalence had dropped to its lowest level ever, approximately 1.5%. However, a study in four cities (including Bangkok and Chiang Mai) found that sex workers reported using condoms only 51% of the time, and mostly with foreigners—a large difference compared to the remarkable 96% rate reported in a 2000 study in Bangkok. Only about one in four Thai clients was likely to use a condom. High HIV prevalence has been found among men who have sex with men in Thailand. In one recent study in Bangkok, 17% of men who have sex with men were HIV-positive and almost one quarter of them had also had sex with women in the previous six months.

In Myanmar limited prevention efforts led HIV to spread freely—at first within the most at-risk groups and later beyond them. Consequently, Myanmar has one of the most serious AIDS epidemics in the region, with HIV prevalence among pregnant women estimated at 1.8% in 2004.

In Bangladesh national adult HIV prevalence is below 1%. Bangladesh began initiating HIV prevention programmes early in its epidemic and, partly due to focused prevention efforts, HIV prevalence in female sex workers has stayed low (0.2%- 1.5% in different sentinel sites). However, the quality and coverage of those initiatives requires strengthening if more rapid HIV transmission is to be prevented.

In the Philippines, national adult HIV prevalence has stayed low, even among at risk populations. However, there are warning signs that this might change. Condom use during paid sex is infrequent, prevalence of sexually transmitted infections has been rising, and high rates of needle-sharing among drug injectors has been found in some parts. According to a major 2003 survey, more than 90% of respondents still believed that HIV could be transmitted by sharing a meal with an HIV-positive person.

### **HIV in the Caribbean**

The AIDS epidemic claimed an estimated 24,000 lives in the Caribbean in 2005, making it the leading cause of death among adults aged 15-44 years. A total of 300,000 people are currently living with HIV in the region, including 30,000 people who became infected in 2005.

Estimated national adult HIV prevalence surpasses 1% in Barbados, Dominican Republic, Jamaica and Suriname, 2% in the Bahamas, Guyana and Trinidad and

Tobago, and exceeds 3% in Haiti. In Cuba, on the other hand, prevalence is yet to reach 0.2%.

The region's epidemics are driven primarily by heterosexual intercourse, with commercial sex a prominent factor, against a backdrop of severe poverty, high unemployment and gender inequalities.

The overall share of reported HIV infections attributed to sex between men is approximately 12%, but homophobia and the robust socio-cultural taboos that stigmatize same sex relations mean that the actual proportion could be somewhat larger. Injecting drug use is responsible for a small minority of HIV infections currently; only in Bermuda and Puerto Rico does it contribute significantly to the spread of HIV.

New HIV infections among women are surpassing those among men. In Trinidad and Tobago HIV infection levels are six times higher among 15-19 year-old females than among boys of the same age. In many countries, sexual activity begins comparatively early—when surveyed, fully one quarter of 15-29 year-old women in Barbados said they had been sexually active by the time they turned 15.

Haiti's epidemic, one of the oldest in the world, could be turning a corner. Overall, the percentage of pregnant women testing HIV-positive shrunk by half from 1993 to 2003/2004—from 6.2% to 3.1%. The trend has been most pronounced in urban areas (where HIV prevalence fell from 9.4% in 1993 to 3.7% in 2003/2004), and especially among 15-24 year-olds—which suggests a significant slowing down of new HIV infections could be occurring in the country's cities. However, Haiti still has the largest number of people living with HIV in the Caribbean.

In the Dominican Republic HIV infections levels in pregnant women have been declining since the late 1990s, with overall HIV prevalence in pregnant women roughly stable at 1.4%. Low HIV infection levels of 3-4% found among commercial sex workers in Santo Domingo probably reflect efforts to encourage consistent condom use and other safer behaviours among them.

HIV infections are on the rise, and Cuba's preventive measures appear not to be keeping pace with conditions that favour the spread of HIV, including widening income inequalities and a growing sex industry. At the same time, Cuba's prevention of mother-to-child transmission programme remains highly effective. All pregnant women are tested for HIV, and those testing positive receive antiretroviral drugs.

While universal access to treatment is being achieved in Cuba, and coverage is relatively high in the Bahamas and Barbados, access to treatment is poor in three of the worst-affected countries in the Caribbean. About one third of people in need of antiretroviral treatment were receiving it in Trinidad and Tobago in September 2005, as were a mere 12% in Haiti and 10% in the Dominican Republic.

### **HIV in Eastern Europe and Central Asia**

The Eastern Europe and Central Asia region has the fastest growing HIV epidemic in the world. An estimated 1.6 million people are now living with HIV, with around

270,000 newly infected in 2004. AIDS claimed almost twice as many lives in 2005, compared with 2003, and killed an estimated 62 000 adults and children.

The epidemic has a young face. 75% of the reported infections between 2000 and 2004 were in people younger than 30 years; in Western Europe, the corresponding figure was 33%. Ukraine, with estimated adult HIV prevalence of 1.4%, remains the worst-affected country in Europe and 25% of those diagnosed HIV-positive are below 20. In the Russian Federation – which accounts for 70% of those living with HIV in the region – 75% of the 860,000 people estimated to be HIV-positive are aged 15-29.

Several Central Asian and Caucasian republics are experiencing the early stages of epidemics. Uzbekistan is experiencing the most dynamic epidemic. In 1999, just 28 HIV diagnoses were reported there; in 2004 there were 2,016 new HIV infections, bringing to more than 5,600 the total number of HIV cases. Kazakhstan's epidemic is centred on young people who inject drugs, some of whom also engage in selling sex. Almost 4,700 HIV cases had been reported there by end-2004—more than three times the total just four years earlier.

In Belarus (where more than 6,200 people had been diagnosed with HIV by the end of 2004) and Moldova (where the figure stood at over 2,300), the epidemic shows no sign of slowing. Quite high levels of risk taking behaviours in south-eastern Europe suggest that HIV could strengthen its presence there unless prevention efforts are stepped up.

Social and economic upheaval have left children and adolescents more vulnerable to HIV infection as a result of poverty, family stress and collapsing social structures. They face sexual and economic exploitation, school dropout and deteriorating social services. The growth of trafficking in drugs and in human beings only exacerbates their vulnerability.

The region faces a deadly combination of HIV and tuberculosis. Multi-drug resistant TB, prevalent in the Russian Federation and Ukraine, is now the leading cause of death among people living with HIV. It is concentrated among the young, the vulnerable and those at greatest risk.

Risks are magnified by low awareness among the young about HIV, low condom use, multiple sexual partners, high rates of sexually transmitted infections, and the sharing of contaminated injecting equipment.

### **HIV in Latin America**

The number of people living with HIV in Latin America has risen to an estimated 1.8 million. In 2005, approximately 66,000 people died of AIDS, and 200,000 were newly infected. Among young people 15–24 years of age, an estimated 0.4% of women and 0.6% men were living with HIV in 2005.

Primarily due to their large populations, the South American countries of Argentina, Brazil and Colombia are home to the biggest epidemics in this region. The highest HIV prevalence has been found in Belize, Guatemala and Honduras—where approximately 1% of adults or more were infected with HIV at the end of 2003.

The region's epidemics are being fuelled by varying combinations of unsafe sex and injecting drug use, with the role of sex between men in HIV transmission being a prominent factor. In nearly all the Latin American countries, the highest levels of HIV infection are being found among men who have sex with men (ranging from 2% to 28% depending on the place). The second-highest HIV levels are found among female sex workers (ranging between 0% and 6.3%). Sex between men has been estimated to account for 25%-35% of reported AIDS cases in countries such as Argentina, Bolivia, Brazil, Guatemala and Peru.

By far the largest and most populous country in the region, Brazil harbours a diverse epidemic which has penetrated all 26 states in the country. Although national HIV prevalence among pregnant women has remained below 1%, a growing share of new HIV infections are among women, and those living in deprived circumstances appear to be disproportionately at risk of infection.

A 2004 survey in Brazil showed that 36% of 15-24 year-olds had had sex before their 15th birthday and that only 62% knew how HIV was transmitted. In Brazil's cities, the contribution of injecting drug use to HIV transmission appears to have declined—this success could be attributed harm reduction programmes. Official estimates show that three quarters of the estimated 200,000 drug injectors in Brazil now use sterile syringes.

In Argentina most new infections have been occurring during unprotected heterosexual intercourse, with increasing numbers of women acquiring HIV. The male-to-female ratio among reported AIDS cases shrank from 15:1 in 1988 to 3:1 in 2004. Injecting drug use and unsafe sex between men continue to provide impetus to the spread of HIV in Argentina, especially in the urban areas of Buenos Aires, Cordoba and Santa Fe provinces, where an estimated 80% of AIDS cases have occurred. When tested in the city of Buenos Aires, some 44% of drug injectors were HIV-positive, while HIV prevalence of 7-15% has been found among men who have sex with men in various studies.

HIV has penetrated rural parts of Paraguay, especially along the borders with Argentina and Brazil.

### **HIV in North America, Western and Central Europe**

The number of people living with HIV in North America, Western and Central Europe rose to 1.9 million in 2005, with approximately 65,000 people having acquired HIV in the past year. Wide availability of antiretroviral therapy has helped keep AIDS deaths comparatively low, at about 30,000 in 2005.

The estimated number of people living with HIV in the United States of America at the end of 2003 exceeded one million for the first time. This reflects the fact that people with HIV are living longer due to antiretroviral treatment, as well as the failure to adapt and sustain the prevention successes achieved during the epidemic's first 10-15 years.

In the United States, unprotected sex between men remains the dominant mode of transmission, accounting for 63% of newly-diagnosed HIV infections in 2003. Injecting drug use accounted for around 20% of new infections in the same year. For

women living with HIV, unsafe heterosexual intercourse is the main mode of transmission—an estimated 73% acquired the virus in that manner in 2003.

As in the United Kingdom, one quarter of people living with HIV in the USA are believed to be unaware that they are infected, and that ignorance is very likely adding impetus to the epidemic.

In Canada just under 58,000 HIV diagnoses had been reported by the end of 2004. The number of reported new annual HIV infections has risen by 20% in the past five years, and women now comprise over one quarter of new diagnoses. This corresponds to the growing proportion of HIV diagnoses attributable to heterosexual transmission (30% in 2004).

More than half a million people are living with HIV in Western Europe, and that number continues to grow amid signs in several countries of a resurgence of risky sexual behaviour. The biggest change in Western Europe has been the emergence of heterosexual contact as the dominant cause of new HIV infections in several countries. Of the more than 20,000 newly diagnosed HIV infections in 2004, more than one third were in women. A large proportion of new diagnoses are in people originating from countries with serious epidemics, principally countries in sub-Saharan Africa.

Sex between men remains an important factor in the epidemics in France, United Kingdom and the Netherlands, and in Belgium, Denmark, Portugal and Switzerland there has been a slight, and in Germany a significant, rise in the number of annual new HIV infections attributed to sex between men. In Germany, new HIV infections in men who have sex with men almost doubled from 2001 to 2004 (from 530 to 982) and unsafe sex between men is the main cause of the steady increase overall in new HIV diagnosis in Germany, which tallied 2,058 in 2004 (44% more than the 1,425 cases diagnosed in 2001).

In Spain HIV cases among drug injectors dropped steeply in the 1990s after methadone treatment and needle-exchange projects had been introduced. New HIV infections among drug injectors have also dropped sharply in Portugal (1,000 in 2004, compared with 2,400 in 2000), and they comprised just over one third of new HIV diagnoses in 2004 (compared with almost one half as recently as 2002).

Overall in Central Europe, the epidemics have remained contained and small. About half the cases in which a mode of transmission was identified in 2004 were due to unprotected heterosexual intercourse, but in a handful of countries— including the Czech Republic, Hungary, Slovenia, and the Slovak Republic— sex between men appears to be the main mode of HIV transmission.

### **HIV in the Middle East and North Africa**

The advance of AIDS in the Middle East and North Africa has continued with latest estimates showing that 67,000 people became infected with HIV in 2005. Approximately 510,000 people are living with HIV in the region. An estimated 58,000 adults and children died of AIDS-related illnesses in 2005.

Available evidence reveals trends of increasing HIV infections in countries such as Algeria, Libya, Morocco, and Somalia. The main mode of HIV transmission in this region is unprotected sexual contact, although injecting drug use is an increasingly important factor and is the predominant mode of infection in Iran and Libya.

Except for Sudan, national HIV prevalence levels are low in all countries of this region. However, most of the epidemics are concentrated geographically and among particular at-risk populations, including sex workers and their clients, drug injectors, and men who have sex with men.

By far the worst-affected country in this region is Sudan, with the highest infections levels found in the south. However, there are recent signs that HIV may be acquiring a stronger presence in the north than previously thought. Among women attending sexually transmitted infection clinics in the capital, over 2% tested positive in 2004, while HIV prevalence of 1% has been found among university students and internally displaced people in states both in the north and south of the country.

According to a recent behavioural study in Sudan, only three quarters of pregnant women have ever heard of AIDS, and fully one fifth of the surveyed women believed they could acquire HIV by sharing a meal with an HIV-positive person. Only 5% knew that condom use could prevent HIV infection, and more than two thirds of the women had never seen or heard of a condom.

Research conducted in Saudi Arabia's capital Riyadh indicates that about half of HIV infections have been occurring during heterosexual intercourse. Most women were married and had acquired the virus from their husbands, while most men had been infected during paid sex. A large proportion (26%) of infections found in the study were attributed to the transfusion of contaminated blood or blood products early in the epidemic.

Official data from Egypt indicate an epidemic that is driven mainly by unprotected sex—with heterosexual intercourse accounting for about one half of HIV cases noted, and sex between men for a further one fifth. Injecting drug use was the mode of transmission in just 2% of HIV cases. Yet, researchers have encountered high levels of risky behaviour among injecting drug users in Cairo, for instance, with more than half the surveyed injectors saying they used non-sterile injecting equipment in the previous month.

In Iran, HIV is circulating widely among drug injectors, of whom there were an estimated 200,000 in 2003, and looks set to spread further. One new study among users attending public drug treatment centres in Tehran suggests close linkages between HIV and drug injecting, incarceration and sexual practices. Most of the drug injectors who participated in the study were sexually active, many either bought or sold sex and only 53% had ever used a condom.

In several countries of this region, a combination of inadequate surveillance data and strong socio-cultural taboos against sex between men could be hiding sex between men as a factor in HIV transmission. Little is known about HIV transmission in prisons, although available data point to elevated risk in those settings. HIV

prevalence of 18% has been reported in prisons in Tripoli, Libya, 2% in Sudan in 2002 and almost 1% in Morocco in 2003.

Knowledge of AIDS in the region is generally poor, and preventive practices are rare, even among populations most at risk of becoming infected. Substantive efforts are clearly needed to introduce more effective HIV prevention strategies in the Middle East and North Africa.

### **HIV in Oceania**

An estimated 74,000 people in Oceania are living with HIV. Although less than 4,000 people are believed to have died of AIDS in 2005, about 8,200 are thought to have become newly infected with HIV. Among young people 15–24 years of age, an estimated 1.2% of women and 0.4% of men were living with HIV in 2005.

HIV infections have now been reported in every country or territory in Oceania, barring Niue and Tokelau. Although the epidemics are still in their early stages in most places, preventative efforts need to be stepped-up.

More than 90% of the 11,200 HIV infections reported across the 21 Pacific Island countries and territories by end-2004 were recorded in Papua New Guinea where an AIDS epidemic is now in full-swing. Since 1997, HIV diagnoses have increased by about 30% each year in Papua New Guinea; approximately 10,000 HIV cases had been diagnosed by the end of 2004, but the actual number of people living with HIV could be five times as high.

Available information points to a mainly heterosexual epidemic in Papua New Guinea in which paid sex and casual sex networks feature prominently. The very high levels of sexually transmitted infections that are being recorded reflect widespread sexual risk-taking which can be expected to fuel continued growth of the epidemic. Unless HIV prevention programmes are drastically and rapidly improved, the combination of wide-scale migration, extreme poverty and severe inequality between men and women (including high levels of sexual violence against women) will fuel the epidemic.

Australia has the oldest epidemic in the region. Having declined by about 25% from 1995-2000, the annual number of new HIV diagnoses in Australia has begun to edge upward again reaching 820 in 2004. This brought the number of people living with HIV in the country to an estimated 14,800 in 2004. A significant proportion (31%) of those infections had occurred during the previous year, possibly reflecting a resurgence of risky behaviour.

The bulk of HIV transmission in Australia still occurs through sex between men, which accounts for 68% of all HIV infections recorded since the epidemic began. However, the share of total HIV infections attributed to heterosexual intercourse has grown from 7% before 1996 to over 23% of new diagnoses by 2004.

There is wide-scale access to antiretroviral therapy in Australia, with more than half the people living with HIV receiving treatment. As a result, median survival time following the diagnosis of AIDS rose from 17 months prior to 1995 to 45 months in 2001.

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New Zealand's epidemic is small by comparison. However, new HIV cases have doubled in recent years—from fewer than 80 in 1999 to 157 in 2004. Sex between men accounted for about half the new diagnoses. Similar to Australia, more than 90% of people with heterosexually-acquired HIV diagnosed in 2004 had been infected abroad. AIDS deaths have declined consistently since the mid-1990s, primarily due to extensive access to antiretroviral treatment.

HIV-infection levels are very low in the rest of Oceania, with the total number of reported HIV cases exceeding 150 only in New Caledonia (246), Guam (173), French Polynesia (220) and Fiji (171).

**Annex 2**

**Confidentiality Agreement**

**(To be completed by all employees, volunteers and ordinands)**

1. I have read and understand this Workplace Policy.
2. I recognise that through association with my church, I may learn information of a highly personal and confidential nature.
3. I understand that such information may include information that someone:
  - may be living with have HIV;
  - has been asked to have an HIV test or been counselled about having a HIV test;
  - is receiving or has received treatment or counselling which suggests he or she may be living with have HIV;
  - may have had experiences which put him or her at risk of contracting HIV; or
  - has a close association or relationship with someone living with HIV.
4. I will only disclose such information when authorised by the person in question.
5. I understand that breach of this agreement may result in disciplinary action, and possible legal proceedings against myself and/or my church.

Signature.....

Date and Place.....

Witness .....

Date and Place.....