



FIFTH ITEM ON THE AGENDA

The labour market and employment implications of the HIV/AIDS epidemic**Contents**

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Introduction: The scale and pattern of the HIV/AIDS epidemic

1. The global HIV/AIDS epidemic shows no signs of abating. If anything, the epidemic is spreading faster than was predicted: the number of people living with HIV/AIDS today is 50 per cent higher than was projected in 1991. According to the latest UNAIDS estimate,¹ 5.3 million people were newly infected with HIV during 2000, of whom 2.2 million were adult women and 600,000 were children under the age of 15. The number of people living with HIV/AIDS by the end of 2000 was estimated at 36.1 million. During the year, 3 million people died of AIDS, bringing the total number of deaths since the epidemic began to 21.8 million, of whom 9 million were adult women and 4.3 million children.
2. Table 1 shows the regional pattern of the epidemic at the end of 2000. Sub-Saharan Africa dominates, in terms of the number of people living with HIV/AIDS, new infections and prevalence rate, but the virus is now spreading faster in other areas of the world. New HIV infections as a percentage of existing cases are highest in Eastern Europe and Central Asia (36 per cent), East Asia and the Pacific, and North Africa (both 20 per cent), compared with the global average of 15 per cent. Also to be noted is the wide variation between regions in the proportion of HIV-positive adults who are women, and in the main modes of transmission. Both of these make a difference to the nature of the epidemic's impact on the labour market.

Table 1. Regional HIV/AIDS statistics and features (end of 2000)

Region	Epidemic started	Adults and children living with HIV/AIDS	Adults and children newly infected with HIV	Adult prevalence rate* (%)	% of HIV-positive adults who are women	Main mode(s) of transmission# for adults living with HIV/AIDS
Sub-Saharan Africa	Late '70s - early '80s	25.3 million	3.8 million	8.8	55	Hetero
North Africa & Middle East	Late '80s	400 000	80 000	0.2	40	Hetero, IDU
South & South-East Asia	Late '80s	5.8 million	780,000	0.56	35	Hetero, IDU
East Asia & Pacific	Late '80s	640 000	130 000	0.07	13	IDU, hetero, MSM
Latin America	Late '70s - early '80s	1.4 million	150 000	0.5	25	MSM, IDU, hetero
Caribbean	Late '70s - early '80s	390 000	60 000	2.3	35	Hetero, MSM
Eastern Europe & Central Asia	Early '90s	700 000	250 000	0.35	25	IDU
Western Europe	Late '70s - early '80s	540 000	30 000	0.24	25	MSM, IDU

¹ UNAIDS/WHO: *AIDS epidemic update: December 2000* (Geneva, 2000).

Region	Epidemic started	Adults and children living with HIV/AIDS	Adults and children newly infected with HIV	Adult prevalence rate* (%)	% of HIV-positive adults who are women	Main mode(s) of transmission# for adults living with HIV/AIDS
North America	Late '70s - early '80s	920 000	45 000	0.6	20	MSM, IDU, hetero
Australia & New Zealand	Late '70s - early '80s	15 000	500	0.13	10	MSM
Total		36.1 million	5.3 million	1.1	47	

* The proportion of adults (15-49 years of age) living with HIV/AIDS in 2000, using 2000 population numbers.

Hetero (heterosexual transmission), IDU (transmission through injecting drug use), MSM (sexual transmission among men who have sex with men).

Source: UNAIDS/WHO: *AIDS epidemic update: December 2000* (Geneva, 2000).

3. The ILO views HIV/AIDS as a major development issue, with wide-ranging and complex economic, social and cultural implications. This paper is on the economic implications, and focuses in particular on the labour market and employment impacts of the epidemic. It first analyses the effects of HIV/AIDS on the labour market, based mainly on the experience of sub-Saharan Africa, where the problem has been greatest until now and where the direct impact of the epidemic is further compounded by persistent poverty, which limits the ability to afford the enormous economic costs of HIV/AIDS. With the virus spreading globally, the paper looks at the emerging HIV/AIDS situation in other regions of the world and considers whether the consequent labour market and employment impacts will be similar to the experience of sub-Saharan Africa. In conclusion, the role of the ILO in dealing with the labour market and employment consequences of HIV/AIDS is reviewed in the light of the Office's mandate and competence.

I. The economic impact of AIDS

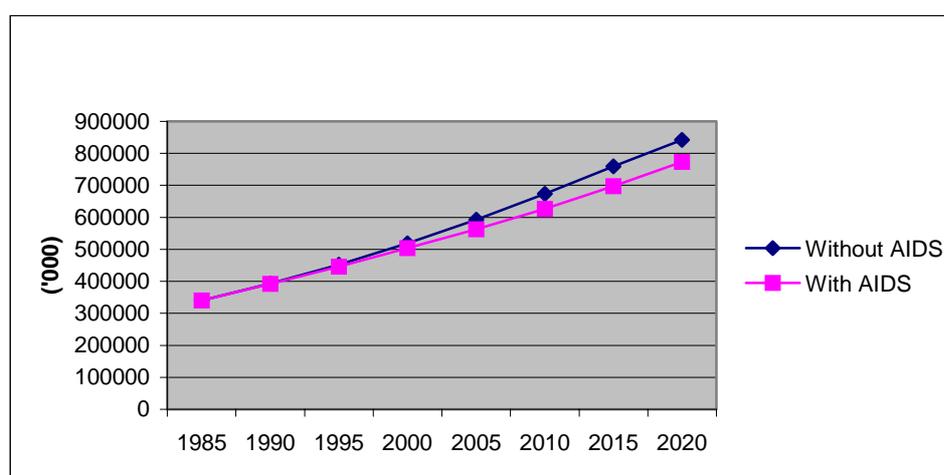
1. Impact on population and labour force

4. The most obvious impact of HIV/AIDS is on the growth of the population. This has been greatest in sub-Saharan Africa. Within this region, the highest rate of infection is in southern Africa: UNAIDS estimates that about 36 per cent of the adult population in Botswana, 25 per cent in Zimbabwe and Swaziland, and 20 per cent in South Africa and Zambia are infected. This compares with a prevalence rate of 8.6 per cent for sub-Saharan Africa and 1.1 per cent for the world as a whole. The United States Census Bureau has projected that by 2010 life expectancy will fall from about 60 years to around 30 years in the worst-affected countries, and that the rate of population growth will stagnate or turn negative for some countries in the subregion.²

² United States Census Bureau: *World population profile 1998* (Washington, DC, 1999).

5. Projections made by the ILO for the 29 African countries with prevalence rates above 2 per cent in 1997³ are shown in figure 1. The total population for these countries is projected at 773 million in 2020 – i.e. 8 per cent smaller than it would have been in the absence of HIV/AIDS. In countries with a higher prevalence rate, the impact is even greater: for instance, the population of Zimbabwe in 2020 is expected to be 20 per cent smaller than it would have been without AIDS. These projections and available evidence on the impact of HIV/AIDS suggest that the economic and social implications of the epidemic will be far-reaching and long-lasting in terms of the toll in human lives and, in particular, the loss of people of working age.

Figure 1. Projections of population with and without HIV/AIDS for 29 African countries, 1985-2020

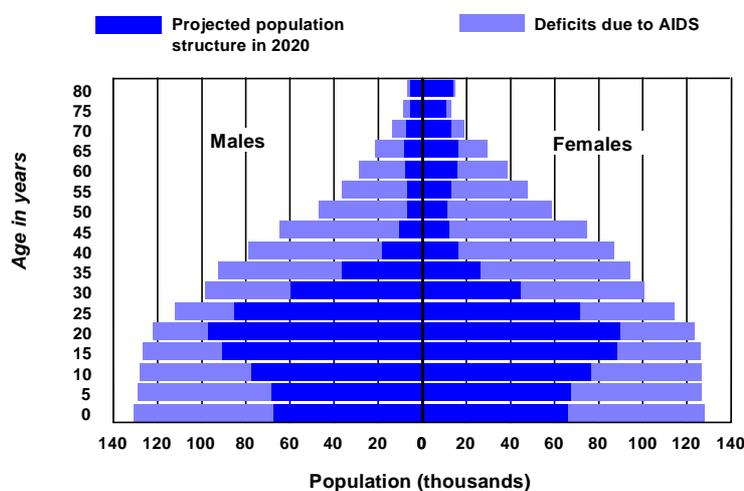


Source: ILO, POPILO population and labour force projection module.

6. Most significant for the labour force is what the epidemic does to the structure of populations. The majority of those who die of AIDS are adults in their productive, sexual and reproductive prime – in 1999, 80 per cent of newly infected people in Rwanda, the United Republic of Tanzania, Uganda and Zambia were aged between 20 and 49 years. For this reason, the impact of HIV and AIDS on the labour force is even more severe than its impact on the population in general. In Botswana, for instance, by 2020 the familiar population pyramid is expected to be replaced by a “population chimney”, as shown by figure 2. The loss of people of working age, particularly those over the age of 35, with the proportions of men and women varying according to the age group, drastically increases the dependency ratio and has profound implications for the world of work.

³ Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, Côte d’Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Gabon, Guinea-Bissau, Kenya, Lesotho, Liberia, Malawi, Mozambique, Namibia, Nigeria, Rwanda, Sierra Leone, South Africa, United Republic of Tanzania, Togo, Uganda, Zambia and Zimbabwe.

Figure 2. Projected population structure with and without the AIDS epidemic, Botswana, 2020

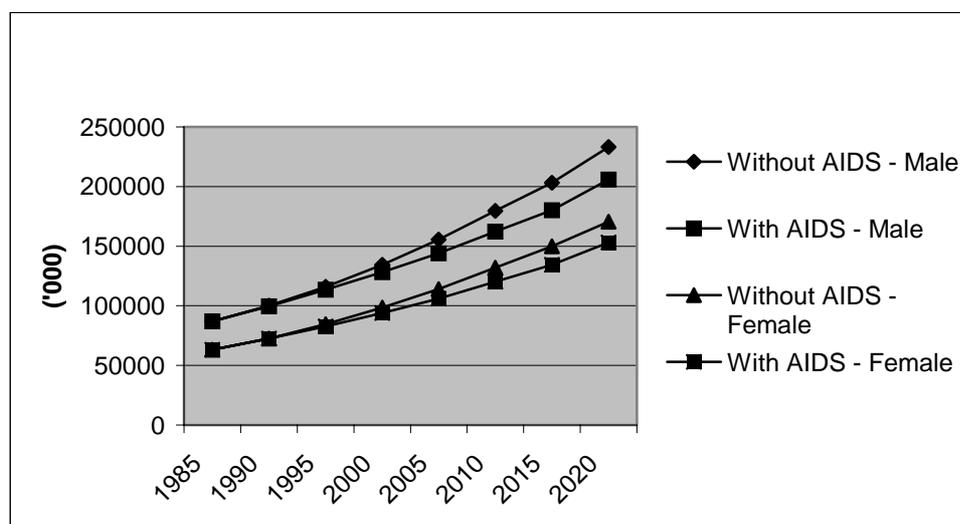


Source: United States Census Bureau: *World population profile 1998*.

7. The concern is not only with the reduction in the size of the labour force, but also its quality. Many of those infected with HIV are experienced and skilled workers in both blue-collar and white-collar jobs. At the same time, the loss of workers to AIDS is creating a generation of orphans (which by 2010 could reach up to 10 per cent of the population in some sub-Saharan African countries), who may grow up without the support and guidance of adults. The loss of skilled workers, together with the entry into the labour market of orphaned children who have to support themselves, is likely to lower both the average age of many workforces and the average level of skills and experience. In this context, it is also significant to note that human capital formation and quality will be seriously eroded by the impact of the epidemic on education: fewer teachers; increasing class size; rising drop-out levels.
8. Changes in population structure are reflected in labour force projections. For instance, figure 3 shows that in the same 29 African countries, the number of male and female labour force participants is expected to be between 12 and 10 per cent smaller respectively by 2020 than it would have been in the absence of AIDS. In the eight African countries with the highest prevalence rates,⁴ the projected cuts are even larger – 19 per cent for men and 18 per cent for women. These projections do not take into account possible age and gender-specific changes in labour force participation rates – as a result, for instance, of the rising number of widows and orphans seeking a livelihood and (as the chimney replaces the pyramid) the early entry of children into the active labour force; the early withdrawal of people with AIDS; and the retention of older persons in the labour force due to economic need. In comparison, the expected impact of AIDS on the labour force in other regions of the world is still relatively small. For instance, the comparable difference between the two projections in the case of Thailand is just over 1 per cent.

⁴ Botswana, Kenya, Malawi, Mozambique, Namibia, Rwanda, South Africa and Zimbabwe.

Figure 3. Projections of labour force, by sex, with and without HIV/AIDS, 29 African countries, 1985-2020



Source: ILO, POPILO population and labour force projection module.

2. Impact on the household: Loss of income

9. The labour market and employment impact of the epidemic is easiest to demonstrate at the household level. Illness of a household member means the loss of the that person's contribution to work and income, an increase in medical expenses and the diversion of other family members from work and school attendance to care for the patient. Death results in a permanent loss of income (whether from farm work, wages or remittances), funeral and mourning expenses, and the removal of children (usually in the 8-15 age group, with a disproportionate number of girls) from school, both to save money and to increase family labour, results in a severe loss of a family's future earning potential. Many out-of-school children are orphans: 12 million African children had lost their mother or both parents to AIDS by the end of 2000 and the number is expected to rise to 40 million over the next decade. Women are particularly vulnerable to the economic impact of HIV/AIDS as a result of their low level of economic security and few rights to land or property. In one way or another, many women end up dependent for survival on the favours or protection of male partners.

3. Impact on agriculture: Threat to food security and family welfare

10. In agriculture, where the majority of Africans work, the loss of adults may cause a switch from cash crops to subsistence farming, a reduction in soil improvement, irrigation and other capital investments and, within subsistence farming, changes to less labour-intensive crops. Families are also forced to sell food grain, livestock, equipment and land to cover AIDS-related expenses, and loss of knowledge and skills has a negative effect on productivity. Specialization by gender is a complicating factor. Women are estimated to be responsible not only for household duties and childcare, but also for ten out of the 13 principal tasks in African farming, including levelling, weeding, harvesting minor crops and transporting produce, and are estimated to produce between 60 and 80 per cent of the continent's food. The increasing incidence of infection among women, shown in table 1 above, is thus a threat to food security, as well as to family health and welfare. On the

other hand, the death of a male head of household may mean the loss of the worker responsible for animal rearing, harvesting, threshing and farm management, as well as access to land.

4. Impact on enterprises: Effects on productivity and labour costs

11. In enterprises, AIDS-related illnesses and deaths reduce productivity and increase labour costs. Enterprises in all sectors in the most seriously affected countries report increases in absenteeism (due to illness and bereavement), in labour turnover (due to illness and death), and in the costs of recruitment, training and staff welfare (including health care and funeral costs). Absenteeism, usually the first sign in a company that something is wrong, has a particularly disruptive effect on productivity. Loss of skills and tacit knowledge make it difficult to replace staff, even where a pool of unemployed exists. The workload of non-infected workers rises, to the detriment of their morale. Increased insurance pay-outs are reflected in rising premiums. Health-care costs increase particularly rapidly in enterprises which extend medical services to employees' dependants. The costs of HIV/AIDS for enterprises are both direct and indirect – many of the “hidden” costs have only recently become apparent. Figure 4 illustrates how these costs combine and reinforce each other to reduce the revenues and profits of enterprises and, therefore, their potential to survive. Available evidence suggests that productivity levels in South Africa and other seriously affected countries in the subregion could decline by up to 50 per cent in the next five to ten years, with devastating consequences for profits.⁵

5. Impact on the informal sector: Loss of livelihood

12. Informal sector activities in Africa have permitted the survival of millions who cannot get formal employment – and have become increasingly important as urban populations have grown and jobs in the public sector have shrunk. Falling wages and rising costs of living have also swollen the numbers of formal sector workers who engage in informal activities on the side. Informal workers are especially likely to suffer from the consequences of HIV/AIDS: first because there are no health facilities or social protection arrangements at their workplaces; secondly because their activities are rarely based on or lead to financial security, and depend heavily on their labour; and thirdly because the transient and vulnerable nature of the workplace itself – a market stall, a pitch by a traffic light, a roadside shelter to sell snacks, a place on a rubbish dump – means that they are likely to lose their place as soon as they are away from it. A study of female traders in Owino market in Uganda⁶ shows how quickly they can lose their livelihoods. When the women's work is interrupted, either through their own illness or the need to care for someone close to them, spoilage of perishable stock quickly occurs, their small financial reserves are rapidly depleted so that they cannot replace stock, they forfeit their stalls and their businesses collapse. Furthermore, it was observed in the same study that many of the women ruined in this way turned to the sale or bartering of sexual services in the hope of regaining some kind of financial security.

⁵ See, for example, ING Barings Bank: *The economic impact of AIDS in South Africa* (1999); Channing Arndt and Jeffrey D. Lewis: “The macro implications of HIV/AIDS in South Africa: A preliminary assessment”, unpublished manuscript (World Bank, Washington, DC, 2000); and ILO: *HIV/AIDS in Africa: The impact on the world of work* (Geneva, 2000).

⁶ Cited in ILO, EAMAT: *The impact of HIV/AIDS on the productive labour force in Africa*, Working Paper No. 1 (ILO, Addis Ababa, 1995).

6. Impact on the public sector: Macroeconomic effects and the implications for labour

(a) Government revenue and patterns of expenditure

13. A reduction in the rate of growth of the labour force, combined with falling productivity, means less government revenue from individuals and enterprises. Botswana's government expenditure, for instance, is expected to shrink by more than 20 per cent over the next 20 years, as revenue bases are eroded. At the same time, the costs to government of dealing with the epidemic account for an increasing proportion of budgets, crowding out other health and social development expenditures. Estimates by UNAIDS and the IMF⁷ for HIV/AIDS-related services in some of the affected countries in southern Africa are substantial, accounting for between 20 and 90 per cent of health budgets. In 1997 public health spending for AIDS alone already exceeded 2 per cent of GDP in seven out of 16 African countries sampled by UNAIDS (countries where total health spending accounts for only 3-5 per cent of GDP).

(b) Human capital

14. The HIV/AIDS epidemic will have a large impact on the supply of labour and human capital. Because of AIDS, there is pressure on children to drop out of school to support themselves. In addition, HIV-positive women have fewer babies, partly because they may die before the end of their childbearing years, and up to one-third of children are themselves infected and may not survive to school age, with the result that the number of children in school is falling. This will affect the supply of human capital in the longer run. The number of teachers is falling even faster, owing to their high rates of HIV prevalence – between 40 and 50 per cent in some countries – and consequent illnesses and deaths. Savings derived from the smaller number of children in school are more than offset by the cost of training extra teachers (in some countries, twice as many as usual) in order to ensure that the number of teachers in service does not fall. Sickness and death benefits for teachers are also an increasing burden on budgets.

15. The early loss of qualified employees in the public sector will result in a decline in the quality of public services, and countries will find it hard to replace highly trained public servants such as doctors and teachers who fall victim to HIV/AIDS. In addition, because of greater employment security in the public sector, the costs of absenteeism will be higher than in the private sector. In some countries, government employees may take up to one year of sick leave with pay. Current estimates suggest that some southern African countries will lose between one-quarter and one-third of their skilled and educated population. These losses will result in a decline in the productivity and effectiveness of public administration.

(c) Pensions and social security benefits

16. The impact on public sector pension funds will be significant. Fewer government employees will reach retirement age, so contributions by employees will decline and, at the same time, expenditure on sickness and death-related benefits and pensions for surviving dependants will increase as a percentage of the government wage bill. Social spending on

⁷ UNAIDS/WHO: *AIDS epidemic update: December 2000* (Geneva, 2000); and IMF: *World economic outlook* (Washington, DC, Oct. 2000).

the growing number of orphans will put further pressure on government spending in the face of declining tax revenues. Efforts to achieve social protection for workers have clearly been set back by increased demands on the system caused by HIV/AIDS. At the same time, a reduction in contributions and an increase in payments from pension funds could result in a reduced supply of investment capital for the government, as well as the private sector. However, the fact should not be overlooked that the great majority of the workforce in Africa is not covered by any form of social protection scheme.

(d) Savings, investment and comparative advantage

17. As domestic and external savings fall, investment and physical capital may also decrease, unless an increase in foreign aid offsets the decrease in investment – an unlikely scenario in most sub-Saharan African countries, judging by recent trends. Analysis of the macroeconomic impact of AIDS in Malawi and South Africa suggests that annual GDP growth rates may drop by 1-2 percentage points as a result of the epidemic.⁸ This suggests that over time, if the trend continues, countries will be faced with the danger of macroeconomic instability as the fiscal position deteriorates, with potential disruptive effects on economic and social relationships. This could have an adverse impact on confidence and, hence, investment.
18. Empirical evidence from the World Bank⁹ suggests that both government and private savings are being squeezed by the HIV/AIDS epidemic – in the case of government, by the pressure on its lower revenues of epidemic-related expenses; in the case of private savings, by the need to devote an increased share of a reduced income to health care. At the same time, incentives to private investment are significantly reduced. The problem of the decrease in foreign direct investment is further compounded by the fall in enterprise profitability, illustrated in figure 4 above, which may induce many companies to look for countries less affected by the epidemic in which to expand their business. Some may try to shift epidemic-related costs to others by contracting services with high-risk workers out to other companies, or to eliminate such costs by replacing workers by equipment and machinery.
19. As unit labour costs rise, the comparative advantage of economies with high prevalence rates will also increasingly be based on their natural resources (land, minerals, tourist attractions, etc.), rather than their human resources. This process will be reinforced in the longer run by the effects of the epidemic on the stock of *human capital*. As already mentioned, losses are thought to be disproportionately high among skilled, professional and managerial workers in many African countries. The epidemic not only reduces the stock of such workers, it also reduces the capacity to maintain the future flow, because of the loss of staff in education and training institutions, and because pressures within enterprises reduce their capacity for on-the-job and other forms of in-plant training. If the loss of educated people exceeds a critical maximum, as Cambodia's post-Khmer-Rouge experience has shown, the institutions that they staffed (universities, schools, hospitals, law courts, the civil service, etc.) become difficult to re-establish.

⁸ J.T. Cuddington and J.D. Hancock: "The macroeconomic impact of AIDS in Malawi: A dualistic, labour surplus economy", in *Journal of African Economies*, Vol. 4, No. 1, pp. 1-28 (May 1995).

⁹ World Bank: "Economic analysis of HIV/AIDS", Annex 5 in Multisectoral HIV/AIDS Programme (MAP) (Washington, DC, 2000); and World Bank: *Intensifying action against AIDS in Africa: Responding to a development crisis* (Washington, DC, 2000).

(e) International competitiveness

20. Because of declines in economic growth and productivity, the most seriously affected countries will find it difficult to improve or even maintain their position in the competitive hierarchy of international economies, at a time when they are faced with the challenge of rapid globalization. For example, in the current rankings in *The global competitiveness report 2000*,¹⁰ South Africa occupies the 26th place (out of 58) in the table based on current competitiveness and is 33rd (out of 59) in the table based on “growth competitiveness” or potential for fast growth (in both cases an improvement over 1999). Given the ravages of the HIV/AIDS epidemic (and the prospects for profits already described), it will be a hard struggle to avoid slipping down the tables. An economy’s position in such tables, it must be emphasized, is not just a matter of prestige: it is a sign of the kind of future that its workers can expect – one based on high technology and skills, or one based on low skills and raw materials.

(f) GDP growth and poverty reduction

21. The implications of HIV/AIDS for GDP growth will clearly be substantial, both through the direct impact on labour supply, human capital and savings, as well as through a decline in total factor productivity. The prospect for high-prevalence economies is, therefore, as already noted, much lower GDP and employment growth rates, and declines in output per head and average earnings. Moreover, poverty is likely to increase as a result of the impact of HIV/AIDS. The epidemic creates a vicious cycle by reducing economic growth, which leads to increased absolute poverty which, in turn, facilitates the rapid spread of AIDS as household expenditure on health and nutrition declines, thereby reducing resistance to opportunistic infections. In addition, the epidemic is likely to increase income inequality by increasing the supply price of scarce skilled labour, leading to higher wages for skilled workers vis-à-vis unskilled and unemployed labour.

7. Workers at special risk

22. The most obvious category of workers at special risk is commercial sex workers, a very high proportion of whom (up to 80 per cent in some areas) are seropositive. In general workers with jobs that involve being away from home and separation from their family, for instance in transport services (long-distance truck drivers, train crews, sailors, etc.), mining, construction, seasonal workers in agriculture and tourism, and migrant workers of all kinds without their families, are particularly vulnerable to HIV infection. They frequently resort to commercial sex, running the risk of becoming infected and later spreading that infection to their spouses and home communities. Other high-risk categories include health workers (exposed to infection by poor medical practices) and the security forces. The police and army are at risk not only because of their mobility and living arrangements (in large concentrations of single men), but also because the vulnerable civilian populations with whom they interact, especially displaced persons and refugees, have higher than average infection rates. A perhaps unexpected category of workers at special risk in Africa is males with higher levels of education, such as teachers and middle/senior civil servants. Their apparently higher than average risk of contracting HIV may be partly related to their geographical mobility and separation from their families as well as to their higher disposable incomes which provide the means to engage in casual sex.

¹⁰ World Economic Forum: *The global competitiveness report 2000* (OUP, 2000).

8. Women's economic vulnerability

23. The underlying ways in which women's livelihoods are affected by HIV/AIDS, to their own detriment and that of the community, touch upon issues concerning women's most fundamental rights, both personal and social, and not just their value as economic agents. Women's economic contribution consists of their reproductive as well as their productive work. Reproduction is not just a biological, personal or even social undertaking – it is also economic because the household is an economic unit which women serve and service. Women bear and care for the workforce, present and future, as well as taking part in it themselves. The fact that much of women's work may not be counted in GDP does not alter society's economic dependence on them. It therefore follows that if women are vulnerable, so are those who depend on them, from the household to the national economy. The acute vulnerability of women to HIV/AIDS based on biological, cultural, social and economic factors, means that they are disproportionately represented in terms of its incidence. This situation, together with the key role of women, including their economic contribution, adds to the urgency of addressing the epidemic.

II. Global prognosis: Lessons from the experience of sub-Saharan Africa

1. Why other regions may think they are different: Key prognostic factors

24. Gloomy prognostications emerge from the analysis of the impact of HIV/AIDS in sub-Saharan Africa – the region with the highest prevalence rate, number of people living with HIV/AIDS and number of deaths. Are these relevant to the HIV/AIDS situation in other regions of the world, or will none of these apply to them? Other regions may have three arguments to support scepticism: (1) adult prevalence rates are much lower – in most cases less than 1 per cent compared with nearly 9 per cent in sub-Saharan Africa; (2) their main modes of transmission are different: through injecting drug use and/or men having sex with men, rather than the almost entirely heterosexual transmission found only in Africa (reflected also in the higher percentage of HIV-positive adults who are women); and (3) unlike in Africa, their incidence is likely to vary inversely with level of education. Each of these arguments will be examined in turn.

(a) Prevalence rates

25. The first is the easiest to dispose of. It is certainly true that adult prevalence rates are much lower outside sub-Saharan Africa. As table 1 shows, only the Caribbean (2.3 per cent) is even comparable. However, in regions with a high rate of new infection, prevalence rates can change quickly. In the Russian Federation, for instance, more new HIV infections were registered in 2000 alone than in all 13 previous years of the epidemic combined, and a comparable acceleration is reported in other parts of Eastern Europe and Central Asia. In the region as a whole, unless early action is taken, a prevalence rate above 2 per cent (the rate at which serious economic consequences begin to be felt) is statistically possible. In Cambodia, which has one of the worst epidemics in Asia, the estimated prevalence rate is already between 3 and 4 per cent and could rise, depending on the effectiveness of preventive action, to 6 per cent or even higher before the end of the decade.

(b) Modes of transmission

26. Modes of transmission and the proportion of women among HIV-positive adults are certainly different outside sub-Saharan Africa, but differ more in some regions than in others. As table 1 shows, heterosexual transmission is already at least part of the story in North Africa and the Middle East, South and South-East Asia, East Asia and the Pacific, Latin America, the Caribbean and North America. And in several regions, the proportion of women among those affected is relatively high – North Africa and the Middle East (40 per cent), South and South-East Asia and the Caribbean (both 35 per cent). Moreover, modes of transmission can also change quite quickly. For instance, in Eastern Europe and Central Asia, where the epidemic started among injecting drug users, an increase in the proportion of newly reported HIV cases due to heterosexual transmission, and in the female-to-male ratio in new cases, has recently been observed. If this is unchecked, the spread of HIV into the general population is inevitable.

(c) Difference in incidence by level of education

27. Even if heterosexual transmission increases, however, the African pattern of an apparently higher than average infection risk among the more educated is unlikely to be repeated in many other parts of the world. For instance, in Thailand, where transmission is now primarily heterosexual, labourers and agricultural workers, generally the poorest and least educated, are the most susceptible to AIDS. Countries in which a very high proportion of teachers are women (such as many in Eastern Europe), are also in a good position to avoid the destruction of educational staff and systems that is happening in parts of Africa. Incidence by level of education is a crucial determinant of the nature of the impact of the epidemic. The capacity of a country with a “population chimney” of the kind shown in figure 2 to cope with its consequences will be much weaker if the more educated are disproportionately represented among those who are lost. Even if the incidence is unbiased, the increase in the dependency ratio will be difficult enough to handle, particularly among countries whose populations are already shrinking and ageing, as in Eastern Europe.

III. The role of the ILO in dealing with the consequences of HIV/AIDS in the workplace

28. Whatever the trajectory and eventual scale of the epidemic in particular countries, the challenge of dealing with its consequences in the workplace will have to be faced worldwide. The costs of the epidemic, illustrated in figure 4, cannot be allowed to fall entirely on workers (to the detriment of current family income and welfare) or employers (to the detriment of profits and future investment). The workplace is also the ideal location for information and education programmes designed to limit the spread of HIV/AIDS and to encourage proper and informed behaviour towards those who are infected. In addition, the impact of the epidemic on the labour force will need to be taken into account in employment and training policies.

29. Central to the role of the ILO in addressing the workplace consequences of HIV/AIDS are workers’ rights, which have to be protected. The unique tripartite approach of the ILO is a major asset in mitigating the impact of HIV/AIDS on the labour market and employment. The ILO’s legal instruments, particularly the core labour standards, and its long experience in promoting health and safety at work and social dialogue, are particularly relevant in shaping an effective ILO response to HIV/AIDS in the context of the world of work. An ILO code of practice which will address the rights and responsibilities of workers and

employers in the workplace, as well as provide guidelines for the training of managers and workers' representatives in the context of developing a workplace policy for HIV/AIDS, is being finalized for discussion and adoption at an ILO tripartite meeting of experts. The proposed code, once adopted, will be presented to the UN General Assembly Special Session on HIV/AIDS in June 2001 for acknowledgement and endorsement.

Geneva, 5 February 2001.