

# Module 1 > 1

contents

Introduction	1
Facts about HIV/AIDS	2
Global and regional trends	5
AIDS, poverty and development	7
The impact of HIV/AIDS on the world of work	9
Responding at the workplace	15
The role of the ILO	16
<i>Learning activities</i>	20
<i>Reference materials</i>	24

ILOAIDS  
Implementing the ILO Code of Practice  
on HIV/AIDS and the world of work:  
an education and training manual

## Introduction: the significance of HIV/AIDS

How has HIV/AIDS become such a global disaster and threat to our common future?

In the twenty years since it appeared, it has killed more people than any previous epidemic such as the bubonic plague of the fourteenth century, or the influenza epidemic in the years following the 1914 -1918 world war.

HIV/AIDS has ceased to be just a health issue. It is undoing many of the development gains made in recent decades. Unless we succeed in stopping the epidemic, countries could be left with reduced populations, fewer people available for productive work, and weakened economies.

It is creating orphans, who in many cases have to work to support their younger brothers and sisters, so it increases child labour.

It is a major cause of poverty and of discrimination. It aggravates existing problems of inadequate social protection and gender inequality.

There is no cure. The available treatments are very expensive and unavailable to the vast majority of victims. Millions more will die.

However, there are many places where the spread of HIV/AIDS has been slowed down and numerous examples of how people with HIV can live a full life for many years after diagnosis. We are learning how to mitigate the effects of the epidemic and live more positively with the virus: HIV is not an immediate death sentence.

From the early days of the disease there have been scare stories, misreporting, panic reactions and discriminatory policies. Gradually, the ignorance and prejudice are being dispelled and a rights-centred approach has developed. But many myths persist which prevent a rational approach to the illness.

## Facts about HIV/AIDS

### Definitions

#### HIV stands for Human Immunodeficiency Virus

The virus weakens the body's immune system.

#### AIDS stands for Acquired Immune Deficiency Syndrome

Because HIV weakens the body's immune system, a person becomes vulnerable to a range of opportunistic infections, which the body could normally fight off. It is one or more of these infections which will ultimately cause death, some years after infection.

The Human Immunodeficiency Virus (HIV) is transmitted through body fluids – in particular blood, semen, vaginal secretions and breast milk. Transmission occurs through these routes:

- unprotected sexual intercourse, both heterosexual or homosexual, with an infected partner (the most common route)
- blood and blood products through, for example, infected blood transfusions and organ or tissue transplants the use of contaminated injection or other skin-piercing equipment - this can be through shared drug use or 'needle stick' injuries
- mother to child transmission (MTCT) from infected mother to child at birth or during breastfeeding.

After infection, a person develops antibodies; these are an attempt by the immune system to resist attack by the virus. If a person is tested for HIV, and the presence of HIV antibodies is found, he or she is sometimes called HIV-positive or simply HIV+.

The risk of sexual transmission of HIV is increased by the presence of other sexually transmitted infections (STIs).

### HIV: percentage of infections by transmission route<sup>1</sup>

Blood transfusion	3-5
Mother to child transmission	5-10
Sexual intercourse	70-80
Injecting drug use	5-10
Health care (needle stick injuries)	<0.01

<sup>1</sup>Department for International Development, *Prevention of Mother to Child Transmission of HIV, A guidance note* (London, 2001)

A person may live for many years after infection, much of this time without symptoms or sickness, although they can still transmit the infection to others. Of course, if a person is not aware that they are infected, they may not take precautions and, without knowing, pass on the virus.

Periods of illness may be interspersed with periods of remission. If a person is well cared for, can eat properly and rest, they can live for a number of years with a fair quality of life. They will be able to work. But AIDS is ultimately fatal.

## **HIV transmission**

HIV is not transmitted by:

- kissing, hugging, shaking hands
- mosquito or insect bites
- coughing and sneezing
- sharing toilets or washing facilities
- using utensils or consuming food and drink handled by someone who has HIV

There is no recorded instance of the virus being transmitted through first aid procedures.

Research is currently under way to develop a vaccine, but it is unlikely that one will be available for many years. Research is also being carried out to develop a microbicide (spermicide) that can be used to prevent infection during intercourse.

There is no cure. Antiretroviral drugs are available that slow the progression of the disease and delay the onset of AIDS, but they are very expensive. They do have some success in preventing mother to child transmission.

Although drug companies have brought down the price of drugs, a substantial problem remains. The regime of administering the drugs requires a level of health infrastructure, including human resources, which is simply not available in many poor countries. For this reason the ILO Code of Practice suggests that in some cases the workplace may be a suitable point of delivery. The ILO also encourages employers to pay for treatment where possible – it is well worth treating common opportunistic infections even if antiretroviral therapy is beyond the resources of an enterprise.

Anglo-American, a large mining group which is the biggest employer in southern Africa, has decided to make the drugs available to its workforce free of charge. It estimates that this may cost between 2.5 and 5 million US dollars. Around 23 per cent of its 134,000 workforce are infected with HIV/AIDS. <sup>2</sup>

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<sup>2</sup> *Financial Times*, London, 7 August 2002

HIV is a fragile virus, which can only survive in a limited range of conditions. It can only enter the body through naturally moist places and cannot penetrate unbroken skin. Prevention therefore involves ensuring that there is a barrier to the virus – condoms, for example, or protective equipment such as gloves and masks (where appropriate) – and that skin-piercing equipment is not contaminated.

The virus is killed by bleach, strong detergents and very hot water. In the event of an accident, and in certain workplaces, it is important to follow the universal blood and body fluid precautions (known as “Universal Precautions” or “Standard Precautions”) which were originally devised by the United States Center for Disease Control and Prevention (CDC) in 1985. These precautions are explained in Appendix II of the ILO Code of Practice on HIV/AIDS and the world of work.

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Levi's  
QUALITY NEVER GOES OUT OF STYLE

## Global and regional trends

The HIV/AIDS pandemic has evolved in different ways in different parts of the world, and at varying speeds. In many regions it is still in its early stages. At the end of the year 2001, the total number of people living with HIV/AIDS was estimated to be 40 million: just under half of them are women, and about 8 per cent are children. HIV/AIDS caused the deaths of 3 million people during 2001 and, despite widespread prevention measures, 5 million new cases were reported.

The following is a breakdown of these figures by region:

### HIV/AIDS in 2001

Region	Total number of people living with HIV/AIDS 2001	People newly infected during 2001	Deaths due to HIV/AIDS during 2001
Sub-Saharan Africa	28,500,000	3,500,000	2,200,000
Asia & Pacific	6,600,000	1,070,000	435,000
Americas and the Caribbean	2,870,000	235,000	115,000
Europe and Central Asia	1,550,000	280,000	31,000
North Africa and the Middle East	500,000	80,000	30,000
Australia and New Zealand	15,000	500	<100

Source: UNAIDS, *Report on the global HIV/AIDS epidemic 2002*

### Latin America and the Caribbean

The Caribbean is the region with the second highest infection rates; adult HIV prevalence is 2 per cent. In certain countries, such as Haiti and the Bahamas, it has reached over 4 per cent. Fifty per cent of infections are among women in the Caribbean, and 30 per cent in Latin America. Brazil's comprehensive programme of prevention and care, including access to antiretroviral drugs, is resulting in falling rates of mortality and of new infections.

### Eastern Europe and Central Asia

This region is experiencing the fastest rate of new infections, especially in Russia and Ukraine. With high levels of other STIs and intravenous drug use it is likely that prevalence will continue to rise. About 20 per cent of those living with HIV/AIDS are women.

### Sub-Saharan Africa

This region has the highest prevalence in the world, with an average of 8.4 per cent of the popula-

tion infected. At 28.1 million, the region has more people living with HIV/AIDS than all the other regions of the world put together; about 55 per cent are women.

Recent antenatal clinic data suggest that several countries in southern Africa have adult prevalence rates exceeding 30 per cent. However, there are signs of hope - HIV prevalence is continuing to decline in Uganda, for example, and it remains relatively low in several parts of West Africa.

### North Africa and the Middle East

Small-scale surveys show that there is a slow but marked spread of HIV/AIDS in this region.

### Asia and the Pacific

The relatively low prevalence rates in this region are deceptive as the numbers involved are large and there are areas of high prevalence, especially in cities. Approximately seven million people are infected.

China's health ministry has estimated that 600,000 people were living with HIV/AIDS in 2000 and localized epidemics are increasingly common.

Although India's adult prevalence rate is not exceptionally high at 0.8 per cent (end of 2001), the absolute numbers involved are large. The epidemic is concentrated in a small number of States so far.

Thailand has successfully reduced annual new infections from around 100,000 in the early 1990s to about 30,000 in 2001. In 1993, one report estimated that the annual infection rate could reach over half a million by the end of the decade.<sup>3</sup> Nevertheless, an estimated 700,000 Thais are living with HIV/AIDS today and it remains a major health and social issue.

In East Asia and the Pacific, women make up 20 per cent of those living with HIV/AIDS, while in South and South East Asia the rate is 35 per cent.

### Western Europe, North America, Australia and New Zealand

A resurgence is being experienced in high-income countries with 75,000 people newly infected in 2001. Between 10 and 25 per cent of those living with the disease are women.

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<sup>3</sup> Viravidya et al, "Economic Implications of AIDS in Thailand", in David E. Bloom and Joyce V. Lyons, *Economic Implications of AIDS in Asia* (UNDP, New Delhi, 1993)

## AIDS, poverty and development

For many years HIV/AIDS was viewed as a medical and health problem, rather than as a broad socio-economic challenge. In the last few years, the damage the pandemic is doing to years of development gains – and to the potential for future development – has been recognized.

The HIV/AIDS pandemic is aggravating current socio-economic problems in developing countries, as well as itself being exacerbated by these problems.

- Poverty is a factor in HIV transmission and strengthens the impact of HIV/AIDS.
- The effect of HIV/AIDS on individuals, households and communities can lead to an intensification of poverty and even push some non-poor into poverty.

Poor people suffer from higher levels of illiteracy, and lack of access to health and social services. This makes it much less likely that they will receive information about HIV and how to avoid infection. Poor diets and poor housing make those infected by the virus more vulnerable to opportunistic infections. So those living in poverty are more vulnerable to infection. Those with HIV often become sick and die faster than the non-poor, since they are more likely to be malnourished and in poor health and to lack access to health services and medication.<sup>4</sup>

At the same time, the impact of HIV/AIDS on households can be catastrophic. In the absence of widespread social safety nets, including health insurance or social security, the illness of a family member means both an increase in medical expenses and a decline in family income, often plunging families into poverty.

The epidemic is placing a huge strain on many countries:

- Kenya expects to be spending 60 per cent of its health budget on the treatment of HIV/AIDS by 2005;
- in Zambia in 1998, deaths of teachers equalled two-thirds of the number of graduates from teacher training colleges;<sup>5</sup>
- a third of rural households affected by HIV/AIDS in Thailand reported a 50 per cent reduction in agricultural output;
- South Africa's GDP is projected to be 17 per cent lower in 2010 than it would have been without AIDS, costing the economy some US\$ 22 billion.<sup>6</sup>

But within the poorer countries where the disease is concentrated, those with a higher than average

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<sup>4</sup>Collins, J. and Rau, B.: *Aids in the Context of Development* UNRISD, Programme on Social Policy and Development, Paper No. 4, December, 2000

<sup>5</sup>ILO: *A future without child labour* (Geneva, 2002), page 43

<sup>6</sup>Brookings Institution: *Meeting the Global Challenge of HIV/AIDS* (Washington, DC, April 2001)

level of education and income do not generally show lower rates of infection. Disposable income, status and occupational mobility can also be risk factors. This means there are serious implications for the labour supply in terms both of quantity and of quality.

The loss of huge numbers of skilled personnel - from teachers and doctors to farmers and mechanics - is having serious effects on the ability of countries to remain productive and deliver basic services. Even more worrying is the impact of the epidemic on the workforce of tomorrow. On the one hand, children are being taken out of school to help with the burden of care or to maintain family income; on the other hand, training and education services are being undermined. There is little evidence, however, of planning to adapt long-term development strategies to the realities of HIV/AIDS and to replace human capital losses.<sup>7</sup>

*“One of the major impediments facing African development efforts is the widespread incidence of communicable diseases, in particular HIV/AIDS, tuberculosis and malaria. Unless [they] are brought under control, real gains in human development will remain an impossible hope.”*  
*Stephen Lewis, UN Special Envoy on HIV/AIDS in Africa.*

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<sup>7</sup> Cohen, D.: *Human Capital and the HIV epidemic in sub-Saharan Africa*, ILO/AIDS working paper number 2, ILO, Geneva, 2002

## The impact of HIV/AIDS on the world of work

The ILO estimates that at least 25 million workers aged 15-49 - the most productive segment of the labour force - are infected with HIV.

### **HIV/AIDS is a workplace issue**

*HIV/AIDS should be recognized as a workplace issue, and be treated like any other serious illness/condition in the workplace. This is necessary not only because it affects the workforce, but also because the workplace, being part of the local community, has a role to play in the wider struggle to limit the spread and effects of the epidemic.*

### ■ ILO Code of Practice on HIV/AIDS and the world of work

HIV/AIDS hits the world of work in numerous ways. In badly affected countries, it cuts the supply of labour and reduces income for many workers. Increased absenteeism raises labour costs for employers; valuable skills and experience are lost. Often, a mismatch between human resources and labour requirements is the outcome. Along with lower productivity and profitability, tax contributions also decline, while the need for public services increases. National economies are being weakened further in a period when they are struggling to become more competitive in order to weather the challenges of globalization.

The impact of HIV/AIDS includes:

- reduced supply of labour
- loss of skilled and experienced workers
- absenteeism and early retirement
- stigmatization of and discrimination against workers with HIV
- increased labour costs for employers from health insurance to retraining
- reduced productivity, contracting tax base and negative impact on economic growth
- a threat to food security as rural workers are increasingly affected
- falling demand, investment discouraged and enterprise development undermined
- social protection systems and health services under pressure
- increased burden on women to combine care and productive work
- loss of family income and household productivity, exacerbating poverty
- orphans and other affected children forced out of school and into child labour
- pressure on women and young people to survive by providing sexual services.

### **Employment and labour market implications**

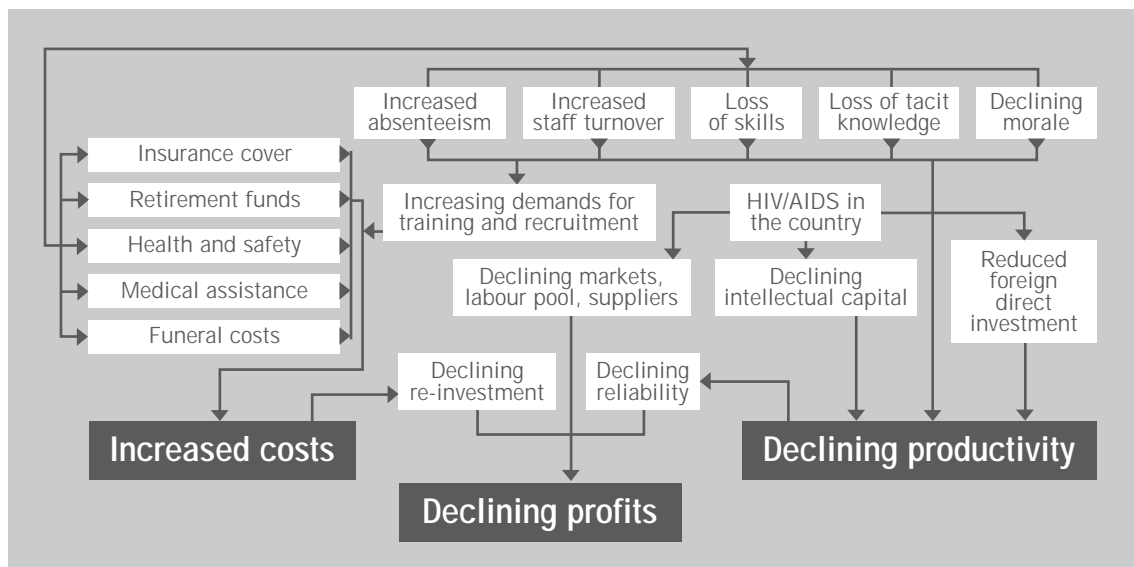
HIV/AIDS impacts directly on the growth of population in countries where the pandemic is most widespread. The US Census Bureau has projected that by the year 2010 life expectancy will fall from 60 years to around 30 years in the worst affected countries in southern Africa. The population of Zimbabwe in 2020 is expected to be 20 per cent smaller than it would have been without AIDS.

Many countries will experience a “population chimney” where the very young and old are supported by a thin pillar of adults in their working prime.

The labour force will be particularly affected by the impact of the epidemic on the structure of the population. The majority of those who die of AIDS are adults in their prime - workers at their most productive. In 1999, for example, 80 per cent of newly infected people in Rwanda, Tanzania, Uganda and Zambia were aged between 20 and 49.

Projections made by the ILO for eight African countries with the highest prevalence rates indicate that the labour force will be 10 to 32 per cent smaller by 2020 than it would have been without HIV/AIDS. Many of those infected with HIV are experienced and skilled workers in blue-collar and white-collar jobs, managers, and vital producers of food.

### The impact of HIV/AIDS on enterprises



Source: UNAIDS, adapted by ILO

### The impact on labour costs and productivity

At the enterprise level AIDS-related illnesses and deaths reduce productivity and increase labour costs. Enterprises in all sectors in seriously affected countries report increases in absenteeism (due to illness, the burden of care, and bereavement), in labour turnover (due to illness and death) and in the costs of recruitment, training and staff welfare (including health care and funeral costs). Absenteeism has a particularly disruptive effect upon production. Loss of skills and knowledge make it difficult to replace staff, even where there is a pool of unemployment. The workload of non-infected workers rises, to the detriment of their morale.

Increased insurance payouts are reflected in rising premiums. Health care costs increase, particularly in enterprises which extend medical services to employees' dependents. The costs of HIV/AIDS for enterprises are both direct and indirect. Many of the hidden costs have only recently become apparent, and include psychological pressures on managers faced with decisions that could have life and death consequences for employees.

Research at Boston University found that AIDS-related costs in the companies studied ranged from 3 to 11 per cent of the annual salary bill in 1999-2000. The difference between enterprises depends on each company's production structure and human resource policies.<sup>8</sup>

The way factors inter-connect and reinforce the negative effects of the epidemic is shown in the figure above.

### Some facts and figures on costs

- Zambia's largest cement company reported that absenteeism for funeral attendance increased by 15 times in the 1992-1995 period.
- In the mid 1990s Uganda Railways were reporting steep increases in absenteeism and an annual staff turnover rate of 15 per cent, with more than 10 per cent of the workforce dead from AIDS-related illness.
- In Kenya 43 of the 50 employees of the Kenya Revenue Service who died in 1998 died from AIDS. The Kenyan Federation of Employers report that HIV/AIDS is costing companies an average of nearly US\$ 50 per employee each year.
- Some mining companies in South Africa believe that 40 per cent of their workforce may have HIV. AIDS will increase labour turnover by 3 to 6 per cent, and the Goldfields Mining Company estimates that AIDS adds US\$ 4-10 to the cost of producing each ounce of gold.
- According to the Zimbabwe Farmers Union, AIDS has reduced the production of maize by 61 per cent, cotton by 47 per cent, vegetables by 49 per cent and groundnuts by 37 per cent.
- One major transport company with 11,500 workers in Zimbabwe found that 3,400 of them were HIV positive in 1996. Costs for the company related to HIV/AIDS amounted to more than \$ 1million or 20 per cent of company profits.
- In Chennai (formerly Madras), India, a study of large industries found that absenteeism was expected to double in the next two years, mainly as a result of STDs and AIDS-related illnesses.
- A Thai government study has calculated that the direct and indirect cost of HIV/AIDS to the nation was US\$ 1.2 billion in 2000.
- A number of firms in the US report annual costs of between US\$ 3,500 and US\$ 6,000 for each worker with HIV/AIDS.

*Source: ILO, UNAIDS and World Bank*

<sup>8</sup> AIDS Economic Team, Center for International Health, Boston University, cited in *The Economic impact of HIV/AIDS in Southern Africa, Meeting the Global Challenge of HIV/AIDS*, Brookings Institution (Washington, September 2001)

### Cost of HIV/AIDS in six companies in Africa (US \$)<sup>9</sup>

Company Name	Total Costs	Cost per employee
Botswana Diamond Valuing	125,941	237
Botswana Meat Commission	379,200	268
Côte d'Ivoire food-processing firm	33,207	120
Côte d'Ivoire packaging firm	10,398	125
Muhoroni Sugar, Kenya	5,830	349
Uganda Sugar Corporation	77,000	300

### HIV/AIDS and fundamental rights

AIDS threatens and undermines efforts to provide women and men with decent and productive work in conditions of freedom, equity, security and human dignity. Many affected by HIV/AIDS have no social protection or medical help. The poor suffer disproportionately.

Discrimination against HIV-positive persons (or even people suspected of carrying the virus) aggravates existing inequalities in society. Screening people for HIV infection in order to bar them from work, deny them promotion or exclude them from social protection and benefits counts as AIDS-related discrimination. So do breaches of confidentiality or the refusal to establish alternative workplace arrangements for workers with HIV/AIDS. This issue is discussed in more detail in the module on human rights.

### HIV/AIDS and child labour

HIV/AIDS is now a key factor affecting the care of children and the pattern of child labour across the world. Children are being orphaned by AIDS. Also, through their vulnerability to sexual exploitation, they are at risk of infection by HIV.

It is estimated that nearly 14 million children under the age of fifteen have lost their mother or both parents as a result of AIDS – 95 per cent of them in Africa. By 2010 there could be 35 million. The epidemic forces children out of school and into child labour, often in exploitative and extremely hazardous forms of work. Young female orphans are especially vulnerable to sexual exploitation.<sup>10</sup>

When an adult in a family becomes ill with AIDS-related illnesses, children, especially girls, are likely to have to take on more household tasks or seek income-generating work in order to make up for lost income and to help pay for medical expenses. They will probably have to leave school.

High school dropout rates lower still further the level of qualifications and skills of the workforce.

<sup>9</sup> Stover and Bollinger cited in UNAIDS *Impact* (Geneva, April 1999)

<sup>10</sup> World Bank, *Findings* No. 201, February 2002

This, in turn, has a negative impact on productivity in the short term and on the human resources that underpin national development.

Girls are being driven into commercial sexual exploitation at an ever younger age, often as a result of myths – for example, that intercourse with a virgin can cure a person of infection – or simply because clients hope that a younger person is less likely to be infected.

### **Gender, work and AIDS**

Gender inequality—linked to patterns of social, economic and cultural inequality—makes women more vulnerable to infection. The situation is made worse by biological differences between men and women. As the epidemic spreads, women are faced with the double burden of having to work and cope with the additional responsibilities of providing care and support for family and community members who fall ill.

Most women are still confronted with limited access to secure livelihoods and socio-economic opportunities. This increases their dependence on male partners and their vulnerability in situations where there are risks of HIV infection.

Men, too, are subject to social and cultural pressures that increase their susceptibility to infection and their likelihood of spreading it. Multiple partners and sexual infidelity are condoned for men in many societies. Certain occupations tend to encourage risk-taking behaviour, especially those that involve men spending long periods away from their families. This in turn increases the risk of infection for their partners when they return home.

### **The impact on trade unions**

Trade unions in several countries have already lost key staff and activists at national and branch level.

Most unions in developing countries have limited resources; they invest what they can in the training and development of core staff and workplace representatives. The loss of these persons will affect how unions are able to organize and support their membership effectively.

In Zimbabwe in the 1990s, the mineworkers union, AMWZ, lost almost 90 per cent of its organizing staff and its national education officer.

The IUF, the global union federation representing food, hotel and plantation workers, reports an increasing loss of trade union leaders amongst its affiliated unions.

Unions in countries with high prevalence rates have to consider how they can best assist with programmes of prevention and care and ensure that workers are not subject to discrimination. They must also consider the direct effects of the epidemic on their own organizations.

### A global campaign

The UN has been active in the struggle against AIDS since the early days of the epidemic. In 1987, the World Health Organization (WHO) took the lead responsibility and set up a Special Programme on AIDS, subsequently the Global Programme on AIDS.

In 1996, the United Nations re-structured its response to the epidemic and set up a collaborative programme: the Joint United Nations Programme on HIV/AIDS (UNAIDS), co-ordinated by the UNAIDS Secretariat in Geneva. In 2001 the ILO became the eighth co-sponsor of UNAIDS.

The role of UNAIDS is to engage the effort of many sectors and partners, and provide countries with the necessary technical and institutional support and information needed to respond effectively to the epidemic.

The United Nations General Assembly Special Session held in June 2001 adopted a **Declaration of Commitment on HIV/AIDS**. It is wide ranging, but five priorities are made clear:

*First, to ensure that people everywhere - particularly the young - know what to do to avoid infection;*  
*Second, to stop perhaps the most tragic of all forms of HIV transmission - from mother to child;*  
*Third, to provide treatment to all those infected;*  
*Fourth, to redouble the search for a vaccine, as well as a cure; and*  
*Fifth, to care for all whose lives have been devastated by AIDS, particularly more than 13 million orphans.*

Key factors needed to achieve these goals were also identified: leadership and commitment at all levels; the engagement of local communities; empowerment of women; improvement of public health care systems; and the commitment of new money. The importance of expanding prevention and protecting rights at the workplace was made explicit in paragraphs 49 and 69, in particular.

The ILO acts as lead agency in all strategies to combat HIV/AIDS at the workplace

## Responding at the workplace

There are three reasons why it is necessary to deal with HIV/AIDS in the workplace.

Firstly, because, HIV/AIDS has a huge impact on the world of work - reducing the supply of labour and available skills, increasing labour costs, reducing productivity, threatening the livelihoods of workers and employers, and undermining rights.

Secondly, because the workplace is a good place to tackle HIV/AIDS. Standards are set for working conditions and labour relations. Workplaces are communities where people come together and they discuss, debate, and learn from each other. This provides an opportunity for awareness raising, education programmes, and the protection of rights.

Thirdly, because employers and trade unions are leaders in their communities and countries. Leadership is crucial to the fight against HIV/AIDS:

*Every advance in the global struggle against HIV/AIDS has borne the mark of leadership. The successes have hinged on the perseverance of visionary and courageous people. Some are high-powered political and religious leaders and international icons. Others, less visible, have been no less effective in their actions as workers, students, business people...*

*Some businesses are implementing workplace programmes to protect workers against HIV infection and its consequences. Along with trade unions, they are also putting their networks and resources at the disposal of broader HIV/AIDS campaigns. However, they are the exception and not yet the rule. The need for committed action in the private sector remains immense.*

*Together we can: Leadership in a world of AIDS, UNAIDS, 2001*

In Module 3, we will look at what initiatives employers and trade unions are taking to combat HIV/AIDS. Fundamental to effective action by employers and trade unions is a joint approach, particularly through the development of a workplace policy.

## The role of the ILO

The ILO is involved in the fight against HIV/AIDS because the epidemic is everybody's business. It is not only the responsibility of health agencies, but a challenge to economic growth and global security. The whole international community is now mobilized against HIV/AIDS. The Special Session of the UN General Assembly in June 2001 was a demonstration of that commitment.

HIV/AIDS threatens the ILO's constituents and compromises the ILO's goal of achieving decent work. In response, the ILO brings particular strengths to the fight against HIV/AIDS:

- its tripartite structure, making it possible to mobilize employers and workers against HIV/AIDS as well as governments
- a central presence at the workplace, a venue well suited to education for prevention
- nearly a century of experience in guiding laws and framing standards to protect the rights of workers and improve their working conditions
- regional and national offices across the world
- specialist expertise in many relevant sectors, from occupational safety and health to social security
- a well-established record of research, information dissemination and technical co-operation, with a particular focus on education and training.

### What is the ILO?

The ILO is the UN Specialized Agency which deals with the world of work. Each part of the UN system is responsible for a particular area - its 'mandate' or mission. The ILO's mandate is to promote social justice and equality, set standards in employment, and improve working conditions. So vocational training, employment creation, child labour, workers' rights, social security, and safety and health at work are some of the ILO's issues.

Like all UN organizations, the ILO is financed by member States. Countries join the ILO separately from the UN. The ILO has 175 member States.

The ILO is actually older than the United Nations. It was set up by the Treaty of Versailles, which marked the end of the First World War, in 1919. It became the first UN Specialized Agency in 1946.

The ILO Constitution states that "universal and lasting peace can only be established if it is based upon social justice."

What makes the ILO unique within the UN is its *tripartite structure*, including employers' and workers' organizations, as well as government.

Each member State sends four delegates to the ILO Conference, which meets every year. Two represent the government, one represents employers and one the trade unions. The ILO Governing Body is composed in the same way.

## **Decent Work**

It is clear that the international community needs and expects the ILO to play a key role in the fight against HIV/AIDS. The ILO's goal has been summarized as the *promotion of opportunities for men and women to obtain decent and productive work, in conditions of freedom, equity, security and human dignity*.<sup>12</sup>

To achieve decent work, four strategic objectives have been developed – and HIV/AIDS is threatening all of them:

### **Fundamental principles and rights at work**

Basic human rights, including fair treatment in recruitment and job security, are compromised by discrimination against people living with HIV/AIDS. This is why the ILO Code of Practice on HIV/AIDS and the world of work places an emphasis on rights (see next module).

### **Employment and income opportunities for women and men**

The negative effects of HIV/AIDS on development and employment have been discussed. The ILO will provide guidance and practical help to sustain employment.

### **Social protection**

The majority of workers in developing countries lack access to social insurance and services. There is concern that HIV/AIDS is undermining even the limited social security that exists.

### **Social dialogue and tripartism**

The spread of HIV/AIDS has been helped by the culture of silence imposed by the stigma against people living with HIV and AIDS, and by reluctance to discuss issues such as drug use and sexual behaviour. The ILO's tripartite structure can open up difficult issues to frank discussion, leading to co-operative solutions.

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<sup>12</sup> *Decent Work*, Report of the Director General to the International Labour Conference, 1999

### ILO standards relevant to HIV/AIDS

Currently, no specific international treaty or convention exists which deals with HIV/AIDS. Some of the main legal instruments of relevance to HIV/AIDS have been developed by the ILO:

Discrimination (Employment and Occupation) Convention, 1958 (No.111).  
This is one the eight fundamental Conventions of the ILO.

Occupational Safety and Health Convention 1981 (No. 155)

Occupational Health Services Convention 1985 (No. 161)

Termination of Employment Convention, 1982 (No.158)

Vocational Rehabilitation and Employment (Disabled persons) Convention, 1983 (No. 159)

Social Security (Minimum Standards) Convention, 1952 (No. 102)

Labour Inspection Convention, 1947 (No. 81) and Labour Inspection (Agriculture) Convention, 1969 (No.129)

### The ILO's Programme on HIV/AIDS and the world of work

The ILO responded early to the threat of HIV/AIDS. In 1988, the World Health Organization (WHO) and the ILO issued a joint statement on AIDS and the workplace.

The response has deepened and quickened in recent years. A number of research studies have been conducted or are being carried out; the first were conducted in the African region in the mid 1990s.

In October 1999, a tripartite conference in Windhoek, Namibia, agreed a Platform of Action as a response to the crisis.

The International Labour Conference adopted a resolution in June 2000, instructing the Office to increase its capacity to address HIV/AIDS. A dedicated unit, the ILO Programme on HIV/AIDS and the world of work (ILO/AIDS), was established in November 2000.

**An ILO Code of Practice on HIV/AIDS and the world of work**

The ILO has produced a Code of Practice to provide practical guidance for governments, employers and workers, as well as other stakeholders, for developing national and workplace policies and programmes to combat the spread of HIV and mitigate its impact.

The Code establishes both the rights and the responsibilities of the tripartite partners as well as key principles of workplace policy. It covers the key areas of:

- prevention through education, gender-aware programmes, and practical support for behaviour change;
- protection of workers' rights, including employment protection, gender equality, entitlement to benefits, and non-discrimination;
- care and support, including confidential voluntary counselling and testing, as well as treatment in settings where local health systems are inadequate.

The Code was developed through widespread consultations, taking into account examples of national codes and company policies in many regions. It was approved by consensus at a tripartite meeting of experts in Geneva in May 2001 and adopted by the ILO Governing Body in June 2001. Launched at the United Nations General Assembly Special Session on HIV/AIDS in 2001, the Code has been enthusiastically welcomed by governments and their workplace partners in all regions and given widespread political support; it has been translated into 15 languages to date at the request of constituents.

The ILO is itself an employer. It is applying the Code of Practice in its own personnel policies: in July 2001, the Director General issued a circular setting out a personnel policy on HIV/AIDS which follows the principles of the Code of Practice.

### ACTIVITY 1

## HIV/AIDS and the work place: fact and fiction

**AIMS** To help you think about why HIV/AIDS is a workplace issue.

**TASK** In your group, discuss the following statements. State whether you agree or disagree, and give your reasons.

‘HIV/AIDS is spread by ignorance, prejudice and complacency.’

‘Now that antiretroviral drugs are available, HIV/AIDS is not an issue.’

‘HIV/AIDS is more than a health issue. It affects us all.’

‘Several workers in our enterprise have, sadly, died from AIDS. But we have always replaced them. Unfortunately, there is such high unemployment that any worker can be replaced.’

‘If a worker does contract HIV/AIDS, it is a private matter. But we should provide an environment at work which would support that worker if he or she chooses to tell the management or fellow workers.’

‘Yes, HIV/AIDS is a problem in our country. If it affects our company, we will deal with it by dismissing workers and paying them compensation.’

‘HIV/AIDS is spread by sex and drug use. Our company does not want to be associated with such things. It would be bad for our image to talk about these things. The workplace is not the right place to discuss things like safe sex.’

## ACTIVITY 2

Dealing with fears  
about HIV/AIDS at work

**AIMS** To help you understand the importance of having an HIV/AIDS policy before problems arise.  
To help you practise common arguments about HIV/AIDS.

**TASK** In your group, discuss how you would respond to the following situations:

Workers refuse to eat with, or use the same toilet as, a worker known to have HIV.

Workers demand protective clothing because of their fear of being at risk of HIV infection.

Management proposes to move a worker known to be HIV+ from a post where s/he meets the public.

First-aiders have resigned their positions because they fear they are at risk from HIV/AIDS infection if they carry out first aid procedures (e.g. mouth-to-mouth resuscitation).

## ACTIVITY 3

## Planning for HIV/AIDS in the enterprise

**AIMS** To help you think about the implications of HIV/AIDS at enterprise level.

**TASK** In your group, consider the following scenario.  
Prepare your response on a flipchart.

You are a human resource manager in a textile mill in southern Africa.

You have been asked to examine the impact of HIV/AIDS on the company over the next twenty years.

What are the main areas you would consider in attempting to assess the impact of the pandemic on the company?

What information sources would you find useful?

What academic, State or NGO bodies might you ask for assistance?

At what point would you seek to involve the union or workers in what you are doing?

### ACTIVITY 4

#### HIV/AIDS and its impact at work

**AIMS** To understand how HIV/AIDS affects the workplace.

**TASK** In your group, think about your workplace (s).  
What might be the consequences if a skilled worker:

- was off sick for one month with an illness caused as a result of being infected with HIV?
- had to leave his/her job because he/she was too ill with AIDS?
- died as a result of AIDS?

**Note :** This activity is suitable for a less experienced group, or for a group in a country where HIV/AIDS is not currently recognized as a high priority.

### ACTIVITY 5

#### HIV/AIDS and union policy

**AIMS** To help you to develop union policy on HIV/AIDS.

**TASK** In your group, prepare a resolution for your trade union branch on a policy for HIV/AIDS.

## ACTIVITY 6

### HIV/AIDS and the union

**AIMS** To help you think about the impact of HIV/AIDS on your union.

**TASK** In your group, discuss the current situation in your union, at any level - workplace, region, national.

Have there been any cases you are aware of where a union activist or official has become infected with HIV? Or where an activist has died? What have been the consequences for the union? Does the union have any specific plans for dealing with such problems?

Prepare a report for your executive on how the union should protect itself from HIV/AIDS.

## News reports

### Head of UN Agricultural Development Agency Says AIDS is 'Ravaging' African Farm Workers

AIDS is "ravaging" farmers in rural Africa and is taking a "tremendous toll" on the continent's ability to produce food, Lennart Båge, President of the UN International Fund for Agricultural Development, said Wednesday. The United Nations estimates that among the 25 African countries worst affected by HIV/AIDS, 7 million farm workers have died of AIDS-related causes, and an additional 16 million workers could die by 2020. Båge, who was speaking at the agency's annual meeting in Rome, warned that HIV/AIDS will have a detrimental effect on African farmers and the continent's economy. Noting that "most people with AIDS" in Africa live in rural areas, Båge stated that the disease is "devastating rural life" on the continent. "You have a disappearing generation," Båge said. He stated that HIV/AIDS is reducing the labour pool of farmers and is "severely hindering" Africa's efforts to achieve the UN goal of halving hunger and poverty by 2015.

■ Reuters (Feb. 22, 2002)

### WHO Report Says Increased Investment in Global Health Could Provide 'Essential' Treatment for AIDS and TB in Developing Countries

Eight million lives could be saved and \$ 186 billion in world income now lost to illness could be recovered each year if the world's richest nations donated \$ 101 billion annually for medical research and treatments for infectious diseases like HIV, malaria and tuberculosis in the developing world, according to a report released yesterday by the World Health Organization, the New York Times reports. A WHO committee headed by Harvard University economist Jeffrey Sachs reached this conclusion after analyzing the correlation between public health and economic development and how an influx of foreign aid, coupled with affected governments' own budgets, could improve health worldwide (Altman, New York Times, Dec. 21). The report, titled "Macroeconomics and Health: Investing in Health for Economic Development," is based on almost 90 studies and was funded in part by the Bill & Melinda Gates Foundation (Schoofs, Wall Street Journal, Dec. 21). Health spending in the developing world must rise to \$ 38 per person per year by 2015 if affected nations are to make "essential health interventions" for AIDS, malaria, TB and childhood diseases, the report concludes. Currently, the world's 60 poorest countries spend only about \$ 13 per person annually on health care. The increased funds would also provide immunizations, prenatal care and other preventive services.

### HIV/AIDS' impact

According to the report, HIV prevention programs reach 10 per cent to 20 per cent of people in developing nations, while 6 per cent to 10 per cent of HIV-positive people are receiving treatment for opportunistic infections and less than 1 per cent are receiving antiretroviral treatment (Brown, Washington Post, Dec. 21). Earning potential lost to AIDS in sub-Saharan Africa amounted to about 17 per cent of the region's gross domestic product in 1999. HIV/AIDS has hit the developing world, which was making health and economic gains prior to the onset of the pandemic, especially hard by reducing life expectancies and draining resources. The report calls on pharmaceutical companies to continue to lower prices for AIDS drugs and to extend those discounts to other "essential medicines." The report also says that poor nations should be allowed to import cheaper generic versions of the drugs as a "last resort" and calls for increased research into new treatments.

### Financing Improvements

The report estimates that about \$ 66 billion in new funds is needed annually to improve international health. The report suggests that industrialized nations donate about \$ 38 billion of that total and that developing countries provide \$ 28 billion a year by devoting an additional 2 per cent of their GDP to health and nutrition programs (Wall Street Journal, Dec. 21). Sachs said he would like to see the United States contribute about \$10 billion a year to the effort. A commitment of that size would double US foreign aid to 1 per cent of the federal budget. The report's suggestions will likely face opposition in Congress, where "foreign aid has many enemies ... and health aid, especially, is fraught with controversy," the Times reports (New York Times, 12/21). However, health activists yesterday called on officials to heed the report. "We have long had the know-how and technology necessary to reduce the tragic and unnecessary deaths of tens of millions of people each year in the developing world," Dr. Nils Daulaire, President and CEO of the Global Health Council, said, adding that the world's richest nations "must act now" (GHC release, Dec. 20).

■ Kaiser Network, Dec 21, 2001