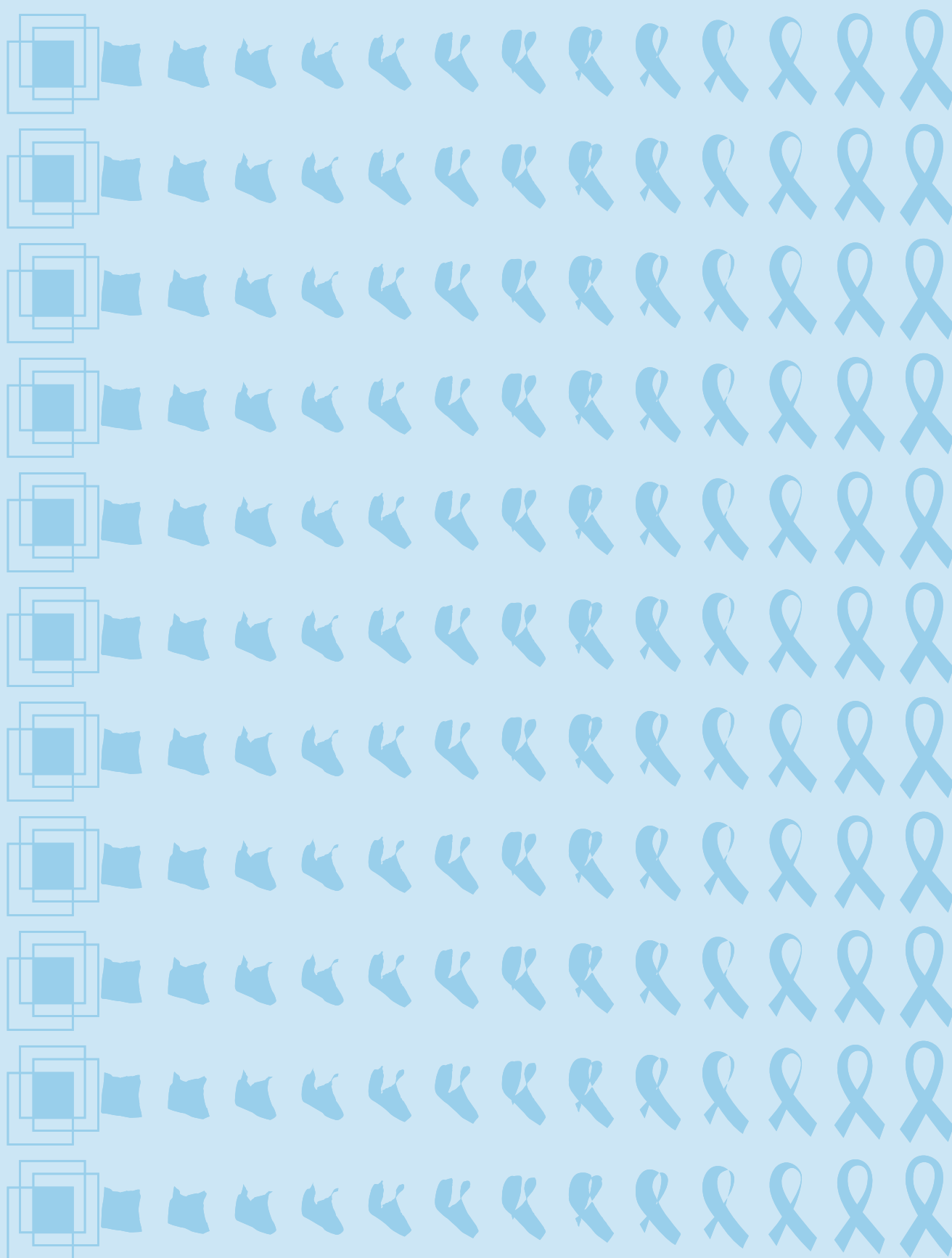


HIV/AIDS and work

in a globalizing world 2005



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In 2004, the ILO produced global estimates of the impact of HIV/AIDS on workers and working-age populations. The estimates were based on the most recent data on global population and HIV prevalence in countries affected by the HIV/AIDS epidemic available from the United Nations and UNAIDS. The ILO plans to renew these estimates on the basis of new population and HIV prevalence data, expected in 2006.

In the interim, this 2005 report by the ILO Global Programme on HIV/AIDS and the World of Work (ILO/AIDS) is designed to document a range of topics at the intersection of the HIV/AIDS epidemic and the process of globalization. They include issues often raised in reactions to the reports: *HIV/AIDS and work: global estimates, impact and response 2004* of ILO/AIDS and *A Fair Globalization: Creating opportunities for all* of the World Commission on the Social Dimension of Globalization, both published by the ILO in 2004.

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Acronyms

AIDS	Acquired immunodeficiency syndrome
ARV	Antiretroviral drugs, therapy or treatment
ASEAN	Association of Southeast Asian Nations
BIMCO/ISF	The Baltic and International Maritime Council/International Shipping Federation
CARAM	Coordination of Action Research on AIDS and Mobility
CBO	Community based organization
CEACR	Committee of Experts on the Application of Conventions and Recommendations
CHR	The Commission on Human Rights
CIVI	Centre d'Information pour le Volontariat International
COMEDS	The Committee of the Chiefs of Military Medical Services in NATO
CRC	Convention on the Rights of the Child
CSR	Corporate Social Responsibility
DPKO	UN Department of Peacekeeping Operations
ECOSOC	The United Nations Economic and Social Council
ECPAT	Ending Child Prostitution in Asian Tourism
EMBO	European Molecular Biology Organization
EPZ	Export-processing zone
FAO	Food and Agriculture Organization of the United Nations
FDI	Foreign direct investment
GBC	Global Business Coalition on HIV/AIDS
GDP	Gross Domestic Product
GHI	Global Health Initiative
GTT	Global Task Team
HIPC	Heavily Indebted Poor Countries
HIV	Human immunodeficiency virus
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICFTU	International Confederation of Free Trade Unions
ICSW	International Committee on Seafarers' Welfare
IH & RA	International Hotel and Restaurant Association
ILC	International Labour Conference
ILO	International Labour Organization
ILO/AIDS	ILO Global Programme on HIV/AIDS and the World of Work
IMF	International Monetary Fund
IOM	International Organization for Migration
IPEC	International Programme on Elimination of Child Labour
IPU	International Parliamentary Union

ITF	International Transport Workers' Federation
M&E	Monitoring and evaluation
MAP	World Bank's Multi-Country HIV/AIDS Programme
MDG	Millennium Development Goals
MNE	Multinational enterprises
MTEF	Medium Term Expenditure Framework
MTN	Multilateral Trade Negotiations
NATO	North Atlantic Treaty Organization
NEPAD	New Partnership for Africa's Development
NGO	Non-governmental organization
OECD/DAC	Organisation for Economic Co-operation and Development/ Development Assistance Committee
OHCHR	Office of the UN High Commissioner for Human Rights
PCV	Peace Corps Volunteers
PEP	Post-exposure prophylaxis
PEPFAR	The President's Emergency Plan for AIDS Relief
PHEIC	Public health emergency of international concern
PPP	Purchasing power parity
PRSP	Poverty reduction strategy papers
SADC	Southern African Development Community
SARS	Severe Acute Respiratory Syndrome
SHARE	Strategic HIV/AIDS Responses by Enterprises, a project of USDOL & ILO/AIDS
SHIP	Seafarers' Health Information Programme
SIDA	Swedish International Development Agency
STI	Sexually transmitted infection(s)
TB	Tuberculosis
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNAMSIL	United Nations Mission in Sierra Leone
UNCTAD	United Nations Conference on Trade and Development
UNDP	United Nations Development Programme
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly in Special Session
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNV	UN Programme for Volunteers
USDOL	United States Department of Labor
VTC (or VCT)	Voluntary Testing and Counselling (or Voluntary Counselling and Testing)
WCSDG	World Commission on the Social Dimension of Globalization
WHO	World Health Organization
WTO	World Tourism Organization
WTO	World Trade Organization

Executive Summary

HIV/AIDS is now a global crisis. It knows no frontiers and is present in every country of the world. Everywhere, also, older adolescents and adults work to earn their livelihoods and care for their families and loved ones, and therefore the epidemic is a threat to individual workers globally. At the same time, poverty pushes workers to migrate in search of a better life, to move in search of work, or to be mobile for their work. In a globalizing world, mobility is made easier, and the probability that people will move is heightened. So, in many places, is the probability that they will be poor, and it is in this way that the risk of HIV/AIDS accompanies globalization.

Nevertheless, globalization also helps in the struggle against HIV and AIDS. Awareness, knowledge, and the global marketing and sales of condoms and of antiretroviral drugs are the major axes of response to the epidemic, and they rely on the globalization of communications, of information, of technology, and of the economy.

This report explores trends in economic globalization, poverty, and human movement, and their interrelations; appraises their impact on the HIV epidemic; and examines how HIV/AIDS in turn affects them. It considers, for example, the ways in which AIDS exacerbates poverty, worsening its critical link with ill-health and threatening prospects for global sustainable development.

An important link between poverty and HIV/AIDS is illustrated by the influence of the epidemic on investment for economic growth and development. Building on earlier research that measured the negative impact of HIV/AIDS on the rate of growth of GDP and GDP/capita, this new ILO research shows that for 50 affected countries worldwide, each year of life expectancy lost due to HIV/AIDS is associated with a loss in foreign direct investment (FDI) that averages 2 per cent. In addition, the lower the level of life expectancy, the more foreign direct investment is forfeited. In countries where life expectancy has in fact decreased substantially due to HIV/AIDS, the loss in average foreign investment inflows is disproportionately large. The region most affected is Sub-Saharan Africa, where FDI

inflows are already 0.7 per cent less on average per country when compared to any country outside the region at the same level of social and economic development.

The relationship between poverty and HIV/AIDS makes it possible to estimate populations at risk of HIV due to poverty by estimating the proportions of those populations that are poor at each level of HIV prevalence. Three major poverty indicators are used - income inequality; the share of income going to the poorest 10 and 20 per cent of the population; and the poverty headcount index (or proportion of the population living under an agreed international poverty line). They show, as expected, that greater inequality and greater poverty are found where HIV prevalence is higher. The relationship is stronger, furthermore, in Sub-Saharan Africa, where income inequality rises systematically with the HIV prevalence and HIV/AIDS explains over 40 per cent of the variance in income inequality.

Based on these links between poverty and HIV/AIDS, the ILO estimated the population of young women at risk in 30 countries affected by the epidemic, in three steps. First, the poverty headcount was applied to the total populations of young working-age women (15 to 24 and 25 to 29 years) to determine the numbers who are at risk because they are poor. Second, the urbanization rate was applied to the numbers of poor young women to distinguish the proportion living in urban areas. Third, the numbers of poor, urban young women at risk of HIV were estimated by applying the HIV prevalence for women 15 to 24 years in the capital city - a rate that is estimated at regular intervals by UNAIDS and WHO to update the national HIV prevalence estimate.

In this way, estimates of young women at risk of HIV were assessed for 34 countries in Sub-Saharan Africa, Asia, Latin America and the Caribbean, and countries of the more developed regions. These estimates suggest that:

- in Sub-Saharan Africa, 1 in 4 (12-13 of 52 million) youngest women of working age

(15 to 24 years) may be at risk of HIV because they are urban and poor, and

- 1 in 7 (7- 8 million) may be at *great* risk due to poverty.
- In Asia, 1 in 7 (31 of 213 million) youngest women of working age may be at risk of HIV due to poverty, and
 - 1 in 18 (12 million) may be at *great* risk.
- In Latin America and the Caribbean, over 1 in 6 (4 of 26 million) women 15 to 24 years may be at risk of HIV due to poverty, and
 - 1 in 19 (1.4 million) may be at *great* risk.
- In the 3 countries from the developed regions, 1 in every 11 young women (1.4 of a total of 16 million young women of working age) may be at risk as a result of poverty, and
 - 1 in 64 (about 250,000 young women) may be at *great* risk.

In sum, over 49 million young working-age women aged 15 to 24 years living in urban areas may be at risk as a result of poverty in the 34 countries for which data are available, and 21 million among them may be at *great* risk. Overall, for all 34 countries, one in every 6 young women - altogether 16 per cent - are potentially at risk of HIV because they are among the poorest populations of their countries.

Similarly, 16 per cent of young working-age women 24 to 29 years living in urban areas may be at risk of HIV due to poverty in the same 34 countries. Overall, over 20 of 131 million young urban women 24 to 29 years are at risk, and about 8.5 million may be at *great* risk. In Sub-Saharan Africa, 1 in every 4 women 24 to 29 years may be at risk.

The risk of HIV/AIDS is transmitted locally and globally as people meet, establish new relations, and then part ways. The movement making this possible - individually or in groups - has expanded in recent times, and in this way the HIV epidemic is influenced by many of the aspects of economic globalization.

The report reviews and discusses the characteristics and consequences of three types of movement in relation to work: movement in the search for work and in the course of work, and movement associated with the travel and leisure industries. People who move in search of work may often be young, as are people who move as part of their work, and people who work in the travel and leisure industries, or who travel themselves. The groups comprising the populations that move each have distinct attributes, but young persons who move share a number of characteristics: they are often outside their usual frame of reference, cultural norms and social constraints; circumstances compel them to consider - or encourage openness to - new experiences; and they have either not yet established families and are single, or spend long periods away from their families or partners. These characteristics tend to be associated with a greater potential for the transmission of sexually transmitted infections and HIV.

In the context of globalization, the epidemic calls for management at national, enterprise, and global levels. At national level, there is a wide need to create an enlightened policy framework, and to ensure that national planning takes account of HIV/AIDS in programming across sectors, and in resource allocation. At the enterprise level, the need for workplace policies on HIV/AIDS is being addressed, but slowly; far more action is required across both developing and more developed regions. At global level, international legal instruments set a standard for national policies and are indicative of the actions required. Finally, the report also assesses a number of proposals that have been advanced recently, notably in regard to forms of global governance that respond to the global reach of HIV/AIDS; management of trade liberalization and debt relief in the context of HIV/AIDS; and considerations of antiretroviral treatment as a global public good.

Introduction

HIV/AIDS is now a global crisis. The earliest and most serious epidemics are in sub-Saharan Africa, where the disease has reduced life expectancy from over 60 years to about 45 years. Yet epidemics in Asia and Eastern Europe have now fully emerged and are growing rapidly; it is projected that by 2010 there will be more Asians living with HIV than Africans. The pandemic brings personal suffering and hardship to countless millions. Apart and beyond the enormous suffering inflicted, the pandemic is destroying development gains achieved over generations because it reinforces every problem that connects ill-health to poverty. Consequently, HIV/AIDS is a development crisis: it is a major threat to social and economic development and the single biggest obstacle to the attainment of the Millennium Development Goals, especially in Africa.

Economic globalization is a centuries-old process that is undergoing exceptional acceleration at this time. Building on the benefits of interdependence and of an increasingly interconnected world, modern globalization stresses material prosperity and comprises a set of changes that are largely voluntary and result from a collective will to alter economic relations between national entities in areas such as production, investment, trade and finance.

Ours is a critical but positive message for changing the current path of globalization. We believe the benefits ...[.]...can be extended to more people and better shared between and within countries, with many more voices having an influence on its course...We are certain that a better world is possible.

*World Commission on the
Social Dimension of Globalization,
2004*

At the same time, as an infectious, sexually transmitted disease, HIV/AIDS has become an epidemic because people meet, establish new relations, and then part ways¹, and the movement making this possible – people moving individually or in groups for reasons of curiosity, need, or desire for supremacy – is characteristic of the human species since its beginning. Historically human movement has often been a matter of political alliances and in extreme cases it has led to total absorption or imposition of an entire way of life. Nonetheless, it has always led, and is increasingly leading to exchanges in commerce or communication, and new social and economic partnerships of individuals and groups. Consequently, the HIV/AIDS epidemic is influenced by many of the aspects of economic globalization.

Human interchange has expanded in recent times for several reasons. There are more human beings living at one time on earth than before, creating more opportunities for interaction between human groups, with both good and bad outcomes. At the same time, mobility has been facilitated by progress in transportation, and as a result of advances in communications of all types, more is known about how others live, their differences and possible advantages, making travel and exchange more attractive, feasible, and unexceptional. Greater knowledge has increased curiosity, just as more opportunities for conflict have increased the need to move away from harm. The creation of nation states has given rise to national borders, slowing movement, hardening admission and fostering intolerance of foreigners, yet it has also given rise to systems of laws that protect individuals and regulate behaviour.

The worldwide transmission of AIDS itself can be viewed as part of the process of globalization, through the impact of globalization on the increased movement of people. At the same time, globalization creates opportunities for the accelerated development of life-extending drugs and technologies to tackle HIV/AIDS and other infectious diseases. In a globalizing world where HIV/AIDS is a factor, education, opportunity and relative

affluence have brought information and understanding, means of prevention, and access to care and treatment to the majority of populations living in the developed countries and to a handful of developing countries. Together, these conditions have served to reduce transmission and the incidence of new cases as well as to mitigate cumulated effects. In due course, as a result, HIV/AIDS has become a disease of poverty, as is the case for other forms of ill health. In developing countries and among poor populations in most regions of the world, the epidemic continues to gain ground and to waste lives. Increasingly, the groups at greatest risk are the poor because populations living in poverty do not have the basic education and information that enable them to engage in effective preventive actions. Another reason is that people who experience poverty are more likely to resort to desperate behaviours and to accept work that is dangerous, disgusting or degrading – which includes sex work - in order to survive.

Certain groups of people are more exposed to the risk of HIV. Data on HIV prevalence indicate that it is rising fastest in young adults, aged 15 to 29 years, especially girls and young women, and this is most particularly the case in regions of Africa. These

are the young entrants into the working-ages and the world of work. Similarly, they are the persons of working-age who are most likely to move in search of work, whether to towns and cities, neighbouring countries, or overseas, because they are young, they are hopeful, and they want to work.

These persons of working-age are not only the population group most exposed to HIV/AIDS, but also those who continually renew the single most important human capital asset of any nation or economy – its economically active population. Economically active adults are the spine of economic growth and sustainable development.

In this report, we explore these three trends – economic globalization, poverty, and human movement in relation to work - and their interrelations, appraise their impact on HIV/AIDS, and examine how HIV/AIDS in turn affects them. We will see in what ways the period of rapid economic globalization has coincided with the expansion of the HIV epidemic, and through what pathways HIV/AIDS exacerbates poverty, worsening the critical link between poverty and illness and threatening the prospects for global sustainable development.

Main tables

Following the report, Main table 1 displays the working-age population and labour force by sex for persons aged 15 to 49, 15 to 24 and 25 to 29 years as well as the most recent HIV prevalence rate for the 64 countries that are reported by the United Nations in 2005 as affected by HIV/AIDS, either because the HIV prevalence is greater than 1 per cent or because the country has a population of persons living with HIV/AIDS that is 1 million or greater.

Main table 2 displays the estimates of numbers of young, urban, working-age women who live in poverty and are at risk of HIV at any time in the 34 countries across the world for which the data were available to calculate that risk. The methodology and the basis for the estimates are described in the section *Global estimates of persons at risk of HIV due to poverty* (see page 17 et seq.).

HIV/AIDS and economic globalization

The global transmission of HIV/AIDS for the past two decades has coincided with the current period of rapid economic globalization – a process spearheaded by liberalization of international trade and financial transactions. Trade liberalization has resulted in increased flows of goods and services across national borders, as well as an increase in the movement of people. In the context of a truly integrated global economy, freer trade between nations would lead to improved allocation of resources and consequent gains in labour productivity and enterprise efficiency. This in turn would promote economic growth and sustainable development everywhere. Yet trade liberalization is a contentious aspect of globalization.

Trade liberalization has been blamed for ills such as rising unemployment and wage inequality in both developing and developed countries, an increase in the exploitation of workers in developing countries in respect of both employment conditions and failed labour standards, resulting in increased economic insecurity and diminished social protection for workers, the marginalization of low-income countries that produce primary commodities, increased poverty and global inequality. It has been argued that the general experience of least developing countries is that trade liberalization has harmed economic growth and development. To date, a handful of developing countries, including China, India and some ASEAN² states, are showing evidence of the potential of economic liberalization and globalization to promote growth and reduce poverty.

The biggest failure of the current model of globalization is that, in too many places, it is not producing the level of work families need to achieve a decent quality of life in their own communities.

*Juan Somavia, Director-General of the ILO,
on the occasion of the International Day
for the Eradication of Poverty,
2005*

In contrast to China and India, the economies of some countries in sub-Saharan Africa highly affected by HIV/AIDS are poorly integrated into the world economy as well as being poor. The absence of beneficial economic links with the global economy reduces the prospects for poor countries to take advantage of the opportunities created by globalization. Furthermore, in cases where countries have succeeded in breaking into global markets and this has generated growth in the sector concerned, a lack of linkages between sectors in the domestic market has prevented the benefits of globalization from wider diffusion in the economy and from reaching the poorer segments of the population. At the same time, it is increasingly clear that the inability of poor countries to benefit from the complex process of globalization under existing conditions is due to the same factors that limit their capacity to respond to HIV/AIDS. Without appropriate and timely interventions by institutions and policy-makers at international, regional and national levels, the benefits of rapid globalization will continue to by-pass poor and least-developed countries, depriving them of access to global markets for vital goods and services, as well as resources for antiretroviral and other drugs to treat AIDS and opportunistic infections.

For many poor countries, globalization has resulted in anxieties rather than expectations, and global risks rather than global opportunities. HIV/AIDS has increased these anxieties and risks.

Further barriers to controlling HIV and mitigating AIDS include the effects of heavy and unsustainable debt burdens carried by many poor countries. Repayments to creditors by some of the poorest countries in the world are using resources needed to respond effectively to current direct and indirect costs of HIV/AIDS, the burden of suffering, and the need to protect future generations. It is ironic that the epidemic continues to cause labour force losses and to erode growth in gross domestic product, while debt repayment

is taking precedence in the expenditure of resources over securing the economy and its future. Until recently, the willingness of resource-rich countries governments to tolerate this state of affairs has been an obstacle to fighting HIV/AIDS in heavily indebted poor countries. Recent moves toward effective debt relief following from the 2005 G8 Summit and the fall 2005 meeting of the World Bank and the IMF could in principle help to break the link between AIDS and poverty by releasing resources available for a concerted assault on both development problems.

There is now ample evidence that HIV/AIDS affects global economic growth and social equity, and that the epidemic is therefore a challenge to sustainable development, in particular efforts to reduce poverty and, paradoxically, control the transmission of HIV. In the short term, the economic and social burden imposed by HIV/AIDS undermines the achievement of sustainable development in poor countries through the income and output losses due to AIDS mortality. In the long term it causes depletion of human capacity as younger generations fail to achieve the skill levels of generations that die before they can fully transmit them.

The social dimensions of globalization and HIV/AIDS: the role of the ILO

Within the poor and less globally integrated developing countries, there are particular population groups, notably migrants, youth and women, who are at greater risk of HIV/AIDS. In many settings, these groups who were already living in poverty may become increasingly more exposed to conditions of poverty and of social exclusion. This is the fundamental reason that the ILO attaches a high priority to the social dimensions of globalization in its agenda for a fairer outcome of the globalization process. The potential of globalization to worsen the plight of populations in particular circumstances and particular settings runs counter to the ILO's values and principles with respect to social justice.

The ILO's concern with the social dimensions of international development and globalization was expressed by the Organization at the *World Summit for Social Development* held in Copenhagen a decade ago, in 1995. Focusing on the theme of "social progress" as an important development goal, the ILO's position emphasized the central role of employment in economic and social policy, and addressed the key issues of employment security and rights at work. It underscored how the attainment of employment goals could serve to reduce poverty and overcome social exclusion, both of which are inputs identified by the ILO as critical to controlling HIV/AIDS in the world of work.

The *Copenhagen Declaration on Social Development* and the ten *Commitments* of the *Copenhagen Programme of Action* gave clear recognition to fundamental aspects of the ILO's core mandate, in particular the links between employment, poverty reduction and social integration. Today these issues are central to the current debate on globalization and social justice.

Since 1995, the ILO took important steps to give practical significance to the *Commitments* made at Copenhagen. Foremost among them is the 1998 "Declaration of Fundamental Principles and Rights at Work" that rests on a number of ILO Conventions and reaffirms the universality of international labour standards. This Declaration provides the basis to address the social dimension of globalization in the context of the world of work. The period since has also seen the emergence of the binding and enforceable rules of the World Trade Organization (WTO) in regard to liberalization of international trade and related issues. As the WTO rules are generally more enforceable than other forms of international standards and obligations, their coexistence with the application of international labour and human rights standards can sometimes give rise to conflicts between the two types of agreements regulating the outcomes of the process of globalization. In the case of HIV/AIDS, for example, conflict has arisen with respect to access to antiretroviral drugs for workers living with AIDS.

International labour standards

A potentially important component of the governance of globalization is implementation of fundamental labour standards. The ILO views this as a requirement for fair globalization, particularly in regard to the impact on labour markets of continued expansion of international trade. The link between labour standards and trade has long been a subject of contentious debate. Some claim that linking international trade with labour standards is a form of disguised protectionism and an unnecessary interference with the working of global markets. Others argue that in view of the rapid expansion of world trade, it is necessary to apply international labour standards universally as a means of promoting fair competition, facilitating efficient operation of labour markets, and protecting workers' rights.

The ILO regards the implementation of global labour standards as necessary to ensure that workers in poor countries are able to share in the benefits of globalization. The organization advocates measures to promote and monitor implementation of fundamental labour standards. Core ILO Conventions relevant to the protection of workers' rights in an era of globalization address prohibition of forced labour and child labour, freedom of association and the right to organize and bargain collectively, equal remuneration for men and women for work of equal value, and non-discrimination in employment. The ILO's tripartite constituents conceive these core Conventions to comprise a set of fundamental human rights that can serve as a standard for the exercise of workers' right in an era of globalization.

The ILO's *Declaration on Fundamental Principles and Rights at Work* incorporates a number of core ILO Conventions on basic workers rights, including non-discrimination in employment and employment security that have implications for the management of HIV/AIDS in the world of work. Some key principles of the *ILO Code of Practice on HIV/AIDS and the world of work*, notably non-discrimination in employment and access to health and safety at work, are based on core ILO conventions. Although the Code itself is not legally binding, those deriving from Conventions constitute an obligation on the part of countries. The ILO and its tripartite constituents now have global experience in implementing the Code which provides valuable lessons for the management of the epidemic in the context of the world of work in countries with limited experience and resources to develop their own policy and programme guidelines. International standards and codes serve to promote adoption of good practices.

The rapid globalization of world production and the need to be internationally competitive have increased the scope for violation of labour standards. The promotion of core labour standards and improvements in ILO supervisory mechanisms can serve to counter a downward spiral in labour standards.

Over and above the loss of labour and human capital, there is a range of immediate costs associated with diagnosing and treating HIV and related opportunistic illnesses, and with long-term, terminal care.

It has become clear, therefore, that globalization itself can radically change the conditions under which economic and social development are being realized. Many of the countries too poor and marginalized to benefit from globalization are the same ones that are overwhelmed by the HIV/AIDS epidemic. These countries are not able to access the gains

of globalization under existing conditions, nor to benefit internally from financial stability or social progress. The epidemic and associated health and social problems in fact intensify poverty and reverse social progress or past development gains in these cases.

Whereas HIV/AIDS poses more of a development challenge to poor and less globally integrated countries than more globally integrated developing economies in terms of ability to cope with and manage HIV/AIDS, the difference is not solely due to economic performance. Not all aspects of the

capacity to fight HIV/AIDS at national level are determined by economic performance. There is a need to focus on the non-economic aspects of the interrelations between HIV/AIDS and globalization. An unique feature of HIV/AIDS is the wide range of causes and consequences associated with the epidemic that include cultural, political, and social factors in addition to its economic aspects. Consequently, also, the interventions found to be effective for controlling the epidemic are similarly of a multidimensional

nature. As a result, from a public policy standpoint, it is important to understand the developmental origins of HIV/AIDS in structural conditions of poverty, income inequality and gender inequity, because they are determinants of the epidemic and produce the conditions in which HIV is transmitted. At the same time, also, it is these structural conditions that largely constrain the ability of countries to respond effectively to HIV/AIDS.

HIV/AIDS and economic growth: pathways of influence

Studies on the relationship between the prevalence of HIV/AIDS and economic growth suggest that the epidemic - through its effects on labour, on enterprise efficiency, and on costs to households and enterprises - slows the rate of GDP growth, which can worsen poverty and impede attainment of sustainable development.

The ILO has estimated that the average loss in the rate of growth of annual GDP due to AIDS between 1992 and 2002 was over 1 per cent in sub-Saharan Africa, which was equivalent to an average US\$9 billion per year shortfall for the 33 countries where loss of GDP was measurable and attributable to the disease (see Figure 1). If nothing changes, the economies of these 33 countries as a group will be 18 per cent less by 2020, representing a cumulative shortfall of US\$144 billion in lost growth due to HIV/AIDS. Paradoxically, aside from the lost opportunities this represents, the shortfall will also erode capacity to respond effectively to the economic and social burden imposed by the epidemic and to reduce poverty. As income declines and costs increase, governments and individuals are less capable to meet the requirements of healthcare.

Yet seen in the wider developmental context, the impact of income on health has a

major effect on the attained education and skill level of the labour force, and on labour productivity, which are strong justifications for investing in healthcare. A healthy and educated workforce can be a critical factor in attracting foreign direct investment and enhancing international competitiveness in global markets. Benefits from the economic growth engendered are abundant, as improvements in health that result from higher incomes also help to reduce poverty. To the extent that improvements in health status are disproportionately more beneficial to the poor than the general population, as they depend more on physical labour for income, the effects on poverty will be greater.

Health is a priority goal in its own right, as well as a central input into economic development and poverty reduction.

Amartya Sen, 1998

In the same way that poor health can be seen to inhibit economic growth, therefore, health improvements can make a difference and should comprise one of the primary benefits and opportunities created by globalization.

Growth rate impact of HIV, 45 countries, 1992–2002 (annual effect)

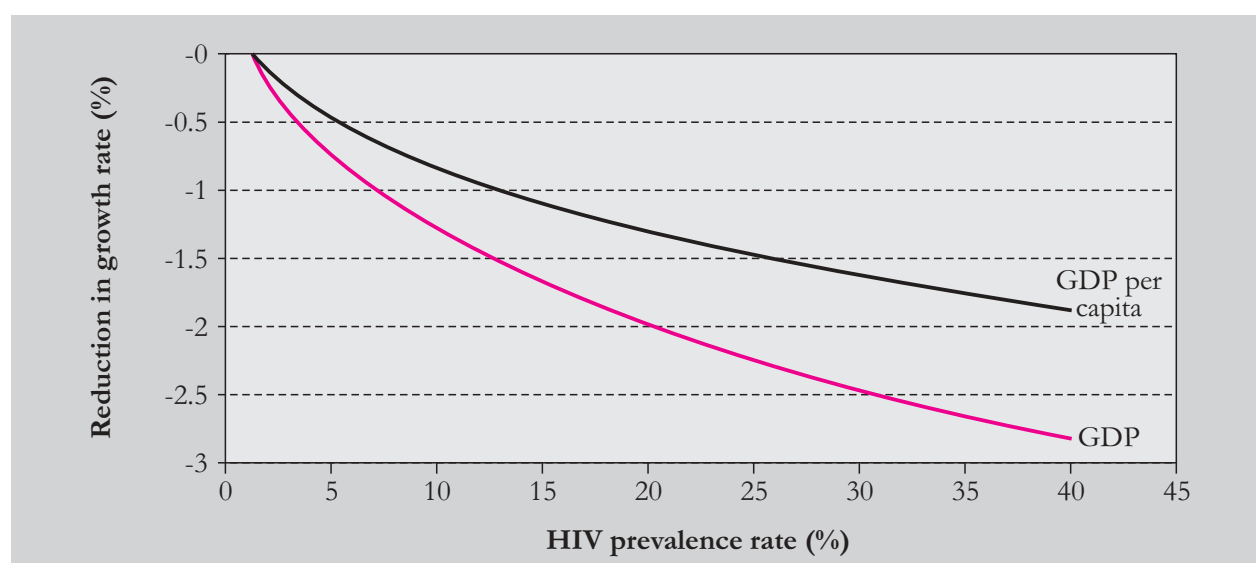


Figure 1

Source: ILO, 2004c

HIV/AIDS and investment for economic growth and development

Investment in general, and foreign direct investment (FDI) in particular, is an important tool for economic development and poverty reduction in developing countries. It can create employment opportunities for the local workforce, serve to transfer managerial skills and technology and generally boost the economy. It is a means to increase access to global markets. With rapid globalization and the liberalization of financial flows, competition for foreign direct investment has intensified, leaving the least integrated developing countries at a disadvantage. The process of locating investment in host countries can be impeded, furthermore, if the labour productivity of the local workforce is undermined by poor health. Healthy workers are physically and mentally more active and vigorous, are likely to be better educated, and are more productive and less likely to be absent from work.

Many forms of poor health affect the very young and the very old, for example infectious diseases of childhood and degenerative and chronic diseases of old age. HIV is a disease that mainly affects working-age persons. Aside from the abominable misery that it inflicts on individuals, the effects that it has on labour productivity and on the supply and quality of labour are highly detrimental to the economy.

Labour productivity is diminished in several ways: persons who become ill become increasingly less able to work at advanced stages of the disease; when skilled workers are lost, they may be replaced by less skilled workers, or new workers who need the time to acquire skills, and replacement workers may be brought in only sporadically to keep labour costs down. Overall, the disease increases the costs of doing business by raising absenteeism, introducing heavier labour costs for recruitment and training and increasing health expenditures, whether in terms of direct costs or insurance.

The supply of labour is evidently reduced by HIV/AIDS; by now a generation of workers has become ill and died. The ILO has estimated that a cumulative total of 28 million labour force participants were lost to the global workforce by 2005, and that 48 million will be lost by 2010 and 74 million by 2015 if nothing changes. At present (2005), nearly 3 million

persons of working-age die every year, and by 2015, 5 to 6 million working-age persons may die each year.

The number of workers lost to the labour force is, however, greater than the number of workers who die. Although workers who are HIV-positive are able to work for many years, the manifestations of the illness make them unable to work first sporadically and then increasingly until they are fully unable to work. As a result, there are at present more than 2 million workers who at any time are partially or fully unable to work as a result of HIV/AIDS.

It is not only the number of workers, but the quality of the workforce that is affected by HIV/AIDS and which contributes to declining labour productivity. The population in the working-ages comprises parents, mentors, employers and teachers, but they often die before fully transmitting their skills to younger workers, to apprentices and to their and others' children. The generation of children not only lose parental guidance and the transmission of life skills when their parents become ill and die, but also the valuable work skills that will permit them to earn their livelihoods. Even the transmission of subsistence survival skills is truncated, leaving orphans unable to learn to feed themselves.

Children in households and families affected by HIV/AIDS lose in other ways as well that influence the quality of future generations of workers. When adult income earners become ill, children are frequently removed from school to provide labour for care, domestic, or income earning activities. As a result, their education is truncated, which leaves them less equipped for life, and their society with a workforce that has a shortfall in the educational basis for skill development.

When the labour supply, its quality and potential productivity are diminished as a result of HIV/AIDS, these trends act to discourage foreign direct investment that is essential for economic development. Health and education are crucial components of human capital in determining foreign direct investments. Although the next section addresses health more directly, health and education are inextricably linked: education is an important input to health, and being healthy improves access to educational opportunities.

Perceived impact of HIV/AIDS on FDI according to HIV prevalence

HIV prevalence group (%)	Serious impact (%)	Some impact (%)	Minimal impact (%)
< 1	2	16	74
1 – 4	4	38	54
5 – 9	9	49	38
10 – 14	5	60	24
15 – 19	6	60	26
> 20	12	61	24

Table 1

Source: World Economic Forum, 2003-2004

The basis for FDI inflows in developing countries rests on two main reasons: first, to increase market size by serving a local market, and second to benefit from lower-cost inputs, notably labour. Foreign investors view a developing country as providing low labour costs for their production but are also attracted by the local market. In assessing the market, investors may take account of the entire region encompassing the country. This perception is aided by regional trade agreements and is especially important in cases where domestic markets are too small to justify several direct investments.

Health status of the workforce as a determinant of FDI

The population of a developing country is more likely to provide the needed labour inputs if healthy, and healthy populations with rising incomes are more likely to provide growing domestic markets for goods and services. Foreign investors recognizing the merits of good health and its positive impact on potential workers are more likely to invest in physical and financial capital in countries with relatively good health standards. In addition to seeing the impact of good health on worker productivity, foreign investors may avoid countries or regions where disease is prevalent and where access to health care is limited. Moreover, they may fear to imperil their own health and that of their expatriate employees.

Recently, outbreaks of Severe Acute Respiratory Syndrome (SARS) and cases of human avian ‘flu have renewed concerns over the relationship between health and macroeconomics. The outbreaks in China and

Hong Kong of SARS showed how disease - and even the fear of disease - can cause a significant drop in FDI in a relatively short period. Investment flows into China declined by US\$2.7 billion during 2003 and FDI into Hong Kong declined by 62 per cent. The decline in FDI did not last long, however, and the figures quickly returned to expected levels once the outbreak was controlled. These incidents suggest that in the absence of a rapid and early resolution of an emerging epidemic, the long-term effects would be to seriously dampen international investment or redirect it, and this would be the case for epidemics such as HIV/AIDS, malaria or tuberculosis (TB) in the developing countries where they are most prevalent.

An opinion survey of 7,700 business leaders from 103 countries conducted by the Global Health Initiative (GHI) of the World Economic Forum in 2003-2004 serves to illustrate the point. Respondents were asked if HIV/AIDS had affected access to FDI in the preceding five years in their countries. The results showed a direct relationship between the HIV prevalence level in the respondents’ country and the perceived impact of HIV/AIDS on FDI. Those in high prevalence countries were much more likely to respond that HIV/AIDS had a “serious impact” or “some impact” on FDI (see Table 1). In countries where the prevalence rate exceeded 20 per cent, three-quarters of the respondents perceived HIV/AIDS to have more than a “minimal” impact on their access to FDI. Another finding of the survey was that respondents from countries with a high prevalence of malaria and TB in Asia were more likely to report that the disease was having “some” or a “serious” impact on business operations.

Impact of HIV/AIDS on life expectancy at birth, 1970-2015

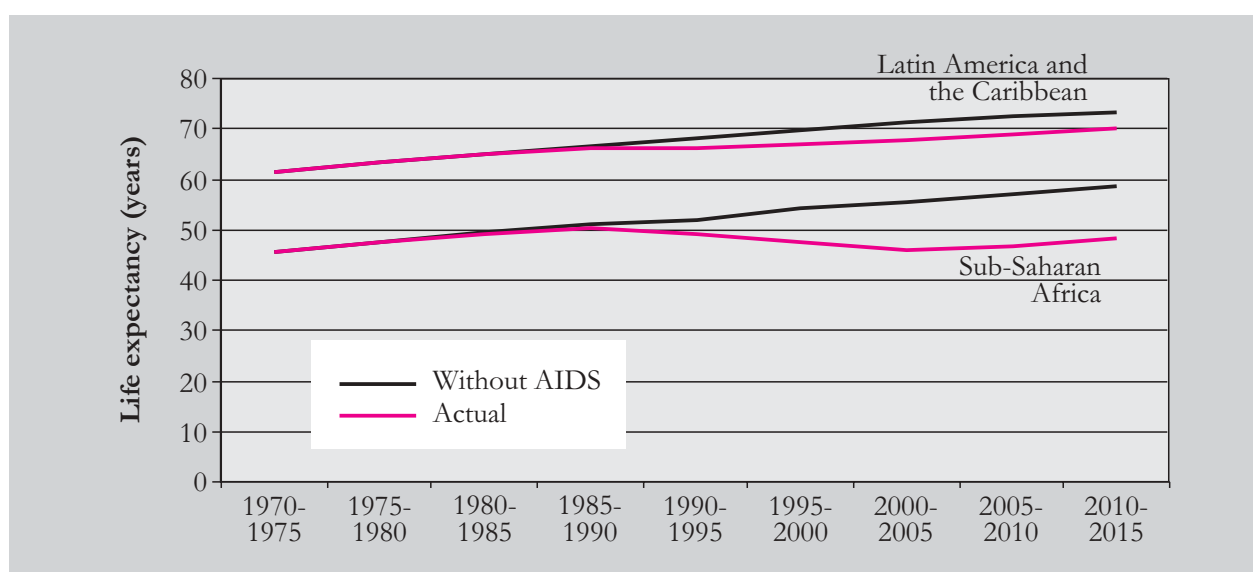


Figure 2

Source: United Nations, 2005a

Research supports the perceptions of the business leaders, and some researchers have gone so far as to argue that AIDS is squarely antagonistic to the twin rationales of globalization, namely the access to cheap labour and the opening-up and growth of new markets for goods and services.

One way to measure the impact of HIV/AIDS on the quantity and quality of labour is to look at its impact on life expectancy. Because HIV/AIDS is a cause of mortality, life expectancy and HIV/AIDS are very much correlated. In fact, the general historical trend of lengthening life expectancy in developing countries is being reversed by HIV/AIDS (see Figure 2). At present, average life expectancy in sub-Saharan Africa for 40 countries most affected by HIV/AIDS has fallen to 47 years, and would have reached 62 years in the absence of HIV/AIDS alone. The life expectancy in countries with HIV prevalence of 20 per cent or more is expected to be 22 years less in 2000-2005 and 29 years less in 2010-2015 due to AIDS. HIV/AIDS has had a similar although lesser impact in Latin America and the Caribbean: in the absence of AIDS in this region, average life expectancy for the 12 most affected countries would have been 72 years, but reaches only 69 years due to the epidemic.

A recent study of the effect on FDI of HIV/AIDS through life expectancy – that can be considered as a “health capital” and which is

heavily affected by HIV/AIDS – found that for 74 developing and developed countries, an additional year of life was associated on average with an FDI inflow that was on average 7 per cent greater. For the sub-sample of 51 low and middle income countries, one year higher life expectancy resulted in an increase in the FDI inflow of 9 per cent³.

Subsequently, the ILO estimated that for 146 countries with World Bank data on foreign direct investment, the correlation between FDI and life expectancy is high indicating that life expectancy is a major factor determining the level of foreign direct investment globally (see Figure 3).

To examine this relationship further, a model was developed at the ILO to examine the effects of life expectancy on foreign direct investment in the countries most affected by HIV/AIDS globally⁴. Data were fully available for the model for 50 of the 60 countries identified by the United Nations as most affected by HIV/AIDS, either because they have reached an HIV-prevalence rate of 1 per cent or more, or they have an absolute number of persons in the population estimated to be HIV-positive of 1 million or more. The list of countries studied includes 33 countries of Sub-Saharan African, 11 countries of Latin America and the Caribbean, 3 countries in Asia, 2 countries of Europe and 1 North American country (see Table 2).

50 countries included in the model on life expectancy and FDI (in alphabetical order)

Angola	Ethiopia	Niger
Bahamas	Gabon	Nigeria
Barbados	Gambia	Russian Federation
Belize	Ghana	Rwanda
Benin	Guatemala	Sierra Leone
Botswana	Guinea	South Africa
Brazil	Guyana	Swaziland
Burkina Faso	Haiti	Tanzania, United Republic of
Burundi	Honduras	Thailand
Cameroon	India	Togo
Central African Republic	Jamaica	Trinidad and Tobago
Chad	Kenya	Uganda
China	Lesotho	Ukraine
Congo, Democratic Republic	Madagascar	United States
Congo	Malawi	Zambia
Côte d'Ivoire	Mali	Zimbabwe
Dominican Republic	Mozambique	

Table 2

To take account of other known influences on foreign direct investment, three further explanatory factors were included in the model, namely the size of the working-age population (as a proxy for the market size); the average rate of GDP growth over the last five years (as a measure of economic growth); and the trade share of the GDP (as a measure of the openness of the economy). To take account of other probable, although lesser known, influences on FDI a number of other potential determinants were added, including the number of telephone mainlines (as an estimate of the quality of infrastructure); the real interest rate (as a proxy for the profitability of investments or the returns to capital); a

measure of democratization based on electoral participation and the degree of political party competition; and the rate of inflation (as a proxy for the level of economic stability).

The study looked at the 50 countries over a 21-year period from 1983 to 2003, which roughly coincides with the history of the HIV/AIDS epidemic. In order to discern trends and changes, data for each country were entered in the analysis for the four five-year periods 1983-1988, 1988-1993, 1993-1998, and 1998-2003. These were difficult data requirements to fill, which is the reason that 10 countries for which data was found to be unreliable or missing had to be left out⁵.

Gross FDI inflows and life expectancy, 2002 (146 countries)



Figure 3

Source: World Bank, 2005a

The ILO study used life expectancy as a proxy for the human health capital of a country, given the impact of HIV/AIDS on the workforce in countries most affected by the epidemic. Findings of the study revealed that life expectancy as health capital had a statistically significant effect on gross FDI inflows. Given that the model takes account of other known and probable determinants, the results confirm that every lost year of life expectancy decreases FDI inflows, and the decrease is about 2 per cent on average in these 50 countries. These results point up that FDI flows to these countries would have been greater if there were no AIDS.

As had been anticipated also, the findings suggest that the proportion of foreign investment flows forsaken because of HIV/AIDS is greater the lower the level of life expectancy, a finding also revealed by research elsewhere. For example, the loss of one year of life expectancy in Swaziland, from 34 to its current low of 33 years, is associated with a 0.4 per cent “forfeit” of FDI, whereas a one-year loss in life expectancy where life expectancy is over 60 years is associated with a negligible shortfall in FDI (see Table 3).

When comparing countries, furthermore, the model shows that countries in which life expectancy has decreased substantially due to HIV/AIDS receive less FDI than other countries with the same level of infrastructure development, growth rate, openness of the economy and working-age population. Specifically, the average gross FDI inflows for a country that had lost 20 years or more of life expectancy due to HIV/AIDS is about 1 per cent less than for a comparable country less affected by HIV/AIDS, which can represent shortfalls of hundreds of millions of US dollars. This finding further highlights the essential role of population health in attracting foreign investment.

The findings also confirm that on a regional basis, Sub-Saharan Africa is the most penalized overall in terms of FDI inflows, which is consistent with the high prevalence of HIV/AIDS in the region. Accordingly, for any given country in Sub-Saharan Africa, FDI inflows are about 0.7 per cent less than for any country outside the region at the same level of social and economic development.

HIV/AIDS and poverty hamper economic performance and impede the process of globalization

Aside from poor health, poor economic performance itself is already an indirect source of discouragement to foreign direct investment. HIV/AIDS has therefore also greatly disadvantaged countries affected by the epidemic in the globalization of foreign direct investment because poorer countries are in any case relatively less successful at attracting FDI than their wealthier counterparts, and the epidemic is a factor of impoverishment.

Inability to compete in global trade and finance has a negative impact on employment, and hence on poverty reduction through decent work, worsening prospects for tackling HIV/AIDS. But chronic unemployment and high HIV/AIDS prevalence reinforce existing poverty.

Indeed, HIV/AIDS contributes to poverty and inequalities on an individual level. HIV/AIDS impoverishes households through the loss of income earners, and firms through increased labour costs and productivity loss.

Estimated percent of FDI forfeited for each 1-year loss in life expectancy, selected countries by ascending life expectancy

Country	HIV prevalence in 2003 (%)	Average life expectancy 1998-2003 (years)	Per cent FDI forfeited
Swaziland	38.3	33	0.41
Zimbabwe	24.6	37	0.32
Cameroon	6.9	46	0.20
South Africa	21.5	49	0.15
Ghana	3.1	57	0.09
Guyana	2.5	63	0.00
United States	0.6	77	0.00

Table 3

HIV/AIDS, poverty, economic performance and globalization

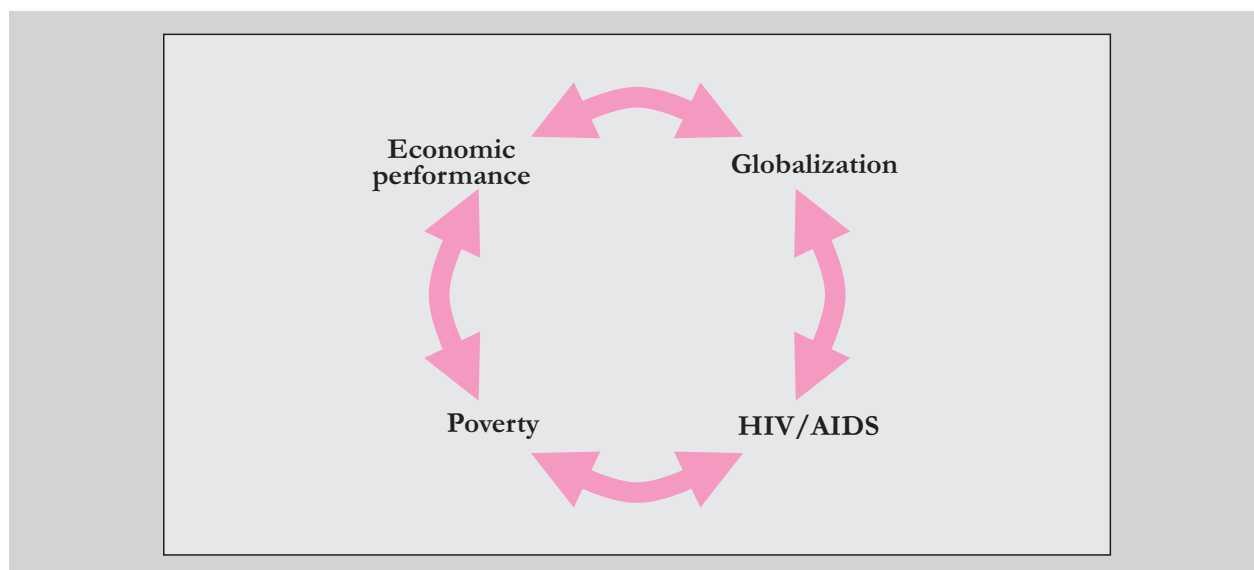


Figure 4

At the national level, the overall effect, as we saw earlier, is to dampen the rate of economic growth. At the same time, however, poor economies are those where transmission of HIV/AIDS is more likely because the conditions and structural factors of poverty increase individual and group risk of exposure to HIV infection. In sum, the interaction of HIV/AIDS and poverty creates an environment that is not conducive to the globalization process, and it is difficult for the poorest affected countries to join the global economy and its benefits such as FDI and trade which could also provide resources to control HIV/AIDS.

Moreover, to the extent that globalization itself may increase inequality within and between countries - because poorer people and countries benefit less proportionately - and raise poverty levels in some settings, it is a contributing factor to the HIV/AIDS epidemic. It is as a result of this apparent impasse in which HIV/AIDS places some of the poorest countries that the epidemic poses the greatest threat, and has the most profound implications for every aspect of sustainable human development.

The interaction between HIV/AIDS and poverty

There are strong bi-directional linkages between HIV/AIDS and poverty in resource-poor settings, in particular sub-Saharan Africa. HIV/AIDS is both a manifestation of poverty conditions that exist, taking hold where livelihoods are unsustainable, and the result of the unmitigated impact of the epidemic on social and economic conditions. HIV/AIDS is at the same time a cause and an outcome of poverty, and poverty is both a cause and an outcome of HIV/AIDS.

HIV/AIDS impoverishes

HIV/AIDS causes impoverishment when working-age adults in poor households become ill and need treatment and care, because income is lost when the earners are no longer able to work, and when expenditures increase due to medical care costs. Poor households often expend their savings and lose their assets in order to purchase medical care for sick members. Assets may have to be sold when many households are facing the same need, and such distress sales are often ill-timed and at a loss. Even when assets are retained, productivity can become severely curtailed: among smallholder farmers, the acreage under cultivation can be limited simply by the lack of able-bodied workers. Physical labour may be the only productive asset possessed by the very poor in the informal and rural sectors, and one that households can least afford to lose.

HIV/AIDS slows economic growth

As a result of labour force losses, the epidemic is an important factor in slowing the pace of economic growth at the national level. This in turn undermines efforts to reduce poverty, critically locking some populations - especially in the poor and least developed countries - into their poverty and a greater exposure to HIV/AIDS.

Poverty exposes the workforce to HIV/AIDS

Poverty increases the risk of HIV/AIDS when it propels the unemployed into unskilled migratory labour pools in search of temporary and seasonal work, which increases their risk of HIV/AIDS. Poverty also drives girls and women to exchange sex for food, and to resort to sex work for survival when they are excluded from formal sector employment and all their work options are too low-paying to cover their basic needs. Abject poverty often leads to a casual, day-to-day existence dominated by survival needs, and at the extreme, poverty fosters a fatalistic attitude that manifests itself in indifference to high-risk sexual and other behaviours. In these circumstances, individuals are poorly motivated and poorly equipped to take the necessary steps to protect themselves from HIV.

HIV/AIDS increases global inequality

At global level, cross-country evidence indicates strong and significant associations between HIV prevalence and aspects of socio-economic performance. In general, the higher the level of HIV, the lower the level of economic performance, whether measured in terms of lost rate of growth in GDP or rate of growth in per capita GDP, level of income inequality, or the poverty headcount index (the proportion of the population living under US \$1 and \$2 per day).

There are, however, exceptions to the relationship between HIV/AIDS and poverty, in particular in Africa where some countries with very high HIV prevalence rates are also among the richer countries in the region. One explanation advanced is that the paradox is due to weaknesses in strategy, policy and programme implementation, and to poor institutional response.

HIV/AIDS reduces the quantity and quality of labour

A grave aspect of impoverishment brought about by HIV/AIDS is the loss of human capital, and of persons with the skills needed to overcome poverty. This *deprivation of human capital* comes about not only directly from labour force losses but also from lost capacity to develop and utilize human capabilities that are necessary for social and economic development. In many poor and least developed countries, a large number and a substantial fraction of public sector personnel with a capital of skills, training, and education, and of experience in management and policy-making – notably in the fields of health and education – are being removed from the labour force as a result of AIDS at a time when the need for their services is greatest for development. In the private sector, the cost of high absenteeism and turn-over among skilled and semi-skilled labour which entails burdensome costs of training for replacement and recruitment translates into reduced profit and discourages investment.

HIV/AIDS deprives younger generations of schooling and skills

Another aspect of lost human capital is the long-term effect of the epidemic on the skills and experience of succeeding generations. Children in HIV-affected households face multiple disadvantages in their access to schooling. These children may have to leave school prematurely for several reasons: the school fees become too onerous when the household loses income or experiences catastrophic medical costs; the child has to take over domestic or agricultural tasks; the child has to stay home to care for a sick adult; the household needs income and the child enters the labour market prematurely to replace the income lost, or even to become the sole earner and become the head of a household of orphans. For HIV-affected households, the purpose of sending children to school can decrease in meaning and importance as adults see the threat to life expectancy posed by AIDS. For orphans, there is most often no alternative to the need to leave school. These pressures to de-school children are not strongly countered when HIV/AIDS is at the same time reducing the capacity of the educational system to train the next generation.

HIV/AIDS and poverty: a multifaceted response on both fronts

Intervention and action are called for in a number of areas to reduce both poverty and ill-health due to HIV/AIDS, such as the following:

- Strong political leadership and commitment
- Taking account of HIV/AIDS at all stages of poverty-oriented development planning
- HIV/AIDS policies and programmes for both prevention and treatment, and actions taken by public and private sector employers and by enterprises in resource-poor settings
- Public information, education and communication about prevention and behaviour change
- Targeted programmes for groups at high risk, including youth, migrant workers, and women
- Better training and conditions of service for health sector workers
- Calculating and addressing the lost human capacity in essential public services
- Protecting access to education
- Scaling-up and coordinating care and treatment for workers living with HIV/AIDS
- Creating or scaling-up programmes to mitigate the effects of HIV/AIDS on carers, households, orphans and communities
- Supporting and encouraging non-governmental, community-based and other local initiatives (NGOs and CBOs)
- HIV/AIDS policies and programmes for prevention and treatment, and actions taken by workers' and employees' organizations in resource-poor settings.

Beyond their loss of formal schooling, children who lose parents, teachers, and mentors to AIDS also lose access to the lessons in life and skills that are transmitted from generation to generation. The break in transmission in a range of physical and mental skills leaves the succeeding generation skill-impooverished and gravely hampered in striving for a better life.

HIV/AIDS is an obstacle to sustainable development

When these causes and consequences of HIV/AIDS are taken together, they point to the epidemic as the biggest single obstacle to the achievement of poverty reduction and sustainable development in poor and least developed countries, in particular sub-Saharan Africa. The HIV/AIDS crisis thus presents a major challenge to poverty reduction strategies and to the achievement of targets and goals such as the Millennium Development Goals (MDGs) as well as other efforts by governments, donors and the international community. Poverty itself is complex and multi-faceted,

and encompasses many forms of deprivation over and above income poverty and consumption deficiencies. It is critical to examine the role of the HIV/AIDS epidemic in maintaining or exacerbating a range of the components of poverty, including *poverty of access to essential public goods and services* (education, healthcare, clean water and sanitation), *poverty of private assets* (physical labour, land, a dwelling, livestock, food), and *poverty of social relationships* (discrimination, social exclusion and lack of mutual support).

There is no simple solution to address the predicament of the linkages between HIV/AIDS and poverty and of their mutual reinforcement. But the very fact that they are so intimately connected means that progress in reducing poverty levels will also reduce HIV transmission, and that success in reducing HIV prevalence will also serve to remove an important obstacle to greater productivity and growth. Intervention and action in a number of areas can help to reduce both poverty and HIV/AIDS ill-health (see box).

Global estimates of persons at risk of HIV due to poverty

Knowing that the impact of HIV/AIDS on slowing the rate of growth of GDP is a clear indicator of the impoverishment effect of HIV/AIDS, the ILO sought to find ways of quantifying the reciprocal impact of poverty on HIV/AIDS. This required a characterization of poverty that could be quantified and related to HIV outcomes. The point of departure was to focus on the particular features of populations who are recognized to be at greatest risk of HIV.

One of the gravest aspects of HIV/AIDS is that the virus is being transmitted increasingly in young working-age adults in resource-poor settings. In affected countries in the developing regions, the groups at highest risk now are young working-age women under 30 years and the risk to young women is growing in affected countries in the more developed regions.

In Africa, women are more likely to become HIV-positive than men – at the end of 2004, 1.3 times as many women as men were living with HIV in the continent as a whole – but in the countries of the southernmost region (e.g. in South Africa, Zambia and Zimbabwe), young working-age women 15 to 24 years were 3 to 6 times more likely to become HIV-positive than young men, and 76 per cent of all young adults living with HIV/AIDS were female. In the Caribbean, also, young women 15 to 24 years were twice as likely as young men to become HIV-positive. In Eastern, South and South-East Asia, whereas women comprise 22–30 per cent of all adults living with HIV/AIDS, young women 15 to 24 years account for 28–40 per cent of young persons who are HIV-positive. In countries where the epidemic was initially driven by injecting drug use and sex work – notably in the Russian Federation, South-East Asia and India – working-age women and girls are becoming increasingly affected as the epidemic is transmitted into the general population. In the US, women from disadvantaged minority groups represent a disproportionate fraction of new cases of HIV, and AIDS is the leading cause of death for African-American women aged 25–34 years.

To capture the potential impact of youth and poverty on the risk of HIV/AIDS, the ILO carried out a study of the relationship between measures of poverty, HIV/AIDS, age and sex⁶. In this study, the ILO first examined the relationship between HIV/AIDS and measures that have been used as world development indicators by the World Bank, such as the share of income that goes to the poorest 10 per cent and 20 per cent of the population, the poverty headcount index or proportion of the population living under \$1 and under \$2 per day, and the Gini coefficient, a measure of the inequality in the distribution of income⁷. The countries included in the analysis were all countries in the world with an estimated HIV-prevalence of at least 1 per cent or a population of persons living with HIV of at least 1 million for which the data on the particular poverty indicator existed.

The results showed a relationship between the poverty indicator and HIV prevalence at global level in all three cases. Income inequality was found to be related to HIV prevalence in 34 countries globally, such that the higher the level of inequality, the higher the prevalence of HIV in adults 15 to 49 years. Similarly, the poverty headcount under \$1 per day and under \$2 per day for the 34 countries were both predictive of HIV prevalence, and the relationship was as strong as for income inequality. Again, for income shares, both levels were systematically related to HIV prevalence at global level, although the relationship was weaker than for income inequality and the poverty headcount ratio.

The relationship between poverty measures and HIV was stronger for the 19 countries in sub-Saharan Africa, especially in the case of income inequality (see Figure 5). The share of income that goes to the poorest 10 per cent and the poorest 20 per cent of the population were also systematically related to HIV prevalence in Africa.

Level of inequality and prevalence of HIV in adults 15-49 years, 19 countries of sub-Saharan Africa, latest available year

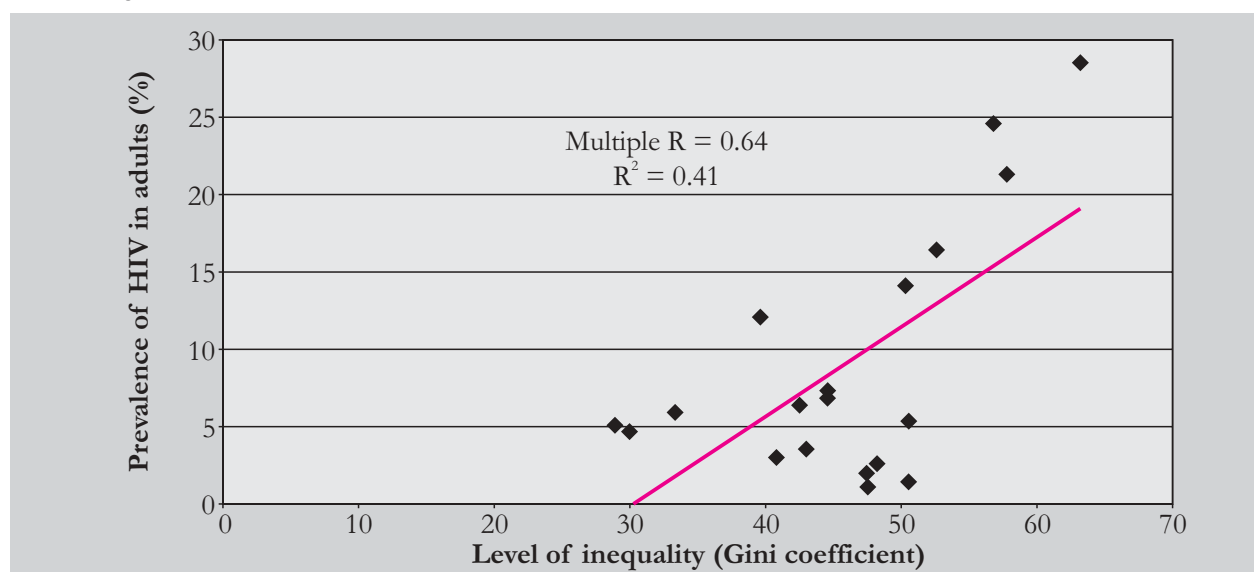


Figure 5

Sources: UNAIDS, 2004b; World Bank, 2005a

On the basis of these findings, the ILO set out to make an estimate of the population at risk of HIV as a result of poverty. The poverty headcount index is the one measure among the three that lends itself to application as a population variable, as it can be used to determine the size (in absolute terms) of the proportion who are poor of any defined population group.

In order to test whether poverty could explain the level of HIV in a population, the next stage was to determine if the levels of HIV could be predicted on the basis of applying the selected poverty measure to the available information about the population at risk by age and sex. Using the knowledge that the most likely age and sex group to become HIV-positive was young working-age women 15 to 24 years and 25 to 29 years, and based on the fact that information was available on the HIV prevalence of young pregnant women 15 to 24 years in the capital city – a very important source for national HIV prevalence estimates in Africa – the poverty headcount was applied to the absolute numbers of working-age women 15 to 24 and 25 to 29 years in each of the 13 countries for which there was information on the HIV prevalence of young, urban pregnant women as well as for the poverty headcount. Then using the urbanization rate for the country, the estimate was shaved down to the urban portion, in view of the fact that the HIV prevalence rate for young pregnant women was based on an urban area only (the capital city). Finally, the HIV prevalence of young pregnant women in the

capital city was applied to each absolute amount to shave down the total number of young, working-age women at risk to the level of an estimate of its true magnitude. The resulting estimates consisted of an approximation of the number of working-age women 15 to 29 years who are poor, urban, and at risk of HIV in the 13 countries with available data (see Table 4).

For the purpose of the analysis, the groups of working-age women 15 to 24 and 25 to 29 years who represent the proportion of all young women of working-age who are both urban and living under \$1 per day were considered “at great risk” of HIV; similarly, the proportion of young urban women living under \$2 per day were considered “at risk” and urban women who were living on more than \$1 but less than \$2 per day were considered “at some risk”.

The relationship between the resulting hypothetical numbers of poor young working-age women at risk of HIV and the total number of adult women 15 to 49 years in the population estimated to be HIV-positive was then measured for the 13 countries and the relationship was found to be strong and positive for both groups of young women, ranging from 0.44 to 0.60 (first line after country data in the table). In effect the application of a poverty measure and an appropriate HIV prevalence rate to the numbers of young, poor, urban women explains between 19 and 35 per cent of the estimated HIV prevalence level for adult

women aged 15 to 49 in the overall population in these countries (second line after the country data). For example, applying the HIV prevalence estimate for young women in the capital to the numbers of working-age women 25 to 29 years who are at risk because they are young, poor (living on less than US\$2 per day) and living in an urban area, yields a number of women that correlates 0.6 with the number of women 15 to 49 estimated to be HIV-positive in the general population, and explains 35 per cent of the overall rate of the estimated HIV prevalence rate for adult women.

These findings lend support to the assertion that a large proportion of working-age women at risk of HIV at any time are young, urban, and poor. Furthermore, they imply that this particular population at risk can be identified and represents the core need for prevention, care and treatment. Finally, it suggests that estimating the numbers of working-age women who are young, urban, and poor in other countries can be a first step in identifying a worldwide population that is unusually exposed to the risk of HIV everywhere.

Accordingly, the numbers of urban, poor, young working-age women were calculated for all countries with the required data, and the findings for 34 countries are displayed in Main table 2 of the appendix. The summary for Main table 2 suggests that of the 52 million youngest women of working age in Sub-Saharan Africa (women 15 to 24 years), between 12 and 13 million are at risk of HIV – or 1 in 4 – because they are urban and poor, of whom between 7 and 8 million are at great risk for reasons of poverty, and a further 5 million are at some risk due to poverty. In Asia, of the 213 million youngest women of working age, 12 million are at great risk, 19 million are at some risk, and a total of 31 million – or 1 in 7 – are at risk of HIV due to poverty. Similarly, of 26 million women 15 to 24 years in Latin America and the Caribbean, 1.4 million are at great risk, 2.5 million at some risk, and altogether 4 million – over 1 in 6 – are at risk of HIV due to poverty. Finally, a total of 1.4 million young women of working age are at risk as a result of poverty in the 3 countries from the developed regions, or 1 in every 11 young women.

Numbers of poor, urban, young women of working age at risk of HIV

Country	HIV/AIDS			Numbers of young women					
	Estimated HIV prevalence		Numbers of women 15-49 years living with HIV 2003 estimates	15-24 years			25-29 years		
	All persons 15-49 years (%) 2005	Pregnant women 15-24 years in capital city (%) 2003		At great risk: urban and applying the risk of HIV/AIDS of urban pregnant women 15-24 years	At some risk: urban and applying the risk of HIV/AIDS of urban pregnant women 15-24 years	At risk: urban and applying the risk of HIV/AIDS of urban pregnant women 15-24 years	At great risk: urban and applying the risk of HIV/AIDS of urban pregnant women 15-24 years	At some risk: urban and applying the risk of HIV/AIDS of urban pregnant women 15-24 years	At risk: urban and applying the risk of HIV/AIDS of urban pregnant women 15-24 years
Burkina Faso	2.6	2.3	150,000	2,500	2,000	4,500	900	700	1,600
Burundi	5.9	13.6	130,000	2,600	3,000	5,600	900	1,000	1,900
Cameroon	6.8	7.0	290,000	2,600	9,600	12,100	1,000	3,600	4,500
Côte d'Ivoire	7.3	5.2	300,000	900	5,400	6,300	300	1,900	2,200
Ethiopia	4.7	11.7	770,000	60,300	143,800	204,100	22,300	53,200	75,600
Ghana	3.0	3.9	180,000	18,400	13,900	32,300	7,000	5,300	12,300
Lesotho	28.5	27.8	170,000	4,300	2,300	6,500	1,400	800	2,200
Malawi	14.1	18.0	460,000	15,600	12,900	28,600	6,100	5,100	11,200
Mozambique	12.1	14.7	670,000	39,800	42,700	82,500	15,500	16,600	32,000
Nigeria	5.4	4.2	1,900,000	184,600	54,100	238,700	66,700	19,500	86,300
South Africa	21.3	24.0	2,900,000	11,400	70,800	82,200	4,700	29,000	33,700
Uganda	3.6	10.0	270,000	30,100	4,100	34,300	10,900	1,500	12,400
Zambia	16.4	22.1	470,000	64,400	24,000	88,400	22,700	8,500	31,200
Multiple r for the numbers of young women in the different risk groups and the numbers of women 15 to 49 years living with HIV/AIDS				0.44	0.54	0.57	0.45	0.57	0.60
Amount of variance explained (r ²)				19%	29%	33%	20%	32%	35%

Table 4

Sources: United Nations, 2004, 2005a; UNAIDS, 2004b

Assumptions in the analysis

The relationships revealed in Table 4 are necessarily founded on a number of assumptions. First, applying the population poverty rate to women 15 to 24 and 25 to 29 assumes that they are neither poorer nor better off than are men, and than are other age groups. Women tend to be poorer than men everywhere, and although young women may not be the poorest in the female population - children, mothers of children and older women are generally among the poorest - the fact that the poverty rate of men is generally lower tends to adequately compensate the differences between women of different ages. Accordingly, this process probably underestimates the poverty rate of young women, strengthening the findings. As the national urbanization rate was applied, for want of more specific urbanization rates, another assumption is that young women are as frequently urbanized as other age groups and the male population. In this case, it is likely that the proportion urban varies quite substantially according to age and sex by country, tending at least to annul the effects of any particular bias. A further assumption is that one can apply the HIV prevalence of pregnant women to the general population of young women. In view of the very high proportion of women who are ever pregnant in these age groups and in the countries listed, the assumption is probably robust. Finally, it is also assumed that the HIV rate for pregnant women 15 to 24 years can be applied to women aged 25 to 29 years. In an epidemic that is growing over time, one could assume that the HIV prevalence of the younger women (15 to 24 years) would be greater than of the older women (25 to 29 years), because the younger women would be exposed to a greater risk as they become sexually active later. However, the older women would be exposed for a longer time, and have on average more partners and experience a larger cumulative risk. They are also more likely to have ever had a pregnancy, which makes them resemble more the population of younger women who are pregnant. Consequently, the error in applying the HIV rate estimated for younger pregnant women to the older group of women to gauge their overall risk of HIV is not likely to be great.

In summary, over 49 million young working-age women 15 to 24 years living in urban areas may be at risk as a result of poverty in the 34 countries for which data are available, and 21 million among them may be at great risk. Overall, for all 34 countries for which the required data were available, one in every 6 young women – or 16 per cent - are potentially at risk of HIV because they are among the poorest populations of their countries.

Similarly, one in every 6 young working-age women 24 to 29 years living in urban areas may be at risk of HIV due to poverty in the same 34 countries. Overall, about 20 million of 131 million young urban women 24 to 29 years are at risk, and about 8.5 million are at great risk. In Sub-Saharan Africa, 1 in 4 women 24 to 29 years are at risk.

HIV/AIDS and the movement of persons in search of work

Another global indicator of pressing economic need that also raises the level of exposure inevitably to the risk of HIV/AIDS is the worldwide movement of persons in search of work, and persons who experience forcible moves in their search for work. Table 5 summarizes the numbers of persons involved in movement globally, according to the nature of the movement involved, and estimates of the numbers of persons who are identifiable as being at particular risk in each case⁸.

Labour migration

The ILO has estimated that there were about 81 million migrant workers globally in 2000 (excluding refugees estimated to exceed 5 million). This number of persons is equivalent to the population of a fairly large country, larger than Turkey in Asia and Ethiopia in Africa (73 and 74 million respectively in 2005) and nearly as large as Germany in Europe and the Philippines or Vietnam in Asia (83, 83 and 84 million respectively in 2005).

Refugees and the risk of HIV/AIDS

Refugees, although neither necessarily moving in search of work, nor forcibly moved in connection with their search for work, nevertheless face high-risk situations because of dislocation. Large refugee camps often present unhealthy environments, where HIV prevention is not one of the priorities. Services for family planning, women's health and STI treatment are incompletely available. Another problem is sexual violence and exploitation. During conflict, many families and communities are separated, and women and children are placed at high risk of sexual violence and exploitation, and therefore exposure to HIV.

In contrast to groups of people who are in effect forced to move because of unliveable conditions such as natural disasters and conflict⁹, the great majority of people who move – labour migrants – do so in search of a better life, and most of them move to fill unskilled jobs. The majority come from developing countries: by the end of the 1990s, about 58 per cent of all migrant workers present in the countries of greatest in-migration were from developing countries. Nearly half of all migrants, however, do not move from a developing country to a developed country, but from one developing country to another, with substantial variation between regions. For example, it was estimated in 2000 that over a quarter (27 per cent) of all migrant workers globally, excluding refugees, had moved from one Asian country to another, and 7 per cent had moved from one African country to another.

Global estimates of groups of people who are moving, including groups identified as being at high risk of HIV/AIDS, latest available year

Nature of movement	Total estimated numbers of persons, latest available year	Estimated number of persons identified at risk*
Labour migration	81 million	
Refugees	5 million	<i>see box</i>
Forced labour, of which:	12.3 million	1.4 million
• Human trafficking	2.5 million	(1.1 million)

Table 5

** Numbers of persons subjected to sexual exploitation for commercial purposes
Sources: ILO, 2004b, 2005c*

At first glance, these findings suggest that migrating for work is more common in Asia than in Africa. And, indeed, it is estimated that there are four times as many migrant workers in Asia than in Africa (about 22 and 5 million persons in 2000 respectively). Nevertheless, because of the differences in the sizes of the overall populations in Africa and Asia, the proportions of their populations who have moved for work are virtually the same, at about 0.6 per cent. Furthermore, if refugees are excluded, but all migrants are counted, the proportion of the population inside Africa that comprises migrants is half again as large as in Asia (1.6 per cent and 1.1 per cent respectively in 2000).

Owing to the fact that it is difficult to monitor human movements in many parts of the world, migrants frequently cross borders in search of work without being recorded, and the global flow of migrant workers is likely to be underestimated. At less than 1 per cent, however, the volume of the flow of migrants in Africa is still indicative of the pressures to search for jobs that prevail in a region where countries are developing, the majority of them are poor, and where the prevalence levels of HIV/AIDS are among the highest in the world.

Forced labour and human trafficking

Persons who move as a result of forced labour and human trafficking comprise a group at special risk of HIV/AIDS, because of the reliance of the sex industry on forced labour and trafficking to supply human beings for exploitation. The ILO estimates that a minimum of 12.3 million persons were in a situation of forced labour in mid-2005, and that 1.4 million – or 11 per cent of cases – were in forced commercial sexual exploitation. The region of sub-Saharan Africa, where HIV/AIDS is particularly prevalent, has the third largest number of persons in forced labour in relation to population size – 1 per thousand – and 8 per cent of them are in forced labour for commercial sexual exploitation. The vast majority of persons in this situation – 98 per cent – are women and girls. Although the proportion of girls is not known, the ILO estimates that in the case of all forced labour, as many as 40-50 per cent of persons exploited may be children.

The risk of HIV is increased in populations in situations of forced labour not only because of the volume of sexual exploitation involved, but also because of the forced

movement that persons undergo. Of the 12.3 million persons estimated to be in situations of forced labour at any time, nearly 2.5 million are in forced labour as a result of human trafficking. Although the single main reason persons are trafficked is for purposes of commercial sexual exploitation (43 per cent), all persons trafficked have been transported under a degree of duress, and the conditions of their movement increase the risk of their exposure to HIV. As a result, regardless of the nature of the exploitation to which they have been subjected, trafficked persons are as a group at high risk for HIV/AIDS.

Quite aside from sexual exploitation that places persons at direct high risk of HIV/AIDS, all forms of movement place people at some degree of risk for a range of reasons that are common to the human experience of moving, and because of conditions frequently associated with movement. For example, many people who move, whether voluntarily or not, are young. Although globally 49 per cent of all migrant workers are women, groups may be imbalanced with respect to gender. For example, unskilled workers attempting to cross borders clandestinely for work may be largely male. Groups of domestic workers recruited in large numbers to work overseas are often largely female.

Owing to their youth, the absence of permanent partners and the desire to work, persons who move may take risks in their search for work and their openness to new experiences and opportunities, because of lack of education, lack of knowledge about other customs, and their great need for resources. Such risks include exposure to exploitation, taking on work that is dangerous or degrading, including unusual exposure to the risk of HIV/AIDS. To an extent all labour migration and movement for work introduces particular risks of exposure to HIV based on the conjunction of such factors as detachment from tradition; loss of family and cultural networks; acceptance of substandard living conditions and/or working conditions; income and consumption poverty; inadequate access to information and services; recourse to sex work; and experience of discrimination, exploitation, violence and abuse.

The exodus of skilled labour in the health sector: a double jeopardy

One form of labour migration that has long been a cause for concern for other reasons is the departure of qualified professionals from developing countries to other developing and

to developed countries. The phenomenon of the “brain drain” is longstanding and complex. On the one hand, individuals move on the basis of personal and professional needs as well as factors such as security, freedom of speech, social and societal respect. Individuals who move are exercising the fundamental human right to move from one country to another, to enhance their contribution to the society they choose to live in and to improve their quality of life. Due to the movement and interaction of highly skilled people, migrants have made substantial contributions in host countries, and globally they have contributed significantly to the scientific and technological advancement of humanity. When they send remittances to their families and communities, they also contribute to local development¹⁰.

At the same time, however, the costs to the home countries of losing their professionals are inestimable in terms of lost development opportunities and lost investment. For example, a 2000 report pointed out that Africa is losing its “best and brightest” to the industrialized world. These “brains” constitute a significant proportion of the human capital necessary to establish a solid foundation for economic growth.

The issue of professional migration is of particular relevance to global efforts to address the HIV/AIDS epidemic when emigration concerns health care professionals. Although professional migrants are, just like all persons who move, individually exposed to an increased risk of exposure to HIV/AIDS for the same range of reasons, it is most especially the labour flow in the health sector that adversely and indirectly affects the health and well-being of the populations they leave. At present, the out-migration of health professionals is compounding longstanding problems of health systems that are now faced with severe human resource constraints at a time of greatest need due to the impact HIV/AIDS. The situation is overwhelming health care systems, with the result that both patients and health care workers are suffering as standards of care are falling, lack of care and abuse become manifest, and health care workers experience stress, excessive workloads and low morale.

As borders disappear, people and goods are increasingly free to move, creating new challenges to global health.

The European Molecular Biology Organization (EMBO)

Magnitude and implications of the crisis

Official records of skilled health professionals who leave their countries are limited, and statistics on the migration of healthcare workers are rarely complete or comparable. Furthermore, reported statistics are likely to be underestimates as many professionals migrate unofficially. Consequently, the exact size of the healthcare workforce who migrates is not well known worldwide.

Right now in Africa, a mere 1.3 per cent of the world's health workers struggle to care for people suffering 25 per cent of the global disease burden.

Physicians for Human Rights (PHR)

An overview of what estimates are available, however, shows three concentrations of physician out-migration; from West Africa (Nigeria and Ghana), Eastern Africa (Ethiopia and Kenya), and Southern Africa, where Botswana, Lesotho, Malawi, South Africa, Swaziland, Zambia and Zimbabwe are the main countries of emigration¹¹. Yet these countries are at the same time among the most affected by HIV/AIDS. Even though HIV/AIDS is rarely reported as the main reason for healthcare worker emigration, the relationship between migration source countries and HIV prevalence is more than suggestive and calls for greater attention.

The out-migration of physicians from sub-Saharan Africa has negatively affected the doctor-to-population ratio of Africa, over and above the mere growth in population. Physicians per 100,000 population in Mozambique increased by only one (from 1 to 2) in the decade 1990-2000 mainly due to sustained out-migration of health workers. Data on South African medical schools reveal that 35 per cent of 1990s graduates emigrated. More than 60 per cent of all physicians trained in Ghana in the 1980s had emigrated by 1999: approximately 50 per cent had emigrated by 4.5 years, and 75 per cent by 9.5 years. Of the 1,200 physicians trained in the 1990s in Zimbabwe, 360 remained in the country in 2001, a loss of 70 per cent. Interestingly, the number of public-sector physicians and nurses remaining in Zimbabwe has declined in parallel to the decline in life expectancy due to HIV/AIDS (see Figure 6).

Public sector healthcare personnel and life expectancy due to AIDS, Zimbabwe, 1991-2000*

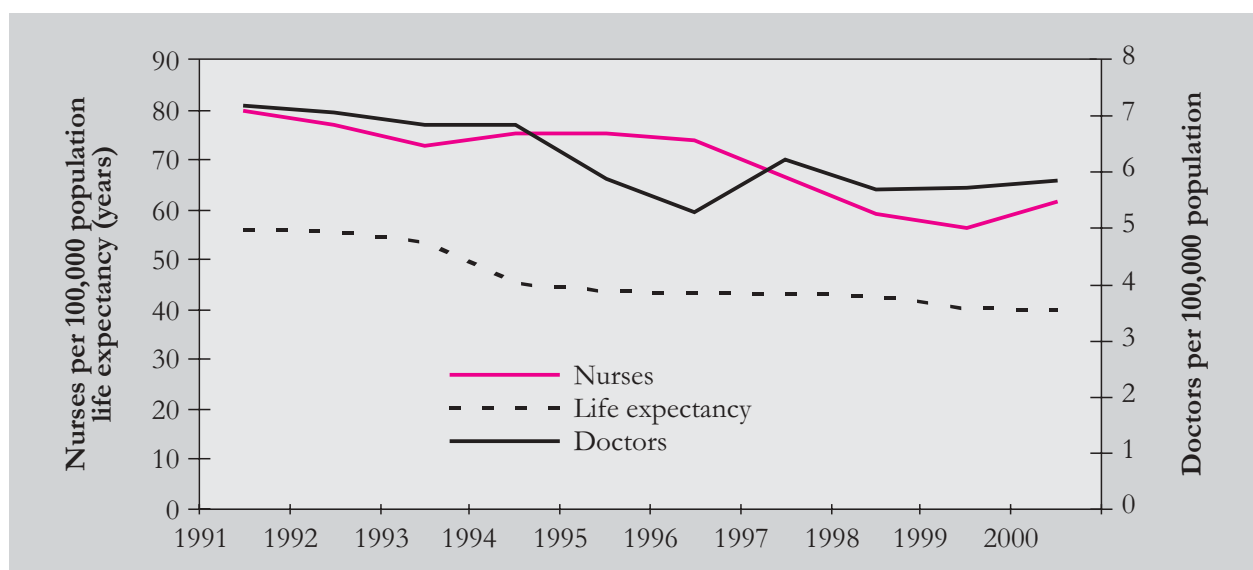


Figure 6

*1998 value for nurses was estimated
Sources: Chikanda, 2004 and United Nations, 2005a

Other countries are experiencing this paradox, including Malawi, Ethiopia and Zambia. Table 6 summarizes some of the available data for 15 Sub-Saharan countries with respect to the HIV/AIDS situation and the ratio of

nurses and physicians to the population and to persons living with HIV/AIDS as well as the presence of nurses in the United Kingdom, one of the destination countries selected by African-trained nurses.

Physicians and nurses per 100,000 population and population living with HIV/AIDS, nurses overseas and AIDS-related death toll, 15 countries of Sub-Saharan Africa, latest available year

Country	Year for physicians & nurses data	Estimated number of deaths per day due to AIDS, 2003	Physicians per 100,000 population	Nurses per 100,000 population	Physicians per 100,000 population living with HIV/AIDS	Nurses per 100,000 population living with HIV/AIDS	Nurses registered in the UK, 2003-04
Botswana	1999	90	29	241	139	1,169	90
Central African Republic	1995	63	4	9	45	113	na
Democratic Republic of Congo	1996	274	7	44	284	1,822	na
Ghana	2002	82	9	64	526	3,743	354
Kenya	1995	411	13	90	301	2,057	146
Lesotho	1995	79	5	60	28	316	na
Malawi	2003	230	1	26	15	344	64
Mozambique	2000	301	2	21	33	282	na
Namibia	1997	44	30	168	246	1,400	29
Nigeria	2000	849	26*	66	858	na	511
South Africa	2001	1,014	69	388	580	3,252	1,689
Swaziland	2000	47	18	320	84	1,520	81
United Republic of Tanzania	2002	438	2	37	51	831	na
Zambia	1995	244	7	113	70	1,152	169
Zimbabwe	2002	466	6	54	41	386	391

Table 6

* Data are for 1992; na is not available
Sources: adapted from UNAIDS, 2004b and WHO, 2005

The loss of nurses has been of similar magnitude. Reports reveal that in 2002-2003, 2,990 nurses from South Africa, Nigeria, Zimbabwe, Ghana, Zambia, Kenya, Botswana, Swaziland and Malawi registered in the United Kingdom, with about half (1,368) from South Africa, which ranks first in African sources of nurse immigration to the United Kingdom. The following year, 3,500 nurses from these 9 countries registered in the United Kingdom, an increase of 17 per cent. The number of nurses from South Africa registered in the United Kingdom rose from 599 in 1998-1999 to 1,368 in 2002-2003 and to 1,689 in 2003-2004. More than 300 specialist nurses are reportedly now leaving South Africa every month. The situation is similar for other countries: 18,000 Zimbabwean nurses work abroad, and Ghana lost 2,972 nurses in 2001 alone, up from 387 nurses in 1999.

The health workforce risk of HIV/AIDS as a push factor to emigrate

There are many factors that “push” or “pull” health professionals to migrate¹², and one push factor is the impact of HIV/AIDS on the health sector of heavily affected countries. As death rates mount in the general population, so more health care professionals are themselves affected by HIV/AIDS, in largest part as a result of transmission unrelated to on-the-job risks. It has been estimated that the risk for health workers is, as one would expect, in proportion to the population risk. A country with 5 per cent

prevalence, for example, can see between 0.5 and 1 per cent of its health-care providers die each year as a result of AIDS, whereas a country with 30 per cent prevalence would lose 3 to 7 per cent of health workers to the epidemic each year. Seeing colleagues who become ill and die due to HIV/AIDS hampers the recruitment and retention of health care workers, and leads health workers to leave the profession or the country as well as discouraging persons from entering health care professions. Beyond personal or professional risk, moreover, the conditions of work of healthcare workers faced with unmanageable patient loads, stressful shortages of resources, and the prospect of working principally for increasing loads of terminal patients serve as powerful disincentives to stay. These factors related to the HIV/AIDS epidemic are also leading to the emigration of health professionals which together with the direct losses to HIV/AIDS are severely depleting the human resources in health that are precisely essential to manage the epidemic.

One reason advanced for the finding that professional experience with HIV/AIDS raises health workers’ fears of becoming infected is the recognized lack of preventive measures in the face of resource constraints. A comprehensive survey of a nationwide representative sample of 595 medical professionals and non-professional health workers in four provinces of South Africa showed a high level of exposure of health workers to HIV/AIDS due to sexual and professional transmission. The study found

Estimated daily deaths due to AIDS and numbers of nurses registered in the UK, 10 countries in Sub-Saharan Africa, latest available year

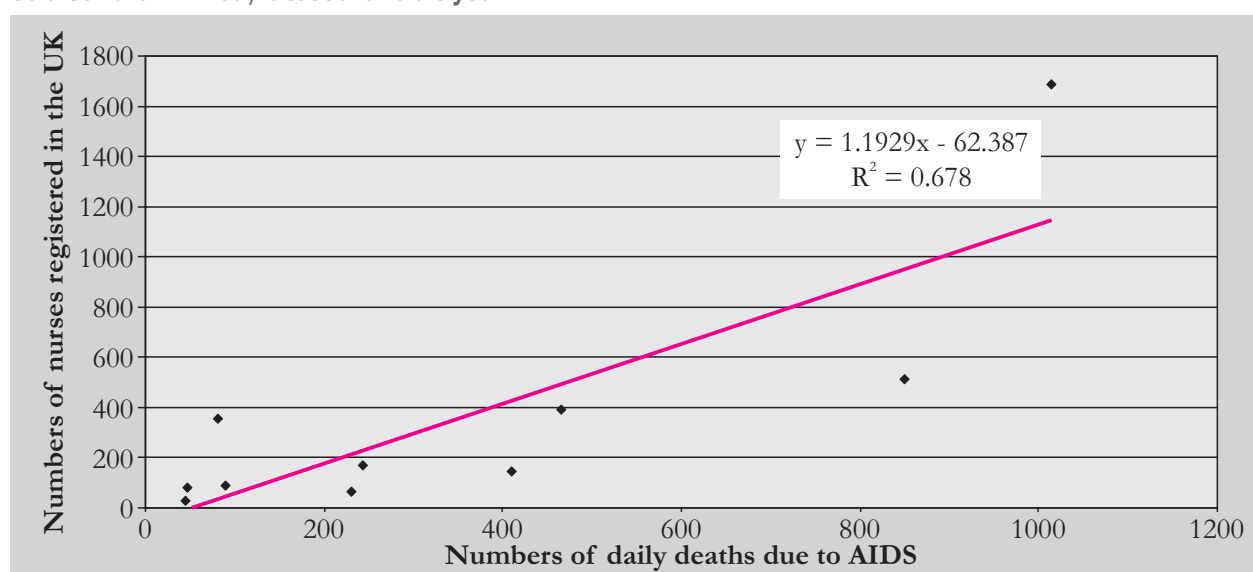


Figure 7

Source: see Table 6

that about 16 per cent of the health workers were HIV-positive, and the risk was highest among younger health workers aged between 18 and 35 years who had an overall estimated HIV prevalence of 20 per cent. Moreover, with respect to the occupational risk of transmission specifically, the study found the risk of health workers being infected by patients to be higher than the risk of HIV-positive health workers transmitting the virus to patients.

Nevertheless, the fear remains even when prevention is in place: a study in Zimbabwe revealed that about 58 per cent of health workers were constantly worried about transmission from an injury at work when 61 per cent also reported that their health institutions took adequate precautions against HIV transmission. Over 58 per cent also reported that they found caring for HIV/AIDS patients stressful.

Figure 7 shows the relationship between the estimated number of daily AIDS-related deaths and the estimated number of nurses who registered in a developed country overseas for 10 countries of Sub-Saharan Africa with the required data. In the case of these countries, the relationship is strong: the greater the number of daily deaths, the greater the number of nurses who have left to work outside the country. The relationship suggests that the prevalence of HIV may be acting as a powerful determinant in the emigration decision of health sector personnel. This observation shows up the terrible contradiction that is arising, as health sector personnel are feeling compelled to leave from places where, and at a time when, their services are most critically needed.

HIV/AIDS and the movement of persons for their work

Whereas millions of people move from their villages, towns, cities or countries in search of work every year, there are millions more who move for short or long periods and for short or long distances, because it is in the nature of their work and their jobs require it. The jobs that immediately come to mind are those in the transport industry, covering the transport of goods and passengers by road, rail, ship and air.

There are other, highly contrasting livelihoods that also have in common that they expose workers to movement and to risks. The fishing industry hires many unskilled workers and is often a lifelong livelihood entailing long absences from home. Similarly, persons who are conscripted or volunteer to serve in the armed forces of their country are posted for long tours of duty away from home and family, whether during armed conflict, in post-conflict situations for peacekeeping, or as part of peacetime operations. In comparison, overseas development agencies hire young skilled and unskilled persons, for whom a volunteer engagement is a relatively short period of a few months or years, the destination often chosen, and the experience a valuable opportunity to learn. In addition, there are land-based non-mobile professionals who interact particularly with persons engaged in mobile livelihoods, notably port workers.

The risk of HIV for all these groups stems from a number of characteristics shared by one or another group among them in their work and lifestyles, which include:

- High mobility, resulting in long periods spent away from home and families, or contact with highly mobile workers
- Isolation and working in confined environments with limited contacts
- Demographics: a majority are very young adults or in sexually active age groups
- Male-dominated professions and a predominantly masculine environment, with cultivation of a 'macho culture', including openness to new sexual relations
- Access to and ready availability of sex workers
- Peer pressure to seek out entertainment and sex workers
- For some livelihoods (e.g. fishermen), receiving daily cash wages, with no safe storage for money on board, or (seafarers) being limited to a few brief spending sprees in seaports
- Stress due to working and living conditions, and, in extreme cases, armed conflict
- Alcohol and/or drug use
- Misinformation or lack of information about HIV/AIDS
- Inadequate access to health services, especially in seaports

In addition to the common causes of their higher level of exposure to the risk of HIV, each category of workers is exposed to specific causes that are particular to their different working conditions and environmental factors.

Transport work

Transport workers include road transport and railway workers, airline and cabin crews, and seafarers. For all the differences between them with respect to mode, distance and purpose of travel, their living and working conditions and the nature of their work all serve to increase their risk of HIV/AIDS. The changes in settings that characterize their way of life increase the chances they will meet new and/or alternative partners and have the opportunity to engage in sexual relations other than with their permanent partners.

An ILO country assessment in Zimbabwe, for example, found the wide reach of land transport operations was associated with an unusually high level of engagement in risky behaviours. In fact, the higher HIV prevalence in communities situated on transport routes has been recognized since the early research on behavioural factors in the transmission of the

epidemic as clearly linked to the living and working conditions of transport workers. Border posts and truck stops offer food, drink, accommodation, and, importantly, safe places to park vehicles loaded with goods overnight. They are also ideal places to offer sexual services, and in the absence of targeted HIV prevention projects, they enable the easy transmission of all sexually transmitted infections (STIs) including HIV.

The recognition of the risk factors faced by truck workers in Africa, and other specific groups of transport workers globally is not designed nor should it lead to unnecessary stigmatization of these groups, who have been sometimes blamed for rising rates of HIV prevalence. The purpose of pointing to the issues raised here is to focus attention on the specific risks associated with aspects of their working conditions, to ensure that HIV/AIDS information and education for prevention are tailored to their situation, as well as to enable access to treatment, care and support.

Transport workers are not as numerous as migrant workers – although there are 1.8 million railway workers in India alone and more than 1.2 million seafarers worldwide – but they are highly mobile, moving between regions and countries with different levels of prevalence of HIV, and have multiple interactions with foreign and local populations who are also moving or travelling. The globalizing economy adds momentum to their mobility. Sub-sectors of this large industry include, among others, road freight, road construction, railways, ports and shipping, passenger transport, aviation and road maintenance, and all these sub-sectors are being affected by economic globalization in one way or another.

An example of the impact of globalization on the mobility of people within and across a country, is the rapid development of transportation and communication in Guangxi Province, China. This Province has seen unprecedented socio-economic reform and change since the launching of the Bridge and Road Economy Strategy in the 1990s. Guangxi is a land transport hub and transit point, and by 1999 had an extensive transportation

network, including major international railway connections, 51,000 kilometres of highway, 45 inland waterways and 5 airports. Its seaport carries the largest volume of commodities traded in southeast China. With the improved economy and a well-developed transport network, mobility and transportation have prospered. In 1998 alone, the Province received 35 million domestic, and over 500,000 overseas tourists.

Road transport workers

Numerous studies have analysed the specific HIV-related risks encountered by truck drivers and their assistants, who have been found to have higher rates of risks of STIs and higher HIV prevalence than the general population in many countries. Whereas some of the working conditions of truck drivers are specific to their occupation, others are common to all transport workers.

Truck drivers are away from home and family for long periods, often in poor and unpleasant conditions. Most truck drivers are men, living and working in a male dominated culture. They often wait for long periods when delayed at borders and customs and police checkpoints, where they can face harassment by police or immigration officials. The minority of women who work as truck drivers frequently experience harassment or coercion. Truck drivers become bored and lonely when long routes are punctuated by few entertainment facilities. They are subject to stress and can feel insecure, marginalized and frustrated as a result of working conditions. As a result, they may resort to alcohol or drugs.

As the sex industry is usually readily present at truck stops, truck drivers avail themselves of the services of sex workers, or have other casual partners on the road. In Thailand, for example, it was reported in the mid-1990s that 87 per cent of truck drivers had occasional relations with sex workers. Similarly, a study in India found that 75 per cent of drivers and 50 per cent of assistants had casual sex on their routes. Moreover, truck drivers interact at most truck stops with foreign and local mobile and non-mobile people, and thereby increase the risk of transmission to other population groups. The conditions of work and lifestyle of truck drivers make it difficult for them to access medical services and to obtain effective treatment.

The improvement of road transport infrastructure spurred by globalization in many countries and the increased volume of transportation worldwide have undoubtedly been associated with increased opportunities for high risk behaviours. In South-East Asia, following significant changes in the road transport infrastructure of several countries (such as Cambodia, Lao People's Democratic Republic, Myanmar, Vietnam, and Guangxi and Yunnan Provinces of China), there has been an increase in the number of trucks, along with increased trade in most areas. At the same time, the number of sex and entertainment venues has increased significantly along the major transport routes. Along the highway between Phnom Penh and Poi Pet on the Cambodian-Thai border ("Highway Five"), for example, in 2000 there were 109 brothels and 46 karaoke lounges where sex workers operate, both places usually frequented by truck drivers and assistants. In Vietnam, a rapid assessment of HIV risks on transport routes conducted in 1999 by the National AIDS Bureau, social scientists, provincial AIDS committees and *World Vision International* found that many of the "hot spots" where there was an active sex industry were near provincial or national borders, or at river and sea ports where land and water transport routes converge. Younger drivers more frequently visit sex workers than older drivers, and alcohol is recognized to play a major role in increasing risky behaviour especially in younger men. Overall, unprotected sex is commonplace.

Several policies and programmes address the risks faced by truck drivers. With support from SIDA (Sweden), the ILO carried out a project beginning in 2002 in eight member countries of the Southern African Development Community (SADC), namely Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland and Zimbabwe to develop national and sub-regional strategies to address HIV/AIDS in the transport sector. The ILO has also produced guidelines for the transport sector based on the *ILO Code of Practice on HIV/AIDS and the world of work*. UNAIDS, the EU and the World Bank are among other organizations funding or implementing projects on HIV/AIDS in the transport sector. Furthermore, many countries have adopted policies that include non-discrimination and HIV/AIDS-related provisions with regard to transport, and bilateral and multilateral agreements have been adopted to harmonize regional transport and border-crossing regulations. National AIDS Commissions are also helping social partners

in the implementation of projects. The International Transport Workers' Federation (ITF), other trade unions, and transport associations are also implementing HIV/AIDS projects in many countries. In the private sector, several NGOs are also implementing projects, and numerous companies based in Asia and in Africa have adopted HIV/AIDS programmes that contain transport-related components. Efforts are therefore broadly-based, but it remains clear that prevention actions with truck drivers must be intensified to substantially alter the behavioural risks in this area of transport work.

Railway workers

Although few studies have focussed on railway workers, it is recognized that many railway workers travel long distances and are absent from home for long periods. In some countries, workers are also regularly placed on duty in places far away from home. Hostels are often provided for accommodation, and bars and sex workers can be found close by. Although many railway companies have traditionally had their own health infrastructures, railway restructuring has increasingly led to their neglect, or their privatization.

National railway companies have become increasingly aware of the serious effect HIV/AIDS has on its workers. Uganda Railway reported that it lost 5,600 workers in the 1990s due to HIV/AIDS, which represented almost 15 per cent of all the company's workers. Indian Railways is the second largest employer in Asia (after the army in China) and the largest public sector entity in the country. It has about 1.8 million employees and almost 7,000 railway stations which service 14.5 million people every day. The distances covered are extraordinary, and a proportion of workers in the railway sector in India are away from home for more than nine days a month. Consequently, there are substantial concerns about the risks they face during absences from home and away from their permanent partners. A baseline survey undertaken in 1994 had already projected that by 2000, 6 per cent of the workers were likely to have become HIV-positive. Actions have been taken by the Government, civil society, the private sector and the Indian National AIDS Control Organization, and Indian Railways is currently providing services to its workers that include voluntary counselling and testing centres, and care and treatment for HIV-positive employees.

Civil aviation workers

Although more than 40 per cent of the total value of world trade of goods is transported by air, the air transport industry contributes in large part to the transport of passengers. In 2003, over 1.6 billion passengers used the world's airlines for business and leisure travel and the industry provided 28 million direct, indirect and related jobs worldwide. About 440,000 flight attendants work on board civil aircraft worldwide. Although the tourism industry has experienced spectacular increases over the past 15 years, airline employment worldwide tended to remain stable in the 1990s, with just a 1 per cent increase between 1992 and 2001; the total number of jobs is expected to rise only slowly to 31 million by 2010.

As the mobility of travellers, tourists and businesspersons has rapidly increased, so have concerns with respect to the HIV/AIDS-related risks faced by workers in the civil aviation industry. Air-travel personnel are at risk of HIV/AIDS in the same ways as other transport workers: even with short absences from home, frequently relationship problems due to mobility can lead to casual sexual encounters. At the beginning of the epidemic, civil aviation as an industry was disproportionately affected, and HIV was diagnosed mainly among men employed in the industry. This was largely due to the relatively high number of men who have sex with men who were employed in the industry at a time when HIV prevalence was high in these populations. As a result, airlines became leaders early on in the response to HIV/AIDS as a workplace issue. Specific problems regarding workplace policies continue to prevail, however, in particular for flight crew living with HIV/AIDS concerning their use of medications and medical regimens. Other outstanding issues concern requirements for pre-employment HIV screening for pilots and co-pilots.

Although airlines were quick to respond, civil aviation workers continue to take risks. In Zimbabwe, for example, findings from a 2002 ILO country assessment revealed that more than 25 per cent of male air transport workers reported multiple sexual partners in the preceding year. Similarly, a recent study of causes of death of 33,063 female and 11,079 male airline personnel in eight European countries found that airline cabin crews are at higher than average risk of becoming HIV-positive. Male cabin crew members were found to have excess mortality from AIDS, and AIDS was the most frequent single cause

of death in this group. On the basis of the study, it appears that HIV/AIDS continues to be an important health problem among male cabin crew in many countries.

Seafarers

There are an estimated 1,200,000 seafarers worldwide¹³ of whom more than half - about 610,000 - are from the Asia-Pacific region¹⁴, principally the Philippines, China, Indonesia and India. Seafarers are young on average: about one third of seafarers in Eastern Asia and 27 per cent in the Indian sub-continent are between 20 and 30 years. Table 7 shows the number of seafarers estimated to come from Asian countries, and national reports of active seafarers for the same countries. The risks associated with mobility in sea transportation also apply to workers in inland navigation systems as inland water transportation is a vital part of integrated long-distance transport networks in many regions. About 1 to 2 per cent of the world's 1.2 million seafarers are women, but their presence is greater in some types of passenger ships: for example, women constitute 19 per cent of personnel on cruise ships, at an average age of 30 years, which is 5 years younger than their male counterparts.

HIV prevalence in seafarers

It has been recognized for some time that seafarers have high rates of STIs. A Danish study for the years 1982-1992 estimated that the HIV risk was about 8 times higher in seafarers than in the general population. In South-East Asia, seafarers have been identified as one of the major mobile groups at above-average risk of HIV infection in Cambodia, Thailand, Vietnam and Myanmar. Even in countries where the overall prevalence of HIV is low, seafarers are at relatively higher risk.

The Department of Health of the Philippines, which supplies the largest number of seafarers of any country, conducted a study of HIV prevalence between January 1984 and December 2003 and found that 12 per cent of an estimated 2,001 persons who were HIV-positive were seafarers and 10 per cent were sex workers. The main mode of transmission in the majority of all cases (85 per cent) was sexual. Of the 2,001 people, 32 per cent originated from the Philippines and worked overseas, and seafarers, who accounted for 38 per cent of HIV-positive overseas workers from the Philippines, were the most affected group among them. Similarly, the Kien Giang

Seafarers, Asia, 1999-2000

Country	Estimates of the number of qualified seafarers 1999-2000	National estimates of the number of seafarers, 2002 or 2003
Bangladesh	9,323	4,273 (1,270 employed)
Cambodia		6,000, mostly fishermen, the majority not registered
China	82,017	500,000 (2/3 serving in coastal or inland waterway fleets; 162,000 in deep-sea fleets)
Fiji	805	5,000
Hong Kong, China	1,943	3,784 (87,424 in 1982)
India	54,700	
Indonesia	83,500	
Japan	31,013	37,063
Korea, Republic of	16,488	
Lao People's Democratic Republic	31	
Malaysia	12,671	
Maldives Islands	2,022	
Myanmar	29,000	57,469 (50% employed)
Pakistan	12,168	2,500 officers (50% employed) 10,000 ratings (25% employed)
Philippines	230,000	563,062 (139,000 sea-based)
Singapore	1,181	
Sri Lanka	10,600	4,466
Taiwan, China	7,046	
Thailand	8,000	10,800
Vietnam	6,667	6,800

Table 7

Sources: BIMCO/ISF, 2000; UNESCAP, 2003; Government of the Philippines, 2003.

Provincial Committee in Vietnam reported 1,239 cases of HIV-positive persons in 2002 in the province, 10 per cent of whom were seafarers.

Working and living conditions

Seafarers are away from their homes for long periods, and this lifestyle gives the opportunity to have multiple sexual partners, including sex workers. The increased mobility of seafarers and inland water transport workers, and of sex workers in search of work is a source of concern with respect to increased HIV/AIDS risks and the potential transmission of STIs and HIV/AIDS in seafarers' home communities, as well as on their transport routes.

Seafarers' working conditions as well as personal circumstances place them at risk. The type of vessel on which they work can constitute the first environmental factor that is a determinant of their level of risk; in comparison with the crew of cargo ships that travel long distances for long periods, for example, the crew of passenger boats are at lower risk of STIs and of HIV/AIDS because they go home much more frequently. In all countries, seafarers may work short trips in

domestic waters and have fair living conditions on board cargo or passenger ships. In all countries also, however, seafarers may be away from their families and homes for long periods while at sea, living in confined areas with limited contacts.

In Kien Giang, Vietnam, for example, seagoing workers typically spend 15 to 20 days per month at sea. When their ships dock at ports, formalities can be time-consuming, and they often wait long periods in ports for ships to be unloaded and the goods on board to be processed. As a result, it is important to many seafarers to maximize their rest and relaxation time. Although many of them strive to maintain contact with their family, long separations provide opportunities to meet new sexual partners at sea or in ports, thus increasing the group's risk of HIV/AIDS. Although no study has established a causal link between the mobility of seafarers and the growth of the HIV epidemic, the contact of seafarers with sex workers remains a cause for concern, and implications for the transmission of HIV are serious because seafarers are a potential disease link between the local populations and their countries of origin as well as every country they pass through, thus

potentially bringing many people into contact with the virus.

All seafarers certainly do not fit the stereotype of “a woman in every port”, but casual sexual relations can become frequent, owing to isolation, the strong sex industry presence in many ports of call, and the limited opportunities for leisure or to spend earnings in other ways while at sea.

Lifestyle studies show that for the same reasons seafarers are more likely than the general population to engage in a range of risky behaviours, such as drinking, which in turn may easily lead to unsafe sex. Few seafarers are aware of the HIV-related risks which accompany drunkenness and the associated state of lost inhibition. When inebriated, people can become more courageous about visiting sex workers, lose awareness of risk, and forget to use condoms. Other risk factors are drug use and misinformation, or plain lack of information. Even when seafarers attempt to engage in healthy lifestyles and to avoid risky activities, the lack of options or access to other leisure activities may defeat them. It appears also that in many ports, there is no organized, effective service where correct information, or treatment for STIs is provided. Nevertheless a number of religious organizations may be found at major ports which provide support to seafarers.

A study of 80 male seafarers in New York early in the epidemic (1988) revealed that they reported sex with 615 women in 1,020 ports in 45 countries. More recent preliminary research results from a study of seafarers in cruise ports in the United Kingdom and the United States confirm that seafarers have multiple sexual encounters at ports, but they appear now more likely to use condoms and take preventive measures when they pay for sex. Nearly a third (29 per cent) of male seafarers reported paying for sex while working on a ship and 20 per cent paid for sex on their most recent or current trip. A fifth (20 per cent) of cruise workers reported a private sexual relationship during their current or most recent trip.

Yet condom use was still found to be highly inconsistent. Many reported they did not think it necessary to use condoms with a woman who is a friend or acquaintance, either at port or on board a ship: only 41 per cent of the seafarers who reported a private sexual relationship used condoms on all occasions, 25 per cent used condoms on some occasions, 6 per cent used condoms the first time, and 28 per cent never used condoms with the person involved.

Other studies in Asia confirm seafarers' risky behaviours. In Indonesia, a behavioural sentinel surveillance of seafarers and other mobile workers revealed a high incidence of sexual relations with sex workers. Up to 72 per cent reported having paid for sex. In Jakarta, Surabaya and Manado, more than half of the 1,600 workers interviewed reported paying for sex in 1999. Their reported frequency of condom use was, however, very low, and condom use was rarely reported for the most recent sexual intercourse with sex workers in most provinces.

Studies of seafarers in Vietnam reveal similarly inconsistent use of condoms, although some changes in behaviour appear to be occurring. A study of seafarers and fishermen in Vietnam after 1998 found that seafarers from all ports were involved in casual sex activities, mainly with sex workers. Sex services were available on-shore and off-shore on boats and small islands off the port coasts. Although sex workers appeared to have a good understanding of HIV and AIDS, they lacked negotiating power with their clients, including seafarers. Many seafarers, on the other hand, did not have a clear understanding of the risk of HIV transmission associated with their behaviour. For example, in Hai Phong, virtually 50 per cent of seafarers, most of whom were married, had never used a condom, and few of them had used condoms with sex workers. A more recent study conducted in 2001 with crew-members of passenger boats in Vietnam found that condom use by crew-members in Haiphong had become common practice when visiting sex workers. But it was not all good news. A significant number of crewmembers had sexual partners in the ports where they docked or had relationships with women traders who travel on boats, and a common view was that condoms did not have to be used with regular partners because the relationship was based on love, not money. Yet casual sex also occurs on board the ships. Finally, a further study carried out by the Kien Giang Provincial Committee in Vietnam in 2001-2002 found once again that having contacts with sex workers or irregular partners was frequently the practice for seafarers, whereas condom use with sex workers was still not consistent. In Kien Giang, 3.5 per cent of the entire population are seafarers.

Women seafarers are at particular risk and they regularly report sexual harassment and occasionally rape. Heterosexual relationships among seafarers aboard cruise ships are a common feature of shipboard life, and it is often on long journeys that condom use

declines. Restricted and frequently non-confidential access to ships' doctors by crewmembers, in keeping with the interests of seagoing employers, may be critical factors in the difficulties women seafarers face in getting diagnosed and treated for STIs, as well as for HIV.

When on shore leave after long journeys that expose them to a high cumulative risk of HIV, seafarers can transmit the virus to their wives and partners in their homes thereby facilitating transmission to their home communities. A study conducted in Denmark in 1994 revealed that 17 of 33 seafarers who became HIV-positive as a result of heterosexual contacts in countries with generalized epidemics transmitted the virus to their spouse or partner in Denmark in at least 5 known cases. In addition, spouses or partners of seafarers may have high awareness of HIV/STIs but the knowledge may not be translated into behavioural change toward the husband or partner.

It is particularly hard for national programmes to reach seafarers with HIV/AIDS prevention information and education as they are away for long periods. Moreover, many shipping companies use flags of convenience from countries which tend to have lower standards for registering and inspecting ships, which places seafarers beyond the reach of their national programmes and generally beyond all regulation. This undermines the application of health and safety standards and any efforts to provide good workplace HIV/AIDS policies for seafarers.

Port workers

Port workers are generally non-mobile, but with globalization many ports have become transport hubs where numerous different types of transport workers from land and sea interact with port workers, other land-based, non-mobile workers, and the local populations. In many countries, ports are places to which entertainment and sex workers come for jobs. The risk encountered by either the sea-based or the land-based workers

depends, however, on the differential in the HIV prevalence in the two populations. In the port of Durban, for example, recent research has shown that the major HIV-risk area is around land-based workers, especially the migrant workers in the city and the long-distance truckers who come to the port to transport cargoes. Consequently, the risk for HIV transmission was far higher from South African truck drivers than from seafarers docking at the port of Durban.

Both inland waterway and sea ports are places where land and water transport routes converge. Although most port workers are non-mobile transport workers, they too are at high risk of HIV. In some countries, there is a high number of migrant workers who are without families amongst ports workers. The sex industry makes sex work readily available in port towns, such as in Cambodia, Indonesia, Thailand, Vietnam, resulting in a high-risk environment for mobile and non-mobile workers alike who dock or work in a port. In Vietnam, for example, there are 19 major ports and many smaller ones, a large fishing industry and cargo ships docking, which all provide a network of meeting places for port workers, seafarers, fishermen and many land-based mobile and non-mobile workers, such as traders and businesspersons, transport workers, migrant labourers, and sex and entertainment workers.

High levels of HIV prevalence have been found in the general population in ports in Asia. In one port in Rayong Province, East Thailand, for example, 4 per cent of women giving birth were found to be HIV-seropositive in the mid-1990s. Many ports lack welfare services for seafarers and port workers: a survey of 136 ports revealed that most ports visited had no welfare services at all, even if several had listed such facilities in port directories.

Fisherfolk¹⁵

Although fisherfolk are not transport workers, their highly mobile work places them at risk of

Safety and health in livelihoods that depend on sea transport

As globalization advances, HIV/AIDS organizations are adapting their programmes and tools in order to address new threats and increased risks. Although the ILO Code of Practice on Safety and Health in Ports, 2003 did not mention the HIV/AIDS-related risks faced by port workers, the guidance provided on the application of the Code does so. The Guidelines on Safety and Health in Shipbreaking for Asian countries and Turkey, 2004 mention HIV/AIDS risk factors in this industry.

HIV, and it has become evident in recent years that fishing communities in many developing countries in Africa, South and Southeast Asia and Central America experience very high HIV prevalence, with rates five to ten times higher than in the general population. Migrant fisherfolk appear to be the most at risk; for example, the highest levels of HIV prevalence of populations present in ports in Asia was found in migrant Cambodian and Burmese fishermen in Thailand.

According to unofficial reports, there are up to 550,000 fisherfolk in Vietnam, and twice that number of persons involved in fisheries and related businesses. Most fishing workers had reportedly little knowledge of health issues such as HIV/AIDS. In Indonesia, over 200,000 households were involved in fishing in 1999, and in Kawthaung, Myanmar, there are an estimated 80,000 fisherfolk. The risk of exposure to STIs and HIV is an important issue in these countries, as well as in Cambodia and Thailand, because workers in the fishing industry take part in the complex movements of persons occurring within and around ports. Fisherfolk are also highly mobile in inland waters, for example in Indonesia and Cambodia, and they dock at port towns where access to sex workers is readily available. In Cambodia, HIV surveillance has confirmed a high HIV prevalence in sex workers in the areas of fisherfolk mobility. Many Burmese work in Thailand, Cambodia and Bangladesh. In Ranong Province alone (South Thailand), there are over 100,000 Burmese persons, most of them working in fishing and fish-related industries.

A survey of 818 fishermen of Thai, Burmese and Khmer origin conducted in five Provinces of Thailand in 1998 found a high HIV prevalence in all three groups. Of the Thai, about 15 per cent were HIV-positive, and HIV prevalence was about 16 per cent in the Burmese, and over 20 per cent among the Khmer. Few men reported having sex with men, and little injecting drug use was reported,

but 16 per cent of the group stated having visited a sex worker outside Thailand, with wide variation between the groups (40 per cent for the Khmer, and 12 per cent for both the Burmese and Thai fishermen).

Deep-sea fishermen in the Philippines are reported also to engage in risky practices such as unprotected sex with sex workers (only about 6 per cent reported condom use) and use of penile implants. In addition, behavioural surveillance in General Santos City in 1997-1999 found a large proportion of deep-sea fishermen engaged in injecting drug use with equipment sharing, reportedly to cope with fear when working in deep seas. Although information dissemination about HIV/AIDS was reported to be extensive in the City, and despite knowledge of the risks involved and the preventive measures needed, risky behaviours were apparently resistant to change.

More recently, sentinel surveillance was extended in 1998-2002 to cover deep-sea fishing boat crews in several provinces in Thailand. HIV prevalence levels were found to vary considerably between provinces and both to decline and rise over the years, but the level of HIV was overall much higher than in the general population (see Table 8).

Several years after establishment of an HIV/AIDS programme, and although fisherfolk had acquired very high knowledge about the disease, it was found in some provinces such as Ranong that the fisherfolk had yet to significantly change their risky behaviours. There is clearly a need to address the specific situations of particular groups of migrant fishermen, as both the frequency of unsafe sex and the use of drugs varied between migrant groups.

Fishermen as a group are exposed to HIV as a result of other factors: they may come from low socio-economic backgrounds and have little education. Their jobs are often

Prevalence of HIV in deep-sea fishing boat crews, 5 Provinces of Thailand, 1998-2002

Province	HIV prevalence by year (%)			
	1998	2000	2001	2002
Songkhla	24.5		5.5	9.5
Pattani	15.5		22	4.5
Ranong	2		9.5	10
Phuket		8.9	7.4	9.3
Trat	8.8		10.2	2.2

Table 8

Source: UNDP, 2004b

dependent on seasonal work and they face hierarchical working relations. Other special risk factors for fishermen include the type of fishing trawler involved, which determines the time spent at sea, during which living conditions on board may be very poor.

In sum, although little is known about seafarers and fishermen in the informal economy, it appears that in Asia a majority of seafarers and fishermen are migrant workers who have an illegal status, and no official estimates take them into account. About 90 per cent of the workers in the maritime industry in Ranong, Thailand, are migrant workers from Myanmar, and most of them are seafarers or members of seafaring families. The majority work illegally as they have not applied for work permits to which they are reportedly entitled. In addition, thousands of Cambodian migrant workers work in the ports, because young men can easily find jobs as fishermen.

Seafarers and fisherfolk: the need for more research and the role of the ILO

Evidence about the transmission of STIs, including HIV/AIDS, among seafarers remains anecdotal and very scattered, and more needs to be known about them in different parts of the world. Also largely unknown is which conditions make crews most vulnerable within the shipping sector, although it would seem that ships with short turnaround times at port, such as container ships, are less likely to provide crews with an opportunity for risky sexual contacts. In addition, most studies use different definitions of seafarers, sometimes including deep-sea fishermen or other categories of fishermen. A consistent methodology to define seafarers and fisherfolk would be needed. In this regard, the 94th ILO (maritime) session of the International Labour Conference which will be held in February 2006 will discuss the definition of seafarers. Furthermore, in many countries, seafarers and fisherfolk in the informal economy are also a significant source of concern, and studies of their HIV risks or HIV prevalence are almost non-existent.

Exposure to the risk of HIV/AIDS increases for seafarers and fishermen when they are illegal migrants. They are often young men with limited knowledge of HIV/AIDS who have opportunities to have multiple sexual partners, but limited access to condoms. Factors that increase their risk include:

- separation from cultural and social norms
- lack or loss of community cohesion and structure
- the need to communicate in a different language
- difficulty in seeking and using existing services which deal with health, legal matters, banking and communication
- lack of alternative occupational opportunities
- poor living conditions
- exploitation
- lack of self-esteem
- lawlessness

Many HIV/AIDS initiatives have targeted seafarers, fisherfolk and sometimes port workers, including national policies, international programmes, trade union and NGO actions, and programmes undertaken by UN agencies such as UNICEF, FAO, UNESCAP, and UNFPA. Also, many large shipping companies have already introduced good in-house training programmes on HIV/AIDS. Nevertheless, smaller companies, which in total represent a large number of seafarers, fishermen and port workers, have not been able to provide such training to date. Moreover, many seafarers and fishermen work in the informal sector, where no activities related to HIV/AIDS have yet been undertaken. Consequently, there remains much scope for improving HIV/AIDS prevention and training programmes as well as care and support activities in these professional groups who are exposed to unusually high risks. Furthermore, efforts to address the mobile professions call for global coordination, in view of the broad reach of their mobility and the virtually global nature of their interactions with land-based populations.

Armed forces

More than 25,000,000 people serve in armed forces globally, excluding civil defence and paramilitary forces. International and national armed forces comprise one of the three occupational groups most affected by STIs, including HIV/AIDS, especially in the developing regions, and HIV prevalence in military personnel has been documented to reach 2 to 5 times that of the general population. The reasons put forward for this

include their age, mobility and working environment. Globalization plays an indirect role in the HIV risk of armed forces, in connection with worldwide deployment in conflict and in peacekeeping missions: in the late 1990s, 36 countries were actively engaged in armed struggle, 8 were confronting international conflicts, and 13 experienced civil disorders. In warfare, both injured military and medical corps personnel are exposed to the occupational risk of HIV transmission from blood.

Uniformed services recruit mainly young, single people. Young people are the most sexually active age group and at the ages of highest transmission with respect to the HIV/AIDS epidemic. In many countries, a large proportion of the nation's young adults spends 1-2 years in the military through either conscription or volunteering, where they live in same-sex quarters away from their families during a life stage when highly influenced by peer pressure. After their period of engagement, they may contribute to the transmission of the HIV/AIDS in the civilian population when they are reintegrated into society.

Lifestyle and working conditions of the military influence their sexual behaviour and multiple contacts. Soldiers for the most part live in closed, mostly masculine communities, where stress, loneliness, tiredness and boredom are commonplace. They are periodically posted to other stations, most often without spouse or partner. Of 480 Nigerian navy personnel surveyed, over 90 per cent had experienced at least one transfer, and 75 per cent of them were transferred up to 8 times, whereas only 15 per cent of transferees travelled with their spouse to the most recent posting. When transferred abroad, the mean duration was 11.5 months. Compared to naval personnel who were not transferred, those transferred abroad reported significantly more risky sexual behaviours, and those who had experienced at least one transfer reported visits to sex workers more often.

In military culture, individuals are trained to knowingly take risks, and may be more inclined to engage in risky behaviours, including drug use, alcohol abuse and unprotected sex. At the same time, they are obliged to endure long periods on duty without access to sex, alcohol and/or drugs that are interspersed with short bouts of leisure leading to intense sexual activity and acute episodes of alcohol and drug use, including injecting drug use.

In many cases, military personnel have more financial resources than the people living where they are posted, giving them means to pay for sex. Military camps including installations of peacekeeping forces, tend to attract sex workers and illicit drug dealers. Not infrequently, military and law enforcement officers are recognized as among the largest groups of clients for sex workers. A study of clients of sex workers in Cambodia found that 7.7 per cent were military or from the police. Law enforcement clients are reported occasionally to provide protection and look the other way in exchange for free sexual services.

Soldiers on deployment have a high rate of sexual contacts with the local population and with sex workers: of Dutch navy and marine personnel on peacekeeping duty in Cambodia, for example, 45 per cent had contact with sex workers or other members of the local population during a 5-month tour. Troop and fleet deployment increase the risk of HIV, in particular when sailors or soldiers are stationed in high HIV prevalence areas, including port cities. An epidemiological study of HIV transmission in the French military revealed that overseas duty tours multiplied HIV risk fivefold.

Estimates of STIs in the uniformed services suggest the level is twice that in the general population. With respect to HIV, studies in the USA, the UK, and France in the mid 1990s have shown soldiers to have a far higher risk of HIV than equivalent age and sex groups in the civilian population. Of more than 80 types of medical events reported to the US Army medical treatment facilities by US military (including dependants and retirees), the most frequently reported by far are STIs suggesting high levels of unprotected sex.

Similarly, HIV prevalence in military and uniformed populations in African countries in the mid 1990s exceeded rates in the civilian population: Cameroon reported HIV rates of 6.2 per cent in the military and 2 per cent in the general population in 1993, and Mozambique rates of 39.1 per cent in the military and 15.3 per cent in the general population in 1997-99. By the late 1990s, very high HIV prevalence rates were reported in military structures across sub-Saharan Africa, in Angola (40 per cent), the Democratic Republic of the Congo (60 per cent), the United Republic of Tanzania (15-30 per cent), Côte d'Ivoire and Nigeria (10-20 per cent), and in Eritrea (10 per cent). HIV prevalence rates are shown for selected Asian countries in Table 9.

Size of armed forces, HIV prevalence, and HIV in the general population, selected Asian countries

Country	Size of armed forces	Reported HIV prevalence in armed forces (year)	Other HIV prevalence (year)
Cambodia	About 120,000	5.9% (1995) 7.0% (1997)	Adult population 2.5% (2005) Police 6.2% (1998) 3.9% (2002)
India	Active military 1,000,000 Reservists 535,000	1.3% (2000) 0.77% (2001)	Adult population 0.9% (2005)
Myanmar	About 330,000	0.56% (1992) 2.22% (1999) 1.4% (2000)	Adult population 1.3% (2005)
Thailand	223,000 (2002) 190,000 (2005)	3.6% (1993) Military recruits 13-14% (1991-95) Military recruits 0.7% (2001)	Adult population 1.4% (2005)
Vietnam	n.a.	Military recruits 0.64% (2002)	Adult population 0.6% (2005)

Table 9

Sources: *Asia-Pacific Military Conference XIII, 2003; Chantavanich et al., 2000; Hugo, 2001; UNAIDS, 2003c; UNAIDS, 2004a; Yeager (post 1999)*

Condom use by military and uniformed personnel varies. Over 40 per cent of military personnel from southern Africa, for example, reported unprotected sex during deployment. Of the 480 Nigerian navy personnel surveyed, 32.5 per cent had contact with a sex worker, and 41 per cent of them had not used a condom. A study of clients of sex workers in Cambodia found that 69.7 per cent of the military and 81.3 per cent of the police used condoms regularly, but these rates are still below the 90 per cent target set by Cambodia's National Program for HIV/AIDS Prevention.

During armed conflict, perceptions of risk can change, and soldiers and civilians may take greater risks. It has been noted that sexual activity increases, more women fall back on sex work, and prevention of STIs recedes in importance. Violence is common and generalizes to sexual violence, including rape, torture and slavery, violating all human rights standards. In 2004, sexual violence against women was reported on a massive scale in at least 8 countries experiencing armed conflicts in the African, Asian, and Latin American and Caribbean regions.

Armed conflict has also been linked to increased drug use, which heightens the risk of personal violence and unprotected sex. In the aftermath of conflict, also, it is not unusual for opportunistic trafficking in drugs and human trafficking by organized crime to raise risk levels in the population for a time, as in the post-Yugoslavia zone and era.

Although a violation of basic principles such as the principle and right of non-

discrimination at work and voluntary guidelines regarding protection of workers' rights such as the *ILO Code of Practice on HIV/AIDS in the world of work*, screening for HIV is common practice in the military. An international survey in 1995-96 of about 60 national military revealed that HIV testing in some form was carried out by 93 per cent of reporting structures, and 74 per cent reported mandatory testing for at least one purpose (46 per cent at recruitment and 43 per cent before overseas deployment). Of the military structures that test, 83 per cent (45 of 54) rejected candidates found HIV-positive at recruitment, 79 per cent restricted HIV-positive personnel to non-combat or non-flight duty (44 of 56), and 90 per cent excluded them from overseas duty (37 of 41).

Such discrimination is not practised by the UN Department of Peacekeeping Operations (DPKO). Although medical examination for peacekeepers determining fitness for service is expected to identify clinical signs of immunodeficiency, if any, and on that basis, individuals with AIDS are excluded, the UN does not exclude HIV-positive personnel from serving in a mission because of their HIV status. Also DPKO does require that all uniformed peacekeepers be offered voluntary testing and counselling (VTC) prior to deployment, but stipulates that this should not be interpreted as a requirement for mandatory testing. Furthermore, DPKO recommends that the countries sending peacekeeping troops offer VTC because they recognize that medical care for DPKO staff who become ill while on mission may not reach the same standards as in their sending country, a

situation of particular relevance in the case of opportunistic infections that are particularly difficult to treat.

A great expansion of peacekeeping operations has occurred in recent years: between 1997 and 1999, 16 DPKO missions got underway, a third of all such operations undertaken since 1948. In 2004, DPKO was involved in 15 missions globally, with more than 45,000 troops, civilian police and military observers from 88 countries. In each situation, there is not only a formidable amalgam of troops from globally distant areas, but a likelihood of sexual networks crossing that might not otherwise come into direct contact: the United Nations Mission in Sierra Leone (UNAMSIL), for example, drew 17,500 personnel from 38 countries in Asia, Africa, and the developed regions in 2002.

HIV/AIDS poses a particular threat because both conflict and post-conflict situations are high-risk environments for HIV transmission. A third of officers and soldiers under UN command are stationed in Africa, where HIV prevalence is highest. The HIV rate in Nigerian peacekeepers returning from Sierra Leone and Liberia in 2000 was 11 per cent when the civilian adult prevalence in Nigeria was 5 per cent. There is evidence of peacekeepers becoming HIV-positive not only in Africa, however, but also in Asian countries.

Involvement of peacekeeping personnel in sexual exploitation and abuse has been documented in operations including Bosnia and Herzegovina, and Kosovo in the early 1990s, Cambodia and East Timor (now Timor-Leste) in the early and late 1990s, West Africa in 2002, and the Democratic Republic of the Congo in 2004. DPKO was informed in 2004 of 105 allegations against DPKO personnel of sexual exploitation and abuse concerning minors (45 per cent), sex workers (31 per cent) and rape that were subsequently investigated. Such acts violate international humanitarian law, international human rights law or both and are intolerable. The UN Secretary General has taken measures to prevent such abuse, to review procedures and strengthen adherence, investigate allegations and conduct stringent follow-up on disciplinary action by States against repatriated peacekeepers.

Authorities are reluctant to release HIV data for strategic or political reasons, but what evidence is available suggests that AIDS in the uniformed services is of concern to many states, especially when uniformed personnel

comprise a significant proportion of the population. Reports suggest that high HIV-prevalence is causing losses in command-level continuity, reducing military preparedness, raising recruitment and training costs and is ultimately debilitating some national uniformed services.

Countries in all regions are increasingly implementing prevention education and condom distribution in their ranks. UNAIDS and DPKO have set up effective HIV/AIDS interventions in peacekeeping operations and in national uniformed services in many countries since adoption of UN Security Council resolution 1308 in 2000 on the global threat of AIDS to international peace and security. Weaknesses are being systematically addressed. All DPKO missions now have a dedicated HIV/AIDS policy adviser or focal point, and a pre-deployment training module on HIV/AIDS was developed for worldwide dissemination. UNAIDS has also established collaboration with NATO and COMEDS, their health advisory body, to address HIV in NATO troops being deployed in non-traditional areas, especially for peacekeeping purposes.

Child soldiers face high risks of becoming HIV-positive, especially during conflict. It is estimated that there were 300,000 child soldiers on active duty in 2002 in more than 30 countries, although this is almost certainly a gross underestimate. Often forcibly recruited, they are targets for sexual exploitation and abuse that place them at high risk of STIs, HIV/AIDS, unwanted pregnancy, and other serious mental and physical damage. Child recruits are often given drugs or alcohol to encourage them to fight. Child soldiers have frequently to provide sexual services in addition to fighting. Girls who are forcibly recruited are frequently attributed to military commanders to sexually service them. In one *Save the Children* programme in West Africa, 32 per cent of all girls in armed service reported having been raped, 38 per cent were treated for STIs, and 66 per cent were single mothers. Such experiences of forced sex in childhood, furthermore, have implications for later life, as they increase the likelihood of engaging in unprotected sex, having multiple partners, participating in sex work, and engaging in substance abuse. Victims of rape and forced sex may find it difficult to negotiate condom use. Most importantly, sexual coercion is associated with low self-esteem and depression, factors that can lead to risk-taking and behaviours linked to HIV exposure.

The use of children in armed conflicts constitutes one of the worst forms of child labour. The ILO, through its InFocus Programme on Child Labour (IPEC), is making every effort to eliminate it.

Volunteers

As globalization increases the supply of information about far-off places and reduces the cost of travel, increasing numbers of young people travel overseas in search of adventure, to discover and learn about other cultures, meet new people, and to pursue job opportunities or higher education and build their careers. Young people also engage in volunteering to support peace, humanitarian relief or development initiatives overseas. Volunteering is not a new phenomenon – many organizations have sent volunteers since the 1960s – but globalization has given momentum to the phenomenon.

Although volunteering constitutes a very positive experience for volunteers and the communities that receive them, it is an experience that also carries a range of health risks, including risk of HIV. As volunteers are often sent to countries where the HIV prevalence of the local general population is higher than in their home countries, the very young age of volunteers and their living and working conditions put them at increased risk of becoming HIV-positive. Yet the risk is one that can be avoided if adequately identified and addressed. As in the case of UN Peacekeepers and other military forces, education and training are provided to many volunteers before their mission, and counselling and condoms are available throughout their time in the field. Peace Corps Volunteers and UN Volunteers, for example, receive pre-departure information on the prevention of STIs and HIV. Studies show that such efforts need, however, to be intensified.

The number of skilled international volunteer personnel was estimated in the second half of the 1980s at about 33,000 globally, including volunteers from government-sponsored organizations and private sources. There are few current estimates of similar quality, although the numbers of volunteers can be assumed to have increased considerably in the last ten years.

The largest sending countries, taking account of government-sponsored organizations and private sources, are the United States, the United Kingdom, Canada, Australia, France,

Germany, Switzerland, Japan, and New Zealand. The United Nations sends volunteers under the UN Programme for Volunteers (UNV). The CIVI programme in France is special in that it sends young professionals to postings in the private sector and in embassies worldwide. Table 10 displays information on these different sources.

Volunteers can be veritable globe-trotters. In 2004, for example, UNV sent more than 7,300 professionals from 163 countries, of which 77 per cent originated from developing countries, to 139 destination countries. The average length of stay of volunteers overseas is around 2 years, sometimes in different countries.

There are three key defining characteristics of volunteering:

- the activity of volunteering is not undertaken primarily for financial reward
- the activity is undertaken voluntarily
- the activity is of benefit to someone other than the volunteer, or to society at large, although it is recognized that volunteering brings significant benefit to the volunteer as well

Within this broad framework, volunteers engage in highly varied activities, including work in the field of HIV/AIDS itself. Peace Corps volunteers, for example, help local communities in education, business development, agriculture, the environment and youth projects, as well as work in the field of health and HIV/AIDS. Also, apart from activities to combat HIV/AIDS and support those affected by the disease, some organizations involve people living with HIV/AIDS in their projects. For example, through the Greater Involvement of People Living with HIV/AIDS Project, UN Volunteers – many of them living with HIV/AIDS – work to develop prevention, care and support activities, in various countries. Furthermore, some volunteers, such as UN Volunteers, may work as humanitarian workers in conflict situations.

The reason that volunteers face unusual HIV risks is that they are often sent to developing countries where HIV-prevalence is generally higher than in their home country, and sometimes to remote areas of those countries. Where they work, they are in close contact with the local population, and may be interacting with specific risk groups or people who are HIV-positive. Many volunteers often find themselves in isolated, unstable and unfamiliar surroundings, totally at the opposite

Volunteers, destinations and length of stay, UNV and government-sponsored organizations, latest available year

Organization	Number of volunteers	Main destinations	Average length of stay
UNV	7,300 in 2004	139 countries: • 52% in Africa • 17% in Asia & the Pacific • 16% in Latin America & the Caribbean	24 months
Peace Corps (United States)	7,733 in 2003	72 countries: • 2,730 in 26 countries in Africa • 2,600 in 32 countries in the Inter-America and Pacific regions	27 months
CIVI (France)	2,316 in 2003	• 38% in Europe • 18% Asia & the Pacific • 13% Sub Saharan Africa & Indian Ocean • 12% North America • 8% Latin America & the Caribbean • 8% North Africa & Middle East	6-12 months, 19-24 months or 13-18 months
Voluntary Service Overseas (UK)	2,000 in 2004	40 countries	24 months
Canada World Youth	1,088 in 2003	About 600 abroad	2 weeks to 8 months
Australian Volunteers International	500 Volunteers June 2005	48 countries	Usually 24 months, or between 12 and 36 months, and 8-12 weeks for younger volunteers

Table 10

UN Volunteers, www.unv.org; Peace Corps, www.peacecorps.gov; CIVI (Centre d'Information pour le Volontariat International) www.civiveb.com; Voluntary Services Overseas www.vso.org.uk; Canada World Youth www.cny-jcm.org; Australian Volunteers www.australianvolunteers.com

of their social, cultural and economic situation at home. They may engage in risky behaviours, including taking sexual risks, which they might avoid in their home setting.

Most volunteers are young, between 18-30 years old. The average age of Peace Corps volunteers, for example, is 28 years; 58 per cent of the candidates who apply for CIVI volunteering in France are 25-28 years old, and 38 per cent are 21-24 years old. Youth constitutes a risk factor of itself, given that 15-29 year-olds are at increased risk of HIV/AIDS and young persons 15-24 years old make up an estimated one-half of all new infections in many developing regions. These risks are for both the local population and for the volunteers because contacts are between young people who are sexually active and may be highly sexually mobile in each population.

In addition to being in sexually active ages, volunteers may often be led to engage in risky behaviours by an idealistic vision, associated with a very malleable stage of life, and their feelings about having a situation that is usually better than that of the local population. As aid or humanitarian workers, volunteers may in

fact be in direct contact with the very poorest or highest risk groups among the local population. In contrast to expatriates, who are usually posted abroad to represent a company or a country, volunteers often choose to bring assistance to disadvantaged people in response to feelings of privilege living in wealthier societies. As a result, like many aid or humanitarian workers, volunteers can become "indigenized" by working in the field and adopt a mentality of embracing the life styles of the local community. In the process, they become more familiar with local cultures and traditions, which can be beneficial to their mission or mandate of work, but also as a result, they may become less aware of, or acquire a feeling of invulnerability to, existing risks in the country. Moreover, the cultural and social gap they face and the difficult situation of people they help can also contribute to create tensions of frustration or stress, which they may in turn try to relieve through risky behaviours.

In this way, among other actions, volunteers may engage in acts of unprotected sexual intercourse, exposing themselves to the risk of HIV/AIDS. Studies of Peace Corps

volunteers underscore the predominance of unprotected sexual intercourse as a risk factor for HIV transmission in the course of Peace Corps service (see box).

The Peace Corps acknowledges that these risks are taken by volunteers and presses the need to continually educate them throughout their service about strategies to reduce risk behaviours. As a result, the Peace Corps achieved a 16-month period ending December 2003 during which returning volunteers were HIV-free (see box).

Expatriates and young travellers

Very few other studies exist on the health of volunteers, and virtually no studies analyse their sexual behaviours and exposure to STIs and HIV/AIDS. Studies on two other groups, however – expatriates (largely for the private sector) and young travellers – provide useful indications of the types of sexual behaviours taking place in connection with work abroad, and a parallel can be drawn between the risks faced by volunteers and those faced by travellers and expatriates when overseas, even if the reasons that lead each group to work abroad can be quite different¹⁶. Aspects of their experiences that contribute to the risk of HIV transmission include:

- Being out of the home setting which can lead to feelings of loneliness, boredom and insecurity
- Unfamiliar surroundings and atmosphere, far away from the day-to-day routine which removes signals and structures of daily behaviour
- The absence of social constraints that prevail at home, releasing limits to behaviours that would not take place at home, such as casual sexual relations
- A freer sexual culture in the place of destination, and easy access to sexual opportunities especially in bars
- For some expatriates, a positive intention prior to departure to have sex abroad, although reasons may differ: for some, it is to get immersed in the local culture and engage in intimate relations with a local person; for others, it is to avail themselves of sexual services not accessible for social or other reasons at home
- The perception of the sexual partner by an expatriate: for example, sexual relations with women who are not working in brothels are viewed as friendship rather than prostitution, and payment, whether in kind or cash is viewed as a gift
- Being a woman, since inconsistent condom use appears to be more prevalent among women expatriates: women more often do not go abroad with condoms, and do not have the intention before departure to have sex abroad
- Work-related stress and other tensions, associated with relief drinking and drug use
- Some expatriates mention being “pressured” by a local partner to continue relations after a first sexual encounter, which increase their risk of HIV
- Expatriates frequently report that they have had to take the initiative to use condoms over the objections of local partners who viewed the use of condom as an accusation of HIV infection
- In rare cases, humanitarian workers have been placed in a position of power and exercised a false superiority in relation to the local population, for example, refugees, by instigating sexual abuse
- Humanitarian staff and volunteers may face occupational exposure to HIV in health-care settings as well as increased exposure to sexual violence.

Being abroad and therefore out of one’s home setting specifically presents opportunities

Peace Corps Volunteers and post-exposure prophylaxis for HIV¹⁷

- Between July 1997 and December 2001 there were 240 consultations to the Office of Medical Services of the Peace Corps in regard to HIV post-exposure prophylaxis (HIV/PEP), and HIV/PEP was recommended for 78 per cent of them (72 per cent accepted the treatment). 150 or 81 per cent of the exposures were sexual exposures
- Of the 150 sexual exposures, 71 per cent reported exposure following consensual sex. Of the 71 per cent, 66 per cent reported using a condom that broke, slipped off or was used improperly, and 34 per cent reported no condom was used
- Of the men receiving HIV/PEP, 19 per cent involved intercourse with a sex worker.

to engage in risky behaviours that are unlikely at home, including alcohol abuse, increased sexual activity, visiting sex workers, and use of drugs. Studies have shown that sexual activity and risk of HIV are relatively high in young travellers and expatriates: for example, studies of European expatriates in 1988 and 1992 found high HIV prevalence rates. As the HIV prevalence associated with heterosexual contact is typically higher in the destination developing countries than in their home countries, unprotected heterosexual contact is riskier in the destination countries for young travellers and expatriates as for many volunteers. Furthermore, studies show that travel itself facilitates increased sexual activity

of travellers when abroad when compared to time spent at home: travellers from the UK, for example, had an average 0.098 sexual contacts per week at home, but 0.247 per week while abroad.

Although the use of condoms by travellers and expatriates reportedly became more frequent in the mid 1990s than in the 1980s, condom use remains inconsistent, and constitutes a major cause of concern as it exposes those groups to sexually transmitted infections including HIV/AIDS in places and in situations that heighten both sexual activity and the risk of HIV transmission.

HIV incidence in Peace Corps Volunteers¹⁷

On the basis of voluntary HIV testing, 32 HIV infections are known to have been acquired by volunteers during Peace Corps service between 1987 and December 2003. Between September 2002 and December 2003, no newly identified HIV infections were reported among Peace Corps Volunteers (PCVs), which represents the longest HIV infection-free interval on record for the last 15 years. Results of studies on HIV incidence in PCVs show also that:

- Despite the introduction of prevention modules and videos on STIs and HIV at the end of 1994, the impact was not maintained: HIV incidence declined in 1995 and 1996, but increased in the years 1997, 2000 and 2001
- The highest age-specific incidence of HIV during 1993-2003 occurred in volunteers 30 to 39 years
- The lowest incidence occurred in volunteers under 25 years
- The incidence in women was 38 per cent higher than in men during 1993-2003
- There were 40 unintended pregnancies in 2003
- Between 1993 and 2003, the incidence of HIV infection in the Africa region was more than 4 times the incidence in the Inter-America and Pacific region. No cases of HIV infection occurred in the European, Mediterranean and Asian regions
- Between 1997 and 2001, 173 volunteers received HIV post-exposure prophylaxis (PEP) and none became HIV-positive (see box).

Unprotected sexual relations of travellers and expatriates¹⁸

A 1996 study of 5,676 unaccompanied young travellers from the UK (18-34 years old) who reported a new partner on a trip showed that 75 per cent used condoms on all occasions and 12 per cent never used condoms. But condom use in 2000 by young travellers in Canada who reported a casual sexual partner while on a trip was only 64 per cent. In addition, increasing numbers of young women who have travelled overseas from the United States are becoming pregnant abroad.

A study of 864 Dutch expatriates revealed that among those who had been abroad for about 2.2 years between 1992-1996, 41 per cent of the men had had sex with casual or regular local partners and 11 per cent with expatriates, as had 31 per cent and 24 per cent of the women. Only 69 per cent of men and 64 per cent of women had consistently used condoms with casual local partners. Supplying oneself with condoms has become customary for many expatriates before travelling, but some expatriates continue to engage in unprotected sex with local partners or other expatriates for a variety of reasons:

- Without the intention before departure of engaging in new sexual relations, they were surprised by the large supply of sexual services, and became accustomed to a freer sexual culture in the country of stay. They report that sex happens unexpectedly, hence condom use is less consistent
- Expatriates who had been posted abroad more frequently and for long periods of time were more likely to report feeling invulnerable when having unprotected sex as they had been abroad for many years and were familiar with the local situation.

Consequently, sexual health promotion for expatriates, travellers and volunteers remains very important, in particular for the youngest groups of adults who might not have been exposed to promotion interventions in their home settings. Targeted interventions are also very important in the countries of destination, not only aimed at expatriates, travellers, volunteers and aid workers – a task that could be more vigorously undertaken by consular services for foreigners as much as by local authorities – but also, importantly, at the local population to enhance their own HIV prevention.

As a contributing risk factor, use of alcohol adds substantially to the risk of engaging in casual unprotected sexual relations. Studies have shown that alcohol and drug consumption have important effects on the sexual behaviour of both travellers and expatriates. Similarly, among problems reported to the Peace Corps Medical Office, the incidence of problems with alcohol is relatively high, although it has declined from a peak in the mid-1990s, in part due to education and information programmes.

HIV/AIDS, global travel and the leisure industry

Aside from young travellers, there are millions of people who move for short periods over long distances because they enjoy travel. Globalization has greatly enhanced opportunities and access to international travel for travellers at different levels of income. The particular circumstances that are favourable to their enjoyment of travel - they have free time, a desire to enjoy themselves, generally have resources, and may have fewer behavioural constraints than when at home - tend also to increase their risk of exposure to HIV/AIDS. Although tourism is clearly not a "job" for the traveller, the majority of tourists and travellers still count among the labour force at home when not travelling. Importantly, moreover, their travel is accompanied, guided, advised, and managed by a group of workers who interact with them and who share similar risks. In addition to the risks to civil aviation workers outlined earlier, there are high risks for people whose livelihoods are part of the network of the hospitality industry, including sex workers.

In terms of transport alone, tourism has experienced a spectacular increase in the last few years, as shown in the table below. About 684 million international tourist arrivals occurred worldwide in 2001, of which nearly 270 million by air, 346 million by road, 20 million by rail and 46 million by ship (see Table 11).

Since then, tourist transport experienced a spectacular rebound. According to preliminary results, international tourist arrivals reached an all-time record of 760 million in January 2005, corresponding to an increase of 10 per cent compared to 2004, which had not occurred in 20 years. The highest level of growth between 2003 and 2004 occurred in Asia and the Pacific region, with an increase of 29 per cent. Some destinations beat all-time records in 2004, such as China which saw a growth in inbound tourism of 37 per cent. China had already gained almost 17 million international tourist arrivals between 1995 and 2002, and registered a total of almost 37 million tourist arrivals in 2002 alone. By 2002 China was already in the fifth position for the world's top tourism destinations.

Travellers, sex workers and workers in the hospitality industry

The last 20 years have seen a boom not only in the tourist industry but also in business travel. In 2002, over 1.6 billion passengers worldwide used the world's airlines for both business and leisure travel, and their number is expected to exceed 2.3 billion by 2010.

International tourist arrivals by known mode of transport and average annual growth, world (millions)

	1990	1995	2000	2001	Average annual growth rate (%) 1990-2000
Air	161.1	207.0	275.9	269.4	5.5
Road	236.5	284.7	342.7	345.9	3.8
Rail	22.0	16.9	19.7	20.3	-1.1
Water	29.3	39.7	46.7	46.2	4.7
Total*	455.9	550.4	687.3	684.1	4.2

Table 11

Source: World Tourism Organization, 2003a

*Known modes do not add up to total because of residual unspecified modes, which represented 7% in 1990, 2% in 1995, 2.3% in 2000, and 2.2% in 2001

The increase in tourism and business travel has also resulted in an increase in the opportunities for risk-taking behaviour and for “sexual tourism”. Tourist-oriented prostitution - known as sex tourism - is a phenomenon that causes consternation. For many developing and developed countries, income from tourism is a significant source of revenue, but the negative impact of sex tourism on their societies is of critical concern, in particular because of the implications for public health. It is not surprising that to some observers the dramatic increase in world-wide movements of people, goods and ideas made possible by globalization of communication and transportation appears to be “the driving force” behind the globalization of the HIV/AIDS epidemic. People travel increasingly, but they also travel much more rapidly, and go to many more places than ever before, thus raising the potential transmission of HIV. Although the specific role that tourism itself has played in the epidemic is not clear, and despite efforts to control the epidemic, travel continues to be perceived as a risk factor associated with the worldwide dissemination of HIV/AIDS. It remains true, in any case, that the travellers themselves are at the nexus of the industry, connecting different sectors of work, such as the transport sector, the hospitality industry and sex workers.

The development of tourism in many countries has brought major foreign currency earnings, and has expanded employment in the service sector, such as in the hotel and restaurant sector, and in related commercial enterprises. As an indirect consequence, tourism has also brought about growth in sex work. Many tourist areas are promoted as special tourist destinations when aside from historical attractions and natural landscapes, they in fact also have a thriving sex industry. In addition to the sex industry that caters to the local population, tourist areas have seen the development of a sex industry catering to foreigners, for example, in Thailand, the Philippines, Indonesia, Cambodia or Vietnam. Direct publicity offers sex tours for foreign tourists, as well as indirect marketing that promotes the night life of many cities with a sex industry.

Travelling and HIV/AIDS

There is evidence that sexual contact is a risk factor for HIV acquired abroad: studies of international travellers from the UK, for example, indicate that a large number of heterosexual cases of HIV in the UK are

associated with sexual activity abroad. Epidemiologists have estimated that the risks associated with sex abroad for heterosexuals may be several hundred times greater than the risks at home.

The factors that place travellers and tourists at increased risk of HIV/AIDS are not unlike the factors that increase the risks for volunteers, humanitarian workers and expatriates:

- *Travellers take risks that they would not take at home.* For some travellers, being abroad on holiday or a business trip is the occasion to indulge in risk-related activities they are less likely to practise at home, including increased sexual activity - sometimes with sex workers - and drug use: even without knowingly taking risks, travellers tend to drink more, use drugs more and generally be more outgoing when abroad than at home.
- *Furthermore, alcohol or drug consumption influence the sexual behaviour of travellers:* most research shows that mood enhancement through alcohol or drug use and a “partying” or “have fun” mode on holiday are closely associated with high-risk sexual behaviours.
- *Length of time abroad:* both very short trips and travelling for longer than 15 days are associated with more risky behaviour.
- *The perception of the partner can alter the perception of risk.* In many settings tourists do not identify themselves as sex tourists or persons from the local population as sex workers. In a study of unaccompanied women who entered into sexual relationships with local and migrant men in a tourist area, the respondents did not see their relationships as a form of prostitution, even though 60 per cent of them acknowledged having given cash or gifts to the local sexual partner.
- *Personal characteristics alter the level of risk.* Unaccompanied and young travellers are among the most at risk. Casual sex while travelling is more frequently reported by men (women are less likely than men to report a new sexual partner while travelling).
- *Individuals travel with different experiences and different expectations:* having a history of casual sex prior to travel, having a higher number of partners prior to travel, having paid for sex, been treated for an STI, or consulted a clinic for STIs in the preceding 5 years, and expecting to have casual sex while travelling are all linked to the level of risk.

Accordingly, increased travel and tourism have been accompanied by an increase in tourism-oriented prostitution, even if many travellers do not plan in advance to visit sex workers in the country of destination. When travellers visit sex workers, it is a risky situation for both groups and leads to a potential doubling of the opportunities for HIV transmission, as travellers and sex workers may each also constitute a means of transmission of HIV while abroad and in their home communities on return, which may be another country for the traveller, and a rural community for the sex worker. In sum, the increase in tourism and travel worldwide allows for the rapid mixing of sexual networks that would otherwise never come into direct contact.

Sexual tourism

People who engage in sexual tourism¹⁹ include not only tourists for whom the main motivation to travel is the opportunity to use the services of sex workers, but also travellers

whose main motivation is tourism or business, but who have sexual relations with sex workers once in the country or place of destination because the situation or opportunity arises. These situations apply in one way or another to different types of travellers, including genuine tourists, business, conference and other travellers²⁰.

Beyond sexual tourists, there is also a small but active group of child sex tourists who are pedophiles. The commercial sexual exploitation of children has paralleled the growth of tourism in parts of the world, and the incidence of child abuse and exploitation at tourism destinations has increased along with the development of their tourism in recent years. Child prostitution is a grave violation of human rights and an intolerable form of child labour, and the protection of children against this scourge is being addressed through numerous international, regional and national human rights and children's rights instruments, including various ILO instruments (see box).

ILO instruments that protect children from sexual exploitation

ILO instruments that address child sexual exploitation include the Minimum Age Convention, 1973 (No.138), the Worst Forms of Child Labour Convention, 1999 (No.182), the Forced Labour Convention, 1930 (No.29), the Abolition of Forced Labour Convention, 1957 (No.105), and the ILO Declaration on Fundamental Principles and Rights at Work (1998).

Each Member State ratifying C.138 undertakes to pursue a national policy designed to ensure the effective abolition of child labour. The ILO Report (1998) *Targeting the intolerable* notes that: "Child prostitution, child pornography and the sale and trafficking of children are crimes of violence against children. They must be treated as crimes... Yet while they are crimes they are also forms of economic exploitation akin to forced labour and slavery." Consequently, the ILO elaborated the Worst Forms of Child Labour Convention, 1999 (No. 182) that calls for immediate action and effective measures to secure the prohibition and elimination of the worst forms of child labour as a matter of urgency, irrespective of the country's level of development. Article 3 of C.182 provides that the term *the worst forms of child labour* comprises, among other things, all forms of slavery or practices similar to slavery, such as the sale and trafficking of children, debt bondage and serfdom and forced or compulsory labour, including forced or compulsory recruitment of children for use in armed conflict; and the use, procuring or offering of a child for prostitution, for the production of pornography or for pornographic performances.

The ILO bodies supervising the application of international labour standards had already addressed the issue of child prostitution in several countries under the earlier Forced Labour Convention, 1930 (No.29). Forced or compulsory labour is a severe violation of human rights and restriction of human freedom. C.29 defines forced labour as "all work or service which is exacted from any person under the menace of any penalty and for which the said person has not offered himself voluntarily" (Article 2(1)). Forced labour is also one of the worst forms of child labour, as defined in C.182. Child labour

amounts to forced labour not only when children are forced, as individuals in their own right, by a third party to work under the menace of a penalty, but also when a child's work is included within the forced labour provided by the family as a whole.

The ILO Declaration on Fundamental Principles and Rights at Work (1998) commits Member States to respect and promote fundamental principles and rights in four categories, whether or not they have ratified the relevant Conventions. These categories include the elimination of forced or compulsory labour and the abolition of child labour.

The Declaration makes it clear that these rights are universal, and that they apply to all people in all States, regardless of the level of economic development. In article 2 of the Declaration, the International Labour Conference declared that all Members, even if they have not ratified the Conventions recognized as fundamental both inside and outside the Organization, have an obligation arising from the very fact of membership in the Organization to respect, to promote and to realize, in good faith and in accordance with the Constitution, the principles concerning the fundamental rights which are the subject of those Conventions, namely:

- (a) freedom of association and the effective recognition of the right to collective bargaining;
- (b) the elimination of all forms of forced or compulsory labour;
- (c) the effective abolition of child labour; and
- (d) the elimination of discrimination in respect of employment and occupation.

Although many countries recognize that they rely on receipts from the tourism industry, in fact a number among them rely as heavily on receipts from the sex industry. The activities of the sex sector are recognized to have indirect growth effects, generating employment in the hotel and restaurant sectors. As a result, in some countries, sex work is tacitly acknowledged as a major attraction bringing in tourists and sex work is ignored by the authorities despite police crackdowns. In one country in South-East Asia, the number of people with financial connections to the sex sector was estimated to exceed 1.2 million, including 200,000 sex workers.

Sex workers

In many countries, the sex worker industry predates tourism and independently caters to demand from local men, mobile workers and foreign businesspersons. Sex tourism has come to represent one segment of the tourism market involving a minority of migrant persons, expatriates and tourists. With the development of tourism and increase in travel, however, in addition to 'sex tourists', there are increasing numbers of ordinary travellers who visit sex workers in the destination country without having planned to do so. So-called 'situational' or 'opportunistic' sex tourists are increasing, owing to various factors including the desire for new experiences, the absence of moral and social constraints, a feeling of

impunity linked to anonymity, and having the means to do so.

The mobility of sex workers plays a key role in their exposure, the exposure of their regular non-paying partners, and the exposure of sex workers' clients and spouses or partners of those clients to HIV and STIs.

Furthermore, potential mobility makes women and young people more easily fall prey to sexual exploitation: women who migrate for economic reasons are especially vulnerable to sexual exploitation or to being trafficked. Both sex workers and clients may be economic migrants who travel for, or in search of work. This mobility makes effective and sustainable prevention far more difficult.

Moreover, children exploited in sex work face high risks of HIV/AIDS, and are much less likely than adult sex workers to have access to information and means of prevention, including condoms. Even when they have access to condoms, many aspects of their situation conspire to render them powerless to negotiate condom use with clients.

In parallel with globalization, sex work has become more mobile within the industry as well as within and across countries. An HIV/STI sentinel surveillance survey conducted in Indonesia in 1998-2000, for example, found a very large turnover in the sex

industry: 50 per cent of sex workers interviewed had come to work from another part of the country within the previous year, and 88 per cent within the previous five years. Similarly, in Guangxi, China, more than 67 per cent of sex workers come from poor rural areas of other Chinese provinces, and most return home every 3-12 months. In Yunnan Province, most female sex workers come from other Provinces, Myanmar and Vietnam. As a result, in most countries, many local sex workers are themselves “migrant workers” within their country, in addition to the sex workers who are migrants from other countries.

The sex industry is, moreover shifting in many countries from brothels to “indirect” sex work taking place in less easily identified settings, often under the guise of another activity, including hotels and motels, tea houses, massage parlours, hairdressing or beauty salons, saunas, bars, pubs, *karaoke* bars, nightclubs, cocktail lounges, restaurants, cafes, coffee shops, and so on. Unlike direct sex work, “indirect” sex work is a moving target, with the sex worker operating on the fringes of, or outside, a potentially regulated environment. One consequence is that it is more difficult for health officials to approach sex workers with information and services. A recent survey in Thailand recorded a 50 per cent increase in the total number of sex service establishments between 1998 and 2003, and as a result more than 90 per cent of female sex workers now work in non-brothel sex service establishments. The legal status of sex work in a country also constitutes a risk factor, since the risk is increased when the activity is illegal and therefore clandestine. Where sex workers

are increasingly illegal migrant workers, access to prevention and health services is made more difficult by their illegal status. Moreover, women - and children - who have been smuggled into a country illegally fear the threat of disclosure and reprisal, or outright deportation if they contact public services.

Poverty plays a large role in the persistence and growth of sex work, and is one major reason that large populations of young persons, particularly girls, are exposed to very high risks of HIV. Although many governments have significantly reduced the proportion of the population living in poverty, the sex sector remains large in many countries, particularly in East and South-East Asia. Some countries have made estimates of the industry (see Table 12), but they are considered to substantially underestimate the large ‘hidden’ populations involved in sex work in this as well as other regions of the world.

It is very difficult - and much more difficult than for adults - to assess how many children are involved in sex work and in tourism-oriented prostitution, because these activities are often linked to organized crime and to trafficking of children. Other evidence speaks to the trends in sex work, and child prostitution is reported to be on the increase in many countries in Asia. But tourism-oriented prostitution involving children is reported in many developing countries as well as in Asia. Sexual exploitation of children occurs in response to local and national demand as well as to the demand of sexual tourism, and sexual tourism tends to arise where it can exploit a pre-existing situation.

Estimates of sex workers, children in sex work and HIV prevalence in sex workers, 4 Asian countries, latest available data

Country	Estimates of sex workers		HIV Prevalence
	All sex workers	Children in sex work	
Cambodia	60,000 – 70,000 according to NCHADS (2000); 100,000 according to NGOs	In Phnom Penh, 31% of sex workers are children	29% brothel based workers 15% non-brothel-based workers (2002)
Indonesia	140,000 – 230,000 (1998)	c.10% children (1992)	8-17% in some areas
Malaysia	43,000 - 142,000 (1998)	Not available	Not available
Philippines	400,000 – 500,000 (1998)	60,000 - 100,000 children	0.03% in sentinel sites (2003)
Thailand	100,000 – 200,000 (2003)	c. 20% began sex work at 13-15 years	7-12% (2002)
Vietnam	c. 200,000 (2000)	7% to 11% are children	8-24% in major cities (2002)

Table 12

Sources: Chantavanich et al., 2000; ECPAT²¹ (several years); Government of the Philippines, 2003; Lim, 1998; UNAIDS, 2004a; UNDP, 2004b

HIV prevention behaviours in the sex work industry

Sex workers remain a high risk group in every country because despite widespread behaviour change, compliance with respect to condom use is far from complete. In South East Asia, for example, there is a 100 per cent condom use programme in place in a number of countries, but the programmes target recognized sex workers. As a result, many sex workers eventually become infected with HIV despite the positive behavioural change that has occurred in the sex industry, in both sex workers and clients, and HIV prevalence levels in sex workers remains very high. A study in provincial cities of Thailand found that only 51 per cent of sex workers used condoms, compared to 89 per cent in Bangkok, and they used them mostly with foreign clients. Similarly, although condom use is “compulsory” for clients of sex workers in Indonesia, condom use was reported at less than 50 per cent by sex workers in the late 1990s. In China, condom use in Guangxi Province was reported at 14 per cent by sex workers in 1999, and in 2003, only 27 per cent of sex workers in the Philippines reported consistent condom use, who reported furthermore that they made a difference between non-regular clients (55 per cent use) and regular clients (28 per cent) in their condom use.

Clients of sex workers are a major bridge of HIV transmission to the general population. In most countries where the HIV/AIDS epidemic is first limited to high risk groups such as sex workers and their clients, the number of persons in the general population who become HIV-positive as a result of sex work increases, largely owing to the insufficient use of condoms. Similarly, clients who are travellers can serve as bridges to the general population where they usually live, and their level of condom use is therefore also of critical importance. Studies conducted in the late 1990s on travellers from the UK suggest that condom use by young travellers has increased: 75 per cent of unaccompanied persons 18 to 34 years who reported a new sexual partner used condoms on each occasion, and 94 per cent of those who reported having visited a sex worker always used condoms. Other studies suggest that intentions are sometimes baffled: a survey of young Canadian travellers in 2000 found that only 68 per cent of those intending to use condoms actually used them, and they perceived their risk of HIV as low. The far from perfect use of condoms by young travellers overseas, and their exposure to the risk of HIV is confirmed indirectly by two observations: a reportedly increasing rate of unwanted pregnancies and a rate of STIs in returning groups estimated at between 2 and 10 per cent.

In sum, although condom use is increasing and has reached high levels in groups of travellers, sexual health promotion of HIV prevention in travellers remains a very important area for action, and for intensifying current programmes, in particular for the successive waves of young travellers who set out each year.

Workers in the hospitality industry

Hotel staff, entertainers, waiters and waitresses frequently have opportunities for contacts with the tourist population, as well as establishing relations in the local population. With the expansion of tourism and travel, many workers in the hospitality industry have adapted to the mass arrivals of tourists, and tourism has come to have a large social impact on the hospitality sector. Studies in different parts of the world have hypothesized, for example, that direct contact with tourists is a factor favouring tourist-oriented sex work.

One study in the UK found that both men and women tourism workers had greater numbers of sexual partners, especially among tourists, and also had more casual relationships than the resident population. A study in the Caribbean found that sexual relations between hotel workers and tourists were commonly reported in Cuba and the Dominican Republic, where many workers in food and beverage services, maintenance, administration, reception, and especially entertainment were engaging in sexual relations with tourists. A study in the Dominican Republic found close to 20 per cent of resort workers had sexual relations

with tourists, and a study of male sex workers that 38 per cent of them had regular jobs in hotels, for example as waiters, porters, and security guards. Hospitality staff include young men and women who instruct guests in dancing, sports, and other forms of recreation. Their work is often sensual and can involve highly sexualized contact with guests, which facilitates progression to sexual relations.

It is likely that these workers expose themselves to a risk of HIV/AIDS, and that both they and their families may be disproportionately affected by the virus. Furthermore, the problem is likely to be of some scale: in an ILO survey in a Caribbean country, for example, 2.5 per cent of the workers surveyed in two hotels stated they had exchanged sex with guests for a gift or favours at least once.

The task of estimating and addressing the problem is compounded by the fact that many workers in the hospitality industry are in the informal economy, which makes them hard to reach with targeted HIV/AIDS prevention programmes. This is confirmed by recent studies of workers in the informal economy of the tourism sector, such as beach boys who regularly work as tour guides, waiters or bartenders, or who rent out beach and sports equipment. Many of the young men and women express the hope that their liaisons with foreigners will lead to marriage and migration. Also, they generally prefer to accept gifts such as clothing, jewellery, or meals from tourists rather than to negotiate money for sex.

Factors that expose the tourism sector's workforce to a high risk of HIV are similar to factors that affect the sector's clients: tourists, travellers, and businesspersons, in particular because:

- The tourism industry hires large numbers of young, single employees
- Industry employees are frequently mobile and away from their families for prolonged periods
- There is significant access to sex workers by employees as well as the tourists
- There are frequent opportunities for sexual interaction between tourists and tourist industry employees
- Alcohol and drugs are used by the industry workers as well as tourists
- There may be few locations to obtain affordable and accessible condoms
- Employees may lack access to treatment for STIs
- There may be no or limited access to HIV counselling and testing services

- Moreover, sex work itself is one of a wide range of services provided in the informal tourism economy where economic-sexual exchange is a frequent transaction, which means that it is outside regulation and beyond the reach of mainstream prevention.

Another factor is the development of the "all-inclusive" resort in response to the growth of mass tourism, especially in the Caribbean. This model means that all tourists' expenses - including tips - are paid in the country of origin, with highly negative consequences for workers in the industry, and consequently a measurable increase in income disparities between categories of workers in the hospitality industry. Hospitality workers who counted on gratuities to complement their wages and earn foreign exchange may fall back on the sex industry to earn tips for allowing tourists to bring their "dates" to their rooms or otherwise facilitating access to sexual relations for tourists: for some hospitality workers providing sexual services to tourists themselves allows them to earn extra cash they need. Although income disparity is not the only factor pushing hospitality workers toward sex work, economic need remains one of the main contributing factors.

Addressing the need for HIV prevention in the hospitality industry

The globalization of transport and communication means has not only promoted tourism but has also resulted in the globalization of information. One positive result is that information on HIV/AIDS is now well circulated in many sectors of work, including in the formal sector of the hospitality industry. Thus it is that in recent years, many workers in the industry have changed their behaviours and are becoming increasingly consistent with respect to condom use. Very recent work by the ILO funded by the US Department of Labor in different countries found that in 2004-2005, hotel workers reported 95 per cent condom use in a sample of South Asian hotels, 80 per cent in a sample of West African hotels, and 83 per cent in a hotel in a country in southern Africa. In contrast, however, the picture in the Caribbean is mixed: condom use with a casual sexual partner differed between 33 per cent and 100 per cent depending on the sample of hotels surveyed. Other behaviour is changing, however, and in the same country, 50 per cent of hotel workers surveyed reported that they were intentionally reducing their number of casual sexual partners.

The risks to which hospitality workers are exposed, and the evidence that it can make a difference when preventive behaviours are adopted point to the large benefits to all concerned from the expansion of workplace policies in the hospitality sector. Employers and tourist enterprises of various size can assist in reducing fears related to stigmatization and discrimination by developing workplace policies on HIV/AIDS through social dialogue. Risk factors particular to the workplace should be addressed with appropriate solutions, such as:

- Providing information for both workers and guests on risks of STIs and HIV
- Providing ready access to condoms
- Providing employees with access to diagnosis and treatment of STIs
- Providing employees with access to HIV testing and counselling
- Seeking ways and options for hospitality workers to be paid tips directly that relieve their need to resort to sex work.

Various initiatives are already underway, and the International Hotel and Restaurant Association (IH&RA) and UNAIDS have drafted guidelines for the hospitality industry (1999) to assist in promoting awareness in the sector. Other initiatives, mainly voluntary commitments, specifically target the commercial sexual exploitation of children in travel and tourism such as the IH&RA campaign to raise global hospitality awareness (1998) and the ECPAT/WTO Code of Conduct for the Protection of Children from Sexual Exploitation in Travel and Tourism (1998). There are also country-based initiatives: for example, the ILO/IPEC office in Mexico is currently elaborating a manual for training for the tourism industry on the prevention of commercial sexual exploitation of children.

Managing HIV/AIDS in a globalizing world

Addressing and managing HIV/AIDS in a world that is globalizing call for commensurate, global approaches. In this final chapter, a review of national, enterprise and international efforts to address the impact of HIV/AIDS from the point of view of legislation is followed by an overview of new, often innovative, approaches to the management of HIV/AIDS from a governance perspective.

National-level initiatives

Legal and policy framework

Several countries have addressed HIV/AIDS by passing legislation or introducing policies that ban the entry or prolonged residence on their territories of HIV-positive aliens, in an effort to contain the impact of HIV/AIDS on their population and the economy. The national legislation of about one third of all countries seeks to address the movements of persons who may be HIV-positive, notably immigrant workers and other persons seeking visas to enter the countries for work or personal reasons.

Restrictions on the entry and stay of HIV-positive persons have been initiated since early on in the epidemic ostensibly for the purposes of protecting the public health and avoiding a country's health system having to bear excessive costs to provide care and social security for HIV-positive aliens. The restrictions may vary according to length of stay, type of migrant and country of origin²², but apply to most aliens who wish to reside in a country for an extended period (immigrants, refugees, migrant workers, students). Some countries also apply restrictions on short-stay visitors, such as tourists, or to their own citizens returning home after a stay abroad. Enforcement varies, relying on questionnaires or the obligation to submit medical certification of HIV status. Mandatory HIV screening test may be imposed prior to departure in the country of origin, upon arrival, or after immigration. Several countries have detention centres to manage the flow of migrants and assess entry

requests²³. In some countries HIV status is one of several factors used to evaluate a residence application, but in others, a positive result leads to automatic rejection²⁴. In their research, CARAM, a community organization network working with migrants and their families in 11 countries in Asia, found that HIV screening is frequently undertaken without migrants' knowledge, testing is rarely accompanied by counselling, confidentiality of the medical data is not protected, and notification of results is followed by deportation (which is immediate in some countries) without psychological support, reference services or care²⁵.

Although issues related to immigration are considered as being within the national competence of States, such restrictions should conform to international obligations. In accordance with international law on human rights, States can impose restrictions on certain rights but only in clearly defined circumstances²⁶. The restrictions must most of all be required in order to meet a legitimate interest such as public health, the rights of others, morality, public order and general well-being in a democratic society, and they must be as non-intrusive or limiting as possible.

Where States prohibit people living with HIV/AIDS from longer term residency due to concerns about economic costs, States should not single out HIV/AIDS, as opposed to comparable conditions, for such treatment and should establish that such costs would indeed be incurred in the case of the individual alien seeking residency. In considering entry applications, humanitarian concerns such as family reunification and the need for asylum, should outweigh economic considerations.

*International Guidelines on HIV/AIDS and Human Rights*²⁷

Public health is one of the most commonly used reasons given by States for restricting access to their territory. Beyond public health and economic considerations, immigration policies are often shaped by media reaction, prejudice and fear rather than objective assessment of the facts²⁸. Migrants have always suffered from hostility and prejudice towards them in the receiving country. These attitudes become more extreme if the immigrants are perceived as carriers of disease. The types of steps taken by governments to prevent entry are often intended to erect psychological and symbolic barriers for individuals and societies.

Nevertheless, the sense of security which results from the erection of these barriers can be misleading when faced with an epidemic that knows no frontiers. Furthermore, many of these restrictions are not justified in accordance with international law on human rights. Restrictive measures to control immigration often entail violations of migrants' human rights, and have been therefore systematically condemned by United Nations agencies, specialized institutions and NGOs working in the field of HIV/AIDS. These actors advocate adoption of an alternative approach to reduce HIV transmission based on respect for fundamental rights in order to end the numerous violations of the rights of persons who are HIV-positive and advocate that effective prevention must be achieved through other measures.

Integrating HIV/AIDS into national development planning

HIV/AIDS is a development challenge to poor countries of such magnitude that the Sub-Saharan African region has regressed in terms of key development indicators over the past quarter-century, and many countries hold out little hope for the future as the epidemic dissipates their meagre stock of human capital. Consequently, it is essential that the multiple impacts and consequences of the epidemic are factored into development planning frameworks, policies and programmes. Of particular concern is the need to ascertain whether current patterns of development planning respond adequately and are on the right track.

Poverty reduction strategy papers and policies (PRSPs), a World Bank initiative complementary to HIPC (see page 68), can be used as a tool to mainstream HIV/AIDS into development planning. PRSP documents set out a country's approach to poverty reduction through specific planned policies and programmes and the associated external

financial needs. The PRSP serves the donor community as a framework and guide for technical and financial support, and it is important to note in this regard that some PRSP documents have included financial commitment for HIV/AIDS programmes.

Based on reviews and on-going analyses by UNAIDS and UNDP, the PRSP process has not, however, been effective so far in helping countries to mobilize additional resources to control HIV, and this represents lost opportunities. Importantly, also, PRSP documents include little analysis of the relationship between HIV/AIDS and poverty, according to a review of 25 full and interim PRSP documents prepared by sub-Saharan African countries. In addition, they do not for the most part include or reflect main strategies of the national AIDS plans of the countries concerned. Furthermore, most PRSPs do not set out clear estimates of the resource implications of responding to the HIV/AIDS crisis; nor do they make use of HIV/AIDS prevention and care goals and targets as indicators for monitoring poverty. Such estimates and targets would help to clarify the external support needed to address the epidemic in a given context. As a whole, PRSPs have not adequately addressed public health issues as development problems, which goes far to explain why major donors have not used this particular planning instrument to channel resources to support national efforts to control AIDS and reduce poverty.

Acknowledgement of these shortcomings led to the recommendation made by a Global Task Team (GTT) set up by UNAIDS in 2005 for the international community, led by the World Bank and the UNDP, to assist developing countries to make better use of the PRSP to mobilize financial and human resources to address HIV/AIDS and public health problems. The GTT made it clear that it was the responsibility of the international community to support efforts by poor countries to integrate HIV/AIDS concerns into PRSPs.

Coordination of lines of response

Although there is now a consensus in the international community to conceptualize HIV/AIDS as a development problem and emphasize the socio-economic context and interactions with concerns such as poverty and inequality, this broad conceptualization of AIDS has actually led to an increase in the number of frameworks (medical, behavioural, economic, social or multi-sectoral) for

HIV/AIDS planning. As a result there is a range of planning responses in terms of goals, objectives and strategies, all falling under the general rubric of “planning for HIV/AIDS” or the “national strategic framework for HIV/AIDS”. While this type of planning to combat HIV/AIDS may constitute a comprehensive response to the epidemic when taken as a whole, it is not necessarily effective with respect to coordination of national development planning.

Today, most countries affected by HIV/AIDS have formulated a national strategy to guide the national response to the epidemic. In recognition of the multi-dimensional impact of HIV/AIDS, there is a consensus that HIV/AIDS requires a multi-sectoral response, often invoked in policy documents and action plans at country level. There are significant departures at the implementation stage, however, which shows up distortions and gaps in intervention relative to stated objectives and strategy formulation. In many cases HIV/AIDS responses are fragmented at micro-level and narrowly address health aspects. This may be indicative of the complex nature of integrated planning, but it also points up the difficulty of conceptualizing and addressing HIV/AIDS as a wide development concern. To avoid this, it is important to ensure that the various planning frameworks are also time-bound with clear targets and implementation strategies, and then incorporated into annual budgets.

Alignment of planning frameworks

Another concern is that the implementation framework of the national strategic HIV/AIDS plan is not synchronized or aligned with the national development planning framework and annual budget cycles. In fact, most countries embarking on HIV/AIDS planning currently have parallel planning processes, with little integration and alignment between processes and outputs. The failure to effectively integrate planning to address HIV/AIDS in national development planning may be due in part to the emergency nature of the epidemic and in part to the uncertain and uncoordinated nature of AIDS funding, but nevertheless presents a problem of some magnitude. Furthermore, there is a lack of uniform data and reporting systems, consistent indicators and standardized guidelines required to measure and link the outcomes of HIV/AIDS interventions to the achievement of national development targets and objectives. A major challenge is to align key frameworks guiding development planning and the national

strategic framework for HIV/AIDS, for example in relation to planning cycles in the case of the PRSP, the Medium Term Expenditure Framework (MTEF), the annual budget and sector plans.

Allocating resources to effectively fight HIV/AIDS also requires comprehensive information on national HIV/AIDS-related expenditures, to improve resource planning and increase a country's ability to respond effectively. Lack of such information, in particular on donor funded programmes and activities, makes it difficult to carry out monitoring and evaluation (M&E) exercises required to assess progress and determine whether resources are allocated efficiently and effectively. Financial and other indicators to track and link resource use to health and development outcomes need to be developed for this purpose.

Coordination of donor funding

While national development planning is usually a state-led activity, a significant part of the response to HIV/AIDS in developing countries is outside the public sector in donor-funded community-initiated and led projects, private sector initiatives especially in the workplace, NGOs, and so on. This increases the difficulty of integrating HIV/AIDS into development planning. Even large external funds for HIV/AIDS provided by the Global Fund, PEPFAR, the World Bank's MAP, and the WHO's 3x5 do not usually go towards budget support for implementation of annual plans, but may be “planned”, disbursed and spent separately, in a manner uncoordinated with the development planning framework or budget cycle. Coordination of donor funding to support national efforts is of major concern to many developing country governments in the context of their relationship with development partners.

Similar concerns of all major stakeholders - the international community, bilateral and multilateral donors as well as developing countries - has led to the adoption of UNAIDS' “Three Ones” principles in 2004, designed to improve coordination between multilateral institutions and international donor partners and to streamline national responses to HIV/AIDS. The need to align donor support with national efforts is as vital to scale up prevention and treatment programmes as building institutional capacities. The Global Task Team (GTT) set up by UNAIDS in mid-2005 reviewed this approach and

recommended further streamlining to harmonize AIDS-funding and expenditure procedures.

The hope is also to reduce the burden placed on the managerial and technical capacity of developing countries for HIV/AIDS planning. The existence of a capacity crisis suggests that a delicate balance is called for between the need to rapidly scale up HIV/AIDS interventions to respond to the urgency and magnitude of the epidemic, and the need to promote longer-term sustainability and capacity-building. This approach was reflected in a recent UN General Assembly resolution (59/27) adopted on “Enhancing capacity-building in global public health”.

Enterprise-level initiatives

Workplace policies and strategies

It is urgent to put in place comprehensive workplace programmes in both the private and public sectors to respond to the challenge of globalization and the impact of HIV/AIDS in the world of work. Such programmes are essential as structures to collectively broaden access to care and treatment. They offer the best way to reach the segment of the population that is currently employed. In the first place, HIV/AIDS programmes in the workplace and at enterprise-level are critical to sustain existing human resources, a fundamental objective for social and economic development. Such programmes should also address key constraints such as discrimination and stigma, and extend services to families and communities. In the community, the workplace initiative can become a vehicle for social mobilization to prevent and treat HIV/AIDS.

Increasing numbers of private employers - including MNEs - are by now supporting comprehensive workplace programmes that include access to antiretroviral drugs because they recognize the economic and social benefits of doing so. These enterprises are finding that such programmes also help them to define and meet some of their objectives of *corporate social responsibility* (CSR). This action path is justified from the standpoints of both a “rights-based” and a “development- oriented” approach, and as reflecting a balance between practical (“business case”) motives and altruism, as well as between regulatory and voluntary action. No longer is the problem how to promote CSR, but how to generalize the practice from relatively small numbers of private employers to all employers and the other major sectors of

employment, especially the public sector where CSR programmes are still generally missing.

The ILO Code of Practice on HIV/AIDS and the world of work provides a distinctive and universal framework to guide and assess progress in the application of CSR-related policies and programmes. The Code encourages coordination of rights and responsibilities, and supports a scope for action reaching beyond legally-mandated employment and workplace relationships to include dependants, former employees, communities, suppliers and contracting partners. The ILO Code also encourages new knowledge initiatives based on social dialogue and partnership as well as effective public-private partnerships (PPP). In an era of globalization and global enterprises, it is important to balance the interests of developed and developing countries and to ensure impartiality in the promotion of CSR partnerships. Above all, the needs of CSR-type partnerships for HIV/AIDS action must be linked to the ILO standards for achieving the objectives of the Code in matters of prevention, treatment and the protection of workers’ and basic human rights.

Global-level initiatives

International law on human rights

Years of experience in the fight against the HIV and AIDS epidemic now show that promotion and defence of human rights represents an essential part of prevention in transmission of HIV and a lowering in the incidence of HIV/AIDS. Despite these developments, many national laws remain in contradiction with international law on human rights, migration and HIV/AIDS²⁹. The low number of ratifications of the main international instruments specifically addressing the rights of migrants, such as ILO Conventions Nos. 97 and 143 and the *International Convention on the Protection of the Right of all Migrant Workers and Members of Their Family* supports the contention that numerous countries are resistant to letting international law influence their immigration policies³⁰.

United Nations agencies, specialized institutions and NGOs operating in the field of HIV/AIDS have constantly pointed out that the restrictions relating to entry or residence of foreigners based on health issues, including HIV/AIDS, should be applied in a manner that respects the human rights of migrants, particularly the right to non-discrimination, the

right to non-refusal of entry for refugees, the right to a private life, the right to the protection of the family, the protection of the best interests of a child and the rights enshrined in specific instruments relating to migrants³¹.

The defence and promotion of human rights is necessary as much to protect the dignity of people living with HIV/AIDS as to achieve the public health goals of reducing HIV transmission, mitigating the harmful consequences of HIV/AIDS, and providing individuals and communities with the means to combat HIV/AIDS.

There are very important links between the transmission of HIV/AIDS and inadequate human rights protection. Violation and non-respect of human rights serve to increase – not decrease – HIV transmission, for a number of reasons. An environment that promotes violations of human rights legitimizes stigma and discrimination, which make the impact of HIV greater, increase risk and create obstacles to positive responses to the epidemic³². To the contrary, an environment in which human rights are taken into account in the context of HIV/AIDS reduces the risks of transmission because it allows those who are HIV or AIDS-infected to live in dignity without being objects of discrimination or stigmatization, which is beneficial to prevention and disclosure, thereby helping to lower transmission³³.

Addressing HIV/AIDS is, furthermore, founded on the indivisibility of human rights, as any effective action against the infection requires that economic, social and cultural as well as civil and political rights be fully exercised. The Vienna Declaration and Programme of Action adopted by the World Conference on Human Rights in June 1993³⁴ affirmed that all human rights are universal, indivisible and interdependent and interrelated. It is the duty of States to promote and defend universal standards related to human rights and fundamental freedoms.

Protection afforded by human rights

The main principles of human rights essential for effective action against HIV/AIDS are enshrined in various international instruments. There are also regional instruments that lay down States' obligations on HIV/AIDS. The *Universal Declaration of Human Rights* of 1948, the *International Covenant on Civil and Political Rights* of 1966, and the *International Covenant on Economic, Social and Cultural Rights* of 1966 (ICCPR and ICESCR which are among the

most ratified international Conventions to date³⁵), the *Convention on the Elimination of all Forms of Discrimination against Women* of 1979 (CEDAW), and the *Convention on the Rights of the Child* (CRC) of 1989 all concern rights established in UN human rights instruments³⁶. Furthermore Article 2 of the *International Covenant on Economic, Social and Cultural Rights* commits States to become involved in international cooperation for the progressive achievement of human rights. International cooperation is particularly vital in the fight against HIV/AIDS.

The right to social security

In addition, the right to social protection is a fundamental right, enshrined in several international instruments. Article 25, paragraph 1 of the *Universal Declaration of Human Rights* provides that each person has the right to a standard of living that ensures the health and well-being of the self and one's family, especially for medical care as well as for the necessary social services. It adds that every person has the right to security in case of unemployment, sickness, disability (...) or in case of loss of earnings due to circumstances beyond the person's control.

The right to non-discrimination and equality before the law

Discrimination is a violation of human rights³⁷. Article 2 of the *Universal Declaration of Human Rights* proscribes discrimination based on race, colour, sex, language, religion, opinion, or *other status*. This protection is also enshrined in Articles 2.1 and 3 of the *International Covenant on Civil and Political Rights*, Articles 2 and 3 of the *International Covenant on Economic, Social and Cultural Rights*, and Article 2.1 of the *Convention on the Rights of the Child*. The UN Commission on Human Rights deemed that the term "other status" used in several human rights instruments "must be interpreted as including health status, including HIV/AIDS", and that discrimination on the basis of a presumed or admitted HIV-positive status is prohibited by current human rights standards.

Stigmatization and discriminatory actions thus violate the fundamental right to non-discrimination. Discrimination is not only a violation of human rights in itself but if used against persons living with HIV or presumed to be HIV-positive, is also a violation of other human rights, among others the right to health, dignity, private life, and equality before the law.

The right to freedom of movement

It is with respect to freedom of movement that there is the greatest tension between national efforts, which seek to control the transmission of HIV/AIDS by limiting the movement of person, and the intent of international instruments to protect the rights of all persons to move freely.

The *International Covenant on Civil and Political Rights*, just as the *International Covenant on Economic, Social and Cultural Rights*, does not give non-nationals the right of residency on the territory of a State Party. In effect, States therefore exercise their sovereignty by imposing travel restrictions designed to address the HIV epidemic.

Article 12 of the *Covenant on Civil and Political Rights* stipulates furthermore that the right to freedom of movement that covers the rights of any person who finds her or himself legally on the territory of a State (which includes legal immigrants) to move freely in that State and to legally take up residence, as well as the rights of nationals of that State to enter and leave their own country shall not be subjected to any restrictions **except those provided by law, and deemed necessary to protect** (emphasis added) national security, public order, **public health** (emphasis added) or morals, or the rights and freedoms of others, and that are consistent with the other rights recognized in the Covenant. Accordingly, the Covenant allows States in all legality to limit entry on their territory by invoking the public health.

Although issues relating to immigration are considered as being within the competency of States, however, the restrictions that they impose should nevertheless conform to their international obligations. On this point, the Commission on Human Rights recently reiterated that the enjoyment of the rights established in the *International Covenant on Civil and Political Rights* is not confined to citizens of the States Parties and that these rights apply to all persons whatever their nationality, mainly to asylum seekers, refugees and migrant workers present on their territory or within their jurisdiction³⁸.

In parallel, all the States Parties to the *International Covenant on Economic, Social and Cultural Rights* are enjoined to undertake to guarantee the exercise of the rights promulgated in the second Covenant **without distinction of nationality** (emphasis added)³⁸.

Civil and political rights for all persons resident on a State's territory

The *Commission on Human Rights (CHR)* recently reiterated that the enjoyment of rights enshrined in the *International Covenant on Civil and Political Rights (ICCPR)* was not restricted to citizens of the States Parties and that these rights should apply to all individuals whatever their nationality, particularly to asylum seekers, refugees, and to migrant workers resident on their territory or within their jurisdiction³⁸.

Moreover, the argument for restriction based on public health does not justify confining those restrictions on the right to freedom of movement or choice of residence on grounds of HIV status alone. In compliance with the *1969 International Health Regulations* adopted by the World Health Assembly, the only disease for which an international travel vaccination certificate was required was yellow fever, and cholera, plague and yellow fever alone were subject to obligatory declaration³⁹.

Revised and updated International Health regulations were adopted by the World Health Assembly on 23 May 2005 that significantly broaden their scope⁴⁰. States are now required to notify single cases of diseases that may constitute a public health emergency of international concern - or PHEIC - defined as an extraordinary public health event constituting a risk to other States, through the international spread of disease, and that may require a coordinated international response. The new regulations will come into force in June 2007.

Any restriction on rights of freedom of movement uniquely based on known or presumed HIV status, including the use of HIV screening in the case of persons undertaking international travel, is of a discriminatory nature and could not be justified on grounds of public health, or on the basis of the definitions provided in the new *International Health Regulations*.

In sum, restricting movement of persons who are HIV-positive is a violation of rights and discriminatory. It is also unnecessary and ineffective. According to the WHO, allowing entry of HIV-positive migrants does not create

an additional health risk for the local population⁴¹. Furthermore, the setting up of legal barriers to prevent the introduction of the disease on national territory has proved ineffective in recent years - it is impossible to close borders in an efficient and permanent way - and is also counterproductive to prevention efforts.

There is no public health rationale for restricting liberty of movement or choice of residence on the grounds of HIV status. According to current international health regulations, the only disease which requires a certificate for international travel is yellow fever. Therefore, any restrictions on these rights based on suspected or real HIV status alone, including HIV screening of international travelers, are discriminatory and cannot be justified by public health concerns.

International Guidelines on HIV/AIDS and Human Rights⁴²

Most migrants are HIV-negative when they leave their country of origin and if they become HIV-positive, it is in part because of the unfavourable and hostile environment they have to cope with on their migratory journey, from its initial stages onward⁴³. Migrants' exposure to risk is worsened by the simultaneous violation of their rights to information, to a private life, to liberty of movement, to equal protection before the law, to health and at work. In a study conducted by the UNDP, 67 per cent of migrants living with HIV/AIDS stated that unprepared and non-secured immigration was the main factor that exposed them to HIV/AIDS⁴⁴. They reasoned that better access to information and preventive services would have protected them against the virus.

Moreover, migrants who fear the imposition of sanctions, are more likely to enter their country of destination illegally. A recent UNDP study in 7 countries in Asia contends that the explosion of illegal immigration is in large part due to restrictive immigration policies⁴⁵. It is estimated that illegal migrants make up 30-40 per cent of the 5,000,000

migrants in Asia⁴⁶. Migrants, especially those in an irregular situation, rarely have access to, or do not dare insist on using prevention and health services in the country where they have taken up residence⁴⁷. Fear of losing a job, of being stigmatized and ultimately deported, forces them to conceal their HIV status, if they know it. As a result, they are at great risk of transmission to others. As closing of borders is not an effective remedy to contain the epidemic, solutions must be sought in strategies that aim to reduce exposure and risk in the migrant population. It is vital that States collaborate and look on the health of their citizens from a global point of view if they truly want to overcome the epidemic.

The protection of migrants' rights is important to respect their dignity and to reduce HIV transmission. Countries of origin and of destination can benefit from both, and should take necessary steps to ensure the protection of migrating workers' rights to eliminate factors that contribute to their exposure to risk. In this respect, the United Nations Special Rapporteur on the Human Rights of Migrants encourages initiatives at regional level in order to stimulate dialogue between governments of countries of origin and transit and those of intended destination⁴⁸.

More specifically, United Nations agencies, specialized institutions and NGOs dealing with HIV/AIDS recommend the abolition of laws and regulations that establish mandatory screening for HIV/AIDS for immigrants, the lifting of restrictions on their movement as well as doing away with coercive measures such as isolation, detention and quarantine as means to address their HIV status⁴⁹. They also support setting up of prevention, care and information services adapted to migrants' needs, the involvement of migrants in the development of programmes targeted to them, as well as adoption of measures to improve their social and legal situations⁵⁰.

The workplace sometimes constitutes the only place where it is possible to come into contact with migrants without papers. Specific interventions in the work environment are required especially in places where there are large numbers of illegal migrant workers, such as factories in the Republic of Korea and EPZs in Sri Lanka⁵¹ (see box).

Export-processing zones (EPZs)

In 2002, there were more than 3,000 EPZs⁵² globally, and more in the planning. These zones are industrial areas that feature special advantages and are set up to attract foreign investment to process and re-export imported goods. Foreign investment plays an essential role and the countries operating EPZs contribute to economic development and job creation: EPZs are important sources of employment⁵³.

Nevertheless they run into problems in the social and labour arenas, especially when investors are allowed to distance themselves from fundamental labour standards. Labour standards and labour relations are the most critical and controversial aspects of EPZs⁵⁴. Labour regulations that establish minimal labour standards and negotiations (both collective and individual) between free trade unions and employers are typically absent. As a result, work conditions lead to high employee turnover, absenteeism, tension and fatigue.

More often than not national labour standards are applicable (for example, in Barbados, Costa Rica, China, the Dominican Republic, Jamaica, Mauritius, the Philippines, Singapore, Trinidad and Tobago). In some countries, national labour standards apply only partially (as in Bangladesh, Namibia, Pakistan and Panama). Given their frequently functional, modern design, EPZ factory buildings may offer better working conditions inside than outside. But labour administration lacks coherence, and the ILO has had to note that ministries of labour are not always sufficiently equipped to supervise and regulate the working conditions effectively.

Furthermore, there are few social security and protection arrangements for EPZ workers, with the consequences being often more serious for women. Women who work in EPZs expect to leave after a period because the work is difficult and social services lacking, which makes the situation unbearable over a protracted period. Without a pension scheme, women who leave nevertheless face difficulties in becoming economically independent afterward, and without skills training, they may find it impossible to find other work.

Health services in the EPZ and in the local community are equally limited and are rarely capable of catering to specific health problems of women. Due to its low priority or religious, political or cultural sensitivities, health education for reproductive health problems is inadequate. Moreover, most EPZs and surrounding communities lack services in family planning and sexually transmissible disease (STI) diagnosis and management.

Trade unions loudly denounce working conditions in EPZs; some do not hesitate to qualify them as 'modern slavery'⁵⁵. Working hours, just as physical and psychological mistreatment, sexual harassment, non-recognition of the right to social security, bans on access to a medical clinic and on the right to organize are all denounced. In addition, in many cases, women submit to mandatory pregnancy tests because pregnancy is cause for dismissal. Practically, the aim is to avoid paying prenatal and postnatal benefits to which women have a legal entitlement.

In its report of December 2004: 'Behind the brand names', the International Confederation of Free Trade Unions (ICFTU) denounced working conditions and the absence of workers' rights in EPZs. The report points out that some EPZs are industrial parks that are well managed where responsible enterprises offer decent working conditions and higher salaries than in the rest of the economy. Among these enterprises, there are many that are aware of the social and business impact on performance and productivity of efficient management of human resources and respect for labour standards and the rights of workers. The report stresses that most EPZs, however, are home to enterprises of a very different type, where employers turn their back on labour legislation, as well as on regulations on employment and health and safety at work. Restrictions on freedom of association, a ban on collective bargaining and the right to strike, low wages and mandatory overtime are common practice in these zones.

ILO's Committee of Experts on Application of Conventions and Recommendations (CEACR) has noted numerous 'contradictions' since 1998 between the obligations featured in ILO Conventions and national standards as applied in EPZs. The Committee has requested governments of the countries concerned to develop strategies to guarantee foreign investment that respects the ILO's Decent Work Agenda, mainly in respect to improvement of working conditions and productivity⁵⁶.

A report on Madagascar prepared by the ILO in February 2005 raised the problem of HIV/AIDS in EPZs with respect to workers' rights and working conditions. The report looked at knowledge and awareness of HIV/AIDS, and at the diversified, albeit timid actions taken by EPZs, such as sensitization campaigns and prevention schemes. The report included a national plan of action to improve productivity in the EPZ sector through the promotion of decent work, of which the third specific objective was to "reduce the risk of HIV/AIDS" and "implement prevention measures". The report led to a project that is under development and awaiting funding at time of writing.

HIV/AIDS knows no frontiers. Moreover, it is already present in every country in the world. It is therefore essential for States to collaborate and think globally if they wish to effectively protect their own economies and populations. It is only by taking the necessary measures to ensure the protection and the rights of migrants and in eliminating the factors which contribute to their exposure to risk at all stages of migration, from recruitment to return, that countries will really be able to prevent HIV transmission.

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The right to seek and enjoy asylum

All persons have the right to seek asylum and have the right to asylum in other countries to avoid persecution. According to the *Convention relating to the Status of Refugees* adopted in 1951 and customary international law, and in conformity with the principle of non-return, States cannot return a refugee whose life or freedom would be threatened⁵⁷.

States therefore cannot return a refugee by claiming that he or she is HIV-positive. In addition, in cases where the treatment of HIV-positive persons is equivalent to persecution, it justifies requesting refugee status⁵⁸. In March 1998, the United Nations High Commission for Refugees (UNHCR) published directives specifying that refugees and asylum seekers should not be targeted by special measures applied according to HIV status and that it was not justifiable to carry out HIV screening to prevent HIV-positive persons from exercising their right to asylum⁵⁹.

The Commission on Human Rights confirmed that the right to equal protection before the law prohibited discrimination in all areas regulated or protected by the public authorities⁶⁰, including legislation applicable to travel, conditions of entry, and procedures for immigration and asylum. Consequently, although there is no right of entry for aliens into a foreign country or right of asylum in any country, discrimination based on HIV status with respect to regulations on travel, entry conditions, and procedures relating to immigration and asylum would be a violation of the right to equality before the law.

The right to the highest attainable standard of physical and mental health

The ICESCR provides for States Parties to recognize the right of each person to enjoy the highest attainable standard of physical and mental health possible⁶¹. It adds that the steps taken by States to ensure the full exercise of this right must include those necessary for “the prevention, treatment and control of epidemic, endemic, occupational and other diseases (...)” and “the creation of conditions which would assure to all medical service and medical attention in the event of sickness”⁶². This right is equally recognized in the Universal Declaration of Human Rights⁶³ and by the Convention on the Rights of the Child⁶⁴. The United Nations Economic and Social Council (ECOSOC) has carefully studied this issue in the framework of a general comment on the “highest attainable state of health”⁶⁵.

To respond to the obligations to be met in the context of HIV/AIDS, States must mostly ensure that appropriate information, education and support be provided, with emphasis on access to the services required by those with STIs, through prevention and voluntary, confidential tests accompanied by counselling, to allow persons to protect themselves and others against disease. States must also ensure access to adequate treatment and drugs in the general framework of their public health policy, so that persons living with HIV/AIDS can enjoy as long and as satisfactory a life as possible.⁶⁶

States may have to take special measures so that all groups in society, especially marginalized groups - of which migrant workers are a part - can enjoy equal access to prevention services, care and treatment of HIV. Their obligations regarding human rights to prevent all discrimination and ensure medical services and assistance to all in case of disease, oblige them to ensure no-one is discriminated against because of HIV status⁶⁷.

Rights at work

In conformity with the *ILO Declaration on Fundamental Principles and Rights at Work and its Follow-up*⁶⁸, adopted on 19 June 1998, all ILO member States undertook, by virtue of their membership of the ILO, to respect, promote and achieve, in good faith and in conformity with the Constitution, four categories of principles and rights at work, even if they have not ratified the relevant Conventions:

- freedom of association and recognition of the right to collective bargaining

- the elimination of all forms of forced or compulsory labour
- the effective elimination of child labour
- the elimination of discrimination in respect of employment and occupation

These fundamental principles and rights at work are universal and applicable to all persons in all States, whatever the level of economic development. The eight ILO Conventions related to these issues consequently cover all migrant workers, whatever their status. When migrant workers are prohibited from joining a trade union and taking part in its activities, this is not only an infringement of rights at work, but an obstacle to campaigns on safety and health that are based in the workplace or carried out by workers' associations⁶⁹. On this basis, some multinationals have taken initiatives to give migrant workers and their families access to healthcare⁷⁰.

Other ILO labour standards protect the rights of migrant workers in areas such as employment, labour inspection, social security, maternity protection, wages, safety and health at work.

Protection of migrant workers' rights

There are a number of instruments that have specific provisions to protect migrant workers' rights. These include two ILO International Conventions and Recommendations on migrant workers, and the *International Convention on the Protection of the Rights of all Migrant Workers and Members of Their Family*. Details of the three instruments are shown in Table 13.

The ILO Conventions

Drafting of international labour standards is a unique feature of the ILO. Each ILO Convention is a legal instrument. Once a member State has ratified a Convention, and it has entered into force, the State is obliged to bring its legislation and practice into conformity with the dispositions of the Convention, and to present periodically a report to the ILO on its application in law and

practice. The effect of standards, Conventions and Recommendations is not, however, limited to countries that have ratified them. States also use them as models, and a number of countries that have not ratified them have nevertheless tended to follow the broad lines of their provisions.

The situation of migrant workers was addressed at the founding of the ILO in 1919⁷¹, and concern for the issue led to the adoption of a Recommendation at the first session of the International Labour Conference in 1919, laying down the two main aims of the Organization in this area⁷²: *equality* of treatment between national and migrant workers, and *coordination* between States, as well as between governments, employers' and workers' organizations regarding immigration policy⁷³.

Non-discrimination and equality at work are inviolable standards

It is noteworthy that the Inter-American Court of Human Rights issued an important advisory opinion on 17 September 2003 that strengthens the application of international labour standards to non-national workers, particularly those in an irregular situation. The Court found unanimously that the fundamental principles of equality and non-discrimination are *jus cogens* ("compelling" or inviolable law) and applicable to all residents, whatever their situation with regard to the law on immigration. The Court decided that the State has an obligation to respect and guarantee the human rights of all workers, irrespective of their status as nationals or aliens, and that undocumented migrant workers possess the same labour rights as other workers⁷⁴.

ILO Conventions 97 and 143, ILO Recommendations 86 and 151, and the International Convention on Protection of Migrant Workers, ratifications at 1 December 2005

Instrument	ILO Convention 97 Recommendation 86	ILO Convention 143 Recommendation 151	International Convention
Year of adoption and coming in to force	Adopted 1949 In force 1952	Adopted 1975 In force 1978	Adopted 1990 In force 2003
Number of ratifications	43 countries	18 countries	34 countries

Table 13

In the 1920s, the ILO was in the vanguard of action aimed at guaranteeing durable equal treatment to migrant workers and members of their families. Protection of migrant workers still occupies a significant place in ILO activities, given that more than other workers, migrant workers are likely to be exploited, especially if illegal and/or victims of trafficking. The Declaration concerning the aims and purposes of the International Labour Organization, or *Declaration of Philadelphia* adopted in 1944 puts special emphasis on the plight of migrant workers⁷⁵.

ILO Conventions on migrant workers were drafted long before the emergence of HIV/AIDS. They remain highly relevant as the wider framework within which to protect the rights of migrant workers in the context of HIV/AIDS. The aim of the ILO in adopting these instruments was twofold: to regulate migration conditions, and to specifically address a category of workers in need of protection. The Conventions aim to provide for equality of treatment between nationals and aliens in the field of social security, and to institute an international system to preserve acquired rights and rights being acquired in the case of workers who move.

In regard to social rights, Article 5 of the Migration for Employment Convention (Revised), 1949 (N° 97) enjoins each ratifying State to maintain appropriate medical services to: (a) ascertain at the time of departure and on arrival, that migrants for employment and the members of their families authorized to accompany or join them are in reasonable health; (b) ensure that migrants for employment and members of their families enjoy adequate medical attention and good hygienic conditions at the time of departure, during the journey and on arrival.

Country reports on ratified conventions are examined by the Committee of Experts on the Application of Conventions and Recommendations (CEACR) of the ILO. The issue of the content of the medical examination to which migrant workers are subject on arrival attracted the attention of the CEACR. In this regard, the Committee points out that medical examination and refusal of entry for reasons of serious risk to public health appears to be current practice before allowing entry onto national territory to aliens.

In 1999, the Committee noted that reports from a minority of States referred to HIV/AIDS screening for various categories of migrant workers⁷⁶, and stated its concern at the

alarming development of the phenomenon of HIV/AIDS screening on arrival⁷⁷. As a consequence, the Committee found it necessary to restate that it considered refusal of entry or repatriation on grounds that the worker concerned had an infection or illness of any kind, which had no effect on the task for which he had been recruited, to constitute an unacceptable form of discrimination⁷⁸. The Committee also drew attention to other ILO Conventions that contained provisions relating to discrimination based on the state of health, and to the plight of women migrant workers (who represent, according to some estimates, half the migrant worker population in the world today), pointing to their particular risk of exploitation and abuse.

Disquiet of the Special Rapporteur on Human Rights regarding migrants

Many of those involved in the debate on migration draw attention to the difficulty to reconcile, on the one hand the sovereign rights of each State to protect its labour market, and, on the other, the fundamental human rights of those who migrate for employment⁷⁹. Despite the existence of many international legal instruments on human rights, migration and HIV/AIDS, protection provided by States is not significant enough. In her report on migrants' human rights⁸⁰, the Special Rapporteur on Human Rights concludes that despite fundamental standards applicable to human rights of non-nationals, the reality is far removed in the case of immigrants, particularly those with an illegal status. She has expressed her grave disquiet on numerous occasions regarding the denial of rights to this group, judging that it is hardly useful for a State to declare that it accepts the provisions of instruments on human rights if the regime that it applies to aliens allows it to justify the use of discrimination in recognition of those rights. The same disquiet emerges from the preamble to the *International Convention on the Protection of the Rights of all Migrant Workers and Members of their Family*, who have not been sufficiently recognized and who should receive appropriate international attention.

The International Convention

The UN's convention began a new era in the history of action to define the rights of migrant workers and ensure that these rights be protected and respected. It is an international treaty of great import that was developed on the basis of existing legal agreements, studies carried out by the UN agencies dealing with human rights, the conclusions and recommendations of expert meetings, and discussions and resolutions that the issue of migrant workers had raised over the preceding 20 years.

Yet it took 13 years for 20 States to ratify it, enabling it to come into effect. This time lag demonstrates the reluctance of States globally to 'surrender' their sovereignty on this issue and conform to certain obligations that favour the rights of migrants. To date, 34 States have ratified the Convention, most recently Nicaragua on 26 October 2005. It is noteworthy that 25 States have declared their intention to ratify the Convention, but have yet to do so.

Although the States having ratified it are in the majority countries of migrant origin⁸¹ (for example Mexico, Morocco and the Philippines), recognizing that it is a major means to protect their citizens working abroad, they must nevertheless also apply the Convention to aliens resident in their own countries. No country of Western Europe or North America that is a destination for migrant workers has ratified the Convention, whereas the majority of migrant workers live in those two regions. Other important destination countries, including Australia, India, Japan, and the countries in the Middle East, have also not yet ratified the Convention.

There are several obstacles to ratification. Some States consider their national legislation provides sufficient protection for migrant workers and argue that ratification is superfluous. Other States note that they have few migrants on their territory and see no need for legislation on the issue. In yet other cases, the Convention is not well known and not a priority on the political agenda. Some States do not possess the legal infrastructure needed. Reluctance of certain States to recognize the rights of illegal migrant workers is also mentioned as a reason for non-ratification, and some States are concerned that ratification will encourage illegal immigration.

There are broader social, economic and political reasons for non-ratification. Some States in effect do not want international treaties to interfere with their immigration policies, which they consider to be sovereign. Economic instability and high unemployment are reasons given by States to give preference to their nationals. Some countries consider that it may give too many rights to migrant workers, even if the Convention was not intended to formulate more liberal immigration policies, and merely ensures that human rights are properly applied to migrant workers. Consequently, States that have ratified other instruments on human rights have little reason not to ratify the Convention on these grounds alone.

In addition to instruments that protect migrant workers' rights, there are UN instruments to protect *all* persons from discrimination based on HIV status that *mutatis mutandi* protect people who move in search of work, or for their work or enjoyment. These are the UN *Declaration of commitment on HIV/AIDS* (adopted by the General Assembly in Special Session - known as the UNGASS - in 2001) and the International Guidelines on HIV/AIDS and Human Rights, jointly published in 1998 by the OHCHR and UNAIDS. Finally, the instrument most adapted to the protection of workers' rights in the context of HIV/AIDS is the *ILO Code of Practice on HIV/AIDS and the world of work*, which has far-reaching relevance for migrant workers and other persons who move in connection with their livelihood, although it is, as are the two preceding instruments, advisory and non-binding.

The UNGASS Declaration of Commitment

The Declaration is one of the most wide-ranging instruments defining a plan of action for all countries with respect to prevention of HIV/AIDS; care, support and treatment; the important role of human rights; addressing the need to reduce the risks faced by women, children and persons in situations of conflict (or having experienced natural disasters); and mitigating the social and economic impact of the epidemic. Article 50 specifically calls for national, regional and international strategies to facilitate access to HIV/AIDS prevention programmes for migrants and mobile workers, including the provision of information on health and social services.

International Guidelines on HIV/AIDS and Human Rights

These guidelines were requested by resolution of the Commission on Human Rights in 1995 and published in 1998. Although non-binding, the guidelines highlight fundamental aspects of discrimination, and underscore the fact that the Commission on Human Rights confirmed that the term “or other status” in non-discrimination provisions in international human rights texts should be interpreted to cover health status, including HIV/AIDS⁸². They added that States should not exercise discrimination towards those living with HIV/AIDS or towards members of groups perceived to be at risk of HIV, based on their known or presumed HIV status.

The Guidelines recall that the groups who experience discrimination – which also limits their ability to act in the context of HIV/AIDS – are women, children, persons without resources, minorities, indigenous populations, **migrants** (emphasis added), refugees, etc., and that action by the State against the epidemic should include the implementation of laws aimed at eliminating systematic discrimination, especially against these groups⁸³.

Recalling that international law on human rights guarantees the right to equality before the law and the right to be free from all types of discrimination, mainly of race, colour, sex, language and nationality, the Guidelines recognize that discrimination based on any of these factors is not only unjustifiable but also creates and maintains conditions which lead to social vulnerability to HIV/AIDS, mainly because the environment is not conducive to changing behaviour and to coping with HIV/AIDS.

In 2003, the Commission on Human Rights issued a resolution stressing the need to redouble efforts to ensure universal respect for and the enjoyment by all of human rights and fundamental freedoms, to reduce the risk of HIV transmission and to prevent the discrimination and stigmatization associated with HIV/AIDS⁸⁴. The Commission invited States to strengthen national mechanisms intended to protect human rights in the context of HIV/AIDS and to take all necessary measures to eliminate stigmatization and discrimination experienced by people living with HIV/AIDS, especially women, children and other risk groups, so that persons living with HIV who disclose their status, those who are presumed to be HIV-positive and other persons living in an environment of HIV/AIDS can protect themselves against

violence, stigmatization and other negative effects.

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

The Code of Practice was the first international tool to provide guidance on HIV/AIDS in the specific framework of the workplace, based on social dialogue between governments, employers and workers, and remains the single most adapted instrument to the particular issues of HIV/AIDS in the workplace. Accordingly, it has critical relevance to reducing the risks faced by all people who move in search of work, as a result of their work, or who work with people who move. The Code is certainly the only instrument linking law with HIV/AIDS in the world of work, and is widely used to ensure recognition and implementation of the rights of migrant workers.

The ILO developed the Code of Practice through tripartite consultations in 2001⁸⁵; the Code then received the support of the General Assembly at its Special Session on HIV/AIDS (UNGASS) the same year.

The Code’s principles are voluntary and, in contrast to international labour Conventions, it contains no legal obligations. The Code is based on the protection of human rights and establishes fundamental principles. It is based on the clear premise that neither prevention nor treatment and care will be effective unless the rights of workers and individuals are respected. In contrast to international instruments that engage States, also, the Code addresses the rights and responsibilities not only of governments, but also employers, workers and their organizations⁸⁶. The Code highlights HIV/AIDS as a workplace issue, and the role of the workplace in the response and solutions to HIV/AIDS.

The Code is founded on 10 key principles to address HIV/AIDS in the world of work which together assure:

- a) *non-discrimination* against workers living with HIV/AIDS on the basis of real or perceived HIV status, *confidentiality* with respect to a job applicant or worker’s HIV status, *exclusion of screening* for HIV of applicants or workers, and *continuation of employment* of workers living with HIV/AIDS for as long as medically fit, a duration that is extended when they benefit from *reasonable accommodation* to assist their participation or advancement in the workplace, and

- b) a *safe and healthy work environment* in which working conditions are based on *more equal gender relations* and *social dialogue*, where the *issue of HIV/AIDS is recognized*, and where *prevention, care, support, and treatment* are provided.

These principles work together not only to safeguard the rights of workers who are or become HIV-positive, but, importantly, serve to encourage voluntary testing and the subsequent adoption of prevention and use of treatment services by the population of workers who are HIV-positive. Workers who have less to fear from disclosure more readily come forward for testing, gain access to prevention information to protect others, and avail themselves of treatment and care.

Article 4.10 of the Code notes that *solidarity, care and support should guide the response to HIV/AIDS in the world of work. All workers, including workers with HIV, are entitled to affordable health services. There should be no discrimination against them and their dependants in access to and receipt of benefits from statutory social security programmes and occupational schemes.*

At the same time, the Code provides practical guidelines to develop workplace HIV/AIDS policies at the enterprise, business, national and sectoral levels⁸⁷.

The Code pays particular attention to the plight of higher risk groups such as migrants and mobile workers⁸⁸. In this regard, the Code stipulates that “governments should take measures to identify groups of workers who are vulnerable to infection, and adopt strategies to overcome the factors that make these workers susceptible. Governments should also endeavour to ensure that appropriate prevention programmes are in place for these workers”.

The Code has been translated into more than 35 languages and disseminated globally. A very large number of countries are covered by four of them (Arabic, English, French, and Spanish); some of the languages of translation cover very large populations (Chinese, Hindi, Russian, Tamil); and other languages such as Ayeri, Filipino, Japanese, Kiswahili, Portuguese, Thai, Turkish and Urdu are read by a collectively large population. In sum, the Code

is likely to be available in principle to governments, workers’, employers’ and their organizations in close to 90 per cent of countries globally. It is at present widely applied at workplaces throughout the world at enterprise and business level and also for the development of sectoral and national policies.

Global governance and HIV/AIDS: proposals for a new architecture

Although the international community and the industrialized countries (e.g. the G8 countries) have come to recognize the impact of the epidemic on development and global equity, sufficient attention has not yet been given to the impact of globalization on the capacity of poor countries to fight AIDS. A better understanding remains crucial to put in place elements and conditions for *a new architecture of global governance* which could be more responsive to the needs of poor countries, and commensurate with the substantive importance of the AIDS crisis. Such an architecture would recognize inter-linkages between financial and social stability; focus on emerging from gender inequality; recognize the importance of social objectives for the attainment of sustainable development; avoid policies that exacerbate social tensions; promote strong social institutions and social partners; promote social cohesion based on investments in health, education and training; and support sound labour relations based on core labour standards.

Action is needed in particular to re-invigorate democratic governance in both the North and the South, in combination with mechanisms that put employment and basic human rights at the heart of economic policy. It is important to ensure that economic gains be accompanied by social progress to result in a more socially responsible pattern of globalization. One approach to this is the concept of global social responsibility.

Global social responsibility

Global social responsibility implies that basic human rights are respected as a prerequisite and accompaniment of social progress. They should encompass rights enshrined in global labour standards to cover issues of social protection, non-discrimination and equality of treatment in employment, and prohibition of child labour. There is a growing consensus internationally about the need for such “social dimensions” to make the process of economic globalization fair and equitable.

There are two avenues for possible action to give a social dimension to the governance of globalization: (1) by understanding better – and acting on – the interrelationship between trade liberalization and social progress, including health status; and (2) through institutional support for the coordination of national responses to HIV/AIDS, so as to ensure parallel development of trade liberalization and human rights protection, including promotion of core labour standards.

A socially responsible pattern of globalization would link issues of global governance to key indicators of human development, and use the opportunities and gains of globalization to combat unemployment and poverty. Access to prevention and treatment of HIV/AIDS is required for human development in many developing countries affected by the epidemic, aside from its intrinsic value within internationally recognized workers' rights. Access is furthermore made feasible by, and is a social benefit of globalization.

Promoting global social responsibility in regard to HIV/AIDS would address two sets of goals. First, measures should be established to remove financial and economic barriers to prevention and treatment and facilitate access to social protection and benefits, including social security and health insurance, for workers and their families. Also, steps would be taken to enforce non-discrimination in employment and occupation. Second, action must be intensified by governments and the international community to curb human trafficking, eradicate forced prostitution and social exploitation, and abolish forced labour and exploitative child labour. To attain both sets of goals, expenditures on public health infrastructure and service delivery at the macro-economic level will need to be protected and strengthened, and the necessary integration of economic and social policies will need to be realized.

From an ILO perspective, global governance should be built on democracy, social equity, the rule of law and human rights, with effective participation and representation of key interests in the world of work – government, employers, workers and civil society, including those in the informal economy.

A new architecture must pay sufficient attention to problems of unemployment and social exclusion, with emphasis on promoting

decent work and guarantee of fundamental rights at work. The ILO, among others, has advocated that particular attention be paid to the development of human resource capacity through education, skill development and knowledge, as well as promotion of the core labour standards. It is now generally recognized that core labour standards are not only a goal but an important means of achieving the social objectives of international development.

Where the market and economic growth have not automatically resulted in improvements in working conditions and workers' well-being, and the power relationship between (often foreign) employers and employees in the labour market is asymmetrical, governments will also be required to meet their obligations to promote labour standards to benefit workers and to assure growth and attainment of sustainable development. The ILO can make use of its unique tripartite structure, social dialogue and the universality of its core labour standards to support national efforts in this regard. Due to its integrated economic and social mandate and responsibility to evaluate economic policies in light of their social and labour impact, the ILO's concern for a fair globalization has been translated into the addition of a social dimension to the process by promoting social dialogue among the tripartite constituents on relevant issues.

The international division of labour provides an opportunity for the ILO to contribute to the strengthening of global governance on four fronts:

- improvement of labour conditions in Multinational Enterprises through regulation of global production systems, by building on the ILO Tripartite Declaration of Principles concerning Multinational Enterprises and Social Policy (the "MNE Declaration") that provides guidelines and frameworks for labour conditions in MNE production through, for example, application of fair rules and arrangements for global production, capital flows and trade to establish a minimum set of global labour norms
- stronger formulation of agreed labour guidelines in specific global production sectors through the ILO's industrial committees, one forum for voluntary framework agreements between Global Union Federations and multinational enterprises based on a shared commitment to standards that are innovative in global

industrial relations and for which the ILO is well placed to monitor and provide advice.

- establishing a coherent framework of fair rules to deal with cross-border movements of workers and people in search of employment
- credibly providing concrete proposals for global social responsibility because of the influence of the ILO's core labour standards and principle of social dialogue on economic decision-making, such as socially responsible investment strategies, social regulation of world trade and the global economy, and global taxes for social needs and purposes.

The ILO's approach is, moreover, founded on a consensus to incorporate equity concerns in global social policy, as manifested in the report of the World Commission on the Social Dimension of Globalization (WCSDG), *A*

fairer globalization; creating opportunities for all, and recent global declarations and reports on international development - such as the Millennium Declaration, the Monterrey Consensus, the Paris Declaration of the OECD/DAC, the G8 Gleneagles Summit, the Blair Commission for Africa, and the Report of the Millennium Project.

The foregoing implies strengthened advocacy of the ILO's contribution to aspects of global governance, including achieving respect for core labour standards and adoption of the *Decent Work Agenda* as global goals to guide the process of globalization towards fairer outcomes. It also implies that the ILO fully achieves its constitutionally mandated role in the multilateral system, as called for in the report of the WCSDG, mobilizes tripartism globally through stronger partnerships of constituents, and advocates more vigorously at all levels.

ILO World Commission on the Social Dimension of Globalization (WCSDG)

The Commission was established to address the development challenge of globalization, taking account of the core mandate of the ILO. Focusing on the impact of globalization on people and their well-being, democratic governance and human rights, and sustainable development, the main thrust of the Commission's work was on social interventions to support a fairer outcome of globalization. The Commission's concluded that a fairer outcome of globalization was a prerequisite to tackle poverty and inequality globally and achieve the MDGs. It noted that, otherwise, poor and least developed countries in the global economy that have experienced slower economic growth, increasing unemployment and poverty and that are least able to compete in global markets because of unfair globalization will continue to have diminished capacity to respond to development challenges including HIV/AIDS.

The Commission's report emphasized social protection for the improvement of human well-being, including access to health and safety in the workplace and community. It recognized HIV/AIDS as a major health problem as well as a development challenge. The link between HIV/AIDS and globalization was most visibly illustrated by the unaffordable cost of patented drugs to treat AIDS and related diseases in poor countries. HIV/AIDS was also identified as an inducement for labour migration, a feature of globalization that is reducing the supply of skilled and experienced labour in developing countries that is required to respond effectively to the epidemic. This is in addition to the larger loss of workers at all skill levels due to AIDS-related morbidity and death. Cross-border movements of people, especially through human trafficking that is also a feature of rapid globalization hinders the prevention of HIV transmission.

In line with the growing international consensus, the Commission holds health to be both a key goal of social development and a requirement for sustainable development. High priority is attached to controlling the HIV/AIDS epidemic in an increasingly interconnected world. The important role of the ILO's partners, notably WHO, UNAIDS and the GFATM is recognized by the Commission as part of the global and multi-disciplinary efforts needed.

The Commission's report identifies poorer education and training opportunities, increasing unemployment, inequality and gender imbalances as outcomes of globalization. These factors at the same time characterize the handicaps and disadvantages encountered by poor and least-developed countries that have negative consequences for the prevention of HIV/AIDS and for the national capacity to respond to the epidemic.

The Decent Work Agenda of the ILO

The ILO's mandated commitment to social justice is founded on employment, equality and social protection. Employment is identified as the main route out of poverty for many people, but the ILO also recognizes that the burden of poverty is greater than lack of income: it encompasses lack of dignity, disempowerment, violation of human rights, lack of self-worth, and the lack of capacity to organize in order to reclaim entitlements. Beyond employment itself, promoting *decent and productive work* in conditions of freedom, equity, security and human dignity serves to give new voice to those excluded by poverty, and to the recognition of their rights, which can more truly, fundamentally and irreversibly serve the eradication of poverty.

Striving to secure decent work for women and men everywhere is therefore the natural convergence of the ILO's strategic objectives regarding rights at work, employment, social protection, and social dialogue. It is designed and intended to contribute forcefully to the eradication of extreme poverty and therefore comprises an overarching goal guiding international policy-making and action.

The *Decent Work Agenda* addresses both productive employment creation and the aspirations of workers with regard to economic security and social protection. The social concerns of *Decent Work* are deemed as relevant to reducing poverty and promoting social inclusion and integration as gains in employment and income. Through the *Agenda*, the ILO promotes integrated action on these fronts, and provides one response to the concern that globalization challenges the capacity of many countries to achieve both economic and social development goals.

In view of the epidemic's significant impact on the labour force and enterprise efficiency, the *Decent Work Agenda* also addresses HIV/AIDS directly. AIDS is construed squarely as a workplace issue, and the *Agenda* seeks to mobilize the ILO's tripartite constituents to take action to limit the transmission of the epidemic, and to mitigate its effects. This includes strengthening the capacity of workers' and employers' organizations and their members to implement appropriate workplace policies and programmes, in accordance with the fundamental principles of the *ILO Code of Practice on HIV/AIDS and the world of work*.

Global financial governance for debt relief

Given that public health and global finance are linked because the burden of external debt diverts resources for creditor repayments which undermines the ability of many poor countries to improve public health and respond to the HIV/AIDS epidemic, international commitments for public health should include

About one in three of all persons living with HIV/AIDS – around 13 million people – live in countries classified by the IMF and World Bank as “Heavily Indebted Poor Countries” (HIPC). These countries have among the highest HIV prevalence rates in the world, and more than 1,000,000 AIDS-related deaths each year. In addition to the damaging impact of HIV/AIDS on their health and education systems and overall economic growth, these countries are currently experiencing reductions in overseas development assistance flows.

reform of the *heavily indebted poor countries* initiative (HIPC and Enhanced HIPC Debt Initiative).

When the Initiative was designed, the full scale of the threat posed by the HIV/AIDS crisis was not evident. As new assessments emerge of the enormous costs of containing and rolling back the epidemic through public policy and spending on health and education, it is becoming clear that levels of debt relief are woefully inadequate. Indeed, current efforts fall far short of need: half of the 26 HIPC countries in mid-2005 are spending 15 per cent or more of government revenues on debt repayments and half are still spending more on debt than on public health. Zambia, for example, is spending 30 per cent more on debt than on health, Cameroon's debt repayment amounts to 3.5 times health spending, and both Malawi and Mali spend less on health than on debt servicing. Assuring the conversion of debt repayment into public investment in health might make a real difference.

Furthermore, some highly-affected HIV/AIDS countries do not even qualify for

HIPC assistance and resort to further borrowing and debt rescheduling to obtain additional resources for health, often because no attempt has been made to revise “debt sustainability indicators” to take account of financial requirements to address HIV/AIDS.

In order to qualify for debt relief in the future, these countries may have to adopt austere externally-imposed adjustment measures and reform programmes: in order to avoid debt relief rewarding poor economic performance, eligibility depends on maintaining a 3-year track record of macroeconomic, structural and social policy reforms, monitored by the World Bank and IMF.

Bold attempts by the international financial institutions are needed to confront the challenge of integrating debt relief into a coherent resource mobilization strategy adapted to the public health needs and the level of control over HIV/AIDS called for to achieve the Millennium Development Goals.

Trade liberalization reforms

The opening of markets and market access through removal of restrictive trade practices

and export subsidies in developed countries are desirable reforms to increase the capacity of developing countries to control HIV/AIDS. Improved opportunities for developing countries to expand and diversify exports will significantly assist their economic growth and achievement of sustainable development. Accordingly, the relatively small share of the least developed countries in international trade has made it vital for them to cooperate to enhance their bargaining power in international trade negotiations, and at the 4th WTO Ministerial Meeting in Doha, African countries acted as a group by setting their own agenda, engaging in collective decision-making; and acting collectively in ‘buying into’ the common agenda on key items such as the TRIPS Agreement (see boxes).

Whereas market access and trade rules have an important contribution to make from a development perspective, overcoming supply side constraints and enhancing trade capacity at country level are of equal importance to economic growth and sustainable development.

TRIPS Agreement and access to ARV drugs in a globalized world

Access to antiretroviral drugs (ARVs) has given rise to conflicts between signatory countries to the World Trade Organization (WTO) rules of trade governing distribution of drugs, as well as conflicts between those rules and national standards. Of greatest relevance to the health sector in general and to the production and distribution of essential HIV/AIDS drugs is the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS).

The TRIPS agreement requires patent protection for products and processes for a minimum duration of 20 years from original date of filing. Concerns in developing countries that patents and the TRIPS agreement restrict access to ARVs by making production and access to cheaper generic drugs difficult are addressed under the agreement. The original Agreement signed in 1994 provided for least-developed member States to have until 2006 to bring their national legislation and practices into conformity with the provisions of the agreement. In recognition of economic, financial, administrative and technological constraints, the agreement also provided for the possibility for further extension of the transitional period. Non-WTO member States are not bound by TRIPS, but are nevertheless encouraged to evaluate TRIPS requirements and incorporate into national legislation and trade-related practices those elements deemed to benefit public health. The impact of TRIPS on access to essential medicines, and particularly ARVs, in developing countries has made it one of the most controversial WTO agreements.

Owing to the impact of patent protection on the price and accessibility of ARVs, developing countries and NGOs have been advocating the abolition of patents with a view to bringing down the prices of essential drugs. Some countries (e.g., Brazil, India, South Africa) have invoked the use of flexibilities and discretionary provisions of the TRIPS Agreement to bypass patents, notably the possibility of declaring HIV/AIDS epidemic as a “national emergency” which allows governments the right to produce a drug needed to address such emergency if necessary (see box *TRIPS and public health*). By their existence alone, such provisions have stimulated generic competition and reduced

the prices for off-patent drugs, thereby facilitating access to treatment. Given that there is virtually always a cost to individuals for ARVs and other essential drugs in developing countries, access to treatment is particularly sensitive to cost.

The experience of developing countries to date with regard to the production of generic ARVs has been mixed. Pharmaceutical companies in developed countries have tended to resist moves toward the abolition of patents on AIDS drugs, which could encourage greater production of generic drugs and cause a price reduction in patent drugs. Furthermore, as the production of generic drugs gathers momentum, multinational and large pharmaceutical companies are less likely to develop drugs and vaccines for diseases that mainly affect people in developing countries on grounds that it is not commercially viable to develop drugs whose patent rights serve for only a short period of time.

There are other significant barriers standing in the way to universal access to ARVs that require attention. In developing countries, they include inadequate healthcare infrastructure and insufficient health sector personnel. In this regard, it is poverty that remains the biggest single barrier to effective healthcare in developing countries. Access to ARVs for HIV/AIDS treatment in poor countries requires political commitment, national resources, and the input of affected communities. It also requires funding from the international community, NGOs, foundations, and the private sector. Universal access should be addressed as a shared responsibility by all sectors of society at global and national levels.

TRIPS and public health

The Doha Declaration on TRIPS and Public Health adopted at the 4th WTO Ministerial Meeting in November 2001 explicitly recognized the gravity of HIV/AIDS as a major public health problem and stressed the need for flexibility in the application of TRIPS. The transitional period for compliance with the agreement regarding pharmaceutical patents was extended for least developed countries from 2006 to 2016. In addition, developed countries member States of WTO were mandated to provide incentives to their enterprises and institutions to promote and encourage technology transfer to least developed countries with little or no manufacturing capacities in the pharmaceutical sectors. The overall aim of the Doha Declaration was to make provisions for developing and least-developed country member States to take action to protect the public health.

Doha reaffirmed the right of poor developing countries to use the flexibility of TRIPS to address HIV/AIDS as a serious public health issue. The issue of *compulsory licensing* is of special significance for HIV/AIDS, as it allows governments to issue a licence to manufacture patented products without consent of the patent owner. WTO members further agreed in August 2003 to modify TRIPS provisions relating to compulsory licensing so that countries unable to produce pharmaceuticals domestically can import drugs under patent that are manufactured under compulsory licensing elsewhere.

From a public health point of view, the intellectual property rights of a patent owner under TRIPS can be weighed against the right to health. It is important that the TRIPS agreement does not limit the access of people in the least developed and poor countries to essential medicines. At the same time, it is similarly important that the protection of intellectual property is recognized as essential to ensure continued investment in the research and development also needed for the health of the world's poorest populations. Greater application of TRIPS flexibilities is called for to achieve the right balance between these two requirements.

Access to essential drugs for the treatment of AIDS is seen by many as the evidence required to demonstrate that individuals and their families in highly affected regions such as sub-Saharan Africa share in the benefits of globalization.

In view of the impact of TRIPS on public health, WHO has an observer status at the WTO to monitor the situation. WHO links access to essential drugs with public health practices that are prerequisites for sustainable development.

It is also of note, with respect to the specific issue of antiretroviral drugs, that whereas progress has been made in bringing down the prices of antiretroviral and other drugs, there remains the issue of the development and distribution of new and more effective medicines and of a vaccine for AIDS at affordable prices. In view of indications that north-based pharmaceutical companies are less inclined to invest in research for the development of the next generations of AIDS drugs if patent rights are not recognized and protected, it is important that the TRIPS Agreement does not prevent people in the least developed countries from access to essential medicines.

TRIPS and fundamental rights

From the view point of the ILO, fundamental rights at work can be interpreted to extend to the prevention and treatment of HIV/AIDS. The protection of workers' rights covered by ILO Conventions is universally binding. These rights are of particular significance in the context of globalization, as they are instruments to enable workers to claim their share of opportunities and benefits in the liberalization of international trade and capital.

Although the developing countries were able at Doha to elicit a common understanding on the rights of member States to protect public health, there are still provisions for more stringent patent protection under the TRIPS Agreement that can raise prices for vital medicines and further stress public health and household budgets. At the time of writing, lack of progress on the Doha round of Multilateral Trade Negotiations (MTN) in the preparations for the Hong Kong WTO Ministerial Meeting in December 2005 raises concerns and fears that continuing liberalization of trade and capital movements may benefit developed more than developing countries.

A global 'public good' policy approach

A global 'public good' policy approach can form the basis to justify investments by north-based pharmaceutical companies to develop and market new HIV/AIDS drugs for the benefit of the world's poorest people at "affordable prices". This approach recognizes that the epidemic is a global threat requiring a global public policy, and that everyone's best

interest is met through a coordinated and effective global response. The alternative for richer countries is to face higher economic and social costs, as a consequence of HIV transmission, and to bear large direct health aid costs and indirect economic costs in terms of lost markets, all more or less inevitable in an irreversibly globalizing world. Self-interest dictates that richer nations support through resource transfers the development of effective responses to HIV/AIDS in poor countries that are experiencing more mature epidemics.

Thus it is that in the case of HIV/AIDS, it can be argued that individual members of societies have an interest in together ensuring that HIV transmission is contained and its impact on development mitigated; if not, HIV/AIDS will come to affect the daily social and economic lives of individuals everywhere. Public policies for prevention of HIV, care, support and treatment, and to mitigate the epidemic's deleterious social and economic effects are required and justifiable on grounds of personal and family self-interest, as well as on grounds of human rights, public health and the achievement of sustainable development.

Globalizing antiretroviral treatment

It can be argued that there are compelling pragmatic as well as moral reasons for greater cooperation between developed and developing countries in the development, production and marketing of ARVs. Even the richest and most advanced countries are not immune to the epidemic, and free movement of people and goods has been a factor in the transmission of HIV. It is in the global interest to support research and development of new drugs and make them accessible to all. In the context of global health needs, and interconnections between countries due to globalization, investment in new drugs can be seen as a *public good* which should benefit poor populations in developing countries as much as pharmaceutical companies in more developed countries. A breakthrough in the development of drugs to treat a disease in poor populations may one day lead to a breakthrough in the treatment of diseases occurring in more developed countries, or serve to prevent a global epidemic.

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Notes (including legal footnotes)

- ¹ The epidemic also expands, although to a substantially lesser extent globally, as a result of sharing contaminated injecting drug use material, transmission from mother to infant at delivery or during breastfeeding, and from lack of rigorous application of universal precautions in procedures for blood transfusion and clinical care. The principal focus of this monograph is sexually transmitted HIV/AIDS, both heterosexually and in the course of men having sex with men.
- ² ASEAN, the Association of Southeast Asian Nations was established in 1967 by Indonesia, Malaysia, Philippines, Singapore and Thailand and the membership was later enlarged: Brunei Darussalam (1984), Vietnam (1995), Laos (1997), Myanmar (1997), and Cambodia (1999). ASEAN reports a current combined gross domestic product of US\$737 billion, and total trade of US\$ 720 billion. See www.aseansec.org/64.htm
- ³ See Alsan, et al., 2004.
- ⁴ See Coulibaly, forthcoming b.
- ⁵ The countries omitted from the analysis for lack of data were Cambodia, Djibouti, Equatorial Guinea, Eritrea, Guinea-Bissau, Liberia, Myanmar, Namibia, Sudan and Suriname.
- ⁶ See Frank and Sehgal, forthcoming.
- ⁷ The poverty headcount index is an estimate of the proportion (per cent) of a population living under an international poverty line (IPL), adopted by the World Bank as the equivalent - or purchasing power parity (PPP) after conversion - of a daily income of US\$1 of 2000, and, additionally, the proportion (per cent) living within a US\$1 of 2000 *above* the IPL (for the US \$2 poverty line) (See World Bank: Human Development Report 1997 - *Human Development to Eradicate Poverty*. Washington, D.C.: The World Bank). For the Gini coefficient, 0.0 is minimum inequality and 1.0 is maximum inequality.
- ⁸ For purposes of this analysis, groups of persons who move internally and across borders are included. Labour migration refers to cross-border movement in search of decent work. Forced labour includes persons forced to move internally. Trafficking refers to “the recruitment, transport, transfer, harbouring or receipt of a person by such means as threat or use of force or other forms of coercion, of abduction, of fraud or deception ‘for the purposes of exploitation’” (See ILO, 2005c:7). Figures provided in Table 5 refer to stocks of persons at the time of the estimates. The large numbers of workers who move internally in search of decent work, for example from rural to urban areas are not shown here. They are poorly known and difficult to estimate. The estimates of urban, poor young women exposed to the risk of HIV discussed in the immediately preceding section (*Global estimates of persons at risk of HIV due to poverty*) address one aspect of the consequences of internal urban migration.
- ⁹ Natural disasters include environmental degradation and famine; conflict includes persecution. Poverty is a major cause of voluntary movement toward a better life.
- ¹⁰ See Özden and Schiff, 2005.
- ¹¹ The American Medical Association reports that of 5,334 persons granted non-federal licenses to practice medicine in 2002, 2,158 were from Nigeria and 1,943 from South Africa. A further 478 physicians were trained in Ghana. Other countries included Ethiopia (257 physicians), Uganda (153 physicians), and Kenya (93 physicians). The 5,334 physicians represent more than 6 percent of the total number of African physicians. Altogether 21,000 Nigerian physicians practise in the US.
- ¹² Factors that influence health professionals to emigrate vary by country and individually. Key reasons for dissatisfaction include poor remuneration, dangerous working conditions, outdated equipment, human rights violations, an oppressive political

climate, persecution of intellectuals, ethnic and religious tensions, discrimination and lack of intellectual stimulation. These factors are termed “push” factors. Other, key, “pull” factors include the attraction elsewhere of better professional development, higher wage opportunities, work in safer environments, better training opportunities, better facilities, less political persecution, and better education for their children.

¹³ Data correspond to estimates of the current supply of qualified seafarers entitled to serve in a designated capacity as an officer or a rating (including trainees) on a ship of 100 gross tonnage or more in the commercial trading fleet. This definition includes only those who are active in the industry, i.e. actually serving at sea, currently unemployed but looking for work at sea, attending training courses or temporarily unfit. The estimates do not include seafarers serving in the fishing industry, on harbour tugs, inland waterways, coastal or estuarial craft, or those providing ancillary or support services on specialist ships such as passenger ships.

¹⁴ Including Australia, India, New Zealand and Pakistan.

¹⁵ There are fishermen and fisherwomen, and the preferred term for all workers is fisherfolk.

¹⁶ Clearly, although expatriates may choose to pursue a job opportunity overseas, their being overseas and therefore at risk is in effect a work-related condition, whereas travellers of any age are not generally overseas for work-related reasons. It is the fact that these groups are studied together that justifies the inclusion of travellers here.

¹⁷ See Russell Gerber & White, 2002.

¹⁸ See Egan, 2001; de Graaf *et al.*, 1998; and Petersen, 2003.

¹⁹ ‘Sexual tourism’ refers to a sex industry that includes prostitution of adults and children, the production and distribution of pornography, and human trafficking. Sexual tourism often links prostitution with organized crime, as adults and child prostitutes are smuggled and forced into sex work. For example, about 60 per cent of prostitutes working in brothels in Cambodia in 2001 had been trafficked into

the sex industry (see section on *Human trafficking*, on page 22 of this report).

²⁰ It is difficult nevertheless to clearly separate sexual tourism from other forms of travel and tourism involving sex, and the line between commercial sex and tourism is therefore blurred.

²¹ ECPAT is an NGO whose acronym originally stood for “Ending Child Prostitution in Asian Tourism”.

Legal footnotes (references may be additional to bibliography)

²² See AIDS & Mobility (n.d.); US Department of State (n.d.) and UNAIDS/IOM, 2004.

²³ See Ratner, 1998.

²⁴ See WHO, 2003.

²⁵ Coordination of Action Research on AIDS and Mobility (CARAM): “Mandatory Testing of Migrant Workers: A violation of rights”, abstract presented at the XV international conference on AIDS, July 2004: see www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol9no32004/bangkok04-14e.htm or <http://caramasis.gn.apc.org/> (visited on 23 March 2005).

²⁶ The exercise of certain rights cannot be restricted in any circumstances. The following rights are concerned: right to life, right not to be subjected to torture, right not to be held in slavery or bondage, protection from imprisonment for debt, right not to be subjected to retroactive criminal legislation, right to liberty and security of person, right to freedom of opinion, conscience and religion. For more details, see OHCHR & UNAIDS, 1998, para. 82.

²⁷ See OHCHR & UNAIDS, 1998, para. 106.

²⁸ Sommerville, M.A.; Wilson, S.: “Crossing boundaries: Travel, Immigration, Human Rights and HIV/AIDS”, December 1998, 43 McGill, L.J 781: 5-7; National AIDS Trust: Impact HIV and Mobility, Policy Bulletin No. 7, 2003: 7-8.

²⁹ See OHCHR & UNAIDS, 1998, para. 72.

³⁰ See the report of the Special Rapporteur on the human rights of migrants, presented

- at the 56th Session of the Commission on Human Rights, E/CN.4/2000/82, paras. 77-78; Filer, D.P.: *Return of the Fourth Horseman: Emerging Infectious Diseases and International Law*, April 1997, 81 Minn.L.Rev, 771, p.27; Fitzpatrick, J.; Bennet, W.: *Symposium on Immigration Policy: A Lion in the Path? The Influence of International Law on Immigration Policy of the United States*, July 1995, 70 Wash.L.Rev. 589: 3 and 16.
- 31 See OHCHR & UNAIDS, 1998; and UNAIDS & IOM, 2004.
- 32 UNAIDS & IPU (1999). *Handbook for legislators on HIV/AIDS, laws and human rights: action to combat HIV in view of devastating human, economic and social impact*. Geneva: UNAIDS and IPU.
- 33 See OHCHR & UNAIDS, 1998, preface, p. v.
- 34 United Nations (1993). Report of the World Conference on Human Rights. Report of the Secretary-General [A/CONF.157/24 (Part I), chap. III.] (13 October).
- 35 151 ratifications at 1 December 2005.
- 36 By 7 October 2005, the International Covenant on Civil and Political rights had been ratified by 154 States, the International Covenant on Economic, Social and Cultural Rights by 151 States, the International Convention on the Elimination of all Forms of Racial Discrimination by 170 States, the Convention on all Forms of Discrimination against Women by 180 States, and the Convention on the Rights of the Child by 192 States.
- 37 United Nations, 1948, Article 2.
- 38 See para.10 of General Comment No. 31 (80), adopted on 29 March 2004. See also General Comment, Commission on Human Rights, No. 27 (67), as well as OHCHR & UNAIDS, 1998, para.109, which states that "...although there is no right of aliens to enter a foreign country or to be granted asylum in a particular country, discrimination on the grounds of HIV status in the context of travel regulations, entry requirements, immigration and asylum procedures would violate the right to equality before the law".
- 39 WHO, 1969.
- 40 International Health Regulations, under WHO administration, are the only constraining global legal instrument dealing with measures to be taken to void the cross-border spread of transmissible diseases. For more information on the updated and revised regulations, see: www.who.int/csr/ihr/
- 41 WHO, 2003, p.18, which cites WHO Global Programme on AIDS, Report of the preparatory meeting. See also: National AIDS Trust: Impact HIV and Mobility, Policy Bulletin No. 7, 2003, p.6, which stresses the fact the United States, which has adopted a strict policy of exclusion since the start of the epidemic, has one of the highest rates of infection in developed countries. In addition, China, India and several CIS countries that have also adopted measures on mandatory screening and travel restrictions are nonetheless located in regions of the world where the incidence of HIV/AIDS is rising.
- 42 OHCHR & UNAIDS, 1998, para. 105. See also UNAIDS & IOM, 2004.
- 43 CARAM, op. cit. in endnote number 25.
- 44 UNDP: No Safety Signs Here (2004). Study on Migration and HIV vulnerability in seven South and North East Asian Countries (Bangladesh, China, People's Democratic Republic of Korea, India, Mongolia, Republic of Korea and Sri Lanka). See p.14. (November).
- 45 Ibid.
- 46 Ibid, quoting Wickrarmasekara 2002, p. 16.
- 47 According to WHO, 2003, p. 20, the legal status of migrants is often a determining factor in access to social and health services.
- 48 Commission on Human Rights E/CN.4/2000/82, op. cit. in endnote number 30, paras. 16 and 91. The Special Rapporteur was referring to the Puebla process, the Manila process and the Bangkok, Dakar, Mediterranean, Cairo, Lima and Commonwealth of Independent States initiatives.

- ⁴⁹ See OHCHR & UNAIDS, 1998, paras. 21(a), 28(d), 30(i) and (j). The Special Rapporteur recommends that firing of a sick migrant worker be made legally impossible without just indemnities in countries of destination. In addition, the law should forbid certain medical tests on these workers without their express consent: E/CN.4/2004/76, para. 83; during her visit to the Philippines, she also encouraged an increase in the number of guidance seminars prior to departure and updating of learning materials to include HIV/AIDS prevention (see E/CN.4/2003/85/add.4).
- ⁵⁰ OHCHR & UNAIDS, 1998, paras. 50, 38(c) and (j), 40(d) and (e); Special Rapporteur's report on the rights of every person to enjoy better physical and mental health, presented at the Sixtieth Session of the Commission on Human Rights (see E/CN.4/2004/49).
- ⁵¹ UNDP: No Safety Signs Here, op. cit. in endnote number 44, p. 10.
- ⁵² ICFTU, 2004.
- ⁵³ Resolution on EPZs presented to the International Labour Conference by Mr. Cortebeek, Worker delegate of Belgium, 88th Session, Geneva, 2000.
- ⁵⁴ See ILO, 1998a.
- ⁵⁵ Mr. Pedro Ortega Méndez, Secretary-General of the Textile, Clothing, Leather and Footwear Federation, Sandinista Workers' Confederation (CST), Nicaragua, 1997.
- ⁵⁶ ICFTU, 2004, p. 8.
- ⁵⁷ See Article 33 of the Convention relating to the Status of Refugees, 1951.
- ⁵⁸ See OHCHR & UNAIDS, 1998, para. 107.
- ⁵⁹ NHCR & IOM (1998). *Health Policy on AIDS* (15 February).
- ⁶⁰ Commission on Human Rights, General Comment no 18 (37), General Assembly Official Documents, Forty-fifth Session, Supplement No. 40 (A/45/40), Vol. I, Annex V and appendix.
- ⁶¹ United Nations, 1966b, Article 12, para. 1.
- ⁶² Ibid, Article 12, paras. 2 c) and d).
- ⁶³ United Nations, 1948, Article 25.
- ⁶⁴ See United Nations (1989). Convention on the Rights of the Child. New York: United Nations. Article 24, para. 1 provides that "States parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment and rehabilitation of health. State parties shall strive to ensure that no child is deprived of his or her right of access to such health care services".
- ⁶⁵ See United Nations document E/C.12/2000/4.
- ⁶⁶ HCHR & UNAIDS, 1998, paras.122 and 123.
- ⁶⁷ HCHR & UNAIDS, 1998, para. 124.
- ⁶⁸ ILO, 1998b, Article 2.
- ⁶⁹ See ILO, 2004b, para. 217.
- ⁷⁰ For example, the Global Business Coalition on HIV/AIDS (GBC) consisting of more than 130 multinational enterprises employing more than four million employees in 178 countries. www.businessfightsaids.org/default.asp
- ⁷¹ The Treaty of Versailles, which lay the foundations of the ILO in 1919, provided in Article 427 that "the regulations laid down in each country on working conditions must ensure equitable economic treatment for all workers legally resident in the country". In addition, the ILO has the obligation as stated in the Preamble to the ILO Constitution to improve the defence of the interests of workers who are employed abroad.
- ⁷² ILO, 2001c.
- ⁷³ The Reciprocity of Treatment Recommendation, 1919 (No.2).
- ⁷⁴ See Inter American Court of Human Rights, Series A n°18. Advisory Opinion OC -18/03 of September 17, 2003 requested by the United Mexican States. Available at: http://www.corteidh.or.cr/serieapdf_ing/seriica_18_ing.pdf. See paras. 10 and 49 of the Advisory Opinion.
- ⁷⁵ Para. III c) "The Conference recognizes the solemn obligation of the International Labour Organization to further among the

nations of the world programmes which will achieve [...] the provision, as a means to the attainment of this end and under adequate guarantees for all concerned, of facilities for training and the transfer of labour, including migration for employment and settlement”.

⁷⁶ ILO, 1999, para. 264.

⁷⁷ Ibid, paras. 288 and 504.

⁷⁸ Ibid, para. 266.

⁷⁹ ILO, 2001c, p. 128.

⁸⁰ See United Nations document A/59/377 (22 September 2004).

⁸¹ See UNESCO, 2003b, p. 3.

⁸² OHCHR & UNAIDS, 1998. See United Nations Resolution 1995/44 of 3 March 1995 and Resolution 1996/43 of the Commission on Human Rights.

⁸³ OHCHR & UNAIDS, 1998, para. 85.

⁸⁴ Commission on Human Rights (CHR) Resolution 2003/47 on the protection of human rights in the context of HIV/AIDS.

⁸⁵ ILO is based on the principle of tripartism, which is enshrined in its Constitution. Hence, all ILO constituent bodies consist of governments of member States, employers’ representatives and workers’ representatives from all regions.

⁸⁶ ILO, 2001d, Section 5.

⁸⁷ Ibid, Section 1.

⁸⁸ Ibid, Sections 5.1 (q) and 5.3 (l).

Main tables

Main table 1: Estimated working-age population and labour force 15 to 49, 15 to 24 and 25 to 29 years, by sex, 64 countries affected by HIV/AIDS, 2005

Country	Estimated HIV prevalence for all persons 15-49 years (%) 2005	Age group																	
		15 to 49 years						15 to 24 years						25 to 29 years					
		Population ('000s)			Labour force ('000s)			Population ('000s)			Labour force ('000s)			Population ('000s)			Labour force ('000s)		
		Total	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females
Sub-Saharan Africa (40 countries)																			
Angola	4.0	7,202	3,552	3,650	5,927	3,200	2,727	3,216	1,598	1,618	2,458	1,322	1,136	1,181	584	597	1,003	551	452
Benin	1.8	3,920	1,997	1,923	3,310	1,631	1,679	1,733	881	852	1,167	557	610	619	315	303	617	302	315
Botswana	36.7	909	450	459	671	322	349	431	217	214	272	137	136	148	75	73	124	58	67
Burkina Faso	2.6	5,907	2,972	2,935	4,928	2,654	2,274	2,722	1,376	1,346	2,063	1,107	957	1,004	510	494	890	489	401
Burundi	5.9	3,482	1,705	1,777	3,121	1,601	1,520	1,703	848	855	1,480	763	717	553	272	281	506	265	241
Cameroon	6.8	7,821	3,905	3,915	5,326	3,313	2,013	3,501	1,757	1,745	1,988	1,240	748	1,303	653	650	967	628	339
Central African Republic	13.4	1,843	904	938	1,369	761	608	850	419	430	533	290	244	311	153	157	250	146	104
Chad	4.7	4,242	2,103	2,140	3,433	1,873	1,561	1,905	948	957	1,391	746	644	697	346	351	600	338	262
Congo	4.7	1,757	875	882	1,223	721	502	791	395	396	446	254	192	296	148	149	232	143	89
Côte d'Ivoire	7.3	8,603	4,393	4,210	5,709	3,791	1,918	3,983	1,993	1,990	2,254	1,440	815	1,397	706	691	1,017	688	329
Democratic Republic of Congo	4.2	25,358	12,642	12,716	15,519	9,593	5,926	11,482	5,741	5,741	5,381	3,599	1,782	4,258	2,122	2,135	2,986	1,813	1,172
Djibouti	3.0	384	193	191	257	163	93	160	81	80	88	54	34	62	31	31	46	30	16
Equatorial Guinea	12.8	222	110	112	152	99	53	98	49	49	60	40	20	35	17	18	25	17	8
Eritrea	2.6	2,053	1,010	1,042	1,655	860	795	906	451	456	640	321	318	371	184	187	320	175	145
Ethiopia	4.7	35,523	17,679	17,844	32,435	16,565	15,870	15,643	7,825	7,818	13,698	6,876	6,821	5,773	2,878	2,895	5,547	2,841	2,707
Gabon	9.2	667	331	335	500	275	225	285	143	142	176	95	81	107	53	54	89	51	38
Gambia	1.1	725	359	367	619	331	289	287	143	144	221	118	103	114	56	57	103	56	47
Ghana	3.0	10,977	5,560	5,418	8,797	4,487	4,310	4,727	2,405	2,322	2,937	1,425	1,513	1,790	907	883	1,650	866	784
Guinea	3.6	4,249	2,191	2,058	3,541	1,898	1,643	1,793	924	869	1,276	676	600	687	355	332	623	341	281
Guinea-Bissau	3.8	683	337	346	506	299	206	299	148	150	196	113	82	111	55	56	88	54	34
Kenya	6.4	16,663	8,391	8,272	13,739	7,417	6,321	7,847	3,931	3,916	5,772	3,087	2,685	2,853	1,439	1,414	2,509	1,391	1,117
Lesotho	28.5	865	390	475	552	310	242	461	226	235	257	150	107	142	65	78	107	63	44
Liberia	6.4	1,473	739	734	849	544	305	663	334	329	279	187	92	241	122	119	162	105	57
Madagascar	2.0	8,597	4,285	4,312	6,802	3,789	3,013	3,627	1,814	1,813	2,440	1,357	1,083	1,393	695	699	1,215	681	534
Malawi	14.1	5,594	2,767	2,827	4,537	2,359	2,177	2,553	1,273	1,279	1,775	903	872	1,007	507	499	898	493	405
Mali	1.9	5,904	2,934	2,970	4,782	2,599	2,184	2,747	1,393	1,353	2,015	1,099	916	999	499	499	864	484	380
Mozambique	12.1	9,068	4,309	4,759	7,756	3,825	3,931	4,015	2,004	2,011	3,024	1,561	1,463	1,492	711	781	1,380	692	687
Namibia	20.8	975	485	490	688	402	286	428	216	213	234	141	94	151	77	75	127	73	53
Niger	1.4	6,077	3,131	2,947	4,978	2,895	2,082	2,701	1,394	1,307	2,035	1,196	839	991	512	479	837	498	339
Nigeria	5.4	60,488	30,654	29,834	40,325	25,880	14,445	27,316	13,915	13,400	15,131	9,747	5,384	9,830	4,987	4,843	7,148	4,700	2,449
Rwanda	5.1	4,370	2,097	2,272	3,934	1,971	1,963	2,151	1,060	1,091	1,874	953	921	694	333	361	641	327	314
Sierra Leone	1.8	2,533	1,253	1,279	1,294	872	422	1,049	523	526	344	234	110	395	196	199	247	168	78
South Africa	21.3	25,203	12,494	12,709	16,986	10,202	6,784	9,624	4,844	4,780	4,869	2,819	2,049	3,962	2,002	1,960	3,238	1,902	1,336
Sudan	2.6	17,887	9,018	8,869	10,467	7,214	3,253	7,272	3,691	3,581	3,260	2,129	1,130	2,979	1,505	1,474	1,999	1,359	640
Swaziland	38.5	500	237	263	305	185	120	271	135	136	142	85	56	77	37	40	58	36	22
Togo	4.1	2,872	1,421	1,451	2,030	1,232	798	1,272	634	638	782	469	313	480	239	241	365	229	136
Uganda	3.6	12,115	6,086	6,029	10,324	5,495	4,830	5,865	2,941	2,924	4,571	2,432	2,140	2,119	1,061	1,058	1,898	1,029	868
United Republic of Tanzania	8.6	18,098	9,079	9,019	15,245	7,893	7,352	8,236	4,126	4,110	6,135	3,077	3,058	3,065	1,540	1,524	2,757	1,472	1,285
Zambia	16.4	5,280	2,674	2,606	4,110	2,331	1,779	2,565	1,285	1,280	1,834	994	840	912	460	452	769	442	327
Zimbabwe	24.6	6,490	3,242	3,249	4,793	2,715	2,078	3,286	1,641	1,645	2,026	1,149	876	1,131	571	560	928	556	372

Main table 1: Estimated working-age population and labour force 15 to 49, 15 to 24 and 25 to 29 years, by sex, 64 countries affected by HIV/AIDS, 2005

Country	Estimated HIV prevalence for all persons 15-49 years (%) 2005	Age group																	
		15 to 49 years						15 to 24 years						25 to 29 years					
		Population ('000s)			Labour force ('000s)			Population ('000s)			Labour force ('000s)			Population ('000s)			Labour force ('000s)		
		Total	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females
Asia (5 countries)																			
Cambodia	2.5	7,187	3,485	3,701	5,836	2,899	2,937	3,404	1,716	1,689	2,270	1,178	1,092	760	372	388	711	357	353
China	0.2	746,268	384,695	361,573	666,018	351,084	314,934	217,349	113,557	103,792	161,460	84,673	76,787	97,360	50,157	47,203	93,184	49,156	44,029
India	0.9	578,927	299,846	279,082	348,199	244,108	104,091	211,254	109,176	102,078	84,458	62,059	22,399	87,787	45,499	42,288	59,982	41,524	18,458
Myanmar*	1.3	27,886	13,873	14,013	21,444	11,716	9,727	9,934	5,005	4,929	5,114	3,134	1,980	4,642	2,315	2,327	4,079	2,254	1,825
Thailand	1.4	35,595	17,505	18,090	27,516	14,934	12,582	10,895	5,483	5,411	5,488	3,312	2,177	5,378	2,694	2,684	4,769	2,572	2,197
Latin America and Caribbean (15 countries)																			
Bahamas	3.0	175	85	90	139	65	74	57	28	29	28	14	14	25	12	13	23	10	13
Barbados	1.5	152	76	76	127	66	61	41	21	20	25	13	11	20	10	10	19	10	9
Belize	2.7	140	70	70	90	60	31	56	29	28	28	19	10	24	12	12	18	12	6
Brazil	0.7	102,444	50,662	51,782	76,868	43,670	33,199	35,342	17,869	17,473	22,062	12,931	9,131	16,256	8,071	8,185	13,286	7,584	5,702
Colombia	1.0	24,453	12,088	12,366	17,832	10,052	7,780	8,349	4,235	4,114	4,530	2,529	2,001	3,805	1,900	1,905	3,154	1,801	1,354
Dominican Republic	1.6	4,852	2,444	2,408	3,507	2,110	1,397	1,836	933	903	1,070	632	438	750	379	371	625	374	251
Guatemala	1.1	5,709	2,697	3,012	3,487	2,253	1,235	2,551	1,253	1,299	1,380	881	499	942	441	501	647	409	238
Guyana	2.6	423	205	217	269	168	101	145	73	72	67	44	22	73	36	37	52	33	20
Haiti	5.6	4,358	2,147	2,211	3,526	1,664	1,863	2,006	1,010	996	1,108	560	548	728	361	367	823	345	478
Honduras	2.1	3,611	1,824	1,786	2,500	1,633	867	1,513	769	744	906	611	295	600	304	296	458	292	166
Jamaica	1.5	1,371	667	704	990	541	449	503	252	251	254	146	108	188	91	97	153	85	68
Panama	1.2	1,718	867	851	1,193	749	445	579	294	284	314	195	118	265	134	131	209	129	80
Paraguay	0.6	3,116	1,575	1,541	2,506	1,355	1,151	1,259	638	621	925	495	430	473	239	234	405	222	183
Suriname	2.0	241	121	120	128	87	41	89	45	44	23	17	5	33	17	17	21	14	7
Trinidad and Tobago	3.3	756	374	381	538	315	223	270	136	134	152	88	64	116	58	58	93	54	39
More developed regions (4 countries)																			
Estonia	1.1	671	331	339	452	246	206	209	107	103	66	43	24	93	47	46	73	42	31
Russian Federation	1.3	78,029	38,492	39,537	56,880	29,373	27,506	24,303	12,306	11,997	9,589	5,452	4,138	10,937	5,448	5,488	9,392	5,023	4,369
Ukraine	1.5	24,004	11,699	12,305	16,831	8,634	8,197	7,331	3,703	3,628	2,789	1,595	1,194	3,334	1,635	1,699	2,699	1,430	1,268
USA*	0.6	149,060	75,014	74,046	116,730	63,131	53,599	42,458	21,721	20,737	25,557	13,444	12,114	19,967	10,136	9,831	17,288	9,525	7,763

* The estimated HIV prevalence rates for Myanmar and USA are for 2003

Main table 1: Summary **Estimated working-age population and labour force 15 to 49, 15 to 24 and 25 to 29 years, by sex, 64 countries affected by HIV/AIDS, 2005**

Country	Estimated HIV prevalence for all persons 15-49 years (weighted) (%) 2005	Age group								
		15 to 49 years						15 to 24 years		
		Population ('000s)			Labour force ('000s)			Population ('000s)		
		Total	Males	Females	Total	Males	Females	Total	Males	Females
Total Sub-Saharan Africa (40 countries)	7.1	337,577	168,952	168,625	253,493	144,567	108,926	150,465	75,723	74,742
Total Asia (5 countries)*	0.6	1,395,863	719,404	676,458	1,069,012	624,741	444,271	452,836	234,937	217,898
Total Latin America and Caribbean (15 countries)	1.0	153,518	75,903	77,615	113,701	64,786	48,915	54,596	27,585	27,011
Total more developed regions (4 countries)*	0.9	251,764	125,537	126,227	190,893	101,385	89,508	74,301	37,837	36,464
Total (64 countries)	1.7	2,138,722	1,089,796	1,048,926	1,627,099	935,479	691,620	732,198	376,083	356,115

Main table 1: Summary **Estimated working-age population and labour force 15 to 49, 15 to 24 and 25 to 29 years, by sex, 64 countries affected by HIV/AIDS, 2005**

Age group									Country
15 to 24 years			25 to 29 years						
Labour force ('000s)			Population ('000s)			Labour force ('000s)			
Total	Males	Females	Total	Males	Females	Total	Males	Females	
97,525	54,944	42,581	55,728	27,979	27,749	45,827	26,552	19,275	Total Sub-Saharan Africa (40 countries)
258,790	154,355	104,435	195,927	101,038	94,890	162,724	95,862	66,862	Total Asia (5 countries)*
32,872	19,176	13,696	24,298	12,065	12,233	19,986	11,374	8,612	Total Latin America and Caribbean (15 countries)
38,002	20,533	17,468	34,331	17,267	17,064	29,451	16,020	13,431	Total more developed regions (4 countries)*
427,188	249,008	178,180	310,284	158,348	151,936	257,989	149,809	108,180	Total (64 countries)

** The estimated HIV prevalence rates for Myanmar and USA are for 2003*

Main table 2: Estimated numbers of young, urban, working-age women living in poverty at risk of HIV/AIDS at any time, 34 countries, latest available year

Country	HIV/AIDS			Poverty headcount (% of population living at specified income in PPP values*)			Urbaniza- tion rate (%)	Numbers of working-age women 15-24 years ('000s)						Numbers of working-age women 25-29 years ('000s)							
	Estimated HIV prevalence for all persons 15-49 years (%) 2005	Numbers of persons living with HIV 2003 estimates		Under \$1 a day	Under \$2 a day	Between \$1 and \$2 per day		In the popula- tion	At great risk (<\$1)	At some risk (>\$1 <\$2)	At risk (<\$2)	At great risk and urban	At some risk and urban	At risk and urban	In the popula- tion	At great risk (<\$1)	At some risk (>\$1 <\$2)	At risk (<\$2)	At great risk and urban	At some risk and urban	At risk and urban
Sub-Saharan Africa (18 countries)																					
Burkina Faso	2.6	270,000	150,000	45	81	36	18	1,346	604	487	1,091	107	87	194	494	221	179	400	39	32	71
Burundi	5.9	220,000	130,000	23	49	26	10	855	194	224	418	19	22	41	281	64	73	137	6	8	14
Cameroon	6.8	520,000	290,000	4	19	15	51	1,745	71	267	338	37	137	174	650	27	99	126	14	51	65
Côte d'Ivoire	7.3	530,000	300,000	2	14	12	45	1,990	38	233	271	17	105	122	691	13	81	94	6	36	42
Ethiopia	4.7	1,400,000	770,000	23	78	55	29	7,818	1,797	4,281	6,078	516	1,228	1,744	2,895	665	1,586	2,251	191	455	646
Ghana	3.0	320,000	180,000	45	79	44	45	2,322	1,041	782	1,823	472	356	828	883	396	297	693	180	135	315
Kenya	6.4	1,100,000	720,000	23	58	36	39	3,916	893	1,391	2,284	352	548	900	1,414	323	502	825	127	198	325
Lesotho	28.5	300,000	170,000	36	56	20	18	235	85	47	132	15	9	24	78	28	15	43	5	3	8
Madagascar	2.0	130,000	76,000	28	52	24	27	1,813	506	432	938	134	115	249	699	195	167	362	52	44	96
Malawi	14.1	810,000	460,000	42	76	44	16	1,279	533	441	974	87	72	159	499	208	172	380	34	28	62
Mozambique	12.1	1,200,000	670,000	38	78	40	36	2,011	761	816	1,577	271	290	561	781	296	316	612	105	113	218
Niger	1.4	64,000	36,000	34	55	21	22	1,307	444	270	714	99	60	158	479	163	99	262	36	22	58
Nigeria	5.4	3,300,000	1,900,000	70	91	21	47	13,400	9,412	2,757	12,169	4,396	1,287	5,683	4,843	3,402	996	4,398	1,589	465	2,054
Rwanda	5.1	230,000	130,000	52	84	32	18	1,091	564	350	913	103	64	167	361	186	116	302	34	21	55
South Africa	21.3	5,100,000	2,900,000	2	13	11	57	4,780	83	519	602	47	295	342	1,960	34	213	247	19	121	140
Uganda	3.6	450,000	270,000	85	97	12	12	2,924	2,483	341	2,824	303	42	345	1,058	898	124	1,022	110	15	125
Zambia	16.4	830,000	470,000	64	87	23	36	1,280	815	304	1,119	291	108	399	452	288	107	395	103	38	141
Zimbabwe	24.6	1,600,000	930,000	56	83	27	35	1,645	923	442	1,365	322	154	476	560	314	150	464	110	52	162
Asia (4 countries)																					
Cambodia	2.5	170,000	51,000	10	34	25	19	1,689	163	419	582	30	78	108	388	38	96	134	7	18	25
China	0.2	830,000	190,000	4	18	15	39	103,792	4,089	15,050	19,139	1,579	5,809	7,388	47,203	1,860	6,844	8,704	718	2,642	3,360
India	0.9	5,000,000	1,900,000	35	81	45	28	102,078	36,034	46,241	82,275	10,198	13,086	23,284	42,288	14,928	19,156	34,084	4,225	5,421	9,646
Thailand	1.4	560,000	200,000	2	32	30	32	5,411	108	1,649	1,757	35	526	561	2,684	54	818	872	17	261	278
Latin America and Caribbean (9 countries)																					
Brazil	0.7	650,000	240,000	8	22	14	83	17,473	1,428	2,492	3,919	1,186	2,071	3,257	8,185	669	1,167	1,836	556	970	1,526
Colombia	1.0	180,000	62,000	2	9	7	77	4,114	91	273	364	70	209	278	1,905	42	126	168	32	97	129
Dominican Republic	1.6	85,000	23,000	2	2	0	59	903	18	0	18	11	0	11	371	7	0	7	4	0	4
Guatemala	1.1	74,000	31,000	5	16	11	46	1,299	60	148	207	28	68	96	501	23	57	80	11	26	37
Guyana	2.6	11,000	6,100	3	11	8	38	72	2	6	8	1	2	3	37	1	3	4	0	1	2
Honduras	2.1	59,000	33,000	21	44	23	46	744	154	173	327	70	79	149	296	61	69	130	28	31	59
Jamaica	1.5	21,000	10,000	2	13	11	52	251	5	28	33	3	15	17	97	2	11	13	1	6	7
Panama	1.2	15,000	6,200	7	18	10	57	284	20	30	50	12	17	29	131	9	14	23	5	8	13
Paraguay	0.6	15,000	3,900	16	33	17	57	621	102	104	206	58	60	118	234	38	39	78	22	22	44
More developed regions (3 countries)																					
Estonia	1.1	7,700	2,600	2	5	3	69	103	2	3	5	1	2	3	46	1	1	2	1	1	1
Russian Federation	1.3	860,000	290,000	2	8	6	73	11,997	240	663	903	176	486	662	5,488	110	304	413	80	222	303
Ukraine	1.5	360,000	120,000	3	31	28	67	3,628	106	1,032	1,138	71	694	765	1,699	50	483	533	33	325	358

* See endnote number 7.

Main table 2: Summary **Estimated numbers of young, urban, working-age women living in poverty at risk of HIV/AIDS at any time, 34 countries, latest available year**

Country	HIV/AIDS			Poverty headcount (% of population)			Urbanization rate (weighted) (%)	Numbers of working-age women 15-24 years ('000s)						Numbers of working-age women 25-29 years ('000s)							
	Estimated HIV prevalence for all persons 15-49 years (weighted) (%) 2005	Numbers of persons living with HIV 2003 estimates						In the population	At great risk (<\$1)	At some risk (>\$1 <\$2)	At risk (<\$2)	At great risk and urban	At some risk and urban	At risk and urban	In the population	At great risk (<\$1)	At some risk (>\$1 <\$2)	At risk (<\$2)	At great risk and urban	At some risk and urban	At risk and urban
		Adults 15-49 years	Women 15-49 years	Under \$1 a day (weighted)	Under \$2 a day (weighted)	Between \$1 and \$2 per day (weighted)															
Total Sub-Saharan Africa (18 countries)	8.0	18,374,000	10,552,000	40	68	28	38	51,757	21,247	14,384	35,628	7,588	4,979	12,566	19,078	7,720	5,292	13,014	2,759	1,838	4,596
Total Asia (4 countries)	0.6	6,560,000	2,341,000	17	45	28	34	212,970	40,395	63,359	103,753	11,841	19,499	31,340	92,563	16,879	26,915	43,794	4,967	8,342	13,309
Total Latin America and Caribbean (9 countries)	0.8	1,110,000	415,200	7	20	13	78	25,761	1,880	3,253	5,133	1,438	2,520	3,958	11,756	853	1,486	2,339	660	1,161	1,821
Total more developed regions (3 countries)	1.3	1,227,700	412,600	2	13	11	72	15,727	348	1,698	2,046	248	1,182	1,430	7,233	160	788	948	114	548	663
Total (34 countries)	1.8	27,271,700	13,720,800	18	44	26	40	306,214	63,869	82,694	146,561	21,115	28,180	49,295	130,631	25,613	34,481	60,095	8,500	11,889	20,389

PHAMIT *Focus*

The Newsletter for the Prevention of HIV/AIDS Among
Migrant Workers in Thailand Project (PHAMIT)



Issue 3: December 2005

The Growing Presence of Migrants Living with HIV/AIDS in Thailand *What will it take before migrants can access treatment?*

The PHAMIT outreach team in Mahachai was approached by the village headman. He took them to a migrant woman from Burma, age

HIV/AIDS, but rather the fact that with increased awareness and access to support services, these migrants standing firm

adherence rates, in turn, potentially breeding drug-resistant strains of HIV.

it will take before migrant workers can access treatment?"

-Brahm Press (Raks Thai Foundation)

PHAMIT

The Prevention of HIV/AIDS Among Migrant Workers in Thailand Project (PHAMIT), funded by the Global Fund to Fight AIDS, TB and Malaria (GFATM), is a collaborative project of eight NGOs working in partnership with the Ministry of Public Health and local health providers. PHAMIT partners are working in over twenty provinces throughout Thailand to prevent the transmission of HIV/AIDS and improve the quality of life among migrant workers, their families and sex workers.

PHAMIT partners use four main strategies to achieve the project's objectives: focused interventions in the language of migrants; development of health systems for migrants; development and support of migrant communities; and advocacy on migrant-related policies.



For more information, please go to our website which is regularly being updated.
www.phamit.org

PHAMIT *Focus*: December, 2005

3

An NGO speaks out on migrants and HIV/AIDS



International Labour Office

This new report from the International Labour Organization highlights the intrinsic links between poverty, HIV/AIDS, movement for work, and globalization. The negative impact of the epidemic on health and the quality of the labour force, which deters foreign direct investment, is underscored and assessed. The report provides estimates of populations at risk of HIV/AIDS because of the impact of poverty in 34 countries in Sub-Saharan Africa, Asia, Latin America and the Caribbean, and in the more developed regions. The links between HIV/AIDS and the movement of persons in search of work, in the course of their work, and in the travel and leisure industries are discussed. Finally, the changes needed to address and manage the HIV/AIDS epidemic at enterprise, national and global levels are outlined.

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