Toolkit for Trade Unions on HIV and AIDS

Booklet 1:

Core information on HIV and AIDS, the impact and the global response

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This booklet contains basic information on HIV and AIDS. Trade union focal persons do not need to be experts on the science of HIV, but some understanding of the virus – and the implications for prevention and treatment - is important. Trade unionists may need to interact with medical and policy professionals and understand the language that they use.

In order for trade unions to operate effectively at national policy level, they also need to understand the broad policy framework for their country's HIV/AIDS response, so information is included on key international policy documents. They should be aware of the implications of the HIV and AIDS statistics, including how they are gathered and the different forms the epidemic takes in different places.

The booklet positions HIV/AIDS as a workplace issue and introduces the work of the ILO, with more detail in later booklets. It presents some of the other key players in the global response to AIDS but fuller information on partnerships is set out in Booklet 5.

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1. HIV AND AIDS: THE FACTS

***HIV* stands for Human Immunodeficiency Virus**
The virus weakens the body's immune system.

***AIDS* stands for Acquired Immune Deficiency Syndrome**
A syndrome, in medical terms, is a group of symptoms that are consistently found together. Because the immune system is, over time, weakened by the virus, a person then becomes vulnerable to a range of opportunistic infections which normally the body could resist. It is one or more of these infections which can eventually cause death - but with proper treatment most people live well for many years.

HIV is a type of virus called 'retrovirus'. It attacks the body's immune system by targeting a type of white blood cells called CD4 cells. These are the cells responsible for helping the body resist infection.

When a person becomes infected by the virus there is a short 'window period' before the body fights back against the virus. During this period a person's HIV status cannot be detected using standard tests, but they are highly infectious. In its early stages, HIV infection has no symptoms or may feel like flu.

Within six to twelve weeks of infection, the body starts producing a specific type of antibody, an attempt by the immune system to resist the attack by the HIV. The antibody is a reliable indicator of whether someone is infected. If a person is tested for HIV and the presence of HIV antibodies is found, they are HIV-positive.

There now follows a long incubation stage, during which a person may live without symptoms for years. Eventually the virus gains the upper hand.

You cannot tell from looking at people if they are infected or not.
Source: Drawing It Out - First International HIV/AIDS Cartoon Exhibition, UN 2006.
Artist: Luciano Felix, Country: Brazil

1.1 How HIV is transmitted

The virus is transmitted through body fluids – blood, semen, vaginal secretions and breast milk. People are infected by the virus through these routes:

- unprotected sexual intercourse with an infected partner (the most common) - this can be heterosexual or homosexual sex
- 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, a particular hazard for healthcare workers
- mother–to-child transmission (MTCT) from an infected mother to a child in the womb, or at birth, or by breastfeeding.

The majority of HIV infections globally are the result of heterosexual intercourse, although in some countries other factors are more important such as sharing drug-taking equipment.

1.2 The onset of AIDS

In every microlitre (one millionth of a litre) of blood in the body, there are between 1,000 and 1,200 CD4 cells. When the CD4 cell count falls (around or below 200), a person will begin to suffer from opportunistic infections, because the immune system is no longer strong enough to fight off disease. At this stage, a person is considered to have AIDS.

On average it takes 7-10 years to develop AIDS. A few people have been living healthily with the virus for even longer. In the absence of antiretroviral therapy most people will progress from HIV infection, with few or no symptoms, to live with AIDS and a range of associated infections which may prove fatal.

In the last 10 years, a range of medicines - antiretrovirals (ARVs) - have become available which can boost the body's own CD4 cells and reduce the viral load or impact. Although there is no "cure for AIDS", the treatment and support now available means that HIV and AIDS can be managed. Millions of people are now able to go to work, stay with their families and lead a normal life although they are HIV-positive. However millions more who need ARVs do not have access to them, because of cost, because of inadequate coverage by health services, or because they do not yet know they are HIV-positive.

Early symptoms of AIDS include: chronic fatigue, diarrhoea, fever, mental changes such as memory loss, weight loss, persistent cough, severe recurrent skin rashes, herpes and mouth infections, and swelling of the lymph nodes. Periods of illness may alternate with periods of remission, when there are no symptoms and a person feels well.

Opportunistic diseases such as cancers, meningitis, pneumonia and tuberculosis may also take advantage of the body's weakened immune system. These diseases can interact: HIV and TB form a lethal combination, each speeding the other's progress. Someone who is HIV-positive and infected with TB is many times more likely to become sick with TB than someone who is HIV-negative. TB is a leading cause of death among people who are HIV-positive (see http://www.who.int/mediacentre/factsheets/fs104/en/).

With the proper treatment, care and support, workers with HIV can carry on working normally for many years.

Improvements in treatment, care and support are being made all the time and the life expectancy of people who are HIV positive is increasing. If somebody who is HIV-positive gets the right treatment, is well cared for, can eat properly and rest, there is no reason why they cannot live a full life.

There is more about treatment, care and support in Booklet 3

1.3 Preventing HIV

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**.

Simple measures can protect against infection:

- avoiding unprotected sex with a person whose HIV status you do not know; if you do not know for certain a person's HIV status, you should regard them as HIV positive;
- ensuring that there is a barrier to the virus, for example condoms or protective equipment such as gloves and masks (where appropriate); latex condoms are essentially impermeable to HIV-sized particles. If used properly and consistently, they are considered highly effective in reducing the risk of transmission – although no protective method other than abstinence is 100 per cent safe.
- not sharing needles or other skin-piercing equipment;
- taking precautions against accidents where blood is spilled and injuries by needles in healthcare situations;
- making sure that blood is tested for HIV and other virus before any transfusion;
- taking medical advice if you are HIV-positive before deciding to have a child;

- men who are circumcised have a lower risk of contracting or transmitting the virus; this can also apply to STIs - uncircumcised men are at three times greater risk than circumcised men of contracting chancroid from an infected partner. [1]

HIV/AIDS is not transmitted through normal contact at work. So why is it an issue in the world of work? See Booklet 2.
In Booklet 3, we look at how the workplace can help prevent HIV transmission.

1.4 Sexually transmitted infections

The risk of sexual transmission of HIV is increased by the presence of other sexually transmitted infections (STIs), such as syphilis and chancroid that give rise to ulcers. The virus cannot pass through unbroken skin, but it can pass through the ulcers caused by STIs. Although there is no cure for HIV, other STIs **are usually curable** and most times by a single dose drug. Anybody who has an STI should get it treated immediately to reduce the risk of HIV.

HIV cannot pass through an effective barrier such as unbroken skin or rubber.
Source: *Drawing It Out - First International HIV/AIDS Cartoon Exhibition, UN 2006. Artist : Fraga (Mexico)*

[1] The evidence is summarized in Male Circumcision and Risk for HIV Transmission and Other Health Conditions: Implications for the United States, Centers for Disease Control, February 2008

1.5 Vaccine development, microbicides, circumcision

A vaccine against HIV would be a tremendous step forward in the response to AIDS. And there is a huge global effort to develop one with more than 30 clinical trials ongoing worldwide. But it is unlikely that a vaccine will be widely available for many years. Research is also under way to develop a microbicide, a gel or similar product that can be used in the vagina to prevent infection during intercourse. It is also known that male circumcision helps reduce the transmission of the virus - although men who have been circumcised should still practice safe sex.

HIV/AIDS is not transmitted through normal contact at work, BUT it is an important issue for anybody at work.

1.6 Myths and misconceptions about HIV/AIDS

"A person who looks clean and healthy cannot have HIV"

When a person becomes infected by HIV there may be slight, temporary symptoms a bit like flu, but no change occurs to the person's appearance. It is impossible to guess if someone has HIV, especially as people can go on living and working normally for many years with the virus.

"A good and moral person cannot have HIV"

HIV is associated with sexual intercourse, just like pregnancy and childbirth – this is a normal function and essential to the survival of the human race. HIV and AIDS should not be a matter of shame or blame. So-called vulnerable groups, such as commercial sex workers, are part of every society and inextricably linked to the general population. It is much more effective in public health terms, as well as arguable more 'moral', to defend rights and ensure universal access to basic services than to blame and isolate particular groups or individuals.

"AIDS is caused by witchcraft"

Witchcraft is usually associated with misfortune. When people begin dying of a mysterious disease, and its causes are not understood, it can be explained by "witchcraft". The logic is that if it is caused by a witch doctor, then another witchdoctor can find a way to remove the

spell. This belief is harmful as it prevents victims seeking proper treatment and of course, they will not take any precautions to prevent the transmission of the virus.

“HIV can be transmitted by mosquitoes”

It is not possible to get HIV from mosquitoes. When taking blood from someone, mosquitoes do not inject blood from any previous person. The only thing that a mosquito injects is saliva, which acts as a lubricant and enables it to feed more efficiently. In addition, studies conducted by the US Centers for Disease Control and Prevention (CDC) and elsewhere have shown no evidence of HIV transmission from mosquitoes or any other insects - even in areas where there are many cases of AIDS and large populations of mosquitoes. This is supported by the fact that there are relatively few HIV cases among children, although they are very susceptible to insect-borne diseases such as malaria.

“HIV cannot be transmitted through oral sex”

The risk is hard to measure but generally agreed to be very low. HIV is not transmitted through saliva: there are binding agents in saliva that stick to the HIV and deactivate it, and also make it too large to pass through the membranes in your mouth. Open mouth kissing is therefore virtually without risk. But if infected semen came into contact with an open sore or cut in the mouth, HIV could be transmitted.

“Sexual intercourse with a virgin will cure AIDS”

Virgin cleansing is a myth that has occurred since at least the sixteenth century, when Europeans believed that they could rid themselves of a sexually transmitted disease by transferring it to a virgin through sexual intercourse. Although the origins of this belief are unclear, it seems to occur worldwide. Sex with an uninfected virgin does not cure an HIV-infected person, and such contact will expose the uninfected individual to HIV, potentially further transmitting the disease.

“Drugs to treat AIDS are very toxic and have severe side effects”

Nearly all medicines have side effects. There are now over 20 antiretroviral drugs available for the treatment of HIV infection. HIV treatment is a complex area of medicine. The correct dose or combination of drugs must be prescribed, or there is a risk that the treatment will not work properly or that it will cause side-effects. It is also the case that without proper and sufficient food, drugs to treat AIDS *may* have some side effects. Again, this is the case with many medicines.

HIV is not transmitted through casual physical contact at work, at leisure, in the family

It is not transmitted by:

- kissing (although deep kissing between two people where both of them have bleeding points in mouth may carry a small risk)
- mosquito or insect bites
- a visit to the dentist
- swimming pools
- shaking hands
- coughing or sneezing
- sharing toilets, towels or washing facilities
- sharing a cup or plate
- consuming food and drink prepared by someone who has HIV.

For more information see
www.who.int and www.unaids.org, especially
http://www.unaids.org/en/KnowledgeCentre/Resources/FastFacts/

1.7 Is HIV different?

HIV is in many ways a disease like no other before, for several reasons.

Latency period

A cholera epidemic will start, peak and finish within a few months. People show symptoms very quickly, and health workers know exactly what to do and can provide the right treatment. This does not happen with HIV. This is because of the 'latency period', the time lapse between exposure and developing a disease. Trade union safety activists know about this. When a worker is exposed to asbestos, he or she will not develop an asbestos-related disease for many years. Or coal miners inhaling coal dust will not develop pneumoconiosis for years. The time lapse between infection and symptoms makes it difficult to track infection routes or gauge the extent of the epidemic.

Mineworkers may not develop pneumoconiosis for many years after exposure to coal dust. There is a similar time lapse or latency period between infection with HIV and the onset of AIDS.

Concentration in adult population

Another major difference from other diseases is that the impact of HIV is most severe among adults in their productive prime, with enormous repercussions for the families, communities and workplaces which depend on them. Most diseases take their heaviest toll among children, the elderly, or those who are already unwell.

Stigma and discrimination

An HIV epidemic often starts slowly, usually in more at risk populations who are already marginalized and stigmatized - they include sex workers, men who have sex with men (MSM) and injecting drug users. They are often denied health treatment or may not seek it for fear of discrimination. If their behaviour is criminalized, which it is in many countries, they will take care not to draw attention to themselves. But in spite of society's public rejection of these groups there are many links between them and the general population, and thus many 'bridges' for HIV transmission.

Early responses to HIV/AIDS were shaped by prejudice and blame, but such attitudes only undermine prevention and encourage the spread of the epidemic. Trade unionists will want to defend the rights of those affected by HIV and challenge stereotyping and blaming (see Booklet 2).

The embarrassment, shame and denial widely attached to sexual relations have also been huge obstacles in efforts to deal with the disease.

Limited access to treatment

Until recently, going to health services for HIV was a waste of time for the vast majority of people as no treatment was available or, later, affordable. While this has started to change as the prices of ARVs come down - five million people are now getting treatment - drugs are still not available for many others.

1.8 How HIV and AIDS are described and measured

Trade unionists need to understand some of the terms and statistics concerning HIV and AIDS.

If we know the particular dynamics of an epidemic in a country, we can plan better. If we can help answer the question: “Who will be the next 1,000 people infected by the virus?”, prevention efforts can be more focused.

Jargon buster

Epidemiology is the branch of medicine concerned with tracking the development of epidemics.

HIV incidence is the number of new infections which occur over a period, usually a year.

HIV prevalence is the number of people in the population who are infected, usually presented as a percentage. This is essentially a snapshot at a particular moment.

Population does not always mean the national population. It could be the people in a province or region, a sector or industry, or a group which share certain characteristics (e.g. pregnant women).

A global epidemic

The latest available UNAIDS statistics [2] show that globally:

- Over 60 million people have been infected with HIV over the last quarter century and 25 million people have died of AIDS-related illnesses.
- More than 15 million children have been orphaned by AIDS.
- In 2009, an estimated 33.3 million people were living with HIV; there were 1.8 million AIDS-related deaths and 2.6 million new HIV infections– that still means about 7 000 people become infected and over 5 000 die every day.
- Sub-Saharan Africa remains the region most affected by HIV with 69 per cent of new infections worldwide. In seven countries, mostly in Eastern Europe and Central Asia, new HIV infection rates have increased by 25 per cent.
- Five million people are on antiretroviral treatment, but another 10 million are still waiting. And for every person who goes on antiretroviral treatment, two become newly infected - which is why we must keep emphasizing prevention.

What stage is your epidemic?

UNAIDS recognizes four stages of epidemic:

- *Low-level* : where HIV prevalence is below 1 per cent and where HIV infection is not significant in many groups.
- *Concentrated* : where prevalence is high in one or more groups - for example, MSM, sex workers, prisoners, but the virus is not widespread in the general population.

[2] Statistics from UNAIDS *AIDS epidemic update 2009* and *Global Report 2010*

- *Generalized* : HIV prevalence has reached between is over one per cent; the virus is present in the general population, and is usually spread through sexual contact.
- *Hyper-endemic* : prevalence rate is over 15 per cent.

Jargon buster

Epidemic - a widespread and rapid rate of infectious or contagious disease in a community.

Pandemic - an epidemic covering a whole region or large part of the world.

Endemic - a disease that is continuously present, such as malaria in some countries.

Why are statistics important?

It is important that adequate resources are put into collecting and analysing HIV statistics. If information is inaccurate, it is more difficult to find the most suitable ways of preventing more infections and treating those people who need it.

In booklet 6 we discuss projects and provide advice to trade unions drawing up proposals. You will see that many donors are now expecting project proposals to be based upon evidence.

If you are planning a project, and you hope that one outcome would be a reduction in new infections, then you would need a good idea at the start of your project of existing numbers of new infections - that would be your 'benchmark' or 'baseline' data. You could then measure the progress of your project after a number of years.

How reliable are the statistics?

Working out HIV prevalence is not easy, particularly when it is estimated that 80 per cent of people who are HIV-positive are unaware of their status.

Therefore many assumptions are made and statistical models developed building on the information available. These assumptions and models are improved as new information becomes available.

The methodology, the source of information, that statisticians use is ‘surveillance’. There are two main types:

Firstly, there is sentinel surveillance. This involves the collection of data from a sample of the total population, usually those attending health facilities. Most of the data on which statistics about HIV and AIDS are based come from sentinel surveillance, particularly at antenatal clinics.

Surveillance can also be conducted at household level. This is more representative of the population overall, though it may not include those who don't live in registered households or those who are more at risk. Sex workers or MSM may not respond to such surveys because they fear discrimination or even arrest. In addition, household surveys are expensive and difficult to carry out on a regular basis.

Jargon buster: sentinel surveillance

In medical jargon, a sentinel is "a thing that acts as an indicator of the presence of disease". Surveillance means the ongoing, systematic collection of health data. HIV sentinel surveillance involves monitoring trends in HIV infection over time, relating to a particular group or place. Sentinel surveillance can be community-based as well as linked to clinics.

By 2006, 44 countries had fully implemented UNAIDS/WHO guidelines on HIV and STI surveillance systems, 42 had partially implemented such systems and 46 had systems that were performing relatively poorly.

There are advantages and drawbacks to using data from antenatal clinics as the basis for statistics. Women presenting themselves at these clinics are, by definition, sexually active. At the same time, coverage of these clinics is still insufficient in many countries and it is only women of childbearing age who will attend. Sentinel surveillance carried out at clinics or services aimed at sex workers or injecting drug users can lead to overestimates of disease among the general population.

This is why, in November 2007, UNAIDS and the World Health Organization issued revised statistics with reduced estimates of the number of people living with the virus, new infections and number of AIDS deaths. As more data have become available, it was possible to improve statistical models and the assumptions made.[3]

[3] A simple explanation of these changes is available at *Understanding the New UNAIDS Estimates,* February 2008, from the Henry J Kaiser Family Foundation http://www.kff.org/hivaids/upload/7742.pdf

2. RESPONSES TO HIV/AIDS

2.1 Milestones in the epidemic

1981	The United States Centers for Disease Control and Prevention (CDC) report a cluster of rare cancers and pneumonia in gay men - seen as the 'start' of the epidemic
1982	The term 'AIDS' formally agreed
1983	The virus HIV identified by scientists
1985	The first international AIDS conference, the first test for HIV
1988	World AIDS Day held for the first time
1991	The Red Ribbon introduced as international symbol of AIDS awareness and solidarity
1996	The establishment of the Joint United Nations Programme on HIV/AIDS (UNAIDS)
1996	Antiretroviral treatment becomes available
1998	Treatment Action Campaign set up in South Africa for access to ARVs nationally and globally
2000	Millennium Development Goals set - includes Goal 6 on HIV, TB and malaria
2000	First resolution on HIV/AIDS by the International Confederation of Free Trade Unions (ICFTU - now ITUC)
2001	UN General Assembly Special Session on HIV/AIDS
2001	The ILO becomes a co-sponsor of UNAIDS
2001	Publication of the *ILO Code of practice on HIV/AIDS and the world of work*
2002	Global Fund to Fight AIDS, Tuberculosis and Malaria established
2003	"Three by Five" plan announced - goal to get 3 million people on treatment by 2005
2003	Joint declaration by ICFTU and International Organisation of Employers: 'Fighting AIDS Together'
2005	UN General Assembly Resolution on Universal Access
2006	*Political Declaration on HIV/AIDS* adopted by the UN
2006	*International Guidelines on HIV/AIDS and Human Rights* (Consolidated Version) agreed
2008	Funding available for HIV/AIDS responses reaches US$ 10 billion - one million more people start treatment, five million in total by 2009
2010	Approval of ILO Recommendation no. 200 Concerning HIV and AIDS and the World of Work

2.2 Legal and policy framework for the global response to HIV/AIDS

In many countries, the consequences of HIV/AIDS have been to set back decades of development efforts. The international community has increasingly linked HIV/AIDS targets and programmes with other strategies for poverty reduction and development, as well as creating a specific agenda for HIV/AIDS.

The Millennium Development Goals

The Millennium Development Goals (MDGs) are common goals for the entire UN system and its member States, agreed at the Millennium Summit in September 2000. They address core development issues such as poverty, education, gender inequality and health. MDG 6 is to "combat HIV/AIDS, malaria and other diseases". The target is "to have halted by 2015 and begun to reverse the spread of HIV/AIDS".

The eight goals represent a partnership between the developed countries and the developing countries "to create an environment - at the national and global levels alike - which is conducive to development and the elimination of poverty." The MDGs are particularly important because international development assistance is focussed on trying to achieve them. Several donor countries specify that their international development cooperation programmes must be seen as contributing towards the MDGs. Regular progress reports are issued by the UN.

For more information, consult

- http://www.undp.org/mdg/

Millennium Development Goals

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development.

Together Achieving the Millennium Development Goals by 2015

UN General Assembly Special Session on HIV/AIDS (UNGASS)

This vital meeting in June 2001 captured the urgency of the situation:

the global HIV/AIDS epidemic, through its devastating scale and impact, constitutes a global emergency … which undermines social and economic development throughout the world and affects all levels of society – national, community, family and individual.

It resulted in some 189 member States adopting a **Declaration of Commitment on HIV/AIDS**, which identified five priorities:

- *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 healthcare systems; and the commitment of new money.

The full text of the UNGASS declaration can be found at

- http://www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html.

Countries are required to submit progress reports every two years to the UNAIDS Secretariat which produces a Global Report. The UNAIDS website also has the individual reports submitted by countries:

- http://www.unaids.org/en/KnowledgeCentre/HIVData/CountryProgress/2007CountryProgressAllCountries.asp

The 2010 Global Report, based on data from 182 countries, shows that at least 56 countries have either stabilized or achieved significant declines in rates of new HIV infections. New HIV infections have fallen by nearly 20% in the last 10 years, AIDS-related deaths are down by nearly 20% in the last five years, and the total number of people living with HIV is stabilizing.

UNGASS recognized the special importance of action in the **world of work**. UN member states committed themselves to:

- *By 2003, develop a national legal and policy framework that protects in the workplace the rights and dignity of persons living with and affected by HIV/AIDS and those at the greatest risk of HIV/AIDS, in consultation with representatives of employers and workers, taking account of established international guidelines* (Paragraph 69)

- *By 2005, strengthen the response to HIV/AIDS in the world of work by establishing and implementing prevention and care programmes in public, private and informal work sectors, and take measures to provide a supportive workplace environment for people living with HIV/AIDS (Paragraph 49).*

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

The Declaration of Commitment was reaffirmed in 2006, when the *Political Declaration on HIV and AIDS* was adopted by the General Assembly, and recognized "that HIV/AIDS constitutes a global emergency and poses one of the most formidable challenges to the development, progress and stability of our respective societies and the world at large, and requires an exceptional and comprehensive global response."

Universal access

The global community, through a UN General Assembly resolution adopted on 23 December 2005 and the Political Declaration on HIV and AIDS adopted in June 2006, committed itself to significantly scale up its response to AIDS towards the goal of universal access to comprehensive prevention, treatment, care and support by 2010.

If the world is to achieve the MDG on HIV/AIDS (to have halted and begun to reverse the spread of the epidemic by 2015), people will require far greater access to HIV prevention and AIDS treatment, care and support than is currently available. The concept of "universal access" succeeded the "Three by Five" campaign which aimed to have 3 million people on treatment by 2005.

Universal access is a commitment to making sustained progress towards a high level of coverage for the most effective interventions needed. The workplace is in a strong position to contribute to universal access, and to the essential aspect of protection of rights.

Universal access does not imply that there will be complete take-up by all individuals of every HIV prevention, treatment, care and support intervention. But countries have committed to setting targets for access and reporting on these

Booklet 3 goes into more detail on the pillars of universal access and how trade unions can help their countries achieve it.

Trade union advocacy campaign on universal access and the G8

The G8 group of countries, the largest industrialized economies (USA, Japan, Germany, France, UK, Italy, Canada and the Russian Federation), made a commitment at their meeting in 2005 to fund universal access. In 2007, the leaders of the G8 pledged to spend US$ 60 billion over the following few years on HIV/AIDS, malaria and TB. Trade unions have run a campaign since 2006 to ensure accountability on these promises through pressuring the G8 to put in place a follow-up mechanism to monitor progress.

The 'Three Ones'

These are a set of principles for the most effective and efficient use of resources and the coordination of national AIDS responses, including UN and donor contributions:

- One agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners.
- One national AIDS coordinating authority, with a broad-based multi-sectoral mandate.
- One agreed country-level monitoring and evaluation system.

This principle is fine, as long as the 'national AIDS coordinating authority' includes representation from workers' organizations and the world of work. Trade unions may find that these bodies are dominated by government and NGOs, but should assert their right to participate.

2.3 Agencies and institutions

The broad international policy framework is clear:

- the MDGs - the UNGASS Declaration - 'universal access' - the 'three ones'.

National organizations

How is it all going to happen? There is a confusing collection of policies and agencies dealing with HIV/AIDS. This brief overview starts at the national level.

At national level, there should be - in accordance with the principle of the 'three ones' - a single co-ordinating body for HIV/AIDS. This may be placed in the Ministry of Health or in the President's or Prime Minister's office. It might have a name like National AIDS Control Organization or National AIDS Council.

One problem is the lack of representation from labour or the world of work in these institutions. Trade unions should be represented.

There are also many civil society organizations active around HIV/AIDS, that is groups that have not been set up or run by government. These might be community-based organizations, faith groups or specialist health organizations. Sometimes these have very good links with trade unions, like the Treatment Action Campaign (TAC) in South Africa which campaigned for ARVs to be made available. Often NGOs have limited understanding of trade unions, are not aware of their track record and do not understand their potential as allies - both sides need to build bridges.

International organizations

UNAIDS: the Joint United Nations Programme on HIV/AIDS

In 1996, the Economic and Social Council (ECOSOC) of the United Nations approved the creation of a joint UN programme on HIV/AIDS, originally made up of six cosponsoring agencies, plus a Secretariat in Geneva. In 2001 the ILO became the eighth cosponsor of UNAIDS; there are now ten UNAIDS cosponsors.

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. UNAIDS produces the regular updates on the epidemic, and best practice in the areas of surveillance, prevention, care and support.

Financial and technical assistance

Bilateral (country to country) and multilateral assistance - including the Global Fund to Fight AIDS, TB and Malaria - has been important in the development of internal and national AIDS programmes. Some private foundations, such as the Bill and Melinda Gates Foundation, and NGOs, such as Oxfam, are also significant international players. For more information on donors see Booklet 5.

2.4 The role of the ILO

The International Labour Organization is the UN specialized agency which deals with the world of work and related social issues. Its main aims are to promote rights at work, encourage decent employment opportunities, enhance social protection and strengthen dialogue in handling work-related issues. This is known as the Decent Work Agenda.

See http://www.ilo.org/global/About_the_ILO/Mainpillars/WhatisDecentWork/index.htm.

The ILO is unique in that it has a tripartite structure, working with and through three partners - governments, employers and workers. Each member State sends four delegates - two representing government and one each representing employers' and workers' organizations - to the International Labour Conference, which meets every year. The ILO Governing Body is composed in the same way. See: http://www.ilo.org/global/About_the_ILO/lang—en/index.htm.

What does ‘decent work’ mean, and how does it relate to AIDS?

Work is central to people's well-being and the main route out of poverty. In addition to providing income, work paves the way for greater social and economic participation, strengthening individuals, their families and communities. Decent work is work that delivers a fair income, that respects the rights of workers, and that provides equality of opportunity and treatment for all.

Mary Robinson, former UN High Commissioner for Human Rights, said at a conference on the Social Determinants of Health, “Decent work can have a powerful impact on health and health equity. It has the potential to redress gender and other social inequalities as well as contribute to financial security and personal development.” In relation to HIV/AIDS, the Decent Work Agenda promotes action against workplace discrimination and for the provision of vital information, education and care for working people.

Why is the ILO involved?

The ILO is involved in the response to HIV/AIDS because the epidemic has a huge impact on the world of work. It is a challenge to economic growth, social justice and basic rights, and threatens the goal of decent work. At the same time, the workplace is an ideal forum for prevention, care and the protection of rights.

- *Over 33 million people are living with HIV/AIDS. Nine out of every ten are adults in their productive and reproductive prime.*
- *HIV/AIDS threatens the livelihoods of many workers and those who depend on them - families, communities and enterprises. In doing so, it also weakens national economies.*
- *Discrimination and stigmatization against women and men with HIV threaten fundamental principles and rights at work, and undermine efforts for prevention and care. (ILO/AIDS website)*

2.5 HIV/AIDS and the world of work

A. DIRECT COSTS	B. INDIRECT COSTS
1. Benefits • Health care/insurance • Pension fund • Death benefit payable to the deceased's family • Funeral expenses incl. transport	**1. Absenteeism** due to • Sick leave/ other leave (formal and informal) taken by sick employees • Attending funerals • Caring for dependants with AIDS
2. Replacement • Costs of advertizing • Administration & staff time spent interviewing and selecting candidates • Productivity losses due to vacant posts • Costs of retraining new employees (incl. lost output during training – supervisors as well as trainees) • Accidents caused by inexperienced employees	**2. Reduced productivity and profitability** related to untreated sickness • Reduction in average levels of skill, performance, institutional memory and experience of employees • Managers' and supervisors' time responding to workplace impacts • Reduction in morale and motivation • Disruption of schedules and work teams • Falling productivity and reduced profits result in less investment as well as less tax income for the state
3. Management time	**3. Suppliers and customers** • Disruption in the supply chain (incl. transport companies & other suppliers of goods and/or services) • Reduced purchasing power in the community and/or changing market demand
4. Litigation associated with claims for benefits or claims of unfair dismissal	

The ILO has a special place in national efforts against AIDS and the achievement of universal access because of its links with the workplace, the active population and the social partners:

- a tripartite structure, so it can mobilize the networks and contacts of governments, employers and workers in 182 countries
- direct access to the workplace, where programmes promote prevention, combat discrimination, provide care, support and treatment (or referral to public services)
- long experience in protecting the rights of workers, opposing discrimination, and improving occupational safety and health
- a global network of field offices, experience in technical cooperation, and capacity for research and information dissemination.

Action on HIV/AIDS

The International Labour Conference adopted a resolution on HIV/AIDS in June 2000. A dedicated unit, the ILO Programme on HIV/AIDS and the World of Work (ILO/AIDS), was established in November 2000.

In May 2001, a tripartite group of experts from all regions finalized the draft of a *Code of practice on HIV/AIDS and the world of work*, and this was approved by the Governing Body of the ILO in June 2001. The Code sets out fundamental principles and practical guidelines from which concrete responses to HIVAIDS can be developed at enterprise, community and national levels. It has been translated into 60 languages to date, most of them available on the ILO/AIDS website (www.ilo.org/aids) - see Booklet 2 for more information on the ILO Code of practice and Booklet 3 for information on ILO/AIDS.

2.6 A final reflection

We are starting to win against HIV and AIDS!

HIV has been with us now for nearly three decades and we know what to do about it. The science exists to prolong the lives of those infected. It is now a matter of the resources and the political will to make sure the lessons are applied at national, industry and enterprise level. Trade unions have a vital role to play.

And campaigns do work. More resources are being devoted to the global response to HIV and AIDS, though there are fears of cutbacks in the wake of global recession.

- The annual number of new HIV infections declined from three million in 2001 to 2.6 million in 2009, according to the UNAIDS *Global Report 2010*. Over this period, the rate of new HIV infections stabilized or decreased by more than 25 in at least 56 countries around the world, 34 of them in sub-Saharan Africa. Four of the five countries with the largest epidemics in the region —Ethiopia, South Africa, Zambia and Zimbabwe—have reduced rates of new HIV infections by more than 25, while Nigeria's epidemic has stabilized.
- The percentage of people living with HIV has been stable since 2000, although the overall number has increased as HIV treatments extend life.

- As treatment access has increased over the last ten years the annual number of AIDS deaths has fallen – nearly a fifth lower in 2009 than in 2004.
- The number of people with access to treatment has risen. Approximately 5.2 million people accessed ARVs in 2009, compared to 700 000 in 2004, with an additional 1.2 million people receiving treatment in the last year alone.
- In 2007, the price of life-saving first line drugs fell below US$100 per person per year for the first time (a reduction by half since 2003).
- Globally, coverage for services to prevent mother-to-child HIV transmission rose from 10 per cent in 2004 to 45 per cent in 2008.
- New infections among women have stabilized, though they are higher among young women. Globally, the percentage of women among people living with HIV has now remained stable at 50 per cent for several years.
- Among young people in 15 of the most severely affected countries, the rate of new HIV infections has fallen by more than 25, led by young people adopting safer sexual practices.
- Condom use and availability have increased significantly. Eleven countries—from Burkina Faso to India and Peru—report more than 75 per cent condom use at last higher-risk sex.
- There has been encouraging progress in the implementation of integrated HIV and TB interventions in Africa.