

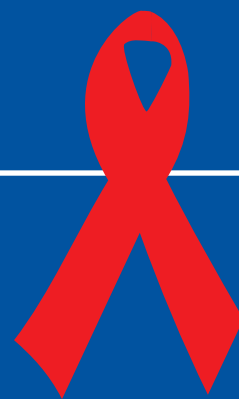


International
Labour Office
Geneva



HIV/AIDS:

A threat to decent work,
productivity and development



Document for discussion at the
Special High-Level Meeting on
HIV/AIDS and the World of Work

Geneva, 8 June 2000

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A THREAT TO DECENT WORK,
PRODUCTIVITY AND
DEVELOPMENT**

DOCUMENT FOR DISCUSSION AT THE SPECIAL
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WORLD OF WORK

GENEVA, 8 JUNE 2000

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CONTENTS

Executive summary	1
Introduction	3
I. The nature and magnitude of the pandemic	4
A. HIV/AIDS: the global picture	4
B. Regional features	5
C. Risk and vulnerability	7
D. The impact on the individual and the household	8
E. Human rights implications	10
II. The social and economic implications of HIV/AIDS	12
A. The social and economic impact at the national level	12
B. The impact on the workforce	14
C. The impact on employers and their organizations	20
III. Current approaches to addressing HIV/AIDS	23
A. The response of governments	23
B. The response by employers and their organizations	27
C. The response by workers' organizations	30
D. Responses at the community level	32
E. The response by international organizations	33
IV. Elements of an ILO response	37
V. Concluding remarks	43
VI. Annex	44

LISTS OF TABLES, TEXTBOXES AND FIGURES

Table 1:	The AIDS pandemic at the end of 1999	4
Table 2:	Regional characteristics of the pandemic, December 1999	5
Table 3:	HIV/AIDS in Africa by the end of 1997	7
Box 1.	Impact of HIV/AIDS on the agricultural sector	14
Box 2.	The impact of HIV/AIDS on commercial farms in Kenya	22
Box 3:	The Philippine AIDS Prevention and Control Act 1998	26
Box 4:	South Africa uses Thailand's recipe to prevent HIV/AIDS in the transport industry	28
Box 5:	The impact of HIV/AIDS on insurance policies	29
Figure 1:	The impact of HIV/AIDS on the social security system	13
Figure 2:	Population growth in nine African countries with an HIV prevalence of 10 per cent or higher	15
Figure 3:	Life expectancy at birth with and without HIV/AIDS in 29 African countries	16
Figure 4:	Projected labour force with and without AIDS in high prevalence countries	17
Figure 5:	Projected labour force with and without AIDS in lower prevalence countries	19
Figure 6.	Distribution of increased labour costs due to HIV/AIDS in Kenya	21

EXECUTIVE SUMMARY

The figures speak for themselves. With an estimated 33 million persons living with HIV in 1999, two-thirds of them in sub-Saharan Africa, and over 5 million newly infected in 1999 alone, HIV/AIDS is an immense human and social tragedy.

It is also now beginning to be more widely, if belatedly understood that HIV/AIDS is a major threat to the world of work.

HIV/AIDS is a threat to workers' rights. People with HIV/AIDS are subject to stigmatization, discrimination or even hostility in the community and at work. The rights of people living with HIV/AIDS, such as the right to non-discrimination, equal protection and equality before the law, to privacy, liberty of movement, work, equal access to education, housing, health care, social security, assistance and welfare, are often violated on the sole basis of their known or presumed HIV/AIDS status. Individuals who suffer discrimination and lack of human rights protection are both more vulnerable to becoming infected and less able to cope with the burdens of HIV/AIDS.

HIV/AIDS is a threat to development. The pandemic has profound negative impacts on the economy, the workforce, the business, individual workers and their families. Economic growth could be as much as 25 per cent lower than it might otherwise have been over a 20-year period in high prevalence countries. Their populations will be about 20 per cent lower by the year 2015 than they would have been without HIV/AIDS, and their labour forces in the year 2020 will be between 10 to 22 per cent smaller. HIV/AIDS also has a significant impact on the composition of the labour force in terms of age, skills and experience.

HIV/AIDS is a threat to enterprise performance. The world of work is affected by increasing costs due to health care, absenteeism, burial fees, recruitment, training and re-training. For smaller firms in both the formal and informal sectors, the loss of employees has major implications. In the rural sector, losses due to HIV/AIDS may reduce food production and food security. Enterprises in sectors such as transportation, tourism and mining are the most vulnerable. Overall, there will be a reduction of growth if rapid measures are not taken to prevent the impact of HIV/AIDS.

HIV/AIDS is a threat to gender equality. Women are highly vulnerable to HIV/AIDS for both biological and cultural reasons. They are particularly affected by HIV/AIDS when a male head of household falls ill. The burden of caring for children orphaned as a result of the pandemic is borne mainly by women. Loss of income from a male

income-earner may compel them to seek other sources of income, putting them at risk of sexual exploitation.

HIV/AIDS increases child labour. The tremendous pressure on households and families often forces children to work. As a result, it is difficult for them to attend school, they do not receive proper care and guidance, and easily fall victim to all kinds of exploitation.

For all these reasons, HIV/AIDS is a major factor undermining the ILO's guiding principle of decent work. People living with HIV/AIDS are often forced to leave their jobs and are isolated in their communities, with minimal opportunities to earn an income. In the absence of adequate public support systems, especially in the developing countries, families have to bear the full cost of the disease, pushing them deeper into poverty. HIV/AIDS prevention is poverty alleviation.

Yet, in so many countries, even those which are worst affected, prevention and care are impeded by a persistent culture of denial, both in society and the world of work.

The ILO has to play a pivotal role in overcoming this culture of denial and in addressing HIV/AIDS in the world of work. A global partnership is required to develop a comprehensive response to the impact of HIV/AIDS on the world of work. Although governments and employers' and workers' organizations have started to respond to the effects of the pandemic on the world of work, the complexity and extent of the pandemic require global initiatives by the ILO and support for action at the national and enterprise levels. The ILO has the expertise in this area and, through its long history, has established the necessary relations with the social partners all over the world. In particular, the large numbers of members of employers' and workers' organizations offer an ideal channel for awareness-raising, prevention and support initiatives at all levels.

INTRODUCTION

FROM MEDICAL PROBLEM

In the early years of the pandemic, HIV/AIDS was regarded almost exclusively as a medical problem. Since then, as the scale of the human tragedy has become clear, particularly in the most affected countries, it has become evident that HIV/AIDS is a major development problem which is threatening to reverse a generation of achievements in human development. HIV/AIDS is also rapidly emerging as a serious issue in the world of work and a major threat to the ILO's guiding principle of decent work. As participants from 20 African countries meeting in Windhoek in October 1999, put it:

.....TO DEVELOPMENT ISSUE.....

“The pandemic has manifested itself in the world of work – the area of the ILO’s mandate – in the following ways: discrimination in employment, social exclusion of persons living with HIV/AIDS, additional distortion of gender inequalities, increased numbers of AIDS orphans, and increased incidence of child labour. It has also disrupted the performance of the informal sector and small and medium enterprises. Other manifestations are low productivity, depleted human capital, challenged social security systems and threatened occupational safety and health, especially among certain groups at risk such as migrant workers and their communities and workers in the medical and transport sectors.”

.....BUT THE POTENTIAL OF THE WORLD OF WORK TO COMBAT HIV/AIDS IS UNTAPPED

Much has been learned about the pandemic and how it should be addressed — and in particular that AIDS prevention and care are complex issues requiring a multi-sectoral approach. However, the full potential role of the world of work as a major venue for partnerships and interventions to prevent HIV/AIDS, protect workers and reduce its impact on business remains untapped. It is therefore the purpose of this paper to examine the social and labour implications of HIV/AIDS, as well as current practices and approaches to addressing the problem. Based on a preliminary assessment of impact, constraints and opportunities, the paper goes on to explore the policy and programme elements of an ILO response to the tragedy.

I. THE NATURE AND MAGNITUDE OF THE PANDEMIC

A. HIV/AIDS: THE GLOBAL PICTURE

Recent estimates indicate that 33.6 million persons were living with HIV by the end of 1999, of whom 32.4 million are in their most productive years, that is between the ages of 15 and 49, while 1.2 million are children aged 15 years and younger. In 1999 alone, 5.6 million people (570,000 children) became infected with HIV and 2.6 million died from AIDS (see Table 1). With the HIV-positive population still expanding, the annual number of AIDS deaths worldwide can be expected to increase.

95 PER CENT OF PERSONS LIVING WITH HIV/AIDS ARE IN DEVELOPING COUNTRIES

Around half of all people with HIV become infected before the age of 25 and die approximately ten years later. By the end of 1999, there was a cumulative total of 11.2 million AIDS orphans, defined as children who have lost their mother before reaching the age of 15. Many of these maternal orphans have also lost their fathers. Approximately 95 per cent of the global number of people with HIV/AIDS live in developing countries. Due to poverty, poor health systems and limited resources for prevention and care, it is expected that this proportion will rise further.

TABLE 1: THE AIDS PANDEMIC AT THE END OF 1999¹

People newly infected with HIV in 1999	Total	5.6 million
	Adults	5 million
	Women	2.3 million
	Children <15 years	570 000
Number of people living with HIV/AIDS	Total	33.6 million
	Adults	32.4 million
	Women	14.8 million
	Children <15 years	1.2 million
AIDS deaths in 1999	Total	2.6 million
	Adults	2.1 million
	Women	1.1 million
	Children <15 years	470 000
Total number of AIDS deaths since the beginning of the pandemic	Total	16.3 million
	Adults	12.7 million
	Women	6.2 million
	Children <15 years	3.6 million

¹ UNAIDS: AIDS epidemic update, December 1999.

B. REGIONAL FEATURES

The pandemic has taken on different forms in the various parts of the world. In some areas, HIV has spread rapidly to the general population, while in others certain sub-populations have been particularly affected, including sex workers and their customers, men who have sex with men (MSM), and injecting drug users. Table 2 provides an overview of the regional features of the HIV/AIDS pandemic, the adult prevalence rate and the main mode(s) of transmission. In global terms, the adult prevalence rate is 1.1 per cent of the population as a whole, of whom 46 per cent are women.

TABLE 2: REGIONAL CHARACTERISTICS OF THE PANDEMIC, DECEMBER 1999²

Region	People living with HIV/AIDS	New infections	Adult prevalence rate as percentage of total population ³	HIV-positive women as percentage of total HIV-positive population	Main mode(s) of transmission
Sub-Saharan Africa	23.3 million	3.8 million	8.0	55	heterosexual
North Africa & Middle East	220 000	19 000	0.13	20	injecting drug use, heterosexual
South & South-East Asia	6 million	1.3 million	0.69	30	heterosexual
East Asia & Pacific	530 000	120 000	0.068	15	injecting drug use, heterosexual, men having sex with men
Latin America	1.3 million	150 000	0.57	20	men having sex with men, injecting drug use, heterosexual
Caribbean	360 000	57 000	1.96	35	heterosexual, men having sex with men
Eastern Europe & Central Asia	360 000	95 000	0.14	20	injecting drug use, men having sex with men
Western Europe	520 000	30 000	0.25	20	men having sex with men, injecting drug use
North America	920 000	44 000	0.56	20	men having sex with men, injecting drug use, heterosexual
Australia & New Zealand	12 000	500	0.1	10	men having sex with men, injecting drug use
TOTAL	33.6 million	5.6 million	1.1	46	

² UNAIDS: AIDS epidemic update, December 1999.

³ The proportion of adults (15 to 49 years of age) living with HIV/AIDS in 1999, using 1998 population numbers.

**TWO-THIRDS OF
ALL PEOPLE
LIVING WITH
HIV/AIDS ARE IN
SUB-SAHARAN
AFRICA**

Over 23 million people in sub-Saharan Africa are reported to have HIV infection or AIDS. This figure amounts to almost 70 per cent of the global total of persons living with HIV/AIDS in a region inhabited by around 10 per cent of the world's population. Table 3 provides estimates for the end of 1997 of the numbers of people in Africa living with HIV/AIDS and the percentage of HIV-positive adults in the 15 to 49 age bracket.

In nine African countries, the rate of adults living with HIV/AIDS was 10 per cent or more, while two countries have rates of more than 20 per cent, meaning that approximately every fifth person between 15 and 49 years of age is HIV-positive and will, in all likelihood, die in the course of the next 10 years.

**HIV/AIDS IN
OTHER REGIONS**

For the Asian and Pacific Region, it is estimated that 6.5 million people were living with HIV at the end of 1999. It has been estimated that around 4 million persons in India are infected with HIV. In China, half a million people are estimated to be HIV-positive. Estimates from Thailand indicate that 780,000 people were living with HIV/AIDS in 1997, that the adult infection rate was 2.2 per cent, of whom 260,000 had AIDS and the cumulative number of AIDS deaths was 230,000. In Viet Nam, the HIV surveillance system indicates that HIV prevalence in pregnant women increased more than ten-fold between 1994 and 1998. Among injecting drug users, HIV prevalence remained stable at 18 per cent over the same period. In Cambodia, 3.7 per cent of married women of reproductive age were living with HIV in 1998 and 4.5 per cent of male blood donors were infected with HIV, compared with 2.5 per cent of female donors.

Approximately 1.7 million people in Latin America and the Caribbean are living with HIV/AIDS. In Guatemala in 1999, up to 4 per cent of pregnant women tested at antenatal clinics in major urban areas were found to be HIV-positive. In Guyana, HIV prevalence was recorded at 3.2 per cent in blood donors, while surveillance of urban sex workers in 1997 showed that 46 per cent were infected. HIV surveillance among pregnant women in Haiti in 1996 found close to 6 per cent to be positive.

TABLE 3: HIV/AIDS IN AFRICA BY THE END OF 1997⁴

Country	Estimated number of persons living with HIV/AIDS	Adult prevalence rate (per cent)	Country	Estimated number of persons living with HIV/AIDS	Adult prevalence rate (per cent)
Botswana	190,000	22.1	Burundi	242,000	7.0
Zimbabwe	1,400,000	21.5	Togo	160,000	6.9
Zambia	730,000	16.6	Lesotho	82,000	6.7
Namibia	150,000	16.1	Congo	95,000	6.4
Malawi	670,000	12.5	Burkina Faso	350,000	6.0
Mozambique	1,200,000	11.9	Cameroon	310,000	4.0
South Africa	2,800,000	11.8	Democratic Republic of the Congo	900,000	3.6
Rwanda	350,000	11.2	Nigeria	2,200,000	3.4
Kenya	1,600,000	10.4	Gabon	22,000	3.1
Central African Republic	170,000	8.6	Liberia	42,000	3.0
Côte d'Ivoire	670,000	8.5	Eritrea	49,000	2.6
United Republic of Tanzania	1,400,000	8.2	Sierra Leone	64,000	2.6
Uganda	870,000	8.1	Chad	83,000	2.2
Ethiopia	2,500,000	7.7	Benin	52,000	1.8
			Guinea-Bissau	11,000	1.7

C. RISK AND VULNERABILITY

In the context of HIV/AIDS, risk is defined as the probability that a person may acquire HIV infection. Certain types of behaviour create, enhance and perpetuate this risk. High-risk behaviour includes for example, unprotected sex with a partner whose HIV status is unknown, multiple unprotected sexual partnerships, lack of adherence to infection-control guidelines by health-care personnel, repeated blood transfusions, especially using untested blood, and injecting drug use with shared needles.

WOMEN ARE INFECTED YOUNGER THAN MEN

The current information available on the pandemic indicates that women tend to become infected far younger than men, for both biological and cultural reasons. According to recent studies of several African populations, girls aged 15-19 are five to six times more likely to be HIV-positive than boys at that age. A number of gender-related risk factors increase women's exposure to HIV and sexually transmitted infections, and impair their ability to protect themselves from infection.

⁴ Source: UNAIDS, 1998: United Nations, *World population prospects: The 1998 revision*.

These include:

- behavioural factors, such as the inability to negotiate use of condoms, refuse sexual intercourse or demand divorce, because of adverse economic, social or legal consequences;
- gender-related cultural factors, such as different expectations regarding sexual roles, fidelity and marriage or harmful traditional practices; and
- socio-economic factors, such as inadequate access to health care and unequal educational and economic opportunities, which may promote dependency on a male partner, or even lead to commercial sex.

VULNERABLE POPULATIONS

Mobile workers, including migrants, are another vulnerable group. A great number of persons working in the transport, fishing and tourism industry belong to this group. Mobile populations tend to be more vulnerable to infection than local populations for reasons which may include lack of hygiene, poverty, powerlessness and the precarious family situations which accompany their status. One significant source of HIV transmission is sex between men who, through their work, spend long periods away from their families in predominantly or exclusively male environments.

8

HIGHER RISK FOR DRUG AND ALCOHOL ABUSERS

Drug and alcohol use is related to a higher risk of HIV infection for at least two reasons. In the first place, the sharing of needles, syringes and other equipment in a group in which one or more persons are HIV-positive significantly increases the risk of HIV transmission. Secondly, the effect of psychoactive substances, such as alcohol and stimulants, can significantly lower the threshold of engaging in high-risk behaviour. Substance abuse prevention is HIV/AIDS prevention.

Military personnel are a population group at special risk of exposure to sexually transmitted infections, including HIV. Recent figures from Zimbabwe and Cameroon show that military HIV infection rates are 3 to 4 times higher than in the civilian population in peace time. In times of conflict, the difference can be over 50 times higher.

D. THE IMPACT ON THE INDIVIDUAL AND THE HOUSEHOLD

HIV/AIDS has an enormous impact on infected individuals and their families, as well as on their extended family and the community at large. The impact at the individual and the household level is mirrored at the enterprise level in the case of family-businesses, micro-enterprises and self-employment. The impact begins as soon as the HIV status of a

member of the household is known and is aggravated when he or she starts to suffer from HIV-related illnesses.

STIGMATIZATION, DISCRIMINATION AND HOSTILITY

Where a person is known to be HIV-positive, he or she is frequently the subject of stigmatization, discrimination or even hostility in the community and at work, particularly where community members and colleagues have little understanding of HIV/AIDS. As a consequence, people living with HIV/AIDS are often forced to leave their jobs and are isolated in their communities. Some of them prefer to leave their community and try to make a new beginning where they are not known. They hide their HIV status as long as they can to avoid stigma and discrimination. In such an environment, it is very difficult to provide people living with HIV/AIDS with the necessary assistance and support, or to enable them to work in conditions of freedom, equity, security and human dignity. Persons with HIV infection or AIDS-related illnesses frequently have no opportunity to obtain decent jobs. Their economic situation often obliges them to take any work they can find, which may be far below their qualifications, in order to survive.

The effect on the family is generally a loss of income and increased expenditure on medical care and funeral costs. As a consequence, savings are used, assets are sold and money may be borrowed. In many cases, the health costs associated with HIV/AIDS eat up all the savings of a family or family business, leaving no reserves to cope with the actual loss of the person (breadwinner, business owner, etc). This directly affects the “risk management capacity” of the other persons involved.

CHILDREN HAVE TO WORK

Other family members, including children, are often forced to work. As a consequence, the number of children engaged in income-earning activities in high prevalence countries increases significantly. Those children, in turn, are not able to attend school and do not receive proper care and guidance. The family composition and role distribution change dramatically. The tremendous pressure on the household frequently prevents family members from finding decent work, and they often have to migrate, or may be forced into homelessness and living in the streets.

ROLE OF THE EXTENDED FAMILY

The role played by the extended family as a safety net is by far the most effective community response to the AIDS crisis. Affected households in need of food send their children to live with relatives. Relatives are then responsible for meeting the children’s food and other requirements. The preparation of food and agricultural work on the affected household’s land or overseeing its livestock may well be carried out by another family member or neighbour, in addition to their own tasks. However, as the number of multi-generational households which lack a middle generation increases, the ability of families and social networks to absorb these demands is bound to decline.

Women are particularly affected by HIV/AIDS in cases where a male head of household falls ill. The women may themselves become infected. The burden of caring for children orphaned as a result of the pandemic is borne mainly by women. Loss of income from a male income-earner may compel women and children to seek other sources of income, putting them at risk of sexual exploitation. If a woman living in an agriculture community in which women are responsible for subsistence farming becomes infected and falls ill, the cultivation of subsistence crops will fall, resulting in an overall reduction in the food available to the household.

**HIV/AIDS
PREVENTION IS
POVERTY
ALLEVIATION**

In the industrialized countries, HIV/AIDS places a heavy burden on the social security systems. However, such systems are practically non-existent in developing countries. As a consequence, the affected families have to cope with the full impact of HIV/AIDS, with the effect that their residual assets are wiped out and they are pushed deeper into poverty. HIV/AIDS prevention is an important aspect of poverty alleviation.

E. HUMAN RIGHTS IMPLICATIONS

Human rights issues become more critical in crisis situations. The HIV/AIDS crisis is no exception. A lack of respect for human rights fuels the pandemic in at least three ways:

- discrimination increases the impact of the disease on people living with HIV/AIDS and those presumed to be infected, as well as on their families and associates;
- people are more vulnerable to infection when their economic, social or cultural rights are not respected; and
- where civil and political rights are not respected, it is difficult for civil society to respond effectively to the epidemic.

**HUMAN RIGHTS
ARE VITAL FOR
HIV/AIDS
PREVENTION**

Protection of human rights, and particularly protection against discrimination, as the core principle in the prevention of HIV/AIDS, was first stressed by the World Health Assembly in May 1988 in the resolution entitled “*Avoidance of discrimination in relation to HIV-infected people and people with AIDS*”. The resolution emphasized that respect for human rights is vital for the success of national AIDS prevention programmes, and urged member States to avoid discriminatory action in the provision of services, employment and travel. The Joint WHO/ILO Statement adopted at the Consultation on AIDS and the Workplace (Geneva, 1988) also came to the conclusion that protection of human rights and the dignity of HIV-infected persons, including persons with AIDS, is essential to the prevention and control of HIV/AIDS. In September 1996, the Office of the United Nations High Commissioner for Human Rights and the Joint United Nations

Programme on HIV/AIDS convened the Second International Consultation on HIV/AIDS and Human Rights, which adopted a set of 12 International Guidelines on HIV/AIDS and Human Rights, which clarify the obligations contained in existing human rights instruments, including various ILO Conventions and Recommendations.

**THE RIGHTS OF
PERSONS LIVING
WITH HIV/AIDS
ARE VITAL TO
PROTECTING THE
UNINFECTED
MAJORITY**

From an ILO perspective, discrimination – especially discrimination in the world of work – is one of the most significant human rights abuses in the area of HIV/AIDS. The rights of people living with HIV/AIDS, such as the right to non-discrimination, equal protection and equality before the law, privacy, liberty of movement, work, equal access to education, housing, health care, social security, assistance and welfare, etc., are often violated on the sole basis of their known or presumed HIV/AIDS status. Moreover, individuals who suffer discrimination and lack of respect for their human rights are both more vulnerable to becoming infected and less able to cope with the burdens of HIV/AIDS. People exposed to HIV will not seek testing, counselling, treatment or support if this means facing discrimination, lack of confidentiality, loss of employment or other negative consequences. Several years of experience in addressing the HIV/AIDS epidemic have confirmed that the promotion and protection of human rights constitute an essential component in preventing transmission of HIV and reducing the impact of HIV/AIDS.

Experience has also shown that the incidence and spread of HIV/AIDS is significantly higher among groups which already suffer from a lack of respect of their human rights and from discrimination, or which are marginalized because of their legal status. These include women, children, people living in poverty, minorities, indigenous peoples, migrants, people with disabilities, sex workers, homosexuals, injecting drug users and prisoners. These populations often have less access to education, information and health care because of the discrimination they face in relation to their economic opportunities, political and social influence, or gender and sexual relations.

Without a rights-based response, the impact of HIV/AIDS and vulnerability to the disease will inevitably increase. As often highlighted by the late Jonathan Mann, the protection of the uninfected majority is inextricably bound up with upholding the rights of people living with HIV/AIDS.

II. THE SOCIAL AND ECONOMIC IMPLICATIONS OF HIV/AIDS

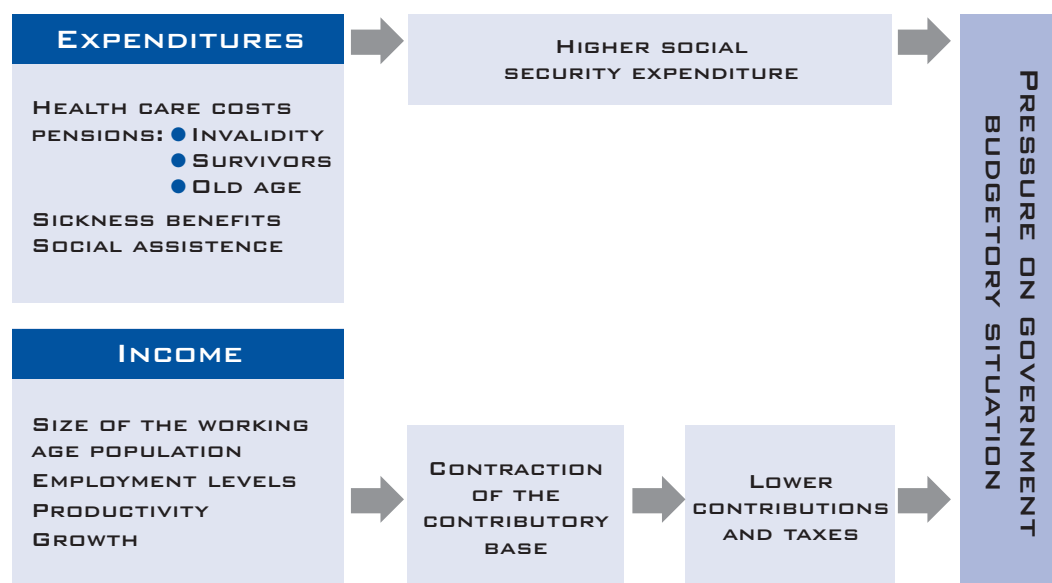
A. THE SOCIAL AND ECONOMIC IMPACT AT THE NATIONAL LEVEL

There are several mechanisms by which HIV/AIDS affects macroeconomic performance:

- AIDS deaths lead directly to a reduction in the number of workers available, and particularly workers in their most productive years. As experienced workers are replaced by younger, less experienced persons, productivity is reduced.
- A shortage of skilled workers leads to higher production costs and a loss of international competitiveness.
- Lower government revenues and reduced private savings (because of greater health care costs and a loss of income for workers) can lead to slower employment creation in the formal sector, which is particularly capital intensive. As a result, some workers will be pushed into lower paying jobs in the informal sector.
- Expenditure increases on the monitoring of high-risk groups, the establishment of prevention strategies, the provision of health care and welfare.
- Pressure increases on the social security system, as illustrated in Figure 1, including life insurance and pension funds, which are important sources of capital for both the government and the private sector.

The macroeconomic impacts of HIV/AIDS are sensitive to assumptions about how AIDS affects savings and investment rates, and whether AIDS affects the best-educated employees more than others. Studies in Tanzania, Cameroon, Zambia, Swaziland, Kenya and other sub-Saharan African countries have found that the rate of economic growth may be reduced by as much as 25 per cent over a 20-year period as a result of the HIV/AIDS pandemic.

FIGURE 1: THE IMPACT OF HIV/AIDS ON THE SOCIAL SECURITY SYSTEM⁵



VULNERABLE ECONOMIC SECTORS

HIV/AIDS has a significant effect on specific sectors. Most evident is the impact on the health system. In countries with a high AIDS prevalence, the number of people seeking care increases dramatically. The treatment of HIV-related illnesses is extremely expensive and in many countries the number of AIDS patients is overwhelming health systems. In many hospitals in affected countries, a great percentage of hospital beds are occupied by AIDS patients.

A number of economic sectors are particularly vulnerable to the impact of HIV/AIDS. These sectors are characterized by the requirement for workers to stay away from their homes for long periods, and include the transport, mining and fishing sectors. Sectors which rely on seasonal and short-term workers, such as agriculture, construction and tourism, are also particularly vulnerable to the impact of HIV/AIDS. Moreover, sectors which rely on highly trained personnel are also in danger of being adversely affected by HIV/AIDS because the loss of even a small number of specialists can place entire systems and significant investments at risk.

The education sector is affected by HIV/AIDS in at least three ways:

- the reduced supply of teachers;
- children are kept out of school because they are needed at home to care for sick family members or to work; and
- children drop out of school because their families cannot afford school fees due to reduced household income.

⁵ Source: ILO work on modelling the impact of HIV/AIDS on social security, 2000.

As noted previously, it has been observed in some countries that HIV/AIDS may be directly related to the increased incidence of child labour.

BOX 1. IMPACT OF HIV/AIDS ON THE AGRICULTURAL SECTOR

Agriculture is the largest sector in most African economies, accounting for a large proportion of production and a majority of employment. Studies carried out in Tanzania and other countries have shown that AIDS will have adverse effects on agriculture, including loss of labour supply and remittance income. The loss of a few workers at crucial periods of planting and harvesting can significantly reduce the size of the harvest. In countries where food security is an important issue because of drought, the decline in household production can have serious consequences. A loss of agricultural labour also causes farmers to switch to less labour-intensive crops. In many cases, this means switching from export crops to food crops, thereby affecting rural economies.

B. THE IMPACT ON THE WORKFORCE

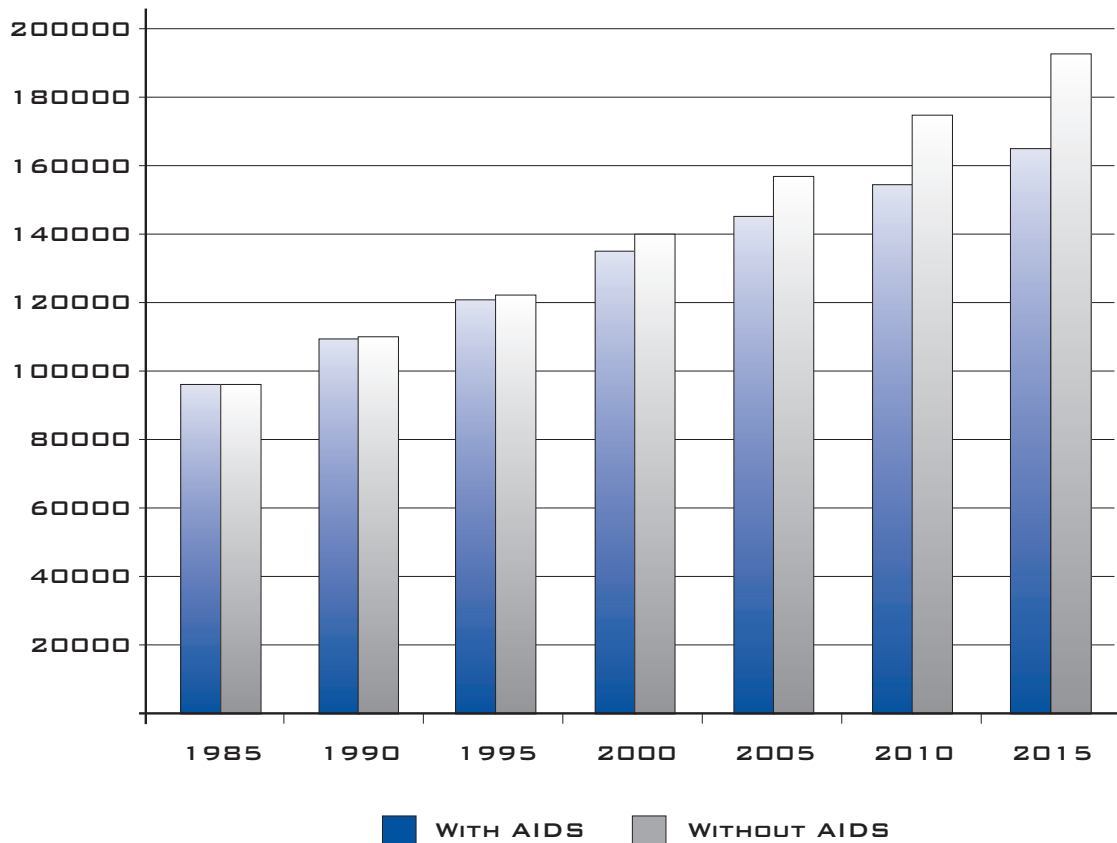
**LIFE EXPECTANCY
20 TO 29 YEARS
LOWER**

AIDS has now become the leading cause of death in many African countries, with one in five deaths being attributed to HIV/AIDS. The expectation of life at birth in some of the 29 countries most affected in Africa has declined by seven years on average, and by as much as twenty years in the most severe cases. Child mortality, especially under the age of two, has increased by up to five fold over recent years. In Botswana, Namibia, South Africa, Zambia and Zimbabwe, the life expectancy at birth in 2000-05 is expected to be between 20 and 29 years lower than it would have been in the absence of AIDS, and their populations are expected to be up to 20 per cent smaller than they would have been by 2015. However, because of the high fertility levels, the population will still continue to grow. As there is an average interval of nine to eleven years between HIV infection and full blown AIDS, the impact of increased mortality is only now being reflected in the demographic situation in countries such as South Africa, where the epidemic started later than in many other sub-Saharan countries.

For the 29 African countries with an HIV prevalence rate of 2 per cent or more in 1997, the population in mid-1995 was estimated at 441 million, or about five million fewer than it would have been without the impact AIDS. By 2015, however, the total population is expected to reach 698 million, or some 61 million lower than it would have been without AIDS. At the country level, the populations of Botswana, Namibia and

Zimbabwe are expected to be about twenty per cent lower by the year 2015 than they would have been without AIDS. However, even in those countries, population growth is still expected to remain positive. Figure 2 illustrates projected population growth with and without AIDS in 9 African countries.

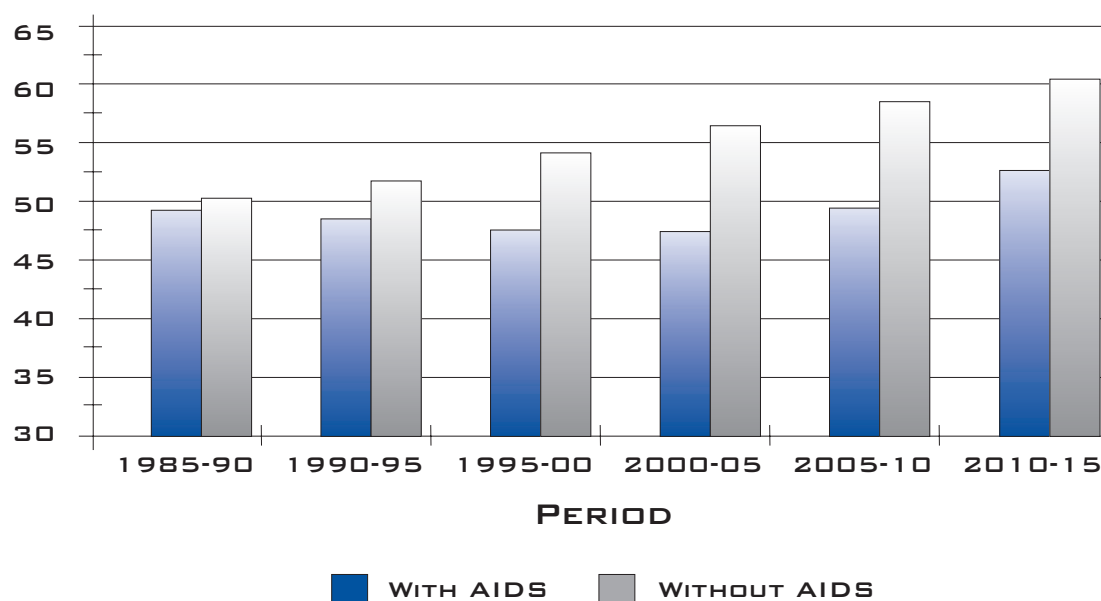
FIGURE 2: POPULATION GROWTH IN NINE AFRICAN COUNTRIES WITH AN HIV PREVALENCE OF 10 PER CENT OR HIGHER⁶



The ILO has also analysed the probable impact of HIV/AIDS on the labour force in fifteen countries, thirteen of which are in Africa, one in Asia (Thailand) and one in the Americas (Haiti). Eight of these countries have a high HIV prevalence (10 per cent or more of the adult population were HIV-positive in 1997), and the other seven had a lower prevalence (less than 10 per cent of the adult population). Projections were used from the United Nations Population Division for populations affected by AIDS, and comparisons were made with projections as if there had been no HIV/AIDS. These latter projections were computed using the ILO POPILO software. The life expectancy at birth for high prevalence and low prevalence countries in Africa is also presented in Figure 3.

⁶ Source: United Nations: World population projects: The 1998 Revision, Vol. I and II, 1997. Countries: Botswana, Kenya, Malawi, Mozambique, Namibia, Rwanda, South Africa, Zambia, Zimbabwe.

FIGURE 3: LIFE EXPECTANCY AT BIRTH WITH AND WITHOUT AIDS IN 29 AFRICAN COUNTRIES⁷



Source: UN Population Division, *World population prospects, The 1998 Revision*

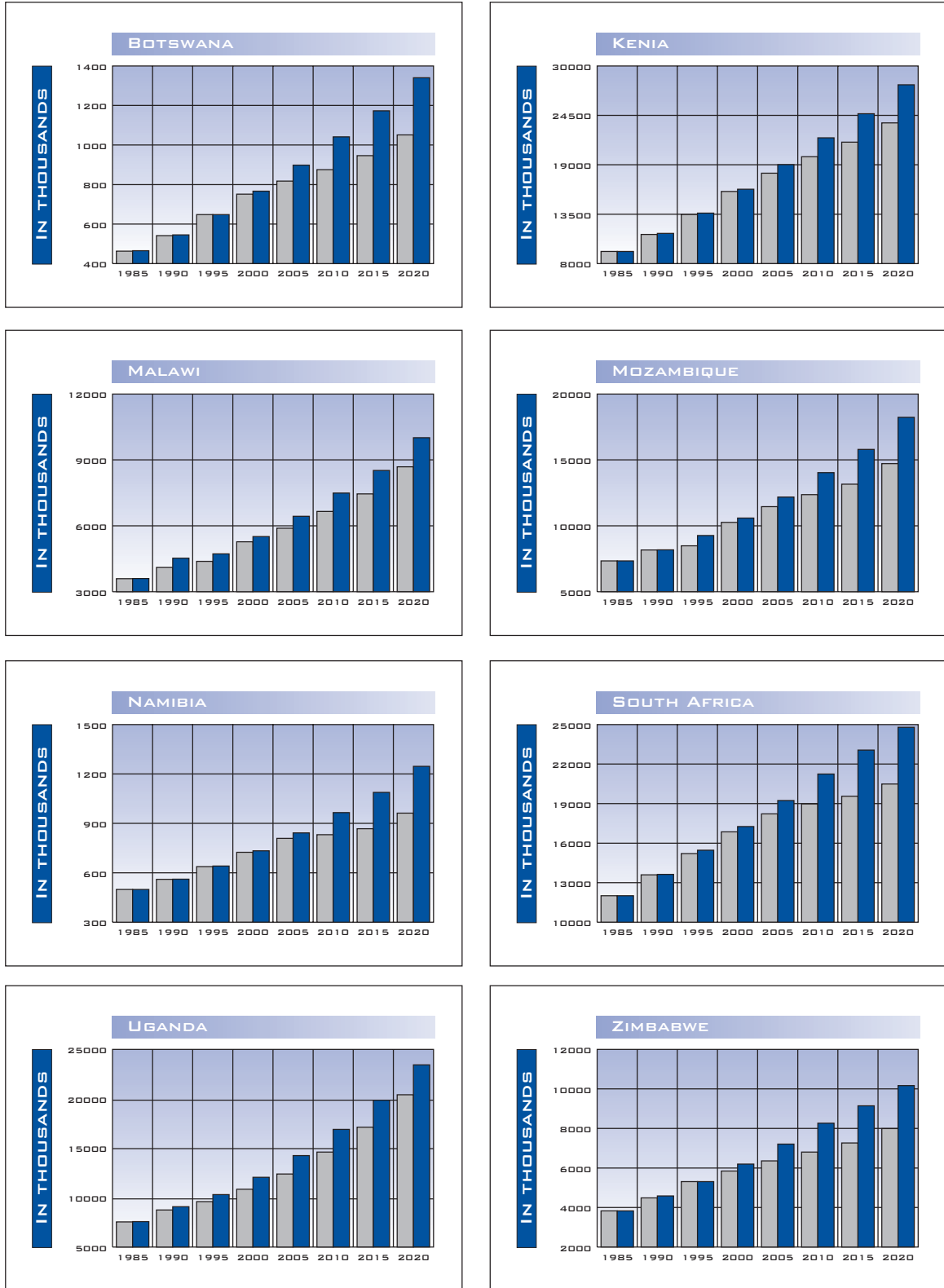
16 CHANGES IN THE AGE AND SEX DISTRIBUTION OF THE LABOUR FORCE

For the labour force projections, the ILO's labour force participation rates were used. Due to the lack of data, the effect of HIV/AIDS on labour force participation rates themselves was not taken into consideration, since no relevant studies are available. It would, however, be expected that the age and sex distribution of the labour force will change, due to the rising number of widows and orphans seeking a livelihood and the large proportion of people with AIDS in the age group 20-49 years, resulting in early entry of children into the active labour force, the early withdrawal of people with AIDS and the retention of older persons in the labour force due to economic need.

⁷ Countries: Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Gabon, Guinea-Bissau, Kenya, Lesotho, Liberia, Malawi, Mozambique, Nigeria, Rwanda, Sierra Leone, South Africa, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

FIGURE 4: PROJECTED LABOUR FORCE WITH AND WITHOUT AIDS IN HIGH PREVALENCE COUNTRIES⁸

■ WITH AIDS ■ WITHOUT AIDS



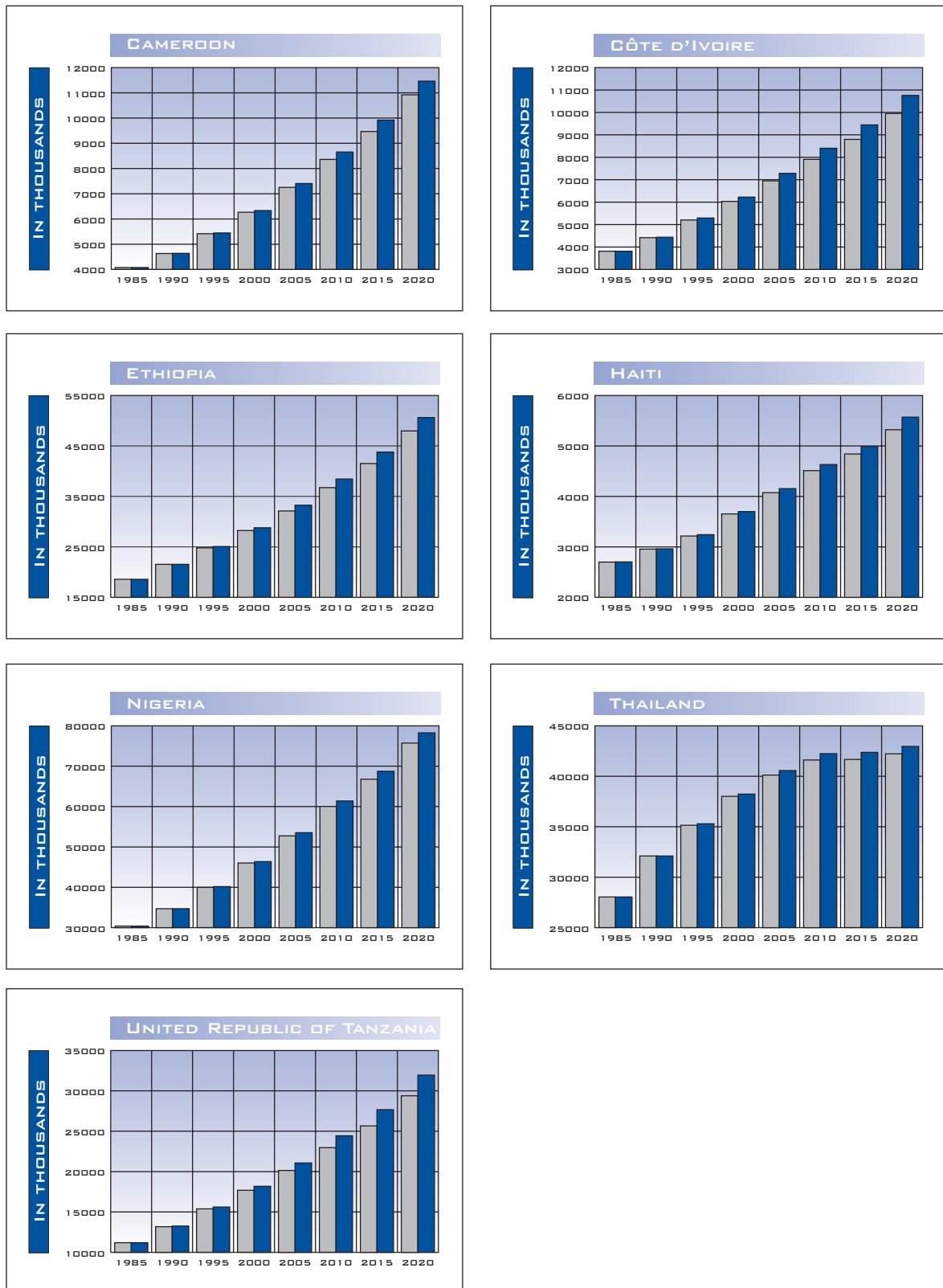
⁸ Source: ILO POPILO population and labour force projection module.

LABOUR FORCE MUCH SMALLER

As illustrated in Figure 4, the labour force in high prevalence countries in the year 2020 is estimated to be about 10 to 22 per cent smaller than it would have been if there had been no HIV/AIDS. The labour force is still expected to continue growing. But because of the increased mortality, there will be about 11.5 million fewer persons in the labour force, without even considering the impact on economic growth of absenteeism, productivity decline and morbidity. In the case of the lower prevalence countries (see Figure 5), the impact is significant but smaller. The labour force is expected to be between 3 and 9 per cent smaller (except for Thailand, where the difference is just over 1 per cent) than it would have been without HIV/AIDS, and the total labour force will grow by about 12.5 million fewer persons over the 35 year period.

FIGURE 5: PROJECTED LABOUR FORCE WITH AND WITHOUT AIDS IN LOWER PREVALENCE COUNTRIES⁹

■ WITH AIDS ■ WITHOUT AIDS



⁹ Source: ILO POPILO population and labour force projection module.

**AVERAGE AGE OF
LABOUR FORCE IS
LOWER**

Labour force projections also provide some indication of the lowering of the average age of the labour force due to the impact of HIV/AIDS. Even assuming the same labour force participation rates, the median age of the labour force in high prevalence countries would be reduced by as much as two years by the year 2020, implying an increasing proportion of younger age groups in the labour force.

Little is known of the impact of HIV/AIDS on the quality of the labour force in terms of education, training and experience. However, it is probable that HIV/AIDS will have a severe impact on these factors, particularly in view of the effect of HIV/AIDS on the education sector, in some countries, where it is reducing the number of qualified teachers and leading to a rise in early school drop-out rates for students whose parents die of AIDS. HIV/AIDS is therefore likely to have profound effects, not only on the size, but also on the composition and quality of the labour force in high prevalence countries.

C. THE IMPACT ON EMPLOYERS AND THEIR ORGANIZATIONS

**HIGHER COSTS
FOR EMPLOYERS**

AIDS-related illnesses and deaths of workers affect employers both by increasing their costs and reducing revenues. They have to spend more in areas such as health care, burial, training and recruitment of replacement employees. Revenues may be decreased because of absenteeism due to illness or attendance at funerals, as well as time spent on training. Labour turnover can lead to a less experienced and therefore less productive work force. However, the relationship between HIV/AIDS and the costs and revenue of employers has rarely been examined systematically up to now. Moreover, little data is available on how HIV/AIDS affects micro and small formal and informal enterprises. Overall there is bound to be a reduction in profits if companies do not take early measures to prevent the impact of HIV/AIDS.

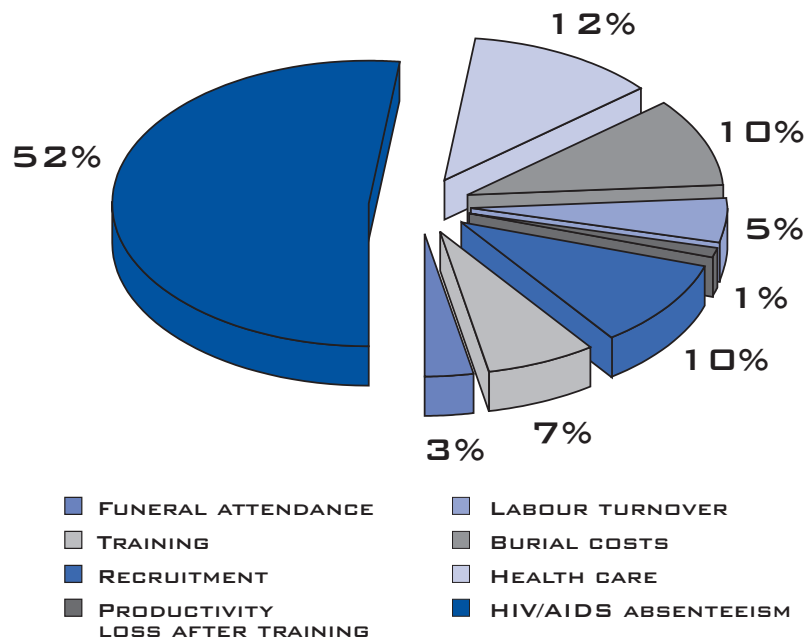
Employers are unlikely to be affected significantly by HIV/AIDS where those employees who have to leave the labour force can be replaced without loss of productivity. This may happen in countries with high unemployment and underemployment rates. However, in view of the expected impact of HIV/AIDS on the composition of the available workforce, there is likely to be a mismatch of human resources and labour requirements in terms of qualifications, training and experience. Other significant impacts may include a loss of markets where the purchasing power of the population declines.

**KEY WORKERS
LOST**

In view of these factors, some companies have already begun to hire or train two or three employees for the same position, if it is feared that employees in key positions may be lost due to AIDS. Employees can also be replaced by importing labour from neighbouring countries, at the risk of creating a bigger immigrant sub-population, which is often more vulnerable to HIV infection.

HIV/AIDS has led to increased demands for spending for health and social welfare, and the cost of insurance benefits for households, companies and governments has increased. Some companies have reported a doubling of medical expenses over a five-year period, while employees who fall ill have to divert their savings into medical care. Greater claims are being made on group life insurance and health schemes. Figure 6 presents the distribution of increased labour costs due to HIV/AIDS in Kenya.

FIGURE 6. DISTRIBUTION OF INCREASED LABOUR COSTS DUE TO HIV/AIDS IN KENYA¹⁰



**IMPACT ON THE
RURAL AND
INFORMAL
SECTORS**

For employers in small firms in the formal and informal sectors, the loss of one or more key employees may be catastrophic, leading to the collapse of the firm. In the rural sector, losses due to HIV/AIDS have led to reduced food production and declining food security, as well as a reallocation of labour and time from agricultural work to non-agricultural care activities. For example, according to a study by the Zimbabwe Farmers Union, the AIDS-related reduction in the production of maize has reached 61 per cent, cotton 47 per cent, vegetables 49 per cent and groundnuts 37 per cent.

¹⁰ Source: AIDSCAP, 1996.

BOX 2. THE IMPACT OF HIV/AIDS ON COMMERCIAL FARMS IN KENYA¹¹

A recent study of commercial farms in Kenya revealed very high levels of HIV infection. On one sugar estate, a quarter of the entire workforce was infected with HIV. Direct cash costs related to HIV rose dramatically – company spending on funerals increased five-fold between 1989 and 1997, and direct health expenditure increased ten-fold. In addition, the estate’s managers reported greatly increased absenteeism, lower productivity (a 50 per cent drop in the ratio of processed sugar recovered from raw cane between 1993 and 1997) and higher overtime costs as workers were paid to work extra hours to fill in for sick colleagues. This is by no means an isolated case. A flower farm in a different part of the country saw a similar ten-fold rise in spending on employee health costs between 1985 and 1995. This expenditure, estimated at over \$ 1 million for a company with 7000 employees, reduced profits so badly that the owners sold the company.

¹¹ Putting HIV/AIDS on the Business Agenda: UNAIDS Point of View, November 1998.

III. CURRENT APPROACHES TO ADDRESSING HIV/AIDS

Social norms and political considerations often make it difficult to design and implement effective HIV/AIDS policies. Chief among these factors are the denial that HIV/AIDS is a problem, a reluctance to help people who practice risky behaviour, a preference for a moralistic approach and pressure to spend on treatment, rather than prevention.

THE CULTURE OF DENIAL

Denial is typically seen at the earliest stages of the pandemic, when its effects are still hardly visible. It is based on an unwillingness to acknowledge that extra-marital sex and illicit drug use exist in a society. Officials often lack information to evaluate the relevance of the HIV/AIDS threat and are therefore reluctant to initiate effective HIV/AIDS programmes. As a consequence, programmes in some countries do not focus directly on the most vulnerable groups or sectors, such as sex workers, drug users, male homosexuals, bisexuals with multiple partners and sectors in which sexual partners tend to be changed frequently.

MORALISTIC APPROACHES HAMPER PREVENTION

Instead, many countries engage in abstinence policies: abstinence from extra-marital sexual relations, homosexual intercourse or drug use. Such policies are widely viewed as morally correct. In contrast, the provision of free condoms and clean needles to injecting drug users is regarded as facilitating immoral activity. Moreover, the view that HIV/AIDS is a problem which requires exclusively medical attention often serves to exclude effective preventive interventions at an early stage addressed at those who are most vulnerable to HIV infection.

Political commitment at the highest levels makes the critical difference. The cultural of denial, which prevents effective action in all other fields, can only be overcome by strong leadership and broad partnerships, involving among others, international institutions, other nations, government agencies, employers' and workers' organizations and non-governmental sectors, with a sharing of specialized skills.

A. THE RESPONSE OF GOVERNMENTS

GOVERNMENT ACTION IS VITAL

Given the massive social and economic implications of HIV infection and AIDS-related deaths, it is evident that governments have a vital role to play in instigating awareness and prevention programmes and in determining the policy framework for coordinated measures to combat the pandemic. Governments can take three broad and interconnected approaches to respond effectively to HIV/AIDS:

- supporting and promoting broad partnerships for prevention and action, including public agencies, the private sector, workers' representatives and community bodies, including civil society, with a view to responding to HIV/AIDS ethically and effectively;
- improving coordination between the public services and authorities responsible for responding to the pandemic; and
- reforming legislation and support services focusing on anti-discrimination, public health protection, privacy and criminal laws and improving the status of women, children and marginalized groups.

LEGISLATIVE BASIS

Moreover, governments have a vital role to play in developing a legislative basis on which action can be taken. This may include health and safety laws listing AIDS as a communicable disease, legislation creating institutional reaction teams, such as National AIDS Councils (see Box 3 for an example) and the prohibition of workplace discrimination based on HIV infection. A review of the WHO's most recent annual *Directory of legal instruments dealing with HIV/AIDS* identifies specific or general health-related enactments in over 120 countries, and a search of the ILO's NATLEX¹² database reveals over 30 countries which have addressed the policy considerations of HIV/AIDS from the point of view of the world of work.

NATIONAL AIDS PLANS

Most governments of affected countries have developed national strategies in response to HIV/AIDS, usually in the form of national AIDS plans, which in some cases address issues related to the world of work. However, only in a few cases are Ministries of Labour, employers' and workers' organizations represented and involved in these plans.

Some of the principal challenges facing national policy-makers in responding to HIV/AIDS, include:

- how to cover workers in the informal sector, who are often excluded from existing labour legislation, social services and representation;
- how to cover mobile working populations, including migrant workers, whose situation may fall outside national legislation, social services and representation structures¹³;
- how to strengthen already stretched enforcement mechanisms, such as labour inspectorates and labour courts, which may have little or no experience of HIV/AIDS-related matters; and
- how to develop effective coordination between national institutions in general, and particularly in such fields as health care and social protection.

¹² <http://natlex.ilo.org>

¹³ *The Code of Conduct on HIV/AIDS adopted by the Southern African Development Community (SADC) has tried to cover such lacunae.*

INTERNATIONAL INITIATIVES

A number of initiatives have also been taken at the regional and international levels. For example, the ILO Ninth African Regional Meeting, held in Abidjan, Côte d'Ivoire, in December 1999 (see Annex), endorsed the Platform of Action on HIV/AIDS in the Context of the World of Work in Africa, which was developed and adopted by the Regional Tripartite Workshop on Strategies to Tackle Social and Labour implications of HIV/AIDS (Windhoek, Namibia, October 1999). The Labour and Social Affairs Commission of the Organization of African Unity, at its twenty-third Ordinary Session (Algiers 16-21 April 2000), adopted the Algiers Appeal for the Intensification of the Fight Against AIDS in Africa, in which it called for adequate legal and regulatory measures, multi-dimensional and comprehensive media action, systematic, operational, sustained and permanent action, and effective therapy at reduced costs.

BOX 3: THE PHILIPPINE AIDS PREVENTION AND CONTROL ACT 1998

The Philippines National AIDS Council includes representation from both Houses of Parliament (the Chairpersons of the respective Committees on Health), as well as the Presidents of the Leagues of Governors and City Mayors. The Philippines Senate created the Ad Hoc Committee on AIDS, which drafted the AIDS Prevention and Control Act 1998, while the Senate Committee on Health ensured its enactment. Features of the comprehensive Act, which provides the legislative basis for the National AIDS Council, include:

- *requiring written informed consent and prohibiting compulsory HIV testing (such as for employment, travel, medical services and admission to educational institutions), unless authorized by the Act (e.g. for blood or organ donation);*
- *guaranteeing the right to confidentiality, subject to certain exceptions, e.g. court proceedings (but with a requirement that medical records be sealed, only to be opened by the judge);*
- *prohibiting discrimination on the basis of actual, perceived or suspected HIV status in the areas of employment, school, travel, public service, credit and insurance, health care and burial services;*
- *establishing universal infection control guidelines for surgical, dental, embalming, tattooing and similar procedures;*
- *prohibiting misleading advertising of drugs and other products for HIV/AIDS prevention, treatment or cure;*
- *requiring educational authorities to integrate HIV/AIDS prevention education at intermediate, secondary and tertiary levels (although limits are placed on the use of explicit materials and promotion of birth control techniques);*
- *mandating HIV/AIDS information as a health service, and requiring specific programmes in the workplace, by local governments and for overseas travellers, tourists and other communities;*
- *recognizing the role and utilizing the experience of infected individuals in information and education campaigns, as well as providing access to health care, community-based services and self-help programmes.*

B. THE RESPONSE BY EMPLOYERS AND THEIR ORGANIZATIONS

Some of the responses to the HIV/AIDS pandemic which have been adopted by employers and their organizations are encouraging. An increasing number of employers have been developing HIV/AIDS prevention and care programmes, designed not only to protect the infected workforce, but also to take into account the rights and problems of those living with HIV/AIDS.

WORKPLACE PREVENTION PROGRAMMES

Some employers have started prevention programmes in the workplace at their own initiative with a view to protecting their investment in human capital. The programmes vary according to company size, resources, structure and employee culture, as well as public policy. In some cases, employers' initiatives have preceded the action taken by governments in the area of public policy. No one programme can therefore serve as a model for all to follow. However, the experience so far indicates that components of an effective HIV/AIDS programme tend to include the following:

- ongoing formal and informal discussion and education on HIV/AIDS for all staff;
- an equitable set of policies that are communicated to all staff and properly implemented, including protection of rights at work and protection against any discrimination at work;
- the availability of condoms;
- prevention and rehabilitation programmes on drugs and alcohol;
- diagnosis, treatment and management of sexually transmitted diseases, for employees and their sex partners; and
- voluntary HIV/AIDS testing, counselling, care and support services for employees and their families.

BUSINESS COALITIONS ON HIV/AIDS

In a growing number of countries, employers have formed business coalitions on HIV/AIDS to pool resources and improve their response to the crisis in their workplaces and communities. Such business coalitions facilitate the inter-country and even inter-regional exchange of experience, as the example in Box 4 indicates.

BOX 4: SOUTH AFRICA USES THAILAND'S RECIPE TO PREVENT HIV/AIDS IN THE TRANSPORT INDUSTRY

The South African Department of Transport is pulling out all stops to prevent HIV/AIDS in the transport industry. The road freight industry is often blamed as being one of the main carriers and distributors of the disease, but Transport Minister, Mac Maharaj, has said that the time of laying blame on one sector of the population is over and action is needed. He called on South African business leaders in the transport industry to learn how Thai businesses succeeded in drastically reducing the HIV/AIDS epidemic in the transport industry. Thailand, along with Uganda, are two developing countries which have achieved some success in fighting the pandemic. The Executive Director of the Thailand Business Coalition on Aids, Anthony Pramualratana, on a visit to South Africa, described how businesses had embarked on what was called the "100 per cent condom distribution programme" in 1990 and that this had raised the figures for the use of condoms among commercial sex workers from 33 to 95 per cent.

Other steps taken in Thailand in the transport industry were: encouraging companies to allow drivers to take their wives or partners with them on long trips; reducing the number of long trips by drivers; and developing solidarity between workers in the industry. Maharaj said that a strategic focus was needed in South Africa and a lot could be learned from the Thai experience.

**SPECIAL
MEASURES BY
HEALTH
INSURANCE
PROVIDERS**

Certain health insurance providers have also established facilities specifically designed for persons with HIV infections, which guarantee and at the same time cap payments for HIV-related treatment. These schemes currently provide enough benefits to cover a significant share of the cost of treatment, but employers are already worried that, as the proportion of HIV-infected workers rises, they will not be able to maintain benefits at these levels. Other responses include radical changes in the way that insurance schemes work. For example, death benefits were traditionally paid to the family by many such schemes only when the employee died in service. Some schemes are now agreeing to pay benefits to employees who are certified as terminally ill, so that they can retire and spend their final days in peace at home, without forfeiting the benefit due.

While the measures taken by health and social security insurance schemes to take into account the specific needs of people living with

HIV/AIDS are encouraging, it has to be emphasized that only a tiny fraction of the population in the countries most affected by HIV/AIDS is covered by formal health insurance and benefits schemes. Even those who are covered will inevitably see their health and death benefits fall significantly over the next few years, as insurance companies and employers pass on at least part of the rising costs to beneficiaries and employees, including those who are not HIV-infected.

INSURANCE PREMIUMS RISING

Premiums on some group life insurance policies in certain countries have already doubled, even though they are still at a relatively early stage of the pandemic, with the vast majority of young adult deaths still to come. Employers will not be able to absorb all of these costs. While the practice is certainly followed of recruiting staff on casual or short-term contracts to avoid paying disability, death or other benefits, a number of employers have begun to work together with the insurance industry to develop policies and benefit packages which meet the needs of people with HIV/AIDS and their families without bankrupting the companies themselves.

BOX 5: THE IMPACT OF HIV/AIDS ON INSURANCE POLICIES

In South Africa, a survey conducted by the financial services group Old Mutual in 1999 showed that 30 per cent of companies are lowering the benefits they pay to their employees as a result of the rising number of claims related to HIV/AIDS. Old Mutual estimated that, without these adjustments, the proportion of the wage bill paid out in death benefits by a typical company in some provinces would rise by two-thirds between 1997 and 2002.

Employers have also begun to respond to HIV/AIDS by hiring extra staff in key areas, and by training staff in a range of important skills so that they can be deployed to fill gaps as the need arises. This requires considerable forward planning, as it often takes a long time for a fresh recruit to become a fully productive specialist. Another option is purchasing special insurance. Some employers are taking out “key man” insurance to cover the costs of recruiting replacements for people in critical positions.

DISADVANTAGES OF HIV/AIDS TESTING

With a view to anticipating the loss of workers due to HIV/AIDS, many companies would like to know the proportion of the workforce they are likely to lose through AIDS. However, increasingly, employers are beginning to recognize the tremendous negative impact of pre-employment and on-the-job HIV screening. Testing the existing workforce is not only unethical, but leads to great hostility and is incompatible with effective HIV/AIDS prevention and care programmes at the workplace. Companies are beginning to find that, by

**RESPECT FOR
WORKERS' RIGHTS
IS A POWERFUL
PREVENTION TOOL**

abandoning testing requirements, a conducive climate can be created for workplace prevention programmes. A steadily increasing number of employers in the worst affected countries are reaching the conclusion that prevention is much more cost-effective than HIV-screening in the long term, and that respect for the rights of workers is a powerful prevention tool in its own right.

**ADDRESSING
HIV/AIDS IN THE
INFORMAL
SECTOR**

While information and experience of addressing HIV/AIDS in large-scale formal enterprises is beginning to be accumulated, the same cannot be said of the informal sector or small enterprises, where the majority of the workers are to be found. Given the very high percentage of employment found in these enterprises, there is an urgent need to amass knowledge of the situation of HIV/AIDS in these enterprises, identify best practices on how to address the problem and develop practical and innovative approaches and tools to prevent HIV/AIDS and mitigate its impact in these sectors. One approach which should undoubtedly be investigated more thoroughly is the development of prevention and care programmes in the context of the mutual health funds which are being established for small enterprises and informal sector operators in many countries, particularly in Africa, and which are being promoted through the ILO's Strategies and Tools against Social Exclusion and Poverty Programme (STEP).

Employers urgently need assistance in developing tools to calculate the cost of HIV/AIDS for their enterprises. Work is also needed to adapt existing prevention programmes to the needs and circumstances of specific enterprises and sectors, with emphasis on specially vulnerable sectors. Employers also need to be encouraged to work through their organizations to exert pressure for action at the national level, pool resources and knowledge for company programmes, and develop means and tools to reach out to small businesses and the informal sector.

**C. THE RESPONSE BY WORKERS'
ORGANIZATIONS**

**WORKERS'
REPRESENTATIVES
INITIATE
DIALOGUE ON
HIV/AIDS**

Many workers' organizations are aware of the impact of HIV/AIDS and have been developing activities, particularly in the fields of awareness-raising and representation of the interests of their members. At the company level, representatives of workers' organizations have often initiated dialogue on HIV/AIDS between employers and employees and have actively participated in the development and implementation of workplace prevention programmes.

Specific issues taken up by workers' organizations include the fight against stigmatization and discrimination against people living with HIV/AIDS and their families, the relationship between low salaries, bad working conditions and HIV infection, the danger of HIV infection in

situations of conflict and the provision of treatment to persons with HIV/AIDS, for whom the availability of affordable medication is essential.

ICFTU POSITION

The 17th World Congress of the International Confederation of Free Trade Unions (ICFTU) in April 2000 expressed its alarm that the world has failed to act effectively to respond to the devastating effects of HIV/AIDS on workers, their families and the community at large. It emphasized that the workplace, in both the formal and informal sectors, is one of the most important and effective channels for addressing the disastrous effects of the HIV/AIDS pandemic. Many workplaces have facilities which could be used for the group discussions that are ideal for education campaigns. The long-term nature of the HIV/AIDS epidemic calls for a strong commitment by governments, trade unions, employers and leaders of civil society for the development of a determined education and prevention campaign.

The World Congress instructed the ICFTU General Secretary to establish a Programme of Action to address HIV/AIDS and mobilize resources for its implementation. It called on affiliates to engage their respective governments and employers to support the strengthening of occupational health and safety programmes, the dissemination of information and the protection of groups at work, with a view to eliminating the stigma and discrimination attached to HIV/AIDS, fighting denial, helping remove the cultural prejudices and barriers related to HIV/AIDS, maintaining HIV/AIDS affected workers in social protection systems and developing social and labour programmes which can mitigate the effects of HIV/AIDS.

TRADE UNIONS WELL-PLACED TO RUN PREVENTIVE CAMPAIGNS

Furthermore, the World Congress called for the strengthening of the capacity of ICFTU affiliates to deal with the impact of HIV/AIDS and develop support programmes on HIV/AIDS for workers, members of their families and the community at large, particularly since trade unions are often active in joint worker/employer occupational health and safety structures and are well-placed to run preventive programmes, such as awareness campaigns, the dissemination of information and educational courses and seminars. It also emphasized that the action campaign for access to low-cost, good quality essential medicines should be supported by building solidarity across national borders and initiating and facilitating the campaign in countries where it has not yet begun.

The importance of the role played by workers' organizations in addressing HIV/AIDS in the world of work cannot be overemphasized. This is partly because they are in a very good position to bring the issue out into the open and help overcome the culture of denial which still persists, even in some of the worst affected countries, and partly because it is difficult for employees to fight for their rights and interests on their own. It is therefore encouraging that workers' organizations have

started to create awareness and initiate programmes for prevention and care, with particular focus on human rights.

**FURTHER
SENSITIZATION OF
WORKERS'
REPRESENTATIVE
S NEEDED**

Nevertheless, to expand the action taken by workers' organizations and ensure that it becomes more effective, the officers and representatives of workers' organizations need to be further sensitized to the needs of people living with HIV/AIDS. Many workers' representatives urgently require training and assistance on how to develop and implement effective workplace programmes. Workers' organizations therefore require assistance in terms of capacity-building, advocacy and political support. Statements, such as that by the ICFTU World Congress, provide workers' organizations with an additional mandate to engage in HIV/AIDS prevention and care activities in the world of work.

**D. RESPONSE AT THE COMMUNITY
LEVEL**

**COMMUNITY
RESPONSE
ESSENTIAL**

The driving force behind many HIV/AIDS prevention and care activities at the community level is provided by non-governmental and community-based organizations. In many countries, the community response has preceded the government response. In almost all cases, it has proved essential to a successful national response, particularly in the areas of awareness-raising, prevention, advocacy, policy and legal changes, and family or community care and support. When addressing HIV/AIDS, where the culture of denial and social attitudes towards prevention and care take on such importance, it is extremely difficult to change attitudes and practices in the workforce in isolation from the community as a whole. Effective prevention and care in the world of work therefore has to be aimed at the community, through the workforce.

**NGOS AND
COMMUNITY
ORGANIZATIONS
VALUABLE
PARTNERS**

ILO experience of prevention programmes in other related areas, such as drug and alcohol abuse, shows that NGOs and community organizations can be extremely valuable partners for government agencies, employers and workers in helping to extend preventive action to the community as a whole, through such channels as women's organizations, schools, training institutions and health care providers.

A range of activities has been found effective at the community level, based on the following main principles:

- upholding the rights and dignity of people affected by HIV/AIDS;
- ensuring the active participation of as many community members as possible;
- providing for partnership and mutual respect between the community and external facilitators;

- building capacity and ensure sustainability;
- building on the realities of people living with HIV and AIDS, while maintaining hope based on collective community action; and
- maximizing the use of community resources, while identifying and using additional external resources as needed.

INVOLVING PEOPLE LIVING WITH HIV/AIDS

One of the most effective ways of combating denial is to give AIDS “a human face” through what is known as the Greater Involvement of People living with HIV/AIDS (GIPA), a principle which was formally launched at the Paris AIDS Summit in December 1994. People who live with or are directly affected by HIV/AIDS bring personal experience to planning and implementing responses to the pandemic. Those who are open about their own HIV status can help others come to terms with the risk of HIV/AIDS and appreciate the need for solidarity between persons living with HIV/AIDS and those fortunate enough to have escaped infection so far.

E. THE RESPONSE BY INTERNATIONAL ORGANIZATIONS

JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

Starting in 1986, the World Health Organization was assigned the lead responsibility in the United Nations system for assisting governments establish national HIV/AIDS programmes. By the mid-1990s, however, it had become clear that the pandemic’s devastating impact on all aspects of human life and on social and economic development constituted an emergency which would require an expanded United Nations effort. As a consequence, in 1996 the United Nations established the Joint United Nations Programme on HIV/AIDS (UNAIDS), which now has seven co-sponsoring organizations: UNICEF, UNDCP, UNDP, UNFPA, UNESCO, WHO and World Bank.

The thematic priorities of the joint programme focus on the greater involvement of people with HIV/AIDS, human rights and gender equality. In the context of the United Nations Theme Groups on HIV/AIDS,¹⁴ representatives of the co-sponsoring organizations share information, plan and monitor coordinated action between themselves and with other partners, and decide on joint support for major HIV/AIDS activities, with emphasis on national efforts to mount an effective and comprehensive response to HIV/AIDS.

¹⁴ ILO participates in several UN Theme Groups

INTERNATIONAL GUIDELINES ON HIV/AIDS AND HUMAN RIGHTS

In September 1996, the Office of the High Commissioner for Human Rights and UNAIDS adopted 12 International Guidelines on HIV/AIDS and Human Rights designed to help translate international standards into practical observance at the country level. The United Nations Commission on Human Rights explicitly recognized the mandates of United Nations agencies in promoting the implementation of the Guidelines¹⁵ and invited them, together with States and non-governmental organizations, to take all necessary steps to protect the human rights of persons with HIV/AIDS, and to combat discrimination, prejudice and stigma in relation to HIV/AIDS.

INTERNATIONAL LABOUR STANDARDS

The ILO has based its response to HIV/AIDS on the principles set out in the Discrimination (Employment and Occupation) Convention, 1958 (No. 111), the Vocational Rehabilitation and Employment (Disabled Persons) Convention, 1983 (No. 159), and the Occupational Safety and Health Convention, 1981 (No. 155). On this basis, over the past decade, the ILO has organized a number of consultations, workshops and seminars, and has carried out research to provide its constituents with assistance in developing their response to the pandemic.¹⁶

STATEMENT ON AIDS IN THE WORKPLACE

As early as 1988, the ILO organized in collaboration with the WHO a consultation on AIDS and the workplace. The meeting adopted a statement on AIDS in the workplace, which spelt out, inter alia, principles for policy development and implementation, and policy components for the prevention of HIV/AIDS at the workplace. The statement is still valid today and has had an important impact on many workplace policies and programmes addressing HIV/AIDS.

HIV/AIDS AND THE INFORMAL SECTOR

In collaboration with UNDP, the ILO organized a Joint Exploratory Meeting on the Informal/MSE Sector and HIV in Harare in May 1999, which recommended that surveys should be conducted on the interaction between the informal sector and the HIV/AIDS pandemic and on initiatives in coping with the impact of HIV/AIDS in this sector at both the micro and meso levels. It also called for HIV/AIDS concerns to be mainstreamed into ongoing ILO projects and programmes, such as the Start and Improve Your Business (SIYB) entrepreneurship-training programme.

In collaboration with the United Nations Joint Programme on HIV/AIDS, and in response to the request made by the President of Namibia to the Director-General of the ILO, a Regional Tripartite Workshop on Strategies to Tackle Social and Labour Implications of HIV/AIDS was also organized in Windhoek, Namibia, on 11-13 October 1999. Fifty-four participants from 20 African countries attended the Workshop.¹⁷

¹⁵ E/CN.4/1999/L. 72.

¹⁶ For details, see the discussion paper on HIV/AIDS and the world of work, entitled *ILO Initiatives on HIV/AIDS*, Geneva, 1999.

¹⁷ The request was formulated during the OAU Labour and Social Commission Meeting held in Windhoek (April 1999).

**AFRICAN
PLATFORM OF
ACTION ON
HIV/AIDS IN THE
CONTEXT OF THE
WORLD OF WORK**

The Workshop adopted an African Platform of Action on HIV/AIDS in the Context of the World of Work, which was endorsed in the resolution adopted by the ILO Ninth African Regional Meeting, held in Abidjan, Côte d'Ivoire, in December 1999.¹⁸ The goals of the Platform of Action include the application of a “social vaccine” for prevention and protection, which would include social inclusion, income and job security, solidarity and the optimal use of treatment. The Platform of Action urges African governments to declare HIV/AIDS a national disaster requiring urgent attention and resource mobilization.

**HIV/AIDS AND
SOCIAL SECURITY
SCHEMES**

Partnerships need to be developed for the joint planning and implementation of programmes and for the collection, dissemination and exchange of information on good practices. The ILO is called upon to strengthen its activities in the region through improved knowledge, vigorous advocacy and expanded services. Member States are requested to adopt and implement this Platform of Action on an urgent, immediate and continuous basis.¹⁹

Approaching the issue from another angle, the ILO's Social Security Department is currently evaluating existing social security schemes, projecting the financial impact of proposed changes in these schemes, and evaluating the financial viability of new schemes in several African countries. Based on the assumption that early awareness would reduce infection rates and the morbidity and mortality associated with HIV/AIDS, the negative impact of the disease on government revenues, expenditures and economic growth could be reduced.

**ILO
PUBLICATIONS ON
HIV/AIDS**

With a view to raising awareness of the need for extensive and broad-based prevention efforts, the combination of an AIDS mortality and social budget model would permit a cost-benefit analysis of the impact of different degrees and intensities of early awareness campaigns. Reference should also be made in this context to an ILO monograph published in 1998, entitled *HIV/AIDS and employment*, which examined the legal framework and enterprise practices concerning HIV/AIDS in many of the most affected countries. While general legal texts make no reference to infection with HIV or AIDS, the universal principles of non-discrimination and respect for privacy, health and social security contained in the Universal Declaration of Human Rights are referred to in the basic legislation in all the countries surveyed. Moreover, anti-discrimination clauses are contained in labour codes and regulations, even though they do not in most cases specifically refer to HIV infection or AIDS as a prohibited ground for discrimination. In the few cases where a specific reference is contained to HIV/AIDS in these texts, it is still time-consuming and difficult to achieve the enforcement of constitutional rights and labour regulations.

¹⁸ GB 277/4.

¹⁹ See Annex and the proceedings of the Regional Tripartite workshop on Strategies to tackle social and Labour implications of HIV/AIDS, Windhoek, Namibia, 11-13 October 1999.

Another publication, *AIDS at the Workplace* (ILO, 1996), a module in the Your Health and Safety at Work collection, provides trainees with basic information on HIV/AIDS, including the transmission of the virus, methods of prevention, policy issues, discrimination in the workplace and the role of health and safety.

**UNITED NATIONS
THEME GROUPS
ON HIV/AIDS**

The establishment of the WHO Global Programme on AIDS and later the United Nations Joint Programme on HIV/AIDS constitutes a substantial effort by the United Nations to address HIV/AIDS. As a consequence, various mechanisms have been established at the national, regional and global levels operating in the fields of advocacy, policy and programme development, strategic planning, surveillance and technical assistance. In priority countries, United Nations Theme Groups on HIV/AIDS have been providing governments with assistance in addressing the pandemic.

Although the foundation was laid a decade ago in the joint WHO/ILO statement, it is only recently that significant importance has been given by international organizations to the issue of HIV/AIDS in the world of work. The tremendous potential for policy and programme development, prevention and care offered by a tripartite approach, and the expertise that the ILO can provide in this respect have been recognized rather belatedly.

IV. ELEMENTS OF AN ILO RESPONSE

There can be no doubt that HIV/AIDS constitutes one of the major human tragedies of our time, particularly in the worst affected countries of Africa, and potentially in many other countries throughout the world. More than 16 million people have already died of AIDS. In some countries, more than 20 per cent of the population will probably die within 10 years.

As we enter the new millennium, there is admittedly belated, yet growing understanding that HIV/AIDS is very much a problem for the world of work. The numbers of workers living with HIV/AIDS have, or will, depending on the country, become a major cause for concern for all employers, in enterprises and organizations of all sizes. Preventing the further spread of the disease is vital for all the parties in the world of work and, as emphasized throughout this paper, respect for the rights of persons living with HIV/AIDS is essential for effective prevention.

The other major respect in which HIV/AIDS concerns the world of work is that the social partners are in a strong position to take effective action to prevent the spread of the disease and improve the situation of many of those living with HIV/AIDS. This is particularly true because, even in some of the countries most affected by HIV/AIDS, the culture of denial is still preventing its full acknowledgement as the national disaster which it plainly is, thereby blocking the allocation of the resources and effort which are urgently required.

The ILO's recent work in a number of fields, most notably child labour, but also in fields such as safety and health and combating drug and alcohol abuse, has shown the power that tripartite plus coalitions and dialogue can have in stimulating political action and changing social attitudes.

The ILO, through its tripartite structure, has the ability to reach workers and mobilize enterprises for the prevention of HIV/AIDS. Acting through workers and enterprises has a multiplier effect: it impacts on families and on communities as a whole. This gives the Organization a unique advantage and a specific role in the global partnership against HIV/AIDS.

An ILO response to HIV/AIDS, based primarily on the mobilization, coordination and guidance of a major partnership between the ILO's constituents in the world of work, reaching out upstream to decision-makers, and downstream to the community, could be built around the following principal elements:

(A) AWARENESS RAISING AND ADVOCACY

The urgent task of preventing the spread of HIV and providing protection and support to people with HIV/AIDS cannot be left to technical solutions or administrative interventions, particularly where the persistence of a culture of denial severely limits the action taken. Policy-makers and programme developers are often not aware of the severe impact of HIV/AIDS, do not have the necessary information at hand and, as a consequence, do not see the urgency for early interventions to prevent the spread of HIV and provide protection to people living with HIV/AIDS. This is also true for the partners in the world of work. The general population and groups at high risk still lack awareness of the dangers of HIV/AIDS, and the knowledge and means to protect themselves.

While governments have considerable power to effect and influence changes, the partners in the world of work must do their utmost to ensure that the appropriate priority is given to action against HIV/AIDS. Moreover, positive results can only be achieved if they enjoy the support and involvement of the social partners and societies at large. The exponential spread of HIV/AIDS in some countries and the limited efficacy of legal and other measures are closely related to the stigma and shame attached to the disease. If the culture of silence and lack of awareness is to be overcome, interventions for preventing HIV/AIDS and mitigating its effects on the workforce must be supported by employers' and workers' organizations and NGOs. Awareness and advocacy campaigns will therefore have to be designed and implemented to ensure the cooperation of all partners and to raise awareness at the community level.

(B) DEVELOPMENT OF PREVENTIVE AND PROTECTION PROGRAMMES

Action against HIV/AIDS should give particular importance to prevention and assistance, including protecting the rights of workers with HIV/AIDS and combating discrimination against them. A coherent labour-management policy is needed to ensure that all aspects of the problem are addressed in a mutually supportive manner. The

willingness of employers and workers to take action should be enshrined in multi-sectoral national policies to combat HIV/AIDS. It is necessary to promote private sector initiatives on an urgent basis and to undertake HIV/AIDS training (prevention and community assistance) at the workplace. It is also indispensable for the public sector to develop resource structures for the dissemination of a permanent message of solidarity among public employees.

For activities of this magnitude and urgency, major political awareness and commitment are vital. Multimedia information campaigns and capacity-building programmes will therefore need to be developed to enable industry, employers' and workers' organizations to address HIV/AIDS effectively. In this context, particular attention should be given to the large number of workers who, due to their profession, are at a higher risk of becoming infected with HIV (hospital and health-care personnel, fire-fighters, police, etc.). Information and training materials should be developed in support of educational and prevention programmes in the workplace. Such materials should cover:

- the facts and myths concerning HIV/AIDS;
- a healthy lifestyle and how to avoid risky behaviour;
- protection in jobs with a high risk of exposure to infection;
- prevention of drug and alcohol abuse, which can lead to high-risk behaviour, such as violence, unsafe sex and the sharing of contaminated needles; and
- specific support for groups at high risk, such as migrant and transport workers.

The ILO should make the maximum possible use in this respect of its various programmes which reach out to small and micro-enterprises and operators and workers in the informal sector, in collaboration with employers' and workers' organizations, to try to ensure that preventive and protection programmes reach the large numbers of workers concerned. ILO programmes which reach out to these workers include training programmes for small and micro-entrepreneurs (including SIYB), cooperative development programmes, employment-intensive infrastructure programmes, initiatives to develop mutual health funds and other community-level forms of social protection, initiatives to create and strengthen associations and organizations of rural and informal sector workers, as well as self-help organizations of women workers, and programmes to combat child labour.

(C) RESEARCH AND STATISTICS

Relatively little is known with certainty of the impact of HIV/AIDS on the labour market, on the performance of firms, including the impact of losing employees with different levels of skills, as well as its effect on labour productivity and its future consequences for health care systems and social security schemes. The lack of detailed and reliable data on the impact of HIV/AIDS on the labour-force impedes the development of realistic targets and the design of effective action to prevent the spread of HIV/AIDS and provide support to its victims. Statistical surveys and analytical studies providing an accurate and broad picture of the economic impact of HIV/AIDS at the enterprise and national levels (including micro and small formal and informal enterprises) are an important tool, both for awareness raising and for effective policy and programme development. At the same time, there is a need for a thorough qualitative analysis of the distribution of the pandemic by sector and category of the workforce. However, the collection and analysis of data has to keep pace with rapidly and frequently changing features and patterns of the HIV/AIDS epidemic. Standard empirical methods, such as sampling surveys, should be accompanied by rapid assessment and response methodologies which are needed to facilitate a quick response at various levels.

These should be supplemented by examples of good practice and successful interventions, translated into local languages to facilitate implementation. Modern technologies, such as Internet web sites and on-line discussion groups provide options for the quick dissemination and discussion of information and should be strengthened wherever possible.

(D) LEGISLATION AND POLICY DEVELOPMENT

The protection of the rights of persons with HIV/AIDS is a very important element in creating the supportive atmosphere necessary to encourage people to come forward, to help them benefit from HIV/AIDS education and services, and to persuade them to change behaviour. The development of an appropriate legal framework is a vital component of a rights-based approach.

The legal framework needs to be multi-faceted but coordinated, strong in enforcement, yet realistic in penalties. Anti-discrimination legislation is crucial, as discrimination is one of the most significant abuses of human rights in the area of HIV/AIDS, and impedes any other effort against the pandemic. International labour standards can provide a guide to national policy and legislation in this respect. These standards cover both protection against discrimination and prevention. A growing

number of countries have used them to develop labour laws which address HIV/AIDS. In parallel, industrial relations systems which encourage negotiation of HIV/AIDS issues need to be expanded and promoted. Moreover, comprehensive legislative audits reviewing labour laws and other legal instruments in a significant number of countries from the view of HIV/AIDS prevention and protection are critically needed and will enable the ILO to provide assistance to member States in developing new or improving existing policy frameworks.

ILO Codes of practice are increasingly being found to be an effective non-binding instrument for the stimulation and guidance of concerted action by the social partners on subjects ranging from drug and alcohol abuse to sectoral safety and health issues. Urgent consideration should be given to the development of an ILO Code of practice on addressing the threat of HIV/AIDS in the world of work. In the meantime, the following policy principles and components can assist and guide policy and programme development:

- Foster in the world of work widespread awareness of the threat of HIV/AIDS, a broad partnership which can push for effective action at the national, workplace and community levels, and a spirit of understanding and compassion for people living with HIV/AIDS;
- Promote and encourage tripartite collaboration and coordination in designing and implementing policies and programmes on HIV/AIDS and the world of work at the national and enterprise levels, and involve women and men affected by the pandemic in policy dialogue;
- Mobilize employers' and workers' organizations to develop workplace policies and programmes designed to increase awareness and knowledge amongst their members, and link these with community-based care initiatives, as means of providing and maintaining an open, informed, healthy and safe working environment for all employees;
- Ensure the right to non-discrimination in the world of work, as well as in access to services and to social security benefits;
- Preserve the right to work of workers with HIV/AIDS as long as they are medically fit and available to work, and respect their entitlements in the workplace with respect to career advancement, discharge, discipline, lay-offs, compensation, training or other terms and conditions of employment, and promote alternative working arrangements and working time flexibility when and if required by their medical conditions but avoid measures which may lead to segregation;
- Ensure the confidentiality of medical and insurance information, eliminate HIV screening as part of pre-employment testing and exclude similar practices in general workplace physical

examinations, and promote the availability of counselling, support and educational programmes for all workers and their families through, for example, Employee Assistance Programmes (EAPs), or similar schemes;

- Provide specific on-going education and training, as well as the necessary equipment to reinforce appropriate infection control procedures aimed at protecting workers in special occupational groups (e.g. health care) against exposure to HIV;
- Promote the development and implementation of income-generating activities for people living with HIV/AIDS, particularly women, and provide timely support to AIDS orphans or children pulled out of school to take care of a sick relative, and specifically address this target group in the implementation of child labour programmes;
- Encourage gender-sensitive programmes, including legislation against domestic and sexual violence; and
- Improve the capacity to measure and project the impact of HIV/AIDS on the labour force, employment situations and social security, and compile and promote best practices within employers' and workers' organizations and in enterprises.

V. CONCLUDING REMARKS

There is no doubt that the HIV/AIDS pandemic is having a severe impact on the world of work. Over and above the immensity of the personal tragedy, it is leading to a reduction in economic growth, loss of precious gains made in development, a decline in the size and quality of the workforce and increased costs and diminished performance for employers. As such, it is severely undermining the right to decent work.

Surveillance information indicates that sub-Saharan Africa is the worst affected area and needs to be the focus of urgent action. Data and trends from other regions, however, indicate that effective and large-scale preventive interventions are required to avoid similar catastrophes elsewhere.

Those involved in the world of work, and particularly workers' and employers' organizations, as well as enterprises, have started to take initiatives to respond to the effects of the pandemic. Various means of prevention and support have been developed. International organizations, through the Joint United Nations Programme on HIV/AIDS, have started to assist the social partners in this respect. However, the complexity and extent of the impact of HIV/AIDS on the world of work requires global leadership by an organization specialized in workplace issues. There can be no doubt that the ILO has to take up this role. Not only has it, throughout its long history, established the necessary relations with social partners all over the world, but the large number of members of employers' and workers' organizations mean that the partners in the world of work have a vital role to play in dispelling the culture of denial which is still prevalent in HIV/AIDS issues. These partners can provide the broad-based support and constituency that is vital for effective HIV/AIDS prevention and protection.

However, all the social partners, including governments, employers' and workers' organizations require assistance in policy and programme development. Inter-country, sub-regional, regional and global partnerships need to be catalysed and fostered. Capacity building in HIV/AIDS workplace issues also needs to be addressed urgently.

In order to avoid duplication and pool technical and financial resources, the ILO should collaborate closely with UNAIDS and its co-sponsors, which would be beneficial to all parties and would offer an ideal channel for the development of the policy and programme frameworks required by those countries worst affected by HIV/AIDS, and for effective prevention in countries where the pandemic is still at an earlier stage.

VI. ANNEX

RESOLUTION CONCERNING HIV/AIDS IN THE CONTEXT OF THE WORLD OF WORK IN AFRICA

The Ninth African Regional Meeting of the International Labour Organization,

Having considered the question of HIV/AIDS in the context of the world of work in Africa,

Noting the Platform for action adopted by the ILO Regional Tripartite Workshop (Windhoek, Namibia, 11-13 October 1999);

Invites the Governing Body of the ILO --

1. to communicate to governments of the African region the Platform for action on HIV/AIDS in the context of the world of work in Africa that is appended to this resolution;
2. to appeal to governments, in collaboration with employers' and workers' organizations and other concerned groups, to use appropriate measures to implement the Platform for action on an urgent, immediate and continuous basis;
3. to request the Director-General of the ILO --
 - (i) to provide, where possible, the necessary expertise and technical assistance to help member States implement the Platform for action;
 - (ii) to strengthen collaboration and cooperation with concerned international agencies, especially UNAIDS, and bilateral and multilateral agencies, with a view to reinforcing national action against HIV/AIDS in the context of the world of work.

Abidjan, 11 December 1999

PLATFORM FOR ACTION ON HIV/AIDS IN THE CONTEXT OF THE WORLD OF WORK IN AFRICA

I. PREAMBLE

AIDS threatens every man, woman and child in Africa today. The pandemic is the most serious social, labour and humanitarian challenge of our time. Since its start two decades ago, AIDS and HIV have taken a catastrophic toll in Africa, decimating its population, tearing apart the very social fabric of its societies and threatening its economies. Its toll of debilitating illness, widespread and indiscriminate death, deteriorating quality of life and life expectancy, threatens to reverse the hard-won social and economic gains of African countries and, ultimately, the very future of the continent.

AIDS is rapidly becoming the single most serious threat to social and economic progress in Africa today. The true cost of the pandemic is almost incalculable. Its impact is aggravated by the overall economic, political and social context, as well as some cultural practices, dominated by a weak economic base, high unemployment, pervasive poverty, and the negative consequences of structural adjustment, all of which further undermine Africa's ability to compete in the global market.

The pandemic has manifested itself in the world of work - the area of the ILO's mandate - in the following ways: discrimination in employment, social exclusion of persons living with HIV/AIDS (PLWHA), additional distortion of gender inequalities, increased numbers of AIDS orphans, and increased incidence of child labour. It has also disrupted the performance of the informal sector and small and medium enterprises (SMEs). Other manifestations are low productivity, depleted human capital, challenged social security systems and threatened occupational safety and health, especially among certain groups at risk such as migrant workers and their communities and workers in the medical and transport sectors.

Clearly, AIDS is no longer just a health problem. It is a developmental crisis with potentially ominous consequences for Africa and the world. Yet, a culture of silence, fear and denial continues to reign and prevent action. The stigma and the fear engendered by AIDS fuels discrimination, persecution and ignorance. Despite this, the spread of AIDS can be prevented. A multidimensional response to AIDS is needed to prevent its spread and protect those who live with its consequences. In the absence of a cure, what is needed is a "social vaccine" that includes

such elements as social inclusion, income and job security, social security and solidarity.

In search of awareness, action and commitment, participants from 20 African countries, meeting in Windhoek from 11 to 13 October 1999, in tripartite delegations, adopted the following Platform for action to respond to this crisis at workplace, community, national, regional and international levels.

The meeting called upon all African governments to declare HIV/AIDS a national disaster requiring urgent attention and mobilization of resources.

II. COMMON VALUES

It was agreed that the following would form a set of overall principles, which should guide the formulation of policies and programmes:

1. Tripartism, allied with civil society, NGOs and other stakeholders.
2. Social justice and compassion for people living with HIV/AIDS (PWLHA).
3. A sense of shared responsibility among all actors.
4. Good governance, transparency and accountability for results.
5. Partnerships among international and national agencies to complement one another on the basis of comparative advantage.

III. GOALS

It was agreed that, while awaiting a medical vaccine, the aim should be to apply a "social vaccine" for prevention and protection which would include elements such as: social inclusion, income and job security, social security, solidarity and optimal use of treatment.

IV. ACTIONS

In order to achieve these goals, action backed by strong African political, religious, traditional and community leadership and commitment should focus on:

1. fighting the culture of denial;
2. raising national awareness of the incidence and impact of the pandemic through, among other things, information, education and communication;
3. eliminating the stigma and discrimination attached to HIV/AIDS by adopting and applying the ILO's international labour standards and national labour legislation;
4. documenting and disseminating information and statistical data through effective labour market information systems;
5. strengthening the capacity of the social partners to address the pandemic;
6. empowering women economically, socially and politically in order to reduce their vulnerability to HIV/AIDS;
7. promoting the transformation of gender roles, norms and social structures;
8. integrating HIV/AIDS in existing social security schemes and developing new ones to ensure coverage for all;
9. building capacity to address the dilemma facing AIDS orphans and children exposed to infection or forced into child labour;
10. incorporating HIV/AIDS considerations into the national development agenda and budget allocations;
11. creating a rapid response mechanism to mitigate against the implications of the pandemic;
12. promoting income and employment opportunities for PLWHA and their families through, for example, informal sector and small enterprise development;
13. strengthening occupational safety and health systems to protect groups at risk;
14. formulating and implementing social and labour policies and programmes that mitigate the effect of AIDS;
15. effectively mobilizing resources;
16. improving availability and affordability of drugs;
17. incorporating HIV/AIDS in collective bargaining agreements.

V. PARTNERSHIPS

In order to mount an effective response to the HIV/AIDS crisis and address its many faceted implications, national level partnerships should be built rapidly among all the key actors: governments, employers' and workers' organizations, NGOs and other civil society groups, including religious and traditional leaders. Partnerships should also be forged among and with bilateral and multilateral agencies, as well as regional organizations and United Nations agencies through among others, joint planning, collection, dissemination and exchange of information on good practice and ensuring synergy in programmes.

VI. ROLE OF THE ILO

The ILO should strengthen its activities in fighting HIV/AIDS in the region through improved knowledge, vigorous advocacy, and expanded services. The ILO tripartite structure provides a unique mechanism for intensifying the response to HIV/AIDS.

1. In order to avoid duplication of efforts, the ILO should collaborate with concerned international organizations, participate in the decision-making process regarding HIV/AIDS at the global level, and consider becoming a co-sponsor of UNAIDS.
2. The ILO should adapt and apply concepts, methods and tools it has developed on labour and social issues for responding to the design of research and programmes on HIV/AIDS.
3. The ILO should expand its capacity to deal with HIV/AIDS, especially in its multidisciplinary teams, through, for example, training, resource mobilization and secondment of experts from UNAIDS.
4. The ILO should undertake research and surveys to determine the implications of HIV/AIDS for the world of work, including its effects on the growth of the labour force and participation rates, women, child labour, union membership, productivity and competitiveness, informal sector and small enterprise development.
5. The ILO should document and disseminate through all appropriate means information on national experiences including best practices.
6. The ILO should engage in advocacy and training on HIV/AIDS and the world of work targeting the political leadership, workers' and employers' organizations and civil society.

7. The ILO should include HIV/AIDS in its regional meetings and consider organizing a special session on the subject at the International Labour Conference.
8. The ILO should integrate HIV/AIDS issues and gender components in all its programmes and technical cooperation projects in the region.
9. The ILO should develop a policy, programme and structure to address the issue of HIV/AIDS and the world of work.
10. The ILO should strengthen the capacity of its social partners to formulate and effectively implement policies, programmes and activities at the national and enterprise levels.
11. The ILO should consider submitting this draft Platform of action on HIV/AIDS in Africa to the Ninth African Regional Meeting (Abidjan, 8-11 December 1999) for its consideration and formal adoption.

VII. A CALL FOR IMMEDIATE ACTION

Action against HIV/AIDS is primarily a national responsibility. The enormity and exceptional nature of the problem require exceptional measures. Member States are therefore urged to adopt and implement this Platform of action on an urgent, immediate and continuous basis.

Windhoek, 13 October 1999