

Executive summary

By 2005, HIV prevalence in the 60 countries of the world most affected by the epidemic ranged from under 1 per cent to well over 30 per cent. African countries continue to bear the brunt of the epidemic: their average HIV prevalence was estimated at 6.4 per cent in adults aged 15 to 49 years, well above the global average of 1.4 per cent. The regional averages for the two other most affected developing regions – Latin America and the Caribbean, and Asia – are below 1 per cent.

UNAIDS estimated that by the end of 2005, there were 38.6 million persons living with HIV globally, of whom the vast majority – 36.3 million – were 15 years and over and thus of working age. On the basis of the most recent population data from the United Nations Population Division and the ILO's own latest estimates of labour force participation, the ILO assessed the current impact of the epidemic on the global labour force, and possible future impact on the labour force as well as on the global population of working age.

According to the ILO assessment, 24,560,000 labour force participants aged 15 to 64 years were living with HIV or with AIDS worldwide in 2005. The vast majority – nearly 67 per cent – lived in Africa. There were more than 1 million workers living with HIV/AIDS in five countries: Mozambique (1.4 million), Nigeria (1.8 million), South Africa (3.7 million), the United Republic of Tanzania (1.2 million) and Zimbabwe (1.1 million). In contrast, more than a million labour force participants are estimated to be living with HIV/AIDS in only one country outside Africa, in Asia where India has an estimated 3.9 million persons living with HIV/AIDS. Globally, 41 per cent of the labour force participants living with HIV are women, and in Africa, the proportion is even higher, at 43 per cent.

Furthermore, assuming that all adults and most youth are economically active to an extent and work in resource-poor settings – in particular in Africa – even if the sustenance they provide is not easily assessed in conventional economic terms, the total number of productive persons living with HIV/AIDS is greater than the number of labour force participants, and likely to be closer to the total number of working-age persons affected. Given that adults contribute in other ways to the economy, for example by raising children who will be the future labour force, it is important to take account of the impact of HIV on the entire adult population, especially in the case of women.

On this basis, the global estimate of 36.3 million working-age persons living with HIV represents more fully the impact of the epidemic on the world of work. Accordingly, over and above the estimated 24.6 million labour force participants who are living with HIV/AIDS, there are nearly 12 million more persons who are engaged in one or another form of productive activity, who are therefore economically productive to some degree, and who are living with HIV/AIDS.

The effects of the HIV epidemic on the labour force and on all persons of working age are measurable in their overall impact on economic growth and on employment growth. The ILO demonstrated in 2004, and again with more recent data in 2006, that the rate of economic growth in countries heavily affected by HIV/AIDS has been reduced by the epidemic's effects on labour supply, productivity and investment over the last decade or more. The ILO found in 2006 that 43 countries lost on average 0.5 per cent of their economic growth rate every year between 1992 and 2004, and, among them, the 31 countries in Sub-Saharan Africa lost 0.7 per cent of their average annual rate of economic growth. In this report, also, the ILO applied a model to estimate the impact on employment growth and found that the same 43 countries lost on average 0.3 per cent in their rate of growth of employment annually over the same period due to the loss in economic growth. This amounts to an employment loss of 1.3 million every year. The 31 countries in Sub-Saharan Africa lost 0.5 per cent of their average annual rate of employment growth, equivalent to an employment loss of 1.1 million per year for Africa alone.

But enterprises, households, families, communities and economies can benefit if workers with AIDS have access to effective antiretroviral drug therapy (ARVs). The ILO model in this report shows, for example, that a worker with AIDS given treatment in 2004 could have worked for 34 of the next 54 months on average worldwide, contributing as a result more than 7 times the global per capita income to the global economy for each 12 months the worker survived. Moreover, the benefit of ARVs would be greater for Africa: the average worker with AIDS could have survived 36 of the next 54 months, contributing 8 times the per capita income of Sub-Saharan Africa to the African economy for every 12 months the worker survived.

In reality, even at the current and anticipated rates of increase in access to ARVs, which are now included

in population projection models, the HIV epidemic continues to have a very damaging impact on the labour force. In 2005, more than 3 million labour force participants worldwide were partially or fully unable to work because of illness due to AIDS, and three-quarters of them lived in Sub-Saharan Africa. Moreover, the global number of labour force participants unable to work is expected to stabilize between now and 2020, and not yet decline, whereas it is expected to continue to increase in Africa, where slower growth of access to ARVs is projected.

Access to ARVs is woefully delayed in resource-poor settings, although there has been some progress in broadening access just in the last year, 2005. Projections of labour force participants who will become ill and die illustrate the expected demand for ARVs that will be newly arising, as well as allowing the calculation of the global cumulative demand for ARVs. Even if some of this demand is met by expanded access to ARVs, the figures underscore the urgent need to raise access to the very highest levels to avert the labour force losses otherwise projected.

For the time being, cumulative mortality losses to the global labour force are expected to continue to increase as a result of the impact of the HIV epidemic, from 28 million estimated for 2005 to 45 million projected by 2010, over 64 million projected for 2015, and nearly 86 million anticipated by 2020, despite projected increases in access to ARVs. Taking account of the global impact of the epidemic on all persons of working age, whereas 3.4 million working-age youth and adults died annually by 2005, the toll is expected to rise to 4.1 million by 2010, 4.4 million by 2015, and to reach 4.5 million by 2020, even with anticipated increases in access to ARVs. In developing regions, fewer deaths are expected to occur in Latin America and the Caribbean, but more deaths are projected in Asia and Sub-Saharan Africa.

As a result of HIV/AIDS, also, the economic burden to labour force participants and the social burden to adult household members are expected to continue to rise due to the combined impact of the illness and death of workers, especially in Sub-Saharan Africa. The economic burden on each labour force participant is expected to increase globally from 0.5 per cent to 1.7 per cent between 2005 and 2020, and from 4 per cent to 7.2 per cent in Sub-Saharan Africa over the same period. The social burden on each person of working age will increase similarly, reaching over 1 per cent globally in 2020, and 5.3 per cent in Sub-Saharan Africa.

The impact of the HIV epidemic is especially flagrant if one looks at the plight of children and youth, whose lives, hopes and future are blighted. Directly or indirectly, HIV/AIDS has life-threatening consequences for children if they are themselves born with HIV, lose one or both parents as a result of AIDS, or are exposed to the risk of HIV in the pursuit of survival, through engagement in the worst forms of child labour.

The future of the labour force is imperilled by the epidemic in the worst-affected countries as a result of these effects on children. This epidemic undermines the process of human capital formation. Deaths of children deprive families and societies of their potential contributions, drain their resources, and sap morale. Such deaths are brutal and de-humanizing. Generations of surviving orphans do not have the support, guidance and education they need to gain skills, pursue opportunities for decent work, and contribute to their societies and their economies. When children become orphans, they have already been exposed to the traumatizing experience of watching their parents become severely debilitated and die. The fact that there are children engaged in child labour, and children who are exposed to the risk of HIV in its worst forms in the battle for survival, contravenes every fundamental principle of social justice, flagrantly violates the rights of children, and demeans the human lot.

The sum of the impact of HIV/AIDS on children is reckoned in bleak statistics: the number of deaths of children, the number of orphans, the number of children engaged in child labour, and the number of children not in school. Nearly 2.3 million children now live with AIDS worldwide at any time, of whom more than 600,000 die each year. There are an estimated 15 million orphans in the world as a result of the death of one or both parents due to AIDS. In Sub-Saharan Africa alone, there are 12 million orphans, and their number is expected to rise to 20 million by 2010. The ILO has estimated that 191 million children were working worldwide in 2004, of whom 166 were in child labour, and 74 million performing hazardous work, without taking account of a further unknown number who were exploited in the worst forms of child labour – slavery, trafficking, exploitation in armed conflict, forced labour, prostitution, pornography, and illicit activities – that harm the health, safety or morals of children. Moreover, an estimated 115 million children were not in school in 2001-2002, and more than a third of primary school children fail to reach the last grade in more than 40 countries, which is a basic cause of illiteracy, whereas literacy skills are the basic tools to escape poverty.

But it is youth who as a group are at greatest risk from the HIV epidemic, for three reasons: young men and women are entering their working lives and as a group of workers have the least training and experience; young people are 2 to 3 times more likely than older adults to be unemployed; and at the same time, youth are starting off their adult sexual lives. Furthermore, many youth live in poverty. It is estimated that 200 million young people, or 18 per cent of all youth, live on less than US\$1 per day, and 515 million on less than US\$2 per day.

Youth represent only one quarter of the world's working-age population but account for nearly half of its unemployed. Young people also work in large numbers in the informal economy, which means they do not know decent work, are underemployed, work under precarious conditions and benefit from little or no social

protection and benefits. Youth experience among the worst conditions in the world of work. Studies often show that the majority of men and women who resorted to the sex industry for their livelihood began sex work in their teens or early 20s, and that in many parts of the world the large majority of sex workers are under 25 years of age.

These factors interact with the result that, according to the most recent data, young people account for half of all new HIV infections. An estimated 5,000 to 6,000 young persons acquire HIV each day. Moreover, the majority of young persons who are living with HIV do not know that they carry the virus, especially in resource-poor settings. The risks are greater for young women than for young men, as are the consequences. Surveys show that the knowledge level about HIV/AIDS is almost always higher in young men than in young women.

Poverty and HIV/AIDS have jointly significant consequences for their education, skills and employability, as youth living in households affected by HIV/AIDS work to support themselves and sick relatives and siblings, and school attendance becomes much more difficult. Without access to the education and training they need, the chances of finding work, especially decent work, are diminished when youth become adults. Young people living in AIDS-affected households often find out only later that decent jobs are unavailable or beyond their reach because of their earlier lack of education and training.

Inadequate skills and mismatched skills reduce employability, which increases the risk of marginalization and social exclusion for under-educated and under-trained youth, while it also undermines enterprise competitiveness. Yet one of the best solutions to social exclusion and the best forms of prevention against HIV is decent work, and the best way to access decent work is through education with the appropriate training and skills. The challenge is to find alternatives when formal education and training systems do not reach marginalized and disadvantaged youth, including youth who have dropped out of school, and who may be affected by HIV/AIDS. Out-of-school training is a very important means to help youth qualify for jobs, giving opportunities for education, skills training and micro-credit, among other interventions. Importantly, out-of-school structures also make it possible to convey HIV prevention messages and information for youth who are at high risk, but who are hard to reach. The high risk of HIV to which disadvantaged youth are exposed calls for tailored responses from the world of work.

Addressing the impact of child labour on youth unemployment is crucial to elaborate long-term strategies both for the elimination of child labour and for the preparation for entry into the labour market of youth at the appropriate age, and to elaborate national policies to reduce youth unemployment. In principle, the removal of children from child labour requires fostering alternative means to encourage the creation of jobs, increase labour productivity and raise wages for young people, as

well as provision of alternative assistance to the current generation of children, enabling them to strengthen their work skills in the long run. Unemployed youth cannot replace child labour in many cases, but the potential to re-orient the demand for labour away from children and towards youth is a compelling priority that cries for attention and deserves thorough examination.

The objectives of the response from governments to the impact of HIV/AIDS on children and youth is to strengthen understanding of all the human rights of children in the context of HIV/AIDS; to promote the realization of the human rights of children, in the context of HIV/AIDS, as guaranteed under the Convention on the Rights of the Child; and to contribute to the formulation and promotion of child-oriented plans of action, laws, and policies to combat the transmission and mitigate the impact of HIV/AIDS at the national and international levels.

Accordingly the current framework to protect children's rights is comprised of legal instruments that regulate their lawful entry into the world of work, their access to education, and their fundamental rights. Notable are the ILO Convention No. 138 (1973) that regulates the minimum age for admission to work or employment, and the ILO Convention No. 182 (1999) that prohibits and seeks to eliminate the worst forms of child labour.

Consequently, there is an array of legal protection that has yet to be forcefully implemented to relieve children and youth of the extraordinary harm befalling them due to HIV/AIDS. Whereas efforts are concentrated on controlling the epidemic through intense and comprehensive programmes, including universal access to treatment, far greater attention must be paid to protecting and building the human capital of children and youth which is the foundation for a world with – or without – AIDS.

These projections for 2006 continue to argue loudly for comprehensive workplace action against HIV/AIDS, especially in the developing regions of Africa and Asia. The ILO upholds the principle and contributes to the UNAIDS strategy of universal access to antiretroviral medication (ARVs). Workers will continue to become ill in large numbers for many years to come, and increasing numbers of workers will require access to treatment as those who start treatment survive in larger numbers. Access to ARVs in the workplace must rise substantially not only to achieve the increased survival of workers anticipated by the projections, but to reach beyond those objectives to achieve truly universal treatment for all the workers who need it.

To document the benefits to the world of work from a more vigorous response to HIV/AIDS, notably in stepped-up efforts to expand access to ARVs, the ILO presents two new projections in this 2006 report. First, recognizing the growing will to implement universal access, the ILO has also projected the potential survival of labour force participants were they to have universal

access to ARVs, taking account of different levels of treatment continuation rates. Second, the ILO has projected the benefits that would accrue from a totally effective and universally available HIV vaccine.

The ILO projections of access to treatment suggest that survival of labour force participants will increase substantially with access to ARVs, and even more so if their adherence to treatment is high. Assuming that treatment is initiated in 2006 for all workers with advanced AIDS and each year new workers are added to the treatment pool, 2.5 million workers would be alive globally at the end of 2010 who would otherwise have died, if 80 per cent of workers continue the treatment each year, and 3.7 million workers would be alive globally by the end of 2010 who would otherwise have died, if 93 per cent of workers continue the treatment each year. The largest share of benefit from access of workers to ARVs would accrue to Africa, where 1.8 million workers would have survived in 2010 at 80 per cent adherence, and 2.6 million at 93 per cent adherence.

Similarly, the advent of a vaccine would save many lives of labour force participants who are not yet HIV-positive. If universal and fully effective vaccination were initiated in 2006, 3 per cent of workers' lives would be saved after 4 years, by 2010; over 11 per cent of workers' lives would be saved after 9 years, by 2015; and over 28 per cent of workers' lives would be saved after 14 years, by 2020. A greater proportion of lives would be saved in the regions where the epidemic matured (or is expected to mature) later. In Sub-Saharan Africa, where many workers are already HIV-positive, the gain by 2020 will be over 24 per cent of workers who would otherwise die. In Asia, where the path of the epidemic implies a later peak, the gain by 2020 will be over 41 per cent, because it is still possible to prevent the transmission of HIV to a large proportion of the labour force currently projected to become HIV-positive.

The projections suggest that an intervention such as instantaneous, universal and effective vaccination would contribute substantially to stemming losses to the global labour force that are projected to occur because of the path of the epidemic. The intervention would especially benefit the regions with later epidemics, and women where much of the growth in heterosexual transmission still lies ahead. Nevertheless, the intervention cannot have an effect on stemming the inevitable losses to the labour force that are the inherent result of HIV transmission that has already occurred. The negative momentum of the epidemic is now so great that even with effective intervention over 70 per cent of the labour force losses currently projected may come about globally by 2020, notwithstanding increased access to ARVs. To save those lives, a more uncompromising and deliberate path to universal access to ARVs must be forged without delay and without reserve.

In sum, the vaccination scenario comprises one critical part of the most optimistic scenario for the labour force. The other critical parts of the optimistic scenario are intensification of prevention to control the number of workers becoming HIV-positive worldwide – most particularly in regions where much of the epidemic and HIV transmission lie ahead – and fundamental, rapid expansion of access to treatment for the millions already living with HIV.

These new analyses show clearly that both prevention and treatment can bring significant benefits to the global labour force and the world of work, even if prevention is too late for millions of persons already living with HIV. At least there is hope for the future for persons already living with HIV. Each labour force life preserved represents a potential productive gain for enterprises, the public sector – in particular health, education, and public services more generally – the household and the family, especially children, as well as recognition of the fundamental rights of each and every working man and woman.