International Labour Office

RISING TO THE CHALLENGE:
The ILO's Response to HIV and AIDS in Africa

COOPERATION RESULTS OVERVIEW 2005-2013

TABLE OF CONTENTS

FOREWORD

The world of work, and the individuals and communities associated with it, represent the single largest group of people living with HIV in the world today. Every day, two-thirds of all the people living with HIV and AIDS go to work. The workplace provides a livelihood and the hope of a decent future and can also be a source of vital, life-saving information on both HIV prevention and treatment, providing support to workers in their struggle with HIV or AIDS. Yet for others, there is a darker side—not only must they live with HIV, but they may face stigma and discrimination from employers and fellow workers. Where discriminatory attitudes are widespread, those already employed may live in constant fear of disclosure of their HIV status or of losing their source of income due to that status. They may face challenges in accessing HIV prevention information or treatment. For others living with HIV, even finding a job may be impossible due to stigma and discrimination.

The ILO mandate is based on the concept that work—decent work—is central to people's well-being. This mandate is especially relevant in addressing the epidemic of HIV and AIDS. In addition to providing income for people living with HIV, work can provide social and economic stability and support that strengthens the ability of individuals, their families, communities and employers to meet the challenges posed by the epidemic. The four key ILO objectives of creating jobs, extending social protection, promoting social dialogue and guaranteeing rights at work provide the foundation for addressing the underlying drivers of the epidemic: social and economic inequalities, stigma and discrimination, violations of fundamental rights at work, and economic and social vulnerabilities.

The ILO Programme on HIV/AIDS and the World of Work (ILO/AIDS) has played a critical role in the global response to the epidemic. Since it was established in 2000, ILO/AIDS has provided guidance to assist workplace actors in responding effectively to the epidemic in and through the workplace. The world of work offers significant opportunities and advantages as a key venue where those most affected by the epidemic can access HIV prevention, treatment, and care and support services. It also provides a platform for reaching those affected across all sectors at all levels, including women and men in the public and private sectors and in the informal economy, their families and dependents and local communities. The ILO response is based on its experience of working with governments, and employers' and workers' organizations and defined by its historic role in standard setting, employment creation, promoting rights at work and gender equality as the basic policy components of a comprehensive response to HIV and AIDS.

Building on more than a decade of experience in the development and implementation of the ILO Code of Practice, the HIV and AIDS Recommendation, 2010 (No. 200), and taking into consideration the UNAIDS Strategy for 2010-2015 and the 2011 UN Political Declaration on HIV and AIDS, the ILO Governing Body adopted in March 2012 a new Strategic Framework (2012-2015) to guide ILO's work over the next biennium.

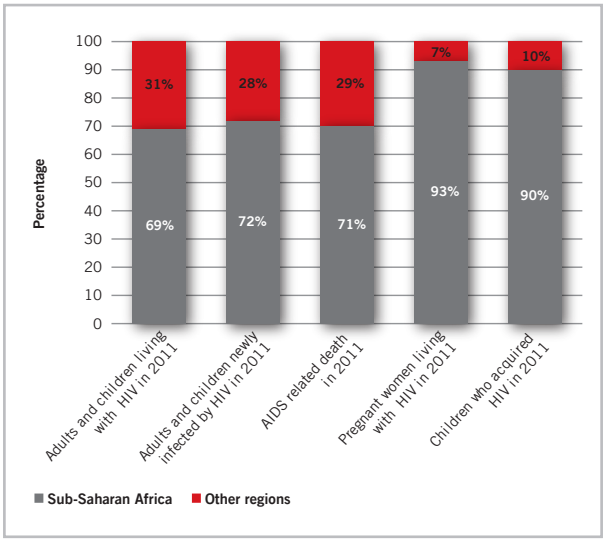
The past year has been one of stocktaking and preparations aimed at facilitating the acceleration of progress towards 2015. What emerges is the fact that much progress has been made, but many challenges remain. AIDS-related illnesses still threaten the lives of many workers and those who depend on them: their families, communities and enterprises. Thus, it is essential to protect the gains achieved while concentrating the limited resources available in those regions with the highest needs to maximize impact, especially in Sub-Saharan Africa. Of critical importance is making workplaces free from HIV-related stigma and discrimination.

Decent work for all, including for people living with or affected by HIV or AIDS, is a cornerstone of the campaign of "Getting to zero new infections, zero discrimination and zero AIDS-related deaths". This report highlights not only the progress the ILO has made so far toward achieving this vision, but also how the ILO plans to get there and to ensure the sustainability of the Three Zeros in the world of work.

I HIV AND AIDS IN AFRICA: THE DEVELOPMENT CHALLENGE

The global response to HIV and AIDS is at a critical juncture, marked by continuing challenges and growing opportunities. Nowhere is this more evident than in the region of Sub-Saharan Africa. Of the global total of 34 million women and men living with HIV today, the vast majority—an estimated 23.5 million or 69 percent—live in Sub-Saharan Africa. In addition, the overwhelming majority—92 percent—of all pregnant women living with HIV and 90 percent of the world's children living with HIV live in this sub-region. Women are particularly affected, representing close to 58 per cent of those living with HIV in the sub-region. The majority—71 per cent—of all AIDS-related deaths worldwide in 2011 were recorded in Sub-Saharan Africa.[1]

Figure 1: The burden of the global epidemic in Sub-Saharan Africa[2]



Nevertheless, significant progress has been made. An accelerated response has significantly reduced the rate of new HIV infections in Africa.[3] Across the African continent, the annual number of new HIV infections fell by 25 percent, from 2.4 million to 1.8 million between 2001 and 2011. Of the 25 low- and middle-income countries worldwide which have seen a reduction of more than 50 percent in the rate of new HIV infections, half are in Sub-Saharan Africa. Increased access to anti-retroviral treatment (ART) has preserved more than 9 million life-years in the region and reduced the number of people dying from AIDS-related causes from a peak of 1.8 million in 2005 to 1.2 million in 2011.[4] There is also increasing awareness that HIV-related discrimination impedes effective responses to the epidemic and that it is therefore essential to take measures to establish and maintain discrimination –free workplaces.

These encouraging developments have been guided by two pioneering international instruments adopted by the ILO's tripartite constituents. The ILO Code of Practice on HIV/AIDS and the world of work (2001) is a set of key principles and guidelines developed by a tripartite group of experts. The Code has helped to shape national legislation and national, regional and enterprise-level policies and programmes on HIV and AIDS in more than 50 countries worldwide—31 of them in Sub-Saharan Africa. Building on the success of the Code of practice, the ILO constituents developed the first international labour standard focused on HIV and AIDS in the world of work. The HIV and AIDS Recommendation, 2010 (No. 200) was adopted by the International Labour Conference in June 2010. As a source of international law, it provides a benchmark for workplace-related HIV and AIDS jurisprudence. To date, the Recommendation has been cited by at least five national labour courts in decisions upholding the labour rights of workers living with HIV.

The world of work response has also seen the mobilization of more than $115 million from donors, including $40.6 million from UNAIDS (between 2002 and 2012). Other key partners include: the African Development Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the German Technical Cooperation Agency (GTZ), the Italian Cooperation, the Ministry of Foreign Affairs of Norway, the OPEC Fund for International Development (OFID), the Swedish International Development Agency (Sida), the United States Department

[1] Global report: UNAIDS report on the global AIDS epidemic 2012

[2] UNAIDS Regional Fact Sheet 2012 : Sub-Saharan Africa

[3] UNAIDS World AIDS Day Report, 2012

[4] Global report: UNAIDS report on the global AIDS epidemic 2012

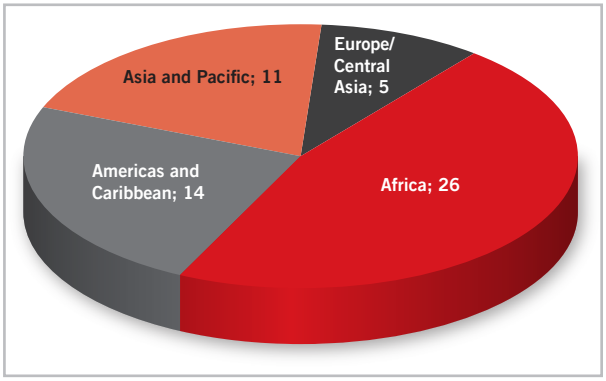
of Labor (USDOL) and the President's Emergency Fund for AIDS Relief (PEPFAR). These donors have provided essential support for effective interventions throughout the region.

Projects and programmes have been implemented in 23 countries in Sub-Saharan Africa, reaching women and men workers, their families and communities and employers, through more than 1,400 partner workplaces. These efforts have increased awareness and knowledge of the importance of behavior change, economic empowerment, voluntary counseling and testing (VCT), and prevention and treatment services that can save lives and livelihoods.

Situating the HIV response in Africa

The HIV epidemic in Africa today is in a state of transformation. As stated previously, significant progress has been made in reducing morbidity and mortality caused by HIV and AIDS, including through the world of work and with the engagement of the private sector. In addition to these encouraging trends, the societal response has also evolved dramatically. A total of 26 countries in Africa now include the world of work in their National AIDS Strategies, providing for the development and delivery of workplace policies and programmes, sector-specific interventions and labour law reforms (See Figure 2 below), almost as many countries as the rest of the world combined.

Figure 2: Countries with a world of work component in National AIDS Strategies (2011)



Yet despite these developments, in providing support for effective HIV responses in the African context, it is necessary to also take into account the impact of the worldwide economic downturn that began in 2007. The global financial crisis has had a significant impact on programmes, individuals and enterprises across Africa.

Africa is now beginning to recover from the initial impact of the global crisis. However, while employment has begun to rebound from the downturn and some economic growth is projected, labour markets have not yet recovered sufficiently to reduce the number of African workers living in poverty or in vulnerable employment. These workers and households continue to face instability and joblessness that excludes them from basic services, including access to prevention and treatment for HIV and AIDS. Moreover, while remarkable gains have been made in expanding access to ART, obtaining antiretroviral drugs remains out of reach for millions of Africans. This is critical both for individuals and economies, as a scaling up of ART has been identified by UNAIDS as demonstrating the "macroeconomic and household livelihood benefits of expanded treatment access, with employment prospects sharply increasing among individuals receiving antiretroviral therapy."[5] The continuing challenge of facilitating access to biomedical treatment also underscores the need to maintain prevention initiatives that are critical to stopping the spread of HIV.

Progress has also come amidst an evolving funding situation. According to the UNAIDS 2012 World AIDS Day Report, an increase in people receiving lifesaving ART "came at a time when international funding for AIDS remained flat."[6] In 2011, US$ 16.8 billion was available. However, the UNAIDS "Investment Framework" estimates that USD $ 22 billion is needed to "increase present rates of coverage to achieve universal access to HIV prevention, treatment, care and support by 2015 and maintain that level of access" by 2015, before declining to US$19.8 billion in 2020. [7]

International assistance represents more than half of HIV investments in 26 of 33 African countries. However, domestic investment in Africa is growing. In 2011, domestic investments from low- and middle-income countries surpassed global giving for HIV for the first time. Botswana, for example, covers more than 75 percent the cost of its national HIV response through domestic public sources. Namibia, Gabon and Mauritius fund more than half of their national HIV responses through domestic sources. Kenya, Togo and Rwanda have doubled their domestic HIV spending in recent years.[8]

[5] Ibid, p. 12

[6] UNAIDS World AIDS Day Report 2012, page 16.

[7] UNAIDS, A New Investment Framework for the Global HIV Response, 2011 at page 7.

[8] Kenya doubled its domestic HIV spending from 2008 to 2010; Togo doubled its domestic HIV spending from 2007 to 2010; and Rwanda doubled its domestic spending from 2006 to 2009.

Table 1

High Impact Countries in Sub-Saharan Africa increasing domestic spending for AIDS[9]				
% Increase in domestic investments for National AIDS response 2006-2011	20-50 %	50-100 %	> 100 %	> 70 % of national AIDS investments are domestic
Sub-Saharan Africa HICs	Cameroon Central African Republic	Botswana Ethiopia Dijbouti Swaziland Tanzania Zambia	Cote d'Ivoire Kenya Lesotho Namibia Nigeria Rwanda South Africa Uganda	Botswana South Africa

Source: UNAIDS, Meeting the Investment Challenge: Tipping the Dependency Balance, 2012, pp. 2-3

To further expand country ownership and support mutual accountability, the African Union launched a roadmap for shared responsibility and global solidarity for AIDS, tuberculosis and malaria in Africa ahead of the XIXth International AIDS Conference held in Washington, DC in July 2012. The roadmap charts a course for more diversified, balanced and sustainable financing for the AIDS response by 2015 and demonstrates Africa's new leadership and voice in the global AIDS architecture.

"The national decline in HIV incidence in populations shows that sustained investments and increased political leadership for the AIDS response are paying dividends. In particular, countries with a concurrent scale up of HIV prevention and treatment programmes are seeing a drop in new HIV infections to record lows… Multiple avenues will need to be pursued if the world is to reach the target of mobilizing US$ 22-24 billion annually for the response. Countries should ensure that HIV spending is focused on effective investments and take steps to further increase their domestic spending for the AIDS response, including developing innovative and sustainable AIDS funding sources."

UNAIDS 2012 World AIDS Day Report[9]

[9] UNAIDS has identified Angola, Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, South Sudan, Swaziland, Tanzania, Uganda, Zambia, Zimbabwe in East and Southern Africa and Burundi, Cameroon, Central African Republic, Chad, Cote d'Ivoire, Democratic Republic of Congo, Ghana, Nigeria in West and Central Africa as "High Impact Countries"

New partnerships are needed within the new funding context to leverage domestic and international investments. With such wide-ranging differences in domestic responses and levels of investment, there can be no "one size fits all" approach. Instead, approaches should be tailored to meet the specific needs and resources of governments and employers' and workers' organizations to ensure maximum effectiveness, efficiency and impact.

HIV and AIDS and TB: significant progress

TB has an enormous impact on HIV-related mortality as well as on output and productivity. TB results in an estimated USD $12 billion in individual and enterprise economic losses each year.[1]However, since 2004, the number of TB-related deaths among people living with HIV has fallen by 28 percent in Sub-Saharan Africa. This result is in part due to the success of programmes in the workplace, a setting that is ideally suited for the prevention and control of TB. Workplace policies and programmes on HIV, AIDS and TB developed through collaboration between management and workers can provide vital prevention information, facilitate access to treatment and reduce impact on productivity, lowering costs while saving lives.

Ethiopia, Kenya, Liberia, Senegal, Sierra Leone have adopted workplace policies aimed at reducing sector-specific HIV and TB vulnerabilities. Economic sectors covered include: agriculture, export processing, transport, maritime, manufacturing, mining, tourism and health.

[1] ILO AIDS TB workplace guidelines

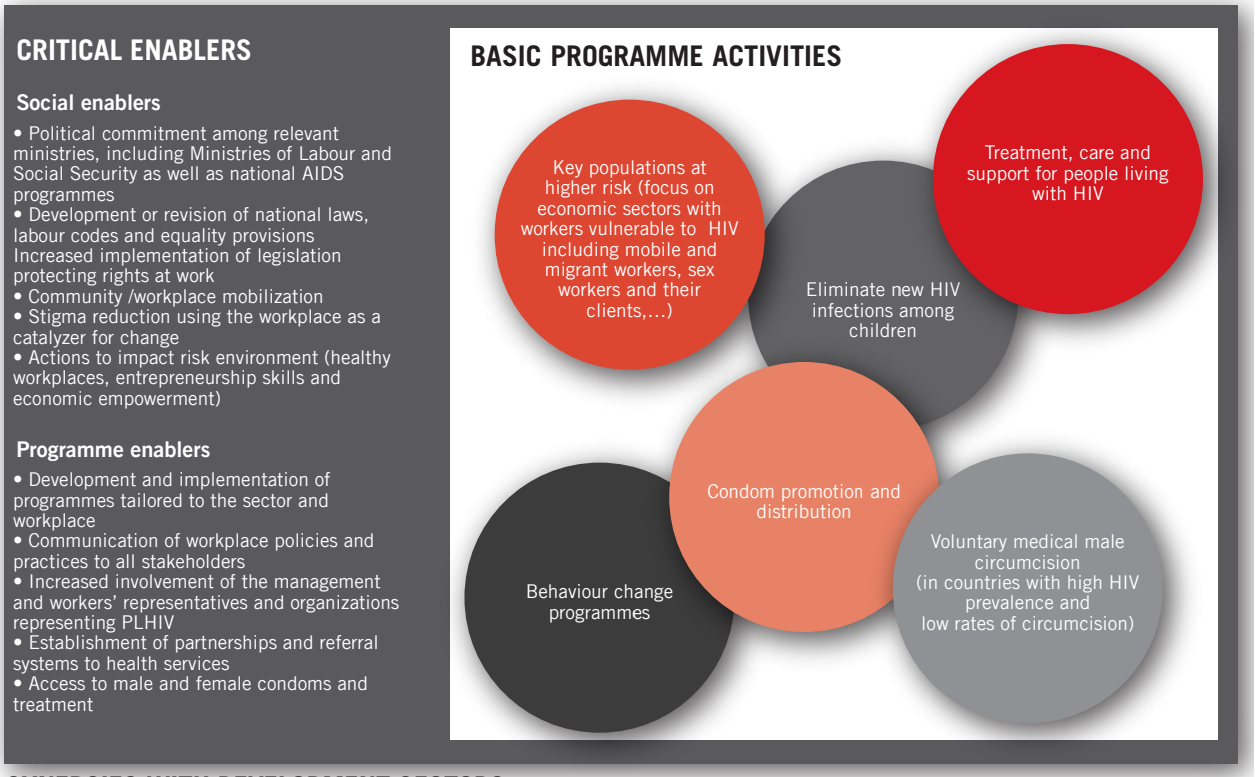
II KEY ILO APPROACHES

Fundamental rights at work are at the heart of the ILO's response to HIV and AIDS, and Recommendation No. 200 establishes key human rights principles to guide efforts to prevent HIV and mitigate its impact in workplaces. In line with the investment framework proposed by UNAIDS, the ILO aims to systematically match needs with investments to achieve optimal HIV responses in and through the world of work that have a significant positive impact on women and men workers, their families, workplaces, and local communities in support of national HIV responses.

To this effect, ILO programme activities aim to focus on populations at higher risk (targeting specific economic sectors in the formal and informal economies where vulnerability to HIV, AIDS and TB is higher due to the characteristics of the sector); reduce risks by inducing behavior change and changing norms and policies; and promote strategies to reduce new

Figure 3: Reach of a worker - centred approach

Figure 4: Investing in an optimal response to HIV in the world of work
ILO adapted from "A New investment framework for the global HIV response", UNAIDS, 2011.



SYNERGIES WITH DEVELOPMENT SECTORS

- A social protection floor to reduce vulnerabilities and facilitate increased access to health services
- A national legal reform to ensure access to employment and ensure zero HIV-related discrimination, including in employment and occupation
- Strategies for poverty reduction, employment creation and reduction of gender equalities
- Public-private partnerships and good employers practices

infections such as PMTC, VCT, male circumcision, increased access to male and female condoms and treatment.

The ILO plays a crucial role in putting in place critical enablers that not only contribute to the success of workplace programmes but that also play a key role in creating policy and legal environments conducive to national HIV responses and that increase demand for services.

The ILO has long standing experience in supporting the socio-economic development of its Member States, strengthening national systems and increasing the capacity of national stakeholders to ensure sustainable impact of programmes. With extensive expertise in relevant areas such as rights at work—including gender equality, labour law reform, social protection, employment creation, poverty reduction and social dialogue, the ILO is an active partner, supporting countries in their efforts to build strategies with the development sector and strengthen systems for a sustainable HIV response. The ILO's unique tripartite structure also facilitates the establishment of long lasting partnerships and the creation of innovative public-private partnerships (PPPs).

Forging Partnerships at the country level

As the lead agency for workplace programmes and private sector mobilization within the UNAIDS family, ILO/AIDS has forged strategic partnerships with a selected number of international organizations, multi-nationals and SMEs. The ILO has reached more than 6,800 enterprises globally, helping them to respond to HIV and AIDS in and through the workplace. Public-private partnerships have been created involving governments and employers' and workers' organizations. The ILO-led Inter-Agency Task Team (IATT) on workplace programmes and private sector mobilization, comprised of 22 institutional partners, is a platform for expanding partnerships to scale up the world of work response to HIV.

Contributing effectively to behavior change, promoting voluntary counseling and testing and other services through workplace interventions

Where people work and what they do at work can increase their risk of contracting HIV. They may be more vulnerable to HIV because of their occupation and related working and living conditions. Poverty may increase the likelihood that people will engage in transactional sex to supplement their income. Spending time away from family also poses risks. In workplaces where leisure facilities are limited and stress levels are high, drinking may also become a risk factor for HIV. Misconceptions held by co-workers and the broader community contribute to stigma and deter people from knowing their HIV status, or up taking voluntary testing or male circumcision.

HIV and AIDS workplace programmes promote behavior change through training peer educators among the workforce and disseminating targeted prevention messages. Management backing and the active involvement of workers' representatives are critically important elements. Workplace programmes may integrate a range of elements, including: a referral

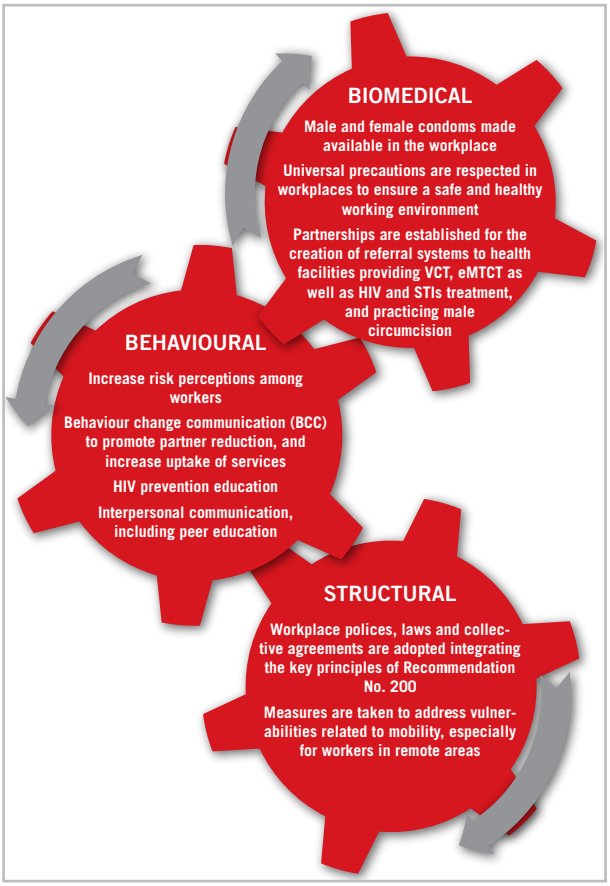
Partnering to eliminate mother-to-child transmission in Sierra Leone

The partnership between the National AIDS Secretariat (NAS), the United Mine Workers' Union and the ILO has resulted in one of the most successful HIV programmes in Africa. Launched six years ago, the programme at Sierra Rutile mining company promotes HIV prevention and access to treatment. It has established a policy environment of zero tolerance with regard to HIV-related discrimination in the workplace. The pioneering programme also reaches deep into the surrounding community - both in nearby urban areas and into some of the most remote parts of Sierra Leone. The programme is characterized by both an unusually high compliance rate amongst those being treated, and a high level of patient confidentiality.

Joint efforts on the part of the ILO, the OPEC Fund for International Development and the Global Fund have enabled the National AIDS Secretariat to provide free male and female condoms, test kits and antiretroviral drugs, as well as training on HIV prevention. Sierra Rutile now provides free clinical services for employees, their families and the local community, which include treatment, information and counseling, as well as testing and treatment for other sexually transmitted infections. In particular, mining sites have become major locations for the prevention of mother-to child transmission (PMTCT). Over 100 trained peer educators became involved in the project, reaching 7,550 people in and around the mining site. The workplace partnership approach proved a sustainable and cost-effective way to make PMTCT services available to many workers.

system to access HIV-related services (STI clinics, VCT and elimination of mother to child transmission (eMTCT) facilities), treatment, care and support. In addition, a policy should be developed and widely disseminated that addresses HIV-related employment discrimination and ensures gender equality, thus helping to create an enabling environment to promote access to HIV-related services.

Figure 5: Combination prevention in action: using the workplace as an entry point



The International HIV and AIDS Workplace Education Programme known as Strategic HIV/AIDS Responses in Enterprises (SHARE), implemented by the ILO and supported by USDOL and PEPFAR, has reached more than 700 enterprises in 24 countries globally, benefiting an estimated 1,130,000 million workers. SHARE is based on two complementary lines of action: working with target enterprises in selected sectors to launch HIV/AIDS workplace Behaviour Change Communication (BCC) programmes, and focusing on policies and mechanisms which reduce discrimination at the workplace and national levels.

Reaching remote safari camps in the Okavango Delta

A tour company in a remote safari camp in Botswana's Okavango Delta was concerned about how best to protect its 300 workers from HIV.

Employees living in the remote camps are often separated from their partners for months at a time, and frequently engage in other sexual relationships. In 2004, the company initiated a partnership with SHARE. A staff member was trained on the human rights' approach to HIV in the workplace and on behaviour change methodology. The partnership led to the development and adoption of a company HIV policy and programme by both management and employees.

The staff member trained now coordinates a group of 14 male and female peer educators and seven lay counselors who live in the four camps managed by the tour company. They provide HIV prevention information and counseling to the staff and ensure that there is a supply of condoms available in guest rooms and staff houses. Almost all staff members know their HIV status. While the national uptake of VCT stood at 51 percent, 98 percent of the camp staff had undertaken the test voluntarily.

Before and after: impact and contribution of workplace programmes

The ILO SHARE programme has gathered data from its projects using its Performance Monitoring Plan. Developed by the ILO and USDOL in partnership with Management Systems International (MSI), the PMP was used by national projects to adopt a set of country-specific indicators to help assess progress and identify the impact of projects on workers at enterprise and national levels. Surveys conducted in Benin, Botswana, Burkina Faso, Cameroon, Ethiopia, Ghana and Togo have demonstrated the positive impact of these programmes.

The results have shown an encouraging increase in availability of HIV services to workers on HIV education, condom availability, STI information services, VCT information services, and care and support information services.

The workplace is key in a male circumcision campaign to reduce HIV transmission

According to UNAIDS, voluntary male circumcision has the potential to prevent[1] an estimated one in five new HIV infections. In countries with high HIV prevalence rates, men are increasingly confronting a sensitive debate on circumcision as a prevention strategy. In Kenya, 54 percent of adult males in Nyanza province have been circumcised, with more than 20 percent of adult males circumcised in Ethiopia and Swaziland. In the latter country, the ILO is teaming up with partners to help employers provide in-depth information to workers about the procedure and its benefits.

Swaziland has the highest HIV prevalence in the world, estimated at 26 percent of all adults out of a total population of 1.2 million. It is also a country where male circumcision is not a traditional practice.

In 2011, the government launched a national programme to raise awareness of the problem and promote circumcision as a voluntary medical procedure for HIV prevention. Two years later, 10,000 men have been circumcised and officials estimate that 90 percent of Swazi men are now aware of the issue.

The ILO supports the campaign through the SHARE programme, which is operating in all four regions of Swaziland in partnership with 26 enterprises and 26 government ministries. The sessions organized in partner workplaces (including in a group of enterprises employing security guards) allow space for discussion regarding concerns and misunderstandings the workers may have in relation to male circumcision. The ILO promotes male circumcision as part of a combination prevention package that includes counseling and testing; treatment for STIs, safer sex practices and the correct, consistent use of male and female condoms.

[1] UNAIDS, 2012 report, p. 35

Figure 6: Workers' use of HIV-related workplace services

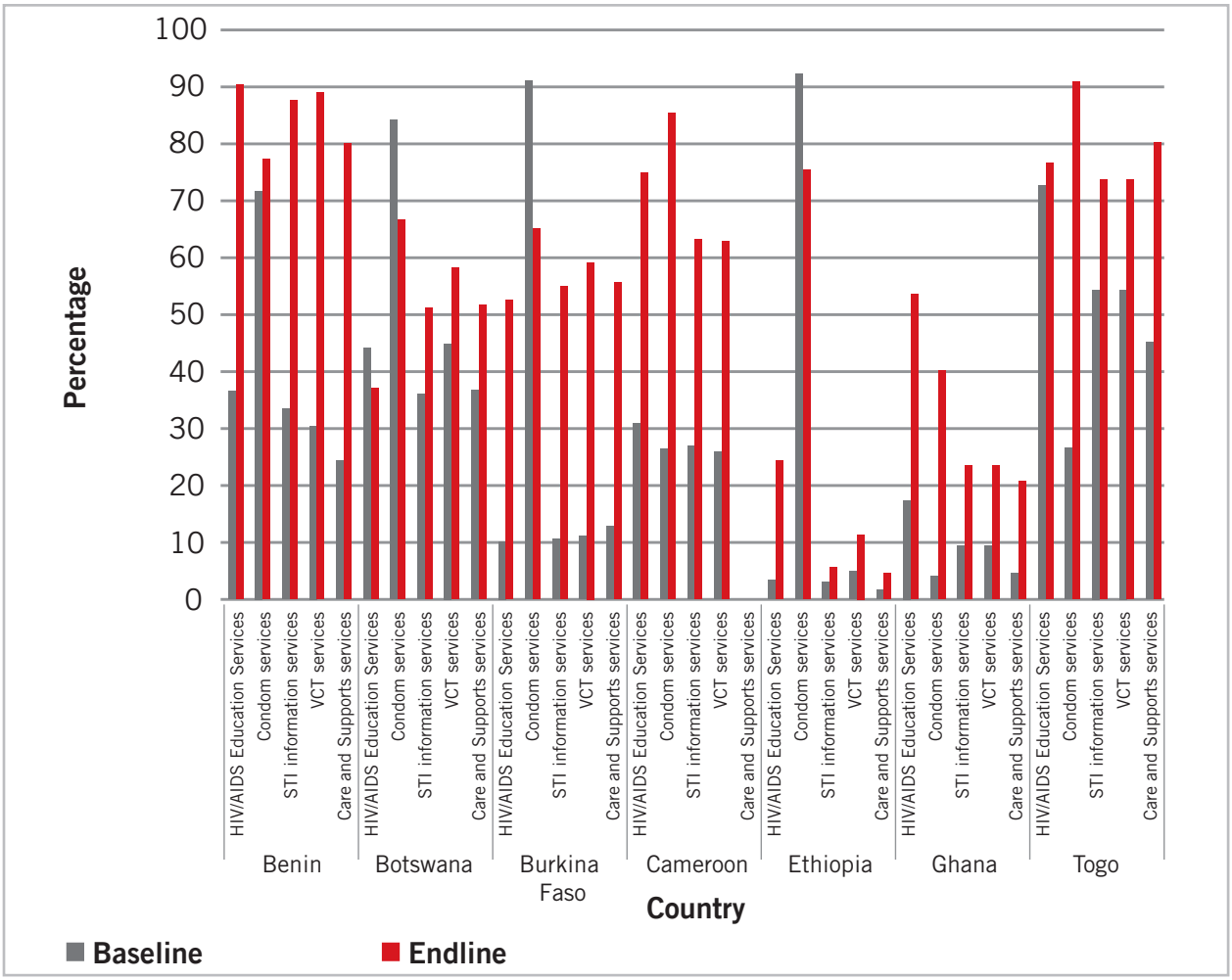


Figure 7: Percentage of targeted workers with a supportive attitude towards HIV+ co-workers

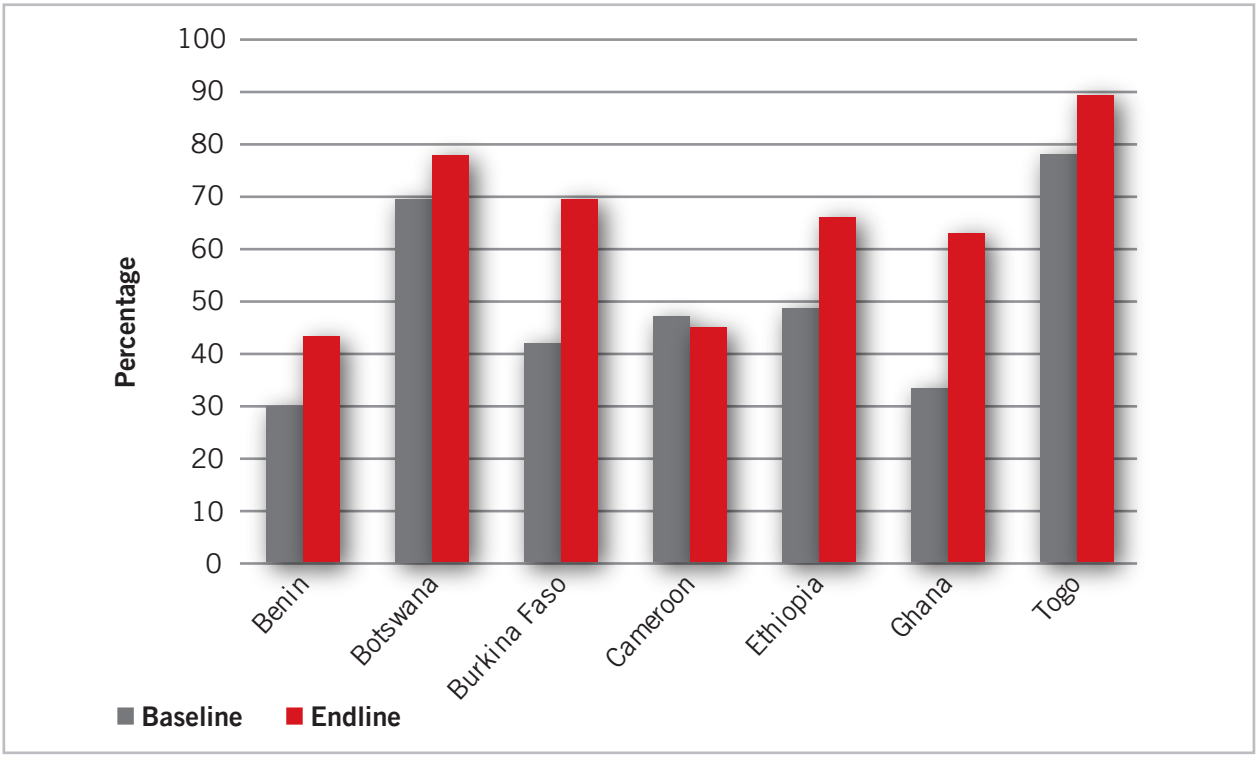
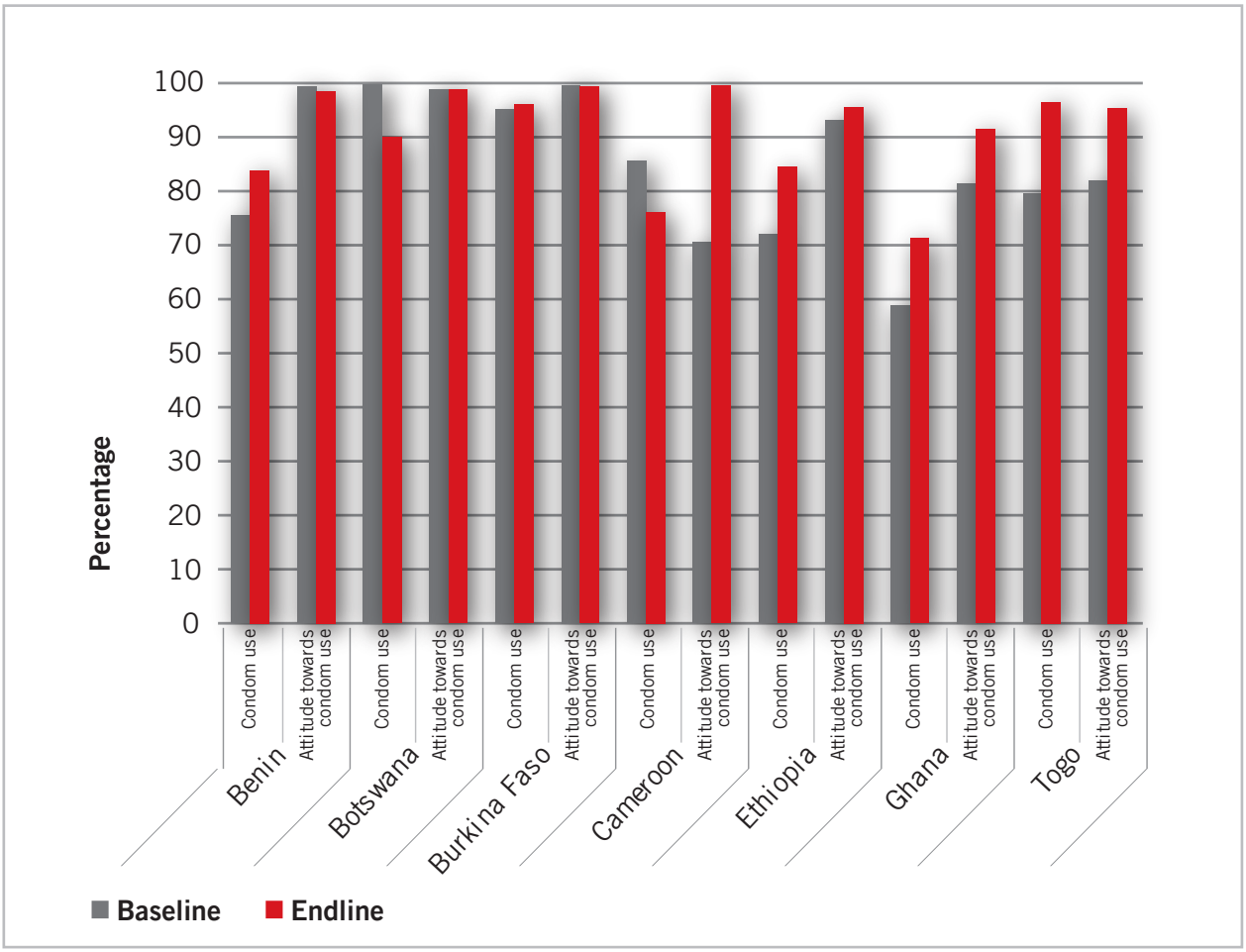


Figure 8: Workers attitudes and behaviors (condoms)



The surveys also demonstrated a change in attitudes by an increased percentage of workers who reported being more accepting and positive toward co-workers and people outside the workplace who were infected with HIV.

The percentage of respondents who reported using a condom the last two times they had sex with a non-regular partner rose on average by 4.5 % . This indicates an increase in safer sex practices. The most significant changes were seen in Togo (79.7% at baseline to 96.7% at end line), Ghana (58.9% to 71.4%) and Ethiopia (72.2% to 84.6%).

Building a discrimination-free working environment for people living with or affected by HIV

Discrimination and stigma based on real or perceived HIV status remains a major obstacle to decent work, particularly equality of opportunity and treatment, employment security, and access to education and training. The recently published PLHIV Stigma Index developed by the Global Network of People Living with HIV (GNP+) reveals the magnitude of the problem of HIV-related stigma and discrimination.

"ILO's efforts on Getting to Zero at Work are critical for an effective response to HIV. The workplace must protect the human rights of workers and ensure a safe and supportive environment for people living with and affected by HIV. "

Michel Sidibé, Executive Director, Joint United Nations Programme on HIV/AIDS (UNAIDS)

The Stigma Index survey interviewed people living with HIV across a sample of nine countries. The survey found that from 40 per cent of respondents in Kenya and Zambia up to 45 per cent in Nigeria reported having lost their jobs or income during the preceding 12 months as a result of their HIV status. The survey also found that 27 per cent of respondents in Nigeria were refused the opportunity to work while 28 per cent in Kenya had had the nature of their work changed or had been refused promotion due to their HIV status. More than half of those living with HIV in Zambia (52%) Rwanda (53%) and Kenya (56%) reported having been verbally abused as a result of their HIV status, while in Nigeria and Ethiopia, one in five people living with HIV (20%) reported feeling suicidal as a result of discrimina-

The key human rights principles of Recommendation No.200 have been **integrated into more than 42 national laws** and workplace policies developed worldwide. Moreover, since its adoption in June 2010, the Recommendation has been **referenced by at least five national labour courts** in decisions upholding the rights of HIV-positive workers.

Recommendation No. 200 in action: justice at work

In Africa, 170 labour judges and magistrates have been trained on HIV and AIDS-related issues, focussing on employment discrimination. This training has led to the development and adoption of national jurisprudence and legislative and policy frameworks that are aligned with Recommendation No 200 and prohibit stigma and discrimination at work. Over 300 factory and labour inspectors have also been trained to integrate HIV and AIDS into their regulatory functions and advisory services.

Rachel Zibelu Banda is a Malawian judge specializing in labour and employment law and is chairperson of the country's Industrial Relations Court. "HIV and AIDS crops up many times in the cases I hear, but indirectly," she explains. "Most involve unfair dismissal on grounds of ill health or absenteeism due to ill health."

To learn more about this issue, Judge Banda signed up for one of the ILO's legal training sessions. There she said she heard case studies from other legal jurisdictions on how courts were using both international and national legal norms in their decisions, holding that HIV status is not a valid ground for dismissal. In one well-publicized ruling, Judge Banda applied a case law learned at the workshop in a case involving an employee who had been dismissed solely on the basis of having tested positive for HIV.

"Since the training I write my judgements involving HIV/AIDS with confidence, knowing I am doing the right thing, that it is acceptable and within international norms, practice and standards," she says. "I am also a great advocate to my fellow judges on total elimination of HIV-related discrimination, not only in the workplace but everywhere in our society."[1]

[1] Ruling against HIV Discrimination in Malawi, ILOAIDS, 4 June 2010

tion and stigma related to their status. In Cameroon, 13% of people living with HIV reported having been denied access to health services, including dental care. The Stigma Index also indicates that HIV-related stigma and discrimination is more frequently experienced by women living with HIV as compared to their male counterparts.

The global goal of achieving zero HIV infections and zero HIV-related deaths cannot be attained unless the pervasive problem of HIV-related employment discrimination is addressed. The ILO works to prevent and eliminate HIV-related discrimination and stigma by promoting the development of national tripartite workplace policies and legal frameworks on HIV and AIDS and the world of work that are tailored to country-specific needs and integrate the key human rights principles of the ILO HIV and AIDS Recommendation, 2010 (No. 200). The ILO also prevents HIV-related discrimination by tackling inequalities and strengthening HIV prevention and social protection programmes and economic opportunities for at-risk workers in both the formal and informal economies.

Addressing the needs of key populations: Scaling up effective responses through economic empowerment

Too many people are still unable to adopt safe behaviours, largely because of income inequalities and lack of opportunities. When governments, employers' and workers' organizations and support organizations (such as cooperative apex organizations and small business associations) work together, they can make a difference by contributing to economic empowerment, disseminating information and building skills. This helps people enhance their economic resilience, especially in areas where HIV prevalence is very high (ports, transport hubs and corridors etc.). The underlying assumption is that awareness and knowledge are not enough to stem the spread of HIV.

The ILO also promotes economic empowerment with enterprise development tools on gender mainstreaming, cooperative management, "Start and Improve Your Business", and women enterprise development. Microfinance can provide loans to associations of business women, cooperatives, the informal economy operators and PLHIV to start and sustain their economic activities.

A preliminary analysis of the findings in Malawi, Tanzania and Zimbabwe shows an increase in net income among the beneficiaries of the programme, and a decrease of concurrent sexual partners among the same beneficiaries (see figures 9 and 10).

Empowering women and men to reduce their HIV vulnerabilities: the case of the Zimbabwe transport corridors

Since 2011, economic empowerment programmes are being implemented in Malawi, Mozambique, South Africa, Tanzania, Zambia and Zimbabwe with the support of the Swedish International Development Agency (Sida). The experience in Zimbabwe offers a vivid example. The ILO programme along the transport corridors in Chirundu, Kotwa, Nyamapanda, Beitbridge and Ngundu provides health- and business-related services to vulnerable populations to help them start or improve their business, form cooperatives and access funds to improve their resilience to HIV and AIDS.

The ILO has engaged with a wide range of different stakeholders—cooperatives, associations of women and small and medium enterprises, cross border officials, trade groups and transport sector workers—to match interventions to their needs. Extensive training covers entrepreneurship, including mentorship and cooperative formation and business planning. In order to minimize possible lending risks, groups are being organized in saving and credit cooperatives

To date, ten savings and credit cooperatives societies have been formed along the corridors and in urban areas, involving more than 500 families and 1,000 beneficiaries including people living with HIV (PLHIV). Hundreds of community members have been able to access HIV counseling and testing through the project, while women without a decent source of income or who engage in transactional sex can borrow resources and start up cross-border trade businesses, food outlets or hair salons that increase their income and improve their livelihoods.

Women and economic empowerment

Economic empowerment increases the bargaining power of women to negotiate safer sex, and may help them afford and have access to HIV testing and counseling services and antiretroviral treatment. Women's inclusion, especially at decision-making levels, in work-related groups and organizations

Figure 9: Increase in net income by the programme's beneficiaries (Malawi, Tanzania, Zimbabwe 2012)

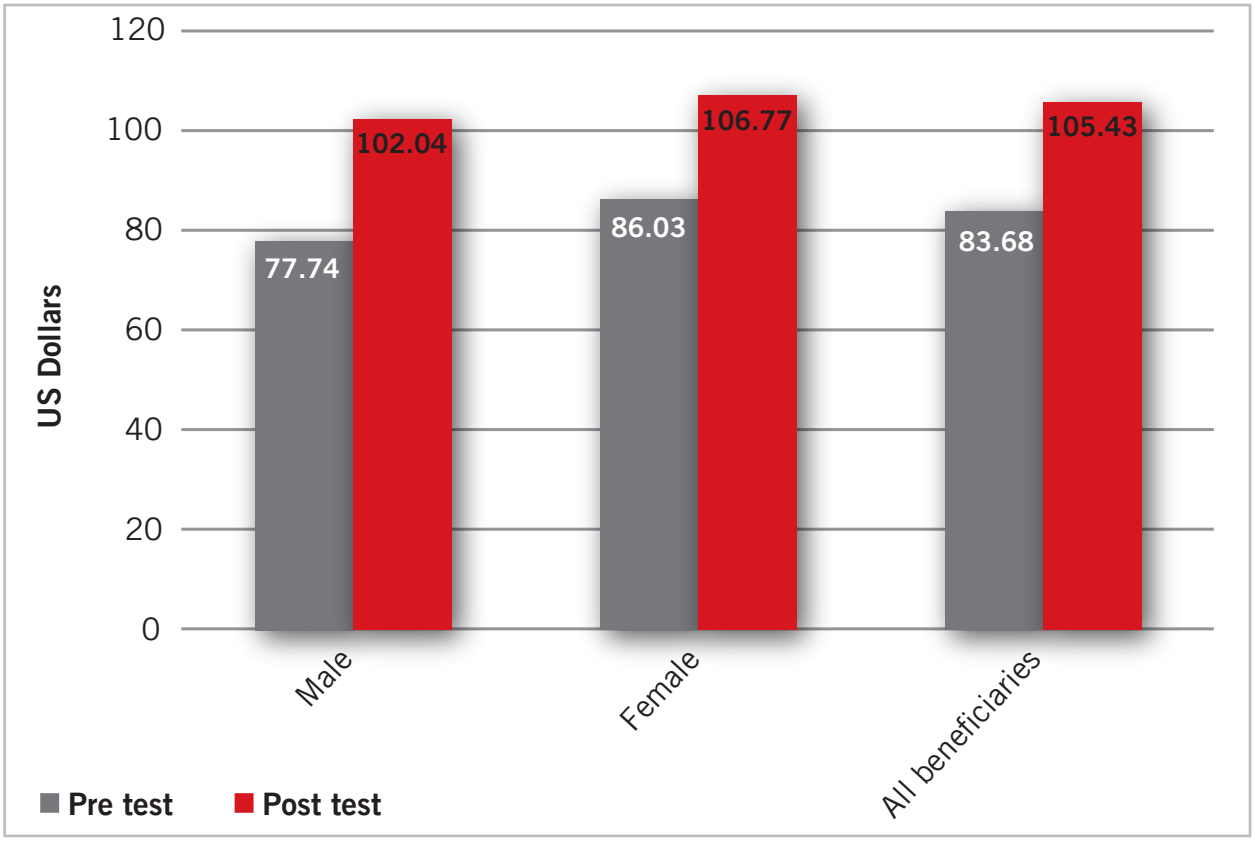
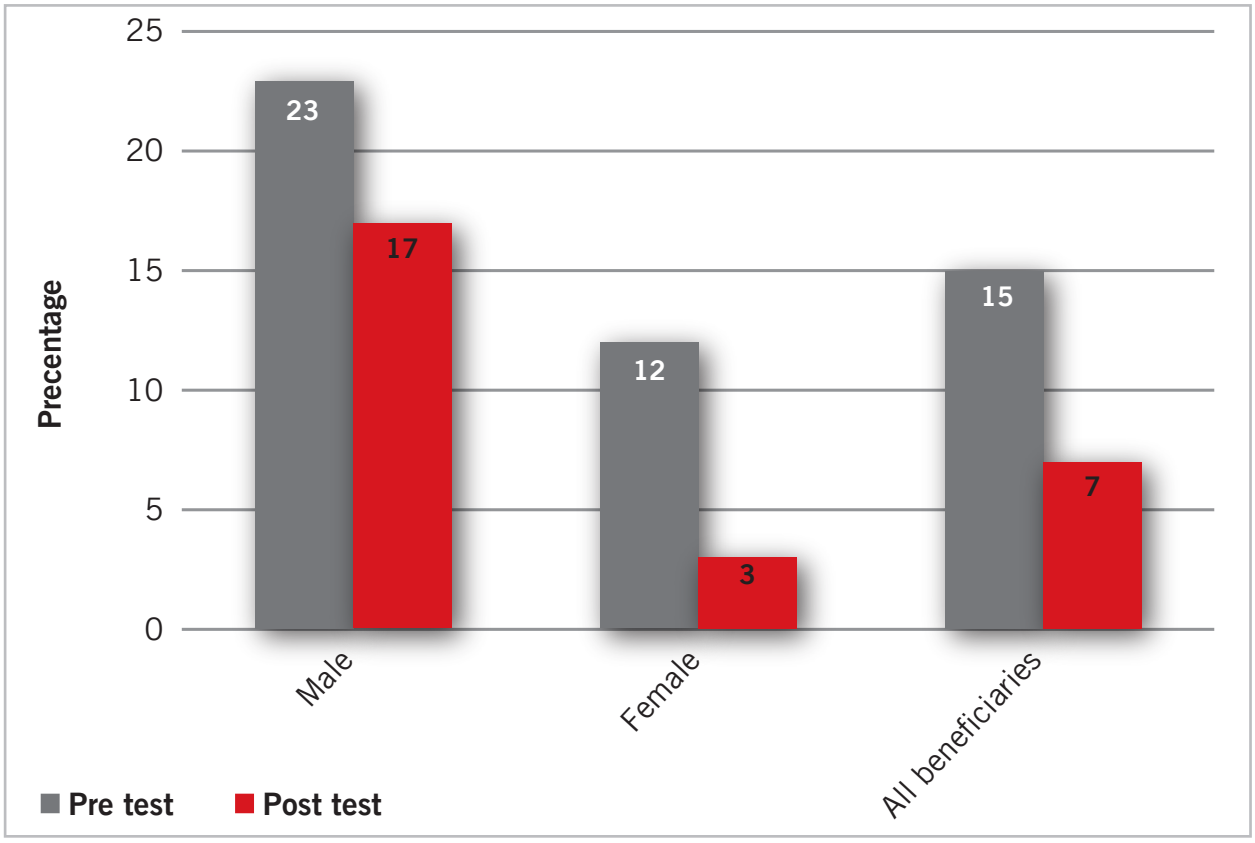


Figure 10: Reduction in beneficiaries reporting concurrent partners (Malawi, Tanzania, Zimbabwe 2012)



such as trade unions can contribute to their greater access to and control over productive resources. It allows women to better access their rights, including sexual and reproductive rights, and lower their vulnerability to HIV.

"Women's empowerment is one of the only HIV vaccines available today. Women are lagging far behind men in access to land, credit and decent jobs. We must abolish the multiple barriers preventing them from seizing economic opportunities and empower them to reduce their vulnerability to HIV. Gender equality is key to getting to zero."

Michelle Bachelet, Executive Director, UN Women

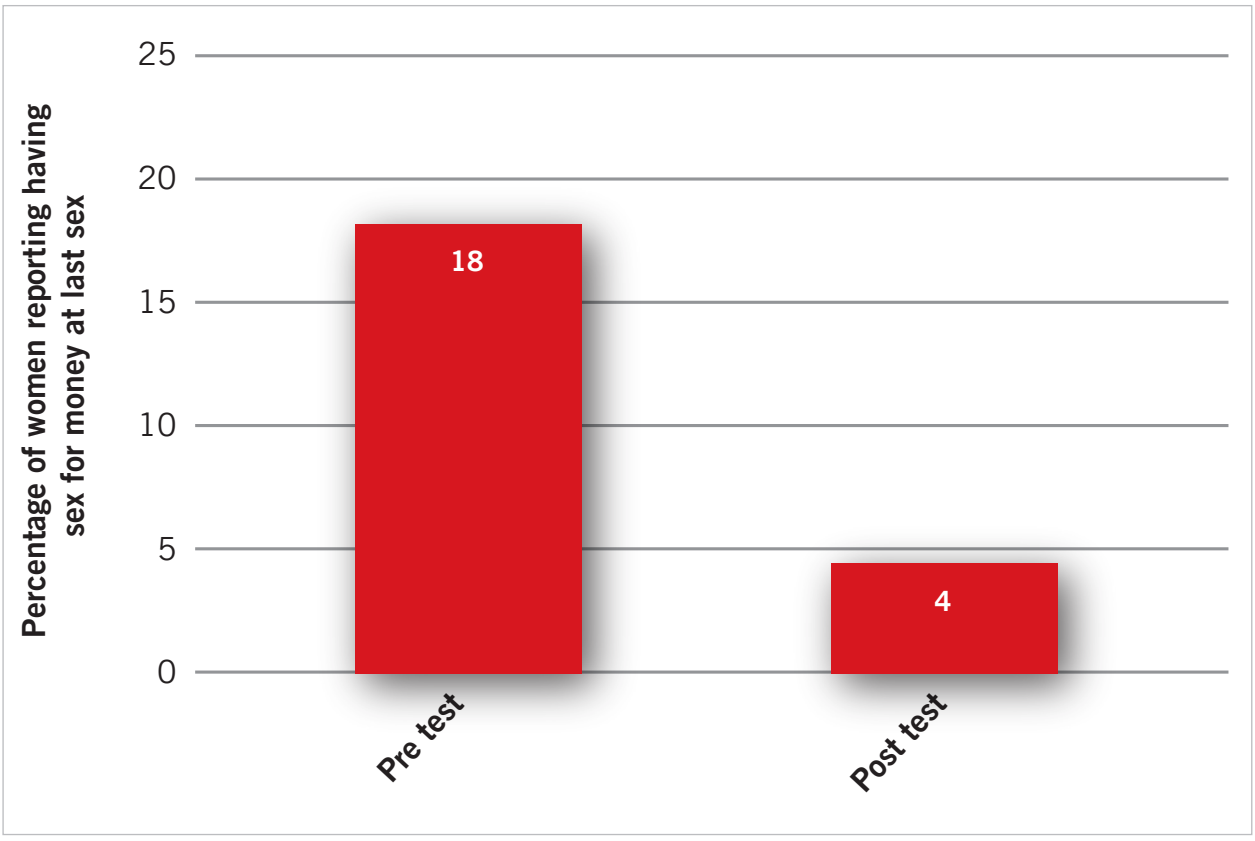
Promoting social protection floors

As little as 20 percent of the world's people have comprehensive social security coverage, and half have no coverage at all. Only about 10 percent of African workers, mostly in formal employment, have some form of social security, primarily in the form of old-age pensions. Establishing a social protection floor is a key element for country programmes in Africa. It is an essential tool to help vulnerable individuals, children and families affected by HIV and AIDS maintain a basic quality of life, keep children in school and maintain their rights and social status.

Empowering women entrepreneurs in Cameroon

In order to empower rural women vulnerable to, or living with, HIV the ILO has utilized existing micro-finance schemes in Kumbo, Wum, Bamenda and Mutenguene provinces of Cameroon. As a first step, women learned business skills, and received counseling, support and awareness-raising to reduce HIV-related stigma and discrimination. The programme provided start-up loans to 178 women for businesses in commerce, tailoring, designing, rearing (piggery, poultry), secretarial duties and communication services. Within one year, 97.7 percent of the women trained successfully operating their businesses, more than 86 percent repaid their loans and 65 percent had opened a savings account for the first time.

Figure 11: Changes in women's behavior around transactional sex, after economic empowerment interventions



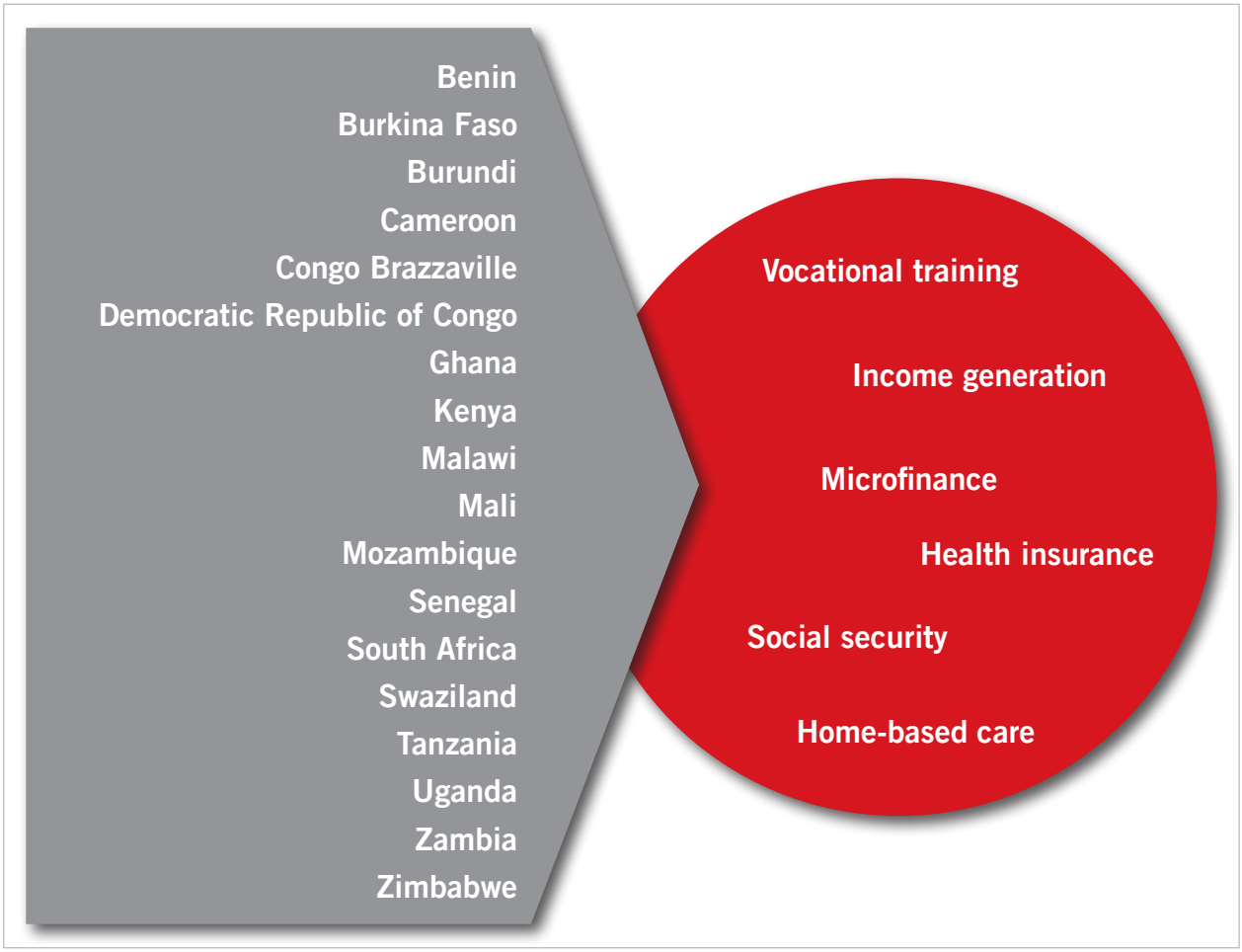
Data from Malawi, Tanzania, Zimbabwe (2012 data collection).

Analytical work is underway on good practices and social security extension schemes. Existing studies conducted in Asia underscore the importance of HIV-sensitive social protection for income generation and improvement in health services. Advocacy for the establishment of HIV-sensitive social protection floors will take place through dialogue involving stakeholders, including insurance providers.

An ILO survey indicated that HIV-related social protection efforts were undertaken in some 18 countries in 2010-2011, involving a variety of activities. The adoption of a new ILO Recommendation on social security,[11] combined with Recommendation 200, is expected to bolster ILO efforts to increase access of workers and their families to HIV-sensitive social protection.

[11] The Social Protection Floors Recommendation, 2012 (No. 202).

Figure 12: Types of social protection activities



III FUNDING OVERVIEW

The ILO has mobilized a total of 42.5 million US dollars to implement programmes in Africa since 2005. An overview of the funding by country, donor, and areas of focus is provided in the graphs below.

Figure 13: Budget per country (2005-2013)

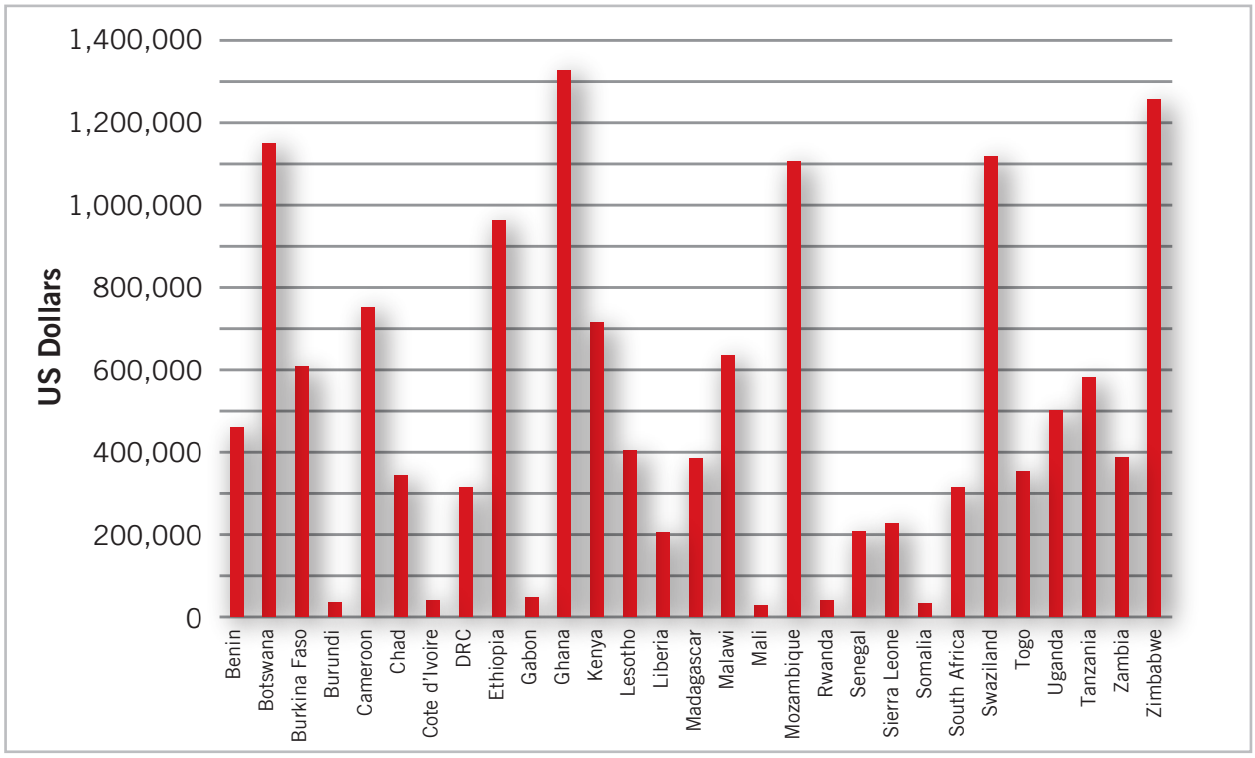


Figure 14: Programmes at the regional and sub-regional levels (2005-2013)

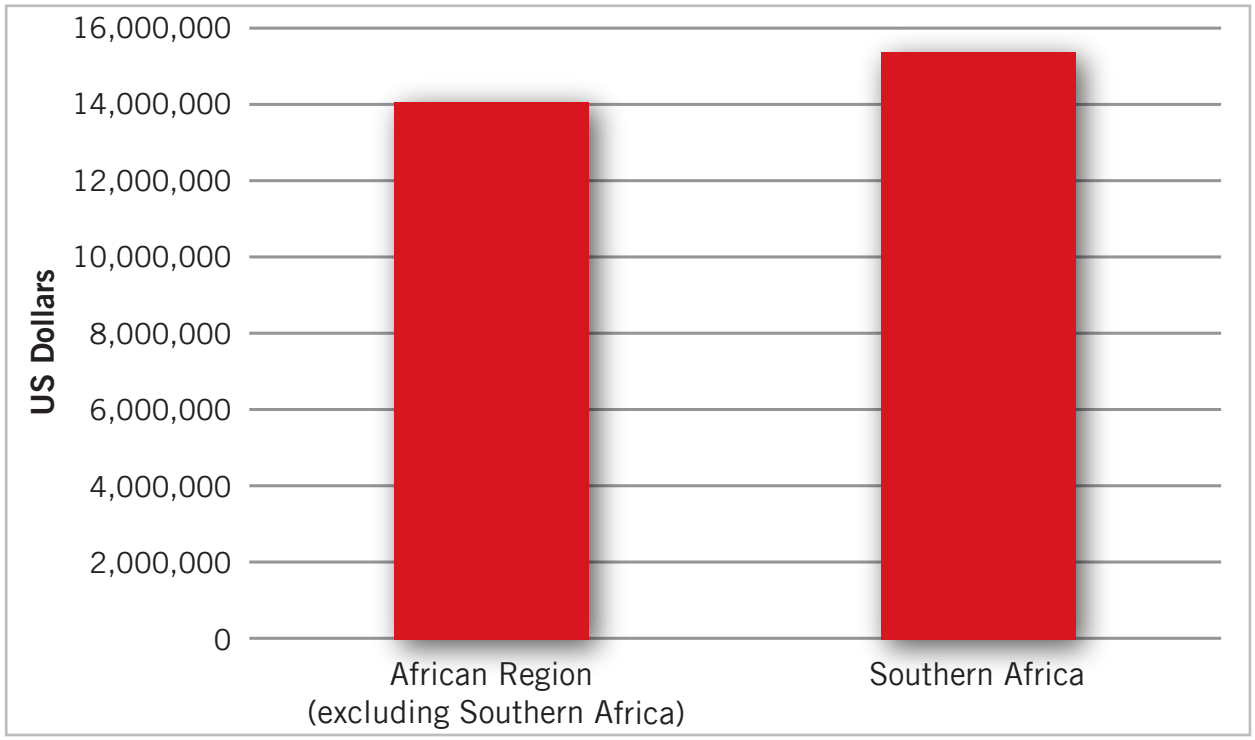


Figure 15: Breakdown of funding by focus areas (2013)

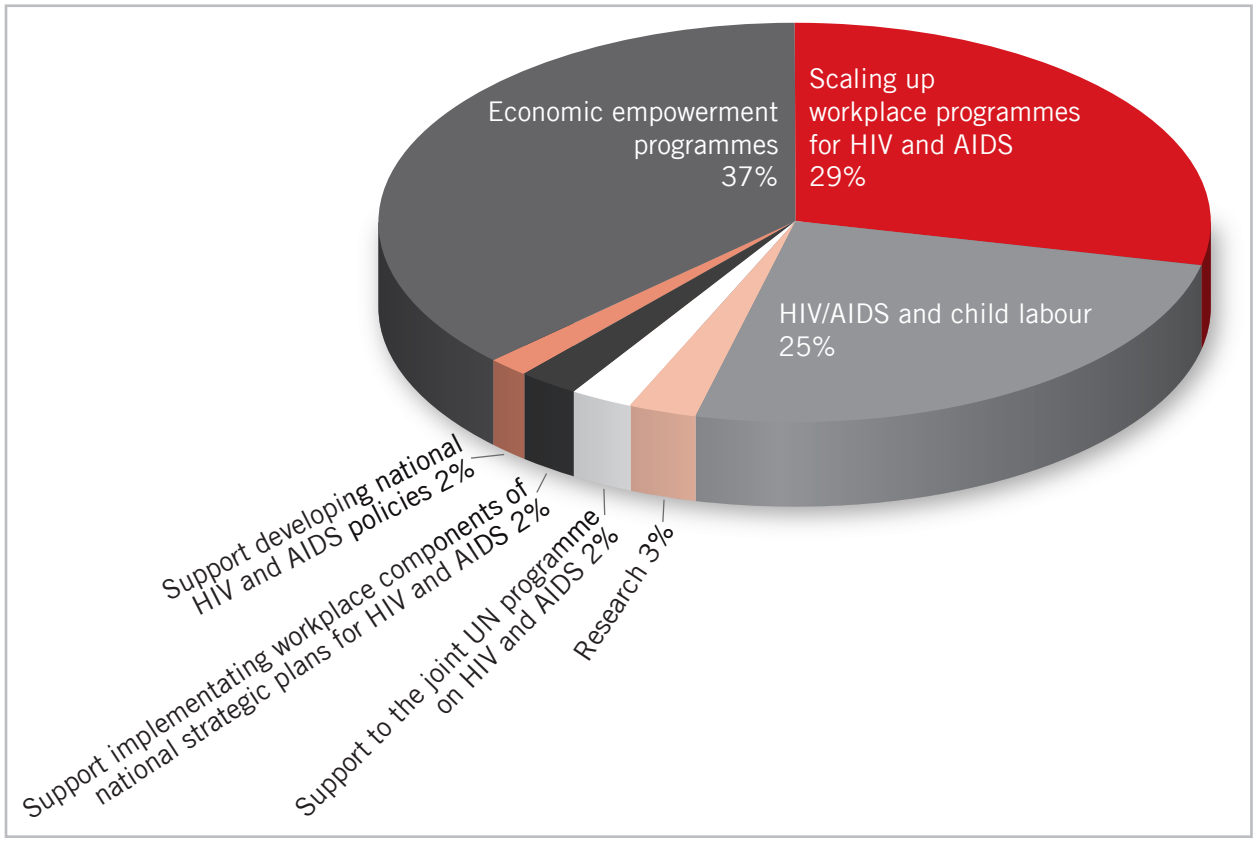
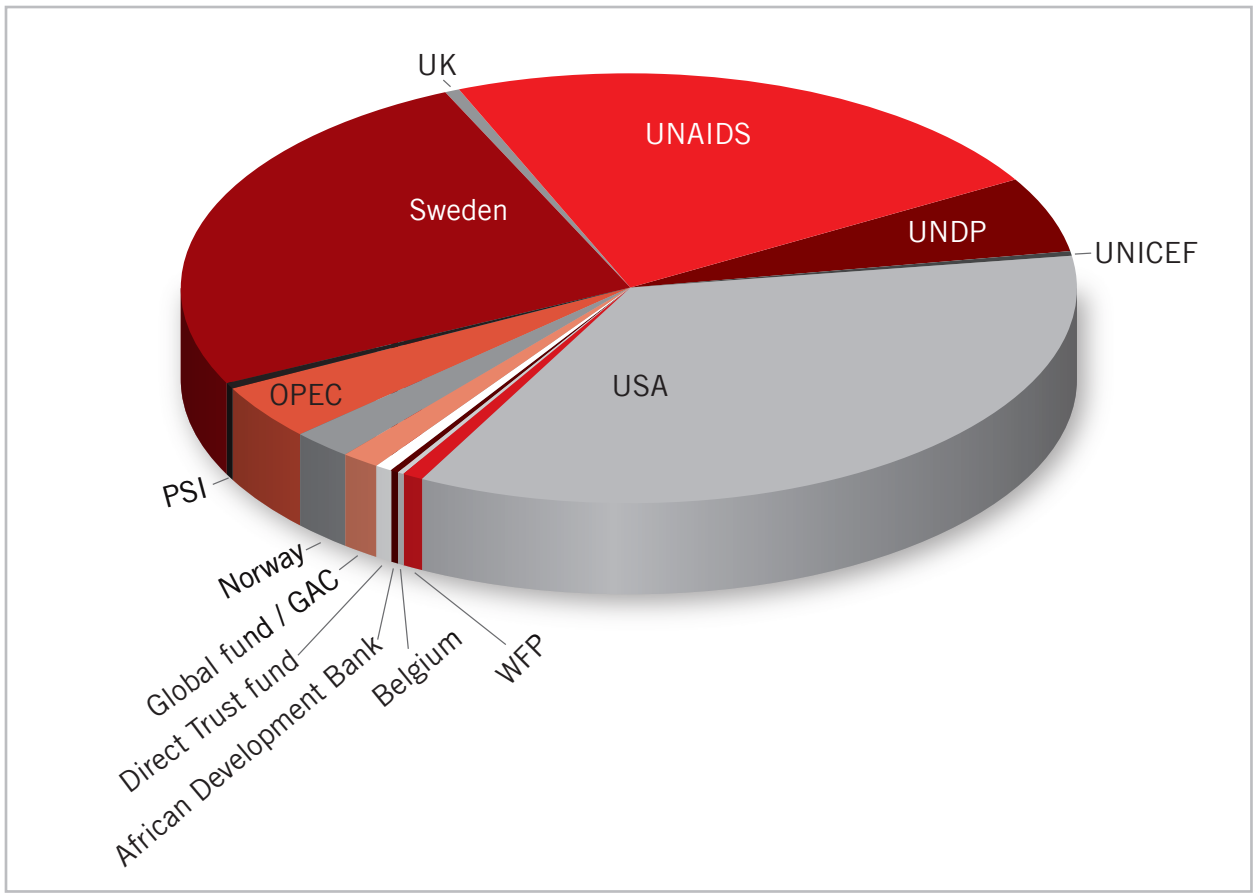


Figure 16: Sources of funding (2005-2013)



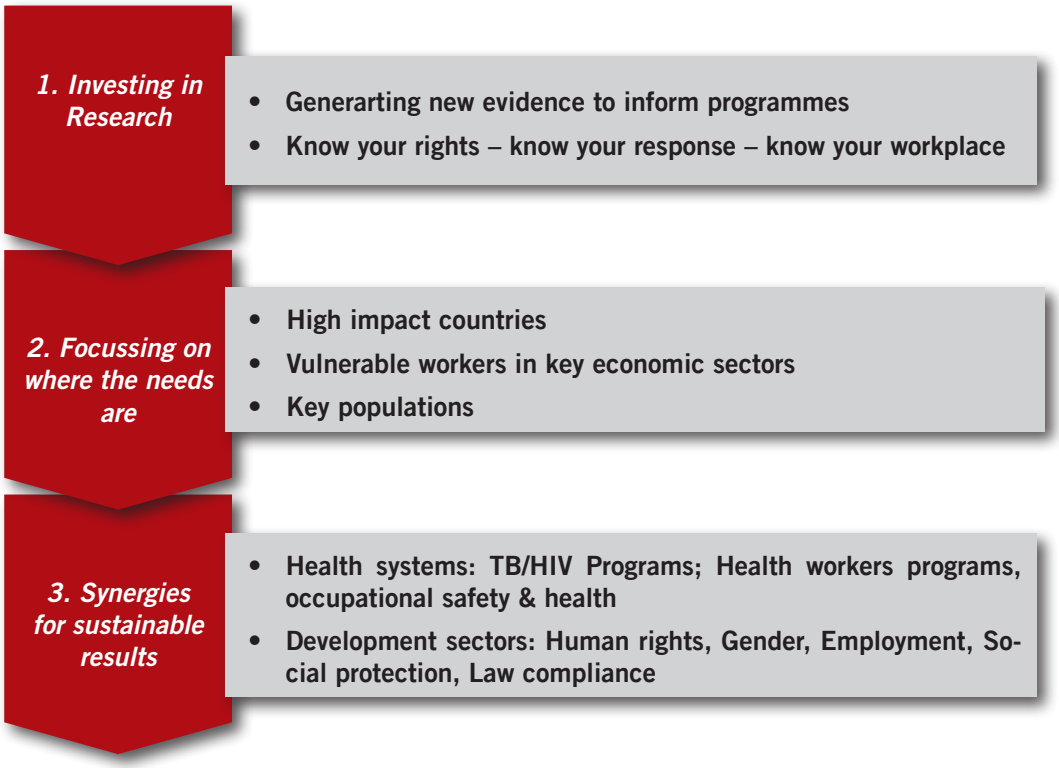
IV MOVING TOWARDS 2015

By 2015, the ILO intends to show evidence of a significant reduction in new HIV infections and an increased level of resilience to HIV and AIDS among vulnerable men and women workers and their families in a critical mass of HICs. This will be achieved through enhancing HIV prevention, reducing HIV-related stigma and discrimination, and increasing access to social protection services while systematically promoting and mainstreaming gender equality. The new strategy builds on lessons learned from the changing global context and 10 years of policy development and programme implementation. It will broaden actions to address HIV through national safety and health systems, labour inspection, working conditions and social security. The strategy will place an increased focus on women and girls, young people and workers in the informal economy. It will target the transport, mining, commerce and tourism sectors, SMEs and cooperatives.

The ILO's focus is on generating evidence to close the existing knowledge gap and provide its constituents with a range of proven interventions to scale up programmes that reduce new HIV infections and increase workers' access to HIV services. In particular, the following research initiatives are underway:

- A global literature review on the role of employment in treatment adherence for women and men workers living with HIV to assess the relationship between the employment status of a person living with HIV and his/her adherence to treatment;
- A global literature review to highlight the contribution of the workplace in reaching key populations through HIV and/or TB services;

Figure 18: Framework for action 2013-15



- A study to review the new funding structure and processes of the Global Fund on AIDS, Tuberculosis and Malaria (GFATM) in order to enhance the workplace actors' ability to mobilize resources;
- A multi-country assessment study to identify what works with regards to achieving good outcomes in HIV workplace interventions;
- Research on "The access to and effect of social protection programmes on women and men workers living with HIV and their households".

At the country level, ILO/AIDS will build its action around four pillars: i) focus on HICs as a priority and other selected countries with a strong, demonstrated political commitment to responding to HIV; ii) support to the implementation of gender-responsive HIV and AIDS programmes in sectors where women and men workers are at elevated risk of infection (transport, mining, tourism, construction, trade, etc.); iii) strengthening of the capacity of ILO constituents to ensure the integration of workplace policies into national frameworks, sustainability and national ownership; iv) and continuing to work with other UNAIDS co-sponsoring agencies at the country level within the UN Country Teams.

This new approach will emphasize country-level responses tailored to specific needs. ILO/AIDS will also broaden the scope of its overarching communications campaign entitled "Getting to Zero in the World of Work" to create a global alliance around the HIV response in and through the world of work. ILO will also use the opportunity of its role as chair of the UNAIDS Committee of Co-sponsoring Organizations (CCO) in 2015 to consolidate the integration of the world of work dimension into the HIV post-2015 agenda and intensify its resource mobilization efforts in view of accelerating the world of work response to the epidemic.

NOTES

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