

Working Paper 1

Labour market and employment implications of HIV/AIDS

by
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1. INTRODUCTION

Analysis of the economic impact of HIV/AIDS has focused mainly on the effects of the epidemic on costs that directly affect productive activities and reduce profits at the enterprise level. While information on costs that enterprises have incurred as a result of HIV infection, such as medical expenditure, recruitment and training costs, funeral expenses, and so on, has been useful as a tool for advocacy, this has been of limited use for an overall assessment of the economic impact of HIV/AIDS because of relative neglect of a whole set of labour market and employment issues. There are also lacunae in the present state of knowledge relating to the impact of AIDS on human capital at the level of productive activities.

From a policy standpoint, it is desirable to look at the impact of HIV and AIDS on factors which influence the supply and demand for labour over time in terms of labour market efficiency and the dynamics of employment generation. Of critical importance for a full assessment of the economic impact of HIV/AIDS is how labour markets have been affected by the epidemic and what the impact has been on productive activity and employment generation.

This paper is on the economic impact of HIV/AIDS, and focuses in particular on the labour market and employment implications of the epidemic. It analyses the effects of HIV/AIDS on the labour market, based mainly on the experience of sub-Saharan Africa where the problem, until now, is greatest 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 experience of sub-Saharan Africa in terms of consequent labour market and employment impacts will be relevant to the emerging HIV/AIDS situation in other regions. The role of the ILO, an international organization with tripartite constituents in all regions and a global network of field offices, is therefore crucial in dealing with the labour market and employment consequences of HIV/AIDS. This is reviewed in the light of the Organization's mandate, competence, and experience.

2. OVERVIEW: THE SCALE AND PATTERN OF THE HIV/AIDS EPIDEMIC

Over 40 million people around the world are infected with HIV, and 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 AIDS today is well over 50 per cent higher than was projected at the start of the 1990s. On the latest UNAIDS estimate¹, 5 million people were newly infected with HIV during 2001 and the majority of new infections occurred in young adults, with young women especially vulnerable. In 2001, some 3 million people died of AIDS, bringing the total number of deaths since the epidemic began to about 25 million, of whom 11.4 million were adult women and 4.9 million children.

Table 1 below shows the regional pattern of the epidemic at the end of 2001. Sub-Saharan Africa dominates in terms of the number of people living with HIV, new infections and adult prevalence rate, or the proportion of adults (15-49 years) living with HIV/AIDS, 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 (43 per cent) and Asia and the Pacific (26 per cent), compared with the global average of 11 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 impact of the epidemic in the labour market.

Table 1: Regional HIV/AIDS statistics and features, end of 2001

Region	Epidemic started	Adults & children living with HIV	Adults & 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	28.1 million	3.4 million	8.4%	55%	Hetero
North Africa & Middle East	late '80s	440,000	80,000	0.2%	40%	Hetero, IDU
South & South-East Asia	late '80s	6.1 million	800,000	0.6%	35%	Hetero, IDU
East Asia & Pacific	late '80s	1 million	270,000	0.1%	20%	IDU, hetero, MSM
Latin America	late '70s-early '80s	1.4 million	130,000	0.5%	30%	MSM, IDU, hetero
Caribbean	late '70s-early '80s	420,000	60,000	2.2%	50%	Hetero, MSM
Eastern Europe & Central Asia	early '90s	1 million	250,000	0.5%	20%	IDU
Western Europe	late '70s-early '80s	560,000	30,000	0.3%	25%	MSM, IDU
North America	late '70s-early '80s	940,000	45,000	0.6%	20%	MSM, IDU, hetero
Australia & New Zealand	late '70s-early '80s	15,000	500	0.1%	10%	MSM
TOTAL		40 million	5 million	1.2%	48%	

* The proportion of adults (15 to 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, 2001. AIDS epidemic update: December 2001, Geneva, UNAIDS

¹ UNAIDS/WHO, 2001. *AIDS epidemic update: December 2001* (Geneva, UNAIDS).

3. THE ECONOMIC IMPACT OF HIV/AIDS: LABOUR MARKET AND EMPLOYMENT IMPLICATIONS

The ILO estimates that at least 26 million people infected with HIV worldwide are *workers*, aged 15 to 49 years, in the prime of their working lives. This is about three-quarters of all adults living with HIV/AIDS. The effects are catastrophic – not just on workers and their families, but on enterprises and national economies.

From the standpoint of its economic impact, HIV/AIDS has become a major threat to employment objectives and labour market efficiency. The loss of workers and work-days due to AIDS-related illnesses or the demands of caring can result in significant declines in productivity, loss of earning, and attrition in skills and experience. HIV/AIDS is changing the age and sex distribution of the labour force, and increasing the number of women, children and the elderly facing economic uncertainty. The vulnerability of women to HIV infection, as compared with men, increases existing gender inequalities. The early entry of orphans into the labour force exacerbates the worst forms of child labour, and the epidemic is forcing older persons back into the workforce due to economic need. The epidemic also strikes hard at the poor who can least afford treatment and care, thereby increasing existing problems of poverty and inadequate social protection. The effects of HIV/AIDS on employment and on the labour market are therefore a major concern of the ILO, which views the epidemic as a workplace issue and a major development challenge.

Another concern of the ILO is the discrimination against workers and people with HIV, which threatens fundamental principles and rights at work and undermines efforts to prevent the spread of the epidemic and mitigate its impact in the world of work. As an organization founded to promote social justice and equity and to protect workers' rights, ILO is committed to fight discrimination and stigma related to HIV status. It has adopted a *Code of Practice on HIV/AIDS and the World of Work*, which forms the cornerstone of ILO efforts against HIV/AIDS through protection of rights at work, including employment security, entitlement to benefits and gender equality.

In terms of responding to the effects of the epidemic on employment patterns and the labour market, particularly from the standpoint of its concentration in the working age population and impact on (working) children, a critical issue is the impact of human capital losses on productive activity and sustainable development. This is a highly complex matter, since the effects of HIV/AIDS on labour supply over time are influenced by a variety of economic, social and cultural factors and are affected both directly and indirectly. The problem is further compounded by the fact that in most developing countries, the most dynamic sector in terms of employment is the 'informal sector', on which data and information are scarce and unreliable. Yet this is the sector where workers are likely to suffer more from the consequences of HIV/AIDS because of poor health facilities; lack of social protection; and greater job and financial insecurity, due to precarious employment and heavy dependence on labour.

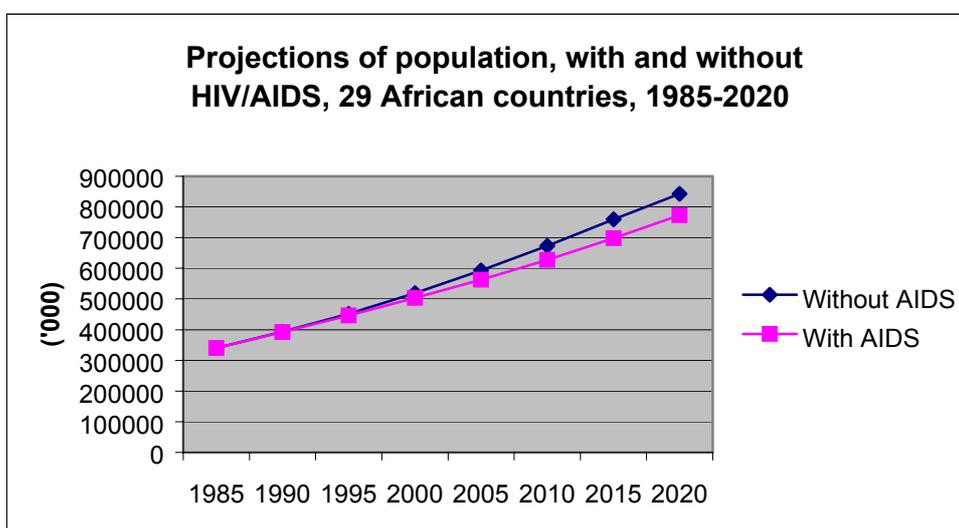
(i) Impact on population and labour force

The most obvious impact of HIV/AIDS on labour is on growth of 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 prevalence rate of 8.4 per

cent for sub-Saharan Africa and 1.2 per cent for the world as a whole. The US 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 sub-region.²

Projections made by the ILO for the 29 African countries³ with prevalence rates above 2 per cent in 1999 are shown in *Figure 1*. Total population for these countries is projected at 773 million in 2020 – i.e. 8 per cent smaller than in the absence of HIV/AIDS. In countries with a higher prevalence rate, the impact is even greater: for instance, Zimbabwe’s population in 2020 is expected to be 20 per cent smaller than 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, through the toll in human lives and particularly the loss of people of working age.

Figure 1



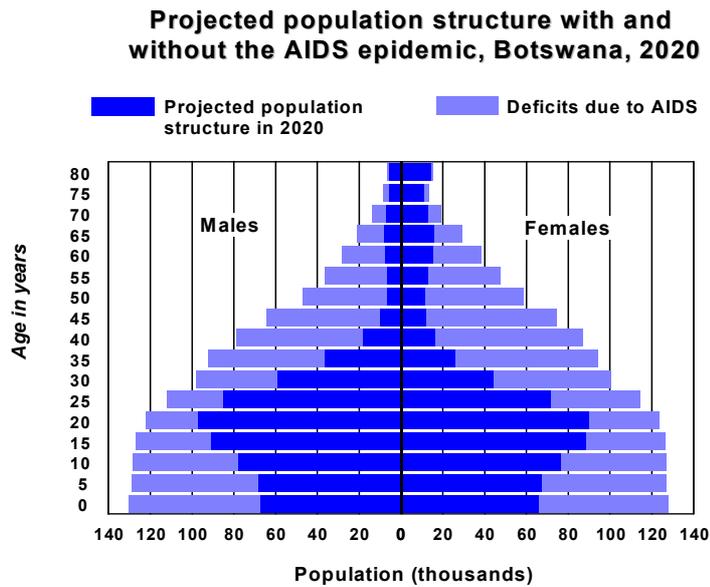
Source: ILO, POPILO population and labour force projection, 2000.

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, Tanzania, Uganda and Zambia were 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 the ‘population chimney’, as *Figure 2* shows. The loss of people of working age, particularly those over the age of thirty-five, with proportions of men and women varying according to age group, drastically increases the dependency ratio and has profound implications for the world of work.

² US Census Bureau, 2000. *World Population Profile 2000* (Washington D.C.).

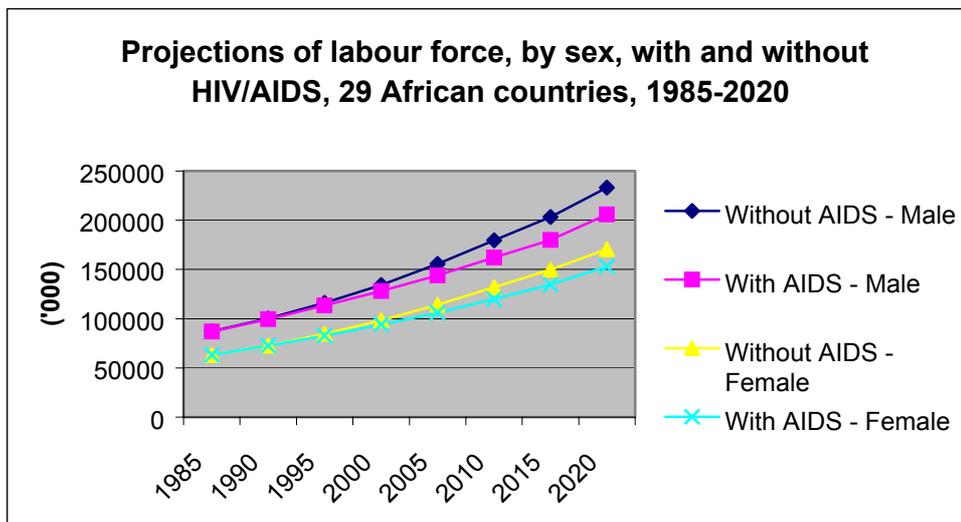
³ Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, Democratic Republic of Congo, Eritrea, Ethiopia, Gabon, Guinea Bissau, Côte d’Ivoire, Kenya, Lesotho, Liberia, Malawi, Mozambique, Namibia, Nigeria, Rwanda, Sierra Leone, South Africa, Tanzania, Togo, Uganda, Zambia and Zimbabwe. See ILO, 2000. *HIV/AIDS in Africa: The impact of the world of work* (Geneva).

Figure 2



Changes in structure are reflected in projections of labour force. For instance, *Figure 3* below shows that in the same 29 African countries, the number of male and female labour force participants is expected to be 12 and 10 per cent smaller respectively by 2020 than in the absence of AIDS: in the eight African countries with the highest prevalence rates⁴, 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.

Figure 3



Source: ILO, POPILO population and labour force projection, 2000.

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

The concern is not only with reduction in the size of the labour force, but also its quality. Many of those infected with HIV are experienced and skilled workers in their productive prime, representing significant human capital losses. 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 – and may grow up without support and guidance of adults and enter the labour force prematurely and with no skills. 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 their 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; rise in drop-out levels.

(ii) Human capital losses

The HIV/AIDS epidemic will have a large impact on the supply of 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 child-bearing years, and up to a third of children are themselves infected and may not survive to school age: so 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.

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 productivity and the effectiveness of public administration.

(iii) Impact in the household: loss of income

The labour market and employment impact of the epidemic is easiest to demonstrate at the household level. Illness of a household member means loss of the contribution to work and income of the person affected, an increase in medical expenses, and diversion of other family members from work and school attendance to caring 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 and disproportionately 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: more than 13

million African children had lost one or both parents to AIDS by the end of 2001 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, with little economic security and few rights to land or property: in one way or another, many end up dependent for survival on the favours or protection of male partners.

(iv) Impact in agriculture: threat to food security and family welfare

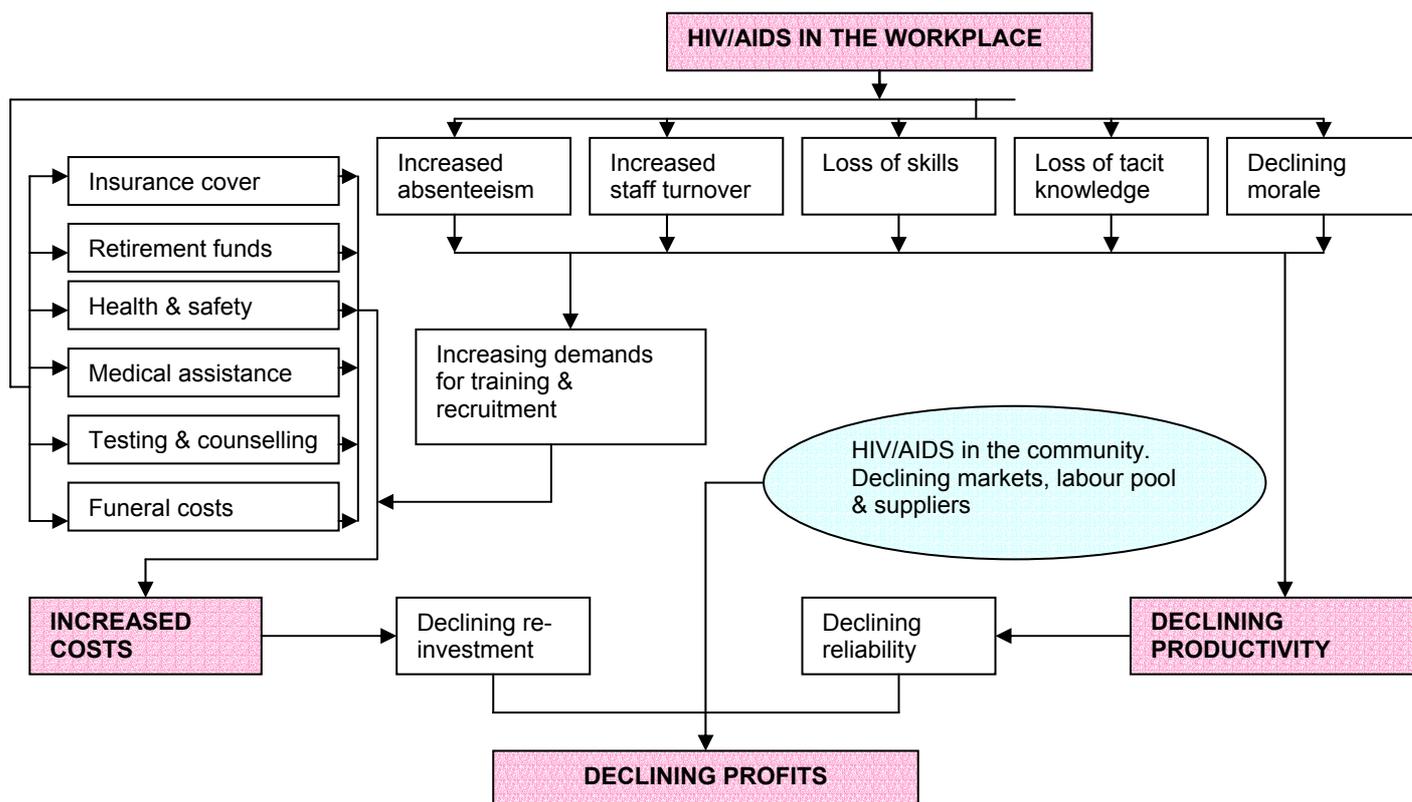
In agriculture, where the majority of Africans work, the loss of adults may cause a switch from cash crops to subsistence farming, a reduction in soil improvement, irrigation and other capital investments, and within subsistence farming changes to less labour-intensive crops. Families are also forced 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 child care but also for most principal tasks in African farming, including leveling, weeding, harvesting minor crops and transporting produce, and 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 family health and welfare. On the other hand, death of a male head of household may mean the loss of the worker responsible for more demanding and remunerative farm work and farm management, and more importantly, of access to land.

(v) Impact in enterprises: effects on productivity and labour costs

In enterprises, AIDS-related illnesses and deaths reduce productivity and increase labour costs. Enterprises in all sectors in the most seriously affected countries have reported increases in absenteeism (due to illnesses and bereavements), in labour turnover (due to illnesses and deaths), and in 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 fast in enterprises which extend medical services to employees' dependents. 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 revenues and profits of enterprises and, therefore, their potential to survive. Available evidence suggests that productivity levels in South Africa and other countries in that sub-region could decline by up to 50 per cent in the next five to ten years, with devastating consequences for profits.⁵

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

Figure 4: Impact of HIV/AIDS on an enterprise



Source: UNAIDS, *The business response to HIV/AIDS: Impact and lessons learned* (UNAIDS, 2000).

(vi) Impact in the informal economy: loss of livelihood

Access to economic activities in the informal economy in Africa has permitted the survival of millions who cannot get formal employment – and has 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, thereby increasing their vulnerability to HIV infection.

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

4. SPECIAL LABOUR MARKET CIRCUMSTANCES AND VULNERABILITY

(i) Workers at special risk

The most obvious category of workers at special risk is that of commercial sex workers, a very high proportion of whom (up to 80 per cent in some areas) are seropositive. In general, also, workers with jobs that involve being away from home and separation from 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 categories facing occupational risks 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 of the power derived from their military status: civilian populations who interact with the military, especially displaced persons and refugees, also 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 mobility but also reflects their higher disposable income and resulting increased propensity for casual sex.

(ii) Women's economic vulnerability

Underlying the ways that women's livelihoods are affected by HIV/AIDS to their own detriment, and that of the community, are 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, and women serve and service this unit. 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 follows, therefore, that if women are vulnerable so are those who depend on them, from the household to the national economy. Hence, the economic vulnerability of women to HIV/AIDS, disproportionately greater than men's, is a matter of serious and urgent concern in addressing the economic impact of the epidemic. Particular attention should also be paid to the fact that women may be exposed to violence at home and often find themselves in positions of weakness and dependence at the workplace, which lead easily to sexual harassment and in turn increase their vulnerability. These factors jeopardize women's long-term economic security in the face of the epidemic and increase existing gender inequalities.

5. MACRO-ECONOMIC EFFECTS AND THE IMPLICATIONS FOR LABOUR AND EMPLOYMENT

(i) Government revenue and patterns of expenditure

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 twenty 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 sixteen African countries sampled by UNAIDS (countries where total health spending accounts for only 3 to 5 per cent of GDP).

(ii) Saving, investment and comparative advantage

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 macro-economic 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 means that over time, if the trend continues, countries will be faced with the danger of macro-economic 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.

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 the 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 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.

⁷ UNAIDS/WHO, 2001. *AIDS Epidemic Update: December 2001* (Geneva: UNAIDS), and IMF, 2000. *World Economic Outlook* (Washington).

⁸ John T. Cuddington and John D. Hancock; 1995. "The macro-economic impact of AIDS in Malawi", *Journal of African Economics*, Vol. 1, pp. 1-28 (May).

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

As unit labour costs rise, also, the comparative advantage of economies with high prevalence rates will increasingly be based on their natural resources (land, minerals, tourist attractions, and so on), rather than on 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 the 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, even the *concept* of the institutions that they staffed (universities, schools, hospitals, law courts, the civil service, and so on) is lost and becomes difficult to re-establish.

(iii) International competitiveness

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 faced with the challenge of rapid globalization. For example, in the 2000 *Global Competitiveness Report*¹⁰ current rankings, 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 emphasised, 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.

(iv) Social Protection

The impact on social protection in terms of public sector pensions and social security will be significant. Fewer government employees will reach retirement age, so contribution by employers will decline and, at the same time, expenditure on sickness and death-related benefits and pensions for surviving dependents will increase as a percentage of the government wage bill. Social spending on 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 clearly have been set back by increased demands on the system caused by HIV/AIDS. At the same time, a reduction in contributions and increase in payments from pension funds could result in reduced supply of investment capital for the government as well as the private sector. However, the fact should not be lost that the great majority of the workforce in Africa is not covered by any form of social protection scheme.

¹⁰ World Economic Forum, 2000. *The Global Competitive Report 2000* (Cambridge, Harvard University).

(v) GDP growth and poverty reduction

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, then, for high-prevalence economies is: much lower GDP and employment growth rates, as already noted, 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.

6. CONCLUSION: THE ROLE OF THE ILO IN DEALING WITH THE CONSEQUENCES OF HIV/AIDS IN THE WORKPLACE

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 human capital and productive activities will need to be taken into account in employment and training policies for workers and management personnel in both public and private sectors and in the informal economy.

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 structure and 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. The ILO has adopted a *Code of Practice on HIV/AIDS and the world of work* which addresses the rights and responsibilities of workers and employers in the workplace, as well as providing guidelines for the training of managers and workers' representatives in the context of developing a workplace policy for HIV/AIDS. The Code was developed through tripartite consultations and approved by an ILO tripartite meeting of experts. The Code received the support of the UN Secretary-General and was presented to the UN General Assembly Special Session on HIV/AIDS in June 2001 for acknowledgement and endorsement. The ILO Director-General has used the Code in formulating an office-wide Personnel Policy on HIV/AIDS. Heads of other UN agencies have endorsed the ILO Code of Practice as a basis for their own policy, and the Code is now the standard for a UN system-wide approach to addressing HIV/AIDS in the workplace.

The ILO Code of Practice is intended to help reduce the spread of HIV and mitigate its impact on workers and their families. It contains fundamental principles for policy development and practical guidelines from which concrete responses can be developed at enterprise, community and national levels. Key principles of the Code include non-discrimination and employment security; confidentiality; healthy and safe work environment; social protection; prevention; care and support; gender equality; and social dialogue.

ILO's commitment to fighting AIDS in the workplace has resulted in the creation of a global *Programme on HIV/AIDS and the world of work* (ILO/AIDS). The main objective of the ILO/AIDS Programme is to raise awareness of the economic and social impact of HIV/AIDS in the world of work, and to strengthen the capacity of government, employers' and workers' organization to respond to HIV/AIDS within their countries. Through policy guidelines, technical cooperation

and advocacy, the Programme supports efforts for a greater involvement of the key social partners in the world of work in the response to HIV and AIDS. The aim is to ensure that each of the social partners is mobilized and activated in ways that maximizes their contribution to the response to the epidemic. This should be pursued within frameworks that reflect an understanding of the threat the epidemic poses for social and economic development, through its impact on labour market efficiency and employment generation.