Best practices in HIV/AIDS prevention in the informal sector

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<<V – this will have to be checked at the end – I’m not sure this list bears much resemblance to what I’ve looked at. Y>>

INTRODUCTION AND OVERVIEW

About the aims and scope of this paper

This paper is based on experiences from the ILO's four-country study on HIV/AIDS mitigation in the informal sector. It considers "best practices" that have been identified in workplace policies and programmes on HIV/AIDS in the informal economy. It focuses especially on examples which might guide and inform practices and policies pertaining to the informal economy with regard to the following:

- information and awareness-raising programmes
- training and behavioural change programmes
- working conditions, including aspects such as travel, hygiene, childcare arrangements
- counselling and testing
- care and support possibilities

The paper gives an overview of good practices taken from the four countries in which the ILO informal economy research project was carried out. Quantitative and qualitative studies, including participatory rapid assessments, were carried out in Uganda, Ghana, Tanzania and South Africa. The studies were conducted (a) to gather necessary KAPB data from informal workers in the four countries and (b) to initiate participatory, community-based approaches with the aim of organising governments, local governments and local communities to implement a sustained response to the challenges of the HIV/AIDS epidemic within the informal economy.

In addition, the various studies required the research teams to identify their respective countries' relevant trade unions, national and local government departments, **<<V Trade unions and govt depts in general, or just those involved in HIV/AIDS work? Y>>** organisations for people infected with HIV/AIDS, and organisations associated with workers in the informal economy and, more specifically, with HIV/AIDS interventions. Each of the studies involved the broad-based consultation with stakeholders that is necessary for generating a "buy in" from stakeholders and also for capacitating stakeholders to ensure subsequent sustained interventions. The data with the participatory **<<V – have wracked the old brains, but haven't been able to make a guess that sounds right. Please would you add the necessary. Thanks. SOS>>** culminated in each of the countries defining its respective action plans, which will be elaborated on in the final paper. **<<V – should you say which final paper you mean?>>**

Also provided in this paper is an outline of how the four countries analysed the problem of HIV/AIDS among workers in the informal sector and how the country teams attempt to mobilise rapid action teams to assist in the various interventions aimed at mitigating HIV/AIDS in the informal economy. The paper then refers to a variety of approaches piloted in the four countries and attempts to highlight aspects of best practice embedded in each approach.

Key assumptions

In many developing countries, particularly in sub-Saharan Africa, the HIV/AIDS pandemic impacts on almost every aspect of society. The informal economy is by no means unaffected, and the pandemic has grim implications for workers in this sector, especially given the inadequacy of social protection systems within the countries and within the sector specifically. In the countries with the highest levels of infection, most workers are to be found in the informal economy and are therefore not easily reached by mainstream interventions.

As is pointed out elsewhere, the formal workplace usually provides workers with opportunities for reducing the risk of HIV/AIDS by improving prevention through practical, sustainable and effective interventions. It is argued that these interventions result in changes in attitudes and personal behaviour, and that organisations facilitate and support these changes through initiatives that reach workers through their workplaces and/or work activities. Workers in the informal economy, however, do not as a rule have these mitigating workplace benefits.

People in informal work represent the largest concentration of "needs without a voice". They are excluded from or under-represented in social dialogue and processes with and in institutions. Unlike the formal economic sector, there is little contact between the informal economy and NGOs, and government's HIV interventions reach few of its workers. Moreover, the sector is usually not a focal point of service providers with regard to HIV/AIDS interventions.

The impact of HIV infection on the informal sector

HIV/AIDS has a negative impact in all sectors and at all levels of the economy. However, as indicated above, informal activities are more vulnerable than others. Profit margins are tight, and access to official support mechanisms is extremely limited. Most of the businesses are individually owned, and illness or death of the operator is therefore very likely to lead to the closure of the business. The epidemic threatens livelihoods and productivity in both urban and rural areas, with particularly severe effects on women because of their double role of caring for sick household members and earning a living. This is particularly the case in the informal sector. HIV/AIDS thus deepens poverty and intensifies economic inequalities.

The costs of HIV/AIDS for informal sector enterprises are the same as those in the formal sector, both directly and indirectly. Direct costs include expenditure on medical care, drugs and funerals. Indirect costs include loss of time due to illness, recruitment and training costs to replace workers, and care of orphans. Not only are these costs (both direct and indirect) high, they also reinforce each other. Ultimately enterprises lose their profitability and their potential for growth, if indeed they do not succumb altogether.

A decline in productivity leads to a decline in profit, which may perhaps be manageable in the short term but is much less so when associated with a long-term, worsening crisis such as sickness and premature deaths of workers and operators as a result of HIV/AIDS. Absenteeism is one of the first signs that something has gone wrong. It probably means that employees are becoming ill due to HIV, or that they are taking time off to care for sick family members and to attend funerals. It is usually harder for smaller businesses with less flexibility and fewer reserves to cope with the consequences of absenteeism.

Another reason for the extreme vulnerability of the informal sector is that workers with HIV/AIDS tend to be “colonised” in this sector. It is not uncommon for workers employed in the formal sector to face workplace prejudice and discrimination, so much so that they are pressured to leave their formal jobs. In the absence of social support, many have no choice but to find alternative means of income in the informal economy.

It is well documented that informal economic activities account for the bulk of employment in developing countries, and that in times of crisis and economic downturn these activities become even more crucial as a form of social assistance and a means of poverty alleviation. This is particularly so in developing countries like South Africa, Uganda, Tanzania and Ghana, where the informal economy provides economic refuge to the illiterate or under-educated members of the population and draws to it women and, increasingly, child workers as children become orphaned or are left to care for parents with HIV/AIDS related illnesses.

The nature of their work means that entrepreneurs and workers engaged in informal economic activities are often hard to reach and are consequently out of reach of educational and health interventions related to HIV/AIDS. Involvement in the informal economy is often driven by poverty. The informal nature of the sector often provides both a “last chance” opportunity for survivalist economic activities for those most hit by poverty as well as an “economic space” for those already affected with HIV. The fact that large numbers of this sector are illiterate or not functionally literate makes this sector more difficult to reach using conventional methods.

The impact of HIV infection on operators and workers in the informal sector

Many informal sector operators and workers living with HIV/AIDS either lose their means of livelihood or see their businesses collapse due to their inability to work. Even if they enter a period of remission or recovery it is often difficult to resume work because they will have depleted their personal resources while unable to work.

The impact of HIV/AIDS on informal sector activities, which are often family enterprises or are operated or owned by sole breadwinners, begins as soon as a family member starts to suffer from an HIV-related illness. This rapidly leads to loss of income of the informal sector operator and increased expenditure on medical and other expenses. Eventually there are also funeral costs. Children are often removed from school to save on educational expenses and increase the household’s labour, but

this ultimately reduces the family's earning potential and affects the human resource base of the whole country.

HIV/AIDS does not affect only the size of the informal sector's labour force; it also affects its quality. Some of those infected with HIV are experienced, skilled workers in the sector. The loss of these workers, together with the entry into the labour market of orphaned children who have to support themselves, is likely to lower both the average age and the average level of skills and experience of the informal workforce. Its gender composition is also expected to change as more orphaned children and widows seek employment in the informal sector.

Nature of work and composition of workforce
The various kinds of work in the informal economy may be seen as forming a continuum which includes, at one extreme, activities that are totally deregularised and informal and characterised by serious deficits and, at the other extreme, activities that are more formalised, with fewer deficits. However, across the continuum, informal jobs are neither recognised nor protected by law, and the absence of rights and inadequate social protection are compounded by lack of representation and voicelessness, especially among women and young workers.

The contextual features and thus the impact of HIV/AIDS among workers of the informal economy vary from country to country. The following table highlights the extent of HIV/AIDS in the four countries in which the research was conducted:

HIV/AIDS in the target countries

	Total number	% Adult infection rate	Women (15-49)	Children (1-15)	AIDS deaths in 1999
Ghana	340 000	3,6	180 000	14 000	33 000
South Africa	4 200 000	19,9	2 300 000	95 000	250 000
Tanzania	1 300 000	8,1	670 000	59 000	140 000
Uganda	820 000	8,3	420 000	53 000	110 000
Totals	6 660 000		3 569 966	220 986	534 999

Informal sector project
As indicated above, four African countries (Ghana, South Africa, Tanzania and Uganda) were selected as targets for the implementation of a project to address issues related to HIV/AIDS in the informal section. While not part of the SADC, Ghana and Uganda were chosen due to the existence in these countries of strong associations of informal sector operators and on the basis of pilot work already carried out by the ILO, on which the four-country strategy built. The project aimed to address these issues at the national and local levels through developing and implementing strategies for the prevention of HIV transmission and mitigation of the impact of HIV/AIDS in the informal sector. Implementation attempted to coalesce with the principles established in the ILO Code of Practice on HIV/AIDS and the World of Work – particularly those of respecting human rights, non-discrimination against people with HIV/AIDS and gender equality – and to follow the guidelines it establishes for concrete action.

Using the data to design interventions
Based on the findings of the KAPB and the workshops, each country was required to define, develop and test interventions for specified target groupings in this sector. This meant that each country (a) devised a training programme for peer educators and for the workers from two subsectors in the informal economy; and (b) evaluated the activities with the intention of informing **<<Should it be forming? Informing a strategy sounds rather odd. Y>>** strategic and sustainable interventions in the informal economy.

The strategies were arrived at through general consultations. The provincial and national workshops gave rise to action plans which included issues such as the following:

- improving working conditions for workers in the informal economy
- pre- and post-testing counselling
- approaches to counselling

- human rights considerations such as the elimination of stigma or discrimination on the basis of real or perceived HIV/AIDS status
- effective support structure planning
- guidelines for care and support
- guidelines and recommendations to determine appropriate vehicles for informing major stakeholders of the importance of HIV/AIDS interventions for this sector

The findings are significant as they highlight important areas which may contribute to the development of national, regional and international HIV/AIDS strategies for workers in the informal economy.

How to implement the *ILO Code of Practice on HIV/AIDS in the workplace* was a challenge faced by the four-country studies. The participatory processes examined the Code in order to determine its *applicability* as well as its *accessibility* to workers in the informal economy in terms of their levels of literacy and language ability. The Code was developed for generic use across all sectors of the world of work and it was therefore necessary to evaluate the extent to which it addressed the situation of informal workers. The various countries offered recommendations on the extent to which the principles of the Code might be made applicable to the non-formal work environment, or as in the case of South Africa, suggested that a Code specific to the informal economy be developed.

The four-country studies hoped – through the utilisation of participatory methods – to arrive at recommended strategic, sustainable and workable plans to be implemented within two subsectors of the informal sector. In this regard, the study aimed to examine ways of improving the access to HIV/AIDS prevention programmes of various target groups of workers in the informal economy so that they might benefit directly from such programmes and from the structures and policies which address HIV/AIDS. The study undertook to develop and implement rapid interventions for the prevention of HIV transmission and the mitigation of the impact of HIV/AIDS in the informal sector, and to mobilise sector stakeholders and various levels of government to support an effective, sustained means of HIV/AIDS prevention and impact mitigation.

In order to execute the above, the following action-oriented research approach was employed:

- Firstly, a ***desk study*** (elucidated in the preceding section) **<<V – I don't think it is mentioned earlier. Y>>** was carried out to identify the most vulnerable informal subsectors, to highlight gender problems and to enable the profiling of good practices both in South Africa and in the other countries targeted by this intervention. These practices had to be identified to inform the subsequent research design, and it was therefore imperative to do this in the pre-project phase.
- Secondly, it was necessary to carry out ***observations*** at various sites to inform the development of the instruments and the design of the rapid assessment workshops.
- Thirdly, ***exploratory, in-depth interviews*** using a snowballing technique were conducted with stakeholders, including informal sector organisations, the unions, departments of labour and other key stakeholders with knowledge about and/or experience of the informal sector. This allowed the team to identify stakeholders who might be engaged in defining the interventions to be carried out during the final stages of the project.
- Fourthly, a ***survey*** was carried out of the knowledge, attitudes, perceptions and behaviours (KAPB) of informal sector workers randomly selected from sites identified as vulnerable in each of the countries. This survey was expanded beyond the issues usually examined in KAPB surveys to establish respondents' health-seeking practices and to probe features of their working experience, to ascertain their assessment of the sites at which they work and gather information about the facilities (or lack thereof) available to workers in the informal sector.
- Fifthly, it was necessary to conduct a ***rapid assessment*** of two subsectors identified by way of the above techniques, in order to provide a qualitative profile of those whom the proposed interventions would target. A further aim of the rapid assessment was to initiate *participatory, community-based approaches* for organising the various informal sector organisations to implement a sustained response to the challenges of the HIV/AIDS epidemic in the informal economy. In this sense the project had a capacity building and an action research component.

Research methodology used by all four countries

A KAPB survey instrument was designed. It was informed initially by the Family Health International (FHI) HIV/AIDS/STD behavioural surveillance surveys for use with female sex workers. However, it was necessary to devise questions for use specifically among informal sector respondents in the local

and southern African context. Accordingly, a range of questions with this target group in mind was developed.

Design of the instrument

While the survey instrument was similar to that of conventional KAPB surveys, it was expanded to include a number of other areas of focus and can therefore be seen to have deviated from the conventional KAPB survey on the following grounds:

- First, the survey included a range of open-ended and qualitative questions that were used to interpret the findings. This is not customary in KAPB surveys.
- Second, the survey focused more broadly on issues that do not usually fall within the parameters of a KAPB survey – for example, it included questions on workers' health-seeking behavioural patterns.
- Third, the questionnaire was customised to suit the context of the informal sector and included specific questions pertaining to the experiences of workers, and their perceptions of their work and working conditions.

Scope of the questionnaire

The survey was intended to gather information pertaining to

- biographical data on the selected respondents
- their experiences as workers in the informal economy
- difficulties peculiar to women workers in the sector
- their knowledge about HIV/AIDS and STDs
- their health problems and health-seeking behaviour
- possibilities for IEC interventions
- their perceptions of risk
- optimal times and sites for the interventions
- the range of interventions needed by the sector

Qualitative and quantitative questions

The questionnaire comprised a mix of qualitative, quantitative and fixed-choice questions, scales and some open-ended questions. The qualitative questions were intended to allow the respondent to reflect and give answers free of the limitations and constraints that are established when the researcher asks questions whose answers are pre-framed. The use of qualitative questions encourages respondents to relate, in their own terms, experiences and attitudes relevant to the issues under investigation. This approach gives researchers the opportunity to probe and explore dimensions of the areas under investigation. The qualitative questions overcome the problem of restricting respondents' answers to pre-framed, "tickable" answers. Instead, interviewees were given an opportunity to express a variety of ideas, to go into as much detail as they wished, to talk about the meanings and experiences of matters of relevance, and to ask questions in return.

The findings from the questionnaire were interpreted and triangulated utilising the qualitative data obtained from the questionnaire, as well as the data obtained from focus groups and interviews with relevant stakeholders.

The data obtained using qualitative methods answered the following questions:

- What facilities are available at work sites?
- What facilities do you think should be available at work sites?
- What are the problems that you experience when working?
- What problems are women informal workers more likely to encounter?
- What are the positive and negative attributes of the job?

Training the fieldworkers and pre-testing the questionnaire

Informed by the literature and by consultations with members of the informal sector, the Project Steering Committee and colleagues within the ILO, a draft questionnaire was developed and piloted

with workers in the informal economy. A team of already qualified fieldworkers was trained to administer the questionnaire at each of the two sites. Their training comprised the following topics:

- introducing themselves and the survey to the respondent
- respecting confidentiality and assuming a non-normative approach during the interview
- understanding the rationale of the instrument, ie understanding each individual question and the rationale for the question
- coping with problems they might encounter in administering the instrument
- approaching the different types of question appropriately, eg noting the differences when asking open or closed and qualitative questions
- accommodating respondents of different educational levels (illiterate, well educated) and different cultures
- adhering to the protocol of dealing with sensitive information
- making “on-the-spot” strategic problem-solving decisions
- recording answers for the qualitative sections
- following the necessary administrative procedures

In addition, it was necessary to select fieldworkers who were linguistically able to deal with respondents from different language groups. While the survey approach is a very suitable method (and is indeed the most common method) for gathering information for KAPB studies, there are problems associated with it.

- In studies that deal with sensitive or intimate topics and where threatening questions are asked, respondents may believe that the information will be used against them. For this reason, respondents often give normative answers based on what they think they should answer. This is known, in research, as a “social desirability bias” and often leads to under-reporting of “incriminating” behaviours, such as the use of drugs.
- The survey approach limits the responses of the respondent to selecting from a handful of predetermined responses. It does not allow the respondent the latitude to give an answer that is not predetermined by the researcher.
- It is also likely, given the emphasis on the right to privacy in the context of HIV/AIDS research, that respondents may see the survey as a breach of this right.
- Respondents may feel that their answers, especially with regard to the “knowledge about HIV/AIDS questions”, will reveal their ignorance and they may therefore be reluctant to answer.
- Because participation is voluntary, people frequently choose to answer some questions and not others, which they may feel are too threatening, invasive or personal. Thus there is often unevenness in the response rate to different questions.

In order to allay the kinds of fears referred to above, it was imperative in this study that the fieldworkers should assure respondents of their anonymity, and that the questionnaire should be structured so that sensitive questions came later in the survey. Questions put to respondents were sensitive insofar as they asked about personal sex matters and therefore required respondents to divulge information about their own sexual behaviour. The findings obtained were, where possible, triangulated using the qualitative data requested in the survey and also the data obtained from the rapid assessment (RA) workshops. The KAPB survey included qualitative questions that provided a filter for interpreting the quantitative data. The quantitative data obtained were triangulated with the qualitative data and this served as a means of “checking” the accuracy of the quantitative **<<Is quantitative correct? If so, the rest of the sentence could be amended to read: “and as a filter for interpreting it.” YK>>**data and as a filter for the interpretation of the statistical data.

The rapid assessment workshops

Interviews were conducted with knowledgeable informants from unions, informal sector organisations, local government, and departments of health and labour in order to obtain data on the possibilities for the proposed interventions. In this sense, the project assumed an action research approach whereby the findings informed the project activities.

Goal of the RA workshops

The goals of these workshops were as follows:

- To establish the *modus operandi* of workers in the informal economy (particularly with reference to women), to find out their vulnerabilities and to explore how these might best be met by the sector, by policy and by support agencies in order to inform the development of peer group educational programmes
- To obtain data which, together with the data obtained from the questionnaire, should be used to inform proposed interventions (sectoral and national) and HIV/AIDS policies for this sector. These data were therefore to be presented to the delegates at the proposed national workshops in order to contextualise the proceedings

In order to execute the above, a *purposive sample* of 100 participants (50% rural and 50% urban) was drawn from workers in the informal sector, from the groups identified as being most vulnerable in each country. The workshops took place at the various sites.

RA methodology is characterised by the potential for empowering participants to contribute to proposed interventions and enabling them to take ownership of the proposed interventions (thereby also securing sustainability). The initial contact with the targeted subsector groupings and local communities was an important component of this project insofar as it

- helped the research teams define the problem more concisely
- helped identify relevant stakeholders
- enabled the research teams to introduce themselves to the sector and explain the rationale of the research.

Through participatory research workshops, the research team obtained data on the following:

- the experiences of the particular workforce
- an understanding of the impact of HIV/AIDS on the subsector
- aspects which make this workforce vulnerable to HIV/AIDS
- aspects which make this sector less accessible to HIV/AIDS interventions
- possibilities for IEC interventions
- strategies for interventions
- difficulties peculiar to women workers in the sector
- risks to one-person companies arising from HIV/AIDS
- relevance and accessibility of the ILO code of conduct
- optimal times and sites for the interventions
- range of interventions needed by the sector

The participatory workshops formed the basis of the data-gathering component. They were intended to identify and integrate stakeholders, and to establish the extent of the HIV/AIDS impact and high-risk concerns. A further aim was to highlight possible points of entry for interventions and to gather information on sites for training, possible times for training and the type of support needed by workers in the informal economy. The workshops will also be **<<Were? The text is sometimes confusing, in that I'm not always sure whether the project and/or its various phases are complete or to be completed. Please would you check. Thanks. SOS>>** used as a forum for testing the ILO Code of Practice.

Engagement with informal sector workers made it possible to select and recruit candidates to be trained as peer educators, and to identify stakeholders to be included in the Rapid Action Teams (RATs), which would become engaged in stimulating and managing the proposed activities at each site. The democratic principle of enabling people to participate in the process of knowledge construction (constructing ideas and insights) is important here. It allows those who want to engage in action to make their own contribution to defining and exploring what it can involve. **<<Not sure what "it" refers to – maybe: exploring what this action could involve - ? Y>>** Action research is about helping people to deal with certain issues in their lives that they find problematic at some point in time. **<<This doesn't seem to be a good description, amended (as here) or in the original. Perhaps you could add something? Y>>**

ILO Code for HIV/AIDS in the workplace
As is indicated in the programme, one of the slots in the national workshops was devoted to presenting the ILO Code of Practice. The Code relates specifically to HIV/AIDS in the world of work and provides guidance for employers, workers and their organisations in the formulation of policies and programmes at national and organisational levels to combat the HIV/AIDS pandemic. The Code stresses the importance of fundamental rights at work, including non-discrimination, gender equity, social dialogue, confidentiality and the provision of care and support. It is based on the understanding that HIV/AIDS is a workplace issue.

In the workshop, delegates had the opportunity to discuss the Code and to consider its accessibility and applicability to workers in the informal economy.

Applicability
While the Code applies to all aspects of work and defines the term "informal sector", workshop delegates felt that it could be customised to meet the needs of the sector more specifically.

Section 4: general principles
While the Code was regarded as important for all workers and while informal workers agreed with the key principles of Section 4.0, they felt that it was not tailored to the particular contexts of the informal working environment. Points raised included the following:

- *Recognition of HIV/AIDS as a workplace issue* means that all workplaces, including informal sites, are to be recognised by government.
- *Gender equality* should be an overriding principle within the sector. The study found women in the informal economy to be much more vulnerable than men, and more vulnerable than women employed in the formal economy.
- *Healthy work environment.* As the study indicates, the informal environment is often far from healthy and hygienic, particularly for children who come to the workplace with their mothers.
- *Social dialogue* is contingent on an organised labour force. The informal economy is not adequately organised and is without a voice.
- *Screening* does not appear to be an issue for workers in the informal economy, although the study reveals considerable stigmatisation, which needs to be addressed through training.
- *Confidentiality* is not applicable, although stigmatisation and gossip are common in small enterprises.
- *Continuation of employment relationship.* Since the relationship is by definition informal, there is no contract to be terminated, nor are they any social security benefits to protect workers who become ill.
- *Prevention* education programmes and mainstream condom distribution for this target group are minimal. Training by peer educators was limited as resources (human and other) were not available to meet these needs.
- *Care and support* arrangements are not integral to informal systems – an issue which was stressed as an area of concern.

Delegates agreed with the general rights and responsibilities outlined in Section 5 of the Code, but felt that they referred to permanent employers and employees and were more specific to the formal sector, where workers have longstanding contracts.

Application of the ILO Code
It was suggested that a Code developed for and based on the unique situation of informal workers would have more relevance. It was argued that the Code was less applicable in the countries where there was no legislation governing the informal economy and that, as such, the Code "had no teeth". It was held that, despite the fact that the number of informal sector workers was growing, (a) the Code was not enforceable given the non-legitimate status of the sector; (b) workers were not organised and (c) as is indicated in the empirical section of the report, the Code was not accessible to workers in this sector, who were predominantly illiterate or not functionally literate in English or French; (d) the level of language was too high (or technical) for those workers who were fortunate enough to be literate; (e) the Code was not available in all local languages; (f) it assumed that workers in this sector were organised and were aware of their basic rights; (g) finally, although the Code made specific mention of workers in the informal economy, this did not make the Code fully relevant to their conditions.

With regard to the latter point, it was emphasised that informal sector works are not formally employed and pre-employment testing and issues like confidentiality are therefore not issues with which they have to contend. Nor indeed are issues such as workplace training directly relevant since informal workers are not employed in organisations that will present training programmes or offer healthcare facilities. It was felt that the Code was premature, that the informal sector had not been consulted, and that their status as workers had to be resolved at policy level so that training, testing, counselling and treatment would then become necessary requirements for all workers. This did not mean that activities should be halted – rather it meant that intervention activities in the sector should start immediately and should parallel developments at the policy level. Subsectors such as the taxi industry relied on employed labour and was highly organised. It was felt that the Code could already be applied and made mandatory within this subsector.

Case studies
Selected examples of good practice developed to address HIV/AIDS in the informal economy are now presented in the form of case studies. The case studies draw attention to the following:

- identification of and rationale for selecting particular target groups
- identification of stakeholders within the informal sector and the roles of specific interventions
- difficulties experienced with interventions
- identification of other agents active in the informal sector, for awareness raising, testing, training, counselling, care and support services

Case studies from the four countries are presented, in which the above aspects are addressed. The paper then concludes with a section on lessons learned.

Country: South Africa
Target Groups: Informal food sellers and informal hard goods hawkers and vendors
Sites for interventions: Johannesburg, urban/metropolitan area; Tzaneen, rural area
Stakeholders: Informal sector organisations, local, provincial and national government, local university, HIV/AIDS, NGOs

Rationale for site and subsector
For the pilot study, two geographical areas were selected for the data gathering stage of this study, as follows:

- Limpopo Province is the northern-most province in South Africa. It shares borders with Botswana, Mozambique and Zimbabwe. The province has a large rural population, large rural-to-urban migration and a growing informal sector. Its per capita income is by far the lowest in South Africa and many inhabitants earn their livelihood as migrant workers. A rural area near the town of Tzaneen was selected for this pilot so that the investigators might gain a sensitivity to the informal sectoral activities in rural areas. This area can be closely correlated with other rural areas in South Africa, which are characterised by weak rural economies and a high rate of urban-rural migration.
- Gauteng was selected as the second province for the investigation. It was decided to conduct this component of the research in Johannesburg, which is also known as *Egoli* ("place of gold"). Gauteng is the most densely populated province in South Africa and has a large inflow of migrant labour from poorer regions in the country. It has the highest per capita income, but also has large and numerous informal settlements, increasing unemployment and therefore increasing inflows into the informal sector. The Johannesburg metropolitan area, on the other hand, can be closely correlated with other metropolitan areas in South Africa.

The subsector
Given the high degree of heterogeneity of the sector, it was necessary that the sample selected for the survey should reflect the diversities. Based on the findings of the desk study, sellers of food and non-food items[1] are two of the most vulnerable subsectors in the informal sector. Work in these subsectors relies less than in other subsectors on skills needed for the provision of services and manufacturing, and makes more demands on the worker, who needs to be available wherever trade opportunities present themselves regardless of time, facilities available and domestic circumstances. In order to

[1] Because the ILO had commissioned separate studies on taxi drivers and informal tavern workers, they were excluded from this study.

determine the extent of this vulnerability, participatory workshops were used to engage members of these two subsectors in an in-depth exploration of their working lives and the risks they face. Informal traders in food retail enterprises include street hawkers, tuck/spaza shops, and people selling prepared food, cold drinks or fruit and vegetables. The size and the lack of organisation of the hawking and vending subsector made it essential that the study should identify these the main areas of focus. **<<The previous sentence is a problem. If I add "as" after "these", it sounds as though the study was manipulated so that these were identified as the main areas of focus, because it was important to do so. Y>>**Given the preponderance of female-headed households in the rural areas, it was important that the study should focus on the plight of women in the sector. In particular, rural women display a high level of mobility between their rural homes and the marketplace.

Intervention strategy

During the RA workshops, women explained that when business is poor they are often compelled to engage in "casual" sexual liaisons. (They were, however, adamant that there were no sex workers among them.) They explained how casual sexual encounters make them more vulnerable in that there is no time to discuss using a condom or to establish whether the man might have an STD.

> In a casual sex, you don't even look if the penis has sores or discharge, because there is no time to waste with foreplay. You just want to grab the money.

> Women are exposed to many male customers who come from outlying areas and who for example work on the roads or drive trucks through the area. They get very excited about the extra money they might get from these visitors.

> Sex during working hours is dangerous because it has to be quick … there is no time to negotiate a condom.

In the RA workshops, it became apparent that sex is intertwined with the business of many informal sector female workers. High levels of poverty make it difficult to resist the additional money that it brings. With each different customer comes the exposure of another possible sex partner:

> Truck drivers usually pass here. They put R10 on my waist and say "I don't want to talk, let's go to the river bed and you can enjoy what you have never tasted."

> Moneyed people usually openly refuse to use a condom. They will tell you clearly that there is no AIDS – people are just lying about the existence of the disease.

Hence, although the women in the area are aware of HIV and have knowledge about AIDS, there is apparently little impact on behavioural change/safer sex practices. The RA workshops showed that the rural women are well aware of their own vulnerability, but, as indicated above, they are often cajoled by male customers into having sex without a condom. In addition, because these workers spend a large portion of their day at their sites, they are not able to benefit from community campaigns promoting safer sex. They are unable to get hold of campaign materials and rely to a large extent on the inaccurate information that is circulated at their work site.

> When we get pamphlets, we can't read them so we wrap our goods in them.

In this regard, it is proposed that the HIV/AIDS intervention should include a component on *negotiating skills* and *women's self-empowerment* which would enable these (usually young) women to assert their right to protect themselves from abuse (assault and rape).

Educational programmes for this sector must go beyond merely raising awareness about AIDS. They need to enable people to change *behaviourally* from their current risk-taking behaviour. Poverty and disbelief about HIV/AIDS, myths and witchcraft are matters that must be taken account of when formulating a behavioural change intervention that will reach these workers.

Impact of HIV/AIDS

The KAPB survey highlights the severe impact HIV/AIDS might have on South African workers, and on the dependants of workers in the informal economy. Ninety-seven respondents (47,3%) stated that they support other family members, relatives or other dependants, while 70,8% of the sample stated

that they live off the *sole earnings* generated by their informal sector activities. The informal sector is extremely vulnerable to HIV/AIDS because workers:

- cannot access health facilities or social protection benefits available to workers in the formal sector
- are trapped in a cycle of poverty as activities rarely go beyond the level of survival.

Provincial mobilisation workshops

As part of the community mobilisation component, provincial mobilisation workshops were conducted in Durban, **<<V – it would be useful to insert a footnote explaining how Durban came to be included or referring reader forward. Y>>** Johannesburg and Tzaneen in order to outline the need for AIDS mitigation interventions and to identify relevant stakeholders in each of the provinces. The provincial workshops were therefore intended to:

- identify stakeholders and mobilise support
- determine the *modus operandi* of the sector
- identify Rapid Action Teams (RATS)
- explore who is doing what in HIV/AIDS in the informal economy.

In addition, the workshops required each province to assist in identifying its own unique sectoral vulnerabilities, what programmes/policies and so on were already operational and which could be built upon, the risks and strengths of these operations and optimal ways of incorporating HIV/AIDS programmes within them. (Large differences in needs were expressed in the urban areas compared to the rural areas.) Based on these outcomes, each province was required to develop its own action plan, which would be tested during the pilot implementation phase. In addition, each of the participating provinces was required to identify stakeholders and to establish a RAT, which would assist with the peer educator training and be assigned to the associated coordinating activities.

Development of provincial action plans **<<Veronica – why, I wonder, are these not called PAPs? Y>>**

Each province settled on its own approach for reaching its target group of informal sector workers. The approaches were contingent on the contexts of the areas in which the project was being implemented and, as will be shown in the descriptions of the action plans, the strategies arrived at were specific to the circumstances of the *three* provinces in which the project was being implemented. While these were only pilot phases of implementation, the "experiments" contributed to our understanding of delivery in urban, rural and informal settings. The action plans arrived at are examined in the sections that follow.

Johannesburg

The Johannesburg area selected a well-known worker from the field to coordinate its RATS. Premises were made available to the informal sector by the Johannesburg Rotary organisation for a wide range of training activities. The building is in the heart of taxi-land, an area alongside the central station in the middle of downtown Johannesburg. The site was therefore ideal for reaching five different areas occupied by the informal sector. After selecting the RATS and the coordinator, the Johannesburg stakeholders defined the roles and an immediate strategy which could be implemented.

It was found that the Johannesburg workers have relatively high levels of HIV/AIDS knowledge but that this does not translate into behavioural change. The RA workshops revealed that women in the sector use sex as a "marketing strategy" to gain clientele. The workforce of this area comprises a large number of single workers (operators) and it also exhibits the characteristics of a more mobile workforce. In addition, conditions for the workers are difficult: they are exposed to violence and crime, and for them, HIV/AIDS is a *lesser* threat. Working conditions and problems surrounding water and sanitation leave much to be desired and lack of safety at the sites makes workers in the area reluctant (and unable) to leave sites to attend training. In arranging training it was necessary to take these aspects into consideration.

Johannesburg training strategy

Each of the informal sector organisations was required to recruit five of its members to attend a *peer educator training* workshop which was to be presented by the RATS together with a trainer from the

University of South Africa (Unisa). The workshop ran for one week before the RATS were able to set up their own training. The strategy was as follows:

- The RATS arranged a training venue, meals and collected training materials from the Research Team for the peer educator training.
- Training for workers was arranged at the Rotary centre adjacent to the informal work sites. The informal sector organisations requested site monitors (usually responsible for preventing violence and theft at sites) to watch or guard their stands while they attended classes. Classes were arranged so that workers could attend during their quiet periods. The monitors were also required to attend to problem males who harassed women at the sites.
- The RATS established a crèche so that workers' children could be looked after while they attended classes. (Unfortunately, the crèche was unable to sustain itself and so its activities were curtailed.)
- RATS addressed the various meetings **<<What meetings were these? Y>>**to advertise classes.
- The RATS were expected to obtain condoms from the local health department (representatives of which were present at the workshop). Linkages with organisations dealing with counselling and testing were sought for referring workers when necessary.

Durban

Although Durban was not initially selected as a research area, the demand arising from the province made it imperative for the ILO research team to respond, given that KwaZulu-Natal (KZN) has the highest HIV/AIDS rate in South Africa. The request was made to the ILO by the *Unemployed women's organisation* and the Durban branch of the *Women's Coalition.* The Ethikweni metropolitan municipality, which serves 61 municipalities, made training venues available for the workshops. Since Durban central **<<V – what is Durban central? Y>>** played host to a large number of informal selling activities, the Ethikweni municipality assumed a very dominant role in unfolding the training. The RATS were selected from among the members of the *Unemployed women's organisation*, the *Women's Coalition* (an informal sector organisation) and the Ethikweni municipality. A RAT coordinator was appointed. His "wearing of a number of hats", as a member of the National Trade Union, as part of the local government Sectoral Education and Training Association and as a member of the Unisa ABET team, made him an ideal candidate, with broad-based knowledge and a wide variety of competencies.

Durban training strategy

The RATS decided on training 150 *peer educators* from the different organisations. Training was to be both *site* and *classroom* based. For the site-based training, the RATS would present one-on-one training for workers at the various selling points. With the cooperation of the metropolitan municipality, the RATS were able to access training venues at the market places. These venues double up as lock-up storerooms at night. The peer educators worked in a number of areas in KZN – urban, rural and informal settlements. All "training venues" obtained had to be located near to where the workers *lived* or *worked*, and were obtained at no cost to the project. Generally the sites were at the selling points, and if training venues were used, these were made available either by the municipality or by the various worker organisations.

Child labour

The RATS in Durban decided to target street children as well (as another subsector of the informal workforce). Generally these children[2] (aged from 9 to 19) were engaged in the sector as parking attendants and car washers. As an intervention, the study resulted in the establishment of a shelter for these children, the presentation of training including *skills for street survival*, and training for *business, literacy* and *numeracy*. The resultant partnership between the Durban metropolitan local government, the ILO's peer educators, the Unisa ABET Institute and (in this case) the South African police (who transported the children to the training venues) gave rise to shelters and training for 80 children. In addition, clean clothes were donated to the children by a local clothing chain.

Tzaneen

This area is less fortunate in that it is isolated in the most northern area of South Africa and lacks the infrastructure commonly found in the larger cities. As a largely farming rural area, there are no active informal sector organisations and it was therefore not possible to enlist the help of any organisation to

[2] At the time of writing this report, home and school placements for the younger children were being attended to by the local municipality.

determine a training strategy. A meeting was held with local community leaders (including local government and the traditional leadership), and it was decided that the Unisa literacy educators who had been involved in working in this area would be called upon to act as RATS.

Tzaneen training strategy
It was decided that two strategies would be piloted:

- Training was to be given close to the homes of the workers as the workers left their selling sites before dark each day.
- Trainers would attempt to provide training at the sites during the workers' quiet times.

It was found that the latter approach was more suitable for face-to face interactions and that the provision of training close to workers' homes was preferred by most workers, especially as family members could attend as well. However, as training would then take place after hours, the educators had to find sites that had electricity. Teaching workers about HIV/AIDS at sites near their homes included training in basic literacy and entrepreneurship as one of the "draw cards" for getting them into training. It had been found during the KAPB survey that workers in this rural area had very little knowledge about HIV/AIDS, and regarded AIDS training as irrelevant to their lives. The findings also suggested a high level of stigmatisation, which meant that workers would not wish to be visibly associated with HIV/AIDS training. For this reason, it was agreed that the literacy and entrepreneurial classes be advertised by the RATS in association with Unisa and that HIV/AIDS be presented in "small doses" at each training session. As a result, peer educators were inundated with requests for workers' enrolment.

It had also been established that condom distribution in the rural areas was either non-existent or erratic at best, and it was decided that the RATS would undertake to make condoms available at training sessions and during the face-to-face contact visits to sites. Lack of adequate health care was a general problem. The KAPB survey indicated that rural workers used traditional healers as the first port of call. Mobile health units were suggested as a way of addressing this problem.

Training intervention **<<V – should this section perhaps be headed "National workshop"? Y>>**
All provinces agreed that the training intervention needed to address the following aspects:

- what HIV/AIDS is and how it is spread and prevented
- caring for the infected and the affected
- making referrals for voluntary counselling and testing
- methods for teaching adults
- roles and responsibilities of peer educators

After piloting the three approaches to training, a national workshop comprising relevant stakeholders was held. This enabled broad-based consultation of relevant stakeholders. The national workshop was intended to interrogate the pilot implementation strategies as well as:

- present the findings of the RA and the quantitative components of the research project.
- report back to stakeholders on the training that had taken place in the three regions
- outline local community-based action plans arrived at during the provincial meetings for prevention and impact mitigation of HIV/AIDS in the informal sector
- test the accessibility and applicability of the ILO Code of Practice in the informal sector
- invite stakeholders to determine action-oriented goals and to establish a way forward for mainstreaming HIV/AIDS mitigation and care programmes
- finally, given the high level of dissatisfaction about working conditions, to draw attention to the work-related problems of the sector

It was necessary to give delegates background on the various stages of the ILO research conducted in South Africa as well as in Tanzania, Uganda and Ghana. During the initial provincial meetings with the sector, it was suggested that the sector lacked an understanding of the debates and general information concerning HIV/AIDS and it was deemed necessary to give all delegates a background to the ILO project and also to the problem of HIV/AIDS.

Stakeholder involvement

Delegates invited included representatives from national and local government, the various provinces, the local government Sectoral Education Training Authority (SETA), the national Department of Labour, HIV/AIDS care organisations, women's organisations, a range of national and regional informal sector organisations, informal sector workers (selected from those who had received training), the RATS and trainers from the provinces, formal business associations, and other associations involved in some way with the informal economy. It was important for government to be visible at the workshop, hence the presentation by a Member of Parliament who was concerned about HIV/AIDS. This gave a strong signal as to how much weight was being given to the programme.

In general, the presentations provided a necessary background for the delegates – for many of the delegates the national workshop presented the first (albeit introductory) opportunity for the stakeholders to reflect on the problems and the need for HIV/AIDS interventions in the informal economy and to alert government to the need to address the problem in the sector.

Problems identified
The workshop commissions **<<V – do you need to say what these are? Y>>** identified a number of problems specific to workers in the sector. These are categorised below:

1. Child-rearing problems
- Women bring babies to work because of insufficient, affordable child care facilities.
- Children at informal worksites are exposed to unsafe conditions.
- Lack of child care is a general problem, especially in urban areas
- Lack of maternity leave means that women work right up to the birth of a baby and return soon afterwards.
- The lack of sanitary conditions is problematic for child-rearing at the work site.

2. Problems of women working in the informal economy
- Sex is often intertwined with business.
- Women are often cajoled into having sex to advance their business.
- Men's reluctance to use condoms is a general problem in South Africa.
- There are many myths surrounding condom use (many of these were referred to in the RA workshops).
- Sex is often hasty and women have no time to negotiate condom use.
- Condom availability is *ad hoc.*
- HIV/AIDS information does not reach many workers in the sector.

3. General problems identified
- The large number of units makes it difficult to obtain information on the actual size and scale of the sector.
- Workers operate with very little capital. Their level of productivity is usually low and incomes are usually low and irregular.
- The sector is not homogenous (there are various categories or sub-sectors), which makes it difficult to plan interventions.
- Work is transient and seasonal, and workers may move in and out of the sector. This makes it difficult to monitor interventions
- Workers in the sector are not organised and are not protected by labour legislation.
- Generally these workers have been overlooked with regard to HIV/AIDS interventions.
- Women and children working in the sector are particularly vulnerable.
- Illegal migrants avoid the formal medical profession for fear of being reported to authorities. (The survey found that 12,5% of the random sample were foreigners who had migrated to South Africa in search of work. Almost all stated that they had chosen to work in the informal sector since they were not eligible for work permits or for residence status.)
- These fears prevented migrants from obtaining free condoms distributed at the various municipal and government clinics.

Recommendations emanating from the workshop
- That HIV/AIDS must be seen as integral to the other social problems in the sector. General problems include aspects such as facilities, harassment and safety – particularly for women.
- That HIV/AIDS should be examined as a problem of poverty as well as within the context of the sector.

- That government (national and local) should recognise the sector, should aim at enhancing it, and should provide minimum standards for the informal working environment.
- That the sector itself should form an umbrella body and ensure that it has a voice to address government on its specific needs.
- That the sector should define the responsibilities of the umbrella body with respect to HIV/AIDS training, coordination, monitoring and implementation.
- That the umbrella body should formulate a policy framework to guide its activities.
- That the umbrella body should be involved in the determination of programmes which should be tailored for the needs, availability and educational levels of the various subsectors. Suggestions referred to sub-groupings such as the disabled members of the informal sector, and to various age groups, including street children.
- That the chain of distributors and suppliers to the informal sector should be brought into the training and the support of programmes. Where possible they should be regarded as points for information and condom distribution.

Difficulties of HIV/AIDS interventions in the sector
The RATS present at the workshop highlighted some of the problems they had encountered during the implementation of the training at the sites:

- Day-to-day survival of the workers takes priority over other concerns such as HIV/AIDS.
- The sector is mobile and is therefore difficult to reach for training and ongoing monitoring.
- There are at present no definite points for condom distribution at the sites and condom distribution is *ad hoc* and erratic.
- The sector is not really organised and it is therefore not easy to use structures to support training.
- Work time and work conditions are not ideal for training and workers have difficulties attending regular classes.
- Illegal migrants avoid formal systems for health care and condom distribution as they fear being discovered by the authorities. For the same reason, they are also reluctant to attend training.
- Generally, the informal workforce is overlooked by mainstream government interventions and by the media. Low levels of education mean that mainstream messages on HIV/AIDS need to be mediated and the skills and human capacity to do this are at present not available in the sector.

Mainstreaming HIV/AIDS training
Delegates laid great stress on the importance of integrating HIV/AIDS programmes with any existing programmes and meetings for informal workers. They mentioned a number of programmes aimed at entrepreneurs, skills training, customer care and so on. These programmes must, with immediate effect, address HIV/AIDS.

- The programme planning needs to take into consideration the workers' quiet times.
- A feasibility study should be carried out to determine how many peer educators have to be recruited and trained. The large numbers of workers suggest a huge need.
- Peer educators should be recruited from the informal economy as they understand the sector and its problems
- The RATS and relevant organisations should determine what particular skills and experience peer educators should have.
- The RATS and other stakeholders should determine criteria for selecting peer educators.
- The teams with the peer educators should establish monitoring procedures.
- Peer educators should be involved in monitoring other peer educators.
- Monthly written reports should be submitted and a form should be designed for this purpose.
- Peer educators should not be expected to work as volunteers. Government should make some incentive/honorarium available to them for their services.
- Provinces should hold award ceremonies for peer educators to give them recognition for their services.
- The sector should forge partnerships with other sectors for materials, support, etc.
- The programmes should address the specific needs of women in the informal economy and should, in addition to the usual HIV/AIDS content, include negotiating skills, affirmative training and awareness-raising for women.

The delegates outlined a number of broad-based needs of the sector:

- There is an urgent need to apply the decent work agenda **<<V – should this be capitalised? Or should it be “a decent work agenda”? Y>>** to informal economy workers.
- Water and sanitation at sites should be minimal requirements for the sector and government should make these available.
- Police services should be available to the sector to provide safety and security, particularly for women.
- Health care services should be available to provide testing and pre- and post-test counselling.
- There are no formal health care systems specifically for workers in the informal economy and the introduction of mobile healthcare units at some sites should be considered.
- There are no informal workplace medical schemes or clinics – consideration should be given to schemes specifically for the sector.
- The lack of know-how with regard to commercial enterprises needs to be addressed and doing so could be used as a means of persuading workers to attend training at the work sites.
- The mobility of the sector is a problem that makes this target group more vulnerable than workers in the formal economy and more difficult to reach for training.

It is necessary to recognise HIV/AIDS as integral to broader social problems and in this way to establish modalities for childcare, hygiene, safety and a way for women to go beyond only earning a survivalist wage – thereby reducing the possibilities of their being lured into sex to secure sales or supplement their income. It is necessary for workers’ organisations and government to take responsibility for ensuring the health and safety of this target group.

Micro insurance schemes

While many of the workers from rural sites felt the need for mobile health care units to be established, some felt that rotating health schemes could be established to address the problems of workers who are too ill to work. This could also offer possibilities for HIV testing and counselling. The roles of the enterprise chain and of formal sector neighbours need to be examined for possible interventions into training for this sector. **<<V: The paragraph should mention micro insurance schemes by name. Also, what training and to whom, and why would examining the roles of these other actors help? Y>>**

Country: Tanzania
Target Groups: Women brew sellers and women who sell second-hand clothing
Stakeholders identified: Government and local/ward government; 49 national organisations operating from Dar es Salaam; in Kinondoni district 19 organisations were identified while in Kyela district there were only two organisations
Sites: Kinondoni and Kyela

Informal sector activities in Tanzania
Informal sector activities employ a substantial labour force in Tanzania. For as long as the formal sector is unable to absorb the growing labour force, this sector will continue growing. Although data on HIV/AIDS prevalence in the informal sector is lacking, the desk research convincingly established that the vulnerability to HIV infection in the informal sector is a crucial area of concern. If this is to be addressed, a thorough understanding of its nature and dimensions is required, while at the same time effective intervention strategies and programmes for the alleviation of the epidemic need to be designed. Moreover, it is emphasised that the risk of HIV infection has a significant gender aspect in that women appear to be potentially more vulnerable to the infection than men.

It has similarly been established that the epidemic affects the livelihood and productivity of the informal sector, both in the rural and urban areas. It is common knowledge that HIV/AIDS is fundamentally a problem of economic hardship and poverty. Since informal sector operators and workers, particularly of small and medium-sized enterprises, generally live in conditions of great poverty, it follows logically that they are particularly susceptible to HIV/AIDS infection.

Rationale for site and subsector selection
Two informal subsectors were selected for the study: brewing and selling local brew (known in Kiswahili as *pombe*) and trading in open markets on commodities like cooked food, used clothes (commonly known as *mitumba*) and grains like rice and maize. **<<V – this suggests a broader group than the sellers of second-hand clothes referred to above. Y>>**

In consultation with the National Steering Committee for the project, the consultant selected Mbeya and Dar es Salaam regions for the RAs. As Appendix 1 shows, **<<V – will there be such an appendix? Y>>** these regions have the highest cumulative **<<V – why cumulative? Y>>** AIDS cases in the country. At the end of 2000, Mbeya region had 26 952 cases while Dar es Salaam region had 16 053 cases. Within each region the district with the highest number of cumulative HIV cases was selected; thus Kyela district for Mbeya region and Kinondoni district for Dar es Salaam region. Kyela district represented rural areas while Kinondoni district represented urban areas.

Subsectors targeted
In Kyela district, respondents consisted of informal sector operators engaged in trading different items at market places while in Kinondoni district operators and workers who brew and sell local beer were covered.

HIV vulnerability of women in the informal sector
This study focused on women in the informal sector and examined what makes them more vulnerable to HIV infection. Women in the informal sector are more disadvantaged than their male counterparts with regard to HIV infection for the following reasons:

First, in many societies there is a culture of silence surrounding sex, which dictates that “good” women are ignorant about sex and passive in sexual interactions. Most women, including those who work in the informal sector, thus have limited power to negotiate safe sex with their male partners, to discuss sex or sexual responsibility, to determine their own sexual behaviour. This means that women’s’ chances of infection through partners who engage in high risk behaviour such as unprotected sex with many other partners, including sex workers, are very high.

Second, as a result of such attitudes, it is unacceptable for women to say “no” to unwanted and unprotected sex. Cultural beliefs, practices and values run so deep that women are unable to refuse unwanted sex, and they therefore often find themselves in positions of weakness and dependence in this regard at the workplace. It is not uncommon for a female operator in the informal sector to have difficulty refusing sex to the landlord of the premises at which she is working or to the boss if she is only a worker; to the official who can deny her a working license; to the lorry/van driver or owner of a

cart who can refuse to transport her goods; and to the policeman who can prevent her from moving along a street on the pretext that she is breaking the law by doing her business in an unauthorised area. In fact, in such circumstances, many women in the informal sector operate in grey areas that are not quite professional prostitution, but where their economic survival is nevertheless dependent on the favours or protection of male partners.

Third, limited health facilities, compounded by the culture of silence, make opportunities to access treatment services for sexually transmitted diseases minimal, and this renders women even more vulnerable to HIV infection. Women are physiologically at greater risk than men of being infected by HIV/AIDS during unprotected sexual intercourse because of the larger surface areas exposed to contact. **<<V – shouldn't this be a separate point? Y>>**

Fourth, women's economic dependence makes it more likely that they will exchange sex for money or favours. It also means they will be less likely to succeed in negotiating protection or to leave a relationship that they perceive to be risky. All of this adds to their vulnerability to HIV infection.

And finally, women working in the informal sector are frequently exposed to violence, which contributes both directly and indirectly to women's vulnerability to HIV.

Stakeholders

A total of 49 national organisations operating from Dar es Salaam were identified. No organisation was operating nationally. **<<V – could you explain this a little further – or should the word "national" be removed from the first sentence? YK>>** In Kinondoni district 19 organisations were identified while only two were identified in Kyela district.

In identifying organisations responsible for HIV/AIDS intervention, it was discovered that such organisations concentrate on the following six categories of intervention:

- care and support to people living with AIDS and orphans
- capacity building
- prevention
- procurement
- research
- mitigation

The majority of the organisations, both at national and local levels, concentrate on preventive measures, which include advocacy, counselling and sensitisation. Few deal with capacity building and care and support and even fewer with research and the procurement of condoms and drugs. None of the organisations directly targets operators and workers in the informal sector.

Problems identified

There are a number of business risks associated with HIV/AIDS in the informal sector, particularly among the women who brew and sell local beer and trade in the Wards' **<<V – Ward's? (here and elsewhere). Y>>** open markets. The most important are briefly discussed below.

Low and unreliable incomes

Informal sector enterprises are generally characterised by low financial and physical capital. For that reason, many enterprises in this sector tend to be less productive, to make less profit and to earn an irregular income. This lowers the economic security of informal sector operators and workers, making them more likely to engage in potentially risky behaviour vis-à-vis HIV/AIDS, such as selling sex as a means of generating a supplementary income for their survival. This puts them and their spouses or sexual partners at high risk of HIV infection. Women are the dominant operators among brew sellers and in selling cooked food and other commodities, mainly second-hand clothes. However, their main customers are men. It is common practice to attract male customers and sometimes to solicit money from them by being sexually seductive.

Excessive drinking

It is not uncommon for women engaged in brewing and selling local beer to get drunk while working, with this resulting in unintended sexual acts with their drunk customers.

Mobility of trading
The majority of those engaged in trading other commodities in the Wards' open market are men. These people are mobile; they tend to do their business away from their home and are away for long periods. While away, they interact with women who are also engaged in the informal sector, selling local beer or cooked food at the markets. This makes this group of traders more vulnerable to HIV infection.

HIV/AIDS prevention needs
Inadequate and inappropriate education on HIV/AIDS
Although the RA revealed that all respondents had heard about HIV/AIDS prior to the study, some of them were not conversant with issues such as how it spreads and can be prevented. For example, one third of all respondents believe that a person can get HIV/AIDS by working or sharing a meal with an infected person. Participants recommended that informal sector operators and workers should be made more aware of HIV/AIDS infection, prevention and related issues.

Lack of IEC materials
The peer educators needed appropriate IEC **<<V – needs to be given in full. Y>>**materials for education and awareness raising programmes on HIV/AIDS.

Too few peer educators
Peer education typically involves training and supporting members of a given group to effect change among members of the same group. It is often used to effect changes in knowledge, attitudes, beliefs, and behaviours in the individual. However peer education may also create change at a group or societal level. It was recommended that a sufficient number of well-trained peer educators should be available at informal sector workplaces.

Breaking the silence
Workshop participants observed that in their communities (especially in the rural areas of Kyela District) the subject of HIV/AIDS remains mystified and is regarded as a taboo that is not open for discussion among family members.

Distribution and use of condoms
Although male condoms are promoted through social marketing and free distribution in the country, the RA showed that their general acceptance and regular use are still limited. People shy away from male condoms because of misconceptions and misinformation or because they do not know how to use them correctly. Female condoms are still widely unknown products and are in any event too expensive for workers in this sector. There is a need for the peer educators to promote the use of condoms by helping to distribute them at their working places and teaching their colleagues about how to use them.

Reliable voluntary counselling and testing (VCT)
By providing medical, psychological and social support, VCT services can be an entry point for the worried as well as for those who are already infected. Only one quarter of the respondents who participated in the RA indicated that they had been tested. The majority of these were female respondents who were tested while visiting clinics when they were pregnant. The need to provide VCT services in their communities was identified by participants.

Proper and immediate treatment of STDs/STIs
Participants recommended that, In order to reduce the prevalence of STDs/STIs in the informal sector, the coverage of quality STD/STI services needed to be expanded. This should include the availability of essential drugs for treating STDs and STIs at all health facilities offering these services.

Sexual behaviour change
It was observed by the local workshop participants that sexual behaviours and the factors that influence them are complex, which makes the behaviours difficult to modify. It was emphasised that there is a need to find ways of effecting sexual behaviour change among workers.

Economic empowerment/poverty cycle
The HIV/AIDS pandemic creates a vicious circle in that it exacerbates poverty among those who are already poor, like most of the informal sector operators and workers. Such people are often driven to

engage in activities like selling sex as a survival strategy, and are consequently exposed to a higher risk of contracting the infection. The conditions of poverty (low income, poor living conditions and insufficient investment) in the informal sector are serious barriers to prevention or mitigating the impacts of the pandemic. People living in absolute poverty are almost totally preoccupied with their immediate survival, and concerns about preventing HIV/AIDS, whose impact will only be felt in the long term, are therefore not given such high priority.

Gender dimension
The HIV/AIDS pandemic also reflects a gender dimension in that women, female adolescents and girl children are more vulnerable than males to HIV infection and its impacts. Not only are they biologically more at risk than men, but their sexual relationships with men also tend to be unequal, they have less access to information and services and, finally, they carry the biggest burden of care and support. Economic empowerment of informal sector operators and workers, especially women and female adolescents, was therefore identified as essential.

Formulation and enforcement of by-laws
Education and awareness raising programmes can only inform people about risky behaviours – they cannot interfere with their traditional ways of life or change how people's traditional ways of thinking. **<<V – am not sure what the original meant – hope I'm not too far off track. Y>>** Accordingly, participants recommended that consideration be given to the formulation of by-laws that would limit traditions that facilitate HIV infection.

Care needs
Creating and strengthening positive attitudes towards those infected are important aspects of prevention. Efforts to control and prevent the rapid spread of the disease have been severely hampered by the strong social stigmatisation of and discrimination against people living with HIV/AIDS (PLWHA). Stigmatisation and discrimination also make it difficult to motivate PLWHA to seek proper and immediate treatment of opportunistic infections. Participants therefore emphasised that care needs should include creating and strengthening positive attitudes towards PLWHA who work in the informal sector, safeguarding their human rights, making basic treatment and medical care accessible for them, and promoting home and community-based care for them.

Creation and strengthening of positive attitude towards PLWHA
Sensitisation people to recognise that HIV/AIDS is just like any other terminal illness and it does not discriminate who should be infected and fight social stigma and discrimination of PLWHA.

Accessibility to basic treatment and medical care
It was recommended that there was a need of PLWHA in the informal sector having access to the best available treatment and medical care.

Promotion of home and community based care
There is an increasing demand for care of PLWHA that increases the burden on the health care system especially on hospital care. In this regard, the participants recommended that there was a need of PLWHA in the informal sector to have access to their immediate relatives and in the case of their absent then their respective communities should take care of them. **<<V – I think all of this should come out. It adds very little to what was said in the previous paragraph. Y >>**

Basic livelihood support
Basic livelihood support, apart from covering food and medical needs, is in itself part of the prevention and positive altitude creation objectives. Food support relieves those affected by HIV/AIDS of the need to rely on risky behaviours as a means of earning their livelihood. Medical support creates a sense of being accepted and cared for by the community and the society.

Self-help groups
Self-help groups are particularly relevant in dealing with the social and emotional problems that typically face people during the early days of knowing they are HIV infected. These groups have the following features:

- Self-help group members have central shared concerns, such as coping with the emotional and psychological effects of HIV/AIDS infection.

- Although a peer educator might have helped establish it, the group itself is led by non-professionals who are struggling to cope with the same issues as members of the group.
- The emphasis of such groups is on interpersonal support and creating an environment in which individuals may once again take charge of their lives (usually referred to as positive living).

Informal sector associations
Informal sector operators and workers in the areas studied lack well-established operating associations. It was pointed out that there is a need for them to form and maintain associations to safeguard their interests and general welfare.

Local action plans
After identifying their needs, the local workshop participants in each district were again divided into three groups to draw up action plans to address these needs. The action plans for each group were discussed in the preliminary sessions, and modified as necessary.

Adequate and appropriate education on HIV/AIDS
IEC materials like leaflets, newsletters and posters are to be **<<V – were? Here again I'm not sure of the time frames. Y>>** distributed by District AIDS Coordinators (DACs) and other stakeholders to the informal sector peer educators, who will disseminate the materials among the informal sector labour force at their workplaces.

Videotapes on HIV/AIDS from DACs and other stakeholders are to be requested by informal sector peer educators and video shows organised at their workplaces for the informal sector labour force. Leaders at all levels, from the districts to village, street and workplace levels, must strongly and continuously advocate HIV/AIDS prevention and impact mitigation at their public meetings, seminars or workshops. Informal peer educators are to organise guidance and counselling sessions at their workplaces.

Availability and distribution of IEC materials
DACs must procure relevant IEC materials and distribute them regularly to informal sector peer educators and to identified centres within the informal sector. The DACs, with the assistance of other stakeholders, are to coordinate the development, preparation and production of locally produced IEC materials, which will help to stop the spread of HIV/AIDS. Local governments and informal sector peer educators must identify community-based distributors (CBDs) such as *pombe* shops, shops, saloons and guesthouses.

Sufficient peer educators
Local governments must identify literate and willing informal sector operators and workers to serve as peer educators at their workplaces. Trained peer educators already functioning in the informal sector, with the assistance of stakeholders, will have to provide training to the newcomers in the following two stages:

STAGE ONE
- basic knowledge of HIV/AIDS: the source of the infection, how it spreads, methods of prevention, its impacts and the tragedy that there is no cure for it
- creating strategies and mitigation
- counselling skills, prevention and mitigation measures, local cultural context and participatory approaches to finding solutions

STAGE TWO
- coordinating and networking skills
- stress management
- resource mobilisation
- advocacy and lobbying
- monitoring and evaluation

Making HIV/AIDS an issue that communities accept and openly discuss
- Informal sector associations must be established at each local government level to enable informal sector operators and workers to freely discuss HIV/AIDS interventions and related issues.
- Informal sector associations are to organise concerts and symposia at ward and district levels.

- Local government and other stakeholders are to ensure that life-supporting skills are imparted to informal sector peer educators to enable them facilitate social dialogue on HIV/AIDS issues among members of the informal sector.
- IEC materials have to be distributed and displayed in their work and social environments by the informal sector peer educators.
- Communities have to promote and support PLWHA (going into public).**<<V – omit “into”?>>**

Availability, distribution and appropriate use of condoms
- Peer educators must regularly and frequently request condoms from the DACs, nearby public health centres or any other stakeholders and make sure that they are frequently distributed to informal sector operators and workers at their workplaces.
- Local government and peer educators must identify potential CBDs of condoms.
- Informal sector peer educators must make sure that all male colleagues know how to use male condoms. Female maternal and child health nurses should be invited to workplaces to train female members of the informal sector in the proper use of female condoms.
- The central and local governments must consider the possibility of subsidising the cost of condoms, particularly female condoms.

Reliable and immediate VCT
- The local governments must establish VCT services at public health centres and encourage private institutions to provide these services so that members of the informal sector can access testing and counselling in the areas where they work.
- In support of the above, there is a need for qualified and ethical counsellors.
- DACs, in collaboration with informal sector peer educators, local government leaders and other stakeholders, must distribute information on the availability of counselling and testing services.

Proper and immediate treatment of STDs/STIs
- Local governments must expand the coverage of quality STD/STI services and must ensure the availability of essential STD/STI drugs at all health facilities offering these services.
- DACs in collaboration with informal sector peer educators, local government leaders and other stakeholders must distribute information on the availability of these services.

Expediting sexual behaviour change
- Informal sector peer educators, local leaders and other stakeholders must sensitise informal sector operators to risky sexual behaviours and encourage them to change their sexual behaviour and adopt safe sex practices.
- Local governments must pass by-laws that prohibit inappropriate traditional customs and emerging deteriorations in moral behaviour.
- Informal sector peer educators must conduct client-centred counselling style “Cycle of Change”**<<V – I’m at a loss – should this be something like: adopting the “Cycle of Change” approach? Y>>** which encourages clients to explore and resolve a problem or problematic behaviour, and become motivated to change.
- Informal sector peer educators must conduct HIV/AIDS behaviour change counselling in group settings.

Economic empowerment
- Local governments must provide and allocate proper working areas for informal sector operators and workers.
- Local governments must provide amenities such as business stalls, toilets and tap water to improve the level of hygiene at informal sector workplaces and to help improve productivity.
- Financial institutions and other stakeholders must provide soft loans and credit to increase informal sector operators’ capital.
- Local governments must establish and support local training centres which cater for informal sector operators in their respective areas.

Care action plans
Creating and strengthening positive attitudes towards HIV-infected people
- DACs must make sure there are enough available IEC materials for distribution to peer educators.
- Informal sector peer educators must distribute whatever IEC materials they receive to their colleagues in the informal sector.

- Local governments and other stakeholders should investigate all possibilities of preparing, developing and producing IEC materials that are more suitable for local conditions.
- Local leaders and informal sector peer educators must, at every opportunity, sensitise people about the importance of positive attitudes towards PLWHA – at their workplaces, in public meetings, seminars or workshops.
- Local governments must encourage and support cultural groups involved in fighting the social stigmatisation of HIV/AIDS and discrimination against PLWHA.

Safeguard human rights of PLWHA (IS Associations)

- NGOs dealing with legal aspects and HIV/AIDS together with the informal sector peer educators must make people aware of human rights issues around HIV/AIDS.
- Local governments must formulate and enforce by-laws to safeguard the human rights of PLWHA.
- PLWHA must form their own associations to safeguard their rights

Accessibility of basic treatment and medical care

Local governments must make sure that they improve the quality of the medical care services available to infected members of the informal sector, including the treatment of opportunistic infections and prolonged illness.

Promotion of home and community-based care

- Local governments and other stakeholders must identify and mobilise available local resources in the community for the care of HIV-infected people.
- Informal sector peer educators must educate and counsel relatives of PLWHA so that they can take care of them when the need arises.

Support needs

Basic livelihood support

- Local governments and other stakeholders in the communities must mobilise resources so that basic livelihood support may be made available to PLWHA.
- Informal sector self-help groups and associations must provide basic livelihood support to PLWHA who are seriously affected.

Self-help groups

Local governments and informal sector peer educators must facilitate the formation and strengthening of self-help groups for informal sector operators and workers.

Informal sector associations (initiation and support)

- Local governments and informal sector peer educators must facilitate the formation and strengthening of informal sector associations.
- In addition, to effectively change informal sector labour force knowledge, attitudes, beliefs and behaviour at the individual level and at group or societal level, more informal sector peer educators are required and must be trained.
- The plans of actions can be fully realised through multi-disciplinary team work at district and local government level. Informal sector associations, households, informal sector peer educators and informal sector operators and workers, both HIV-infected and HIV-negative, should be involved in a participatory manner with other HIV/AIDS stakeholders.
- There were no affiliations or organisations either for the operators or for the workers interviewed. However, there were local saving and credit associations, commonly known as “UPATU”, although these were constituted on a purely friendship or kinship basis.

<<V – I think the following has crept in by mistake. I don’t think there’s an appropriate place to insert it, because the case study doesn’t give detailed feedback on the findings. Y>>

On the other hand, 64% of all female respondents, including some of the married ones, had had sex with their usual male friends (commonly known in Kiswahili as “*Hawara*”, “*Bwana*”, “*Mshikaji*” or “*Buzi*”) and other men (casual sexual partners) in most cases on a payment basis. While 77% of male respondents, including some of the married ones, had had sex with their usual female friends (commonly known in Kiswahili as “*Hawara*”, “*Bibi*”, “*Mshikaji*” or “*Nyumba Ndogo*”) and other women (casual sexual partners) payment basis in most cases on a payment basis. Only 24% of all respondents indicated they had used male condoms the last time they had had sexual intercourse. Of those who did not use condoms, 41%, most of whom were married, thought it unnecessary. The

second reason mentioned (by 28% of all respondents mostly females) was that their sexual partners objected to it.

Forty-one percent of all respondents admitted to having known at least one colleague who had been infected with HIV/AIDS. Half of the respondents observed that there were tendencies of discriminating against people with HIV/AIDS. Three-quarters of all respondents were able to mention at least one place, mostly a health facility, where they could be tested. Twenty-three percent, the majority being female respondents selling local beer, admitted to having been under the influence of alcohol the last time they had had sex.

Possible intervention

Business risks

During the local workshops, participants identified certain business risks associated with HIV/AIDS in the informal sector, and particularly with the two informal subsectors identified for the RA, namely brewing and selling local beer and trading in the Wards' open markets. Three risks were identified: low and unreliable income, excessive drinking and mobile trading.

Informal sector labour force needs

Participants went on to identify informal sector labour force needs as far as HIV/AIDS prevention, care and support were concerned. The identified needs were:

<<V – no doubt you'll add the missing bit here. Y>>

Country: Ghana
Target Groups: Garage owners and hairdressers
Stakeholders identified: Ghana AIDS Commission (GAC); National AIDS Control Program (NACP); the Institute of Statistical, Social and Economic Research (ISSER); community-based organisations
Sites: Tema - Community 4, an urban area in the Greater Accra region; Pokuase/Amasaman, a rural area in the same region.

Rationale for sites and subsectors
The HIV/AIDS situation in Ghana continues to pose a major challenge to the government and people of Ghana. Currently the national prevalence rate in Ghana is estimated at 3,8%, although this has been exceeded in some regions and areas. The prevalence rate in the capital, Accra, among certain subsectors such as commercial sex workers is 75%. The rate among persons with STDs is 17%. Ninety per cent of all those infected and affected by HIV/AIDS in Ghana fall into the 15-49 age group, which is unfortunately the group that represents the bulk of the nation's human resource base.

HIV/AIDS affects virtually all sectors of the economy, and the formal and informal sectors have both been hit by the epidemic. The characteristics of these two sectors and their contributions to the Ghanaian economy are varied. In Ghana, as in most sub-Saharan countries, the majority of the working populace (an estimated 80,4%) works in the informal sector. The sector therefore contributes significantly to national development.

Ironically, the informal sector is the more vulnerable of the two with regard to HIV/AIDS. It lacks adequate health facilities and social protection arrangements for its workers, few of whom have any kind of insurance cover. The low levels of education, high illiteracy levels and extreme poverty all compound the problems within the sector. There is little, if any, respect for human rights within the sector. Employers dispense with the services of their employees at will. All these factors increase the vulnerability of operatives within the informal sectors.

Most people in the informal sector are far from financially secure, and a significant number end up undertaking additional jobs to supplement their meagre incomes. Such jobs include contractual sex. In fact, research findings have indicated that an estimated 27,7% of people in the informal sector, especially the women, engage in some kind of contractual sex to supplement their incomes. Unsuspecting young women lack the ability to negotiate safer sex with their more prosperous, more experienced and probably older male partners. As in most parts of Africa, socio-cultural factors in Ghana provide a supportive environment for male dominance and polygamy, and with the low educational levels within the informal sector these problems become even more complex.

Since the sector employs more women than men, and since women are more vulnerable than their male counterparts, the sector is doubly vulnerable.

Organisational affiliations
While some informal sector groups have strong associations, others exist only as disjointed, fragmented groups without the capacity to respond adequately to any emerging public health problem. In many instances, employees do not feel committed to the associations, where they exist. For the informal sector to play the role it ought to play, the associations must be strengthened and supported.

The success of the HIV/AIDS programme in Ghana will depend to a large extent on how effectively the informal sector is integrated into the programme design. It will also depend on how well the operatives within the sector can communicate their views and concerns and how effectively they can make their voices heard.

Project activities
Identification of stakeholders
An intense process of identifying key players responsible for HIV/AIDS campaigns and prevention was carried out by GSMF. **<<V – please give in full. Y>>** This included the identification of national and community-based organisations as well as of informal associations. Key national organisations and players identified included the Ghana AIDS Commission (GAC), National AIDS Control Program (NACP) and the Institute of Statistical, Social and Economic Research (ISSER), who in turn provided general information and listed key players who could be contacted. Community-based organisations

and informal associations were identified in the selected urban and rural communities targeted for the intervention.

Desk research on HIV vulnerability and the impact of HIV/AIDS in the informal sector was carried out in October 2002. Particular emphasis was placed on the different subsectors in the informal sector and the gender dimension of HIV vulnerability. A major limitation identified in this phase was a paucity of data on vulnerability to and the impact of HIV/AIDS in the informal sector. This was ascribed to a lack of proper record keeping and of specific research conducted in the informal sector in Ghana. All the documented statistics and information on vulnerability to and the impact of HIV/AIDS kept by key actors such as GAC and NACP are of a very general nature. Accordingly some deductions had to be made to describe specific issues concerning HIV/AIDS in the informal sector.

On the basis of the desk research and in consultation with stakeholders, GSMF identified two subsectors of the informal economy (garage owners and hairdressers) as the focus for the two components of the ILO project, namely rapid assessment and community mobilisation. The two groups were selected because although some HIV/AIDS prevention programmes had been carried out with some subsectors of the informal sector, garage operators and hairdressers have been under-researched and have not benefited from any such programmes.

GSMF identified Tema - Community 4, an urban area in the Greater Accra region, and Pokuase/Amasaman, a rural area in the same region, as the focal geographical areas for the project.

- Garage operators (mechanics) were selected as a group because they had in the past received no HIV/AIDS prevention intervention.
- Hairdressers were selected because of their acute vulnerability to HIV/AIDS. In addition, it was determined that hairdressers in the Pokuase/Amasaman area had never benefited from any HIV/AIDS prevention programmes.

Both the groups selected have existing organised associations in their respective communities and are easily reachable through the association head.

Rapid Assessment Activities

Training activities

Based on the rapid assessment (RA) and desk research, two groups (or subsectors) were selected for the intervention. The groups were garage owners (mechanics) and their apprentices, a male-dominated profession, and hairdressers and their apprentices, a female-dominated profession.

As part of the development of IEC materials, peer educator kits were developed for the programme. These kits included the following:

- HIV/AIDS training manual
- HIV/AIDS at a glance – cue cards
- HIV/AIDS planner – cue cards
- STD cue cards
- polo-shirts
- T-shirts
- baseball caps
- penis models
- male condoms
- female condoms
- HIV/AIDS question and answer booklets
- 8 different HIV/AIDS leaflets

Some of the IEC materials were specifically developed to address major gender issues in the informal sector. The materials are simple and illustrative and easy for the target audience to use.

Prior to the recruitment and training of peer educators, advocacy was undertaken among the leadership of the garage owners and the hairdressers to build consensus and increase commitment to and support for the programme. The advocacy sessions were extended beyond the leadership of both groups to include a cross-section of the entire membership. This strategy aimed at generating the

necessary groundswell to carry the programme to a successful conclusion. The advocacy sessions served as appetisers and stimulated considerable interest in the programme even before its actual inception.

Peer educators
Peer educators were recruited in a participatory manner by the leadership of both the hairdressers and garage owners. Recruitment was based on the following qualities:

- ability to communicate clearly and persuasively
- good interpersonal skills including good listening skills
- similar socio-cultural background to that of the audience
- accepted and respected by the target audience
- non-judgemental in attitude
- strongly motivated and prepared to work with little supervision
- self-confident and good leadership skills
- time and energy to devote to work
- role models among their colleagues

Based on past experience, peer educators were recruited from the executives/leadership of both the hairdressers and the garage owners. Even though these people do not have as much time at their disposal as other peer educators, they are able to facilitate the programme in many diverse ways. They also provide some support from the leadership, which is a crucial factor in ensuring the success of an HIV/AIDS intervention.

Peer educators were also recruited from both the masters and the apprentices. This ensured a wide age distribution among the peer educators, and achieved total coverage of the target audience.

Two experienced workshop facilitators were recruited per workshop. The recruited peer educators were taken through a comprehensive GSMF International training programme. The training curriculum included:

- anatomy and physiology
- sexually transmitted diseases
- HIV/AIDS
- condoms
- fertility management
- communication skills
- Journey of Hope training methodology
- peer educator activities
- gender and HIV/AIDS
- motivational/inspirational discussions

The facilitators were also taken through the RA findings in order to increase their comprehension of issues relating to the target audience.

All the peer educators recruited from among the hairdressers and their apprentices in the Pokuase/Amasaman district were female. Two of the peer educators from among the garage owners and their apprentices (from Tema) were female while the rest were males. This ensured a female-dominated group in Amasaman/Pokuase and a male-dominated group in Tema.

The basic training was conducted over a two-day period. The trained and equipped peer educators elected their own executive, who were responsible for supervising and coordinating all peer educator activities. Action plans were drawn up for the year. These plans were presented to the leadership of both associations (hairdressers and garage owners) for their support, approval and endorsement. This strategy was aimed at ensuring commitment and ownership.

The trained peer educators were very enthusiastic about the programme. They promised to make a difference in their respective communities and to contribute their quota towards reducing the number of new infections among their peers. Their initial motivation emanated from their own desire to make a difference in their communities. The IEC material and the fact that they would receive certificates

provided additional motivation. Finally, the thought of being singled out and trained as a peer educator was a powerful motivator.

Limitations (Phase 1)
The project was timed to take place very close to the Christmas period, and most of the hairdressers and some garage owners stated that this was their peak season. They wanted the project to be postponed for two to three weeks, by which time their peak season would be over. They suggested that programme designers and implementers needed to take into consideration the target audiences' preferences with regard to times and seasons when implementing programmes.

The fact that the informal sector is not well organised was a major challenge. Obtaining the approval and commitment of the leadership of the garage owners was quite an arduous task since the leadership either did not see the urgent need for an HIV/AIDS intervention for its membership or did not feel confident enough to rally and mobilise its membership for the programme.

Informal sector operatives almost always seem to want some money before they will allow NGOs to reach their membership. Their view was that a considerable amount of resources had been allocated to fight HIV/AIDS, and that they should receive their share.

These limitations notwithstanding, GSMF International was able to successfully execute the first phase of the project and submit the phase 1 report by December 31st 2002. It was a successful phase.

***Phase II* <<V – a Phase I heading is needed somewhere – perhaps in brackets after Rapid Assessment, which is the previous main section heading. Y>>**
The second phase built upon what had been achieved during the first phase. The aims for this phase included the following:

- development of IEC material
- recruiting a second set of 50 peer educators (25 from each group)
- training the "new" peer educators (basic training)
- equipping newly-trained peer educators with IEC material
- re-training all 100 peer educators (intermediate training)
- organising four community mobilisation workshops (two in each area)
- organising a national planning workshop (involving all stakeholders)
- organising networks
- preparing final report

Development of IEC materials
The peer educator toolkit developed for the previous basic training was maintained. Two new leaflets were developed in addition to the eight used for the first batch of training. The new leaflets addressed cross-infection prevention, emphasising salon activity and the need for and importance of voluntary counselling and testing. The two new leaflets were developed based on the findings of the RA report.

Selection and training of new peer educators (basic training)
Fifty additional men and women were recruited for training in the two subsectors. Similar standards were used during the selection process. Recruitment was based on the following qualities:

- ability to communicate clearly and persuasively
- good interpersonal skills including listening skills
- similar socio-cultural background to that of the audience
- accepted and respected by the audience
- non-judgmental in attitude
- strongly motivated and prepared to work with little supervision
- self-confident and good leadership skills
- time and energy to devote to work
- role models among their colleagues

During this phase the organisational executive gave better support and assistance during the recruitment of the new peer educators. Their commitment increased because they had a greater appreciation of the issues relating to HIV/AIDS and could better identify colleagues who would make

good peer educators. Apprentices were given more representation due to their greater number (as compared to the masters). The activities of the old peer educators prompted and motivated many others to volunteer. Eventually the challenge was to reduce the number of recruited peer educators to 25 from both groups. All 25 selected peer educators in Pokuase were female, while 23 of the 25 people selected in Tema were male. Two facilitators were recruited by GSMF for the training. Participants were taken through the full GSMF training curriculum, which included:

- anatomy and physiology
- fertility management
- sexually transmitted infections
- HIV/AIDS
- condoms
- Journey of Hope (a participatory HIV/AIDS approach)
- communication skills
- gender and HIV/AIDS
- question and answer discussions
- rapid assessment findings

Facilitators also took into consideration lessons learnt from the previous basic training sessions as well as issues about which the previous peer educators had gathered information in the field. These lessons included the following:

- There was a need to increase education on fertility management. During the first basic training in Pokuase, participants expressed a lot of interest in fertility management. Accordingly during that session in the second round of training, facilitators provided more detailed material. Participants were trained on how to deal with the myths and excuses surrounding fertility management. This need was more specific to the female-dominated group.

- Reports from previously trained peer educators indicated that serial monogamy was very prevalent in their workplace and in the community as a whole. Most of their colleagues changed sexual partners quite often, for one reason or another. In a period of about three years a person might have two to four partners and still feel safe because he or she had been faithful to each at the time of the liaison. Participants were made to understand that such behaviour is no different from having three sexual partners at a time. The session thus illuminated the problems and practice of serial monogamy.

Training in Pokuase/Amasaman
A different strategy was adopted in Pokuase during this round of training. Sessions were delivered at a slower pace to accommodate the low level of education of participants. This could also be attributed to the fact that there were more apprentices in this group. A lot of visual aids such as films, slide shows and diagrams were used in the basic training. Facilitators guided the participants to generate most of the concepts themselves in order to improve comprehension.

Training in Tema
In Tema, the situation was different. Though there were more apprentices in this group, just as in Pokuase, these apprentices seemed sharper than the masters and the knowledge level was higher than in the first group. Interaction and the exchange of ideas between participants were impressive. This could have been because the apprentices from Tema were located in an urban setting and had therefore been exposed to more information. Most of the participants were also already motivated before entering the training, and this, too, contributed to their high level of performance. The male-dominated group did not seem to have any serious concerns about fertility management (family planning).

Peer educators had been given their toolkits and certificates. The toolkits included an HIV/AIDS training manual, HIV/AIDS at a glance cue cards, HIV/AIDS activity planner cue cards, STD cue cards, polo shirts, baseball caps, penis models, male and female condoms, HIV/AIDS question and answer booklets, and ten different leaflets on HIV/AIDS.

Refresher for all 100 peer educators (intermediate training)

Two intermediate training sessions were organised for peer educators who had undergone the basic training in both communities. Two workshop facilitators were recruited for each training session. As a strategy, the same workshop facilitators were recruited to build upon the experiences they had acquired during the basic training. The training curriculum was upgraded to include two new topics, voluntary counselling and testing (VCT) and cross-infection prevention. The training session also provided a platform for peer educators to share experiences and have their questions answered. The training curriculum consisted of the following:

- sharing of experiences
- STDs
- fertility management
- HIV/AIDS (current statistics and developments)
- condoms
- voluntary counselling and testing
- cross-infection prevention
- case study

The participants were asked to share the experiences of their five months as peer educators. They admitted that the basic training had been an eye-opener for them and that they regarded themselves as better informed than their colleagues in terms of knowledge. They commented that the programme had changed their own sexual behaviour as well as that of some of their colleagues. They were of the opinion that their confidence had grown with the training. Most of them said they had become bolder than they had been at the beginning of the project.

Participants were briefly taken through the major topics during the training (fertility management, STDs, HIV/AIDS, and condoms). Difficult questions as well as issues raised during their advocacy activities were addressed. A film entitled *Ama Djafoule* was used as a case study. The facilitators had decided on a film show because of the educational backgrounds of the participants. This particular film was chosen because it addresses most of the issues in the training curriculum and because it is most appropriate for the informal sector. The main issues the film raises include:

- the importance of negotiating condom use
- the fact that STDs could occur in stable relationships (marriages)
- the need for consistent condom use with all partners
- the fact that sex with a prostitute who uses condoms consistently is safer than sex with a non-prostitute who seldom uses condoms
- the use of a water-based gel with male condoms during sex
- myths and excuses surrounding voluntary counselling and testing
- the role of VCT in promoting trust and confidence in relationship
- the need for regular medical examinations

After the film show, participants were divided into four groups and asked to identify and discuss the main ideas and themes of the film. Participants were asked to share their experiences as well as the lessons learned during their advocacy/educational activities. A number of issues were raised by the peer educators during the intermediate training. Most of these issues had to do with their peer educator educational activities and included the following:

- There were insufficient adequate promotional and IEC materials for mass distribution. Peer educators who had embarked on outreach activities outside their workplaces could not cope with the increasing demand for materials. They requested additional resources for the development of IEC materials.
- Apart from their advocacy activities at their workplaces and homes, peer educators wished they had the resources to cover the costs of conducting frequent outreach programmes (such as transport costs). In Pokuase, for instance, hairdressing salons are very widely dispersed across the town, and peer education was becoming limited to only the shops with peer educators.
- Peer educators emphasised the need for occasional programmes like film shows and durbars in the communities. This would promote awareness and increase people's interest in the programme
- Awareness and acceptance of the programme would be greater if the programme had been launched formally and peer educators had been introduced to their colleagues and the rest of the community.

- In Pokuase/Amasaman, where all the peer educators and most of the audience were women, negotiation for safer sex still remained a major issue. As these are rural communities the prevalence of polygamy and gender inequality pose a challenge to behaviour change. Some of the peer educators admitted that they had not been able to convince their male partners of the need to manage their fertility.
- Female peer educators in Pokuase/Amasaman emphasised the need for their male counterparts (the majority of whom were informal sector workers) to be included in future programmes. They contended that until their male counterparts understood the issues, their efforts would have little impact.

Peer educator activities (summary)
The peer educators from both Tema and Pokuase/Amasaman have been actively involved in the education of their peers for five months. Their strategies include one-on-one talks with their peers, talks during leisure hours when business is slow, educational activities at general meetings for both the masters and apprentices and occasional community outreach. Peer educator reports are submitted periodically to the GSMF office. On average, 800 persons are reached on a monthly basis at the two sites.

In Tema, the peer educators meet on a monthly basis, while in Pokuase/Amasaman they meet weekly. In total there are 21 condom sales outlets in Tema and Pokuase/Amasaman. Nine of these are located in Tema and 12 in Pokuase/Amasaman. Even though condom sales started slowly, there has been a gradual increase in sales. About 5 000 male condoms were sold between April and July 2003. This represents an increase of 100% over the same four months last year. The female condom sells better in Pokuase/Amasaman than in Tema.

Generally speaking, motivation and enthusiasm have remained high among peer educators throughout the project period. Lack of funds has, however, limited their activities to their shops and immediate surroundings. A community workshop was organised in each of the two districts and involved representatives of informal sector associations, local government, community-based organisations and peer educators.

All workshops commenced with presentations on the current HIV/AIDS situation in Ghana. This was done to enable workshop participants to understand the concepts of HIV/AIDS in relation to the needs in terms of prevention, care and support.

Needs in terms of prevention and care and support
Healthcare (Pokuase/Amasaman – rural)
- Health facilities (ie clinics, hospitals, etc) are inadequate.
- There are not enough health personnel to handle STIs and HIV/AIDS.
- There are no facilities for prevention of mother to child transmission (PMTCT).
- Home-based care for PLWHAs does not exist in the community.
- There are no ARVs **<<V – in full?>>**for persons living with HIV/AIDS.
- Even though there are trained counsellors in the area, they are virtually unknown and their services are untapped.
- No VCT is offered in the area.
- Treatment of STIs occurs more in the chemist shops than at health posts since the chemist shops are perceived as more patient and friendly. There might be a need to train or re-train the owners of the chemist shops in the syndromic management of STIs.
- There is no post-exposure prophylaxis (PEP) for medical personnel in the area.

Healthcare (Tema – urban)
- In Tema most of the healthcare requirements are available in Pokuase/Amasaman. **<<V – the inclusion of Pokuase/Amasaman here must be an error? Y>>** Government hospitals and private clinics are in abundance. There may be a need to promote the government institutions since personnel are perceived as being impatient and unfriendly.
- VCT sites are present but unpopular. The sites need some promotion.
- PMTCT takes place in the government hospitals but again the larger community does not know about this.
- There is no post-exposure prophylaxis (PEP) for medical personnel.

- There might be a need to re-train pharmacists and owners of chemist shops in the syndromic management of STIs since they are the first points of call for most patients with STIs.

Condom accessibility (Pokuase/Amasaman – rural)
- Both male and female condoms are available in the numerous chemist shops in the area. In most instances condoms are affordable.
- There is a need to educate people about the correct use of male and female condoms.
- The female condom is perceived as being cumbersome to use. This notion can be corrected through effective promotion.

Condom accessibility(Tema – urban)
- Both male and female condoms are available in the numerous chemist shops in the area. In most instances condoms are affordable.
- There is a need to educate people about the correct use of male and female condoms.
- The female condom is perceived as being cumbersome to use. This notion can be corrected through effective promotion.

IEC materials (Tema and Pokuase/Amasaman)
- IEC materials are available but woefully inadequate
- Accessibility of IEC materials is also a problem since they are mostly located in the health facilities or District Assemblies.
- There is a need to create IEC materials that are simple and pictorial since most of the operatives of the informal sector have low levels of education.
- Specific IEC materials that address the unique circumstances and needs of the informal sector should be developed.

NGOs working on HIV/AIDS
- Even though there are many NGOs working in both areas (Tema and Pokuase/Amasaman), their activities are uncoordinated and their impacts are not really felt. The coordination of all NGOs working in an area needs to be strengthened to improve the efficiency of their operation.
- NGOs need to get into the field of care and support for PLWHAs. There are very few NGOs working in this field.
- There is a need for the District Assembly to create a platform for networking and experience sharing for all NGOs within a particular community.

Socio-cultural factors (Tema and Pokuase/Amasaman)
- Strong stigmatisation of PLWHA jeopardises HIV/AIDS prevention programmes in both communities.
- Churches and other religious groups are beginning to respond better to PLWHA as a result of the current "Reach Out" Compassion Campaign.
- Some believe that traditional healers can cure HIV/AIDS, and this notion needs to be corrected.

Political factors (Tema and Pokuase/Amasaman)
- Even though the political will to fight HIV/AIDS in Ghana is generally high, a lot more could be achieved if more resources were made available to the informal sector.
- There is a need to build the capacity of informal sector associations to make them capable of responding adequately to the HIV/AIDS menace.
- Informal sector associations need to be made aware of the availability of funds and sourcing procedures to enable them to run their own programmes.
- There is a need for political leaders to speak openly on prevention, care and support in their communities.

Business risks

Most people who work in the informal sector do not have enough information to accurately evaluate their own vulnerability. A hairdresser's work is risky because of pedicures and manicures, which involve the use of skin piercing instruments, and hair retouching, which involves the use of chemicals. Unlike hairdressers, dressmakers have low business risks because they rarely deal with any such instruments.

The risk involved in barbering is high because of the use of sharp instruments. In addition, barbers share the same equipment with their clients. **<<V – does this perhaps mean: the same equipment is used with more than one client? Y>>** Some barbers use alcohol to sterilise their equipment.

Drivers are at risk because of the large number of people they interact with. Long-distance drivers leave their partners for days, increasing the possibility that they will have casual sex relationships.

Mechanics, carpenters and plumbers indicate that their work sometimes involves travelling to distant places for days, which means leaving their partners at home. They meet new people and being away from home gives them the freedom to explore casual sexual relations.

Traders are also at risk in that they travel to the rural areas to buy foodstuffs and if they do not have enough money to pay for the produce or the transport, the farmers and drivers take advantage of this, and contractual sex is used to pay off these debts.

In sectors that are female-dominated, apprentices are especially vulnerable. They earn very low incomes (some earn nothing at all), and men who have adequate disposable incomes easily lure them. As a result, they are exposed to unprotected sex under "contractual sexual agreements" because there is no or little negotiation for condom use (particularly with informal sector workers such as drivers, masons, carpenters, etc).

Generally speaking, it may be concluded that the different professional groupings of the informal sector have different vulnerabilities based on the nature of their work. Nevertheless, the informal sector as a whole is vulnerable because it lacks the ability and capacity to adequately respond to HIV/AIDS. Some interesting facts in this regard include the following:

- Participants from informal sector associations had never heard about the ILO Code of Practice on HIV/AIDS.
- Though some have heard about the ILO as an organisation, they had no knowledge of its activities.
- Participants did not know where to obtain the ILO Code of Practice on HIV/AIDS. They had absolutely no idea about the location of any ILO office in Ghana.

Action plans

Participants were asked to outline an action plan for the community. They did so, but expressed their concerns about the availability of resources to implement their action plans.

In Tema, participants outlined the following as their action plans:

- All representatives of the informal sector associations should meet for detailed discussions of the ILO Code of Practice on HIV/AIDS.
- Informal sector associations must be strengthened so that they can streamline the activities of all their members.
- The associations should consider including some aspects of the ILO Code of Practice as part of their constitutions and should encourage its implementation.
- Workshops on HIV/AIDS should be organised for the various informal sector workers.
- Protective working equipment in the informal sector should be made available and affordable, and its use should be enforced.
- Tema Municipal Assembly will identify all local NGOs involved in HIV/AIDS work in the community and ensure collaboration among them to improve their impact in the community.
- Condom accessibility at workplaces should be increased. For example, Tema Municipal Assembly could buy condoms and add the cost to their revenue tickets, which they issue for the payment of tolls/bills.

In Pokuase/Amasaman, participants outlined the following:

- Networking between the sectors of the community. This would provide a platform for information dissemination and experience sharing between all stakeholders involved in the fight against HIV/AIDS, particularly within the informal sector. This would minimise duplication and increase

efficiency. In order to increase the networking and coordination of all sectors in the community, the District Assembly, with the help of GSMF, would hold quarterly networking meetings.
- Care and support programmes must be put in place for HIV/AIDS infected and affected persons.
- Pictorial and simplified IEC materials must be developed and extensively distributed.
- Educational programmes must be organised for both in-school and out-of-school youth.
- Training of trainers workshops should be arranged for District Assembly staff and leaders of informal sector associations.
- Mobile vans should be hired to educate people in the community.
- Video centres in the community would be contracted to show films on HIV/AIDS and STIs.

Some of these plans do not require funds but others will be achieved only if funds are sourced.

Formation of networks
In order to ensure knowledge transfer among the various sectors of the communities, networks have been formed in both Tema and Pokuase. These will serve as a forum to share experiences and will attempt to address the problems of informal sector workers in the communities.

Two representatives from each association, together with representatives of NGOs and local government, would meet every quarter to discuss developments in each sector as far as HIV/AIDS prevention is concerned. Peer educators at the two sites would visit each other occasionally to share ideas and experiences. GSMF would collaborate with the local authorities to ensure the participation of all stakeholders.

National workshop
A national planning workshop was organised in Accra at Miklin Hotel to bring together stakeholders in the informal sector. Two representatives each from various informal sector associations, government and local government officials, as well as representatives of the Ghana AIDS Commission, were invited to participate.

Recommendations were made by GSMF to strengthen the role of the informal sector in the development of the national strategic plan. The recommendations are as follows

1. First of all, there is a need for government and other stakeholders to accept and recognise that the impact of HIV/AIDS strategies in the informal sector is critical for the national impact assessment, considering the size and vulnerability of the sector.

2. Existing associations must be strengthened and new ones created. The leadership of informal sector associations must be made to understand the issues of HIV/AIDS and the dynamics of the pandemic in the informal sector.

3. Informal and non-formal education for people (adults and youth) in the informal sector should be stepped up. Increased literacy facilitates information dissemination and this improves the understanding of issues relating to HIV/AIDS. Non-formal education would also empower informal sector workers to make better-informed decisions.

4. Capacity in the informal sector should be built. Top and middle level executives should be given the capacity to design programmes and access funding from GAC and other donors for HIV/AIDS prevention, care and support programmes for their members. It would also be appropriate if they developed the capacity to amend various constitutions to include HIV/AIDS and related issues.

5. The capacity of NGOs working in the informal sector must be strengthened so that they can provide prevention programmes, care and support and collaborate for better impact. Regular networking sessions must be held to facilitate knowledge transfer between the various players in the informal sector.

6. Affirmative action to address gender inequalities in the informal sector should be strengthened and enforced. Policies must be initiated to address the gender dimensions of poverty and inequality.

7. Civic education must be strengthened in the informal sector to encourage knowledge of individual rights. Human rights abuses are very common within the sector. Improved civic education would contribute significantly towards alleviating this problem

The informal sector has a major role to play in the battle against HIV/AIDS. Governments, stakeholders within the HIV/AIDS fraternity, NGOs and the leadership of informal sector operatives must all collectively leverage the resources of each group to effectively fight HIV/AIDS in Ghana. A case has been made for the informal sector operatives. They have made an input into the development of the national strategic plan. This input must be continuous and sustained if we are to achieve our desired objectives.