HIV/AIDS in Africa: The Impact on the World of Work

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HIV/AIDS IN AFRICA:
The impact on the world of work

International Labour Office
Geneva
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Introduction

AIDS threatens every man, woman and child in Africa today. The pandemic is the most serious social, labour and humanitarian challenge of our time (Platform of action on HIV/AIDS in the context of the world of work in Africa).1

This quotation, short and stark as it is, sums up the crisis facing Africa. But in the very act of recognizing the gravity of the threat of HIV/AIDS lies the possibility of overcoming it. National and international leaders are at last acknowledging that AIDS is no longer just a health problem, and African leaders are giving voice to the fears of their people.

This African Development Forum is putting the responsibility for action squarely on Africa’s leadership: it challenges political leaders to take effective national action, it requires the international community to make real resources available, it honours the initiatives taken by community and civil society leaders, and it lays the burden on each and every individual and organization present to take part in a major cooperative effort at the highest as well as the most local level – the “emergency response” the world has been waiting for.

The ILO is pleased to participate in the Forum’s reflections and to contribute substantively to an agreed plan of action. The primary goal of the ILO is to promote opportunities for women and men to obtain decent and productive work, in conditions of freedom, equity, security and human dignity. This goal is being threatened by the HIV/AIDS pandemic at every point: in terms of discrimination in employment, the size and composition of the labour force, the productivity of enterprises, the costs of health and social security, the economic opportunities of women, and the rising numbers of orphaned children being thrown out of education and onto the labour market. As a result the ILO has been asked by member States to help them combat the spread of HIV/AIDS and provide protection and support to those affected by the epidemic. The ILO accepts that it has a moral responsibility to integrate the world of work in HIV/AIDS programmes, a practical role in extending its educational and technical cooperation expertise to AIDS prevention and mitigation, and a political role in helping redefine the scope and nature of the response to HIV/AIDS – it will use its political weight in advocacy not only for the rights of workers but for the rights of poor countries to share in whatever knowledge, processes and treatment may reduce the impact of AIDS.

The ILO has undertaken a series of activities which, in the space of a few months, turned the recommendations of a regional tripartite workshop in Windhoek, Namibia, into a global programme that will engage the whole Organization, and in particular its field staff all over the world. Since May 2000, the ILO has passed a resolution at the highest level, committing itself to action and establishing priorities. A cooperation agreement has been signed with UNAIDS, a number of meetings have been organized by the social partners in collaboration with the ILO to develop a global strategy focusing on HIV/AIDS and the world of work, and a consultation workshop held to guide the development of its work on HIV/AIDS. Today that programme is firmly in place: in the context of this the ILO commits its political weight to advocacy within governments, workers’ and employers’ organizations as well as the private sector and mobilizes its contacts and experience in that community it knows so well, the world of work.
Part I. Human tragedy and threat to development: The impact of HIV/AIDS on the social partners in Africa

HIV/AIDS in Africa

Nine million Africans have died of AIDS, 2.2 million in 1999 alone.

Over 23 million Africans are currently living with HIV, two-thirds of the world's total; in 16 countries more than one in ten adults under 50 are infected.

There were 4 million new infections in 1999.

Twelve million African children have lost their mother or both parents to AIDS.

1. An overview of HIV prevalence in Africa

(i) Geographical distribution

Only five years ago an ILO report on HIV and labour in Africa described an “AIDS belt” across East and Central Africa, with relatively few cases in West, southern and northern Africa. Today, seven countries in Africa’s southern cone have adult prevalence rates of over 20 per cent; in Botswana, one in three adults are living with HIV/AIDS. South Africa has the largest infected population not only in Africa but in the world, and the fastest rate of new infections. In West Africa, infections are fewer but increasing. Côte d’Ivoire and Cameroon have adult prevalence rates of 10.7 per cent and 7.3 per cent respectively; in Nigeria over 2.5 million adults are living with HIV/AIDS though this represents only 5 per cent of the population. Ten countries in Africa were described as badly affected in 1995 – 29 are today.

These figures show how rapidly infections both increase and spread. In Swaziland, for example, the year 1994 saw infection rates go from 4 per cent to 21 per cent of the adult population. The pattern is constantly shifting, constantly wrong-footing those trying to respond. No country can afford to wait until it is convinced it has a problem; the challenge is to move faster than the infection. For this reason it is important not only to identify and analyse a pattern across the continent, but also to attempt to explain the exceptions. One example is Uganda, with a falling HIV prevalence rate, while most neighbouring countries are experiencing rising rates of infection.

(ii) Demographic implications

A child born in Africa in the next five years can expect to live to the age of 47; in a world without AIDS that child would probably have reached the age of 60.

HIV/AIDS is the leading cause of death in Africa, having overtaken malaria and far exceeding deaths in war. Life expectancy at birth in a number of African countries has fallen by an average of seven years, by over ten years in eight countries, and by 30 years in
Botswana and Zimbabwe. And because of the long interval between infection and death, worse is still to come. Although most deaths are among adults, child mortality, especially for those under two, has also increased over recent years – by up to five times in some countries. For teenagers the future looks particularly bleak: in countries with HIV prevalence rates of 15 per cent and over, at least a third of those now aged 15 will die of AIDS – and over half in Botswana, Kenya, South Africa, Zambia and Zimbabwe.

Though the future for each individual is uncertain, the consequences of AIDS deaths for total population numbers are clear: for the 29 countries in Africa with prevalence rates of over 2 per cent, total population is expected to reach 627 million by 2010 – that is nearly 50 million fewer than in the absence of AIDS. The populations of Botswana, Namibia and Zimbabwe are projected to be some 20 per cent smaller than they would otherwise have been.

The implications for the structure of populations are even more severe than for their size. The most recent UNAIDS report on the epidemic (June 2000) describes a new shape replacing the traditional population pyramid in badly affected countries: what they call the “population chimney” because it is so much narrower than the pyramid as a result of AIDS deaths and children not born. In 20 years’ time in Botswana, for example, there will be more adults in their 60s and 70s than in their 40s and 50s. There will also, in many countries, be more men than women. Women are becoming infected at a younger age than men, and their infection rates are higher: within the next few years men may outnumber women by an average of 11 to nine.5

It is well known that those most susceptible to HIV infection are not the weaker members of society – the young and the old – who fall sick with diarrhoea, respiratory infections, or malaria. 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, United Republic of Tanzania, Uganda and Zambia were between 20 and 49 years old. For this reason, the impact of HIV on the workforce is even more severe than its impact on the population in general (see below): by 2020, the population of the 29 most-affected African countries will be about 9 per cent smaller than without AIDS, but the workforce will be over 12 per cent smaller.

2. The impact of HIV/AIDS on the labour force

The development of Africa depends on its human resources.

(i) How AIDS affects labour

Many countries in Africa are rich in natural resources, from fertile agricultural land to valuable minerals; but these have often been exploited by others, and the control and profits lost to Africa. Most countries therefore can only depend on their human resources – their people. The economy is built by the work of individuals who, collectively, make up the labour force. The development of these human resources entails the promotion of their skills and education and the protection of their health. The economy depends on the adequate supply and quality of the labour force.
Africa today is losing its prime labour force to HIV/AIDS. At first it was not thought that debilitation and death as a result of AIDS could be more than a local problem and a human loss. But enterprises, towns and governments are now starting to measure the cost in terms of lost productivity, health and social security costs, and even falling GDP. Already including many of the poorest countries in the world, Africa has to bear both enormous direct costs and loss of income as a result of the depredations of AIDS on its active population.

How does HIV/AIDS affect the workforce?

- Reduced supply of labour.
- Loss of skilled and experienced workers.
- Changes in composition of labour force and early entry of children into employment.
- Increased pressure on women to earn income as well as care for the sick.
- Mismatch between human resources and labour requirements.
- Reduced productivity.
- Absenteeism and early retirement.
- Increased labour costs for employers.
- Loss of wage earners in a household.
- Reduced remittances from migrant workers.
- Increase in female-headed households.

The size of the labour force in high-prevalence countries will be between 10 and 30 per cent smaller by 2020 than it would have been without HIV/AIDS (see table 1). The projected loss for Côte d’Ivoire is 12.8 per cent, for Ethiopia 10.5 per cent, for Malawi 16 per cent and for Zimbabwe 29.4 per cent. In the case of lower-prevalence countries the impact is smaller but still significant – well over 5 per cent in most cases. These figures do not take into account the reduced capacity of many of those still in the labour force but sick from AIDS-related illnesses. The age and sex composition of the workforce is also expected to change as more orphaned children and widows seek employment; another trend might be the retention of workers beyond retirement age in order to keep experienced staff.

Table 1. Projected labour force with AIDS, 2005 and 2020. Losses due to HIV/AIDS in 29 African countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage loss, compared to situation without HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2005</td>
</tr>
<tr>
<td>Benin</td>
<td>-2.0</td>
</tr>
<tr>
<td>Botswana</td>
<td>-17.2</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>-8.1</td>
</tr>
<tr>
<td>Burundi</td>
<td>-6.5</td>
</tr>
<tr>
<td>Cameroon</td>
<td>-5.5</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>-10.3</td>
</tr>
<tr>
<td>Chad</td>
<td>-5.3</td>
</tr>
<tr>
<td>Congo</td>
<td>-7.9</td>
</tr>
<tr>
<td>Democratic Republic of the Congo</td>
<td>-6.7</td>
</tr>
<tr>
<td>Country</td>
<td>Percentage loss, compared to situation without HIV/AIDS</td>
</tr>
<tr>
<td>--------------------</td>
<td>---------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>2005</td>
</tr>
<tr>
<td>Côte d'Ivoire</td>
<td>–9.0</td>
</tr>
<tr>
<td>Eritrea</td>
<td>–2.8</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>–8.3</td>
</tr>
<tr>
<td>Gabon</td>
<td>–5.0</td>
</tr>
<tr>
<td>Guinea-Bissau</td>
<td>–4.4</td>
</tr>
<tr>
<td>Kenya</td>
<td>–8.6</td>
</tr>
<tr>
<td>Lesotho</td>
<td>–4.8</td>
</tr>
<tr>
<td>Liberia</td>
<td>–2.0</td>
</tr>
<tr>
<td>Malawi</td>
<td>–10.7</td>
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<tr>
<td>Mozambique</td>
<td>–9.0</td>
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<tr>
<td>Namibia</td>
<td>–12.8</td>
</tr>
<tr>
<td>Nigeria</td>
<td>–3.8</td>
</tr>
<tr>
<td>Liberia</td>
<td>–10.7</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>–6.1</td>
</tr>
<tr>
<td>South Africa</td>
<td>–10.8</td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>–9.1</td>
</tr>
<tr>
<td>Togo</td>
<td>–7.4</td>
</tr>
<tr>
<td>Uganda</td>
<td>–16.3</td>
</tr>
<tr>
<td>Zambia</td>
<td>–4.7</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>–19.7</td>
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</table>


The concern is not only with 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. The loss of these 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 average level of skills and experience.

Between 1984 and 1992 in Zambia, 62 per cent of deaths among managers were the result of AIDS-related illnesses: this rate was slightly higher than middle-level workers and slightly lower than lower-level workers. A survey of blood donors in Malawi found higher infection levels among the educated than unskilled workers. In South Africa, the ING Barings Bank projects that one-third of the semi-skilled and unskilled workforce will be HIV-positive by 2005, 23 per cent of the skilled and 13 per cent of the highly skilled workforce. It takes time to replace skilled workers because of the training or retraining necessary, and even longer to replace the experience lost as key workers are affected. A recent ILO pilot study of enterprises in South Africa found that fewer than 40 per cent of employers believed they had a good chance of replacing skilled workers. Section 3 below looks in more detail at the impact of HIV/AIDS on enterprises.

(ii) Workers and their families

"The effects of HIV/AIDS on socially reproductive labour … have not been explored and may be more important than some more obviously measurable economic impacts" 8

Whatever affects the individual affects the family, and the impact on many families of HIV/AIDS has been devastating even as they have mobilized their resources and networks to cope with the crisis. But families are also implicated in the transmission of infection: the sexual act and childbirth are both at the heart of the family but also the point of entry for disease. This bitter irony has made people’s response to the sickness of a loved one even more complicated and sensitive than it might have been, and secrecy and denial are used as ways of coping.
In any case, the disease will take its toll. Few symptoms may appear until some years after infection, but the progressive weakening of the body’s immune system makes the individual increasingly vulnerable to opportunistic infections; energy levels fall, as does the ability to concentrate. Workers living with HIV/AIDS need rest and care, with an adapted workload; retirement should be a last resort as longer life expectancy seems to be linked with the continuation of work. They are more likely, however, to find their needs ignored, or to become the target of suspicion and ostracism, or to be dismissed.

As the illness progresses, a worker’s earnings are likely to be reduced and the costs of care increased. Hospital-based care is beyond the reach of most workers: in the United Republic of Tanzania, for example, treatment for the duration of illness amounted to four times the average annual income in 1990 – and this was without specialized drugs. Savings are drawn on, family members needed for care, perhaps taking them away from school or employment, and so a vicious circle is perpetuated. In urban areas of Côte d’Ivoire, where a family member has AIDS, spending on schooling falls by half, food consumption per capita falls by 40 per cent, and spending on health care goes up four times on average. Other studies show families spending the equivalent of a year’s income during the last months of an AIDS patient’s life.

If illness ends in the premature death of a key family member, and in particular the mother, the family and household may literally fall apart. The impact on the family of the father’s sickness or death is severe because he may well be the main income-earner; but that of the mother has even wider implications not only because women are the primary carers in the family, but also because they generally work longer hours both inside and outside the home. In four out of five families living with HIV/AIDS, more than one family member is infected – most often the husband and wife – and carers may themselves be ill. A study of the impact of HIV/AIDS in Monze District in Zambia showed that women have little “elasticity” in their time, so the need to care for sick family members puts great pressure both on the woman and the whole household. A conflict may arise between the different roles and responsibilities of women, and in the end certain tasks are carried out at the expense of others: this leads to a decline in the standard of living of the family.

After the death of their parents children become even more vulnerable: there are increasing numbers of child-headed households and also street children, as orphans who cannot stay in the family home move to towns and cities. The majority are still taken in by other members of family networks – in one town in Monze 80 per cent of households had an orphaned child living with them – but it is clear that for many households there are limits to how far they can expand in this way and survive.

Studies in Uganda have found that, following the death of one or both parents, children’s chances of going to school are halved, and those at school spend less time there. This is because children are now thrown on to their own resources and have to find work in order to survive. They are swelling the numbers of child labourers, but in worse conditions than those who work as part of family units, or even to support their parents. Many have to move away from their roots in order to find work, and may be homeless as well. Children as young as 4 years old have been found on the street and scraping a living as best they can. “AIDS and age will be significant contributors to an increase in crime over the next ten to 20 years … Growing up without parents, and badly supervised by relatives and welfare organizations, [the] growing pool of orphans will be at greater than average risk to engage in criminal activity.” Before AIDS, about 2 per cent of children in developing countries were orphans. Today the proportion of children who have lost one or both
parents to AIDS is 7 per cent in many African countries, and over 10 per cent in some. There are likely to be 40 million African children orphaned by AIDS over the next decade.

<table>
<thead>
<tr>
<th>13th International Conference on Child Abuse and Neglect, Durban, September 2000</th>
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<tr>
<td>A Cape Town children's organization told the Conference that children as young as 4 are being traded for sexual purposes, many of them orphaned by AIDS in South Africa and neighbouring countries. Others – 200,000 by one estimate – are working as farm labourers, often for board and lodging only, from the age of 8. Thousands of children are abandoned as a result of AIDS each year; the UN believes that there could be 5 million AIDS orphans in South Africa by 2010.</td>
</tr>
</tbody>
</table>

(iii) Workers in agriculture

In spite of rapid urbanization in the last quarter of the twentieth century, the rural population of developing countries remains higher than their urban populations, especially in Africa. Farming and other rural occupations provide a livelihood for 70 per cent of the population of sub-Saharan Africa. It has been estimated that ten out of the 13 principal tasks in farming are done mostly by women, and that women produce between 60 and 80 per cent of the food in Africa. The increasing incidence of infection among women, therefore, has particularly serious implications for food security and the health of rural communities, as well as the individual and her family.

HIV/AIDS and rural areas

- The countries most affected by HIV are those most reliant on agriculture and the rural labour force.
- HIV prevalence rates are harder to measure in rural areas but seem to be rising steadily while they are falling in some other sub-populations.
- Assumptions about knowledge of HIV/AIDS may well be overestimates in remoter rural regions.
- The infrastructure is weaker and services are less accessible in rural areas, including information, testing, condom availability, etc.
- Rural communities bear a disproportionate share of the burden of AIDS care as many urban dwellers go back to their villages of origin when they fall ill.

Traditional farming

HIV/AIDS is increasing at a time when African agriculture is facing a number of other crises from desertification to the rising cost of agricultural inputs, often combined with the neglect of the traditional farming sector by governments. FAO states that there is increasing evidence that the pandemic is intensifying existing labour bottlenecks in agriculture; increasing malnutrition; and adding to the burdens on rural women, especially those who head farm households. Reduced food production has already been reported as a result of the labour losses caused by HIV/AIDS. These stem from the direct toll of infection on workers and also the need for some to reallocate their time from farming to the care of sick relatives. The Zimbabwe Farmers’ Union reports a loss of production in maize, cotton, vegetables, and groundnuts – in some cases of over half their normal levels. Studies in the United Republic of Tanzania, Burkina Faso and Côte d’Ivoire also show adverse effects on agriculture.


The impact of HIV/AIDS on smallholders in Zimbabwe

Fifty-three households in Gweru district were asked about their health and ways in which their farming had changed since the advent of AIDS. It was not easy to collect data because of the stigma associated with the disease, but key findings included the following:

- the households had lost a total of Z$486,000, in the 1997-98 season through not cultivating all of their land;
- reasons for the non-cultivation of land included labour shortages due to the death of family members, reduced inputs due to the death of an income earner, lack of draught power and farm implements (sold to cover medical and funeral expenses);
- the number of tasks carried out had to be reduced as a result of labour shortages: cultivated land was partially neglected so yields fell; some cattle died or were stolen when they could no longer be herded properly.16

There are important variations in the prevalence rates among farming communities, even in the same country, and in levels of awareness about HIV/AIDS. These factors are obviously connected, but are also linked to the importance of indigenous religion and traditional practices in a given rural area, and the degree of migration with an urban centre. Another important finding has been the fact that the consequences of HIV/AIDS for the household or village also vary.17 Kinship ties, lineage systems and land ownership are all factors which help determine how badly the economy of a rural household or community may be hit by HIV/AIDS. A middle-aged household, with several grown-up children still at home, copes better than a young one with small children. Wealthier households can hire labour while poorer ones have to sell assets, reduce their farming hours, or switch to less labour-intensive – but possibly also less productive or lucrative – crops. Tasks which yield more benefits in the long term tend to be neglected in favour of more immediate returns. Weeds, pests, and a deterioration of the land may rapidly follow.

Plantations

Commercial farms and estates provide the main exception to the generally lower HIV prevalence rates to date in rural areas. Living conditions on estates vary enormously, as do infection rates – but much work needs to be done on the particular risk factors for workers here. Some estates employ many migrant workers, others are part of the local community; where accommodation is provided it is often overcrowded and unsanitary. Many women work on plantations, sometimes as part of family groups and sometimes in their own right, though the composition of the workforce varies among countries and companies.

A recent study by FAO of two districts in Kenya showed that the country’s commercial agriculture sector is particularly susceptible to HIV/AIDS: high levels of infection were found on many commercial farms; on one sugar estate a quarter of the workforce was infected with HIV and this was not atypical. The industry is facing a social and economic crisis as a result of escalating direct and indirect costs. One of the most serious consequences for workers is that the companies’ response to date has concentrated on reducing these costs rather than planning strategies to control the spread of infection.
(iv) The urban informal sector

There is a danger that the needs and problems of the informal sector will be overlooked as there are no well-placed business leaders there with the capacity to count the costs for their enterprises and put pressure on governments to react. But in Africa’s urban areas, this is where most people work – especially women. Informal activities have permitted the survival of millions who cannot get formal employment – and have become increasingly important as urban populations have grown, and as structural adjustment has cut back jobs in the public sector and led to many price increases, especially in food. Falling wages and rising costs of living have also swollen the numbers of formal sector workers who engage in informal activities on the side. UNDP has pointed out that the informal sector generated nearly ten times more jobs than the formal sector in the course of the 1980s, and that it makes a serious contribution to GDP: “Women’s economic interventions, however small scale and petty they may appear, have in the case of Tanzania proven to be the backbone sustaining entire urban populations in the face of industrial decline.”

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. Many informal workers are traders, often of highly perishable goods such as vegetables. A study of female traders in Owino market in Uganda 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 stock quickly occurs, their small financial reserves are rapidly depleted so that they cannot replace stock, they forfeit their stalls, and their businesses collapse. Sentongo found 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.

(v) Women’s economic vulnerability

This section will concentrate on the ways that women’s livelihoods are affected by HIV/AIDS to their own detriment and that of the community; however at the heart of these issues are 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 – from cutting firewood to tending children, from weeding vegetables to selling snacks by the roadside – is not 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.
Women’s lower status in society and their poorer income-generating possibilities make them more vulnerable to the economic impact of HIV/AIDS. Women are more likely to be in the urban informal sector, in subsistence farming, or in the most poorly paid jobs in the formal sector – this has a number of implications:

- they have little economic security – few savings to draw on during a period of sickness, little income to spend on medicine;

- the jobs most women do have no sick pay or health insurance, no “safety net” which a job in the formal sector might include;

- women have few rights to land or property, so the death of a husband can mean the loss of the means of production, be it farm or small business;

- women often find themselves in positions of weakness and dependence at the workplace which lead easily to sexual harassment. It can be very difficult to say “no” to the boss or the landlord, to the official who can deny you a licence, to the lorry driver who can refuse to transport your goods, to the policeman who can keep moving you on in the street. A survey of 200 women in the United Republic of Tanzania discovered that 90 per cent of them felt that sexual harassment threatened their jobs and economic survival. Once a woman has lost her income, there are not many options left to her – selling sex being one. In fact, many women operate in a grey area that is not quite professional prostitution, but where their economic survival is nevertheless dependent on the favours or protection of male partners.

Other trends which may jeopardize women’s long-term economic security include the increased incidence in some countries of early marriages. On the one hand girls feel that they will be safer with one regular partner, and on the other men feel they will be safer with young girls; sick parents, too, may see early marriage as a way of assuring their daughter’s future. Apart from the fact that for women marriage is more of a risk factor than a means of protection, girls are also sacrificing their chances of education and a better job, and increasing their dependency.

**(vi) Workers at special risk**

Certain groups of workers have come to be seen as particularly susceptible to HIV infection because of particular risk factors in their relationships and environments. Sex workers are the most vulnerable group, with seropositive rates in certain areas of over 80 per cent; some of the earliest studies into HIV transmission and prevalence focused on these workers, and much data is available. It is important, however, not to see sex workers as just another statistic: anyone who is a link in the spread of infection can also be a link in the spread of information and advice for protection; associations of prostitutes are among the many groups organizing themselves to offer both prevention strategies and support systems (and see under “Migrant workers” below).

A number of occupational groups in many different countries show higher than average rates of HIV infection: they include miners, transport workers, security personnel, teachers, health workers, and seasonal workers in agriculture, construction and tourism.
Certain risk factors are common to most of them; these include mobility – from the journeys of long-distance lorry drivers to the temporary migrations of mineworkers – and separation from family. Others are specific to one group, for example the exposure of health personnel to infection by patients or the blood products they handle.

Workers at risk: Security forces

It has long been recognized that war encourages the spread of disease, as fighting displaces people – both civilians and military – causes normal family life and social organization to break down, and compromises health services. But military personnel and police forces are not only at risk from HIV/AIDS in situations of war: training, exercises and peacekeeping take them away from their homes, even out of the country; the power inherent in their military status plays a significant role in their sexual relations, both consensual and not; high levels of sexual intercourse with multiple partners are usually associated with large concentrations of single men. In May 2000, President Obasanjo of Nigeria announced that about 11 per cent of Nigerian soldiers in the UN’s West African peacekeeping force (ECOMOG) were HIV-positive (over twice the adult average), while Cameroon and Zimbabwe have both found military infection rates three to four times higher than in the civilian population.

The risk works in both directions, of course, and civilian populations who interact with the military, especially displaced persons and refugees, also have higher than average infection rates. The civil-military alliance, however, is a partnership between civil and military organizations which has led the way in documenting risk and setting up programmes for care and prevention, both in the armed forces and the communities with which they interact.

Workers at risk: Transport workers

Labour mobility in many forms, from migration to professional driving, is clearly a risk. Lorry drivers and their contacts have been the subject of many studies which have helped the understanding of patterns of both behaviour and transmission. A major truck stop may have ten bars and seven guest houses or hotels; women outnumber men by about 1.5:1. A survey of a group of drivers in East Africa revealed an average infection rate of 33 per cent, and rates among the bar girls and sex workers at the truck stops of between 44 and 88 per cent.

In a private comment to a visitor, the manager of a brewery in Malawi said that he expected all his drivers to die – sooner or later – from AIDS-related infections, because of the combined risk factors of travel and alcohol.

The International Transport Workers' Federation has interviewed lorry drivers in Uganda as part of a wider programme on AIDS and transport workers in Africa. Most of the drivers are from Uganda and Kenya, but also from Rwanda, Burundi and Somalia. Many voiced their growing fear of AIDS as they see more and more workmates dying from the disease. Asked about their problems, they emphasized their long absences from home: 70 per cent of them had spent less than a week at home in the previous four months. They also spoke of their difficult working conditions, including harassment from the authorities, hostility from members of the communities where they stopped, poor health caused by poor pay and working/living conditions – especially problems with sleeping arrangements which encouraged them to turn to alcohol, marijuana and sex. "When certain groups are excluded from community life or victimized, they are driven [to behaviour] which results in the rapid spread of HIV. Without observance of the rights of truckers, no meaningful and effective responses to the control of HIV transmission is possible."
Workers at risk: Health personnel

It is important to be clear about the true nature of the risks to health workers of infection by contaminated blood products or by infected patients. Casual contact is not a risk factor, so working with HIV-positive people is not a dangerous activity. If standard protection and sterilization procedures are followed, almost all risk of HIV infection is also eliminated. But in many cases such procedures are not followed, because the employer has failed to provide full and correct information, equipment, and health and safety structures. In effect, health workers are more at risk from their employers than their patients, and this is where action should be concentrated. In one Zambian hospital deaths among the staff increased 13 times between 1980 and 1990, mainly because of AIDS. In the Kagera region of the United Republic of Tanzania, 55 health workers died of AIDS between 1987 and 1993, such a high proportion that other health workers refused to be posted there.

Discrimination is another risk factor – against infected personnel but also against patients. Wherever the culture is one of blame and victimization, fear and secrecy are encouraged to the detriment of care and prevention programmes.

Apart from risk factors, enormous extra stress is being placed on health workers as a result of the increased demand for HIV-related care, especially for TB which now affects some 40 per cent of all those with HIV.

Migrant workers

The main reason for voluntary migration is economic – people leave their homes because they believe the opportunities will be better somewhere else, or they are driven away by the impossibility of making a living. There are many types of migration, both permanent and temporary. Rural-urban migration, the most common form of migration in many countries and a major factor in urbanization, may be both permanent and temporary. Although Africa’s urban population is relatively low, the rate of urbanization in the 1990s was higher than in any other region. In any case, contacts and movements between the town and the village – as urban dwellers return “home” for visits, or invite other family members to stay – are many and complex. Rural and urban areas are tightly linked and the village remains a retreat for many working in the towns.

Temporary migrants include seasonal workers and men who take up particular labour opportunities, such as mining or construction, where there are poor or non-existent facilities for families – workers may travel to another region or another country, and absences may be prolonged. In some sugar plantations in Uganda, over half the workers are from neighbouring countries. Many mineworkers in Africa are migrant workers and as a group have higher than average infection rates. Approximately 25 per cent of miners in South Africa are living with HIV/AIDS according to the country’s Medical Research Council, which expects this to increase to 30 per cent by 2005. The AIDS Society, however, believes the true figure to be nearer 45 per cent already.

Both permanent and temporary migration are associated with the transmission of HIV, especially where family separation is involved. This is even more true for refugees and other forced migrants; people are six times more likely to contract HIV in a refugee camp than outside. It is also necessary to remember that migrant workers are not only the miners, soldiers or construction workers themselves, but those with services to offer who are attracted to any sizeable community with spending power, especially if most members are single males. A recent study of Carletonville, the centre of South Africa’s gold industry, found that 60 per cent of women under 25 were HIV-positive. At the same time, mining communities have been among the first to develop workplace prevention programmes: the Harmony Company programme in South Africa, supported by the National Union of Miners, has also involved a number of women working as prostitutes to act as links between the local community and medical staff.
3. The impact of HIV/AIDS on enterprises

Just when we’re measurably losing production because our workers are getting sick or just not turning up, our labour costs are rocketing because of AIDS (Manager of fruit-canning factory, Natal Province, South Africa).

The enterprise is at the heart of the economic development of a nation in that it is the means of structuring work and transforming it not only into individual profit and local benefit, but also into national growth. The idea of the enterprise is broadly interpreted here, encompassing farms, workshops, factories, offices and indeed many activities of the informal sector. It is almost inevitable that most of the rather scantly information about the effects of HIV/AIDS on commercial activity comes from larger companies and formal enterprises, but as business people start to count the costs of the pandemic, we see increased advocacy among them both to recognize and to analyse these costs. Even though few enterprises can, or will, give reliable data on the numbers of HIV-infected workers, there are other indicators. Most formal enterprises are in urban areas and rates of infection are likely to reflect those of the community in which they are based; sero-prevalence rates in a number of towns are above 25 per cent, suggesting similar levels of infection in offices, factories and hospitals.

There are perhaps two main reasons why many enterprises have been slow to understand how badly HIV/AIDS is affecting them and to attempt to respond. One is that – especially without a lead from government, and compounded by secrecy and denial – it simply took time to realize that what was happening in one factory was not an isolated problem but part of a wider phenomenon. A recent ILO survey of South African employers shows that not only do many of them underestimate the present levels of infection in their enterprises but they appear to have little understanding that the impact of HIV could worsen rapidly. Second, the costs of HIV/AIDS for enterprises are both direct and indirect – many of the “hidden” costs have only recently become apparent. A useful flow chart appears in The business response to HIV/AIDS: Impact and lessons learned (see figure 1): what is striking is not only how many those costs are, but how they reinforce each other to the detriment of the enterprise’s profitability and potentially its survival.
Figure 1. Impact of HIV/AIDS on a company

(i) Productivity losses

Research at the University of Natal suggests that productivity levels in South Africa could decline by up to 50 per cent in the next five to ten years.

A decline in productivity leads to a decline in profits – possibly manageable in the short term but probably not when associated with a long-term, and worsening, crisis such as the sickness and premature death of workers and managers as a result of HIV/AIDS. Absenteeism was one of the first signs that something was wrong. The increase in absenteeism was the result of employees becoming ill due to HIV, taking time off to care for sick family members, and attendance at funerals. Recent studies of businesses in East Africa show that absenteeism accounts for between a quarter and a half of costs – these stem from the disruption of the production cycle, the underutilization of equipment, and the costs of temporary staff. Both quality control and reliability of supply may suffer: this can lead to the loss of reputation and of customers, and in a worst-case scenario to the inability to remain competitive; a Kenyan sugar estate measured a 50 per cent drop in the amount of sugar processed from the raw cane between 1993 and 1997. It is usually harder for smaller businesses, with less flexibility and fewer reserves, to cope with the consequences of absenteeism.

As the community lived longer with HIV, the infection took its final toll – AIDS soon became the main cause of death among employees, not those nearing retirement but those in the middle of their working lives: the mean age of death among workers in seven
enterprises studied in the United Republic of Tanzania was between 31 and 37 years. And clearly AIDS is no respecter of persons: managers are as affected as the workforce in general; indeed, wealth, status and mobility are clearly risk factors. High rates of morbidity and mortality from HIV/AIDS undermine the organization of an enterprise and thus its productivity through rising turnover of staff, loss of skills and costs of retraining, loss of tacit knowledge, and falling morale among workers. Morale is further affected, and staff lost earlier than they need be, where there is discrimination against workers known or believed to be living with HIV/AIDS.

Business Response emphasizes the consequences of the loss of skills compounded by the loss of tacit knowledge of the working environment:

These losses have become increasingly important with the progressive changes in the way companies are valued; strength of intellectual capital is becoming increasingly important relative to financial capital.

The existence of a pool of unemployed labour is therefore not necessarily a mitigating factor, and a mismatch often occurs between labour requirements and available human resources. In view of these pressures, some companies have already begun to train two or three people for the same position where they fear that key employees may be lost due to AIDS.

(iii) Labour costs

The greater the social benefits provided by the enterprise, from health care to life insurance, the more they are now costing as a result of HIV/AIDS. The less an enterprise provides, the more pressure on individual workers, usually the most poorly paid, to cope privately – through family and community networks; this rebounds on the enterprise through increased absenteeism and perhaps earlier loss of workers than if health care was available.

HIV/AIDS increases costs in a number of ways:

- **Insurance cover**: Premiums on life and health insurance are already rising as the risks of large and early pay-outs increase – in Zimbabwe, life insurance premiums quadrupled over a two-year period.

- **Health care**: Where medical services are provided, these direct costs are rising rapidly. A flower farm in Kenya experienced a tenfold rise in health costs for employees between 1985 and 1995: profits were so badly affected that the owners sold the company. Some companies extend medical services to employees’ dependants and these have been particularly badly hit. The INDENI Petroleum Refinery in Ching’amo, Zambia, found that by 1991 it was already paying out more for medical services than it was making in profits; in addition, the company was paying salaries to the relatives of sick workers and funeral grants. A sugar estate in Kenya experienced a tenfold increase in health costs (1995-97) and a fivefold increase in spending on funerals.
– **Funeral costs**: These are increasing massively, especially in companies that provide funeral costs, because they are compounded by the absenteeism of employees: an agricultural extension worker in Zimbabwe estimated that funerals took up three days a month, or 10 per cent of his working time. Costs may be even higher in some countries than others where, as in Uganda, custom dictates that people should be buried in the village of their origin. Community-based savings and insurance groups, such as the iddir in Ethiopia which save for funeral expenses, are also facing financial collapse due to the increase in AIDS-related deaths.

– **Recruitment, training and retraining**: The matching of skills to labour needs is a complex process which can only become longer and more expensive as the turnover of staff increases in an enterprise. Coping with the situation may not simply involve replacing missing workers but the reorganization of production, the restructuring of tasks and skills needs, the monitoring of human resources, and training or retraining new or existing personnel. Related costs may include the need to invest in new or different machinery or equipment, and the possibility that more highly skilled workers will seek higher wages.

(iii) **Employment security and the costs of discrimination**

It needs to be repeated again (and again) that discrimination against those known or believed to be HIV-positive is not only an assault on the rights of those concerned, and the community at large, but also encourages the spread of HIV/AIDS and worsens its impact:

– individuals who deny they are or may be HIV-positive, for fear of the consequences, are more difficult to help and support, worsening the burden on themselves and their families;

– they are unavailable to help with awareness-raising, whereas people living with HIV/AIDS have been shown to be particularly effective educators and agents of behaviour change;

– people whose civil and human rights are not respected become marginalized and more vulnerable to infection;

– denial and secrecy mask the extent of infection locally and nationally, and make it harder to plan an effective response.

Discrimination in the world of work has become a major issue of the pandemic. Surveys of four countries by the ILO in the mid-1990s – Rwanda, United Republic of Tanzania, Uganda and Zambia – showed that while official national and workplace polices protected employment security and opposed discrimination, the reality was very different. Covert screening of job applicants for HIV regularly took place, disguised as a routine medical examination: in Zambia 15 out of 18 companies surveyed used this method to keep out people living with HIV/AIDS. It was no more difficult to get rid of existing employees, usually on the pretext of restructuring and rationalization. To date little research has been gender-sensitive, but it is important to make sure that further analysis of
AIDS-related discrimination takes into account differences in how men and women are treated.

The importance given to workers’ rights by the ILO is not simply a matter of principle but of sound practice: it is at the heart of poverty alleviation, of enterprise development and of economic growth. There are well-established international standards which affirm the rights of workers to confidentiality, to protection against unfair dismissal, and to freedom from discrimination on a range of grounds. Fundamental principles are embodied, in particular, in the Discrimination (Employment and Occupation) Convention, 1958 (No. 111). Also relevant in the context of HIV/AIDS are the Occupational Safety and Health Convention, 1981 (No. 155), and the Vocational Rehabilitation and Employment (Disabled Persons) Convention, 1983 (No. 159). These principles apply whatever the specifics of the situation – the fact that AIDS is a crisis does not exempt employers or any institution or individual from respecting them.

While employees can use general anti-discrimination legislation for their protection, employers have the right to guidance and legal provisions in the new circumstances created by HIV/AIDS. The social partners in many countries are calling for an expansion of ILO instruments to cover HIV/AIDS, but meanwhile it is essential that enterprises should not be left to cope alone with the consequences of escalating infections among the workforce. Policy reactions in terms of workplace practice have been slow to emerge: only 30 countries have addressed policy considerations in the world of work, either through specific laws or the adaptation of existing legislation. Employers needed to be supported, and workplace AIDS programmes given a sound basis, through the creation of a national framework of legal requirements and workplace guidelines. In this way employers can be quite clear about the real costs and risks of HIV/AIDS, the best ways of preventing its spread, and the inalienable rights of their workers. The growing willingness of leaders, including many in the business community, to be open about HIV/AIDS has led to persuasive advocacy on the part of employers, particularly addressed to their peers. Many are now convinced that care and prevention strategies will cost them much less in the longer term than doing nothing and so encouraging infections.

If you lose someone you've trained for 20 years, that's a great loss. Condoms and AIDS education cost peanuts (Kenyan company manager).33

It was this rationale, as well as humanitarian concern, which led the Ford Motor Company to set up a comprehensive programme in its three plants in South Africa; this includes both prevention – from education to condom distribution – and medical and support facilities. The company is now extending its reach into the local community – taking AIDS information into 40 primary schools, for example. The company stresses that the programme is based on “zero tolerance” of discrimination and believes that prevailing attitudes of blame and denial are already changing.34
Discriminatory practices inevitably lead to tensions between employers and workers, manifest perhaps in resentment and lower morale or outright conflict, but in any case reducing the smooth running of the enterprise and potentially jeopardizing productivity. The ILO has the concept of social protection at the core of its work because it is clear that both workers and employers have more to gain from cooperation than conflict. If this is true for the general run of business, it can only be more true in the face of crisis. The continued functioning of enterprises is clearly in the interest of both partners, as falling profitability threatens in the first instance the social benefits which may be available and, in the longer run, jobs. Trade unions, therefore, are a vital element in the advocacy directed towards enterprises as they can use collective bargaining mechanisms to introduce concerns about the effects of HIV/AIDS. Some of the most effective workplace programmes have been the joint creation of employers and workers: one example is the Botswana Taskforce on HIV/AIDS at the workplace. Trade unions also share responsibility with the employer to counter the discrimination and stigmatization that can sadly occur between colleagues.

4. The impact of HIV/AIDS on governments: Macroeconomic effects and the implications for labour

This Forum is rightly focusing on leadership across the spectrum, but faced with a national crisis, national governments are in the front line. They can harness the efforts of civil society but need both to give a lead and to accept final responsibility.
Africa achieved notable progress in the decades following independence – literacy rates rose, life expectancy increased, infant mortality fell in all countries, but the precariousness of those gains and the vulnerability of Africans to disaster has been revealed and worsened: by the debt crisis, by wars and poor governance, by climatic change – and by HIV/AIDS. Thirty-three of the world’s poorest countries are in Africa; Africa’s trade gap has widened more and faster than any other; Africa is the only continent where food production per capita fell during the 1960s and 1970s when globally it grew. This economic weakness, and the structural adjustment programmes which targeted public spending, left the health and social services of many countries in a weakened position just as they needed all their resources to respond to the challenge of the new epidemic.

The impact on governments and nations has many strands that are extremely difficult to identify separately and untangle. As a human tragedy and health problem, HIV/AIDS was already a challenge in its earliest days: early goals included the need to mobilize ministries of health, investigate transmission routes, and provide both information and reassurance. But before even such a limited response was truly in place, it became clear that the reach of the pandemic, especially at its epicentre in Africa, was both wider and deeper. As the national budget-holder, provider of key services, and policy-maker, governments now find that the consequences of the epidemic are affecting every sector of responsibility.

(i) Slowing economic growth

Until recently it was widely believed that AIDS would not have a macroeconomic impact, whatever its effects on local areas or specific sectors. The World Bank and others, however, are now suggesting that this impact may be significant enough to slow the growth of national income in countries where prevalence rates are above 5 per cent, and to cause negative growth in the worst affected. Studies in Cameroon, Kenya, Swaziland, United Republic of Tanzania and Zambia have found that GDP may be reduced by as much as 25 per cent over 20 years. A recent report by the Botswana Institute for Development Policy Analysis estimates that Botswana’s economy will be nearly a third smaller in ten years time than if it had not been affected by AIDS.33

The projections are based on so many variables – both epidemiological and economic – that it is necessary to take the figures as indicative of a problem that needs investigation rather than absolutes. But they are far from improbable, as the economic pressures stemming from HIV-related sickness and deaths accumulate:

- reduced earnings, savings, disposable income, investment and market demand;

- disincentive to foreign investment;

- lower government revenues from individuals and enterprises;

- increased health care and social security costs;
- productivity and production losses due to absenteeism, staff turnover and reduced levels of skills;

- a declining human capital as experienced workers are lost, teachers die and children leave school.

(ii) **Pressure on public spending**

The macroeconomic impact of HIV/AIDS is the result of lost revenues combined with increased costs for government. Two key costs are health services and social security.

Health services

The health sector has obviously been under pressure since HIV was first identified. In order to understand the financial burden of the medical response it is worth noting that, apart from the actual care of the sick, health service responsibilities have included: epidemiological and behavioural surveillance; blood safety; voluntary counselling and testing; vaccine development; and the planning and management of initial prevention responses. The tidal wave of need for care quickly stretched under-funded and inadequate services beyond their limits in terms of personnel, hospital beds, medicine and funds.

By the mid-1990s HIV treatment was already consuming 66 per cent of health spending in Rwanda and over a quarter in Zimbabwe; the figures are expected to rise to 70 per cent in Zimbabwe by 2005, and to reach 60 per cent in Kenya. In seven of 16 African countries where total health spending is in the range of 3 per cent to 5 per cent of GDP, it was found in 1997 that spending for AIDS alone exceeded 2 per cent of GDP. Over recent years HIV-positive patients have occupied over 70 per cent of beds at the Prince Regent Hospital in Bujumbura, Burundi. The dangers of personnel shortfalls have been mentioned but few countries appear to be monitoring the situation. As the demand for HIV-related care increases, patients with other conditions may be admitted later or not treated. Other infections may spread more easily: the World Bank estimates that 25 per cent of people without HIV who die of tuberculosis would not have been infected in the absence of the HIV epidemic.

Social security

Social security is a goal for many countries but one that is far from being achieved. Some formal sector employment such as government service or jobs in large, possibly foreign, companies may include sickness benefits and pensions, but the great majority of the workforce in Africa is not covered by any form of medical let alone unemployment insurance. Efforts to achieve social protection for workers have been set back by the increased demands on the system caused by HIV/AIDS. The other side of the social security picture is investment: life insurance and pension funds are important sources of capital for the government as well as the private sector. A reduction in contributions, and an increase in payments – both inevitable consequences of HIV/AIDS – will result in a reduced supply of capital to invest.
Social protection – including occupational safety and health, income protection and the development of social security systems – is one of the ILO’s core responsibilities and the Organization is now working on adapting both its methodology and its programmes in this sector to the new demands caused by HIV/AIDS.

(iii) The threat to development targets

There is no other single factor in the world today that so systematically undermines the gains of decades of investment in human resources, education, health, and the well-being of nations (Peter Piot, Executive-Director, UNAIDS).

In that HIV/AIDS impacts on all areas of social and economic development – from the capacity of the household to provide for the needs of its members to the capacity of governments to protect the rights of their people to health, education and income security – it is clear that it also puts back hopes in many countries of achieving international development targets.

Child mortality

Targets for a two-thirds reduction in child deaths have been severely compromised by HIV/AIDS because of mother-child transmission of the virus: downward trends in child mortality in several countries began to be reversed in the mid-1980s. Half a million children may have died already in Africa, and another million are living with HIV/AIDS; the gap between infection and death is generally shorter in children than in adults.

Education

The achievement of free and universal primary education on the continent by 2015 is also unlikely, in part as a result of HIV/AIDS. Education is increasingly recognized as a key to development but it is emerging as a sector at particular risk from the epidemic. On
the one hand, high levels of infection are being found among teachers: between 40 per cent and 50 per cent in some countries. Six teachers died every week in Côte d’Ivoire between 1996 and 1998; 1,300 teachers died in Zambia in the first ten months of 1998, two-thirds of the number trained each year.37 The Central African Republic has a third fewer primary schoolteachers than it needs; 107 schools have closed due to staff shortages and only 66 are still open. Almost as many teachers died as retired between 1996 and 1998; their deaths were an average of ten years earlier than the minimum retirement age of 52.38 On the other hand, children are also being deprived of their right to be educated when their families take them out of school as a way of coping with AIDS in the household. This may be to save money, as school fees have been widely introduced as part of structural adjustment, or it may be that their labour is needed – to help look after sick family members or to take over their tasks. Once orphaned, children’s chances of staying in school fall still further. In a study of commercial farms in Zimbabwe, half the orphans interviewed had dropped out of school, usually at the time of a parent’s illness or death; no orphans of secondary-school age were still at school.

Gender equality

Increasing women’s opportunities through education is being undermined by the fact that when children are taken out of school they are more likely to be girls: the value of their daughters’ labour is often greater than the benefits the family may expect from educating them, and they are more likely than boys to be involved in caring for the sick. HIV/AIDS puts many other pressures on women which increase their workload but not their status, from the expectation that they will care for the sick to the fact that many lose their homes and livelihoods when male family members die.

Poverty reduction

Most of the sections above have already outlined a range of pressures which reduce the capacity of individuals, enterprises and governments to improve earning capacity and economic security while HIV/AIDS is still a major factor.

(iv) Managing the crisis

Planning a policy response to HIV/AIDS is still a challenge of daunting complexity, in part because so little is still known or understood of the knock-on effects of the epidemic throughout society. Tony Barnett points out that analysis of the impact of the epidemic has been led by demographers and economists, so other models are needed in order to get a fuller picture.39 There is speculation, for example, that the increasing numbers of AIDS orphans, many without the support of family or schooling, may be a threat to social stability. Barnett and Whiteside write about generations of young people “untutored and uncared for” in some localities, with serious implications for the State, civil society and development.40 There is anxiety about the worsening dependency ratio as the active population is reduced: small numbers of young adults will have to support large numbers of young and old; the local situation, in particular villages and urban districts, is already very bad. There is uncertainty about how enterprises will manage, not just to compensate for the loss of skills and experience, but to grow and expand. There is pressure on the very individuals who are mobilizing to combat AIDS – in government departments and in NGOs and in trade unions – because they are dying too.
Part II. The role of the ILO in meeting the development challenges of HIV/AIDS in Africa

1. Decent work and development objectives

“At the beginning of the 1990s I travelled widely preparing ... the World Summit for Social Development. In multiple dialogues ... I enquired as to the country's principal social problems; in different formulations ... the answer was crisp and targeted: poverty and social exclusion. When I asked what was the solution, the answer was simple: jobs” (Juan Somavia, Director-General of the ILO).

From an ILO perspective, the main development challenge facing African countries today is:

… to promote opportunities for women and men to obtain decent and productive work, in conditions of freedom, equity, security and human dignity.

This overriding goal of the ILO encompasses key development targets and reaffirms the Organization’s focus and commitment to the reduction of poverty and greater social integration on the continent.

The underlying concept of decent work, which is at the heart of the ILO’s development agenda, advocates the provision of economic security and social protection to all workers and their families as a central objective of national and international development policies. The concept also advocates gender equality, based on the principles of equity and equality at work and the household level. Furthermore, in an increasingly globalized world, an immediate concern of the ILO’s decent work agenda is to provide “a social floor for the global economy” which emphasizes basic rights at work and a worldwide acceptance of the inviolability of those rights.

The ILO’s development agenda as summarized above is an integrated approach which links rights at work and social dialogue with employment policies and social protection: these represent the four strategic objectives of the ILO for putting decent work into practice.

The HIV/AIDS pandemic and its impact on the world of work in Africa is a major threat and barrier toward fulfilling the objectives of the ILO decent work development agenda.
2. The ILO as a partner in the fight against HIV/AIDS

(i) Applying ILO principles to the challenge of AIDS

The ILO’s decent work development agenda and its four strategic objectives provide the basis for a coherent and focused policy related to HIV/AIDS. It will ensure that the ILO’s specific mission always provides the framework for action – ensuring its appropriateness, and that it builds on its specific strengths and expertise – ensuring its effectiveness. Each strategic objective will drive a key aspect of the ILO’s response:

- **Fundamental principles and rights at work**: Provides the ethical and legal framework to guide workplace policies and programmes, and to protect the rights of workers – especially those infected or believed to be infected against discrimination.

- **Employment and income opportunities**: Protects employment as well as employees through education and prevention programmes at the workplace, and counselling and support for people living with HIV/AIDS – this support would include skills development and assistance with finding or making new income opportunities where necessary.

- **Social protection**: Provides the policy framework to plan for the social and economic consequences of AIDS and to mitigate the impact on individuals and communities.

- **Social dialogue and tripartism**: Provides both a methodology for negotiation and networks of contacts among the social partners which can be mobilized.

(ii) Identifying the ILO’s comparative advantage to make a difference in combating HIV/AIDS

What are the particular strengths of the ILO that could be most usefully harnessed to reduce the spread and effects of AIDS? The process of identifying these has established the basis for the ILO’s global programme on HIV/AIDS and the world of work.

- **Tripartite structure**: Making possible the mobilization of the three social partners, giving access to their extensive networks of influence and communication, and using social dialogue as a tool for negotiation around AIDS.

- **Direct access to the world of work**: Where most people spend most of their day and where structures often exist for information-sharing and education, standard setting, and the support of behaviour change.

- **International labour standards**: Nearly a century of experience in framing laws and standards to protect the rights of workers and combat discrimination.
– Technical cooperation: A well-established record of technical cooperation, with particular expertise in education and training and provision of advisory services to governments and the social partners. This encompasses substantial specialist expertise in many relevant sectors, from safety and health at work to social security.

– Knowledge management: Substantial experience and resources in research and information dissemination.

– Global network: Regional and national offices across the world, now strengthened by subregional multidisciplinary technical teams.

(iii) The way forward: The ILO Global Programme on HIV/AIDS and the World of Work

Initiatives already undertaken by the ILO to mobilize the social partners into action in Africa included a Regional Tripartite Workshop on the Labour and Social Implications of HIV/AIDS (Windhoek, Namibia, October 1999) which drafted a Platform of action. The draft Platform of action on HIV/AIDS in the context of the world of work in Africa (see Appendix I) was unanimously approved by African Ministers of Labour and their social partners at the Ninth ILO African Regional Meeting (Abidjan, Côte d'Ivoire, December 1999). ILO has also collaborated with and participated in meetings of regional organizations of employers and workers in Africa on action against HIV/AIDS in the workplace: the OATUU Seminar on Trade Union Action against HIV/AIDS in Africa (Accra, July 2000); the ICFTU-AFRO Pan-African Conference on HIV/AIDS (Gaborone, September 2000); and a subregional workshop for employers’ organizations organized by the African Employers’ Confederation (Douala, November 2000).

These activities culminated in an urgent request to the ILO to play a fuller role in national and international partnerships against HIV/AIDS. In June 2000 the International Labour Conference included a Special High-Level Meeting on HIV/AIDS at the Workplace: the high point of this Meeting was the keynote address by the President of Namibia, H.E. Sam Nujoma, and a vivid and moving testimony by an HIV/AIDS victim from South Africa. A cooperation agreement was also signed between the ILO and UNAIDS.

The Conference adopted a resolution on HIV/AIDS and the world of work (see Appendix II) which, among other things, instructed the ILO Director-General to create a capacity within the ILO to deal with HIV/AIDS at the workplace and to strengthen the capacity of the social partners to formulate and effectively implement appropriate policies, programmes and activities at national and enterprise level. In response to this resolution the ILO has now established a Global Programme on HIV/AIDS and the World of Work. The new ILO global programme was endorsed by the ILO’s Governing Body in November 2000, and the programme is now an integral part of ILO policy. The main priorities for action within the framework of the programme are outlined below.

The process of ILO’s involvement in the global struggle against HIV/AIDS has been guided throughout by three imperatives which the ILO believes has resulted in a programme which, on the one hand, is directly relevant to its mandate and, on the other, is focused and viable: (i) to root its HIV/AIDS policy in its fundamental principles; (ii) to
concentrate action where it has a comparative advantage; and (iii) to decide on priorities and activities through active consultation with those most involved in implementation.

The five pillars of ILO’s Global Programme on HIV/AIDS and the World of Work

- To improve knowledge and understanding of the economic, labour force and social consequences of HIV/AIDS.
- To pursue advocacy at all levels and to raise awareness of the urgency of the socio-economic impact of HIV/AIDS and its implications for workers’ rights and enterprises.
- To set standards and frame laws that guide national action programmes against HIV/AIDS, which include the world of work components, and oppose discrimination.
- To strengthen the capacity of employers’ and workers’ organizations, and mobilize their contacts and resources, for education and prevention, counselling and support, and action against discrimination.
- To apply the specialist expertise of the ILO’s sectoral and technical cooperation programmes to particular workplace needs, especially in training, social security, and safety and health at work.

Conclusion

HIV/AIDS is no longer just a health issue; it is a development issue with wide-ranging and complex economic, social and cultural implications. Efforts to contain and reduce the impact of HIV/AIDS are made harder by the knowledge that fighting against AIDS is not the same as fighting for development – it is defensive, reactive, a rearguard action, not the sort of pioneering action the ILO was set up to promote. But unless we tackle it with the full range of resources at our disposal, development efforts, community initiatives and technical assistance will be constantly set back by the depredations of the disease. It is also possible that a truly cooperative effort by the multilateral system – if we can “stop behaving like independent actors” as the Director-General put it – could enable the response in terms of global efforts to get ahead of the problem, and bring about a real change in the rate and pattern of HIV infections in Africa and elsewhere.

Leadership is sorely needed at this decisive moment: a renewal of commitment and energy is being made to the struggle against HIV/AIDS, but this may be the last chance to get it right. Political leadership is needed in countries so that programmes are put in place which connect with people’s needs and fears, and make action more effective. Leadership is needed in terms of international advocacy to support national commitment, to counter denial where it continues, and to mobilize other vital players such as the pharmaceutical companies who now have a real role to play even in the poorest countries. Community leadership is needed to open up discussion, to reduce the stigma of the disease, and to initiate strategies that reach the people.

Above all, at this time what is needed is sensitive leadership which takes its strength and validity from consultation, indeed partnership, with the affected communities. It is increasingly acknowledged that “the success of most HIV programmes depends on the quality of the interpersonal interface into which they are embedded: … telling or forcing others to act in certain ways, even if done for their benefit, strips them of a sense of agency and rarely leads to change … The resource most needed for an effective response is people willing to … work supportively in partnership with others on all aspects of the epidemic”.

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Because leadership is needed at all levels, the ILO is responding at all levels. It is giving its political support to international advocacy in two key spheres: first, it is using its political weight and special contacts in cooperation with UNAIDS to persuade member States, where necessary, of the need for a multisectoral AIDS programme which includes workplace components supported by the highest level of political commitment and openness. The ILO is in the unique position of being able to mobilize the leadership potential of the other social partners, namely employers and trade unions, each of whom is in a position of trust and influence in the community. Not only are they in the position to run programmes in that most key of locations, the workplace, but they can serve as role models, a source of peer pressure and support systems for the infected; secondly, on the international stage, it is working with key players – in particular donors and pharmaceutical companies – to persuade them of the escalating socio-economic impact of HIV and the urgent need for support in poorer countries, both in terms of funding and the provision of affordable drugs. At the same time, the ILO recognizes the need for the international response not only to connect with communities but to be guided by them. The ILO therefore fully endorses the decision of the United Nations General Assembly to convene a special session of the Assembly in June 2001 to review the problems of HIV/AIDS in all its aspects including effects on human development. The ILO is committed to being an active participant in the process leading up to the special session and at the session itself.

Notes


5 Worldwatch Institute.


19 C. Sentongo, quoted in EAMAT 1, 1995.

20 H. Kasungu, quoted in EAMAT 1, 1995.


28 op. cit.


31 UNAIDS fact sheets.


33 UNAIDS fact sheets.


38 UNAIDS Best Practice Digest, UNAIDS Website.


40 ibid.


Short list of useful reading

**ILO publications**


*Your health and safety at work*, ILO, 1996 (also CD-ROM, 1997).


UNAIDS publications


*Guidelines for studies of the social and economic impact of HIV/AIDS, Tony Barnett and Alan Whiteside, UNAIDS, 2000.*


*Sustainable agricultural/rural development and vulnerability to the AIDS epidemic, Daphne Topouzis and Jacques du Guerny, FAO/UNAIDS Best Practice Collection, 1999.*


Other sources


*Guidelines for developing a workplace policy and programme on HIV/AIDS and STDs, South African Department of Health, 1997.*


Appendix I

Platform of action on HIV/AIDS in the context of the world of work in Africa

I. Preamble

AIDS threatens every man, woman and child in Africa today. The pandemic is the most serious social, labour and humanitarian challenge of our time. Since its start two decades ago, AIDS and HIV have taken a catastrophic toll in Africa, decimating its population, tearing apart the very social fabric of its societies and threatening its economies. Its toll of debilitating illness, widespread and indiscriminate death, deteriorating quality of life and life expectancy, threatens to reverse the hard-won social and economic gains of African countries and, ultimately, the very future of the continent.

AIDS is rapidly becoming the single most serious threat to social and economic progress in Africa today. The true cost of the pandemic is almost incalculable. Its impact is aggravated by the overall economic, political and social context, as well as some cultural practices, dominated by a weak economic base, high unemployment, pervasive poverty, and the negative consequences of structural adjustment, all of which further undermine Africa's ability to compete in the global market.

The pandemic has manifested itself in the world of work – the area of the ILO’s mandate – in the following ways: discrimination in employment, social exclusion of persons living with HIV/AIDS (PLWHA), additional distortion of gender inequalities, increased numbers of AIDS orphans, and increased incidence of child labour. It has also disrupted the performance of the informal sector and small and medium enterprises (SMEs). Other manifestations are low productivity, depleted human capital, challenged social security systems and threatened occupational safety and health, especially among certain groups at risk such as migrant workers and their communities and workers in the medical and transport sectors.

Clearly, AIDS is no longer just a health problem. It is a developmental crisis with potentially ominous consequences for Africa and the world. Yet, a culture of silence, fear and denial continues to reign and prevent action. The stigma and the fear engendered by AIDS fuels discrimination, persecution and ignorance. Despite this, the spread of AIDS can be prevented. A multidimensional response to AIDS is needed to prevent its spread and protect those who live with its consequences. In the absence of a cure, what is needed is a “social vaccine” that includes such elements as social inclusion, income and job security, social security and solidarity.

In search of awareness, action and commitment, participants from 20 African countries, meeting in Windhoek from 11 to 13 October 1999, in tripartite delegations, adopted the following Platform of action to respond to this crisis at workplace, community, national, regional and international levels.

The meeting called upon all African governments to declare HIV/AIDS a national disaster requiring urgent attention and mobilization of resources.
II. Common values

It was agreed that the following would form a set of overall principles, which should guide the formulation of policies and programmes:

1. Tripartism, allied with civil society, NGOs and other stakeholders.

2. Social justice and compassion for people living with HIV/AIDS (PLWHA).

3. A sense of shared responsibility among all actors.

4. Good governance, transparency and accountability for results.

5. Partnerships among international and national agencies to complement one another on the basis of comparative advantage.

III. Goals

It was agreed that, while awaiting a medical vaccine, the aim should be to apply a “social vaccine” for prevention and protection which would include elements such as: social inclusion, income and job security, social security, solidarity and optimal use of treatment.

IV. Actions

In order to achieve these goals, action backed by strong African political, religious, traditional and community leadership and commitment should focus on:

1. Fighting the culture of denial.

2. Raising national awareness of the incidence and impact of the pandemic through, among other things, information, education and communication.

3. Eliminating the stigma and discrimination attached to HIV/AIDS by adopting and applying the ILO’s international labour standards and national labour legislation.

4. Documenting and disseminating information and statistical data through effective labour market information systems.

5. Strengthening the capacity of the social partners to address the pandemic.

6. Empowering women economically, socially and politically in order to reduce their vulnerability to HIV/AIDS.
7. Promoting the transformation of gender roles, norms and social structures.

8. Integrating HIV/AIDS in existing social security schemes and developing new ones to ensure coverage for all.

9. Building capacity to address the dilemma facing AIDS orphans and children exposed to infection or forced into child labour.

10. Incorporating HIV/AIDS considerations into the national development agenda and budget allocations.

11. Creating a rapid response mechanism to mitigate against the implications of the pandemic.

12. Promoting income and employment opportunities for PLWHA and their families through, for example, informal sector and small enterprise development.

13. Strengthening occupational safety and health systems to protect groups at risk.

14. Formulating and implementing social and labour policies and programmes that mitigate the effect of AIDS.

15. Effectively mobilizing resources.

16. Improving availability and affordability of drugs.


V. **Partnerships**

In order to mount an effective response to the HIV/AIDS crisis and address its many-faceted implications, national level partnerships should be built rapidly among all the key actors: governments, employers’ and workers’ organizations, NGOs and other civil society groups, including religious and traditional leaders. Partnerships should also be forged among and with bilateral and multilateral agencies, as well as regional organizations and United Nations agencies through among others, joint planning, collection, dissemination and exchange of information on good practice and ensuring synergy in programmes.

VI. **Role of the ILO**

The ILO should strengthen its activities in fighting HIV/AIDS in the region through improved knowledge, vigorous advocacy and expanded services. The ILO tripartite structure provides a unique mechanism for intensifying the response to HIV/AIDS.
1. In order to avoid duplication of efforts, the ILO should collaborate with concerned international organizations, participate in the decision-making process regarding HIV/AIDS at the global level and consider becoming a co-sponsor of UNAIDS.

2. The ILO should adapt and apply concepts, methods and tools it has developed on labour and social issues for responding to the design of research and programmes on HIV/AIDS.

3. The ILO should expand its capacity to deal with HIV/AIDS, especially in its multidisciplinary teams, through, for example, training, resource mobilization and secondment of experts from UNAIDS.

4. The ILO should undertake research and surveys to determine the implications of HIV/AIDS for the world of work, including its effects on the growth of the labour force and participation rates, women, child labour, union membership, productivity and competitiveness, informal sector and small enterprise development.

5. The ILO should document and disseminate through all appropriate means information on national experiences including best practices.

6. The ILO should engage in advocacy and training on HIV/AIDS and the world of work targeting the political leadership, workers’ and employers’ organizations and civil society.

7. The ILO should include HIV/AIDS in its regional meetings and consider organizing a special session on the subject at the International Labour Conference.

8. The ILO should integrate HIV/AIDS issues and gender components in all its programmes and technical cooperation projects in the region.

9. The ILO should develop a policy, programme and structure to address the issue of HIV/AIDS and the world of work.

10. The ILO should strengthen the capacity of its social partners to formulate and effectively implement policies, programmes and activities at the national and enterprise levels.

11. The ILO should consider submitting this draft Platform of action on HIV/AIDS in Africa to the Ninth African Regional Meeting (Abidjan, 8-11 December 1999) for its consideration and formal adoption.

VII. A call for immediate action

Action against HIV/AIDS is primarily a national responsibility. The enormity and exceptional nature of the problem require exceptional measures. Member States are therefore urged to adopt and implement this Platform of action on an urgent, immediate and continuous basis.

Abidjan, 11 December 1999
Appendix II

Resolution concerning HIV/AIDS and the world of work

The General Conference of the International Labour Organization,

Recalling that HIV/AIDS is at present a universal pandemic that threatens all people, but also recognizing that it disproportionately impacts on economically and socially disadvantaged and excluded groups,

Recognizing that HIV/AIDS is a growing health problem, as well as a developmental crisis with disastrous consequences for the social and economic progress of many countries,

Noting with deep concern that, of the nearly 34 million people worldwide currently living with HIV/AIDS, 95 per cent are in the developing countries; that in African countries development gains of the past 50 years, including the increase in child survival and in life expectancy, are being reversed by the HIV/AIDS epidemic, and that HIV infection is increasing rapidly in Asia, particularly in South and South-East Asia, and in the Caribbean, and that it threatens the political, economic and social sustainability of these regions, while recognizing that in the rest of the world a complacent attitude cannot be adopted and efforts on prevention reduced,

Recognizing the effects of HIV/AIDS on the world of work: discrimination in employment, social exclusion of persons living with HIV/AIDS, additional distortion of gender inequalities, increased number of AIDS orphans, increased incidence of child labour, and the retention of older persons in the labour force,

Recognizing that HIV/AIDS threatens decent work in an all-embracing manner, and noting that HIV/AIDS has adversely impacted on economic growth and employment in all sectors of the economy, depleted human resources, challenged social security and health systems, and threatened occupational health and safety systems,

Recognizing that the spread of AIDS can be prevented, including through actions at the level of the workplace, and that it is possible, by a multidimensional, integrated, sustained and coordinated international response, to prevent its spread and protect those who live with it and its consequences, including the families and communities affected,

Noting that a number of important initiatives have already been undertaken, including those by the United Nations organs and specialized agencies,

Recognizing that the non-availability and limited access to HIV/AIDS-related drugs and treatments at affordable costs in developing countries also has further accentuated the spread of the disease in those countries,

Recalling the adoption by the International Labour Conference of relevant and related instruments, including the Discrimination (Employment and Occupation) Convention, 1958 (No. 111), the Vocational Rehabilitation and Employment (Disabled Persons) Convention, 1983 (No. 159), the Occupational Safety and Health Convention, 1981 (No. 155), and the Occupational Health Services Convention, 1985 (No. 161),
Also recalling the adoption by the International Labour Conference of the Declaration on Fundamental Principles and Rights at Work, in 1998,

Noting the effect of some structural adjustment programmes on public health structures and services, education and social protection systems,

Recognizing the enormous potential of employers’ and workers’ organizations, in partnership with governments, to contribute to the fight against the spread of HIV/AIDS and to support the needs of workers living with HIV/AIDS;

1. Calls upon the governments of member States and, where applicable, employers’ and workers’ organizations to:

(a) raise national awareness, including by involving other concerned groups as appropriate, particularly of the world of work, with a view to eliminating the stigma and discrimination attached to HIV/AIDS, as well as to fight the culture of denial, and thereby preventing the spread of HIV/AIDS;

(b) strengthen the capacity of the social partners to address the pandemic;

(c) strengthen occupational safety and health systems to protect groups at risk;

(d) formulate and implement social and labour policies and programmes that mitigate the effects of AIDS;

(e) effectively mobilize resources.

2. Requests the Governing Body of the International Labour Office to instruct the Director-General to:

(a) continue and intensify, where appropriate, research on action to be taken and behaviours to be adopted in dealing with HIV/AIDS at the workplace;

(b) present, within the framework of the discussion of the Programme and Budget for 2002-03, a proposal regarding a meeting of experts which will develop international guidelines on action to be taken and behaviour to adopt on HIV/AIDS at the workplace;

(c) collaborate with concerned international organizations in order to avoid duplication of efforts;

(d) expand its capacity to deal with HIV/AIDS at the workplace, especially in its multidisciplinary teams;

(e) undertake research and surveys to determine the implications of HIV/AIDS for the world of work;
(f) document and disseminate all useful information on national experiences including examples of good practices on HIV/AIDS at the workplace;

(g) engage in advocacy and training on HIV/AIDS and the world of work;

(h) strengthen the capacity of the social partners to formulate and effectively implement policies, programmes and activities at the national and enterprise levels.

Geneva, 14 June 2000