

International Labour Conference, 98th Session, 2009

Report IV(1)

HIV/AIDS and the world of work

Fourth item on the agenda

International Labour Office Geneva

ISBN 978-92-2-120640-8
ISSN 0074-6681

First edition 2008

The designations employed in ILO publications, which are in conformity with United Nations practice, and the presentation of material therein do not imply the expression of any opinion whatsoever on the part of the International Labour Office concerning the legal status of any country, area or territory or of its authorities, or concerning the delimitation of its frontiers.

Reference to names of firms and commercial products and processes does not imply their endorsement by the International Labour Office, and any failure to mention a particular firm, commercial product or process is not a sign of disapproval.

ILO publications can be obtained through major booksellers or ILO local offices in many countries, or direct from ILO Publications, International Labour Office, CH-1211 Geneva 22, Switzerland. Catalogues or lists of new publications are available free of charge from the above address, or by email: pubvente@ilo.org.

Visit our web site: www.ilo.org/publns

Contents

	<i>Page</i>
List of recurring abbreviations	v
Introduction.....	1
The reasons for proposing a new Recommendation	1
Chapter I. HIV/AIDS and the world of work	5
Global and regional trends for HIV/AIDS	5
Trends in the world of work	6
The world of work as a focus of action.....	7
The informal economy and HIV/AIDS.....	9
International action on HIV/AIDS	11
Global commitments.....	11
Action by the Joint United Nations Programme on HIV/AIDS (UNAIDS).....	12
ILO action	18
Changes in the international responses	22
Scaling up the response	24
Developments calling for the adoption of an ILO Recommendation.....	25
Chapter II. Key areas for intervention.....	27
Universal access to prevention, treatment, care and support.....	27
Human rights concerns associated with HIV/AIDS.....	28
Elements of universal access	34
Universal access to prevention.....	34
Universal access to treatment, care and support	35
Testing, screening and confidentiality.....	43
Forms and modalities of testing.....	45
Risk and vulnerability.....	46
Broader social, economic and political factors	47
Behaviour and risk.....	52
Chapter III. The situation at the national and regional levels.....	57
Law and practice at the national level.....	57
General national policies and strategies.....	59
National coordinating bodies	60
Adoption of specific national measures	61

Inclusion of principles of the code of practice in national law	64
Testing and confidentiality in national law and practice	66
Exceptions to the prohibition of mandatory testing	68
Confidentiality	69
Disclosure of HIV testing results	70
Law and practice at the regional level	71
Business responses	73
The role of the ILO's tripartite constituents	75
Joint statements and policies	75
Interventions and actions by employers' organizations	77
Interventions and actions by workers' organizations	78
Chapter IV. Considerations for the proposed Recommendation	81
Developments since the adoption of the ILO code of practice	81
Form and content of the Recommendation	82
Possible approaches	82
Preamble	83
Scope	83
National policy	83
Employers and workers	84
Follow-up to the Recommendation	84
Questionnaire	87
Appendices	
I. An ILO code of practice on HIV/AIDS and the world of work	107
II. Non-exhaustive list of national HIV/AIDS laws and policies	133
III. National HIV/AIDS laws and policies	141

List of recurring abbreviations

AIDS	acquired immune deficiency syndrome
APEC	Asia-Pacific Economic Cooperation
ARV	antiretroviral
ASAP	AIDS Strategy and Action Plan
CARICOM	Caribbean Community
CGI	Clinton Global Initiative
DWCP	Decent Work Country Programme
ECOWAS	Economic Community of West Africa
EDUCAIDS	Global Initiative on Education and HIV and AIDS
EU	European Union
GAMET	Global AIDS Monitoring and Evaluation Team
GBC	Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	human immune deficiency virus
ICAO	International Civil Aviation Organization
ICFTU	International Confederation of Free Trade Unions (merged with WCL (and eight national trade unions) to form the ITUC)
IDU	injecting drug user
ILO	International Labour Organization
IOE	International Organisation of Employers
IPEC	International Programme on the Elimination of Child Labour
ITUC	International Trade Union Confederation (comprises the affiliated organizations of the former ICFTU and WCL together with eight national trade union organizations)
MDG	Millennium Development Goal
MSEs	micro- and small enterprises
MSM	men who have sex with men
MTCT	mother-to-child transmission
NEPAD	New Partnership for Africa's Development
OSH	occupational safety and health

PEPFAR	President's Emergency Plan for AIDS Relief
PICT	provider-initiated counselling and testing
PLHIV	people/persons living with HIV
PRSP	Poverty Reduction Strategy Paper
STI	sexually transmitted infection
TB	tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United National Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
WEDGE	Women's Entrepreneurship Development and Gender Equality Programme
WEF	World Economic Forum
WFP	World Food Programme
WHO	World Health Organization

Introduction

1. At its 298th Session in March 2007, the Governing Body requested the Office to place an item on HIV/AIDS in the world of work on the agenda of the 98th Session (2009) of the International Labour Conference, for a double discussion leading to the adoption of an autonomous Recommendation.
2. It was decided that it was necessary to adopt an international labour standard in the form of an autonomous Recommendation on this subject in order to increase the attention devoted to the subject at the national and international levels, to promote united action among the key actors on HIV/AIDS, and to increase the impact of the ILO code of practice on HIV/AIDS and the world of work adopted in 2001 (hereinafter cited as the “code of practice” or “code”), and other action, as well as to review developments since 2001. The code of practice is reproduced in an appendix to this report.
3. Owing to the limited time frame for the preparation of this law and practice report, it has been prepared on the basis of materials provided by member States in reply to past surveys, meetings of experts, and other sources available to the International Labour Office. The approaches described in the report are representative samples of existing practices and identify the relevant issues for discussion.

The reasons for proposing a new Recommendation

4. Several reasons were given in the Office paper proposing the inclusion of this item on the agenda of the Conference. The first was that most national instruments, adopted or drafted, include the fundamental principle of non-discrimination. Beyond this, however, the number and nature of the principles included varies. The code of practice is not followed in all cases. It is a voluntary instrument; uptake is optional, and there is no provision for monitoring the quality or extent of its use, as there would be in the case of a standard. For example, provisions such as mandatory HIV testing or an obligation to disclose HIV status, both of which contradict principles of the code, appear in national legislation and policies that are in other respects in conformity with the code.
5. Moreover, the code’s guidance presumes that ministries responsible for labour and employment will be full partners in national responses to HIV/AIDS. In reality, national HIV/AIDS strategies often falter because key actors – such as labour administrations and inspectorates, and the social partners – are not part of the response. As many national AIDS bodies fail to involve representatives of the world of work, there may be no critical mass of good practices, or no clear vision of how to encourage compliance in the workplace. Indeed, it emerges from the examples of law and practice assembled for this report that, while virtually all countries have taken steps – in some cases very substantial and effective steps – to address the issue of HIV/AIDS, some aspects of these responses are not taken into account in national planning and activities. Substantial parts of the population, especially in the informal economy, are not being reached by national efforts.

An international standard would help to establish the basis for an institutional tripartite presence within the single national AIDS authority and the joint United Nations (UN) response.¹

6. Existing ILO standards that address various issues relevant to the HIV epidemic are listed in Chapter II.² In 2006, the ILO adopted the Maritime Labour Convention, which contains two explicit references to HIV/AIDS – the first international standard to do so. In addition, after adopting the Work in Fishing Convention (No. 188) in 2007, the International Labour Conference adopted a resolution concerning the promotion of welfare for fishers which invited the Governing Body to request the Director-General to consider, as part of its programme and budget, “the education of fishers and their families by working together with appropriate bodies for the prevention of HIV/AIDS among fishers and in fishing communities”.³ In addition, most Office programmes have worked on the topic, given the reach of the epidemic and the cross-cutting strategy adopted by the ILO. These responses are not necessarily as well coordinated as they might be; a new Recommendation would respond better to the need to coordinate ILO action on HIV/AIDS in the world of work on a broad and consistent front, and would be a stronger rallying point than the voluntary code of practice, which would still give added impetus to these efforts.

7. When it placed this item on the Conference agenda, the Governing Body felt that a standard could offer a clearer delineation of state responsibilities and of the roles of the social partners, particularly in matters of treatment, care and support. It would leave to governments the choice of measures to implement the policy, whether through laws, regulations, collective agreements between employers and workers and their organizations, court decisions, or other methods appropriate to national conditions and practice. It could thus provide the flexibility suited to the worldwide diversity of conditions, in order to ensure that the standard would be universal, while providing for greater equity in access to comprehensive services.

8. Although the implementation of a new Recommendation would be voluntary, it would have to be submitted, once adopted, to the competent national authorities under article 19, paragraph 6, of the ILO Constitution “for the enactment of legislation or other action”. This would provide the ILO and its constituents with an opportunity for discussions in each country on the appropriate responses to the HIV epidemic, and to review action already undertaken. In addition, a Recommendation could be the subject of requests for reports under article 19 of the Constitution and consequent General Surveys by the Committee of Experts on the Application of Conventions and Recommendations or other follow-up measures. Neither obligation exists with regard to the code of practice.

9. A Recommendation would give detailed guidance and set out good practice options. The guidance would not affect the validity of the code of practice, nor would it transform the latter into another form of instrument. The Governing Body did not mandate any

¹ Concerted efforts are being made by the multilateral and donor community to encourage and support a single national AIDS body, programme and monitoring system in each country (the “three ones” principle), as well as to ensure scaled up and harmonized UN action at country level (as recommended by the Global Task Team on improving AIDS coordination among multilateral institutions and international donors, and endorsed by the ILO Governing Body in March 2006).

² See the relevant box in GB.297/2, and Chapter IV of this report. These instruments are only some of those relevant to HIV/AIDS, even if they do not explicitly refer to it.

³ ILO: *Report of the Committee on the Fishing Sector*, International Labour Conference, 96th Session, Geneva, 2007, available at <http://www.ilo.int/public/english/standards/relm/ilc/ilc96/pdf/pr-12.pdf>

revision of the code of practice, or any lowering of the standards contained in it, when it included this item on the Conference agenda. The guidance in the Recommendation would rather be designed to uphold the code's integrity and to provide a range of measures to delineate a national policy framework in order to facilitate its broader use. The Recommendation would be inspired by the code. At the same time, its discussion and adoption would provide a useful occasion for a review of the principles of the code in the light of the extensive experience acquired by the ILO and its partners and the evolving policy context. The consultations in preparation for this standard could enhance international cooperation, and promote exchange and transfer of critical information on good practices, lessons learned, and outcomes.

10. The discussion on HIV/AIDS in the world of work at the Conference will also be an occasion to bring together all ILO constituents and leading global specialists to consider in detail the valuable experience gained in a decade in the ILO. It will provide a valuable opportunity to reflect on the direction of future activity in this vital area.

11. Chapter I of this report covers trends in HIV/AIDS epidemiology, and responses in the ILO and the rest of the international system. Chapter II focuses on key areas for intervention through the adoption of the proposed Recommendation. Chapter III examines law and practice at the national and regional levels to deal with HIV/AIDS. Chapter IV outlines the considerations that have framed the questionnaire.

12. In order to allow the Office time to draft the final report, which in accordance with article 38, paragraph 2, of the Standing Orders of the Conference must be communicated to governments not less than four months before the opening of the 98th Session of the Conference, governments are requested to send their replies so as to reach the Office no later than 31 August 2008. In this respect, the Office draws the attention of governments to article 38, paragraph 1, of the Standing Orders, under which governments are asked to consult the most representative organizations of employers and workers before finalizing their replies, which should reflect the results of that consultation, and to indicate which organizations have been so consulted. In addition, owing to the broad scope of the subject, it would be advisable for ministries of labour to consult other relevant national ministries and institutions dealing with HIV/AIDS, including ministries of health, social affairs, education, justice, gender, youth, finance and planning, and the national AIDS commissions, for the preparation of the replies. It might also be desirable to consult other relevant organizations, including organizations of persons living with HIV and others working with them, and to reflect their advice in the government's report.

Chapter I

HIV/AIDS and the world of work

13. The world of work is a vital front in the global struggle against HIV/AIDS. It experiences many of the deepest impacts of the epidemic and is also a key factor in the response, especially at the country level. As States and employers' and workers' organizations have acquired hard-won experience, the ILO and its partner organizations have helped to shape the responses. Both the progress achieved and the limits on that progress, along with changes in the epidemiological situation, require that responses continue to be refined and strengthened.

14. In addition, the efforts being made in relation to the world of work take place within a much larger context, and must be closely coordinated with responses across a broader front.

Global and regional trends for HIV/AIDS ¹

15. Even though there have been promising developments in recent years, including increased access to effective treatment and prevention programmes, the number of people living with HIV (PLHIV) continues to grow, as does the number of deaths due to AIDS. As will be seen below, efforts in most countries to address the epidemic have made progress, but even so usually reach only a part of the population, often omitting those most in need of access to prevention, treatment, care and support. The situation varies from region to region.

16. Since the publication of the ILO code of practice in 2001, the number of adults aged 15 to 49 years and children under 15 years living with HIV rose globally from about 29 million to over 33 million in 2007 – a 14 per cent increase. The most recent estimates show that the number of PLHIV rose in every region in the world in the six years between 2001 and 2007. The largest increases occurred in East Asia, where the number nearly doubled, and in Eastern Europe and Central Asia, where the total number in 2007 is estimated to have grown to over 250 per cent the level in 2001.

17. The total number of adults and children living with HIV in sub-Saharan Africa is estimated to have increased from 20.9 million in 2001 to 22.5 million in 2007. Sub-Saharan Africa thus continues to bear the brunt of the epidemic. More than two-thirds of all adults (68 per cent) and the vast majority of children (nearly 90 per cent) living with HIV in the world live in sub-Saharan Africa, where there is a further concentration in southern Africa (35 per cent of all persons living with HIV globally). In 2001,

¹ UNAIDS and WHO: *AIDS epidemic update: December 2007*, Dec. 2007, available at www.unaids.org/; and WHO, UNAIDS and UNICEF: *Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector: Progress report*, Apr. 2007, available at www.who.int/hiv/mediacentre/universal_access_progress_report_en.pdf

disproportionately more AIDS deaths occurred in sub-Saharan Africa (more than 82 per cent of all deaths worldwide). The proportion of global deaths in the region had declined by 2007 – to 76 per cent – as a result of increased access to treatment, but remains disproportionate in relation to sub-Saharan Africa's share of persons living with HIV. Declines in HIV prevalence are now reported for several sub-Saharan African countries, but such trends will need to continue, accelerate, and become generalized to all countries of the region before they are sufficiently widespread to diminish the epidemic's overall impact in this region.

18. In South and South-East Asia, the number of PLHIV rose by 14 per cent over the same period, at the global average rate of increase. In Latin America, Western and Central Europe, the Caribbean and North America, the number of PLHIV rose somewhat more, by about one fifth (23, 23, 21 and 18 per cent respectively). In the Middle East and North Africa, the number rose by more than one quarter (27 per cent). In Oceania, although the numbers of adults and children living with HIV remain small in absolute terms, they nevertheless tripled between 2001 and 2007.

19. The proportion of women among all adults living with HIV who are aged 15 years and over remained stable globally over this period, at about 50 per cent. An estimated 15.4 million women and 15.4 million men were living with HIV by the end of 2007, up from 13.8 and 13.7 million respectively in 2001, representing an increase of about 12 per cent in each case. In contrast, the proportion of women living with HIV in sub-Saharan Africa, which exceeded 50 per cent by 1990, has comprised 60 per cent of all adults living with HIV since 2000. This means that there are 15 women with HIV for every ten men with HIV in sub-Saharan Africa. In other regions of the world, the proportion of women in the population living with HIV is still increasing. In the Caribbean, 43 per cent of adults living with HIV are now women, up 5 percentage points since 2001. Similarly, in Asia overall, the proportion of women has risen from about 26 to 29 per cent over the same period, and in Eastern Europe and Central Asia, the proportion of women has increased from about 23 to 26 per cent.

20. Access to treatment and care has increased globally in recent years, and the benefits for those who have access are significant. In one year, between the end of 2005 and the end of 2006, over 50 per cent more persons in need of antiretroviral (ARV) drugs gained access to them, an increase from about 1.3 to 2 million persons globally. However, coverage at the end of 2006 was still only 28 per cent of all persons needing treatment globally. Coverage rose somewhat more in some regions (to 72 per cent in Latin America), but in other regions to levels still well below the world average (to 6 per cent in the Middle East and North Africa and 15 per cent in Eastern Europe and Central Asia). The largest population served is in sub-Saharan Africa, where the number of persons receiving ARVs rose from 810,000 to 1.34 million, and coverage stood in late 2006 at the global average of 28 per cent.

Trends in the world of work ²

21. According to the most recent estimates of HIV prevalence, over 33 million adults aged from 15 to 49 years were living with HIV at the end of 2007. ³ Although the bulk of the working-age population and of the labour force is covered by the age range 15 to 49 years, the HIV prevalence estimates nevertheless exclude persons living with HIV in the

² ILO: *HIV/AIDS and work: Global estimates, impact on children and youth, and response*, ILO/AIDS, 2006, available at: http://www.ilo.org/public/english/protection/trav/aids/publ/global_est06/global_estimates_report06.pdf

³ UNAIDS and WHO: *AIDS epidemic update*, op. cit.

age group 50 to 64 years who are still of working age and in many cases in the labour force. The current global estimate of adults living with HIV thus underestimates the total number of persons in the working age group who are living with HIV.

22. Also, assuming that all adults and most young people are economically active to some extent – even if the sustenance they provide is not easily assessed in conventional economic terms – the total number of productive persons living with HIV is likely to be close to the total number of working-age persons and to be greater than the number of labour force participants, in particular where a large proportion of the population is working in the informal economy or the labour force may be underestimated (see the following section). This highlights the necessity of adding the number of older working-age adults to gain a true appreciation of the HIV epidemic's impact on the world of work.

23. Furthermore, given that many adults contribute in other ways to the economy, for example by raising children who will be the future labour force, it is important to take account of the impact of HIV on the entire adult population, and especially to include women. As indicated earlier, the proportion of women living with HIV has reached 60 per cent in sub-Saharan Africa and continues to increase in other regions. In a report published in 2006, the ILO estimated that the proportion of women in the global labour force living with HIV was 41 per cent.⁴ As women globally comprise half of all persons who are HIV-positive, it is likely that women comprise at least half of all adults who are not in the labour force but still of working age, and a proportion of them are aged over 49 years. Many of these women are contributing in one way or another to the economy.

24. The effects of the epidemic on the labour force and on all persons of working age are measurable in their overall impact on economic and employment growth. The ILO demonstrated in 2004, and again with more recent data in the 2006 report cited earlier, that the rate of economic growth in countries heavily affected by HIV/AIDS has been reduced by the epidemic's effects on labour supply, productivity, investment and employment over the last decade or more. But enterprises, households, families, communities and economies can benefit if workers with AIDS have access to effective ARVs. The same 2006 report showed, for example, that a worker with AIDS given treatment in 2004 could have worked for 34 of the next 54 months on average worldwide, contributing as a result more than seven times the global per capita income to the global economy for each 12 months he or she survived. The benefit of ARVs would be correspondingly greater for sub-Saharan Africa: the average worker with HIV/AIDS could have survived for 36 of the next 54 months, contributing eight times the per capita income of sub-Saharan Africa to the African economy for every 12 months he or she survived.

The world of work as a focus of action

25. It has become steadily more apparent that the HIV/AIDS epidemic has had, and continues to have, a severe effect on the world of work as well as on society at large in a significant number of countries. This makes the workplace an indispensable focus of efforts at the national level.

26. The first responses of the ILO to HIV/AIDS focused on a combination of measures to prevent infection and measures to counter discrimination at work. Some workers are affected as a result of their occupational activities: this is a discrete part of the ILO's

⁴ ILO: *HIV/AIDS and work: Global estimates, impact on children and youth, and response*, op. cit.

efforts, especially in the realm of occupational safety and health (OSH). In very many cases, regardless of how workers contracted HIV, they are subject to discrimination and stigmatization, at the workplace as elsewhere. With the continued development of the epidemic, and with the lessons learned in combating it, the field of action is now much wider.

27. The ILO is concerned by the epidemic because HIV/AIDS is an obstacle to reducing poverty, to achieving sustainable development and to implementing the Decent Work Agenda. HIV/AIDS requires a response at all levels of society and by all sectors of the economy that far exceeds the capacity of any one sector, ministry or UN agency. It reminds us that we compartmentalize the development agenda at our peril: HIV/AIDS shows up the fault lines of society, in particular the inequalities between men and women, between majorities and minorities, and between those in formal employment and those outside it. It illuminates connections that are in danger of being forgotten – between health and work, between education and the economy, and between rights and social and economic progress.

28. The central fact is that unlike any other disease, HIV/AIDS disproportionately affects the adult working population. This means that it has had far-reaching social and economic consequences. The loss of workers, managers and employers rebounds on their families and communities through lost wages and a missing cohort of carers and educators. It rebounds on enterprises, public and private, through the loss of skills and experience at the same time as it causes an increase in direct and indirect labour costs.

29. Increasingly, responses to HIV/AIDS now include other related and serious diseases such as tuberculosis (TB) and malaria. The cumulative effort requires the strengthening of core health systems and social structures, especially in relation to human resource development and gender relations.

30. HIV/AIDS has also reinforced the central role of the world of work in promoting development as well as in combating the epidemic: it recalls the broader potential of the ILO's constituents to contribute to national efforts as social actors, and the fundamental link between social dialogue and ownership both of the problem and of its solution. Employers and trade unions are leaders in their communities, and there is an urgent need for leaders to speak out about HIV/AIDS and encourage action.

31. The workplace is a good setting for HIV/AIDS programmes. Standards have already been established with regard to working conditions, including care for workers with chronic illnesses, while procedures exist for labour relations, and training is a core activity. Occupational health services have a long tradition of promoting safety and health. Workplaces are communities where people meet and discuss, debate with and learn from one another. This provides an opportunity for awareness raising, education and the protection of rights. The simple fact is that most people spend a large amount of time at work, and this offers undeniable advantages for taking action or for education, prevention and access to care, support and treatment.

32. The ILO's Decent Work Country Programmes (DWCPs) have established the framework for an integrated and coherent response to HIV/AIDS. They provide the means to apply the strengths of the four core sectors of the ILO's work to the epidemic and its effects, to link both decent work and HIV/AIDS to national development plans and poverty reduction strategies, and to involve the constituents at all stages.

The informal economy and HIV/AIDS

33. The large majority of the labour force in developing countries is engaged in informal employment, and workers in the informal economy are considerably more vulnerable to HIV infection, and less able to gain access to care, support and treatment, than those in the formal sector. Despite this, most efforts to deal with HIV/AIDS are focused on the formal economy.

34. In most developing countries, between 50 and 75 per cent of non-agricultural employment is in the informal economy (48 per cent in North Africa, 51 per cent in Latin America, 65 per cent in Asia and 72 per cent in sub-Saharan Africa).⁵ In Uganda, the informal sector employs about 90 per cent of all non-agricultural private sector workers.⁶ The informal economy consists of micro- and small enterprises (MSEs), together with substantial self-employment. The latter accounts for 70 per cent or more of informal employment in sub-Saharan Africa, 62 per cent in North Africa, 60 per cent in Latin America and the Caribbean, and 59 per cent in Asia.⁷ The various kinds of work in the informal economy may be seen as forming a continuum which includes, at one extreme, activities that are totally “deregularized”, informal and characterized by serious decent work deficits and, at the other extreme, activities that are partly formalized, with correspondingly fewer deficits.⁸

35. The informal economy is generally a more important source of employment for women than for men. Women’s share of informal employment worldwide remains between 60 and 80 per cent.⁹ In sub-Saharan Africa, 84 per cent of women workers outside agriculture are informally employed compared to 63 per cent of male workers; in Latin America the figure is 58 per cent for women, compared to 48 per cent for men. In Asia, the proportion of women and men non-agricultural workers in informal employment is roughly the same. The number of women in the informal economy labour force continues to rise, and it is expected that in the future a growing proportion of workers in the informal sector will be very small-scale women-operated units.¹⁰

36. A number of conditions in the informal economy make it more vulnerable to the spread of HIV and make the impact more severe. Relevant factors include: the informal economy’s labour-intensive nature and inadequate or non-existent labour legislation and enforcement of existing laws; absence of worker representation; absence of steady income; gender inequality; inadequate social protection; low levels of literacy; fewer employment-related benefits; the presence of many young people; poor opportunities for

⁵ ILO: *Women and men in the informal economy: A statistical picture*, Employment Sector, 2002, available at: <http://www.wiego.org/publications/women%20and%20men%20in%20the%20informal%20economy.pdf>

⁶ World Bank: *Urban informal sector in Uganda*, Key labour market issues course, held in Uganda April/May 2005, available at: http://info.worldbank.org/etools/docs/library/211247/Uganda_Urban%20Informal%20Sector.pdf

⁷ ILO: *Women and men in the informal economy*, op. cit.

⁸ V. McKay: *Consolidated report on HIV/AIDS interventions in the informal sector*, Sep. 2003 (Geneva, ILO).

⁹ K. Flodman Becker: *The informal economy*, Fact-finding study, SIDA, Mar. 2004, available at: <http://rru.worldbank.org/Documents/PapersLinks/Sida.pdf>

¹⁰ K. Dixon-Fyle and C. Mulanga: *Responding to HIV/AIDS in the world of work in Africa: The role of social protection*, ILO/AIDS, Working Paper No. 5, June 2004, available at: <http://www.ilo.org/public/english/protection/trav/aids/publ/wp5socialprotectiondakarpaper.pdf>

skills enhancement; poor health and safety standards; and lack of access to health facilities.¹¹

37. Many factors account for the difficulties of reaching out to the informal economy with HIV/AIDS programmes and policies. They include the following:¹²

- Structures available in the formal economy to support programmes and policies do not usually exist in the informal economy.
- For the workers, day-to-day survival takes priority over other concerns such as HIV/AIDS.
- The sector is mobile and it is therefore difficult to reach workers within the sector. For the same reason, monitoring is difficult.
- Working time and working conditions are not ideal for capacity building, and workers have difficulties attending regular training sessions.
- Undocumented migrants, of whom there are many in this sector, avoid formal health-care systems as they fear discovery by the authorities. For the same reason, they are also reluctant to be part of any kind of prevention or support programme.
- Low levels of education mean that mainstream messages on HIV/AIDS need to be adjusted, and the skills and human capacity to do this are at present not normally available in the sector.

In addition, informal sector workers enjoy less recognition, and have a harder time being heard, than workers in the formal sector.¹³

38. Despite this, research on the social and economic implications of the epidemic has focused almost entirely on private and public sector institutions in the formal sectors of the economy. Little attention has been given to the impact of HIV/AIDS on business and production in the informal economy, and only a few initiatives on HIV/AIDS are targeting informal economy workers, despite their economic importance and growing numbers.

39. Some of these factors also affect the degree to which the ILO's code of practice can be effective in the informal economy. The code was developed for generic use across all sectors of the world of work (formal and informal). While it is intended to be as applicable to the informal economy as to the formal economy, it may not, as already indicated, be well tailored to the particular contexts of the informal working environment.¹⁴ Some of the key issues include the following:

- *Recognition of HIV/AIDS as a workplace issue.* This implies that all workplaces, including informal sites, are to be recognized by governments, which often is not the case in the informal economy.

¹¹ Conference of African Ministers: *An issues paper: Meeting the challenge of employment in Africa*, Meeting of the Committee of Experts of the Conference of African Ministers of Finance, Planning and Economic Development, May 2006, available at: http://www.uneca.org/cfm/2006/docs/Issues_paper.htm

¹² V. McKay: *Consolidated report on HIV/AIDS interventions in the informal sector*, op. cit.

¹³ V. McKay, *ibid.*

¹⁴ V. McKay, *ibid.*

- *Gender equality* is an overriding concern in the code of practice. However, women in the informal economy are much more vulnerable than men, and more vulnerable than women employed in the formal economy.
- *Healthy work environment*. The informal environment is often far from healthy and hygienic, particularly for children who come to the workplace with their mothers.
- *Social dialogue* is contingent on an organized labour force. The informal economy is not adequately organized and is without a voice.
- *Screening* does not appear to be an issue for workers in the informal economy. There is, however, considerable stigmatization, which needs to be addressed.
- *Confidentiality* is not applicable in the informal economy. Stigmatization and gossip are common in small enterprises.
- *Continuation of the employment relationship*. Since the relationship is by definition informal, there is no contract to be terminated, nor are there any social security benefits to protect workers who fall ill.
- *Prevention*. Education programmes and mainstream condom distribution for the informal sectors are minimal.
- *Care and support* arrangements are not integral to informal systems.¹⁵

International action on HIV/AIDS

Global commitments

40. The Millennium Development Goals (MDGs) are common goals of the entire UN system and of the member States, addressing core development issues including poverty reduction, education, gender inequality and health. MDG 6 is to “combat HIV/AIDS, malaria and other diseases”.

41. At a special session of the UN General Assembly in June 2001, some 189 Heads of State adopted a Declaration of Commitment on HIV/AIDS.¹⁶ They expressed concern at the fact that “the global HIV/AIDS epidemic, through its devastating scale and impact, constitutes a global emergency ... which undermines social and economic development throughout the world and affects all levels of society – national, community, family and individual”.

42. Two of the key commitments from 2001 recognize the need to expand the global response into the world of work:

- By 2005, strengthen the response to HIV/AIDS in the world of work by establishing and implementing prevention and care programmes in public, private and informal work sectors, and take measures to provide a supportive workplace environment for people living with HIV/AIDS (paragraph 49).
- By 2003, develop a national legal and policy framework that protects in the workplace the rights and dignity of persons living with and affected by HIV/AIDS

¹⁵ See V. McKay, *ibid.*, based in part on a study on the informal sector in Uganda, Ghana, the United Republic of Tanzania and South Africa.

¹⁶ UN General Assembly, 26th Special Session, doc. A/RES/S-26/2, 2 August 2001, available at: www.un.org/ga/aids/docs/aress262.pdf

and those at greater risk of HIV/AIDS, in consultation with representatives of employers and workers, taking into account established international guidelines on HIV/AIDS and the workplace (paragraph 69).

43. In 2006, the General Assembly adopted a further Political Declaration on HIV/AIDS, recommitting the Members to combating the disease after a review of progress since the 2001 special session.¹⁷

44. Besides action in the General Assembly, there are innumerable international conferences specifically on HIV/AIDS, other meetings in which the subject figures prominently, and action plans adopted at the regional or universal international levels by various entities. The richness of this response is impressive, and aspects of it are referred to below.

Action by the Joint United Nations Programme on HIV/AIDS (UNAIDS)

45. The ILO is part of a broad international effort against HIV/AIDS. It has been a co-sponsor of UNAIDS¹⁸ since 2001, and works closely with the other nine co-sponsors (see below). It is envisaged that they would have an important role to play in promoting the implementation of the proposed Recommendation. Much of the information on the progress of global and national responses to HIV/AIDS, and many of the statistics cited in this report, have been assembled under the direction of UNAIDS.

46. The failure of half-measures to stem the worldwide expansion of HIV has led the global community to embrace the goal of achieving universal access to HIV prevention, treatment, care and support by 2010.¹⁹ The move towards universal access reflects a commitment to undertake an accelerated scale-up of evidence-informed measures in all regions of the world in response to an epidemic that has inflicted what the Human Development Report in 2005 termed history's "single greatest reversal in human development".

47. Substantial progress has been achieved in bringing essential HIV services to those in need in the low- and middle-income countries which are home to 95 per cent of all PLHIV. The number of people receiving antiretrovirals in these countries increased fivefold between 2003 and 2006, and a decline in HIV incidence has been reported in several countries following the implementation of strong prevention measures. Nevertheless, the current pace of scale-up will not achieve universal access by the agreed

¹⁷ General Assembly, 60th Session, A/RES/60/262, 15 June 2006, available at: www.un.org/documents/instruments/docs_en.asp

¹⁸ <http://www.unaids.org>

¹⁹ Universal access does not imply that there will be, or should be, 100 per cent utilization by all individuals of every HIV prevention, treatment, care and support intervention. Even in high-income countries where health care is universally available, some patients who are medically eligible for antiretrovirals are not receiving the drugs for a variety of reasons (for example, a deliberate decision not to undergo testing, or a decision to initiate antiretroviral therapy at a later time). Rather, by moving towards universal access, the world has committed itself to making concrete, sustained advances towards a high level of coverage for the most effective interventions needed to manage diverse epidemics in all regions. For example, countries with generalized and hyper-endemic epidemics require very high coverage for interventions aimed at the general population – such as mass media awareness campaigns, school-based education, and workplace prevention programmes – while lower coverage for such strategies may be appropriate for low-level and concentrated epidemics, where very high coverage levels are needed for programmes targeting populations most at risk of HIV infection. See UNAIDS: *Financial resources required to achieve universal access to HIV prevention, treatment, care and support*, 2007, available at: http://data.unaids.org/pub/Report/2007/20070925_advocacy_grne2_en.pdf

target date of 2010, imperilling the world's ability to halt and begin to reverse the HIV epidemic by 2015, as provided for in the MDGs. As countries and national partners have worked to expand critical programmes, many have had difficulty in translating increased funding into comprehensive programmes. As one example of the enormous challenges associated with scaling up HIV programmes in resource-limited settings, sub-Saharan Africa – though home to 11 per cent of the global population and nearly two-thirds of all PLHIV – has only 3 per cent of the world's health-care workers.

48. Overcoming such obstacles – and strengthening global resolve to achieve universal access – will require significant, long-term financing, in addition to sustained political support, increased national capacity, and reliance on strategies that have proven to be effective in addressing HIV and AIDS. However, despite marked increases in financing for the HIV response during this decade, the gap between resources available and the amounts needed to achieve universal access will widen over the next several years if current funding trends continue.

49. HIV/AIDS has provoked a development crisis that can be resolved only through a multi-sectoral response. UNAIDS²⁰ brings together the efforts and resources of ten UN system organizations in the AIDS response. All these organizations are committed to helping countries move towards universal access to prevention, treatment, care and support, within the framework of one national plan, one implementing body and one system for monitoring and evaluation (see box 1.1). While coordination among them is crucial, each agency also works within its own areas of comparative advantage. Working relations are guided by an agreed “division of labour” which defines the lead roles of each, as well as encouraging partnerships and joint programming. Detailed information on the work of each of the other co-sponsoring agencies of UNAIDS is beyond the scope of this paper, but the following brief indications will be useful.

Box 1.1
The “three ones” principle

Principles for the coordination of national AIDS responses

On 25 April 2004, UNAIDS, the United Kingdom and the United States co-hosted a high-level meeting at which key donors reaffirmed their commitment to strengthening national AIDS responses led by the affected countries themselves.

They endorsed the “three ones” principle to achieve the most effective and efficient use of resources, and to ensure rapid action and results-based management:

- One agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners.
- One national AIDS coordinating authority, with a broad-based multi-sectoral mandate.
- One agreed country-level monitoring and evaluation system.

There has been a marked shift in the global response to the complex AIDS crisis, which continues to worsen. National responses are broader and stronger, and have improved access to financial resources and commodities.

It is this challenge that the “three ones” are specifically designed to address. Built on lessons learned over two decades, the “three ones” will help improve the ability of donors and developing countries to work more effectively together, on a country-by-country basis.

²⁰ www.unaids.org/

50. The Office of the United Nations High Commissioner for Refugees (UNHCR)²¹ is the lead agency for HIV/AIDS responses for refugees and internally displaced people. It has extensive ongoing HIV programmes and logistics in place to reach refugees, internally displaced persons, and other persons of concern, as well as the surrounding host communities, which are often located in remote areas. The UNHCR works with national governments and international bodies to ensure the inclusion of refugees, returnees, internally displaced persons and other persons of concern in national and international HIV programmes. HIV programmes have now expanded from Africa to Asia, the Americas, Middle East and Eastern Europe. Over the last three years, the UNHCR's HIV programmes have become more comprehensive by including areas such as assessments, voluntary counselling and testing, prevention of mother-to-child transmission, HIV prevention, development and dissemination of information–education–communication materials and in monitoring and evaluation.

51. The UNHCR follows a subregional approach and works increasingly on HIV in conflict and post-conflict situations. A comprehensive information system is in place and includes baseline data on risks and the results of behavioural and surveillance surveys. The UNHCR is a strong advocate against stigmatization, discrimination and misperceptions on HIV and refugees, and promotes gender-sensitive measures to reduce HIV vulnerabilities specifically among refugee women and girls. To ensure greater integration of AIDS issues across its work and mandate, the UNHCR has included AIDS in its protection and resettlement training and in the *Handbook for emergencies*.

52. For 60 years, the United Nations Children's Fund (UNICEF)²² has been working with partners around the world to promote the recognition and fulfilment of children's human rights. HIV/AIDS is a key priority in its programming for the coming years. UNICEF is committed to an aggressive response to HIV/AIDS not only because of the extraordinary threat it poses to children and women, but also because it is preventable. To confront the challenges of HIV/AIDS, UNICEF focuses on four key areas:

- HIV prevention among young people;
- prevention of parent-to-child transmission of HIV;
- expansion of protection, care and support for orphans and children affected by HIV/AIDS; and
- expansion of care and support for children, young people and parents living with HIV/AIDS.

53. UNICEF operates in partnership with governments, other UN agencies, non-governmental organizations and community-based organizations at the global, national and community levels. It works to: understand the epidemic and assess its impact, particularly on children and young people; evaluate the adequacy of responses and design and support programmes to prevent HIV infection; address the impact of HIV/AIDS on children, young people and families; eliminate stigma and empower children, young people, families and communities to cope with the impact of HIV/AIDS; and bring about social change. UNICEF has an extensive field presence and programmes of cooperation in 162 countries, areas and territories.

²¹ www.unhcr.org/

²² www.unicef.org/aids/

54. The World Food Programme (WFP)²³ is the world's largest humanitarian agency, and assists those affected by HIV and AIDS as the pandemic exacerbates malnutrition and threatens livelihoods. With and through its national and local partners, the WFP supports prevention, care and treatment programmes by providing food assistance to the most vulnerable. In order to bolster their immune systems and improve their general nutritional status, PLHIV receive food rations in conjunction with antiretroviral treatment. HIV-positive pregnant women enrolled in prevention of mother-to-child transmission (MTCT) programmes also benefit from nutritional supplements and education which enables them to stay strong and give birth to healthy babies. In addition, food support is used to help improve the nutritional status of TB patients and enable them to adhere to their lengthy treatment. Orphans and other children affected by HIV and AIDS receive school meals combined with take-home rations which help to offset the associated costs of education, and community-based training programmes for out-of-school youth are strengthened with a nutritional food component.

55. The WFP promotes HIV prevention and AIDS awareness in all its programmes and with all its employees, including the transporters who deliver food. In this way WFP food distribution venues provide opportunities to reach at-risk populations with important HIV prevention and care messages.

56. Responding to HIV/AIDS is one of the core priorities of the United Nations Development Programme (UNDP),²⁴ which helps countries to place HIV/AIDS at the centre of national development plans and processes within the framework of the MDGs. The UNDP works to build national capacity at all levels of government and civil society for coordinated, multi-sector responses to the epidemic – addressing the underlying causes of HIV/AIDS and protecting the rights of people affected by it, women, and vulnerable populations. It focuses on three areas:

- *HIV/AIDS and human development.* In partnership with the World Bank and the UNAIDS secretariat, the UNDP provides technical support to assist countries in integrating HIV/AIDS more effectively into poverty reduction strategies and national development plans. In addition, the UNDP supports countries in generating enabling legislation on trade, health and intellectual property for sustainable access to low-cost, high-quality AIDS medicines.
- *Governance of HIV/AIDS responses.* The UNDP supports the harmonization and alignment of UN system and donor assistance to national AIDS authorities, and the coordination of national AIDS responses, including implementation of multilateral funding initiatives. Through the Resident Coordinator system, the UNDP supports the integration of HIV/AIDS into UN country team common country programming processes.
- *Human rights, gender and HIV/AIDS.* The UNDP supports countries in creating an enabling human rights environment to protect the rights of people living with HIV/AIDS, women and vulnerable populations. This includes addressing issues of stigmatization and discrimination, and gender relations that render women and girls vulnerable to infection. The UNDP actively supports the involvement of PLHIV in the planning, implementation and evaluation of responses to HIV/AIDS.

²³ www.wfp.org/food_aid/food_for_hiv/index.asp

²⁴ www.undp.org/hiv/

57. The United Nations Population Fund (UNFPA) ²⁵ focuses its AIDS response on HIV prevention among young people and pregnant women, comprehensive male and female condom programming and strengthening the integration of reproductive health and AIDS. HIV prevention is an institutional priority within its programmes in more than 140 countries, and the Fund has recently added 70 (mostly national) staff members to work on AIDS issues. It supports a broad spectrum of immediate and long-term initiatives to prevent the sexual transmission of HIV, including behavioural change communication, voluntary testing and counselling, and services for sexually transmitted infections (STIs). It also supports the demographic and socio-cultural surveys needed to develop appropriate prevention policies.

58. The UNFPA promotes safer sexual behaviour among young people, the empowerment of young women to refuse unwanted and unsafe sexual relations, and efforts to persuade young men to assume more responsibility by protecting themselves and their partners. Another priority is the prevention of infection among pregnant women. The Fund supports the provision of “youth-friendly” reproductive health information, education and services. Its third priority is to reduce the transmission of HIV and other STIs that contribute to the spread of HIV/AIDS, by improving access to male and female condoms and promoting their correct and consistent use, taking into account user needs and perspectives, as well as cultural influences.

59. Established in 1997, the United Nations Office on Drugs and Crime (UNODC) ²⁶ is responsible for addressing the interrelated issues of drug control, crime prevention and international terrorism in the context of sustainable development and human security. As a co-sponsor of UNAIDS since 1999, the UNODC is also mandated to lead the global response relating to HIV prevention and care among injecting drug users and in prison settings, and to facilitate the development of a UN response to AIDS associated with human trafficking. To that end, the UNODC assists countries in building national capacity to conduct situation assessments and legal or policy reviews, develop and implement enabling policies, and rapidly scale up effective evidence-based HIV prevention and care programmes for populations of concern. In collaboration with other UNAIDS partners, the UNODC launched a strategic framework for HIV prevention and care in prison settings at the 16th International AIDS Conference in Toronto.

60. In parallel with its efforts to facilitate policy and programme development, the UNODC seeks to generate, collect and disseminate strategic information related to HIV prevention and care among injecting drug users, prisoners and people vulnerable to human trafficking. The main focus is on helping policy-makers and programme managers to: identify how best they can measure and assess programme success across a range of outcomes; follow epidemiological trends; and devise tailored advocacy strategies.

61. The United Nations Educational, Scientific and Cultural Organization (UNESCO) ²⁷ is the designated lead organization for HIV prevention with young people in educational institutions. In order to focus and intensify the engagement of the education sector in national AIDS responses, UNESCO is leading the Global Initiative on Education and HIV and AIDS (EDUCAIDS) – a partnership that aims to put in place

²⁵ www.unfpa.org/hiv/

²⁶ www.unodc.org/

²⁷ www.hivaidsclearinghouse.unesco.org/

a comprehensive education sector response. UNESCO also convenes the UNAIDS Inter-Agency Task Team (IATT) on education.

62. UNESCO's approach is based on the assumption that preventive education must help to generate the attitudes, provide the skills and sustain the motivation necessary for promoting behaviour that reduces risk and vulnerability. UNESCO is committed to the following five core tasks:

- *Advocacy at all levels.* UNESCO engages ministries, agencies and non-governmental organizations, such as those involved in education, science, culture, communication and sports, as well as civil society and the private sector.
- *Customizing the message.* UNESCO develops effective and culturally sensitive information intended for target groups, starting with those most at risk.
- *Reducing risky behaviour and vulnerability.* Formal and non-formal education programmes are developed so that all young people know the facts about HIV/AIDS and how to prevent it, and can act on this knowledge.
- *Caring for the infected and affected.* Those infected and affected are actively engaged and supported in their efforts to address the epidemic in communities around the world. Treatment is an integral part of prevention.
- *Coping with the institutional impacts.* In order to protect the core functions of key social, economic and political institutions under the onslaught of HIV/AIDS, UNESCO develops and disseminates tools for monitoring, assessing and responding to the impact of the epidemic on schools, students, teachers and other key institutions at the country level.

63. The World Health Organization (WHO)²⁸ leads the health sector response to the HIV/AIDS epidemic. The health sector plays a central role in promoting and delivering effective prevention, care and treatment services, but its capacity to perform this role has been constrained by underdeveloped health systems and the heavy burden created by the epidemic. Renewed political commitment, increased global resources for HIV/AIDS, a stronger evidence base on cost-effective interventions, new prevention modalities, and expanded access to antiretroviral therapy, now present a unique opportunity to strengthen health systems as a whole and mount a stronger overall response.

64. HIV/AIDS is an organization-wide priority for the WHO, which has intensified its support for member States' efforts to combat the epidemic within the context of the comprehensive and multi-sectoral response called for in the Declaration of Commitment on HIV/AIDS (2001). The normative guidance provided by the WHO is backed by a technical support strategy designed to strengthen the capacity of countries. Its core HIV/AIDS programme ties in closely with a range of related programme areas, including sexual and reproductive health, TB, health education, and substance dependence. The WHO's five-year plan²⁹ is structured around five strategic directions and a set of priority health sector interventions. These are:

- (a) enabling people to know their HIV status through confidential testing and counselling, as well as infant diagnosis;

²⁸ www.who.int/topics/hiv_infections/en/

²⁹ WHO: *WHO's contribution to scaling up towards universal access to HIV/AIDS prevention, care and treatment, 2006-10*, Feb. 2006, available at: http://www.who.int/hiv/universalaccess2010/WHOstrategicdirections_en_may2006.ppt

- (b) maximizing the contribution of the health sector to HIV prevention through all modes of transmission, and promoting the development of new prevention technologies such as microbicides;
- (c) accelerating the scale-up of HIV/AIDS treatment and care for adults and children, including palliative care as well as antiretroviral therapy, and linking HIV/AIDS and TB services;
- (d) strengthening and expanding health systems through support for planning, management, human resource development and sustainable financing;
- (e) investing in strategic information to guide a more effective response, including STI and HIV surveillance, monitoring of treatment, and operational research.

65. The World Bank ³⁰ has a mandate to alleviate poverty and improve quality of life. It contributes to scaling up with a view to achieving universal access to HIV prevention, treatment, care and support through efforts to strengthen national strategies, monitoring and evaluation, funding comprehensive AIDS programmes, and helping to ensure that AIDS is part of the broader development agenda. By December 2006, the World Bank had committed more than US\$2.7 billion for AIDS programmes globally, almost half of it through the multi-country HIV/AIDS programmes for Africa and the Caribbean. In its policy dialogue with borrowing countries, the Bank stresses that HIV/AIDS is a development priority and highlights the need for top-level political commitment, systematic health sector reforms, human rights protection, and a range of multi-sectoral reforms to help reduce the factors contributing to HIV transmission.

66. The World Bank is committed to improving coordination, and to better aligning and harmonizing its support with country responses. The first annual meeting of the three major donors (the Global Fund, the President's Emergency Plan for AIDS Relief (PEPFAR) and the World Bank) in January 2006 produced action plans to enhance donor coordination and implementation assistance. The World Bank hosts two key services on behalf of the entire UNAIDS family. The AIDS Strategy and Action Plan service (ASAP) supports strategic and operational planning of national AIDS responses. The Global AIDS Monitoring and Evaluation Team (GAMET) was established to improve national monitoring and evaluation capacity.

ILO action

67. The ILO's particular contribution to UNAIDS includes:
- its tripartite membership, encouraging the mobilization of governments, employers and workers against HIV/AIDS (the particular roles of employers' and workers' organizations will be outlined below);
 - direct access to the workplace, with its opportunities for HIV/AIDS prevention as well as care, support and treatment;
 - long-standing experience in framing international standards to protect workers' rights; a number of ILO standards relate directly to the prevention and management of HIV/AIDS, and others are less directly related to this effort;
 - a global network of field offices and technical cooperation projects; and
 - substantial capacity for research, information sharing, and training.

³⁰ http://www.worldbank.org/hiv_aids/globalprogram.asp

68. The ILO Programme on HIV/AIDS and the world of work (ILO/AIDS) functions as part of the Social Protection Sector. Its action is guided by the ground-breaking code of practice on HIV/AIDS and the world of work, adopted in 2001 with the agreement of governments, employers and workers. The same year the ILO became the eighth co-sponsor of UNAIDS. Since then, with the assistance of contributions from member States, the programme has focused on implementing the code of practice and on providing direct assistance at the national level as constituents craft their responses to the HIV/AIDS pandemic. It has also been an active participant in the UNAIDS programme, and in this context has helped to formulate UN system-wide responses and coordination.

69. The code of practice is a blueprint for workplace action that sets out principles for policy development and the protection of rights as well as practical guidelines for programmes of prevention, care and support. It has been translated (at the time of writing this report in 2007) into 54 languages, and other translations are in preparation.³¹ The ILO implements the code through technical cooperation, training and advisory services for governments, employers and workers in all regions. Its accompanying education and training manual contains information, advice on methodology, course outlines and learning activities.

70. Beyond the activities of ILO/AIDS and its direct promotion of the code of practice, action on HIV/AIDS is woven into the work of all parts of the ILO. The epidemic is a threat to each of the Organization's four strategic objectives (fundamental principles and rights at work; employment, income generation and skills; social protection; and social dialogue). With the establishment of the ILO Programme on HIV/AIDS and the world of work the Director-General emphasized the importance of integrating HIV/AIDS in all programmes of the ILO, as indicated in the following quote: "In view of the diversity and multi-sectoral nature of the HIV/AIDS-related activities, it will be ensured that HIV/AIDS issues and concerns are mainstreamed into other ILO programmes and activities both at headquarters and in the field".³²

71. *Technical assistance.* The ILO is providing technical assistance to member States to strengthen their response to HIV/AIDS at and through workplaces. The technical cooperation budget of ILO/AIDS grew from US\$2 million in 2001 to over US\$20 million in the 2006–07 biennium. Projects are financed by a range of countries, in addition to the funding received through UNAIDS and other international organizations. The common objective is to help build the capacity of the ILO's tripartite constituents to contribute to national AIDS efforts by ensuring that the world of work is appropriately placed within the national AIDS plan, by developing rights-based workplace policies, and by implementing effective programmes. The strategy builds on the comparative advantage of the ILO's networks, experiences and materials, in particular the code of practice. Core elements include support and guidance for advocacy, planning and policy development; the training of focal points among the constituents and of workplace peer educators; the integration of HIV/AIDS in enterprise activities and structures (including human resources and welfare programmes, and OSH committees);

³¹ Albanian, Amharic, Arabic, Armenian, Azeri, Bahasa, Bangla, Bosnian, Bulgarian, Chinese, Dari, English, Estonian, Ewe, Filipino, French, Ga, Georgian, German, Hindi, Hausa, Hungarian, Ibo, Italian, Japanese, Kabyès, Mina, Khmer, Kiswahili, Kyrgyz, Malagasy, Mongolian, Nepali, Oromifa, Ouolof, Pashto, Polish, Portuguese, Romanian, Russian, Sesotho, Setswana, Sinhala, Siswati, Spanish, Tajik, Tamil, Thai, Turkish, Twi, Ukrainian, Urdu, Vietnamese and Yoruba.

³² ILO, Circular No. 187(Rev.1), Series 2, 26 Feb. 2001.

and provision of services or referral to public services, including active “know your status” campaigns.

72. HIV/AIDS workplace activities and projects are currently implemented in over 70 countries. ILO/AIDS has helped governments to formulate, integrate and implement workplace responses within the national HIV/AIDS response. Comprehensive workplace programmes are being implemented to address issues of stigmatization and discrimination, promote universal access, through the combined efforts of employers and workers, support selected enterprises, and help with the training of ministry of labour officials such as labour judges, industrial tribunal officials and labour inspectors. The sectors covered include retail, tourism and hospitality, transport, commercial agriculture, public utilities, mining, manufacturing, finance and the informal sector.

73. Despite the demonstrable benefits of workplace programmes, the funding available to the world of work represents only a small proportion of the international assistance flowing to countries to deal with the epidemic and its effects. As the bulk of financial resources for HIV/AIDS is now mainly available at country level, it is a priority for the ILO to ensure an increased share of funding for the tripartite constituents, and for the enterprises that have to craft their own responses to the epidemic. In this context, collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has been strengthened and efforts are geared to mobilizing resources with ILO constituents to broaden and better sustain the world of work response at country level.

74. *Other ILO programmes.* Because HIV/AIDS affects many parts of the ILO’s work, responses are located in all its main departments and programmes.

75. *International labour standards.* Although there is no international labour standard dedicated to HIV/AIDS,³³ the ILO’s supervisory bodies have recognized the negative implications of the epidemic for the realization of human rights and workers’ rights. As will be outlined in subsequent chapters, this has sometimes been seen in terms of discrimination within the meaning of the Discrimination (Employment and Occupation) Convention, 1958 (No. 111). The serious implications of the epidemic for child labour, and the contribution that can be made to combating it through freedom of association and collective bargaining, are an additional important reason to take account of HIV/AIDS in considering how the Conventions on these subjects have been applied. In addition, the application of ILO standards on social security, occupational health services, and OSH, has been a vital element of the ILO response to HIV/AIDS.

76. The International Programme on the Elimination of Child Labour (IPEC) has been working on the linkages between HIV/AIDS and child labour since 2001, focusing on children who have lost one or both parents to AIDS. Recent estimates indicate that by the end of 2007, 11.4 million orphans were living in sub-Saharan Africa alone.³⁴ IPEC has assembled a knowledge base on the linkages between child labour, in particular its worst forms, and AIDS orphanage and vulnerability.³⁵ This has resulted in a three-year project entitled “Combating and preventing HIV/AIDS-induced child labour in sub-Saharan Africa”. The project aims at assisting HIV/AIDS-affected boys and girls who are in child labour or at risk of entering child labour in Uganda and Zambia. It also aims at disseminating tools on HIV/AIDS and child labour issues. The project has set up

³³ The Maritime Labour Convention, 2006, is the first to refer directly to HIV/AIDS.

³⁴ UNAIDS and WHO: *AIDS epidemic update: December 2007*, op. cit.

³⁵ Available at www.ilo.org/child_labour

community structures and social protection mechanisms for the HIV/AIDS-affected families. Successful social protection mechanisms include the area of income-generating activities and savings schemes. These pilot models will be available for replication in other countries in the subregion. In addition, the project supports the Governments in Uganda and Zambia to mainstream HIV/AIDS issues in national child labour policies and programmes. It is working with employers' and workers' organizations in both countries to raise awareness and conduct training on the issue. It is also developing tools for policy-makers and programme planners to deal with HIV/AIDS and child labour issues and facilitate replication of best practices in the subregion.

77. *Employment Sector* (EMPLOYMENT). The Women's Entrepreneurship Development and Gender Equality Programme (WEDGE) has adopted measures to mainstream HIV/AIDS in its activities. WEDGE is one component of an ILO/Irish Aid Regional Partnership Programme, the other two components being "Developing Entrepreneurship among Women with Disabilities" (DEWD) and "Promoting the Employability and Employment of People with Disabilities through Effective Legislation" (PEPDEL). The Employment Sector works with ILO/AIDS to develop strategies and practical actions to provide employment and income-generating opportunities for PLHIV.

78. *Social Dialogue Sector* (DIALOGUE) has responsibility for a work programme that takes into account the importance of reinforcing legal systems, in order to ensure that any action adopted in response to HIV/AIDS finds support within an effective legal framework with associated enforcement mechanisms; this will assist social partners and other stakeholders (labour courts, judges and labour inspectors) in strengthening their capacity to apply relevant labour standards, improved national laws and the ILO's 2001 code of practice. In 2006 and 2007 ILO/AIDS, in collaboration with DIALOGUE, trained 100 labour inspectors from Mozambique, Zambia and Malawi and 170 judges from 15 countries (Benin, Burkina Faso, Cameroon, the Democratic Republic of the Congo, Ethiopia, Lesotho, Malawi, Mauritius, Mozambique, Nigeria, South Africa, the United Republic of Tanzania, Togo, Zambia and Zimbabwe). This will in turn improve compliance with labour and OSH law and regulations in the workplace, enhancing a non-discriminatory and safe work environment. ILO tools already exist to enrich the training, and include:

- *Guidelines on addressing HIV/AIDS in the workplace through employment and labour law*, which provide technical guidance on how best to incorporate, taking into account the various national circumstances and legal traditions, the body of international principles that have arisen in the field of labour law, in particular citing good practices.
- *A handbook on HIV/AIDS for labour and factory inspectors*, which helps labour and factory inspectors to deal with the issue of HIV/AIDS using the ILO code of practice to make it clear why HIV/AIDS is a labour issue and development challenge, to examine the links between HIV/AIDS and the principles and practice of labour inspection with particular reference to OSH, and to develop practical tools for use during inspections and help inspectors integrate HIV/AIDS into their future activities.
- *Using the ILO code of practice and training manual: Guidelines for labour judges and magistrates*. Training has been carried out to promote a fuller understanding among labour judges and magistrates of ILO standards and principles relevant to HIV/AIDS and of ways in which they can integrate them into their work. This training, and the Guidelines that have been crafted from it, have used the ILO code

of practice as a basis, and provided examples of the ways in which the key principles of the code have been applied through national legislation and jurisprudence.

79. The countries selected for this training and research component are: Benin, Botswana, Burkina Faso, Cameroon, Democratic Republic of the Congo, Ethiopia, Lesotho, Malawi, Mauritius, Mozambique, Nigeria, South Africa, Togo and Zimbabwe. Benin, Botswana, Lesotho and Togo will be piloted for intensive training of trainers to development networks for dealing with psychosocial issues related to HIV/AIDS.

80. Target groups are private sector enterprises and employers' organizations, trade unions and relevant government institutions (tribunals and courts, labour advisory boards and national OSH and AIDS councils): their awareness of the impact of HIV/AIDS will be increased and their capacity will be strengthened to implement national legislation, policies and programmes and to assist in improving such laws, where necessary, on the basis of research compiled in a comprehensive digest.³⁶

81. Since 2004, the ILO's Sectoral Activities Programme (SECTOR) has been implementing a multi-sectoral action programme on HIV/AIDS. This involves the development of tools and activities jointly with ILO/AIDS in agriculture, construction, education, health, hotels and tourism, mining and transport. Examples include: the development and validation of joint ILO/UNESCO workplace policies on HIV/AIDS in the education sector in the Caribbean and in southern Africa; guidelines on HIV/AIDS for the transport sector, a training workshop in South Africa, and a tool kit for managers, drivers and instructors; and guidelines (in preparation) for the construction, hotels, mining and retail sectors. Of particular significance are the Joint ILO/WHO Guidelines on health services and HIV/AIDS, which promote OSH, raise AIDS awareness among health workers, oppose discrimination, and support the strengthening of health systems.

82. The Bureau for Employers' Activities (ACT/EMP) and the Bureau for Workers' Activities (ACTRAV) provide the essential liaison between ILO/AIDS and the constituents, offering information, advice and contacts to ILO/AIDS and information, guidance and support to organizations of employers and workers. It is central to the work of ILO/AIDS that its activities are implemented with and through the constituents, and the issue of HIV/AIDS has led to an unprecedented level of response from the global, regional and national bodies representing the social partners (see below for further details). This process requires technical inputs from ILO/AIDS but is managed and overseen by the two bureaux, separately and in consultation.

Changes in the international responses

83. As well as increased commitments by affected countries themselves, the advent of the GFATM, the AIDS programmes of the World Bank, expanded commitments from donor countries (especially the United States) and the work of private sector foundations, have resulted in an increase in total AIDS funding from US\$2.8 billion in 2002 to an estimated US\$8.9 billion in 2006. While more resources are needed, there is also an urgent need for greater support and collaboration with heavily affected countries and to avoid duplication and fragmentation of resources.

- The Global Fund was created in order to “dramatically increase resources to fight three of the world's most devastating diseases and to direct those resources to areas

³⁶ J. Hodges: *Digest of good legislative practices relating to HIV/AIDS in selected African countries*, ILO/DIALOGUE, to be published in November/December 2007.

of greatest need".³⁷ It is conceived as a partnership between governments, civil society, the private sector and affected communities. It has spent about US\$7 billion in 136 countries since 2002³⁸ and is the chief source of funding for the fight against the three diseases. It reports that it has saved 2 million lives so far, largely through the distribution of mosquito nets and the provision of anti-HIV drugs. The Global Fund:

- operates as a financial instrument, not an implementing entity;
- makes available and leverages additional financial resources; and
- support programmes that reflect national ownership.

84. Since 2001, the Global Fund has attracted US\$4.7 billion in financing through 2008. In its first two rounds of grant-making, it committed US\$1.5 billion to support 154 programmes in 93 countries worldwide. This substantial infusion of resources will enable many countries to scale up existing programmes to a level commensurate with need. Still others will initiate new programmes where none existed before owing to a critical shortage of funds. In future years, the Global Fund's ability to support the expansion of proven interventions will depend entirely on its ability to raise additional funding. The Fund calculates that it will need to spend US\$8 billion a year by 2010 to bring the three diseases under control. It works closely with other multilateral and bilateral organizations involved in health and development issues to ensure that newly funded programmes are coordinated with existing ones. In many cases, these partners participate in local country coordinating mechanisms, providing important technical assistance during the development of proposals and programme implementation.

85. The next biggest source of funds is the programme established by the US Government to fight AIDS and malaria, under PEPFAR.³⁹ This aims to support treatment for at least 2 million people living with HIV/AIDS, prevent 7 million new infections, and support care for 10 million people infected with and affected by HIV, including orphans and vulnerable children. PEPFAR works in over 120 countries around the world, with a special emphasis on 15 countries in Africa, Asia and the Caribbean which are home to approximately 50 per cent of HIV infections worldwide: Botswana, Côte d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, the United Republic of Tanzania, Uganda, Viet Nam and Zambia.

86. Another non-governmental source of coordination is the Clinton Global Initiative (CGI),⁴⁰ launched by former American President Bill Clinton in 2005 "to help our world move beyond the current state of globalization to a more integrated global community of shared benefits, responsibilities, and values". The CGI brings together a community of global leaders to devise and implement innovative solutions to some of the world's most pressing challenges. The CGI neither gives grants nor collects direct donations to implement programmes. Instead, it serves as a dynamic "marketplace", matching up people who have resources with others who have organizational capabilities, in order to produce high-impact results in the field. CGI staff work with participants in advance of, during, and after each annual meeting to define, develop, and track the progress of commitments.

³⁷ The Global Fund's web site: <http://www.theglobalfund.org/EN/about/how>

³⁸ Donald G. McNeil, in an article in the *International Herald Tribune*, 28 Sep. 2007.

³⁹ See: www.usaid.gov/our_work/global_health/aids/pepfar.html

⁴⁰ www.clintonglobalinitiative.org

87. The Bill and Melinda Gates Foundation⁴¹ works on the principle that preventing the spread of HIV is the most durable long-term solution to the AIDS epidemic and a top priority for the foundation. It supports efforts to stop HIV transmission, including development of a safe, effective and affordable HIV vaccine, microbicide gels or creams that women can apply to protect themselves from sexually acquired HIV infection, large-scale initiatives to expand access to existing HIV prevention tools, both in countries with emerging epidemics and those with already high HIV infection rates, and advocacy to build commitment for a science-based approach to stemming the epidemic.

88. The Global HIV Prevention Working Group⁴² is a panel of over 50 leading public health experts, clinicians, biomedical and behavioural researchers, representatives of the UNAIDS secretariat and co-sponsors, advocates and people affected by HIV/AIDS convened by the Bill and Melinda Gates Foundation and the Henry J. Kaiser Family Foundation.⁴³ The Working Group seeks to inform global policy-making, programme planning, and donor decisions on HIV prevention, and to advocate a comprehensive response to HIV/AIDS that integrates prevention, treatment and care.

Scaling up the response

89. There have been recent reports that in spite of the massive new funding and coordination of responses, these responses remain inadequate to meet the goal to halt and reverse HIV/AIDS.

90. A September 2007 publication by UNAIDS⁴⁴ states that “despite marked increases in financing for the HIV response during this decade, the gap between resources available and the amounts needed to achieve universal access will widen over the next several years if current funding trends continue”.⁴⁵ It notes significant increases in financing in recent years, but calculates that “even with such increases, the world will not reach universal access by either 2010 or 2015”.⁴⁶ It is however not merely the availability of resources but how effectively the resources are utilized in pursuance of universal access and addressing problems such as poverty, youth unemployment and gender concerns, that will make a difference.

91. The Global HIV Prevention Working Group stated in a recent report:⁴⁷

We should be winning in HIV prevention. There are effective means to prevent every mode of transmission; political commitment on HIV has never been stronger; and financing for HIV programs in low- and middle-income countries increased six fold between 2001 and 2006. However, while attention to the epidemic, particularly for treatment access, has increased in recent years, the effort to reduce HIV incidence is faltering. ... Unless the number of new infections is sharply reduced, global efforts to make AIDS treatment widely available will become increasingly difficult, and millions more people may die as a result of preventable HIV infections. The dramatic rise in antiretroviral coverage, with global access increasing from 8 per

⁴¹ www.gatesfoundation.org

⁴² www.GlobalHIVPrevention.org

⁴³ www.kff.org/

⁴⁴ UNAIDS: *Financial resources required to achieve universal access to HIV prevention, treatment, care and support*, 2007, op. cit.

⁴⁵ *ibid.*, p. 1.

⁴⁶ *ibid.*, p. 5.

⁴⁷ Global HIV Prevention Working Group: *Bringing HIV prevention to scale: An urgent global priority*, Executive Summary, June 2004, available at: <http://www.globalhivprevention.org>

cent to 28 per cent between 2003 and 2006, illustrates what the world can accomplish with strong global commitment, increased financing, and collective action. To date, a similar confluence of forces has not been applied to HIV prevention.

92. The report goes on to make a series of recommendations, all relevant to the ILO's efforts, which include: tripling the available funding; establishing an inclusive national process in each country to develop, monitor, and update a national strategic HIV plan that simultaneously brings evidence-based HIV prevention and treatment to scale; increased collaboration among multilateral agencies and other donors; and recommendations for health-care providers, research institutions and civil society.

93. UNAIDS has recently published a set of practical guidelines for intensifying HIV prevention in which this proposal is fleshed out.⁴⁸

94. The ILO itself, with its limited financial resources, cannot contribute to filling the funding gap. It can, however, contribute to increased cooperation and collaboration, and to bringing the experience it has acquired in the workplace to more countries, and in improved ways. Most important for the present report, the ILO and its constituents can ensure that the opportunities and the challenges offered in the workplace are not omitted from the global responses to HIV/AIDS.

Developments calling for the adoption of an ILO Recommendation

95. Since the adoption of the ILO code of practice in 2001, there have been developments both in the effect of the epidemic and in the ways in which countries, international organizations and others have responded to it. First, as outlined above, the epidemic has continued to spread, and in some regions its spread has accelerated drastically. There are a number of countries which must now respond to it for the first time, as they realize the effects it is having and will continue to have on their societies. Methods of measurement have improved, and revised epidemiological data will help to focus responses and target them more effectively at the different types of epidemic in different regions and countries.

96. The fact that effective treatment is now available, often at more widely affordable prices, transforms the discussion in many cases, with a shift in emphasis from putting in place a defensive strategy towards efforts to reverse the effects of the epidemic, save lives and help to preserve and restore economies that have been devastated by it. The successes need to be better publicized and analysed, and the lessons learned need to be documented and put into place on a larger scale. One of the lessons of this report is that responses are often partial and need to be made more consistent and wide-ranging.

97. A third consideration is that large amounts of international assistance are now available to help poorer countries cope with the epidemic. While enterprises and trade unions in many countries are of necessity providing their own responses, many of them imaginative and effective, the world of work often does not receive the share of the international assistance that would allow these efforts to be integrated successfully with wider responses. This discussion will, it is hoped, begin to reverse that trend.

98. It has become evident that progress against HIV/AIDS is possible when proper precautions and other measures are adopted. The first aspect of this is prevention. HIV is

⁴⁸ UNAIDS: *Financial resources required to achieve universal access to HIV prevention, treatment, care and support*, op. cit.

transmitted through body fluids (blood, semen, breast milk), principally in the course of unprotected sex, blood transfusions, childbirth and breastfeeding, or through contaminated injecting equipment. Workplace action effectively supports prevention in all these areas, whether through direct OSH measures or through information and education – especially directed towards uptake of voluntary counselling and testing and of antiretroviral treatment to prevent mother-to-child transmission. Occupational risk can be prevented in most settings when proper precautions are put into place. The code of practice explains the use of universal precautions (also called “standard precautions”), which are based on the principle that the blood and certain body fluids of all persons regardless of their presumed infectious status should be considered potentially infectious. Precautions should be taken to prevent these fluids, especially blood, from entering the body whether through occupational exposure or a workplace accident. Transmission as an occupational disease can be prevented in most occupational settings when universal precautions become the norm and when post-exposure prophylaxis (PEP) is made available. The knowledge of how to implement the above is widely available, but there are obstacles and inconsistencies in the practical application, such as lack of material and equipment. One of the purposes of the Recommendation should be to help establish situations in which this can be accomplished, bringing into play the ILO’s knowledge and experience on OSH, and the efforts of ILO constituents.

99. Much HIV transmission takes place in ways that have no direct relation with the workplace. Nevertheless, its effect on the workplace is undeniable. This is one reason why employers are in many cases promoting awareness raising and even more direct action against HIV/AIDS in ways that go well beyond OSH, as will be seen in Chapter III.

100. For individuals who contract HIV, treatment is becoming increasingly available and affordable in many places. However, availability is still very uneven, and the ARVs and other treatments, unless heavily subsidized, are still beyond the financial reach of most of the people infected.

101. In summary, there have been rapid changes both in the epidemiology and in the responses to HIV/AIDS, and thinking has evolved on the relationship between the workplace and this epidemic. The ILO’s response has been built on a foundation of human rights, and it is time to review and reinforce this response. At the same time, the interactions between different considerations are complex and are changing. These considerations have led the ILO’s Governing Body to conclude that it is time to consider the adoption of a Recommendation on HIV/AIDS and the world of work.

Chapter II

Key areas for intervention

102. Consultation inside and outside the ILO has indicated that some of the principles of the code of practice are not being fully applied. The questions for this report are these: how should these and other concerns, including new developments in the epidemic and the response to it, be reflected in the proposed Recommendation; and what other measures might be taken to promote the implementation of the code of practice and of the proposed Recommendation? In any case, the Recommendation will serve as a basis for reinforcing national responses to the epidemic, and for guiding the ILO's work in this area.

103. Efforts to combat HIV/AIDS involve many considerations that impact upon one another. The concept of "universal access" seeks to capture the core elements of a comprehensive response and link them to the specific national situation, but it needs to be set in a broader context that is rights-based and acknowledges the range of factors driving the epidemic.

Universal access to prevention, treatment, care and support

104. The overall goal of the ILO's promotion efforts as a part of UNAIDS is universal access to prevention, treatment, care and support. If the world is to achieve the MDG on HIV/AIDS (to halt and reverse the spread of the epidemic by 2015), people will require far greater access to HIV prevention and AIDS treatment, care and support than is currently available. For this reason the global community, through a UN General Assembly resolution adopted on 23 December 2005 and the Political Declaration on HIV and AIDS adopted in June 2006, committed itself to significantly scale up its response to AIDS towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010.¹ The proposed Recommendation is part of that response.

105. The concept of universal access succeeded the "Three by Five" campaign which aimed to have 3 million people on treatment by 2005. It is an important step forward in two main ways. First, it reinstates the centrality of prevention. Second, many countries have taken responsibility for implementation and are currently in the process of revising their national AIDS plans and establishing targets. Universal access rests on the principle that everyone should be entitled to health care and social protection, and is part of the ILO's commitment as a co-sponsor of UNAIDS. The workplace is in a strong position to contribute to universal access, and to the essential aspect of protection of rights.

¹ UN General Assembly resolution 60/262: Political Declaration on HIV/AIDS.

106. Health care and social protection involve the following vital elements in terms of the HIV/AIDS epidemic:

- Access to preventive measures.
- Access to ARV treatment in cases of need (and treatment for opportunistic infections including TB).
- Access to health care.
- Access to family health cover and other kinds of support.

107. For workplaces this also means confidentiality, as well as job security, underpinned by social dialogue. Companies with the highest percentage of workers who have undergone voluntary counselling and testing are the ones that have ensured that these conditions are met. That in turn ensures the sustainability of these businesses. The many facets of the response must be placed within a human rights framework.

Human rights concerns associated with HIV/AIDS

108. Human rights are an integral part of the response to HIV/AIDS. They include rights that will help prevent the transmission of the disease, the rights of those who are, or are perceived to be, living with HIV, the rights of families, health workers and others who are stigmatized by association, and the rights of populations such as injecting drug users (IDUs) or men who have sex with men (MSM) who may be exposed to higher than average risk of HIV. Some of these rights are contained in international conventions directly applicable to HIV/AIDS, and some are found in other documents.² In all cases, HIV/AIDS is, in very large part, a question of human rights.

109. The UNAIDS web site puts the point as follows:³

The risk of HIV infection and its impact feeds on violations of human rights, including discrimination against women and marginalized groups such as sex workers, people who inject drugs and men who have sex with men. HIV also frequently begets human rights violations such as further discrimination and violence. Over the past decade the critical need for strengthening human rights to effectively respond to the epidemic and deal with its effects has become ever more clear. Protecting human rights and promoting public health are, in fact, mutually reinforcing.

The international human rights system explicitly recognizes HIV status as a prohibited ground of discrimination in its time-bound commitments, most recently in the Political Declaration of the 2006 High-level Meeting on AIDS. However, reports indicate that stigma and discrimination against people living with HIV remain pervasive. Moreover, the HIV response is insufficiently grounded in the promotion, protection and fulfilment of human rights. Several countries still have policies that interfere with the accessibility and effectiveness of HIV-related measures for prevention and care. Examples include laws criminalizing consensual sex between men, prohibiting condom and needle access for prisoners, and using residency status to restrict access to prevention and treatment services. At the same time, laws and

² A number of international human rights instruments are referred to in this report. One of the first enunciations of the human rights principles involved was the International Guidelines on HIV/AIDS and Human Rights in 1996, which were reaffirmed in 2002 and have been reflected in the work of UNAIDS and its co-sponsors since then. They are also reflected in the ILO code of practice. They may be found at http://www.ohchr.org/english/issues/hiv/docs/consolidated_guidelines.pdf

³ See the UNAIDS web site at http://www.unaids.org/en/Policies/Human_rights/default.asp

regulations protecting people with HIV from discrimination are not enacted, or fully implemented or enforced.

110. In 2001, the UN General Assembly in a special session adopted a Declaration of Commitment on HIV/AIDS which includes a commitment on human rights at the national level:

37. By 2003, ensure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS that: address the epidemic in forthright terms; confront stigma, silence and denial; address gender and age-based dimensions of the epidemic; eliminate discrimination and marginalization; involve partnerships with civil society and the business sector and the full participation of people living with HIV/AIDS, those in vulnerable groups and people mostly at risk, particularly women and young people; are resourced to the extent possible from national budgets without excluding other sources, inter alia, international cooperation; fully promote and protect all human rights and fundamental freedoms, including the right to the highest attainable standard of physical and mental health; integrate a gender perspective; and address risk, vulnerability, prevention, care, treatment and support and reduction of the impact of the epidemic; and strengthen health, education and legal system capacity.⁴

111. In reviewing these commitments in another special session in 2006, the General Assembly for the first time involved civil society, which emphasized the importance of involving PLHIV in efforts to combat the epidemic. The General Assembly adopted the following language:

11. [We, Heads of State and Government and representatives of States and Governments] Reaffirm that the full realization of all human rights and fundamental freedoms for all is an essential element in the global response to the HIV/AIDS pandemic, including in the areas of prevention, treatment, care and support, and recognize that addressing stigma and discrimination is also a critical element in combating the global HIV/AIDS pandemic.⁵

112. The ILO code of practice contains no comprehensive human rights statement, but it is rights-based and its principles protect and promote fundamental rights. While there is no international labour Convention that specifically addresses the range of rights issues raised by HIV/AIDS at the workplace, the code of practice draws on the many instruments which cover both protection against discrimination and prevention of infection. These can be and have been used in many contexts. The Conventions that are particularly relevant⁶ to promoting respect for human rights in the context of HIV/AIDS and whose application can contribute to achieving universal access include:

- Discrimination (Employment and Occupation) Convention, 1958 (No. 111).
- Occupational Safety and Health Convention 1981 (No. 155).
- Occupational Health Services Convention 1985 (No. 161).
- Termination of Employment Convention, 1982 (No. 158).
- Vocational Rehabilitation and Employment (Disabled Persons) Convention, 1983 (No. 159).
- Social Security (Minimum Standards) Convention, 1952 (No. 102).
- Labour Inspection Convention, 1947 (No. 81), and Labour Inspection (Agriculture) Convention, 1969 (No. 129).

⁴ General Assembly resolution A/RES/S-26/2: Declaration of Commitment on HIV/AIDS, 2 Aug. 2001.

⁵ General Assembly resolution A/RES/60/262: Political Declaration on HIV/AIDS, 15 June 2006.

⁶ As is outlined below, these are not the only ILO or other international Conventions that are relevant.

- Maritime Labour Convention, 2006 (the only ILO instrument to contain explicit references to HIV/AIDS as a question of safety and health).
- Work in Fishing Convention, 2007 (No. 188).

113. In addition to protection against discrimination and stigmatization, other fundamental workers' rights are also important. If they are in place, prevention of infection and proper care and treatment of the disease is easier. Freedom of association and collective bargaining (Conventions Nos 87 and 98 in particular) are indispensable to framing adequate and appropriate responses to the epidemic, preventing exposure to situations in which HIV is transmitted, and ensuring that the voices of the social partners are heard in the discussion at the wider national and international levels. Inclusion of HIV/AIDS policies in collective bargaining agreements is a strong tool for protecting workers and adopting workplace policies that are appropriate to particular situations.

114. Workers who are in a situation of forced labour (as defined in Conventions Nos 29 and 105) are particularly vulnerable because most of them are, by definition, beyond the protections often afforded to workers in regular employment situations. Child labour (Conventions Nos 138 and 182) not only often results from AIDS in that it leaves children orphaned and having to find work to support themselves, but also exposes children to HIV – especially in the worst forms of child labour such as sexual exploitation, when child labour leaves them particularly exposed to sexual abuse, or when they are in a situation in which normal workplace protections are neglected or ignored.

115. The clearest statements of human rights concerns associated with HIV/AIDS are those arising from the knowledge that people who are, or are perceived to be, living with HIV are subject to *discrimination*. This discrimination takes many forms, and results in loss or denial of jobs, denial of insurance coverage, and social ostracism, among other things. Because it excludes people from the protection, access to services, and support they find in workplaces, this discrimination shortens lives and drastically increases the cost of HIV/AIDS to individuals and to societies.

116. The ILO code of practice includes two basic principles directly related to discrimination.

4.2. *Non-discrimination*

In the spirit of decent work and respect for the human rights and dignity of persons infected or affected by HIV/AIDS, there should be no discrimination against workers on the basis of real or perceived HIV status. Discrimination and stigmatization of people living with HIV/AIDS inhibits efforts aimed at promoting HIV/AIDS prevention. [This principle is reinforced by points 4.6 and 4.8 which protect employment, and by 4.7 which protects confidentiality.]

4.3. *Gender equality*

The gender dimensions of HIV/AIDS should be recognized. Women are more likely to become infected and are more often adversely affected by the HIV/AIDS epidemic than men due to biological, socio-cultural and economic reasons. The greater the gender discrimination in societies and the lower the position of women, the more negatively they are affected by HIV. Therefore, more equal gender relations and the empowerment of women are vital to successfully prevent the spread of HIV infection and enable women to cope with HIV/AIDS.

117. Discrimination against HIV-positive workers is not only a violation of their human rights; it also has serious effects on their families and households as well as their place of work. HIV-positive workers who are medically fit to work should be allowed to do so, in order to earn a living for themselves and their families, and keep their skills and

experience in the workplace. While they work, they also continue to benefit in many cases from health care and insurance coverage, when this is available through their jobs.

118. Associated discrimination is often suffered by groups who are known to be exposed to risk of HIV transmission, for example health workers, MSM, sex workers and others. The discrimination to which such groups are subject is thus reinforced by the assumption that they may be HIV-positive, while their risk of exposure is increased when they are excluded from jobs and health-care programmes as a result of discrimination.

119. The main ILO Convention concerning discrimination is Convention No. 111. Article 1(1)(a) defines discrimination as “any distinction, exclusion or preference made on the basis of race, colour, sex, religion, political opinion, national extraction or social origin, which has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation”. While this does not refer to HIV/AIDS, Article 1(1)(b) extends coverage to “such other distinction, exclusion or preference which has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation as may be determined by the Member concerned after consultation with representative employers’ and workers’ organizations, where such exist, and with other appropriate bodies”. Article 5(2) specifies that special measures adopted on the basis of “disablement”, *inter alia*, are not necessarily to be regarded as discrimination. Thus, if governments make the necessary determination in consultation with workers’ and employers’ organizations, the prohibition against discrimination on the basis of HIV/AIDS status – actual or perceived – may be protected by Convention No. 111, which is one of the most widely ratified ILO instruments and a fundamental human rights Convention.

120. The ILO Committee of Experts on the Application of Conventions and Recommendations has noted a number of countries in which the national labour or other non-discrimination legislation covers HIV status, or health more generally, and where it has asked for governments’ confirmation that the coverage of the Convention has been extended to that effect.⁷ As this confirmation has generally not been forthcoming, owing perhaps to a lack of understanding of the implications of using Article 1(1)(b) for this purpose, some additional incentive to this effect might be appropriate.

121. Convention No. 111 *does* refer explicitly to discrimination based on sex. Discrimination against women in society generally, as well as in work and in education, lowers women’s social status and weakens their negotiating power at home and at work. It thus renders them more susceptible to HIV infection and makes their access to prevention, care and treatment more difficult.

122. In addition, discrimination on the basis of sexual orientation has been added to the prohibited grounds of discrimination in a number of countries, which may also increase protection against discrimination based on perceived, as opposed to actual, HIV status. MSM are in many cases perceived to be at risk of HIV, and experience discrimination unrelated to their actual health status.

123. Non-discrimination is of course a central principle of international human rights law. Article 2 of the Universal Declaration of Human Rights proscribes discrimination based on race, colour, sex, language, religion, opinion, or “other status”. It is also generally accepted that the broader protection from discrimination contained in other

⁷ See also Ch. III.

international instruments such as the International Covenant on Economic, Social and Cultural Rights (1966) and the Convention on the Elimination of All Forms of Discrimination against Women (1979), can apply to HIV status. The UN Commission on Human Rights has stated that the term “other status” must be interpreted as including health status, including HIV/AIDS, and that discrimination on the basis of a presumed or admitted HIV-positive status is prohibited by current human rights standards.⁸

124. As regards wider questions related to discrimination, while most statements prohibiting discrimination in this area relate to gender (including both “sex” and “sexual orientation”) and to HIV status, there are wider questions of discrimination that should also be raised in the proposed Recommendation.

125. Membership of any group subject to discrimination increases the risk of transmission, and at the same time reduces access to prevention, care and treatment. This is particularly the case when such discrimination results in more difficult access to the workforce or to the formal economy, where HIV/AIDS measures are generally available. For instance, discrimination on the basis of race and colour, national origin and other grounds referred to in Convention No. 111 and other international standards are factors in the propagation of HIV, because people belonging to these groups often suffer discrimination in access to jobs or to the protections that should be available generally. Ethnic minorities and indigenous and tribal peoples are particularly affected. Persons in occupational categories such as health workers, migrant workers, agricultural workers, sex workers and others in the informal economy are generally at increased risk of HIV transmission and associated problems, in many cases because of lack of access to the structures and services available in formal economy workplaces. These workers are in principle covered and should be protected under the same rights that are applicable to all workers, but in many cases they are excluded from the protection of national legislation, either explicitly or because of lack of legislative coverage and enforcement mechanisms.

126. There are two conclusions that might be drawn from this for the proposed Recommendation. One is that there might be a reference to the desirability of ratifying States’ explicitly extending coverage of Convention No. 111 to cover HIV/AIDS status and other excluded workers, in accordance with Article 1(1)(b) of that Convention. The other is that the Recommendation might extend its reference to the right to non-discrimination beyond those groups to which Convention No. 111 explicitly refers, and refer to this right as one of general application to all groups that might suffer discrimination.

127. The Termination of Employment Convention, 1982 (No. 158), is also directly relevant here. Article 4 provides that the employment of a worker “shall not be terminated unless there is a valid reason for such termination connected with the capacity or conduct of the worker or based on the operational requirements of the undertaking, establishment or service”. While the specific grounds listed in Article 5 as being prohibited as justifications for termination do not contain a reference to HIV status, the general statement that any termination should be connected with the capacity or conduct of the worker would suffice to prohibit termination merely on the basis of being, or being perceived to be, HIV-positive. Of course, if the worker becomes ill with related infections to the point of becoming unfit to work, termination would not be prohibited under Convention No. 158, thus highlighting the importance of prevention and treatment in the workplace to ensure that this situation arises as infrequently as possible. Access to

⁸ See UNHCR resolutions 1995/44 and 1996/43, available at: www.unhcr.ch/Huridocda/Huridoca.nsf

ARV treatment, for instance, would ensure in many cases that workers remain fit for work for a much longer time.

128. One more aspect of equality of opportunity that should be mentioned is reflected in the Vocational Rehabilitation and Employment (Disabled Persons) Convention, 1983 (No. 159). Workers who have developed AIDS may still be able to continue working for some time, with the advantages of earning a living for themselves and their families and remaining within the support networks that have already been mentioned. Once again, this is especially the case if the workers concerned have access to ARV treatment, which does not cure the HIV infection, but diminishes or postpones its symptoms and thereby enhances an individual's capacity to work. According to Article 2 of this Convention, ratifying States are required to "formulate, implement and periodically review a national policy on vocational rehabilitation and employment of disabled persons". Article 4 states that this policy "shall be based on the principle of equal opportunity between disabled workers and workers generally. Equality of opportunity and treatment for disabled men and women workers shall be respected. Special positive measures aimed at effective equality of opportunity and treatment between disabled workers and other workers shall not be regarded as discriminating against other workers". These provisions mean that workers who are disabled but not incapacitated should be given opportunities while they can work, on a basis of equality. This kind of provision should be incorporated into the national HIV/AIDS policy, and might also be included in the proposed Recommendation.

129. As regards the right to a safe and healthy working environment, the Preamble to the ILO Constitution refers to "the protection of the worker against sickness, disease and injury arising out of his employment" as one of the ILO's responsibilities. Article 23(1) of the Universal Declaration of Human Rights proclaims the right "to just and favourable conditions of work", a theme developed in the International Covenant on Economic, Social and Cultural Rights (Article 7) as "the right of everyone to the enjoyment of just and favourable conditions of work which ensure, in particular ... (b) Safe and healthy working conditions".

130. This has been developed further in a number of ILO standards on safety and health, especially the Occupational Safety and Health Convention, 1981 (No. 155), the Occupational Health Services Convention, 1985 (No. 161), and the Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187), and Recommendation (No. 197). In addition, the ILO has adopted a large number of codes of practice that relate to safety and health at work. It has also adopted specific guidelines, in some cases jointly with other international organizations, on HIV risk in various sectors, including health,⁹ education¹⁰ and transport.¹¹

131. These instruments concern one category of action against HIV/AIDS, which is the protection of workers from occupation-related infection. Another aspect of safety and health that has been neglected in the discussion on HIV/AIDS is that it is a *direct* workplace hazard, as well as an *indirect* one. When conditions of work are such that they

⁹ ILO/WHO: *Joint ILO/WHO guidelines on health services and HIV/AIDS*, 2005, available at: <http://www.ilo.org/public/english/protection/trav/aids/publ/hsgl.pdf>

¹⁰ ILO/UNESCO: *HIV/AIDS workplace policy for the education sector in the Caribbean*, 2006, available at: <http://www.ilo.org/public/english/dialogue/sector/papers/education/carib-ed-policy.pdf> and ILO/UNESCO: *HIV/AIDS workplace policy for the education sector in southern Africa*, 2006, available at: <http://unesdoc.unesco.org/images/0014/001469/146933E.pdf>

¹¹ ILO/AIDS: *Using the ILO code of practice on HIV/AIDS and the world of work – Guidelines for the transport sector*, 2005, available at: <http://www.ilo.org/public/english/protection/trav/aids/publ/trgl.pdf>

do not allow workers to be fully protected, when hours of work are long and lead to fatigue, and when workers are not provided with the education and training they need fully to apprehend the risks of their working environment, they are placed at greater risk of exposure to the virus. In parallel with this is the fact that their conditions of work are made worse where there is a high prevalence of HIV/AIDS. This brings into the discussion the concept of decent work, and engages the ILO throughout its core programme of work.

132. As regards the right to social security, this is considered in detail below.

Elements of universal access

Universal access to prevention

133. The ILO code of practice gives great prominence to prevention as part of an overall strategy:

4.9. Prevention

HIV infection is preventable. Prevention of all means of transmission can be achieved through a variety of strategies which are appropriately targeted to national conditions and which are culturally sensitive.

Prevention can be furthered through changes in behaviour, knowledge, treatment and the creation of a non-discriminatory environment.

The social partners are in a unique position to promote prevention efforts particularly in relation to changing attitudes and behaviours through the provision of information and education, and in addressing socio-economic factors.

134. The code of practice also provides for government action towards prevention. Point 5.1(d) states that: “The competent authorities should instigate and work in partnership with other social partners to promote awareness and prevention programmes, particularly in the workplace.” Point 5.2(a) defines the employers’ role as follows: “Employers should consult with workers and their representatives to develop and implement an appropriate policy for their workplace, designed to prevent the spread of the infection and protect all workers from discrimination related to HIV/AIDS.” Point 5.2(c) calls for employers and their organizations, in consultation with workers and their representatives, to “initiate and support programmes at their workplaces to inform, educate and train workers about HIV/AIDS prevention ...”; and point 5.3 calls on workers and their organizations to cooperate with employers in these efforts of education and prevention.

135. Section 6 of the code of practice is devoted to “prevention through information and education”. It notes among other things that “Workplace information and education programmes are essential to combat the spread of the epidemic and to foster greater tolerance for workers with HIV/AIDS. Effective education can contribute to the capacity of workers to protect themselves against HIV infection”. Various guidelines are provided on the form, content and methodology for such educational programmes, and the need to support them with practical measures such as condom distribution. Since the adoption of the code it has become clear that senior and line management in workplaces are often not included in training programmes and businesses therefore do not benefit from the latest information and good practices available. This delays or impedes implementation of effective and timely cooperation and universal access programmes.

136. In practice, there are many obstacles to preventive measures being put into place. The first of these is a lack of recognition in some countries that the epidemic is a real

threat to people and to the economy. In low-prevalence countries in particular, it is necessary to create a greater sense of urgency for governments, the social partners and others, to examine how to prevent the further transmission of HIV.

137. A second obstacle – one which, fortunately, is being overcome progressively in the face of necessity – may be a reluctance in some cultures to speak publicly of sexual practices and related matters. Where governments have been reluctant to do so, they have failed to convey to their populations, and in particular to the highest-risk groups, how they can reduce their chances of transmitting or contracting HIV; on the other hand, when they have undertaken open information campaigns, this has had a real effect. The workplace has enormous potential as a model of openness, non-discrimination and peer support.

138. The absence of public infrastructure often prevents or limits access to preventive measures. The lack of adequate public health services, including the absence of education and training on how to avoid HIV infection, and lack of access to condoms along with the information necessary to use them correctly, means a failure to make available the information that can have a preventive effect. This is not, of course, directly a workplace issue, but there are a number of instances of employers furnishing both education and even condoms to their workers, thus extending their assistance to their workers and their families into areas in which governments have proven unable to respond to the needs, in order to sustain their businesses and contribute to economic growth. This is not something for which employers should continue to bear principal responsibility in the long term, and a coherent reaction to the epidemic, including measures to implement the proposed Recommendation, could help to shift responsibility for these measures back to governments. The experience of workers' and employers' organizations will be crucial to helping governments design the necessary measures, when they are able to do so.

139. Lastly, it can be mentioned that prevention strategies (peer education, information and awareness, condom distribution) have proven more effective when they have encouraged ownership and the participation of communities, including the workplace community and its actors employers, workers and their representatives.

140. As indicated in Chapter I, there are countries in which preventive efforts have made real progress, but that is not generally the case and cannot be attributed to single factors. Success is also related to greater access to treatment, where this has been achieved, as there is an interaction between the two that cannot be neglected.

141. This may in itself be one of the contributions which a new Recommendation can make to preventing the spread of the disease, especially if it encourages the involvement of employers, workers and labour ministries in national strategies to combat HIV, and if it brings a sense of urgency to efforts to put preventive measures in place.

Universal access to treatment, care and support

142. In the code of practice, this principle finds the following expressions as concerns HIV/AIDS:

4.10. Care and support

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

...

5.1. *Governments and their competent authorities*

...

- (f) *Social protection.* Governments should ensure that benefits under national laws and regulations apply to workers with HIV/AIDS no less favourably than to workers with other serious illnesses. In designing and implementing social security programmes, governments should take into account the progressive and intermittent nature of the disease and tailor schemes accordingly, for example by making benefits available as and when needed and by the expeditious treatment of claims.

...

9.5. *Benefits*

- (a) Governments, in consultation with the social partners, should ensure that benefits under national laws and regulations apply to workers with HIV/AIDS no less favourably than to workers with other serious illnesses. They should also explore the sustainability of new benefits specifically addressing the progressive and intermittent nature of HIV/AIDS.
- (b) Employers and employers' and workers' organizations should pursue with governments the adaptation of existing benefit mechanisms to the needs of workers with HIV/AIDS, including wage subsidy schemes.

9.6. *Social security coverage*

- (a) Governments, employers and workers' organizations should take all steps necessary to ensure that workers with HIV/AIDS and their families are not excluded from the full protection and benefits of social security programmes and occupational schemes. This should also apply to workers and their families from occupational and social groups perceived to be at risk of HIV/AIDS.
- (b) These programmes and schemes should provide similar benefits for workers with HIV/AIDS as those for workers with other serious illnesses.

The context

143. Provision of health care for PLHIV cannot be seen in isolation from the broader context of health-care coverage, and is intimately linked to the ILO's work on social security.¹² Recent ILO research shows that, in spite of the urgent need for universal access to health care in accordance with the ILO's social security policy, there are significant gaps. These gaps affect those living with HIV, and in many cases are made worse for them.

The rights dimension

144. The first aspect of this discussion is one of human rights, and specifically the right to health and to access to medical care. The Universal Declaration of Human Rights states in Article 22 that: "Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international cooperation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality."

145. Article 9 of the International Covenant on Economic, Social and Cultural Rights provides that: "The States Parties to the present Covenant recognize the right of everyone to social security, including social insurance." Article 12 of the Covenant

¹² See ILO: *Social health protection: An ILO strategy towards universal access to health care*, Social Security Department, Issues in Social Protection, Discussion Paper 19, Aug. 2007, available at: <http://www.ilo.org/public/english/protection/seccoc/downloads/healthpolicy.pdf>

relates to health care and lays down the obligation of States parties to take steps for the full realization of the right to health, which include the prevention, treatment and control of epidemic, endemic, occupational and other diseases. Article 12 reads as follows:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

- (a) the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
- (b) the improvement of all aspects of environmental and industrial hygiene;
- (c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases;
- (d) the creation of conditions which would assure to all medical service and medical attention in the event of sickness.

146. The ILO is the principal guarantor of this right in international law, as it pertains to the workplace. Article III of the Declaration of Philadelphia includes among the obligations of the ILO:

- (f) the extension of social security measures to provide a basic income to all in need of such protection and comprehensive medical care;
- (g) adequate protection for the life and health of workers in all occupations.

147. The ILO has adopted a number of international labour standards on the subject, the most important being the Social Security (Minimum Standards) Convention, 1952 (No. 102). There are also elements of protection of the right to equal treatment under Convention No. 111, and of OSH under the broad range of instruments on that subject (discussed below).

How is health care provided?

148. Health care may be provided under public health systems, social and national insurance schemes, employer-financed workplace schemes, private commercial and not-for-profit health insurance schemes including community-based schemes, or a combination of these. While each of these schemes has advantages and disadvantages, for example, with regard to equity and quality of services, they are often uncoordinated at the national level, which results in gaps in access and coverage for the poor – in particular, for the purposes of this report, for those affected by HIV/AIDS. This can be addressed by rationalizing all existing health-financing mechanisms in a country with a view to achieving universal coverage that includes PLHIV.

149. As for estimating the scale of the global access deficit, globally comparable data on access to health services are unfortunately rather weak and incomplete for the purpose of international comparisons. Available WHO data indicate that, worldwide, about 1.3 billion people have no access to effective and affordable health care when it is needed, while 170 million people are forced to spend more than 40 per cent of their household income on medical treatment. The UN Human Development Report estimated in 1997¹³ that most of the poor who lack access to health services live in developing countries: 34 per cent of the population in South Asia, 27 per cent in sub-Saharan Africa and 19 per cent in South-East Asia and the Pacific lack access to health services, and this

¹³ UNDP: Human Development Report 1997, available at: <http://hdr.undp.org/en/reports/global/hdr1997/>

was before the full impact of the HIV/AIDS epidemic on the health-care infrastructure had been felt. Millions more have some access to health care, but when it is incomplete it does not in practice ensure that all workers and their families receive the kind of care and support they need in order to stay alive.

150. With regard to social security systems, the Office noted, in a report to the 2001 session of the International Labour Conference concerning social security, that social security coverage is far from universal:

One of the key global problems facing social security today is the fact that more than half of the world's population (workers and their dependants) is excluded from any type of social security protection. They are covered neither by a contribution-based social insurance scheme nor by tax-financed social benefits, while a significant additional proportion is covered for only a few contingencies. In sub-Saharan Africa and South Asia, statutory social security personal coverage is estimated at 5 to 10 per cent of the working population and in some cases is decreasing. In Latin America, coverage lies roughly between 10 and 80 per cent, and is mainly stagnating. In South-East and East Asia, coverage can vary between 10 and almost 100 per cent, and in many cases was until recently increasing. In most industrialized countries, coverage is close to 100 per cent, although in a number of these countries, especially those in transition, compliance rates have fallen in recent years.¹⁴

151. This discussion resulted in an agreement on social security to give highest priority to “policies and initiatives which can bring social security to those who are not covered by existing systems”.¹⁵ It is part of the ILO's Global Campaign on Social Security and Coverage for All.

152. Mechanisms for financing social health protection range from tax-funded “national health service” delivery systems to contributions-based mandatory social health insurance financed by employers and workers (involving tripartite governance structures) and mandated or regulated private non-profit health insurance schemes, as well as mutual and community-based non-profit health insurance schemes. All these financing mechanisms normally involve the pooling of risks among the persons covered, and many of them explicitly include cross-subsidizations between the rich and the poor. Some form of cross-subsidization between the rich and the poor exists in all social health protection systems; otherwise the goal of universal access could not be pursued or attained.

153. Virtually all countries have built systems based on various financing mechanisms that combine two or more of these options. The ILO's social health protection policies explicitly and pragmatically recognize the pluralistic nature of national health protection systems, and advise governments and other key players in social health protection to pursue strategic systemic combinations of national financing systems that aim to ensure universal and equitable access, financial protection in case of sickness, and overall efficient and effective delivery of health services. In this context it is important to ensure that national health financing systems do not crowd out other social security benefits.

154. Social health protection is increasingly seen as contributing to building human capital that yields economic profits through gains in productivity and higher macroeconomic growth. The current debate also focuses on the links between ill health and poverty: they figure prominently in Poverty Reduction Strategy Papers (PRSPs) and have been addressed in the MDGs aimed at halving extreme poverty and improving health. Implementing universal social health protection might turn out to be a milestone

¹⁴ ILO: *Social security: Issues, challenges and prospects*, Report VI, ILC, 89th Session, Geneva, 2001, p. 3, available at <http://www.ilo.org/public/english/standards/relm/ilc/ilc89/rep-vi.htm>

¹⁵ ILO: *Decent work and the informal economy*, Report VI, ILC, 90th Session, Geneva, 2002.

on the way to achieving the MDGs by 2015. This subject is therefore part of a much wider debate on the relationship between health, social protection and development, to which the challenge of AIDS has added an increased sense of urgency.

Making social security available to all

155. While it is an accepted principle that everyone should have access to social security, this is manifestly far from the case in practice today, especially in the context of HIV/AIDS. There are some initiatives that address this problem.

156. One approach is to ensure that persons otherwise entitled to social security coverage do not lose it because they are HIV-positive or have symptomatic AIDS. In a number of countries, there is legislative protection ensuring that workers and their families are covered by social security schemes and other insurance benefits when they are living with HIV/AIDS. For example, in Malaysia¹⁶ PLHIV have the right to insurance coverage, and HIV status is treated like any other similar medical condition. This is also the case in Nepal.¹⁷ In Nicaragua¹⁸ PLHIV continue to receive benefits from the social security system. The Office has been unable to verify the extent to which these provisions have been given practical effect, but clearly the adoption of such legislation should be part of the national policy that would be declared and pursued under the proposed Recommendation.

157. Another approach is to make social security coverage more available to those who are excluded for other reasons, in particular the poor and those who work in the informal economy. The ILO is supporting African countries in a new social protection initiative to create or reinforce local structures in charge of extending social protection, and seeking to promote the extension of social security throughout society, including the informal economy. The aim is to have all major components of social protection (social security, OSH, working conditions, measures to address HIV/AIDS, and improvements in the situation with regard to labour migration) fully taken into account in exercises such as the PRSPs, the United Nations Development Assistance Framework (UNDAP) and the New Partnership for Africa's Development (NEPAD).¹⁹

158. The ILO promotes a step-by-step approach to the extension of social health protection schemes. These usually start by providing a certain level of benefits, including services and financial protection, to a limited number of groups in society, and progressively improve the level of services and financial protection as well as extend benefits to a larger group of the population. In the context of the response to HIV/AIDS in Africa, a priority in the provision of effective access to health services and financial coverage should be women, children, workers in the informal economy and older persons. The range of social initiatives represents an opportunity for African societies to redevelop their social arrangements on a more realistic, comprehensive and effective basis.

159. It is hoped that the Recommendation can help guide member States, including labour ministries and the social partners, to frame the HIV/AIDS response in the context

¹⁶ See in Appendix II: Malaysia 1, s. 7.

¹⁷ See in Appendix II: Nepal 3, Goal 5.2.5.

¹⁸ See in Appendix II: Nicaragua 1, s. 23.

¹⁹ See further: UN: *The New Partnership for Africa's Development: Fourth consolidated report on progress in implementation and international support*, General Assembly, A/61/212, Aug. 2006.

of an extended social protection system, developing sustainable safety nets and social policies that are not confined to palliative measures.

Private insurance companies

160. While the primary avenue for providing health care and coverage to PLHIV should be through social insurance schemes, an important element of access to health care for many workers is private insurance companies, which provide supplementary or alternative coverage. A number of countries have required by law that insurance be furnished on a non-discriminatory basis to PLHIV. For example, in Malaysia,²⁰ Nepal,²¹ Nigeria²² and Zimbabwe,²³ HIV/AIDS is treated for insurance purposes like other chronic diseases, while in Papua New Guinea²⁴ it is provided that it shall not be considered to be a discriminatory act if HIV/AIDS is treated as other chronic diseases. In the Philippines²⁵ it is provided that all credit and loan services, including health, accident and life insurance, must not be denied to a person on the basis of her or his actual, perceived or suspected HIV status, provided that the person has not concealed or misinterpreted the fact to the insurance company when submitting an application. Similarly, extension and continuation of credit and loans cannot be denied solely on the basis of said health condition. In Togo²⁶ people with HIV have the right to subscribe to any insurance, in particular life insurance, with the insurance companies of their choice. In Sierra Leone²⁷ no one can be compelled to undergo an HIV test or disclose his or her HIV status for the sole purpose of gaining access to credit or insurance or the extension or continuation of such service. Life and health insurance companies are required to devise a reasonable limit of cover for which a proposer cannot be required to disclose her or his HIV status. If a person asks for a coverage exceeding the “no-test-limit”, tests may be done and if the result is positive, the insurer may add an additional sum to the premium. A grievance procedure is available to decide what is considered “reasonable” in this respect.

161. In Namibia²⁸ the relevant law provides that occupational benefits must not be discriminatory, and should make efforts to protect the rights and benefits of the dependants of deceased and retired employees. Information on these schemes must be confidential. Private and public health financing mechanisms should provide standard benefits to all employees regardless of their HIV status. Section 6.7.4 of the law provides that counselling and advisory services must be made available to inform all workers on their rights and benefits from medical aid, life insurance, pension and social security funds. This should include information on intended changes to the structure, benefits and premiums of these funds. The Collective Bargaining Agreement of 2001 between Jowells Transport and the Namibia Transport and Allied Workers’ Union states in section 2.5 that “employees who are clinically ill or medically unfit for work shall enjoy

²⁰ See in Appendix II: Malaysia 1, op. cit.

²¹ See in Appendix II: Nepal 3, op. cit.

²² See in Appendix II: Nigeria 3, s. 14.

²³ See in Appendix II: Zimbabwe 4, s. 7.

²⁴ See in Appendix II: Papua New Guinea 1, s. 8.

²⁵ See in Appendix II: Philippines, s. 30.

²⁶ See in Appendix II: Togo 2, s. 31.

²⁷ See in Appendix II: Sierra Leone 1, s. 27.

²⁸ See in Appendix II: Namibia 1, s. 6.7.

benefits in terms of the relevant conditions of employment as negotiated from time to time between the parties”. Section 2.6 states that “[i]n respect of employees who are infected and cannot perform their duties, the parties should consult on how the workers could best be accommodated in respect of sick leave entitlements and/or the disability process”.

162. There are other cases, however, in which insurance companies have responded by excluding HIV-positive persons from coverage. In such cases, the principles of the ILO code of practice are seriously infringed.

163. Private insurers have adopted various methods of denying PLHIV access to insurance. These include:

- Exclusion clauses which dictate that no payment will be made in respect of any insurance claim in the event of HIV/AIDS-related death or disability within a certain period of the issue date of the insurance policy (for instance, ten years).
- Medical record access clauses requiring medical examinations for various types of diagnostic and predictive medical procedures, including HIV tests, along with other blood or urine tests, before determining whether to cover an individual for new life insurance, disability insurance, or medical expenses insurance.
- Alternatively, insurers ask applicants questions about HIV infections and AIDS, including whether they have been tested, diagnosed, or treated for either an HIV infection or AIDS. In such cases the insurance companies reserve the right to verify the information given by the applicant, and the insured agrees to waive confidentiality between doctor and patient.
- Retroactive rescission clauses which allow the insurance companies to rescind policies in the event that the insured person is believed to have misled the insurer or concealed information regarding his or her HIV status before signing the insurance contract.

164. Some positive measures have also been identified in some countries to overcome this problem. The advances that have been made in the insurance sectors in those countries have derived either from the fact that those countries appear to have attached a greater sense of urgency to addressing this issue or have been compelled by the scale of the HIV/AIDS crisis facing them to pursue more progressive policies and practices. Examples of the latter include South Africa and Uganda.

165. In some cases, these approaches have been mandated by legislation or legislative interpretation. In the United States, both federal and state law provides PLHIV with varying degrees of protection against adverse differential treatment. The application of the various anti-discrimination laws to insurance address discrimination based on a variety of grounds, including race, sex, age, disability, genetic makeup, domestic violence, and mental illness. With regard to PLHIV, where insurers provide coverage for socially “favoured” catastrophic conditions such as cancer or heart disease, federal law requires actuarially similar “disfavoured” diseases such as HIV/AIDS to be covered as well.

166. In a number of other cases, insurance companies have responded to the need without legislative prompting. In Uganda, AON Uganda Ltd has created the country’s first ever medical insurance programme for PLHIV. Companies that have signed up to AON’s medical insurance scheme make quarterly deposits into AON’s medical account. Under the programme, individuals with HIV receive medical treatment at hospitals and clinics. Treatment is provided for pre-existing and chronic ailments and includes ARV

drugs. Employees covered by the scheme have varying treatment cost ceilings which can be adjusted by the company. The programme also covers treatment for family members on some treatment options including ARV drugs and dental treatment. The scheme guarantees confidentiality, including separate invoices, and numbers, rather than names, are used to identify participants.

167. In South Africa, African Life lifted HIV/AIDS exclusions on life insurance policies in 2004,²⁹ although benefits are not paid in cases where immediate family members of insured persons die of an AIDS-related illness within a specified time after the signing of the contract, or in cases where extended family members die within 12 months. In addition, the 36 member companies of the South African Life Offices Association have scrapped HIV exclusion clauses for clients applying for new policies, and removed HIV exclusion clauses from existing and new life policies.

168. In the United Kingdom, the Association of British Insurers (ABI), which has a membership of more than 200 insurance companies, has issued a new Statement of Practice entitled “Underwriting Life Insurance for HIV/AIDS”. This stipulates that British life insurance agents cannot ask male applicants questions about their sexual practices in order to determine their HIV risk.³⁰ The new guidelines prevent insurers from asking general practitioners about patients’ sexuality or from engaging in “speculative underwriting”. The ABI has also changed its statement of best practice for HIV/AIDS to state that persons applying for insurance should not be asked questions pertaining to HIV exposure or testing in the last five years.³¹ Under the guidelines, HIV tests are required on policies worth more than approximately US\$1.75 million for women and married men, while tests are required on policies of more than about US\$440,000 for single men.³²

169. The Namibia Business Coalition on AIDS (NABCOA),³³ with technical and financial assistance from the ACCA project and the BACKUP initiative of GTZ, has commissioned a study of the existing health-care industry in Namibia in order to evaluate the gaps that exist in terms of the existing insurance and medical aid fund coverage offered to the public and the potentially large number of employees who cannot afford the premiums. The results of the investigation clearly indicate that the existing levels of cover provided by medical aid funds are insufficient and unaffordable for the lowest-income employees. In addition, it has been found that employers normally only provide coverage for their workforce, although in some cases subsidization of coverage is extended to include employees’ immediate households. The dependency of the extended family on low-income workers is often overlooked. In reality, these employees frequently provide financial assistance and access to medical treatment not

²⁹ From <http://ch.planetout.com/health/hiv/?sernum=3044> (Planet Out web site – on health and HIV), “South African life insurance company removes HIV exclusions” by Gus Cairns, 2004.

³⁰ Henry G. Kaiser Family Foundation: *Daily HIV/AIDS report*, Global Challenges, “New British Insurance Association Guidelines say questions about sexuality cannot be asked to determine HIV risk”, 4 Oct. 2005, available at: http://www.kaisernetwork.org/daily_reports/rep_hiv_recent_rep.cfm?dr_cat=1&show=yes&dr_DateTime=10-03-05

³¹ Reported in the web site Gay.com UK, Nov. 2004, available at: www.gay.com/

³² Association of British Insurers: *ABI statement of best practice on HIV and insurance*, came into force on 30 Sep. 2005, available at: http://www.abi.org.uk/Display/default.asp?Menu_ID=946&Menu_All=1,946,0&Child_ID=197

³³ See further World Economic Forum: *Namibia Business Coalition on HIV/AIDS (NABCOA): Profile*, June 2006, available at: <http://www.weforum.org/pdf/GHI/Namibia.pdf>

only for their immediate family, but also to family members who may be living in rural areas. The study further found that small and medium-sized enterprises (SMEs), in certain instances, do not have access to medical aid fund coverage, and that a dedicated HIV/AIDS disease management programme is simply unaffordable or inaccessible. It is recommended that those institutions currently offering such products to the market should amend their product design so as to make it more affordable and accessible for SMEs.

170. It appears necessary to continue to explore how to ensure that private health coverage remains available to all who need it, to supplement social security coverage and provide universal access to health-care financing for all PLHIV.

Access to treatment, including ARVs

171. This section has concentrated on the financing of treatment, but there is another, equally important, aspect of the question which is the availability of treatment that has proven to be effective – namely, ARV drugs. While this is partly a financial question, as these drugs are beyond the financial reach of most of the poor unless they are subsidized, there is also the problem of availability in much of the world, unless governments, employers or other actors intervene. Once treatment with ARVs has begun, people need to continue to take them as long as they live and, if the drugs are available, this may extend to many years. How can sustainability be assured?

172. The problem of some “roll-out plans” to make ARV treatment available has been that they tend to isolate the provision of the drugs from the social context. Beyond the financing of the treatment itself, some patients struggle to continue taking these drugs because they are not financially able to get to the health facilities where the drugs are provided, or because of particularly difficult working conditions (such as long and irregular hours, or long travel between home and workplace) which prevent strict adherence to a course of treatment. They may also find it difficult to continue with the regime as a result of persistent stigmatization. These are important reasons for community and workplace-based strategies to be closely coordinated and integrated, and to involve ministries of labour and the social partners in crafting plans for addressing HIV/AIDS in the country. Thus, stigmatization and discrimination need to be seen in the context of treatment strategies, as well as in prevention strategies. It is necessary also to envisage strengthening of health systems and the training and retention of health workers, if treatment is to be sustainable. The proposed Recommendation might therefore reflect the need to link treatment uptake to measures that ensure an improvement in the overall social and economic context as well as health care generally, and to involve the ILO’s constituents in national planning and implementation, as well as improving workers’ socio-economic conditions.

Testing, screening and confidentiality

173. The way in which testing, screening and confidentiality are dealt with is central to whether national action against HIV/AIDS is consistent with the code of practice and with the principles adopted by almost all actors on this question. The code treats this very difficult subject at some length, as follows:

4.6. Screening for purposes of exclusion from employment or work processes

HIV/AIDS screening should not be required of job applicants or persons in employment.

4.7. Confidentiality

There is no justification for asking job applicants or workers to disclose HIV-related personal information. Nor should co-workers be obliged to reveal such personal information about fellow workers. Access to personal data relating to a worker's HIV status should be bound by the rules of confidentiality consistent with the ILO's code of practice on the protection of workers' personal data, 1997.

...

8. Testing

Testing for HIV should not be carried out at the workplace except as specified in this code. It is unnecessary and imperils the human rights and dignity of workers: test results may be revealed and misused, and the informed consent of workers may not always be fully free or based on an appreciation of all the facts and implications of testing. Even outside the workplace, confidential testing for HIV should be the consequence of voluntary informed consent and performed by suitably qualified personnel only, in conditions of the strictest confidentiality.

8.1. Prohibition in recruitment and employment

HIV testing should not be required at the time of recruitment or as a condition of continued employment. Any routine medical testing, such as testing for fitness carried out prior to the commencement of employment or on a regular basis for workers, should not include mandatory HIV testing.

8.2. Prohibition for insurance purposes

- (a) HIV testing should not be required as a condition of eligibility for national social security schemes, general insurance policies, occupational schemes and health insurance.
- (b) Insurance companies should not require HIV testing before agreeing to provide coverage for a given workplace. They may base their cost and revenue estimates and their actuarial calculations on available epidemiological data for the general population.
- (c) Employers should not facilitate any testing for insurance purposes and all information that they already have should remain confidential.

174. Although they are dealt with extensively in the code of practice, these principles are not always easy either to reconcile or to apply in practice. They also express conflicting imperatives. Both individuals and society as a whole have a significant interest in discovering and knowing everyone's HIV status, especially in high-prevalence situations or when health and safety are at stake. On the other hand, the possibility – indeed likelihood – of stigmatization and discrimination against HIV-positive persons is a powerful disincentive to undergoing tests and getting treatment and care in and beyond the workplace.

175. The principle that testing should not be compulsory, which has been accepted by all co-sponsors of UNAIDS and by most activist organizations, is in fact widely violated. Pre-employment testing is a persistent phenomenon, in spite of widespread legislative prohibition of the practice. In addition, a number of countries require HIV testing before allowing migrants to enter their countries, and do not allow HIV-positive individuals to enter. In many cases, this reflects a conviction that HIV/AIDS is a “foreign” phenomenon and that it can be blocked by such measures (see below).

176. Nevertheless, there is today a change in the medical aspects of HIV/AIDS since this principle was adopted in the code of practice in 2001. The importance of knowing one's status is more fully understood, and treatment for the control of the virus is now available far more widely. As was already indicated in Chapter I, the expanded provision of ARV treatment has meant that significant numbers of lives have been extended.

177. This naturally raises the question of whether it has become more imperative to require that testing be carried out, so that people can know their status and obtain treatment. Is there any valid reason for qualifying the rule against compulsory testing in this situation?

178. The response of the AIDS community remains negative. In the first place, treatment is *more* widely available; it is far from *universally* available, and for financial and institutional reasons remains beyond the reach of most sections of the population in most places. Second, in spite of progress in awareness, persons living with and affected by HIV/AIDS are still subject to rampant discrimination, stigmatization, loss of employment and social ostracism. Although the code of practice calls for a more open and accepting environment, the time has not yet arrived when it is actually the prevailing philosophy.

179. The discussion on testing has now been put into a wider framework of encouraging everyone to “know their status”. This makes it incumbent on all those concerned – governments, health services, employers, and others – to work towards a situation in which most people wish to know their status and it is relatively easy for everyone wishing to know their status to be able to do so. A broad societal response is required for this to be practical. It means, among other things, that workplaces need to be able to ensure confidentiality and job security, and to promote access to treatment. Knowing one’s status helps to ensure sustainability of enterprises, while maintaining the material benefits and dignity for individuals with HIV that comes from having access to and maintaining gainful employment. The work the ILO has been doing together with the UNAIDS secretariat on employment opportunities for PLHIV is in the early stages but has already been a significant advance. Nevertheless, a great deal remains to be done.

Forms and modalities of testing

180. The ILO code of practice provides not only that testing must be voluntary, but that it should take place only with informed consent. As Chapter III shows, some national laws provide that this consent has to be in writing.

181. Nevertheless, the proportion of people who actually do know their status is very low in most regions. A Joint WHO/UNICEF/UNAIDS Technical Consultation on scaling up HIV testing and counselling in Asia and the Pacific was informed that fewer than 10 per cent of PLHIV in the region are aware of their status.³⁴ The consultation concluded that there is an urgent need to scale up access to HIV counselling and testing as a means of enhancing access to comprehensive HIV prevention, care and treatment. It also stated that existing models of voluntary counselling and testing need to be strengthened, scaled up and complemented by approaches that build on the potential of health services to offer HIV counselling and testing. This kind of approach to HIV testing, initiated by health-care providers – so-called “provider-initiated counselling and testing”, or PICT – should be accompanied by counselling and confidentiality and conditional on the person’s informed consent (that is, the “three Cs”). The WHO and UNAIDS secretariat issued guidance on PICT in May 2007.³⁵ Another aspect of this

³⁴ Conclusions and recommendations, Joint WHO/UNICEF/UNAIDS Technical Consultation on scaling up HIV testing and counselling in Asia and the Pacific, Phnom Penh, Cambodia, 4–6 June 2007, available at: http://www.searo.who.int/LinkFiles/AIDS_ConclusionsNRecommendations.pdf

³⁵ See WHO/UNAIDS: *Guidance on provider-initiated HIV testing and counselling in health facilities*, 2007, available at: http://whqlibdoc.who.int/publications/2007/9789241595568_eng.pdf

approach has been applied with respect to the prevention of mother-to-child transmission, whereby all pregnant women are tested for HIV unless they refuse.

182. This kind of approach is formally in compliance with the ILO code's position that testing must be voluntary and based on informed as well as formal consent. It certainly has advantages in increasing the number of people who are informed of their status, and in the right circumstances may also reduce the stigma often attached to testing, since it does not test only patients at risk, but all patients attending health facilities even if they are asymptomatic.

183. However, the Office has noted concerns that PICT may in fact result in disguised mandatory testing because the persons concerned must take action to prevent tests being carried out, which puts them under considerable pressure to agree to testing. Given the wide variations in the way testing is made available, and the practical difficulties of ensuring that the "three Cs" are in fact in place in all situations, there are so many cases in which the conditions of voluntariness are questionable that considerable care needs to be exercised in the application of PICT. The Office has therefore found it difficult to endorse this principle without reservations, in the light of the code of practice and lessons drawn from experience.

184. The Recommendation does not have to impose on member States the choice of means by which the principle of voluntary testing is reconciled with the urgent need to expand the number of people who know their status. It could leave open the possibility for member States, in consultation with relevant stakeholders and the community, including social partners, to look at their specific context and reflect on an effective solution to testing with respect for fundamental rights, reinforcing the need for member States to design and implement prevention strategies hand-in-hand with detection. It might be appropriate for the Recommendation to call for more widely available testing, outside the workplace, and safeguards for privacy, supported by measures to make treatment more widely available and more affordable.

185. In addition, in view of the widespread practice of requiring that some occupational categories be tested (see Chapter III), there should be a discussion in the course of adopting the proposed Recommendation as to whether the code's language should be re-examined to set the conditions under which limitations to voluntariness may be permissible. This is a basic human rights principle, but the number of countries or professional certifying bodies that have found it necessary to qualify that principle is sufficient to make further discussion necessary.

Risk and vulnerability

186. Many factors of risk and vulnerability need to be considered when international standards on HIV/AIDS in the workplace are adopted and subsequently put into practice. Many of these factors have nothing to do directly with the workplace, but result nevertheless in severe consequences for workers and their families, and for the world of work. It is important that labour ministries, employers and workers do not take the mistaken position that they only need to consider occupational risks that may lead to HIV transmission. HIV responses need to combine two complementary strategies: the reduction of risk through specific programmes for prevention; and the mitigation of vulnerability through more broadly based interventions for social, cultural, political, and economic change. It is particularly important not to associate the disease only with populations assumed to be "vulnerable" or "at risk".

Broader social, economic and political factors

187. Appendix I to the code of practice outlines a number of wider social factors that contribute to vulnerability. It notes that AIDS thrives where economic, social and cultural rights are violated, and also where civil and political norms are ignored. On the economic side, poverty is a major factor (see below). On the social and cultural side, inequality in personal and working relations leads to unwanted sex in conditions of risk because women have weak negotiating power. Attitudes and behaviour should also be recognized as factors that may increase risk. HIV may be transmitted through intravenous injection of drugs with equipment contaminated by needle sharing. There is also evidence that drug and alcohol abuse can impair an individual's ability to practise safer sexual and injecting behaviour. The stigmatization of PLHIV/AIDS fuels a natural desire to keep quiet about HIV status, thus abetting transmission. Cultural pressures and denial mask HIV prevalence locally and nationally, making it harder to plan an effective response for communities as well as individuals. On the civil and political side, conflict situations, the breakdown of law and order, poor legal frameworks and enforcement mechanisms, together with the denial of organizational rights and collective bargaining, hamper development in general and undermine essential health promotion measures in particular. In many countries, poorly resourced health systems, already weakened by debt and structural adjustment, have been unable to provide the care or the prevention needed. In summary, a climate of discrimination and lack of respect for human rights leaves workers exposed to HIV transmission and less able to cope with AIDS, because it makes it difficult for them to seek voluntary testing, counselling, treatment or support; they will also not be in a position to take part in advocacy and prevention campaigns.

188. Most of these factors have little or nothing to do with personal or occupational characteristics, and take the HIV epidemic out of the realm of being purely a medical and health problem.

Poverty

189. Poverty makes transmission of the virus more likely.³⁶ Those living in poverty – and countries at the bottom of the economic scale – lack resources for education, testing, treatment, and all the other successful strategies that many countries have been able to adopt. Poor people exhibit higher levels of illiteracy and lack access to health and social services. This makes it much less likely that they will receive information on HIV and how to prevent transmission. Poor people with HIV may die faster than the non-poor, as they often lack access to health services and medication, whether to treat opportunistic infections or to treat HIV itself with ARV drugs.³⁷

190. The disease also aggravates poverty where it already exists, and the impact of HIV/AIDS on individual households can be catastrophic. In the absence of social safety nets, including health insurance or social security, the illness of a family member means both an increase in medical expenses and a decline in family income, often plunging families into poverty. In the last few years, the damage the epidemic is doing to years of development gains – and to the potential for future development – has been recognized. The HIV/AIDS epidemic is aggravating current socio-economic problems in developing countries and is itself exacerbated by them. It can lead to a worsening of poverty and

³⁶ ILO: *Implementing the ILO code of practice on HIV/AIDS and the world of work: An education and training manual*, Geneva, 2002.

³⁷ J. Collins and B. Rau: *AIDS in the context of development*, UNRISD, Programme on Social Policy and Development, Paper No. 4, Dec. 2000.

even push some non-poor into poverty. A 2001 report³⁸ indicated that the epidemic was already at that time placing a huge strain on many countries. For example:

- Kenya expected to be spending 60 per cent of its health budget on the treatment of HIV/AIDS by 2005;
- in Zambia in 1998, deaths of teachers equalled two-thirds of the number of graduates from teacher training colleges;³⁹
- one third of rural households affected by HIV/AIDS in Thailand reported a 50 per cent reduction in agricultural output.

191. But within the poorer countries where the disease is concentrated, those with a higher than average level of education and income do not generally show lower HIV prevalence. This means that when HIV is implanted in a country, there are serious implications for the labour supply in terms both of quantity and of quality. The loss of huge numbers of skilled personnel – from teachers and doctors to farmers and mechanics – is having serious effects on the ability of countries to remain productive, deliver basic services, and work their way out of poverty.

192. In addition to the general considerations outlined here, it must be recalled that women are more vulnerable to being poor, and more likely to suffer its consequences, than are men. While gender is considered in a subsequent section, it cannot be isolated from the wider question of poverty.

Unemployment

193. Unemployment, and in particular youth unemployment, can be an important factor in HIV transmission and in access to prevention, care, treatment and support. In the first place, those who are unemployed lack access to workplaces where HIV/AIDS can be addressed most effectively. They are likely to be poorer than other parts of the population, and thus be unable to get to community centres where HIV prevention and treatment are available.

194. Young people are particularly vulnerable when they are unemployed. The latest ILO report on youth employment (2006)⁴⁰ adds to growing evidence of a global situation in which young people face increasing difficulties when entering the labour force. One of the report's principal findings is that a global deficit of decent work opportunities has resulted in a situation in which one out of every three young people in the world is seeking work but unable to find it, or has given up the job search entirely, or is working but still living below the US\$2 a day poverty line. Without the right foothold from which to make a good start in the labour market, young people are less able to make choices that will improve their own job prospects and those of their future dependants. This in turn perpetuates the cycle of inadequate education, low-productivity employment and working poverty from one generation to the next, and may make them more vulnerable to HIV infection if they turn to risk-taking behaviours out of a sense of

³⁸ Brookings Institution: *Meeting the global challenge of HIV/AIDS*, Washington, DC, Apr. 2001, available at: <http://www.brookings.edu/comm/policybriefs/pb75.pdf>

³⁹ See also ILO: *A future without child labour*, Global Report under the follow-up to the ILO Declaration on Fundamental Principles and Rights at Work, ILC, 90th Session, Report I(B), 2002 (Geneva, 2002), para. 142, available at: http://www.ilo.org/dyn/declaris/DECLARATIONWEB.DOWNLOAD_BLOB?Var_DocumentID=1566

⁴⁰ ILO: *Global employment trends for youth*, 2006, available at: <http://www.ilo.org/public/english/employment/strat/download/gety06en.pdf>

hopelessness and exclusion, or simply in order to make a living. They are also less likely to have access to prevention, care, treatment and support.

Lack of government services

195. The progression of the epidemic can also be linked closely to the lack of government services. In a number of countries, public health services are overwhelmed by the HIV epidemic. This often results in government services being unable to provide education and training in how to avoid transmission, testing that would help people to learn their status and know what to do about it, and lack of availability of treatment and care. Treatment deficits may stem from the lack of affordable medication or from infrastructural and organizational gaps, including in primary health care and financing for social security systems. Of particular concern is the prevention of mother-to-child transmission (MTCT). Without ARV treatment, 20 to 45 per cent of infants of HIV-positive mothers will acquire the virus during pregnancy, birth or breastfeeding.⁴¹ For 2005, estimates of ARV prophylaxis coverage for HIV-positive pregnant women were 11 per cent in sub-Saharan Africa, 75 per cent in Eastern Europe and Central Asia, 24 per cent in Latin America and the Caribbean, 5 per cent in East, South and South-East Asia, and under 1 per cent in North Africa and the Middle East.⁴² However, fewer than 8 per cent of pregnant women worldwide are currently offered services to prevent this type of HIV transmission.

196. Poor public provision has in many cases been a contributing factor to employers taking on responsibilities that belong properly to government. Employers are concerned in any case for the welfare of their workers and the survival of their enterprises; they want to reduce absenteeism and retain skilled workers, and may be responding to pressure from trade unions. Many have a broader sense of corporate social responsibility. However, in addition to these reasons, employers may find themselves obliged to assume some tasks, to make up for the lack of government services, which are beyond their capacity and competence. The Recommendation may contribute to establishing the respective roles and responsibilities of public and private sectors in the face of HIV/AIDS.

197. As regards incomplete coverage of legislation,⁴³ the importance of a legislative framework for establishing and defending basic principles concerning HIV/AIDS in the workplace was recognized in the Declaration of Commitment adopted by the UN General Assembly's special session on AIDS (UNGASS) in June 2001. The Declaration includes the following target:

⁴¹ K.M. De Cock, et al.: "Prevention of mother-to-child HIV transmission in resource-poor countries: Translating research into policy and practice", *Journal of the American Medical Association*, Vol. 283, No. 9, 2000, pp. 1175–1182.

⁴² WHO, UNAIDS and UNICEF: *Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector*, Progress Report, Geneva, 2007.

⁴³ This section and the related section on legislation in Chapter III are based on: J. Hodges: *Guidelines on addressing HIV/AIDS in the workplace through employment and labour law*, ILO, InFocus Programme on Social Dialogue, Labour Law and Labour Administration, Paper No. 3, 2004, available at: <http://www.ilo.org/public/english/dialogue/ifpdial/downloads/papers/hiv aids.pdf>. See also J. Hodges: *Policy and legal issues relating to HIV/AIDS and the world of work*, prepared as part of the ILO response to the Windhoek Platform of Action (Namibia, 1999) and presented to the 14th International AIDS Conference, Barcelona, 7–14 July 2002; J. Hodges: *An outline of recent developments concerning equality issues in employment for labour court judges*, Geneva, Nov. 1997; M.-C. Chartier: *HIV/AIDS and human rights: Promoting human rights through the ILO code of practice on HIV/AIDS and the world of work*, ILO/AIDS Working Paper No. 3, 2002, available at: <http://www.ilo.org/public/english/protection/trav/aids/publ/d3aids.pdf>; and J. Hodges, *Digest of good legislative practices relating to HIV/AIDS in selected African countries*, to be published in Nov./Dec. 2007.

By 2003, develop a national legal and policy framework that protects in the workplace the rights and dignity of persons living with and affected by HIV/AIDS and those at the greatest risk of HIV/AIDS, in consultation with representatives of employers and workers, taking account of established international guidelines on HIV/AIDS in the workplace.

As no systematic follow-up to this is entailed by the adoption of this Declaration of Commitment, measures taken under the proposed Recommendation may help to fill this gap.

198. Unfortunately, as will be seen in the next chapter, legislation is often lacking, either in general terms or in relation to particular sections of the national population. When governments fail to adopt the necessary legislation, or to adapt it to a changing situation, or to regulate it in a way that allows it to function effectively, or keep it in draft form for years, which has unfortunately often been the case, the resulting gap in government action once again favours the spread of HIV infection and discourages effective responses.

199. The contribution of the labour inspectorate is – at least potentially – of key importance. The ILO Committee of Experts noted in its 2006 General Survey concerning labour inspection that “Labour inspectors have an especially important role in protecting workers in relation to the HIV/AIDS pandemic”.⁴⁴ In 2005, ILO/AIDS published a handbook on HIV/AIDS for labour and factory inspectors.⁴⁵ Among the reasons it cited for labour inspectors to take account of HIV/AIDS were the following:

- Many countries have now adopted legislation dealing specifically with the subject of HIV/AIDS and employment, and inspectors will often be called upon to enforce these laws.
- The workplace is an important arena for fighting HIV/AIDS – inspectors can make a huge difference to the fight against HIV/AIDS when they speak about the issue and help workplaces adopt sensible policies.

200. The approach described here can only be useful, of course, when there is a functioning labour inspectorate of sufficient size and expertise to cover the entire economy. In all too many countries, labour inspectorates are underfinanced, understaffed and under-trained, leaving an important gap in government services that does nothing to prevent the transmission of HIV and can become in itself a risk factor in HIV transmission.

Gender

201. The code of practice contains two specific provisions concerning gender (point 4.3 on gender equality is quoted in Chapter III):

6.3. Gender-specific programmes

- (a) All programmes should be gender-sensitive, as well as sensitive to race and sexual orientation. This includes targeting both women and men explicitly, or addressing either women or men in separate programmes, in recognition of the different types and degrees of risk for men and women workers.
- (b) Information for women needs to alert them to, and explain their higher risk of, infection, in particular the special vulnerability of young women.

⁴⁴ ILO: *Labour inspection*, General Survey, ILC, 95th Session, 2006, para. 56, available at: <http://www.ilo.org/public/english/standards/reln/ilc/ilc95/pdf/rep-iii-1b.pdf>

⁴⁵ ILO/AIDS: *Handbook on HIV/AIDS for labour and factory inspectors*, Geneva, Feb. 2005.

- (c) Education should help both women and men to understand and act upon the unequal power relations between them in employment and personal situations; harassment and violence should be addressed specifically.
- (d) Programmes should help women to understand their rights, both within the workplace and outside it, and empower them to protect themselves.
- (e) Education for men should include awareness-raising, risk assessment and strategies to promote men's responsibilities regarding HIV/AIDS prevention.
- (f) Appropriately targeted prevention programmes should be developed for homosexually active men in consultation with these workers and their representatives.

202. With regard specifically to women, while the provisions themselves are quite strong, there is a persistent concern from those involved in addressing the HIV epidemic that more needs to be done in practice to take account of the situation of women and to incorporate gender concerns more fully in action at both national and international levels.

203. That increasing numbers of women are living with HIV and its consequences is beyond dispute. According to the 2007 report from UNAIDS and WHO:⁴⁶

That estimated 15.4 million [13.9–16.6 million] women living with HIV in 2007 numbered 1.6 million more than the 13.8 million [12.7–15.2 million] in 2001 ... In **sub-Saharan Africa**, almost 61% of adults living with HIV in 2007 were women, while in the **Caribbean** that percentage was 43% (compared with 37% in 2001). The proportions of women living with HIV in **Latin America, Asia and Eastern Europe** are slowly growing, as HIV is transmitted to the female partners of men who are likely to have been infected through injecting drug use, or during unprotected paid sex or sex with other men. In **Eastern Europe** and **Central Asia**, it is estimated that women accounted for 26% of adults with HIV in 2007 (compared with 23% in 2001), while in Asia that proportion reached 29% in 2007 (compared with 26% in 2001).

204. Much of the problem lies in the fact that in many societies, women have an inferior status both in law and in practice. This often means that women have less control over their own sexuality, and less access to wider options including information and treatment, than do men. For these reasons, point 4.3 of the code of practice stresses that the greater the discrimination against women in society generally, the more negatively they are affected by HIV, and that more equal gender relations and the empowerment of women are vital to prevent the transmission of HIV infection and enable women to cope with HIV/AIDS. Efforts to allow women to achieve greater economic, social and political equality generally must continue if the HIV epidemic is to be halted and reversed.

205. This discrimination also operates in the workplace. The ILO's education and training manual⁴⁷ points out that the world of work is unequal in many ways. Women still face unequal hiring standards, unequal opportunities for training and retraining, unequal pay for equal work or work of equal value, segregation and concentration in a relatively small number of "women's jobs", unequal access to productive resources including credit, unequal participation in economic decision-making, unequal promotion prospects, and greater likelihood of being unemployed. They are also subject to workplace violence and sexual harassment, including rape, as a form of sexual blackmail, in the workplace or on their way to or from work. This is sometimes even considered as being justified in the case of women who work outside the home, when this violates some traditional notions about the role of women.

⁴⁶ UNAIDS and WHO: *AIDS epidemic update*, Dec. 2007, available at: <http://www.unaids.org/>

⁴⁷ ILO: *Implementing the ILO code of practice on HIV/AIDS and the world of work*, op. cit.

206. But the concern with gender is not simply about the situation of women. The pressures on men and boys, the norms that influence them, and their attitudes and behaviour are critically important factors. For this reason gender-aware responses do not only focus on the personal, social, economic and political empowerment of women – vital as this is – but on working with men and boys to understand, for example, their resistance to condoms, and to take responsibility in their sexual lives. They also need to address accepted sexual practices linked to work (sexual favours provided as entertainment to clients, sexual harassment, and sex as a trade off for services). It concerns working men and women from managerial to support workers.

207. The code of practice also draws attention to the problems associated with lack of respect for sexual orientation. Although some countries have addressed the question directly, reference to MSM is severely lacking in many countries as well as in many international programmes that address HIV/AIDS. The focus is on heterosexual relationships, and the specific needs and vulnerabilities of MSM are rarely taken into account. Even when sexual relationships between same-sex couples are not widely accepted in a given country, HIV workplace programmes should address this issue, use neutral and sensitive language, include educational materials that are targeted to MSM, and adapt tool kits to include training that covers same-sex relationships.

Age

208. Children are widely affected by HIV/AIDS, especially in southern Africa but also elsewhere. Many experience parental death and life as orphans, and are often forced into child labour. When they work, they may be at risk of sexual exploitation – especially, of course, if they are domestic servants or trapped in the sex industry. On the one hand, children are taken out of school to help with the burden of care or to maintain family income; on the other hand, training and education services are being undermined. Many children are born with HIV and require treatment, care and support, and HIV/AIDS has increased infant mortality. There is little evidence, however, of planning to adapt long-term development strategies to the realities of HIV/AIDS and to replace human capital losses.

209. Older people may also be affected. The significant shortfalls in public health sector capacity will be mostly made up by communities, particularly older women at the household level. The impact of HIV/AIDS means that as the productive contributions of the 15–49 age cohort diminishes, the labour shortfall grows. As labour and savings are diverted away from income-generating and subsistence activities towards care work, HIV/AIDS creates a negative economic impact that deepens the risk of absolute poverty. The cumulative effect of age and sex discrimination means that most informal care workers, who are likely to be older women, are overburdened, unremunerated, and lack social protection. ILO Conventions – particularly those concerning home work (No. 177), health services (No. 161) and discrimination (No. 111) – provide a basis for promoting the rights of care workers and extending the coverage of social protection to HIV/AIDS-affected households. HIV/AIDS interventions in workplaces should ensure sustainable universal access by addressing the social and economic impact of HIV/AIDS on households, in particular tailoring education and training to meet the needs of older women workers, and facilitating access to social insurance and microcredit.

Behaviour and risk

210. Some people are exposed to risk because of aspects of their behaviour and lifestyle, even where they have access to HIV information and services. The reasons for behavioural choices are beyond the scope of this report, and may indeed not always be a

matter of choice. The issue of concern is how society, including the workplace, deals with people who are perceived to behave in ways that do not conform to widely accepted norms. In any case, the behaviour of individuals does not negate their rights and should not give rise to stigmatization or discrimination. Rejection and exclusion only put people out of reach of the essential information, services and support they may need. Most MSM, injecting drug users, and sex workers and their clients, are in the economically active population, and the workplace is an appropriate setting for targeted interventions

211. While these modes of transmission were once seen as the main engines of HIV/AIDS transmission, this is no longer the case in some regions. As already mentioned above, in countries with generalized epidemics, the HIV infection has crossed over into the general population. However, the centrality of high-risk behaviour is especially evident in the HIV epidemics of Asia, Eastern Europe and Latin America. In Eastern Europe and Central Asia, for example, two in three (67 per cent) of all HIV infections in 2005 were due to the use of non-sterile injecting equipment. Paid sex and injecting drug use accounted for a similar overall proportion of prevalent HIV infections in South and South-East Asia. Excluding India, more than one in five (22 per cent) of infections were among injecting drug users. A small but significant proportion of infections (5 per cent) was found among MSM. In Latin America, by contrast, about one in four (26 per cent) of the HIV infections in 2005 were in MSM, while 19 per cent were in injecting drug users. Although the epidemics also extend into the general populations of countries in those regions, they remain highly concentrated around specific population groups. This highlights the need to ensure that population groups who are most at risk of HIV infection are targets of prevention, treatment and care strategies.⁴⁸

Characteristics of occupations with higher exposure to risk

212. Appendix I to the code of practice lists factors that increase the risks for certain groups of workers. An indicative list of such factors, based on that appendix, includes:

- work involving mobility, in particular the obligation to travel regularly and live away from spouses and partners;
- work in geographically isolated environments with limited social interaction and limited health facilities;
- single-sex working and living arrangements among men;
- situations where the worker cannot control protection against infection;
- work that is dominated by men, where women are in a small minority;
- work involving occupational risks such as contact with human blood, blood products and other body fluids, needle-stick injury and infected blood exposure, where universal precautions are not followed or equipment is inadequate;
- work in prisons, often excluded from the generally applicable provisions of labour law and human rights protections.

213. Appendix I also suggests that the above list could include “non-work” to cover situations in which unemployed workers congregate in urban centres in the hope of obtaining any kind of small income and are thereby exposed to HIV risk. Young people are particularly vulnerable. Displaced persons and refugee camp inhabitants are subject to similar pressures due to the lack of work.

⁴⁸ UNAIDS/WHO: *AIDS epidemic update*, Dec. 2006, available at: www.unaids.org/en/HIV_data/epi2006/

214. Workers in mining are at greater risk, not so much because of the nature of their work as of the circumstances in which it may be carried out. This is particularly the case for miners in many parts of southern Africa, where they live far from their families and home communities for long periods of time, rendering them vulnerable to HIV/AIDS.

215. As regards transport, although most attention has been given to road transport, the key issues apply equally to most other groups of transport workers,⁴⁹ for example seafarers, train crews, civil aviation workers, and workers on inland waterways. Expanding transport services means that more workers spend longer periods away from home and their families. The consequences are not only national, but also subregional and even beyond, as transport workers move across borders.

216. Transport workers experience insecurity, vulnerability to harassment and extortion, and limited access to health services, particularly for sexually transmitted infections. Many work on long-distance routes and spend time away from home. Transport workers report a lack of proper accommodation or insufficient money to pay for it, and a lack of respect for their rights. When seafarers put into port, they often have to wait long periods for ships to be unloaded and for the goods on board to be processed, which means long periods in port. When at sea, they may live for weeks at a time with the same small group of fellow workers. When basic wages are low, workers may spend longer away in order to earn allowances and overtime. They may also forego accommodation to save money. Sleeping with a sex worker may be cheaper than the rent for a night in an “official” hostel.

217. Workers in health care are exposed to the risk of HIV transmission, predominantly through needle-stick injuries, although data are lacking on the extent of occupational transmission. In a number of cases, HIV/AIDS has been recognized as an occupational disease, but in any case special protections need to be put in place for these workers and those in related occupations such as hospital cleaners, mortuary attendants and members of the emergency services.

218. Sex work is obviously a factor in the HIV epidemic, and one where rights, vulnerability and diminished opportunities for prevention converge. Sex workers are particularly vulnerable to HIV, and are likely to be among those for whom the least support is available to manage it. They are under continuing pressure by clients – often accompanied by violence – to offer unprotected sex. Sex work is neither legal nor recognized in most countries, but is nevertheless widely practised, and in some countries is regulated even when it is not legal. Recognizing its existence and the risks associated with it does not imply accepting that it is legitimate, but does make it possible to protect those who practise it and to enlist the support of sex workers for prevention strategies.

219. The situation of sex workers is not always conducive to collaborative responses. In the many cases in which this form of work is illegal, there are both practical and legal obstacles to intervening with sex workers. In addition, the response to the situation of these workers is often coloured by perceptions that they do not deserve assistance, or that, because they follow this occupation, they have no rights.

220. The practical reasons for intervening with sex workers are obvious. Such workers exist in all societies, whether legally or not, and unless they receive assistance and education to prevent transmission, as well as periodic health inspections, they will continue to be vulnerable to infection. It is therefore vital that the situation of sex

⁴⁹ See: ILO/AIDS: *Using the ILO code of practice on HIV/AIDS and the world of work – Guidelines for the transport sector*, op. cit.

workers be examined frankly and openly, and that they receive the same access to prevention, treatment, care and support as all other workers.

221. Whether or not the occupation is legally recognized, and whether sex workers benefit from labour legislation, they are covered by the general human rights that apply to everyone. They should be protected from discrimination, forced labour and child labour; without such protection, they are all the more likely to be subjected to the kind of abuse that favours HIV transmission because of the lack of control they have over their own situation. This will be the case especially – but not only – if they have been trafficked into sex work. Beyond this, most international labour standards and UN or regional instruments do not confine their provisions to regularly employed or so-called “legal” workers. The right to health and access to health care, and protection against the many forms of exploitation or denial of rights, applies to all workers.

222. With regard to migration for work, the information available to the Office indicates that most countries are working to establish programmes of protection and access for workers in relation to HIV/AIDS, and their legislation and policies include provisions prohibiting discrimination against workers who are infected or may be perceived to be at risk. The great exception concerns migrant workers. As is evident in Chapter III of this report, more than 60 countries have required HIV testing for people seeking to enter their countries, whether as workers or in other capacities. While not all of them state this clearly, this usually means that HIV-positive persons are denied the right to become documented migrant workers on the same basis as other workers. This has a number of negative consequences.

223. In the first place, access to migration for employment is in many cases the only opportunity for workers to have access to an income if their home country is suffering from poverty and high unemployment. Migration is a survival strategy for the poor in particular, and HIV-positive persons may be denied this access.

224. Secondly, denying these workers access to employment also means they are denied access to prevention, care, treatment and support. This makes them more vulnerable to developing AIDS and its symptoms, and denies them and their families the income that HIV-positive workers can generate before they become medically incapacitated – and of course, with treatment, they can in many cases delay or even prevent the development of symptoms for extended periods. These factors have been recognized by countries, particularly in the Caribbean, that have explicitly rejected testing of migrants for employment, in some cases removing previous restrictions.

225. Migrant workers are also often denied preventive education and services, both pre-departure and in the host countries; they may not cope well with the language, culture and procedures of the receiving country; and they may be cut off from their families and roots. When they are undocumented, they cannot avail themselves of the health facilities of the countries in which they are working. They are, as has been extensively documented elsewhere, subject to discrimination, poor working conditions, and the lack of regular working contracts and access to the rights other workers enjoy.

226. This may be particularly the case for particular categories of migrant workers. Domestic workers, the vast majority of them women, are more subject to sexual abuse than are other migrant workers, which exposes them to a greater risk of contracting HIV. Many migrant workers are kept apart from the local population, often in single-sex environments, which also increases the risk of sexual transmission of HIV, as well as fostering drug and alcohol use which in turn increase the likelihood of unprotected sex. Many migrant workers in both regular and irregular situations are found in agriculture, construction and other worksites removed from health prevention and treatment facilities.

227. According to both ILO and UN Conventions, however, migrant workers are entitled to the same protection as workers in their host countries. While their conditions of work and residence may be subject to certain qualifications as concerns undocumented migrant workers, they are entitled to enjoy the same human rights as other workers, and this includes the right to health. These basic protections apply even when the relevant ILO Conventions (Conventions Nos 97 and 143) or the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families have not been ratified; they are provided for in the two widely ratified International Covenants, in particular the International Covenant on Economic, Social and Cultural Rights.

228. Several conclusions may be drawn from this. First, as with a number of other subjects, the ratification and implementation of other workers' rights instruments will contribute to reducing the incidence of HIV among migrant workers, by improving the conditions under which they work and live. Second, measures are incumbent on sending and on receiving countries to increase migrant workers' access to prevention, education, care, support and treatment. Finally, countries should review their demand that migrant workers be subject to testing and exclusion. Such a requirement directly contradicts a position held by all the international organizations working on the subject and, at least in principle, widely supported by their member States. It is moreover likely that the effects of this demand will be to ensure that migrant workers who are or may be infected, or who do not have access to information on their own status, will choose to migrate outside formal channels, removing them even further from access to prevention, care, support and treatment, and increasing the dangers to themselves, their families, and society.

Chapter III

The situation at the national and regional levels

Law and practice at the national level

229. One of the reasons it is proposed to adopt the Recommendation is the lack of any means of gathering information on national measures taken to implement the code of practice. The new instrument is also intended to provide guidance on the measures to be taken in the light of best practice.

230. The Office has drawn on the information available to it and on that made available by other co-sponsors of UNAIDS, as well as on legislative research to assemble information on the situation at the national level on how countries are dealing with HIV/AIDS in the workplace. This information, though extensive, is far from complete.¹ It is not based on communications from governments or on the systematic provision of information from the social partners, except in so far as information has been gathered in the course of other work – including technical cooperation provided by the Office or by others. The Office does intend, as part of its preparation for the Conference discussions, to make the information it has gathered on law and practice publicly available, and as far as possible to keep it updated, as a tool for its own work and as a further contribution to constituents and UNAIDS.

231. The information below should therefore be taken as indicative. The Office looks forward to supplementing this information with that provided by member States and others. Some of the information the Office has assembled is presented in a general framework here, and some is used as illustrations in other chapters of this report.

232. In addition, this chapter refers mostly to texts that have been adopted at the national level, and less extensively to actual practice. As in many other instances, legislation or policies are indispensable to setting national priorities and stimulating action, but they are not necessarily applied in practice, and in some cases are simply gestures which are not implemented. Nevertheless, in the instances cited below there has at least been an effort to adopt policies, in many cases with the help of the ILO or other international partners in UNAIDS, and this is already progress.

233. As indicated in the previous chapter, laws concerning the world of work provide an ideal channel for responses to HIV and for countering damaging myths surrounding the disease. All countries, whatever their infection rate, can benefit from a legal framework that brings workplace issues into the open, protects against employment discrimination,

¹ As indicated elsewhere, it is not possible in this report to include all the information at ILO/AIDS' disposal. It is intended to make it available to the greatest degree possible through the ILO/AIDS web site and other means.

promotes prevention and care through the workplace and ensures the participation of stakeholders in the mechanisms and institutions that might be created. A growing number of countries have now adopted legislation which deals specifically with employment aspects of HIV/AIDS. Some have opted to do this in the framework of specific AIDS laws, equality laws, disability laws or employment or labour relations acts, including codes of conduct adopted under such acts. Governments need to reflect on what kind of labour laws best fit their national circumstances and the stage of the epidemic in their country. The Office has prepared a study of good practice by type of labour law which analyses the advantages of various types of legal framework.²

234. Labour laws – a generic term covering all of the above options that cover the world of work – are an important point of entry. The strategy promoted by the ILO emphasizes social dialogue and participation in the elaboration process by the social partners, and other civil society groups having a stake in the issue, especially associations of people living with HIV. The ILO also assists its constituents – labour administrations, in particular their inspectorates and dispute resolution mechanisms on the one hand, and trade unions and employers’ organizations on the other – in meeting the challenge of applying the laws.

235. Equally important is the role of labour inspection.³ This has been changing from one of enforcing labour legislation and promulgating detailed, prescriptive standards. Inspectors have a limited ability to act to correct the infringement of laws, in particular when laws apply – de facto or de jure – only to a small formal economy. The modern approach involves the labour inspectorate in setting goals, in conjunction with employers and workers, and helping them to be met. Increasingly inspectors help to elaborate, implement and evaluate plans and campaigns, promoting prevention instead of compensation, applying technological solutions, and balancing advice and compulsion. Where a labour inspectorate in a given country has not yet adopted this approach, it should consider doing so particularly in the face of rising threats such as the HIV epidemic.

236. The Conventions on labour inspection (Nos 81 and 129) provide a sound basis for this new approach. Implementation of national legislation remains an issue, as the existence of laws does not in itself guarantee a properly functioning system. For this reason, more emphasis is now placed on the involvement of all concerned parties, especially employers’ and workers’ organizations, and on the process of social dialogue.

237. New skills are also needed, including skills in negotiation, motivation and communication. These must be supported by new materials for policy advice and technical guidance. A relatively new tool, based on the goals-setting approach, is the ILO’s *Guidelines on occupational safety and health management systems*.⁴ The Guidelines, often known as ILO–OSH, were agreed in 2001 through tripartite social dialogue at an international level, and command broad-based support. They provide a systematic framework to help the workplace integrate an OSH management system into wider policy and management arrangements. Instead of safety being an “add-on”, or measures taken to avoid trouble with inspectors, it becomes a regular part of the

² M.-C. Chartier: *Legal initiatives that can help fight HIV/AIDS in the world of work* (ILO/AIDS, Sep. 2003), available at http://www.ilo.org/public/english/protection/trav/aids/publ/legal_initiatives.pdf

³ ILO: *A handbook on HIV/AIDS for labour and factory inspectors* (ILO/AIDS, 2005), available at <http://www.ilo.org/public/english/protection/trav/aids/publ/gl-labourinspectorshandbook-feb05.pdf>

⁴ ILO: *Guidelines on occupational safety and health management systems* (SafeWork, 2001), available at www.ilo.org/public/english/protection/safework/cops/english/download/e000013.pdf

everyday work of the enterprise. As the Guidelines become used increasingly widely as a voluntary framework, the role of inspectors is changing from a detailed inspection of the workplace to reviewing management systems, checking them as necessary through inspection. If these are good and working well, safety and health in the enterprise should be of an acceptable standard. This fits well with the best way to address HIV/AIDS. The basis for action at any workplace is the adoption of a policy on HIV/AIDS, and an informed inspector can encourage social partners to do this, and help guide its implementation.

General national policies and strategies

238. As a general statement, a majority of countries⁵ are known to have taken some kind of action, with a clear majority having adopted as a first step a general national development policy or strategy that includes reference to HIV/AIDS, or a national policy or strategy specifically dealing with HIV/AIDS. There are, however, significant differences in the character and extent of these policies, varying from country to country and from region to region and corresponding to a very large degree to the prevalence of HIV in the countries concerned.

239. In Africa, all of the 48 countries on which information is available have adopted a general national policy or strategy. There are a few countries for which the Office has not been able to locate the text of the national policy but where its existence appears likely, as a national authority has been appointed.⁶ In addition, there are a few countries which are currently in the process of adopting a national policy, often to replace an outdated one.⁷

240. In Asia and the Pacific there is a similar pattern, with a national policy existing in 22 of the 26 countries for which information is available. In three countries its existence is likely as a national authority has been appointed,⁸ and Sri Lanka is currently in the process of adopting one.

241. In the Americas all countries appear either to have adopted a national policy (23 of 35 countries) or to be in the process of adopting a new policy to replace an outdated one. The existence of a national authority in a few of these countries suggests that such policies do exist but have not been located.⁹

242. With respect to Europe, different patterns exist in different parts of the continent. The number of persons living with HIV in Eastern Europe and Central Asia is growing faster than in most other regions; between 2001 and 2007, their number increased by 150 per cent.¹⁰ There are also great differences in economic development between the countries in this region. National policies have been located in only 30 of 50 countries,

⁵ The Office has been unsuccessful in locating valid information for Brunei Darussalam, Libyan Arab Jamahiriya, Oman and United Arab Emirates.

⁶ Côte d'Ivoire, Guinea, Guinea-Bissau and Niger.

⁷ Liberia, Mauritius, Namibia, Sudan, Togo and Zimbabwe.

⁸ Japan, Republic of Korea and Singapore. In Vanuatu it is the Ministry of Health.

⁹ Suriname has adopted an HIV National Strategic Plan but the Office has not been able to locate a copy, nor any reliable information for Suriname.

¹⁰ UNAIDS and WHO: *AIDS epidemic update* (Dec. 2007).

but all the countries have either established a national authority or make the ministry of health responsible, suggesting the existence of a national policy.

243. The Middle East and North Africa is the region in which there is the lowest proportion of national policies, according to the available information. Only ten of 17 countries¹¹ are known to have a national policy in any form. This reflects the low average prevalence of HIV infection in this region at present, though it is growing. Various co-sponsors of UNAIDS are just beginning to work in this region. According to UNAIDS,¹² among the middle-income countries in the Middle East and North Africa, by the end of 2006 only Morocco had endorsed the target of universal access, with Algeria, Egypt, Tunisia and Yemen having drafted but not endorsed their universal access targets, and the Syrian Arab Republic and Iraq not having drafted targets.

National coordinating bodies

244. This term is used quite loosely here, as the character, powers and coverage of such bodies vary widely from country to country.¹³ The Office has found that all countries have a body responsible in some way for dealing with HIV/AIDS. In many of them national AIDS authorities have been established and, where none has been created, often the ministry of health or one of its departments (in certain countries the infectious diseases department) has been appointed as the responsible authority, and in some countries the ministry of labour is involved. In Africa, all countries for which information is available have a national body responsible for HIV/AIDS.¹⁴ This is also the case in Asia and the Pacific where all 26 countries have established national bodies,¹⁵ and in the Americas, where the available information indicates that all 35 countries have such bodies.¹⁶ In Europe all 50 countries have either established a national authority or are making use of the ministry of health, while in the Middle East and North Africa nine of the 17 countries¹⁷ are known to have established AIDS authorities.

245. Most of these bodies appear to be in the form of national councils or national committees, which have various kinds of coordinating power over the range of national efforts to combat HIV/AIDS. Generally, they include non-governmental actors, including organizations of PLHIV, as well as various ministries. Most have been established by ministerial decree, though some have been established by legislation

¹¹ Algeria, Egypt, Islamic Republic of Iran, Jordan, Lebanon, Morocco, Saudi Arabia, Syrian Arab Republic, Tunisia and Yemen. It has not always been possible to find all the information that might be available, for linguistic and logistical reasons.

¹² UNAIDS: *Towards universal access to HIV prevention, treatment, care and support in the Middle East and North Africa* (Oct. 2006), available at http://data.unaids.org/pub/Presentation/2006/20061126_mena.pdf

¹³ It should also be noted that UNAIDS and other international governmental and non-governmental organizations are currently creating joint UN teams to organize under one authority their collaboration in each country. This may have an effect on the national coordinating bodies created at the government level.

¹⁴ Somalia has established individual authorities for Somaliland, Puntland and South Central Somaliland, and Gabon is currently establishing an authority for AIDS control and AIDS orphans.

¹⁵ With the possible exception of Vanuatu, concerning which the Office's information is uncertain.

¹⁶ Canada, beside the federal, provincial and territorial levels, has also established a National Aboriginal Council on HIV/AIDS. Paraguay is in the process of establishing a national AIDS commission.

¹⁷ Algeria, Egypt, Islamic Republic of Iran, Jordan, Lebanon, Morocco, Saudi Arabia, Syrian Arab Republic and Tunisia.

adopted by the national parliament. Many of them are mandated to coordinate the execution of multi-year national plans or programmes on HIV/AIDS.

Adoption of specific national measures

246. In addition to adoption of a general national policy and the establishment of the national AIDS authorities referred to above, most countries in all regions have adopted more specific measures on HIV/AIDS, in the form of laws, regulations, guidelines or policies. Some countries have integrated HIV/AIDS into existing legislation: public health legislation (infectious/communicable diseases);¹⁸ general discrimination or equal opportunities legislation (under the discrimination grounds “disability” and/or “sexual orientation”);¹⁹ or employment legislation.²⁰ It may be mentioned that confining discussion of HIV/AIDS in some of these categories may limit the broad perspective which is necessary to deal with it in a multidisciplinary framework.

247. The integration of HIV/AIDS into an already existing set of laws has the advantage that the rules applicable to other matters under these laws will also be applicable to HIV/AIDS. If it is included in general labour legislation, for example, then OSH rules, grievances procedures,²¹ labour inspections and so on will apply to it. Some countries that have integrated HIV/AIDS in existing laws have in addition issued special rules applicable to HIV/AIDS, for example in relation to infectious diseases.²² Finally, many countries have adopted specific measures regulating HIV/AIDS, either in addition to the above or as the only other measures. The Office has found that 73 countries have adopted or are in the process of adopting a general HIV/AIDS law, most of them applicable to the workplace, and that 30 countries have adopted or are in the process of adopting rules explicitly regulating HIV/AIDS in the world of work.

248. In Africa HIV/AIDS has been integrated into the labour legislation in Malawi, Seychelles and Uganda,²³ while a general HIV/AIDS law has been adopted in Benin, Chad, Djibouti, Guinea, Guinea-Bissau, Kenya, Madagascar, Mali, Mauritius, Senegal, Sudan, Swaziland and Togo.²⁴ Both Burkina Faso and Burundi have integrated HIV/AIDS into their general labour legislation and adopted a general HIV/AIDS law.²⁵ Lesotho, Mozambique, South Africa, United Republic of Tanzania, Zambia and

¹⁸ For example, see in Appendix II: Bulgaria 1; Croatia; Dominican Republic 3; Egypt 1; Estonia 1; Finland 1; France 1; Iceland 1; Marshall Islands; Mexico 1, 2; Montenegro; Switzerland; Tunisia; Uruguay.

¹⁹ For example, see in Appendix II: Austria 2; Belgium; Bosnia and Herzegovina; Bulgaria 2; Burundi 1; Cyprus; Czech Republic; Denmark; Finland 2; France 2; Germany; Greece; Hungary; Iceland 2; Ireland; Israel 1; Italy 2; Lithuania; Luxembourg; Netherlands; Portugal; Romania 1; San Marino; Slovenia 1, 2; South Africa (the Constitution has been interpreted by the Constitutional Court as covering HIV/AIDS, in *Hoffman v. South African Airways*, 2000); Spain; Sweden; Turkey; United Kingdom.

²⁰ For example, see in Appendix II: Dominican Republic 1; Estonia 2; Latvia 2; Malta 1, 2; Norway; Poland; Slovakia; Slovenia 1, 3; Solomon Islands.

²¹ A few countries provide for grievance procedures in their HIV/AIDS legislation, for example, Mozambique (s. 12 of Act No. 5 of 2002 on HIV/AIDS and workers); Kenya (Part VII of the HIV and AIDS Prevention and Control Act, 2006) establishes an HIV and AIDS tribunal.

²² For example, see in Appendix II: Singapore (Part IV of the Infectious Diseases Act provides rules for pre- and post-counselling, confidentiality and disclosure of testing results); China 2, 3; Japan 2; Republic of Korea 2.

²³ See in Appendix II: Malawi 1; Seychelles; Uganda.

²⁴ See in Appendix II: Benin 2; Chad; Djibouti 1, 2; Guinea 2; Guinea-Bissau 2; Kenya; Madagascar 2, 3; Mali; Mauritius; Senegal; Sudan; Swaziland 1, 2; Togo 2.

²⁵ See in Appendix II: Burkina Faso 1, 3; Burundi 3, 4.

Zimbabwe have both integrated HIV/AIDS into their labour legislation and adopted special rules applicable to the workplace,²⁶ while Angola, Botswana and Sierra Leone have adopted both a general HIV/AIDS law and rules applicable to the workplace.²⁷ Niger has adopted rules applicable to the workplace, and Ethiopia, Namibia and Nigeria have integrated HIV/AIDS into their labour laws, adopted a general HIV/AIDS law and adopted special rules applicable to the workplace.²⁸ Both Cameroon and Mauritania have adopted legislation relating to HIV/AIDS but not yet a general law dealing with HIV/AIDS in the world of work.²⁹

249. In Asia and the Pacific, HIV/AIDS is treated under equal opportunities legislation in Australia and New Zealand,³⁰ while in China, Japan, Kiribati, Republic of Korea and Singapore HIV/AIDS is dealt with under infectious diseases legislation,³¹ with some countries having adopted special rules applicable to HIV/AIDS.³² In addition, China³³ has adopted a general HIV/AIDS law and rules applicable to the workplace in Guangdong Province. Afghanistan, Bangladesh, Cambodia, Mongolia, Pakistan, Philippines, Sri Lanka and Viet Nam have all adopted a general HIV/AIDS law.³⁴ India, Malaysia and Nepal have adopted a general law and special rules applicable to the workplace,³⁵ while Indonesia, Lao People's Democratic Republic and Thailand have adopted special rules applicable to the workplace.³⁶ Fiji³⁷ has integrated HIV/AIDS into its labour legislation and adopted special rules for the workplace, while Papua New Guinea³⁸ has integrated HIV/AIDS into its labour law and has adopted a general HIV/AIDS law and special rules applicable to the workplace.

250. In the Americas, HIV/AIDS is treated under the general equal opportunities legislation in both Canada and the United States,³⁹ while Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Mexico, Nicaragua, Panama, Peru and the Bolivarian Republic of Venezuela have all adopted a general law on HIV/AIDS.⁴⁰ In the Caribbean,

²⁶ See in Appendix II: Lesotho 1, 2; Mozambique 1, 2; South Africa 1, 2, 4, 5; United Republic of Tanzania 1, 2; Zambia 1, 2; Zimbabwe 1, 3.

²⁷ See in Appendix II: Angola 1, 2; Botswana 1, 2, 4; Sierra Leone 1, 2, 3, 4.

²⁸ See in Appendix II: Niger; Ethiopia 1, 2, 3; Namibia 1, 2, 3; Nigeria 1, 2, 3.

²⁹ In Cameroon technical and provincial groups and committees have been created at various levels and several laws have been adopted providing rules for ARV treatment. See also in Appendix II: Mauritania 1, 2.

³⁰ See in Appendix II: Australia; New Zealand.

³¹ See in Appendix II: China 1; Japan 1; Kiribati; Republic of Korea 1; Singapore.

³² See in Appendix II: China 2; Japan 2; Republic of Korea 2.

³³ See in Appendix II: China 2, 3.

³⁴ See in Appendix II: Afghanistan; Bangladesh; Cambodia; Mongolia 1; Pakistan; Philippines; Sri Lanka 1; Viet Nam 1, 2.

³⁵ See in Appendix II: India 2, 3; Malaysia 1, 2; Nepal 1, 2.

³⁶ See in Appendix II: Indonesia 2, 3; Lao People's Democratic Republic; Thailand.

³⁷ See in Appendix II: Fiji 1, 2.

³⁸ See in Appendix II: Papua New Guinea 1, 2, 3.

³⁹ See in Appendix II: Canada; United States.

⁴⁰ See in Appendix II: Argentina 1, 2, 3; Bolivia 1, 2; Brazil 1, 2; Chile; Colombia 1, 2; Costa Rica; Cuba; Dominican Republic 2; Ecuador 1; El Salvador; Guatemala; Guyana; Honduras 2, 3; Mexico 1; Nicaragua 1; Panama; Peru; Bolivarian Republic of Venezuela 2.

Jamaica has adopted workplace rules, Belize has adopted both a general HIV law and workplace rules, Barbados has integrated HIV into its labour legislation and adopted workplace rules, and Bahamas has integrated HIV/AIDS into its labour legislation.⁴¹

251. In Europe, all Members of the European Union (EU) are under the obligation to implement EU Directives in their national legal system. With respect to HIV/AIDS (and while waiting for a future Directive to be adopted) persons infected or affected by HIV/AIDS are protected under anti-discrimination legislation, specifically under Employment Equality Directive 2000/78/EC that prohibits discrimination based on disability and provides that accommodation shall be provided for disabled workers. Most Members of the EU have introduced this into their national legislation or are in the process of doing so, and this has also been the case of the candidate countries.⁴² In addition, Austria, Italy, Latvia, The former Yugoslav Republic of Macedonia, Republic of Moldova, Romania and Montenegro have adopted a general law on HIV/AIDS.⁴³ Bosnia and Herzegovina is in the process of preparing a draft law. HIV/AIDS is also dealt with under infectious/communicable diseases legislation in most of these countries, as is also the case in Israel.⁴⁴ In the Far East/Asian countries general HIV/AIDS legislation has been adopted in Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan,⁴⁵ while Armenia and Georgia have integrated HIV/AIDS into their labour legislation.⁴⁶

252. In the Middle East and North Africa the HIV/AIDS Regional Programme in the Arab States (HARPAS) was launched in October 2002 and has implemented a multi-sectoral approach to create an enabling human rights environment, promote good governance and respond to HIV/AIDS as a crucial development and gender issue.⁴⁷ The programme involved religious leaders, the private sector, legal review initiatives, the arts and media, the Regional Arab Network Against AIDS (RANAA), the Greater Involvement of People Living with AIDS (GIPA) Initiative and Women's Leadership. Currently, examination of national laws protecting the rights of PLHIV exists for Egypt, Iraq, Jordan, Kuwait, Lebanon, Morocco, Syrian Arab Republic, Tunisia and Yemen.⁴⁸

⁴¹ See in Appendix II: Jamaica; Belize 1, 2; Barbados 1, 2; Bahamas.

⁴² The former Yugoslav Republic of Macedonia and Turkey. The same applies for Iceland and Norway, which are not EU Members.

⁴³ See in Appendix II: Austria 1; Italy 1; Latvia 1; The former Yugoslav Republic of Macedonia; Republic of Moldova; Romania 2; Montenegro.

⁴⁴ See in Appendix II: Israel 2.

⁴⁵ See in Appendix II: Azerbaijan; Belarus 1; Kazakhstan 1; Kyrgyzstan; Russian Federation 1; Tajikistan 1; Turkmenistan; Ukraine; Uzbekistan.

⁴⁶ See in Appendix II: Armenia; Georgia.

⁴⁷ UNDP/HARPAS, *Saving lives, saving money – The private sector's response to HIV/AIDS in the Arab region* (May 2006), available at http://www.harapas.org/reports/Saving%20Lives_Saving%20Money-UNDP-HARPAS.pdf

⁴⁸ In Arabic only, available at <http://www.harapas.org/reports/>

Inclusion of principles of the code of practice in national law

253. The principles of the code of practice are fairly widely incorporated directly into national law, but in some cases they are reflected less explicitly. Examples of this are given below.

254. *HIV/AIDS as a workplace issue.* The principles of the code have been included in a large number of national laws, policies and strategies, though because of the different forms in which this is done it is difficult to quantify with precision. This report has indicated a number of ways in which the wider social questions raised by HIV/AIDS intersect with the workplace, and where the workplace is an essential element of a national response. A clear majority of all countries in Africa, Asia and the Pacific, Americas and Europe have recognized HIV/AIDS as a workplace issue by the measures adopted at the national level. Only in the Middle East and North Africa have no policies been located which apply specifically to the workplace.

255. *Prohibition of discrimination and stigmatization.* Discriminatory acts in employment are prohibited against people living with HIV, as concerns hiring, access to promotion, assignment and dismissal, including the deliberate omission to offer an employment, promotion or assignment.⁴⁹ Some laws explicitly state that PLHIV shall enjoy the same opportunities in employment and occupation as non-infected workers⁵⁰ and shall be treated with dignity.⁵¹ In Togo⁵² employers are obliged to take measures to ensure a work atmosphere that avoids the rejection or humiliation of HIV-positive workers, while in Nigeria⁵³ affirmative action must be taken by employers to eliminate discrimination and ameliorate equal opportunities for PLHIV.

256. Numerous countries provide that HIV status must not affect a person's eligibility for any occupational or other benefit scheme provided for employees.⁵⁴ In Namibia⁵⁵ private and public health financing mechanisms provide standard benefits to all employees regardless of their HIV status, and counselling and advisory services must be made available to inform them of their rights and benefits from medical aid, life insurance, pension and social security funds. In addition, efforts should be made to protect the rights and benefits of the dependants of deceased and retired employees. A number of countries provide that if an HIV test is necessary, it must be treated like any other life-threatening illness.⁵⁶ In Kenya⁵⁷ mandatory testing is prohibited as a condition for the provision of health care, insurance coverage or any other service.

⁴⁹ For example, see in Appendix II: Papua New Guinea 1 (s. 7(a)).

⁵⁰ For example, see in Appendix II: Mozambique 1 (s. 7).

⁵¹ For example, see in Appendix II: Togo 2 (s. 25).

⁵² For example, see in Appendix II: Togo 2 (s. 30).

⁵³ For example, see in Appendix II: Nigeria 3 (ss 5 and 6(c)).

⁵⁴ For example, see in Appendix II: Zimbabwe 4 (s. 7).

⁵⁵ See in Appendix II: Namibia 1 (s. 6.7).

⁵⁶ See in Appendix II: Malaysia 1 (s. 7); Nepal 3 (goal 5.2.5); Papua New Guinea 1 (s. 8); Zimbabwe 5.

⁵⁷ See in Appendix II: Kenya 1 (s. 13(2)).

257. Many countries provide that PLHIV must have the same access to credit and loans as uninfected persons, including health, accident and life insurance.⁵⁸ In Togo⁵⁹ all PLHIV have the right to subscribe to all kinds of insurance with the insurance company of their choice, in particular life insurance, and no financial institution can refuse to grant a bank loan to a person because of her/his serological status. In the Philippines⁶⁰ no credit or loan services can be denied a person on the basis of HIV status, provided that the person has not concealed the fact from the insurance company or misrepresented it upon application. In Bangladesh⁶¹ the national authorities are required to cooperate with private insurance companies to elaborate a code of practice with a view to ensuring respect for the dignity and private life of the individual. In India⁶² a draft Act provides that one year after the entry into force of the law the appropriate governments must formulate, frame and implement health insurance and social security schemes. In Sierra Leone⁶³ no one may be compelled to undergo a test or disclose his/her status for the purpose of gaining access to credit or insurance or the extension or continuation of such service. It is even stated that life and health service insurance providers must devise a reasonable limit of cover for which people are not required to disclose their HIV status, a so-called “no-test limit”. If another limit is requested by the person and a test is carried out, the insurer may impose an additional premium, with a special grievance procedure made available to decide what is “reasonable” in this respect. In Papua New Guinea⁶⁴ risk assessment is not considered as discriminatory if the assessment of risk is based on reference to actuarial or statistical data on which it was reasonable to rely.

258. With respect to the right to treatment, some countries have spelled out that PLHIV not only have the right to treatment⁶⁵ but also the right to social and health services,⁶⁶ including access to hospitals.⁶⁷ In Cambodia and Senegal, it is even stated that they may not be charged a higher fee.⁶⁸ Furthermore, some countries have explicitly stated that it is prohibited to deny or remove treatment and care⁶⁹ and that it is also prohibited for medical personnel to refuse to accept or to offer treatment.⁷⁰ Finally, the right to refuse medical examination and treatment when being treated for AIDS has been provided for in some countries.⁷¹

⁵⁸ For example, see in Appendix II: Burundi 3 (s. 36); Cambodia (s. 40); Djibouti 2; Fiji 2 (s. 10.2); Guinea-Bissau 2 (s. 33); Madagascar 2 (s. 51); Mali; Nigeria 3 (s. 6(h)); Papua New Guinea 1 (s. 8); Philippines (s. 39); Senegal (s. 28); Sierra Leone 1 (s. 11); Togo 2 (s. 33).

⁵⁹ See in Appendix II: Togo 2 (s. 31).

⁶⁰ See in Appendix II: Philippines (s. 39).

⁶¹ See in Appendix II: Bangladesh.

⁶² See in Appendix II: India 3 (s. 22).

⁶³ See in Appendix II: Sierra Leone 1 (s. 27).

⁶⁴ See in Appendix II: Papua New Guinea 1 (s. 8).

⁶⁵ See in Appendix II: Djibouti 2 (s. 14).

⁶⁶ See in Appendix II: Djibouti 2 (s. 14); Mali (s. 20).

⁶⁷ For example, see in Appendix II: Cambodia (s. 41); Guinea-Bissau 2 (s. 31); Philippines (s. 40).

⁶⁸ See in Appendix II: Cambodia (s. 41); Senegal (s. 29).

⁶⁹ For example, see in Appendix II: Nigeria 3 (s. 6(a)); Viet Nam 1 (s. 8(9)).

⁷⁰ See in Appendix II: Nigeria 3 (s. 6(b)); Togo 2 (s. 37).

⁷¹ For example, see in Appendix II: Viet Nam 1 (s. 4(e)).

259. Measures prohibiting discrimination and stigma provide a rich illustration of the everyday difficulties faced by people living with HIV: this includes, for example, their right to seek public positions,⁷² to enjoy equal access to goods and services and to public facilities⁷³ and to join partnerships.⁷⁴ In Cambodia it is explicitly stated that PLHIV have the same rights that are guaranteed to all citizens under the Constitution,⁷⁵ while certain countries have felt it necessary to provide that PLHIV have the right to marry,⁷⁶ to inherit property,⁷⁷ to have children,⁷⁸ to have access to and use religious or worship areas and services⁷⁹ and to have access to communal areas such as parks and beaches.⁸⁰ Some countries have provided for the right to burial services,⁸¹ the right to accommodation (including rental, hotel and guesthouses and lodging),⁸² the right to become or remain a member of clubs, sporting and other associations⁸³ and freedom to live and travel.⁸⁴ It is even at times stated that the manner in which surveillance or research is carried out and used must not discriminate against PLHIV.⁸⁵

Testing and confidentiality in national law and practice

260. The importance of knowing one's HIV status is widely acknowledged, and a number of States have taken measures to encourage people to make the necessary inquiries. Ethiopia,⁸⁶ for example, has adopted strategies to ensure decentralized provision of testing services, and has trained some 50,000 community members to provide them. At the end of 2006, Kenya⁸⁷ launched a rapid results initiative requesting all districts to establish treatment targets to be achieved within 100 days, and it was able to report the remarkable result that almost all districts achieved their target. In the

⁷² For example, see in Appendix II: Cambodia (s. 39); Djibouti 2; Guinea-Bissau 2 (s. 32); Nigeria 3 (s. 6(g)); Senegal (s. 27); Philippines (s. 38).

⁷³ For example, see in Appendix II: Burkina Faso 1; Papua New Guinea 1 (s. 7(h)).

⁷⁴ For example, see in Appendix II: Papua New Guinea (s. 7(b)).

⁷⁵ See in Appendix II: Cambodia (s. 42).

⁷⁶ For example, see in Appendix II: China 2 (s. 3); Djibouti 2 (s. 7); Madagascar 2 (s. 29); Sierra Leone 1 (s. 11).

⁷⁷ For example, see in Appendix II: Djibouti 2 (s. 7).

⁷⁸ For example, see in Appendix II: Madagascar 2 (s. 30); Senegal (s. 15(3)).

⁷⁹ For example, see in Appendix II: Nigeria 3 (s. 6(e)).

⁸⁰ For example, see in Appendix II: Nigeria 3 (s. 6(f)).

⁸¹ For example, see in Appendix II: Philippines (s. 41); Viet Nam 1 (s. 8(10)).

⁸² For example, see in Appendix II: Burkina Faso 1; Mali; Papua New Guinea 1; Philippines (s. 37); Senegal (s. 26(2)).

⁸³ For example, see in Appendix II: Papua New Guinea 1 (s. 7(c)).

⁸⁴ For example, see in Appendix II: Cambodia (s. 28, including the prohibition to be put in quarantine or in isolation); Burkina Faso 1; Djibouti 2; Guinea-Bissau 2 (s. 31); Mali; Senegal (s. 26(1)); Sierra Leone 1 (s. 11); Philippines (s. 37).

⁸⁵ For example, see in Appendix II: Fiji 2 (s. 10.3); Papua New Guinea 1 (s. 7(g)).

⁸⁶ UNAIDS: *Financial resources required to achieve universal access to HIV prevention, treatment, care and support*, p. 14, available at: http://data.unaids.org/pub/Report/2007/20070925_advocacy_gme2_en.pdf

⁸⁷ *ibid.*

Caribbean, the Model Caribbean Workplace Policy⁸⁸ provides for voluntary testing and counselling to be promoted. China⁸⁹ has adopted regulations stipulating that counselling and testing for those who want to know their status are free, and Japan⁹⁰ provides that central and local governments should intensively promote free anonymous testing and counselling services at public health centres.

261. The principle that testing should not be mandatory appears to be widely accepted, at least in laws and policies adopted by governments – though, as seen below, there are limitations on this acceptance, and this should be read in the light of the section in the previous chapter on this question. While information is not available for all countries, where it is the information indicates that countries have adopted extensive legislation on the issue of testing and confidentiality, and related matters.

262. *Voluntary testing and informed consent.* A significant number of laws provide that testing for HIV can be administered only with the informed consent of the person concerned, with a majority of countries prohibiting mandatory testing for employment purposes. In Africa, rules on voluntary testing with informed consent have been located for 28 of the 48 countries for which information is available.⁹¹ Some of the rules are subject to some qualifications. For instance, in Botswana⁹² the draft text allows for tacitly confirmed consent, which it appears therefore does not have to be explicit (so-called “opt-out” provision); while in Burundi⁹³ testing can be carried out only with the explicit request of the person concerned. The draft legislation in Guinea-Bissau⁹⁴ provides that a request for testing must be made in writing. A majority of countries provide specific rules for minors and incapacitated adults, with respect both to consent and to the disclosure of information.

263. In the Americas there is a prohibition on mandatory testing for employment purposes in 27 countries, with rules for voluntary testing and a guarantee of confidentiality.⁹⁵ In addition, the Model Caribbean Workplace Policy on HIV/AIDS provides that, if mandatory testing is required by a country for entry or residence, the body that arranges the employment must not only facilitate pre- and post-test counselling but also, when the worker is unable to take such an assignment, must take all reasonable steps to find an alternative post. The voluntary nature of testing is called into question in most countries only in the case of blood transfusions or similar procedures, where the

⁸⁸ Developed by the Caribbean Tripartite Council which was formed in September 2005, comprising the Caribbean Congress of Labour, the Caribbean Employers’ Confederation, Caribbean governments represented by the CARICOM secretariat, the ILO and the Caribbean Network of Persons Living with HIV.

⁸⁹ See in Appendix II: China 2 (s. 44(3)).

⁹⁰ Ministry of Health, Labour and Welfare: *Selected guidelines for HIV prevention and testing using rapid tests: For local government initiative* (Specific Disease Control Division Health Service Bureau, 2006), p. 7.

⁹¹ Angola, Benin, Botswana, Burkina Faso, Burundi, Djibouti, Ethiopia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritius, Mozambique, Namibia, Nigeria, Senegal, Sierra Leone, South Africa, Swaziland, United Republic of Tanzania, Togo, Uganda, Zambia and Zimbabwe.

⁹² See in Appendix II: Botswana 4.

⁹³ See in Appendix II: Burundi 3 (s. 11).

⁹⁴ See in Appendix II: Guinea-Bissau 2 (s. 17(1)).

⁹⁵ Antigua and Barbuda, Bahamas, Barbados, Belize, Bolivia, Chile, Colombia, Costa Rica, Dominica, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago and the Bolivarian Republic of Venezuela.

voluntary decision to donate blood, sperm or tissue is in itself interpreted as informed consent.

264. Asia and the Pacific shows the same pattern, with 18 of 25 countries prohibiting mandatory testing, including for employment purposes. In Europe the legislation applicable to medical examinations for workers would in theory regulate this issue, unless it is explicitly regulated, as for example, in Belarus and Bulgaria.⁹⁶ In the Middle East and North Africa the Office has identified rules providing for voluntary testing only in Egypt.⁹⁷

Exceptions to the prohibition of mandatory testing

265. Even though the code of practice contains no exceptions to the prohibition on mandatory testing, a number of exceptions have been found at the national level. The most frequent exception is for migrant workers, with more than 60 countries⁹⁸ requiring HIV tests for migrant workers entering the country. Most of them require tests for anyone applying for entry for longer than a specified period, usually between one and 12 months. Some specify such tests for those intending to work or for those applying for residence, while others require them for any visa.⁹⁹ However worded, these restrictions do impose mandatory testing as a condition of obtaining work. A number of other countries, particularly in Latin America and the Caribbean, have adopted legislation specifically prohibiting testing for those entering the country, which may be related to the fact that their nationals often encounter such mandatory testing when attempting to go to other countries as migrant workers.

266. Another exception has been found for certain occupations, such as health-care workers, where a few provisions have been located. For instance, in Djibouti,¹⁰⁰ the law provides that mandatory testing can be applied only to occupational health personnel (as well as blood, sperm or tissue donors) in their own interests and in the interest of the right to health. Similar provisions exist in Nigeria.¹⁰¹ Such provisions are found more frequently in Latin America. Several of these also require testing of health-care workers after exposure to the virus.¹⁰² Indonesia¹⁰³ provides for testing of those who may be

⁹⁶ See in Appendix II: Belarus 2; Bulgaria 3.

⁹⁷ See in Appendix II: Egypt 2, 3.

⁹⁸ For example, Algeria, Angola, Australia, Bahrain, Belarus, Belize, Brunei, Bulgaria, Canada, Central African Republic, China, Colombia, Comoros, Cuba, Cyprus, Dominica, Dominican Republic, Egypt, Eritrea (may be required upon entry), Fiji, Greece (only persons arriving to work as legal prostitutes), Hungary, India, Iraq, Israel, Jordan, Kazakhstan, Republic of Korea (persons entering to be engaged in performance or entertainment activities at tourist hotels and entertainment places), Kuwait, Lebanon (persons intending to work as maids), Lithuania, Malaysia, Marshall Islands, Mauritius, Republic of Moldova, Montserrat, Oman, Palau, Paraguay, Qatar, Russian Federation, Samoa, Saint Vincent and the Grenadines, Saint Kitts and Nevis, Saudi Arabia, Seychelles, Singapore, Slovakia, South Africa (all mineworkers, irrespective of their positions), Syrian Arab Republic, Tajikistan, Tonga, Turkey, Turkmenistan, Ukraine, United Arab Emirates, United Kingdom, United States, Uzbekistan and Yemen.

⁹⁹ This information is taken from a list provided by the US State Department and updated in 2006, available at <http://www.thebody.com/content/legal/art2244.html>. The US State Department's own site contains a similar list but updated only to March 2003.

¹⁰⁰ See in Appendix II: Djibouti (s. 9(4)).

¹⁰¹ See in Appendix II: Nigeria 3 (ss 15–19).

¹⁰² Argentina, Bolivia, Colombia, Costa Rica, Dominica, Dominican Republic, Ecuador, Guatemala, Honduras, Panama and Bolivarian Republic of Venezuela, using the theory of “universal precautions” for those in certain professions involving close bodily contact.

¹⁰³ See in Appendix II: Indonesia 3 (Part C, s. 2(c)).

working in an environment where they will be exposed to the virus, while in the United Kingdom ¹⁰⁴ mandatory testing applies to medical personnel performing “intrusive” medical acts. In Botswana, ¹⁰⁵ if for any reason an employer or public authority determines that HIV testing is necessary and is a bona fide occupational requirement, such as the protection of public health and safety, the authorization of the courts of law must be sought.

267. Provisions have also been adopted to allow mandatory testing for certain aviation personnel, particularly pilots. The International Civil Aviation Organization (ICAO), ¹⁰⁶ the Joint Aviation Authority (JAA) of Europe, ¹⁰⁷ the Federal Aviation Association (FAA) of the United States ¹⁰⁸ and Viet Nam ¹⁰⁹ all provide for mandatory testing for pilots. The ICAO provides that a person with HIV shall be assessed as unfit unless full investigation provides no evidence of clinical disease. It further provides that evaluation of applicants who are HIV-positive requires particular attention to their mental state and follows the United States Centers for Disease Control classification, which looks at the CD4+ cell count to evaluate disease status and the risk of developing opportunistic infections. This is also the case for the United States. The JAA provides that AIDS is an absolute bar to flight duties because of the high risk of opportunistic infections. Their criteria for diagnosis of AIDS include a positive result on an HIV test, a finding of immunodeficiency and a history of opportunistic infections. In Viet Nam the law accommodates pilots who are already engaged, but not to those attempting to enter service.

268. There are a few cases in which mandatory testing can take place “in accordance with the law”, but where no law or regulation authorizing such testing in relation to any employment situation has been found, or in which a judge can order such testing. While these provisions are not very clear, they may be intended principally to cover non-employment situations (instance of rape or similar situations), but their wording is sufficiently unclear as to leave a door open. Similarly, mandatory testing applies to the armed forces in many countries.

Confidentiality

269. Confidentiality relates to the right of an individual to protect her/his data during their storage, transfer and use, etc. in order to prevent unauthorized disclosure of the information to third parties. ¹¹⁰ Most countries in Africa, Asia and the Pacific, the

¹⁰⁴ Department of Health: *Health clearance for TB, hepatitis B, hepatitis C and HIV: New healthcare workers* (16 March 2007), Annex B, available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073132

¹⁰⁵ See in Appendix II: Botswana 4 (s. 7.5.6).

¹⁰⁶ ICAO: *Manual of civil aviation medicine* (2006), Ch. 12, available at www.icao.int/icaoet/dcs/8984/8984_chapter_12_en.pdf

¹⁰⁷ JAA: *Manual of civil aviation medicine* (2006), available at http://www.jaat.eu/licensing/manual_civil_aviation_2006.html

¹⁰⁸ Code of Federal Regulations, etc., available at http://www.faa.gov/about/office_org/headquarters_offices/avs/offices/aam/ame/guide/dec_cons/disease_prot/hiv/

¹⁰⁹ s. 20 of Civil Aviation Law (Decree No. 108 of 2007).

¹¹⁰ UNAIDS: *Guidelines on protecting the confidentiality and security of HIV information* (2007), available at http://data.unaids.org/pub/manual/2007/confidentiality_security_interim_guidelines_15may2007_en.pdf. See also ILO: *Code of practice on the protection of workers' personal data* (1997), available at <http://www.ilo.org/public/english/protection/condtrav/pdf/wc-code-97.pdf>

Americas and Europe have rules to ensure confidentiality of information on HIV status. For example, in Indonesia¹¹¹ the guarantee of confidentiality covers all information obtained from counselling activities, HIV tests, medical treatment, medical care and other related activities. However, the issue of confidentiality actually begins when a person decides to take the test. For example, if tests are done in an ambulating bus in rural areas where a screen is put around the bus to mask who is going or coming, it is obvious that confidentiality will be difficult to maintain. In order that the rules on confidentiality are respected, many countries provide that the test itself shall be made anonymously (with a specific coding system attached to it) to avoid identification of the person. Other countries provide that the tests can only be carried out by approved persons and/or by approved entities. For example, Botswana¹¹² and Nepal¹¹³ provide that testing opportunities can be arranged at the workplace and if tests are to be carried out in the workplace, these can only be carried out by persons qualified in accordance with national and global standards. In Madagascar¹¹⁴ mobile testing centres may be used, while in Sierra Leone¹¹⁵ tests can only be carried out in approved centres. Some countries provide that the personnel who are in direct contact with persons being tested must, in addition to being approved, also have been properly trained to provide psychological support in both pre- and post-test counselling.

270. Many countries provide, in accordance with the code of practice, that there is no obligation for workers to disclose HIV-related personal information, nor are co-workers obliged to reveal such information about fellow workers. In theory, information on HIV status is generally stored in the workplace only if there is mandatory testing, which is the case for certain occupations. Some countries encourage workers to inform their medical doctor, and any information should then be protected under the general system of protection of patients' privacy. In theory, the worker does not need to come forward with the information to the employer until the moment when he or she can no longer perform work tasks. Most countries provide for confidentiality of this information covering a wide group of people.

271. In order to ensure that the confidentiality rules are respected, many countries provide for punishment for any breach of the confidentiality rules. For example, in Cambodia¹¹⁶ any violation of confidentiality is punishable by a fine or imprisonment, and for any repeated offence the punishment is doubled; in Benin¹¹⁷ a breach of confidentiality is considered as aggravating the offence if it results in a divorce, loss of employment or property, or suicide.

Disclosure of HIV testing results

272. Disclosure of test results to third parties is generally prohibited. It is regulated in a few countries where it is allowable only by court order, often to be carried out in a specific manner (such as specifying that the information shall be given in a sealed envelope and may only be opened by the competent person). A number of countries

¹¹¹ See in Appendix II: Indonesia 2 (s. 6).

¹¹² See in Appendix II: Botswana 4 (s. 7.5.4).

¹¹³ See in Appendix II: Nepal 3 (goal 5.3.9).

¹¹⁴ See in Appendix II: Madagascar (s. 16).

¹¹⁵ See in Appendix II: Sierra Leone 1 (s. 13(1)).

¹¹⁶ See in Appendix II: Cambodia (ss 31 and 51).

¹¹⁷ See in Appendix II: Benin 2 (s. 24).

provide rules for disclosure of HIV status to a spouse and/or sexual partner(s).¹¹⁸ In some countries the HIV-positive person is to be encouraged to disclose the fact,¹¹⁹ and a few provide that medical personnel should encourage it during post-testing counselling.¹²⁰ In certain countries the disclosure to a spouse and/or partner(s) has to be done within a specific time limit.¹²¹ Some countries provide that a person with HIV has an obligation to inform the spouse and/or partner(s),¹²² while others even authorize third parties to disclose such information to the infected person's spouse and/or partner(s) in very specific situations.¹²³ In some countries, third parties (often the medical personnel) are obliged to pass on testing results to the tested person's spouse and/or partner(s) if the infected person is unable or unwilling to do so.¹²⁴

Law and practice at the regional level

273. The ILO code of practice is the framework for all workplace responses supported by the UN system, and has been used often in relevant international processes, in particular at the regional level. In some cases direct reference is made to the code, while others take it into account less directly but follow a similar set of recommendations. What follows is simply an indication of the kind of regional and subregional responses that exist – there are too many to list in detail, and the subject is of such interest that guidelines, policies and strategies are being adopted on an almost daily basis.

274. *Europe.* Among the responses to HIV/AIDS, the EU has made the HIV/AIDS epidemic an important focus of concern and action within the EU's public health activities.¹²⁵ In February 2004 the Dublin Ministerial Conference adopted the "Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia"¹²⁶ in order to highlight the worsening situation. A number of other initiatives have been taken since. Ministers of health from the EU and 16 non-EU countries adopted the "Bremen Declaration on Responsibility and Partnership – Together against HIV/AIDS" at a Conference organized by the German Government on 11 and 12 March 2007 to examine the impact of AIDS in Europe and strategic responses.¹²⁷ Critical issues for Europe, especially in the world of work, are discrimination and the protection of rights, confidentiality and the reintegration in the labour market of HIV-positive workers on ARV treatment. The Conference Declaration recognizes the role of the workplace and the contribution of the ILO code of practice in the fight against AIDS in Europe, and invites governments, employers and workers to promote non-discriminatory policies for PLHIV and care and support for those affected.

¹¹⁸ A majority of countries provide specific rules for disclosure of HIV status for minors and incapacitated adults.

¹¹⁹ For example, in Costa Rica, Colombia, Mauritius, Senegal and Uganda.

¹²⁰ For example, in Bangladesh, Pakistan, Senegal, Singapore and the Bolivarian Republic of Venezuela.

¹²¹ For example, in Benin, Burundi, Burkina Faso, Guinea, India, Madagascar, Malaysia, Philippines, Sierra Leone, Singapore, Togo and Viet Nam.

¹²² For example, in Benin, Burundi, Burkina Faso, Estonia, Guinea, Honduras, India, Madagascar, Malaysia, Republic of Moldova, Philippines, Sierra Leone, Singapore, Togo and Viet Nam.

¹²³ For example, in Equatorial Guinea, India, Pakistan, Singapore and Togo.

¹²⁴ For example, in Burundi, El Salvador, Guatemala, Guinea-Bissau, Guinea, Kenya, Madagascar and Mali.

¹²⁵ See http://ec.europa.eu/health/ph_projects/comdiseases_project_en.htm

¹²⁶ Available at www.eu2004.ie/templates/document_file.asp?id=7000

¹²⁷ Available at http://www.eu2007.de/en/News/download_docs/Maerz/0312-BSGV/070Bremen.pdf

275. *Asia and the Pacific.* Among the many initiatives in the region, in 2005 the Pacific Community adopted the Pacific Regional Strategy on HIV/AIDS 2004–08.¹²⁸ The Asia–Pacific Economic Cooperation (APEC) adopted Guidelines for APEC member economies for creating an enabling environment for employers to implement effective workplace practices for people living with HIV/AIDS and prevention in workplace settings, which were endorsed by APEC health ministers in Sydney in June 2007. The Third Asia–Pacific Ministerial Meeting on HIV/AIDS was held in July 2007 and came to further agreements on how to combat HIV.¹²⁹ ASEAN member countries have made significant moves to include a world-of-work perspective in their AIDS responses. One example is the ASEAN Commitments on HIV and AIDS agreed in January 2007 in Cebu, Philippines, which includes the commitment to “put into place necessary legislation and regulations (including workplace policies and programmes) to ensure that persons living with HIV and affected groups are ... not subjected to stigma and discrimination, have equal access to health, social welfare and education services”. The Strategic Framework for the Third ASEAN Work Programme on HIV and AIDS, 2006–10, includes a significant section on HIV and the world of work.

276. *Caribbean.* There is an extremely lively response to HIV/AIDS in the Caribbean region. A UNAIDS report prepared for the General Assembly Special Session on HIV and AIDS in 2006¹³⁰ gives an overview of regional responses. The Caribbean Community (CARICOM), in which the ILO Subregional Office is closely involved, has established policies and activities that are excellent models for other regions. In addition to the Model Caribbean Workplace Policy adopted by the Caribbean Tripartite Council and Pan-Caribbean Partnership against HIV/AIDS (PANCAP), the 15th Inter-American Conference of Ministers of Labor of the Organization of American States adopted on 13 September 2007 the Declaration of Port-of-Spain stating: “We commit to promoting the development and implementation of policies that will assist in reducing discrimination in the workplace against workers with HIV/AIDS. Further, we support policies that reduce the incidence of HIV/AIDS and chronic non-communicable diseases”. The Ministers also adopted a plan of action for sharing information on policies and best practices aimed at reducing the incidence of HIV/AIDS and for analysing and advancing policies and measures centred on the promotion of decent work in the Americas.¹³¹

277. *Africa.* The African Union (AU) has played a lead role in mobilizing political and financial support for the response to HIV/AIDS, TB, malaria and related diseases on the continent. In April 2001 the then Organization of African Unity (OAU) convened a special summit to address HIV/AIDS, TB and other related infectious diseases; in July 2003 the African Union (AU) devoted a special session of its Assembly meeting to this subject, at which HIV/AIDS was included as a cross-cutting issue in the New Partnership of Africa’s Development (NEPAD). The meeting also led to the establishment of initiatives such as the AIDS Watch Africa (AWA) and the Commission

¹²⁸ Available at <http://www.spc.int/hiv/images/stories/regionalstrategy%20-red.pdf>

¹²⁹ See <http://www.apecsec.org.sg/>

¹³⁰ UNAIDS: *Keeping score: AIDS responses in the Caribbean* (2006), available at http://data.unaids.org/pub/Report/2007/20070605_keeping_score_caribbean_ungass_2006_en.pdf

¹³¹ Organization of American States: *Declaration of Port-of-Spain making decent work central to social and economic development*, adopted at the 15th Inter-American Conference of Ministers of Labor, 11–13 September, 2007, Port-of-Spain, Trinidad and Tobago (doc. OEA/Ser.K/XII.15.1), available at [http://www.sedi.oas.org/ddse/documentos/TRABAJO/15cimt/post_reunion/DEC1%20ING%20\(Declaracion\).doc](http://www.sedi.oas.org/ddse/documentos/TRABAJO/15cimt/post_reunion/DEC1%20ING%20(Declaracion).doc)

for HIV/AIDS and Governance in Africa (CHGA). In May 2006 a special summit of the African Union on HIV/AIDS, TB and malaria reviewed the status of implementation of the earlier declarations and frameworks for action, and adopted a renewed commitment to ensure universal access to HIV/AIDS services.

278. *Subregional response to HIV/AIDS*. In December 2000 the Economic Community of West Africa (ECOWAS) adopted a Control Strategy on HIV/AIDS in West Africa stating among other things that member States should develop and adopt culturally acceptable HIV/AIDS prevention and treatment policies and involve the communities in the preparation of such strategies. In 2005, the ILO and ECOWAS concluded a Memorandum of Understanding (MOU) to strengthen cooperation. The MOU provides for consultation on planning and execution of programmes for promoting decent work in relation with HIV/AIDS in the workplace. The response of the Southern African Development Community (SADC) to HIV/AIDS has been strengthened with the establishment of a five-year plan for HIV and AIDS (2004–08).

Business responses

279. It makes strong business sense for companies to respond to the epidemic. Increased costs, loss of productivity and overall threats to the foundations of the economies in which they operate threaten the bottom line. The workforce is placed at increasing risk, with the epidemic disproportionately affecting people during their most productive years.

280. As the International Organisation of Employers (IOE) states on its web site:

Business has played a leadership role in tackling the HIV/AIDS pandemic, which is gaining increasing recognition. With the impact of this deadly scourge being felt most among those of working age, HIV/AIDS is a key workplace issue. Global partnerships thus are an essential part of the response. In this respect, the IOE has developed close working relations with UNAIDS and the Global Fund to fight HIV/AIDS, TB and Malaria. The Global Fund Executive Director, Richard Feachem, addressed the Employers' group at the June 2004 International Labour Conference to discuss possibilities of collaboration between federations and the Fund at national level. The IOE also took part in the Fund's first partnership forum held in Bangkok in 2004.

281. Founded in 2001, the Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria (GBC)¹³² is an alliance of over 200 international companies dedicated to combating the AIDS epidemic through the business sector's unique skills and expertise. Since 2005 it has served as the official focal point of the private sector delegation to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and now provide its members with guidance, services, and expertise on malaria and TB, as well as on HIV/AIDS. The Global Health Initiative of the World Economic Forum (WEF) provides tools and guidelines to help businesses manage HIV/AIDS, TB and malaria in the workplace and in local communities, and includes many case studies of business responses on its web site.

282. Business coalitions have been created at the regional and national levels, several of them with the assistance of the ILO or ILO constituents. In Sri Lanka, for example, where there was already a National Tripartite Declaration on HIV/AIDS, individual companies joined with the National STD/AIDS Control Programme, the ILO, the Employers' Federation and the Chamber of Commerce to form the Sri Lankan Business Coalition on HIV/AIDS. This was launched at the International Conference on AIDS in

¹³² See <http://www.businessfightsaids.org/site/pp.asp?c=gwKXJfNVJtF&b=1008711>

Asia and the Pacific held in Sri Lanka in August 2007. It includes trade unions in its membership, and uses the ILO code for guidance.

283. There are also a number of responses from business at the national level. Although this is not their traditional role, many workplaces are providing services because of the implosion of public health systems under the pressure of HIV/AIDS. Businesses explain their involvement by reference to factors which range from cost-effectiveness to the expression of corporate social responsibility.

284. Multinational enterprises took the lead in providing treatment at workplaces, and their programmes are well documented, especially by the GBC and WEF (see above). Many diamond and gold mines as well as automobile companies in southern Africa provide treatment at the workplace through occupational health services, or other arrangements made with private or public health service providers. Companies including Anglo-America, DaimlerChrysler, BMW, Volkswagen¹³³ and Coca-Cola provide ARV drugs for HIV-positive staff. The Debswana HIV/AIDS project in Botswana provides ARV drugs for workers and their spouses.¹³⁴ In Malawi 12 company-owned clinics were providing ARVs to their staff and communities by the end of 2005.¹³⁵ There appears to be an increasing trend towards companies providing ARVs to their staff in the worst-affected regions. In African regions with a high rate of HIV infection, more than 70 per cent of the companies surveyed are fully subsidizing staff access to HIV treatment.¹³⁶

285. Employers in some medium and small enterprises in high-prevalence countries have also responded by sharing an occupational health service or by a referral service, on an agreed basis, to public hospitals or general practitioners near workplaces. Several enterprises in Brazil, India and South Africa have established occupational health services and as a result, increased access to ARVs for staff. Bringing treatment close to the workforce is important as it provides the opportunity for tailoring the treatment to suit the needs of workers within their work environment. Additionally, support for treatment adherence can be enhanced.

286. Some of the large enterprises in India, both public and private, have taken the lead in making ARV treatment available to their employees. As part of their workplace policy they have made a commitment to provide ARV treatment to their employees at their own cost. Examples include private companies such as Gujarat Ambuja Cement Ltd and the SRF Group India Ltd. The public sector includes Brihnamumbai Electric Supply and Transport (BEST) Undertaking in Mumbai, the Mumbai police and Central Coalfield Ltd., Ranchi.

287. ARV treatment is also provided under India's largest social security scheme, the Employees' State Insurance Scheme, under the auspices of the Ministry of Labour and Employment (MOLE); the scheme covers factories that employ more than ten

¹³³ R. Stewart, A. Padarath and L. Bamford: *Providing antiretroviral treatment in southern Africa – A literature review* (Durban, Health Systems Trust, 2004), available at www.hst.org.za/uploads/files/providingart.pdf

¹³⁴ *ibid.*

¹³⁵ Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria: *The private sector and the Global Fund: 2006 Year in review* (2007), available at <http://www.businessfightsaids.org/documents/media/publications/2006%20PSD%20Year%20In%20Review.pdf>

¹³⁶ Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria: *The state of business and HIV/AIDS (2006): A baseline report*, available at <http://www.businessfightsaids.org/documents/media/publications/The%20State%20of%20Business%20and%20HIVAIDSFINAL.pdf>

employees and run on power.¹³⁷ Treatment of contract workers in enterprises and workers in the informal economy is being covered in the government ARV treatment programme.

The role of the ILO's tripartite constituents

288. The ILO promotes the implementation of the code of practice and supports workplace action with and through its tripartite constituents. They have the potential to integrate HIV/AIDS responses in well-established networks, structures and programmes, and to strengthen the involvement of private sector enterprises, as well as the public sector, in contributing to universal access through the workplace. The ILO encourages employers and workers to take part in national HIV/AIDS programmes, and supports efforts to increase their capacity to do so.

289. Social dialogue among workers' and employers' organizations and governments is indispensable to implementing effective programmes in the workplace. Social dialogue is built on communications, consultation and collaboration, and leads to ownership of policies and plans. One of the key principles in the code of practice states: "The successful implementation of an HIV/AIDS policy and programme requires cooperation and trust between employers, workers and their representatives and government, where appropriate, with the active involvement of workers infected and affected by HIV/AIDS."

290. It is important to remember that government is also an employer. In South Africa the Department of Public Service and Administration produced a guide for government departments in 2002 on managing HIV/AIDS in the workplace. In Nigeria an effective response in the public sector is the AIDS care and support programme of the Federal Ministry of Labour. This programme has created an awareness among all the staff of the issue of HIV/AIDS and advocates "knowing your status" as an essential step to personal health and the creation of a safe and healthy work environment. The programme provides free ARV treatment to employees and testing every three months through the occupational health physician who visits the officers where they work in full confidentiality. The Ministry also applies the concept of reasonable accommodation – the adjustment of tasks, hours or workstations – to help HIV-positive workers manage their jobs. The programme has established linkages with the Government's Programme for Prevention of Mother-to-Child Transmission. The care and support provided has encouraged staff to seek information and voluntary counselling and testing, and has contributed to the reduction of the stigma and discrimination associated with HIV/AIDS.

Joint statements and policies

291. At the international level, this has resulted in a number of joint initiatives between workers' and employers' organizations. In 2003 the ICFTU (now the ITUC) and the IOE adopted a programme¹³⁸ in which they jointly recognized the direct impact of the HIV/AIDS pandemic on the world of work, stated their common interest in cooperating on the issue at national, international and workplace levels, including the development of joint action programmes, and pledged to continue working together on it. At the

¹³⁷ See also Mumbai District AIDS Control Society: *HIV/AIDS workplace policy* (BEST Undertaking, 2005).

¹³⁸ IOE and ICFTU: *Fighting HIV/AIDS together: A programme for future engagement* (12 May 2003), available at www.ilo.org/public/english/protection/trav/aids/ioeicftudecl.pdf

international level, this has resulted in a number of joint initiatives between workers' and employers' organizations at the regional and national levels.

292. A resolution on the role of social dialogue in addressing HIV/AIDS in the world of work, submitted jointly by the Employers' and Workers' delegates was adopted at the Tenth African Regional Meeting of the ILO in December 2003. The following year a meeting was held by the IOE and ICFTU to launch joint action plans in eight African countries.

293. A number of statements of commitment have been made and policies adopted at the international and national levels by tripartite consensus, or by employers' or workers' organizations on their own or together. Recent regional initiatives between the social partners include the ITUC–AFRO/IOE joint capacity-building meeting on HIV/AIDS for employers' and workers' organizations (Kampala, December 2006) which was hosted by the National Organization of Trade Unions of Uganda (NOTU) and the Federation of Uganda Employers (FUE), with support from the ILO. Employers' and workers' organizations are guided by the code to forge partnerships at all levels: one example is in Ghana, where the Ghana Trades Union Congress (GTUC) runs its HIV/AIDS project in cooperation with the Ghana Employers' Association (GEA). In cooperation with the Canadian Labour Congress, the ITUC's regional organization in Asia, APRO, carried out a survey among its affiliates on trade union responses to HIV/AIDS and then held a conference to agree upon a regional strategy that includes lobbying government to adopt the code of practice as part of their health policy.

294. Tripartite statements are most frequent in Africa, where available information indicates that they have been adopted in 16 countries,¹³⁹ and where there are 11 countries with employers' policies¹⁴⁰ and seven with workers' policies.¹⁴¹ They appear to be less frequent in the Americas, where two tripartite policy statements,¹⁴² six employers' policies¹⁴³ and four workers' policies¹⁴⁴ have been located. In Asia and the Pacific there are tripartite policy statements in six countries,¹⁴⁵ employers' policies in seven countries,¹⁴⁶ and workers' organizations' policies in four countries.¹⁴⁷ In Europe three tripartite declarations¹⁴⁸ have been located, and in the Middle East and North Africa, the tripartite Algiers Platform of Action on HIV/AIDS in the world of work was agreed upon in 2003.¹⁴⁹

¹³⁹ See in Appendix II: Benin 1; Botswana 4; Burkina Faso 5; Burundi 5; Cameroon 1; Democratic Republic of the Congo 2; Côte d'Ivoire; Ghana; Guinea 1; Guinea-Bissau 1; Madagascar 1; Malawi 2; Swaziland 3; United Republic of Tanzania 3; Togo 1; Zimbabwe 2, 3.

¹⁴⁰ Botswana, Cameroon, Democratic Republic of the Congo, Ethiopia, Ghana, Lesotho, Liberia, Mauritania, Nigeria, Uganda and Zambia.

¹⁴¹ Botswana, Ethiopia, Kenya, Namibia, Nigeria, Swaziland and the United Republic of Tanzania.

¹⁴² See in Appendix II: Belize 2; Honduras 1.

¹⁴³ Barbados, Guyana, Jamaica, Saint Kitts and Nevis, Saint Vincent and the Grenadines and Trinidad and Tobago.

¹⁴⁴ Barbados, Dominican Republic, Guyana and Jamaica.

¹⁴⁵ See in Appendix II: China 3; India 1, 2; Indonesia 1; Mongolia 2; Nepal 2, 3; Sri Lanka 2.

¹⁴⁶ Cambodia, India, Nepal, Pakistan, Papua New Guinea, Singapore and Sri Lanka.

¹⁴⁷ Cambodia, India, Nepal and Philippines.

¹⁴⁸ See in Appendix II: Kazakhstan 2; Russian Federation 2, 3; Tajikistan 2.

¹⁴⁹ Available at http://www.ilo.org/public/french/region/afpro/algiers/download/region_annexe2.pdf

295. Workplace policies agreed by employers and workers are too numerous to document, but the increasing number of sector-wide agreements offer a useful model. In India, for example, the National Federation of Indian Railwaymen and All India Railwaymen's Federation, representing some 70 per cent of the railway workforce, are in discussion with the Indian Railways Board to include HIV/AIDS in the curriculum of the schools for drivers and guards when they undertake induction courses and ongoing "refresher" training. The International Maritime Health Association (IMHA) and the International Transport Workers' Federation (ITF) jointly put on record at the International Congress on AIDS in Asia and the Pacific (19–23 August 2007, Sri Lanka) that HIV cannot be a cause for discrimination at sea. The two organizations made it clear that they consider that HIV as a workplace issue should be treated like any other serious illness or condition on board a vessel, that it is not a threat to public health in shipping, that it is not a cause for discrimination, and that testing for the virus should be voluntary.

296. The International Federation of Chemical, Energy, Mine and General Workers' Unions (ICEM) and the Building and Wood Workers' International (BWI) have negotiated framework agreements with multinational employers such as Impregilo, Lafarge, Veidekke, Lukoil and Statoil. The BWI advocates in its model framework agreement that an HIV/AIDS awareness-raising and prevention programme be provided in compliance with the ILO code of practice on HIV/AIDS and the world of work. The BWI also has an agreement with the World Bank and the International Finance Corporation to make HIV prevention programmes mandatory in all Bank-funded construction projects.

Interventions and actions by employers' organizations

297. Organizations of employers have a particular role in helping to motivate and support smaller, nationally owned and less well-resourced companies. These organizations provide leadership and advocacy, as well as offering guidance and practical support for their members, and encourage the pooling of resources and partnerships between large and smaller companies. They are supported by a global body, the IOE, which works actively to secure the commitment of its membership of 143 national organizations in 137 countries. These include the following examples:

- The Barbados Employers' Confederation, which helped the Ministry of Labour to draft a national code for the workplace, promotes examples of good practice among members, arranges training and provides guidance materials, such as a booklet for supervisors and managers entitled *HIV/AIDS discrimination in the workplace is wrong*.¹⁵⁰
- The Botswana Confederation of Commerce, Industry and Manpower helped set up the Business Coalition on HIV/AIDS and is represented on its board. Together the two bodies sponsor an annual competition, the Red Ribbon Awards of Business Excellence in HIV/AIDS.
- The National Confederation of Industry in Brazil founded a social service programme, SESI, in 1996, which has adapted to undertake HIV-related training and condom distribution. SESI has trained peer educators for 5,000 enterprises to date and has reached 1.6 million workers.

¹⁵⁰ See also Barbados Employers' Confederation: *Dealing with AIDS in the workplace: Guidelines for managers and supervisors* (11 August 2007), available at <http://www.kintera.org/atf/cf/{4AF0E874-E9A0-4D86-BA28-96C3BC31180A}/Barbados%20Employers%20Confederation%20Guidelines.doc>

- The Cambodian Federation of Employers and Business Associations has enrolled 12 companies in its programme, and two of the largest – in garment manufacturing and beer brewing – conduct education programmes targeting young female employees.
- The Inter-enterprise Group of Cameroon helps to implement the workplace components of the National Strategic Plan to Fight HIV/AIDS, and has provided guidance to employers' organizations throughout the subregion as well as to national businesses. Recent developments include a programme to share knowledge and resources with small enterprises.
- The Federation of Kenya Employers issued its first guidelines on HIV/AIDS in the workplace in 1994, and in 1999 was identified by the Government as focal point for workplace HIV/AIDS interventions.
- The Employers' Confederation of Thailand places high priority on helping its members develop a non-discriminatory workplace policy on HIV/AIDS, as well as providing guidance on education for prevention and OSH.
- The Federation of Ugandan Employers has one of the longest-established HIV/AIDS programmes. It has produced a range of materials, including the film *It's not easy*, and has trained over 10,000 peer educators, nearly 1,000 trainers, and over 300 top executives.

Interventions and actions by workers' organizations

298. Trade unions, with their mass memberships, leadership role and concern for social justice, have a vital role to play. They represent the interests, protect the rights and strengthen the capacities of workers. The ITUC alone consists of 304 national trade union centres, and the combined membership of the Global Unions¹⁵¹ exceeds 200 million. These bodies have passed resolutions¹⁵² on HIV/AIDS, started individual activities, and jointly put into place the Global Union AIDS Programme.¹⁵³

299. Unions have taken up rights-related issues such as pre-employment screening, continuity of employment for people with HIV, provision of sickness benefits, and death benefits for dependants. In Central America and the Caribbean, the ITUC regional organization ORIT has brought together trade unions and AIDS organizations from eight countries for a joint programme to combat stigma and discrimination in the workplace. Efforts have also focused on awareness raising and education for prevention, supported by the training of union officials and activists as AIDS focal points, peer educators and trainers. The African regional organization of the ITUC, for example, has a programme in nine countries based on the training of shop stewards as peer educators. There is a growing emphasis on access to care and treatment, and unions are helping to establish clinics (South Africa), lobby for ARV treatment provision, promote voluntary confidential counselling and testing, set up drop-in centres along key transport routes, organize solidarity funds and health insurance schemes, and campaign against sexual

¹⁵¹ The Global Unions consist of the ITUC, ten sector-specific international federations and the Trade Union Advisory Committee to the OECD.

¹⁵² See <http://congress.icftu.org/displaydocument.asp?Index=991220325&Language=EN>

¹⁵³ See <http://www.global-unions.org/hiv-aids/>

violence.¹⁵⁴ Trade union leaders often have a standing and influence in the community beyond their formal membership, and when the general secretaries of the two national union centres in Swaziland took HIV tests publicly it was a major media event.

300. The degree to which both business and trade unions have demonstrated their awareness of the seriousness of the epidemic and the importance of the workplace as centre for action, also suggests the importance of collective bargaining as a tool. The questionnaire accompanying this report asks whether the constituents consider that the measures to be taken under the proposed Recommendation should place a responsibility on both employers and workers to include this issue in collective bargaining.

301. There are several examples of activities of the Global Union federations. A project in Swaziland and Zimbabwe to help women workers defend their rights in sexual relations is being organized by the BWI. Public Services International (PSI) is working with WHO, the ILO and UNAIDS to help increase access to treatment and apply the joint ILO–WHO guidelines on HIV/AIDS for health services. The Federation for Agricultural, Food and Hotel Workers (IUF) has joined local women’s groups in Uganda to set up clinics on plantations where workers can get access to voluntary counselling and testing (VCT) and family planning. Education International started a teachers’ training programme on HIV/AIDS prevention in schools in 2001; with support from the WHO and the Education Development Centre (EDC) the programme is being implemented in ten anglophone and seven francophone countries (all but two in Africa). The International Federation of Journalists (IFJ) is conducting an 18-month programme to improve reporting of HIV/AIDS; the project targets IFJ affiliates in Cambodia, India, Nigeria, Philippines, South Africa and Zambia. The ITF includes HIV/AIDS in education and policy development work for all its sectors, with specific projects in Africa and South Asia for road transport; it has undertaken research into risk and vulnerability and helped set up roadside wellness clinics in southern Africa and the Great Lakes Region. The ITF Seafarers’ Trust has invested nearly US\$1 million in a three-year Seafarers’ Health Information Programme (SHIP) being run by the International Committee on Seafarers’ Welfare. SHIP covers HIV/AIDS, physical fitness, cardiovascular disease, food, obesity and malaria.

302. Individual trade unions at the national level are also taking significant action in this area. Many initiatives are the result of solidarity programmes between unions in different regions, for example the Norwegian national centre and the ITUC–AFRO programme. Examples of union activity include the following:

- Brazil’s Single Central Organization of Workers (CUT) has created a National Commission on AIDS Prevention formed by trade unions and civil society organizations. It promotes HIV prevention, seeks to improve the quality of life of workers living with HIV and defends their basic rights.
- The Guatemalan health workers’ union ANTRASPG/SNTSG conducts prevention education activities with unionized and non-unionized workers from various sectors, including health care and agriculture, and in the informal economy.
- The Dockworkers’ Union of Kenya includes HIV/AIDS-related provisions in its collective bargaining agreement. A ban on HIV-related discrimination is embodied

¹⁵⁴ Global Unions/ILO/UNAIDS, *Global reach: How trade unions are responding to HIV/AIDS: Case studies of union action*, UNAIDS Best Practice Collection, July 2006, available at http://data.unaids.org/Publications/IRC-pub07/JC1276-GlobalReach_en.pdf

in the agreement, which also provides for shop stewards to receive HIV/AIDS training, financed by their employers.

- The Trade Union Congress of the Philippines (TUCP) seeks to ensure that workers' rights are respected in line with national legislation, such as the HIV/AIDS Prevention and Control Act of 1998. A number of companies support the programme by offering workers paid leave to attend HIV/AIDS seminars, funding education activities and providing company training rooms at no cost. The TUCP also has a well-established sexual and reproductive health programme in which HIV/AIDS is fully integrated, and it is represented on the National AIDS Commission.
- Union Aid Abroad (Australia) supports the AIDS programmes of a number of unions in South-East Asia and southern Africa, including courses run by the Cambodian Prostitutes Union which offer sex workers skills for alternative paid work. The unions in Cambodia have also been closely involved in developing the national workplace policy on HIV/AIDS.
- The South African Clothing and Textile Workers' Union (SACTWU) has had a significant HIV/AIDS programme since 1998, implemented in three phases. Phase 1 focused on awareness and education, phase 2 provided testing and counselling, access to treatment and home-based care, phase 3 saw the establishment of comprehensive HIV/AIDS clinics which provide counselling services, testing, treatment and psychosocial support. There is also a hospice for the terminally ill, an orphanage and a service to advise on rights. The training programme targets every level from senior leadership and management to shop stewards and workers generally. The union also has a positive workers' support group and an income-generating programme. Links with the community are a priority for the two rural VCT sites and treatment centres as well as the income-generating project for retrenched workers.
- The AFL-CIO and its Solidarity Centre's HIV/AIDS programme in South Africa operated in partnership with the ITUC affiliates COSATU, NACTU and FEDUSA. The programme is being extended to other countries in the region.
- The British public sector union UNISON coordinates twinning arrangements to support southern African trade unions' HIV/AIDS programmes, and its International Trade Union Development Fund is helping develop the HIV/AIDS work of a number of public service trade unions in southern Africa and Bangladesh. It also collaborates with the United Kingdom's Stop AIDS Campaign on advocacy and campaigning around universal access, labour migration in the health sector, and the involvement of trade unions in development and HIV/AIDS programmes supported by the Department for International Development.
- The Zimbabwe Congress of Trade Unions developed a pioneering project on HIV awareness and behavioural change for couples in the late 1990s.
- In August 2007 the Central Trade Unions of India, comprising the All India Trade Union Congress (AITUC), Centre of Indian Trade Unions (CITU), Indian National Trade Union Congress (INTUC), Bharatiya Mazdoor Sangh (BMS) and Hind Mazdoor Sabha (HMS), signed a Joint Statement of Commitment on HIV/AIDS, based on the ILO code of practice.

Chapter IV

Considerations for the proposed Recommendation

303. The wealth of material outlined in the previous chapters, and the complex interactions between policies and circumstances, make it difficult to determine exactly what should figure in the proposed Recommendation.

Developments since the adoption of the ILO code of practice

304. As indicated in preceding chapters, there have been several developments even in the short time since the code of practice was adopted.

305. Firstly, as illustrated by the statistics in Chapter I of this report, the epidemic has continued to gain ground, and in some cases its rate of increase has accelerated. In addition, it has penetrated regions – such as Asia and Eastern Europe – which were relatively unaffected in 2001 but which today show signs of becoming major loci of future infections. At the same time, the infection has spread beyond specific high-risk groups, and is now transmitted very largely through heterosexual relations, including in nations and among sections of the population that previously considered their risk to be very low. This highlights the global character of the threat and the need for all parts of the world to learn from each other how to deal most effectively with HIV/AIDS.

306. On the other hand, the development of affordable and effective treatment, with a more focused emphasis on prevention and improved techniques for surveillance, mean there are solutions that were not available in 2001. This may have implications for the responses of governments, employers and workers.

307. Beyond these developments is the fact that in some countries the national public health system and other mechanisms have simply collapsed under the weight of the epidemic. The public sector response is in some cases virtually non-existent. At the same time, ILO constituents have sometimes found responses that were not available a few years ago.

308. Many enterprises – both multinationals and purely local employers – have stepped in to compensate for the failure of public systems. They have provided prevention, protection, treatment and support for their own workers and their families. This has been done by individual enterprises, as well as by coalitions of employers working together. They have had good reason to do so, quite apart from humanitarian considerations and a willingness to assume their social responsibilities, in order to ensure that a workforce will still be available when needed.

309. On the other hand, parts of the business community have limited or withdrawn support to workers and their families in the event of HIV infection. Insurance providers

in both the public and private sectors have often required screening before and during employment, and insisted on infected persons being denied employment or removed both from the workforce and from the health insurance coverage available to all other workers.

Form and content of the Recommendation

Possible approaches

310. The principles and most of the guidance embodied in the code of practice remain valid. The code has demonstrated its usefulness in many countries around the world and helped to set the ILO's own priorities. In certain instances – such as when governments insist on testing potential migrants and refusing admission to workers who are infected – the code has lacked impact because its principles are not being followed, and there may be ways of reinforcing them in the Recommendation. The code should therefore be left intact, while the Recommendation should concentrate on embodying its basic principles and on shedding light on the most effective ways of implementing it.

311. Various options are open as regards the form and content of the proposed Recommendation.

312. One option for the present discussion would be simply to propose converting the code of practice into a Recommendation. This would have the advantage of using already established language, and of simply raising the status of the code to that of an instrument adopted by the International Labour Conference. However, the great detail contained in the code would not entirely suit the form of a Recommendation and the Office has therefore not retained this option in drafting the questionnaire. In addition, it would not allow the Conference to discuss whether provisions of the code should be expanded, or new developments taken into account, without reducing the protection under the code.

313. A second option would have been to propose adopting an entirely new instrument in the light of developments since 2001, taking the code as a point of departure. This option does not appear desirable either, in part because it would call into question the continuing validity of the code itself.

314. The option that has been adopted in the questionnaire, subject to the responses of the ILO's constituents, is to base the questionnaire – and the Recommendation – on the main principles of the code of practice, and to propose appending the code to the Recommendation. The Recommendation would thus be firmly grounded in the code. At the same time, if there are provisions of the code on which thinking has evolved at the international level, or if there are subjects that were not fully considered and incorporated when the code was adopted in 2001, this approach will also allow a restatement of approaches in the code in the light of more mature reflection, or the addition of more subjects.

315. In taking this approach, the Office is convinced that the Governing Body and the constituents do not wish to call into question the code of practice, nor to diminish the level of protection and guidance offered by it. The questionnaire is therefore based on the assumption that the code constitutes a minimum standard which the Recommendation should aim to improve.

Preamble

316. The Preamble of an international labour standard normally includes various considerations relevant to the subject at hand, but which do not form part of the operative provisions. The Preamble sets the stage for the instrument itself.

317. The questionnaire asks the ILO constituents about a variety of subjects which might appear in the Preamble.

318. The Preamble might refer to the impact of the epidemic on workers and workplaces, to the critical situation of the world of work in the face of the HIV/AIDS epidemic, and to the socio-economic impact of the epidemic. It should also refer to the code of practice.

319. The Preamble might also refer to existing international law of relevance to HIV/AIDS in the workplace, including ILO standards and those adopted by other international organizations.

320. The important role of the workplace as a centre for information, prevention, support and treatment should be stated.

321. It is clear that the Preamble should include a reference to the need to engage in social dialogue and to the roles of employers' and workers' organizations.

322. The value of cooperation with other intergovernmental organizations, including the ILO's co-sponsors of UNAIDS, and with non-governmental organizations working at the national and international levels, should also be mentioned.

Scope

323. The code, along with many national laws and policies, applies to all parts of the national population, including all workers and members of their families. It also applies to all workplaces. Because a Recommendation is an instrument intended to provide guidance and examples, and does not directly create substantive obligations, there appears to be no reason to restrict its coverage. The questionnaire therefore asks constituents whether they agree that the instrument should be applicable to all workers and all enterprises, including those in the informal economy.

National policy

324. The questionnaire is divided into sections, including one on national policy. This section begins with questions on whether governments, in consultation with the social partners and others, should adopt a national policy on HIV/AIDS of the kind contemplated in the code of practice. In exploring the contents of such a policy, the questionnaire refers to areas that governments and others might include to guide their own actions. The questions are naturally very broad, and the policy adopted at the national level would have to be adapted to the national situation. The broad scope of the questions reflects the fact that, as we have seen, while almost all governments have adopted some kind of policy on HIV/AIDS, many of these policies cover only some of the questions that are relevant to the handling of the epidemic.

325. The question of integration with broader national health and social policy is of paramount importance. Employers and workers cannot act in isolation, and workplace programmes should both contribute to national responses and benefit from them. Workplace health care should complement and reinforce national health-care systems, and also relate to other diseases, including TB and malaria.

326. Various considerations are laid out under the section on "Principles", which is based on the corresponding section in the ILO code of practice. Emphasis is placed on

certain points, including making responses to HIV/AIDS consistent with policies adopted in the application of other ILO standards including those on human rights and OSH.

327. The duty of governments to encourage and facilitate social dialogue on this issue is extremely important. This should be focused on employers' and workers' organizations for workplace-related issues. It is also important to involve organizations of persons living with and affected by HIV/AIDS.

328. Preventive measures and the role of public services are highlighted. In far too many cases, workplaces have had to assume burdens imposed upon them by the collapse or inadequacy of public health services, and the continuing inadequacy in many countries of national labour inspectorates, labour justice systems and other institutions.

329. This section also emphasizes the special needs of various groups of workers and their families, including protection on the basis of gender, and protection of migrants, children and young persons.

Employers and workers

330. Employers and workers have their own specific rights and obligations. One of the considerations reflected in the questionnaire is the fact that workplaces are central to the attainment of universal access, and this has implications for both employers and workers and their organizations. Among other things, they both have a duty to deal with these issues in workplace policies and collective agreements.

Follow-up to the Recommendation

331. One of the weaknesses that has been identified in the code of practice, and one of the reasons for which it is desirable to adopt a Recommendation, is the fact that there is no follow-up mechanism inherent in the code at either the national or international level. It is a fundamental lesson from ILO experience that following up an international instrument increases the chances of its implementation.

332. At the international level, this can be done in a supervisory context as a result of obligations undertaken under a Convention or the ILO Constitution; alternatively, it can be done in a more promotional context under the terms of article 19 of the Constitution, either by calling for General Surveys to be carried out by the Committee of Experts on the Application of Conventions and Recommendations, or under the Declaration on Fundamental Principles and Rights at Work.

333. The possibilities inherent under a Recommendation were outlined in the report on strengthening ILO capacity submitted to the 96th Session of the International Labour Conference in 2007, as follows:

163. In the case of a Recommendation these consequences are defined in the Constitution. This concerns their follow-up, to which Recommendations are, in principle, subjected under article 19 of the Constitution. Although non-binding, Recommendations nevertheless place a dual obligation on all Members: first, an obligation to bring the Recommendation before the competent authority (19.6(b)), that can pave the way for a "transformation" of its content in national legislation; second, the "residual" obligation, provided for under article 19.6(d), that obliges Members, in principle, to respond to requests from the Governing Body from time to

time to “show the extent to which effect has been given, or is proposed to be given, to the provisions of the Recommendation”.¹

334. A footnote² to this part of that report added that “it should be recalled that a standard-setting instrument, even if it is of a non-binding nature as in the case of a Recommendation, nevertheless makes it possible to establish a peer review, as a follow-up element inherent in a Recommendation”.

335. It is premature at this stage to consider in detail what mechanism might be adopted, but some indications might be useful to guide the discussion. Traditionally, article 19 of the Constitution has been used to call for reports leading to the drafting of a General Survey by the Committee of Experts. More recently, it has been used to call for annual reports under the Declaration. Before the adoption of the Declaration, article 19 was invoked to call for periodic reports on the Discrimination (Employment and Occupation) Convention, 1958 (No. 111) and, in a later development, for periodic reports on six other fundamental rights Conventions.³ While either of these might be referred to on the basis of precedent, the wording of article 19(6)(d) imposes no specific methodology or timing. It states:

(d) apart from bringing the Recommendation before the said competent authority or authorities, no further obligation shall rest upon the Members, except that they shall report to the Director-General of the International Labour Office, at appropriate intervals as requested by the Governing Body, the position of the law and practice in their country in regard to the matters dealt with in the Recommendation, showing the extent to which effect has been given or is proposed to be given, to the provisions of the Recommendation and such modifications of these provisions as it has been found or may be found necessary to make in adopting or applying them.

336. As indicated above, such reports are normally examined by the Committee of Experts or by the Expert-Advisers on the Declaration. But they could also be examined by other bodies, such as a committee of the Governing Body, or through some other ad hoc procedure. On this basis, the Conference might discuss whether provision for reporting on the Recommendation, either regularly or as called for by the Governing Body, should be included in the Recommendation, and, if regular reporting is called for, at what intervals and what the follow-up procedure should be.

337. At the national level, it can be noted from Chapter III that there is great inconsistency among ILO Members in terms of whether and how they review the implementation of the code of practice, and other related measures to combat and deal with HIV/AIDS in the workplace. In addition, such review as exists at the national level may be in a coordinated or other inclusive body, or it may be done piecemeal by different bodies with different mandates and timing.

338. It is therefore suggested that some provision on follow-up and review at the national level would be a valuable addition under the Recommendation. If it is decided to include such a provision, the Recommendation might follow the example of certain other ILO instruments which provide for coordinating bodies, and make suggestions as to how they might be composed and how they would function, but leave the precise composition and functioning to decisions at the national level.

¹ ILO: *Strengthening the ILO's capacity to assist its Members' efforts to reach its objectives in the context of globalization*, ILC, 96th Session, Geneva, 2007, para. 163, available at: <http://www.ilo.org/public/english/standards/relm/ilc/ilc96/pdf/rep-v.pdf>

² *ibid*, footnote 11, p. 50.

³ This procedure was replaced by the Declaration procedure before it came into force.

339. Within these limits, the Recommendation might provide that a coordinated follow-up to the implementation of the code, or other measures taken in regard to HIV/AIDS in the workplace, should be established.

340. This might involve of a single national body that would coordinate all measures, or more specific bodies that would adopt measures in different respects – for instance, a specific oversight body for measures taken relating to the workplace. In either case, information on all such efforts should be collected and reviewed periodically at the national level, and there should be provision for this review to be followed up by recommendations for action to correct any gaps or to respond to developments. The body could have the power either to recommend or to order action, according to decisions taken at the national level.

341. The composition of any body that would conduct reviews of measures concerning the workplace should include the ministry or government authority responsible for labour, and representatives of employers and workers appointed under a procedure that would ensure that they are represented on an equal footing. It might also include other relevant ministries, such as those responsible for health, planning, development, or others, and should include representatives of persons living with and affected by HIV/AIDS. It might also be appropriate to include other civil society organizations that have an interest in the question, as is provided for in, for example, the Tripartite Consultation (International Labour Standards) Convention, 1976 (No. 144).

342. Finally, this part of the questionnaire raises the question of continuing cooperation with other intergovernmental organizations, especially the ILO's fellow co-sponsors in UNAIDS.

Questionnaire

At its 298th Session in March 2007, the Governing Body requested the Office to place an item on HIV/AIDS and the world of work on the agenda of the 98th Session (2009) of the International Labour Conference, for a double discussion leading to the adoption of an autonomous Recommendation.

It was decided that it was necessary to adopt an international labour standard in the form of an autonomous Recommendation on this subject in order to increase the attention to the subject at the national and international levels, to promote united action among the key actors on HIV/AIDS, and to increase the impact of the ILO code of practice on HIV/AIDS and the world of work (2001), hereinafter cited as the ILO code of practice, and other action, as well as to review developments since 2001.

The purpose of the questionnaire is to request the views of member States on the scope and content of the proposed instrument, after consultation with the most representative organizations of employers and workers.

Due to the broad scope of the subject, it would be advisable for ministries of labour to consult other relevant national ministries and institutions dealing with HIV/AIDS, such as ministries of social affairs, health, education, justice, gender, youth, finance and planning, for the preparation of the replies. It might also be desirable to consult other relevant organizations, including organizations of persons living with HIV/AIDS and others working with them.

In drafting the questionnaire, account was taken of information available to the ILO from its work on HIV/AIDS and related matters, including in its capacity as a co-sponsor of the Joint United Nations Programme on HIV/AIDS (UNAIDS), and of the information supplied by governments and the social partners in reporting on relevant international Conventions under article 22 of the ILO Constitution. It also takes account of information available to other intergovernmental organizations with which the ILO works.

Form of the instrument

1. *Do you consider that the International Labour Conference should adopt an instrument concerning HIV/AIDS in the world of work?*

Yes No

Comments:

2. *Do you consider that the instrument should take the form of a Recommendation?*

Yes No

Comments:

Preamble

3. *Should the instrument include a Preamble referring to:*

(a) *the impact of the HIV epidemic on workers and their families, and on enterprises;*

Yes No

Comments:

(b) *the discrimination faced by persons affected by HIV;*

Yes No

Comments:

(c) *the socio-economic impact of the HIV epidemic on the world of work, and on society at large;*

Yes No

Comments:

(d) *the impact of HIV/AIDS on the attainment of decent work;*

Yes No

Comments:

(e) *the links between HIV/AIDS, poverty and sustainable development;*

Yes No

Comments:

(f) *the fact that more women become HIV-positive and are more adversely affected by the HIV epidemic than men;*

Yes No

Comments:

(g) *the need for the International Labour Organization (ILO) to strengthen its efforts with regard to HIV/AIDS in all aspects of its work;*

Yes No

Comments:

(h) *the value of the ILO code of practice on HIV/AIDS and the world of work;*

Yes No

Comments:

(i) *international Conventions and Recommendations, including those of the ILO and the United Nations, that are relevant to HIV/AIDS in the world of work;*

Yes No

Comments:

(j) *the critical role of the workplace for information and access to prevention, treatment, care and support in the national response to HIV/AIDS;*

Yes No

Comments:

(k) *the unique role of employers' and workers' organizations in promoting and supporting the national effort against HIV/AIDS in and through the world of work;*

Yes No

Comments:

(l) *cooperation among international organizations, in the context of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and beyond, to ensure universal access to HIV prevention, care and treatment and to mitigate the impact of AIDS;*

Yes No

Comments:

(m) *the value of cooperation with other relevant organizations, especially organizations of persons living with HIV, at the national and international levels.*

Yes No

Comments:

I. Definitions and scope

4. *Should the proposed instrument contain the following definitions:*

(a) *“HIV” means the Human Immunodeficiency Virus, a virus that weakens the body’s immune system, ultimately causing AIDS;*

Yes No

(b) *“AIDS” means the Acquired Immune Deficiency Syndrome, a cluster of medical conditions, often referred to as opportunistic infections and cancers and for which, to date, there is no cure;*

Yes No

(c) *“persons living with HIV” means those infected with HIV;*

Yes No

(d) *“affected persons” means persons whose lives are changed in any way by HIV/AIDS due to the broader impact of this epidemic?*

Yes No

5. *Should the proposed instrument cover:*

(a) *all workers, including self-employed persons, and applicants for work;*

Yes No

Comments:

(b) *all sectors of economic activity, public and private, in both the formal and informal economies?*

Yes No

Comments:

II. National policy

6. *Should the instrument provide that Members should adopt a national policy on HIV/AIDS in the world of work, in consultation with the most representative organizations of employers and workers and with organizations of persons living with HIV?*

Yes No

Comments:

7. *Should the national policy on HIV/AIDS in the world of work deal with the following areas:*

(a) *prevention of HIV;*

Yes No

Comments:

(b) *mitigation of the impact of HIV/AIDS on workers and on the world of work;*

Yes No

Comments:

(c) *care and support of workers affected by HIV/AIDS, and of their families;*

Yes No

Comments:

(d) *elimination of stigma and discrimination on the basis of real or perceived HIV status;*

Yes No

Comments:

(e) *the role of the workplace for information and action, including voluntary counselling and testing, prevention, treatment, care and support;*

Yes No

Comments:

(f) *the role of the workplace in collaborating with the local communities and in extending programmes through the supply chain and distribution networks?*

Yes No

Comments:

8. *Should the national policy on HIV/AIDS in the world of work:*

(a) *be given effect, in consultation with the most representative employers' and workers' organizations and other parties concerned:*

(i) *in national laws and regulations;*

Yes No

Comments:

(ii) *through collective agreements;*

Yes No

Comments:

(iii) *in national, sectoral and workplace policies and programmes of action?*

Yes No

Comments:

(b) *be brought to the attention of labour justice and labour administration authorities, and training on it be provided to them;*

Yes No

Comments:

(c) *provide incentives to encourage national and international enterprises to implement the national policy, including in export processing zones;*

Yes No

Comments:

(d) *promote social dialogue, consultation, negotiation and other forms of cooperation among government authorities, employers and workers and their representatives, occupational health personnel, specialists in HIV/AIDS, and other parties concerned, including organizations of persons living with HIV;*

Yes No

Comments:

(e) *take into account scientific and social developments when the policy is formulated, reviewed and implemented;*

Yes No

Comments:

(f) *be coordinated with national health and social security systems?*

Yes No

Comments:

III. Principles

9. *Should the instrument express the following principles and provide for them to be taken into account in the national policy?*

(a) **General principles**

(i) *HIV/AIDS should be recognized as a workplace issue.*

Yes No

Comments:

(ii) *Governments should integrate their policies on HIV/AIDS in the world of work in development plans and poverty reduction strategies.*

Yes No

Comments:

(iii) *Governments should adopt and implement policies and programmes on HIV/AIDS for all workers employed in the public sector.*

Yes No

Comments:

(b) **Discrimination**

(i) *There should be no discrimination against workers on the basis of real or perceived HIV status, nor on the basis of belonging to parts of the population perceived to be at greater risk of HIV infection, taking into account the Discrimination (Employment and Occupation) Convention, 1958 (No. 111).*

Yes No

Comments:

-
- (ii) *Governments, in consultation with the most representative employers' and workers' organizations, should ensure that coverage of Convention No. 111 is extended to persons living with HIV, under Article 1(1)(b) of that Convention.*

Yes No

Comments:

- (iii) *HIV status should not be a cause for termination of employment. Persons with HIV-related illnesses should be allowed to work for as long as medically fit, in available, appropriate work.*

Yes No

Comments:

- (iv) *Temporary absences from work because of illness related to HIV/AIDS should not constitute a valid reason for termination, in accordance with Article 6 of the Termination of Employment Convention, 1982 (No. 158).*

Yes No

Comments:

- (v) *Measures should be taken to promote equal gender relations and the empowerment of women in order to reduce the transmission of HIV and enable women to cope with HIV/AIDS.*

Yes No

Comments:

(c) Social dialogue

- (i) *Implementation of an HIV/AIDS policy and programme should be based on cooperation and trust between employers, workers and their representatives, and, where appropriate, government, with the active involvement of workers living with HIV.*

Yes No

Comments:

- (ii) *Employers' and workers' organizations should be encouraged to promote prevention and non-discrimination through the provision of information and education.*

Yes No

Comments:

- (iii) *Workers and employers should be encouraged to include the matter of HIV/AIDS in collective agreements.*

Yes No

Comments:

(d) Occupational safety and health

- (i) *The work environment should be healthy and safe, taking into account the Occupational Safety and Health Convention, 1981 (No. 155), and the Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187), and other relevant ILO instruments, in order to prevent transmission of HIV.*

Yes No

Comments:

- (ii) *Occupational health services and occupational safety and health-related workplace mechanisms should address HIV/AIDS concerns.*

Yes No

Comments:

(e) **Testing and confidentiality**

- (i) *HIV screening should not be required of workers or job applicants.*

Yes No

Comments:

- (ii) *Workers should be encouraged to know their HIV status through voluntary testing and counselling. Job security and confidentiality should be ensured, and access to treatment made available if it becomes necessary.*

Yes No

Comments:

- (iii) *Workers and job applicants should not be required to disclose HIV-related personal information about themselves or others. Access to such information should be bound by rules of confidentiality consistent with the ILO's code of practice on the protection of workers' personal data, 1997.*

Yes No

Comments:

(f) Prevention, treatment, care and support

- (i) *Prevention of all means of HIV transmission should be a fundamental priority. Prevention strategies should be adapted to national conditions and the workplace concerned, and should be sensitive to gender and culture.*

Yes No

Comments:

- (ii) *Prevention programmes should ensure:*

- (1) *the provision of accurate and relevant information, including prevention of mother-to-child transmission;*

Yes No

Comments:

- (2) *education to help men and women understand and reduce risk;*

Yes No

Comments:

- (3) *practical measures, such as improving condom availability.*

Yes No

Comments:

- (iii) *All workers, including workers living with HIV and their dependants, should be entitled to affordable health services. These services should include the provision of antiretroviral treatment and treatment for opportunistic infections, especially tuberculosis, and for sexually transmitted infections.*

Yes No

Comments:

- (iv) *Governments should ensure that persons living with HIV and their dependants benefit from full coverage for health care under public or private insurance schemes.*

Yes No

Comments:

- (v) *There should be no discrimination against workers living with HIV and their dependants in access to statutory social security programmes and occupational insurance schemes, nor in relation to benefits, including health care, disability and survivors' benefits.*

Yes No

Comments:

- (vi) *Programmes of care and support should include measures of reasonable accommodation for workers with HIV-related illnesses.*

Yes No

Comments:

(vii) *In appropriate cases, HIV/AIDS should be recognized as an occupational illness.*

Yes No

Comments:

(viii) *Measures should be taken to promote income-generating opportunities for persons affected by HIV/AIDS.*

Yes No

Comments:

(g) Training

(i) *All training, safety instructions and any necessary guidance should be understandable to all women and men and, in particular, to newly engaged or inexperienced workers, including migrant workers, and tailored to the characteristics and risk factors of the workforce.*

Yes No

Comments:

(ii) *Up to date scientific and socio-economic information and training on HIV/AIDS should be provided to senior and line managers.*

Yes No

Comments:

(iii) *Workers have the right to be informed and consulted on measures taken to implement the policy, to participate in workplace inspections, and to receive training in these areas.*

Yes No

Comments:

(h) Migrant workers

Governments should ensure that migrant workers, or those seeking to migrate for employment, are not subject to compulsory HIV testing, and are not excluded from migration if they are HIV-positive. Measures to ensure access to prevention, treatment, care and support services should be adopted by both country of origin and of destination.

Yes No

Comments:

(i) Children and young persons

(i) *National and international commitments on combating child labour, in particular when it results from the death or illness of family members due to AIDS, and action should be reinforced to:*

(1) *raise awareness of the links between HIV/AIDS and child labour;*

Yes No

Comments:

(2) *identify key areas of intervention; and*

Yes No

Comments:

(3) *reduce the risk of child labourers contracting HIV.*

Yes No

Comments:

(ii) *Measures should be taken to protect young workers against HIV infection, and to include the special needs of youth in response to HIV/AIDS. This may include the integration of information on HIV/AIDS in vocational training and youth employment programmes.*

Yes No

Comments:

(j) Public services

(i) *The role of the labour administration services, including the labour inspectorate, in the response to HIV/AIDS should be reviewed and if necessary strengthened.*

Yes No

Comments:

- (ii) *Public health systems should be strengthened, where necessary, in order to ensure greater access to prevention, treatment, care and support, and to reduce the additional strain on services and health workers caused by HIV/AIDS.*

Yes No

Comments:

IV. Follow-up

10. *Should the instrument provide:*

- (a) *for follow-up measures to be adopted at the national level, for regular and periodic review of the measures taken to implement the policy;*

Yes No

Comments:

- (b) *for cooperation and coordination between the ILO and other intergovernmental organizations in order to promote and implement the instrument?*

Yes No

Comments:

V. Special problems

11. *Are there unique features of national law or practice which are liable to create difficulties in the practical application of the proposed instrument as conceived in this questionnaire?*

Yes No

Comments:

12. ***For federal States only:*** *In the event of the instrument being adopted, would the subject matter be appropriate for federal action or, wholly or in part, for action by the constituent units of the federation?*

Yes No

Comments:

13. *Are there any other pertinent problems not covered by the present questionnaire which ought to be taken into consideration when the instrument is being drafted?*

Yes No

Comments:

Appendix I

An ILO code of practice on HIV/AIDS and the world of work

Preface

The HIV/AIDS epidemic is now a global crisis, and constitutes one of the most formidable challenges to development and social progress. In the most affected countries, the epidemic is eroding decades of development gains, undermining economies, threatening security and destabilizing societies. In sub-Saharan Africa, where the epidemic has already had a devastating impact, the crisis has created a state of emergency.

Beyond the suffering it imposes on individuals and their families, the epidemic is profoundly affecting the social and economic fabric of societies. HIV/AIDS is a major threat to the world of work: it is affecting the most productive segment of the labour force and reducing earnings, and it is imposing huge costs on enterprises in all sectors through declining productivity, increasing labour costs and loss of skills and experience. In addition, HIV/AIDS is affecting fundamental rights at work, particularly with respect to discrimination and stigmatization aimed at workers and people living with and affected by HIV/AIDS. The epidemic and its impact strike hardest at vulnerable groups including women and children, thereby increasing existing gender inequalities and exacerbating the problem of child labour.

This is why the ILO is committed to making a strong statement through a code of practice on HIV/AIDS and the world of work. The code will be instrumental in helping to prevent the spread of the epidemic, mitigate its impact on workers and their families and provide social protection to help cope with the disease. It covers key principles, such as the recognition of HIV/AIDS as a workplace issue, non-discrimination in employment, gender equality, screening and confidentiality, social dialogue, prevention and care and support, as the basis for addressing the epidemic in the workplace.

This code is the product of collaboration between the ILO and its tripartite constituents, as well as cooperation with its international partners. It provides invaluable practical guidance to policy-makers, employers' and workers' organizations and other social partners for formulating and implementing appropriate workplace policy, prevention and care programmes, and for establishing strategies to address workers in the informal sector. This is an important ILO contribution to the global effort to fight HIV/AIDS.

The code will help to secure conditions of decent work in the face of a major humanitarian and development crisis. Already, valuable lessons have been learned in attempting to deal with this crisis. A few countries have achieved a degree of success in slowing down the spread of the infection and mitigating its effects on individuals and their communities. The best practices have included committed leadership, multi-sectoral approaches, partnership with civil society, including people living with HIV/AIDS, and education. These elements are reflected in the key principles of the code and its reliance on the mobilization of the social partners for effective implementation.

This is a forward-looking and pioneering document which addresses present problems and anticipates future consequences of the epidemic and its impact on the world of work. Through

this code, the ILO will increase its support for international and national commitments to protect the rights and dignity of workers and all people living with HIV/AIDS.

Geneva, June 2001.

Juan Somavia,
Director-General.

Contents

Preface	107
1. Objective	111
2. Use	111
3. Scope and terms used in the code	111
3.1. Scope.....	111
3.2. Terms used in the code.....	111
4. Key principles	113
4.1 Recognition of HIV/AIDS as a workplace issue.....	113
4.2. Non-discrimination.	113
4.3. Gender equality	113
4.4. Healthy work environment.....	113
4.5. Social dialogue.....	113
4.6. Screening for purposes of exclusion from work or work processes.....	113
4.7. Confidentiality	113
4.8. Continuation of employment relationship.....	113
4.9. Prevention	114
4.10. Care and support.	114
5. General rights and responsibilities	114
5.1. Governments and their competent authorities.....	114
5.2. Employers and their organizations.....	115
5.3. Workers and their organizations	117
6. Prevention through information and education	118
6.1. Information and awareness-raising campaigns	118
6.2. Educational programmes.....	119
6.3. Gender-specific programmes	120
6.4. Linkage to health promotion programmes.	120
6.5. Practical measures to support behavioural change.....	120
6.6. Community outreach programmes	120

7. Training	120
7.1. Training for managers, supervisors and personnel officers	121
7.2. Training for peer educators	121
7.3. Training for workers' representatives	121
7.4. Training for health and safety officers	122
7.5. Training for factory/labour inspectors	122
7.6. Training for workers who come into contact with human blood and other body fluids	122
8. Testing	123
8.1. Prohibition in recruitment and employment.....	123
8.2. Prohibition for insurance purposes.....	123
8.3. Epidemiological surveillance	123
8.4. Voluntary testing.....	123
8.5. Tests and treatment after occupational exposure	124
9. Care and support	124
9.1. Parity with other serious illnesses	124
9.2. Counselling	124
9.3. Occupational and other health services.....	125
9.4. Linkages with self-help and community-based groups.....	125
9.5. Benefits	125
9.6. Social security coverage.....	125
9.7. Privacy and confidentiality	126
9.8. Employee and family assistance programmes	126

Appendices

I. Basic facts about the epidemic and its implications	127
II. Infection control in the workplace.....	131
III. A checklist for planning and implementing a workplace policy on HIV/AIDS	132

1. Objective

The objective of this code is to provide a set of guidelines to address the HIV/AIDS epidemic in the world of work and within the framework of the promotion of decent work. The guidelines cover the following key areas of action:

- (a) prevention of HIV/AIDS;
- (b) management and mitigation of the impact of HIV/AIDS on the world of work;
- (c) care and support of workers infected and affected by HIV/AIDS;
- (d) elimination of stigma and discrimination on the basis of real or perceived HIV status.

2. Use

This code should be used to:

- (a) develop concrete responses at enterprise, community, regional, sectoral, national and international levels;
- (b) promote processes of dialogue, consultations, negotiations and all forms of cooperation between governments, employers and workers and their representatives, occupational health personnel, specialists in HIV/AIDS issues, and all relevant stakeholders (which may include community-based and non-governmental organizations (NGOs));
- (c) give effect to its contents in consultation with the social partners:
 - in national laws, policies and programmes of action,
 - in workplace/enterprise agreements, and
 - in workplace policies and plans of action.

3. Scope and terms used in the code

3.1. Scope

This code applies to:

- (a) all employers and workers (including applicants for work) in the public and private sectors; and
- (b) all aspects of work, formal and informal.

3.2. Terms used in the code

HIV: the Human Immunodeficiency Virus, a virus that weakens the body's immune system, ultimately causing AIDS.

Affected persons: persons whose lives are changed in any way by HIV/AIDS due to the broader impact of this epidemic.

AIDS: the Acquired Immune Deficiency Syndrome, a cluster of medical conditions, often referred to as opportunistic infections and cancers and for which, to date, there is no cure.

Discrimination is used in this code in accordance with the definition given in the Discrimination (Employment and Occupation) Convention, 1958 (No. 111), to include HIV status. It also includes discrimination on the basis of a worker's perceived HIV status, including discrimination on the ground of sexual orientation.

Persons with disabilities is used in this code in accordance with the definition given in the Vocational Rehabilitation and Employment (Disabled Persons) Convention, 1983 (No. 159), namely individuals whose prospects of securing, retaining and advancing in suitable employment are substantially reduced as a result of a duly recognized physical or mental impairment.

Employer: a person or organization employing workers under a written or verbal contract of employment which establishes the rights and duties of both parties, in accordance with national law and practice. Governments, public authorities, private enterprises and individuals may be employers.

Occupational health services (OHS) is used in this code in accordance with the description given in the Occupational Health Services Convention, 1985 (No. 161), namely health services which have an essentially preventative function and which are responsible for advising the employer, as well as workers and their representatives, on the requirements for establishing and maintaining a safe and healthy working environment and work methods to facilitate optimal physical and mental health in relation to work. The OHS also provide advice on the adaptation of work to the capabilities of workers in the light of their physical and mental health.

Reasonable accommodation: any modification or adjustment to a job or to the workplace that is reasonably practicable and will enable a person living with HIV or AIDS to have access to or participate or advance in employment.

Screening: measures whether direct (HIV testing), indirect (assessment of risk-taking behaviour) or asking questions about tests already taken or about medication.

Sex and gender: there are both biological and social differences between men and women. The term “sex” refers to biologically determined differences, while the term “gender” refers to differences in social roles and relations between men and women. Gender roles are learned through socialization and vary widely within and between cultures. Gender roles are affected by age, class, race, ethnicity and religion, and by the geographical, economic and political environment.

STI: sexually transmitted infection, which includes, among others, syphilis, chancroid, chlamydia, gonorrhoea. It also includes conditions commonly known as sexually transmitted diseases (STDs).

Termination of employment has the meaning attributed in the Termination of Employment Convention, 1982 (No. 158), namely dismissal at the initiative of the employer.

Universal Precautions are a simple standard of infection control practice to be used to minimize the risk of blood-borne pathogens (see full explanation in Appendix II).

Workers in informal activities (also known as informal sector): this term is described in Appendix I.

Workers’ representatives, in accordance with the Workers’ Representatives Convention, 1971 (No. 135), are persons recognized as such by national law or practice whether they are:

- (a) trade union representatives, namely, representatives designated or elected by trade unions or by members of such unions; or
- (b) elected representatives, namely, representatives who are freely elected by the workers of the undertaking in accordance with provisions of national laws or regulations or of collective agreements and whose functions do not include activities which are recognized as the exclusive prerogative of trade unions in the country concerned.

Vulnerability refers to socio-economic disempowerment and cultural context, work situations that make workers more susceptible to the risk of infection and situations which put children at greater risk of being involved in child labour (for more detail see Appendix I).

4. Key principles

4.1. Recognition of HIV/AIDS as a workplace issue

HIV/AIDS is a workplace issue, and should be treated like any other serious illness/condition in the workplace. This is necessary not only because it affects the workforce, but also because the workplace, being part of the local community, has a role to play in the wider struggle to limit the spread and effects of the epidemic.

4.2. Non-discrimination

In the spirit of decent work and respect for the human rights and dignity of persons infected or affected by HIV/AIDS, there should be no discrimination against workers on the basis of real or perceived HIV status. Discrimination and stigmatization of people living with HIV/AIDS inhibits efforts aimed at promoting HIV/AIDS prevention.

4.3. Gender equality

The gender dimensions of HIV/AIDS should be recognized. Women are more likely to become infected and are more often adversely affected by the HIV/AIDS epidemic than men due to biological, socio-cultural and economic reasons. The greater the gender discrimination in societies and the lower the position of women, the more negatively they are affected by HIV. Therefore, more equal gender relations and the empowerment of women are vital to successfully prevent the spread of HIV infection and enable women to cope with HIV/AIDS.

4.4. Healthy work environment

The work environment should be healthy and safe, so far as is practicable, for all concerned parties, in order to prevent transmission of HIV, in accordance with the provisions of the Occupational Safety and Health Convention, 1981 (No. 155).

A healthy work environment facilitates optimal physical and mental health in relation to work and adaptation of work to the capabilities of workers in light of their state of physical and mental health.

4.5. Social dialogue

The successful implementation of an HIV/AIDS policy and programme requires cooperation and trust between employers, workers and their representatives and government, where appropriate, with the active involvement of workers infected and affected by HIV/AIDS.

4.6. Screening for purposes of exclusion from employment or work processes

HIV/AIDS screening should not be required of job applicants or persons in employment.

4.7. Confidentiality

There is no justification for asking job applicants or workers to disclose HIV-related personal information. Nor should co-workers be obliged to reveal such personal information about fellow workers. Access to personal data relating to a worker's HIV status should be bound by the rules of confidentiality consistent with the ILO's code of practice on the protection of workers' personal data, 1997.

4.8. Continuation of employment relationship

HIV infection is not a cause for termination of employment. As with many other conditions, persons with HIV-related illnesses should be able to work for as long as medically fit in available, appropriate work.

4.9. Prevention

HIV infection is preventable. Prevention of all means of transmission can be achieved through a variety of strategies which are appropriately targeted to national conditions and which are culturally sensitive.

Prevention can be furthered through changes in behaviour, knowledge, treatment and the creation of a non-discriminatory environment.

The social partners are in a unique position to promote prevention efforts particularly in relation to changing attitudes and behaviours through the provision of information and education, and in addressing socio-economic factors.

4.10. Care and support

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

5. General rights and responsibilities

5.1. Governments and their competent authorities

- (a) *Coherence.* Governments should ensure coherence in national HIV/AIDS strategy and programmes, recognizing the importance of including the world of work in national plans, for example by ensuring that the composition of national AIDS councils includes representatives of employers, workers, people living with HIV/AIDS and of ministries responsible for labour and social matters.
- (b) *Multi-sectoral participation.* The competent authorities should mobilize and support broad partnerships for protection and prevention, including public agencies, the private sector, workers' and employers' organizations, and all relevant stakeholders so that the greatest number of partners in the world of work are involved.
- (c) *Coordination.* Governments should facilitate and coordinate all interventions at the national level that provide an enabling environment for world of work interventions and capitalize on the presence of the social partners and all relevant stakeholders. Coordination should build on measures and support services already in place.
- (d) *Prevention and health promotion.* The competent authorities should instigate and work in partnership with other social partners to promote awareness and prevention programmes, particularly in the workplace.
- (e) *Clinical guidelines.* In countries where employers assume a primary responsibility for providing direct health-care services to workers, governments should offer guidelines to assist employers in the care and clinical management of HIV/AIDS. These guidelines should take account of existing services.
- (f) *Social protection.* Governments should ensure that benefits under national laws and regulations apply to workers with HIV/AIDS no less favourably than to workers with other serious illnesses. In designing and implementing social security programmes, governments should take into account the progressive and intermittent nature of the disease and tailor schemes accordingly, for example by making benefits available as and when needed and by the expeditious treatment of claims.
- (g) *Research.* In order to achieve coherence with national AIDS plans, to mobilize the social partners, to evaluate the costs of the epidemic on workplaces, for the social security system and for the economy, and to facilitate planning to mitigate its socio-economic impact, the competent authorities should encourage, support, carry out and publish the findings of demographic projections, incidence and prevalence studies and case studies of best practice.

Governments should endeavour to provide the institutional and regulatory framework to achieve this. The research should include gender-sensitive analyses that make use of research and data from employers and their organizations and workers' organizations. Data collection should, to the extent possible, be sector-specific and disaggregated by sex, race, sexual orientation, age, employment and occupational status and be done in a culturally sensitive manner. Where possible, permanent impact assessment mechanisms should exist.

- (h) *Financial resourcing.* Governments, where possible, in consultation with the social partners and other stakeholders, should estimate the financial implications of HIV/AIDS and seek to mobilize funding locally and internationally for their national AIDS strategic plans including, where relevant, for their social security systems.
- (i) *Legislation.* In order to eliminate workplace discrimination and ensure workplace prevention and social protection, governments, in consultation with the social partners and experts in the field of HIV/AIDS, should provide the relevant regulatory framework and, where necessary, revise labour laws and other legislation.
- (j) *Conditionalities for government support.* When governments provide start-up funding and incentives for national and international enterprises, they should require recipients to adhere to national laws and encourage recipients to adhere to this code, and policies or codes that give effect to the provisions of this code.
- (k) *Enforcement.* The competent authorities should supply technical information and advice to employers and workers concerning the most effective way of complying with legislation and regulations applicable to HIV/AIDS and the world of work. They should strengthen enforcement structures and procedures, such as factory/labour inspectorates and labour courts and tribunals.
- (l) *Workers in informal activities (also known as informal sector).* Governments should extend and adapt their HIV/AIDS prevention programmes to such workers including income generation and social protection. Governments should also design and develop new approaches using local communities where appropriate.
- (m) *Mitigation.* Governments should promote care and support through public health-care programmes, social security systems and/or other relevant government initiatives. Governments should also strive to ensure access to treatment and, where appropriate, to work in partnership with employers and workers' organizations.
- (n) *Children and young persons.* In programmes to eliminate child labour, governments should ensure that attention is paid to the impact of the epidemic on children and young persons whose parent or parents are ill or have died as a result of HIV/AIDS.
- (o) *Regional and international collaboration.* Governments should promote and support collaboration at regional and international levels, and through intergovernmental agencies and all relevant stakeholders, so as to focus international attention on HIV/AIDS and on the related needs of the world of work.
- (p) *International assistance.* Governments should enlist international assistance where appropriate in support of national programmes. They should encourage initiatives aimed at supporting international campaigns to reduce the cost of, and improve access to, antiretroviral drugs.
- (q) *Vulnerability.* Governments should take measures to identify groups of workers who are vulnerable to infection, and adopt strategies to overcome the factors that make these workers susceptible. Governments should also endeavour to ensure that appropriate prevention programmes are in place for these workers.

5.2. Employers and their organizations

- (a) *Workplace policy.* Employers should consult with workers and their representatives to develop and implement an appropriate policy for their workplace, designed to prevent the

spread of the infection and protect all workers from discrimination related to HIV/AIDS. A checklist for workplace policy planning and implementation appears in Appendix III.

- (b) *National, sectoral and workplace/enterprise agreements.* Employers should adhere to national law and practice in relation to negotiating terms and conditions of employment about HIV/AIDS issues with workers and their representatives, and endeavour to include provisions on HIV/AIDS protection and prevention in national, sectoral and workplace/enterprise agreements.
- (c) *Education and training.* Employers and their organizations, in consultation with workers and their representatives, should initiate and support programmes at their workplaces to inform, educate and train workers about HIV/AIDS prevention, care and support and the enterprise's policy on HIV/AIDS, including measures to reduce discrimination against people infected or affected by HIV/AIDS and specific staff benefits and entitlements.
- (d) *Economic impact.* Employers, workers and their organizations, should work together to develop appropriate strategies to assess and appropriately respond to the economic impact of HIV/AIDS on their particular workplace and sector.
- (e) *Personnel policies.* Employers should not engage in nor permit any personnel policy or practice that discriminates against workers infected with or affected by HIV/AIDS. In particular, employers should:
 - not require HIV/AIDS screening or testing unless otherwise specified in section 8 of this code;
 - ensure that work is performed free of discrimination or stigmatization based on perceived or real HIV status;
 - encourage persons with HIV and AIDS-related illnesses to work as long as medically fit for appropriate work; and
 - provide that, where a worker with an AIDS-related condition is too ill to continue to work and where alternative working arrangements including extended sick leave have been exhausted, the employment relationship may cease in accordance with anti-discrimination and labour laws and respect for general procedures and full benefits.
- (f) *Grievance and disciplinary procedures.* Employers should have procedures that can be used by workers and their representatives for work-related grievances. These procedures should specify under what circumstances disciplinary proceedings can be commenced against any employee who discriminates on the grounds of real or perceived HIV status or who violates the workplace policy on HIV/AIDS.
- (g) *Confidentiality.* HIV/AIDS-related information of workers should be kept strictly confidential and kept only on medical files, whereby access to information complies with the Occupational Health Services Recommendation, 1985 (No. 171), and national laws and practices. Access to such information should be strictly limited to medical personnel and such information may only be disclosed if legally required or with the consent of the person concerned.
- (h) *Risk reduction and management.* Employers should ensure a safe and healthy working environment, including the application of Universal Precautions and measures such as the provision and maintenance of protective equipment and first aid. To support behavioural change by individuals, employers should also make available, where appropriate, male and female condoms, counselling, care, support and referral services. Where size and cost considerations make this difficult, employers and/or their organizations should seek support from government and other relevant institutions.
- (i) *Workplaces where workers come into regular contact with human blood and body fluids.* In such workplaces, employers need to take additional measures to ensure that all workers are trained in Universal Precautions, that they are knowledgeable about procedures to be

followed in the event of an occupational incident and that Universal Precautions are always observed. Facilities should be provided for these measures.

- (j) *Reasonable accommodation.* Employers, in consultation with the worker(s) and their representatives, should take measures to reasonably accommodate the worker(s) with AIDS-related illnesses. These could include rearrangement of working time, special equipment, opportunities for rest breaks, time off for medical appointments, flexible sick leave, part-time work and return-to-work arrangements.
- (k) *Advocacy.* In the spirit of good corporate citizenship, employers and their organizations should, where appropriate, encourage fellow employers to contribute to the prevention and management of HIV/AIDS in the workplace, and encourage governments to take all necessary action to stop the spread of HIV/AIDS and mitigate its effects. Other partnerships can support this process such as joint business/trade union councils on HIV/AIDS.
- (l) *Support for confidential voluntary HIV counselling and testing.* Employers, workers and their representatives should encourage support for, and access to, confidential voluntary counselling and testing that is provided by qualified health services.
- (m) *Workers in informal activities (also known as informal sector).* Employers of workers in informal activities should investigate and, where appropriate, develop prevention and care programmes for these workers.
- (n) *International partnerships.* Employers and their organizations should contribute, where appropriate, to international partnerships in the fight against HIV/AIDS.

5.3. Workers and their organizations

- (a) *Workplace policy.* Workers and their representatives should consult with their employers on the implementation of an appropriate policy for their workplace, designed to prevent the spread of the infection and protect all workers from discrimination related to HIV/AIDS. A checklist for workplace policy planning and implementation appears in Appendix III.
- (b) *National, sectoral and workplace/enterprise agreements.* Workers and their organizations should adhere to national law and practice when negotiating terms and conditions of employment relating to HIV/AIDS issues, and endeavour to include provisions on HIV/AIDS protection and prevention in national, sectoral and workplace/enterprise agreements.
- (c) *Information and education.* Workers and their organizations should use existing union structures and other structures and facilities to provide information on HIV/AIDS in the workplace, and develop educational materials and activities appropriate for workers and their families, including regularly updated information on workers' rights and benefits.
- (d) *Economic impact.* Workers and their organizations should work together with employers to develop appropriate strategies to assess and appropriately respond to the economic impact of HIV/AIDS in their particular workplace and sector.
- (e) *Advocacy.* Workers and their organizations should work with employers, their organizations and governments to raise awareness of HIV/AIDS prevention and management.
- (f) *Personnel policies.* Workers and their representatives should support and encourage employers in creating and implementing personnel policy and practices that do not discriminate against workers with HIV/AIDS.
- (g) *Monitoring of compliance.* Workers' representatives have the right to take up issues at their workplaces through grievance and disciplinary procedures and/or should report all discrimination on the basis of HIV/AIDS to the appropriate legal authorities.

- (h) *Training.* Workers' organizations should develop and carry out training courses for their representatives on workplace issues raised by the epidemic, on appropriate responses, and on the general needs of people living with HIV/AIDS and their carers.
- (i) *Risk reduction and management.* Workers and their organizations should advocate for, and cooperate with, employers to maintain a safe and healthy working environment, including the correct application and maintenance of protective equipment and first aid. Workers and their organizations should assess the vulnerability of the working environment and promote tailored programmes for workers as appropriate.
- (j) *Confidentiality.* Workers have the right to access their own personal and medical files. Workers' organizations should not have access to personnel data relating to a worker's HIV status. In all cases, when carrying out trade union responsibilities and functions, the rules of confidentiality and the requirement for the concerned person's consent set out in the Occupational Health Services Recommendation, 1985 (No. 171), should apply.
- (k) *Workers in informal activities (also known as informal sector).* Workers and their organizations should extend their activities to these workers in partnership with all other relevant stakeholders, where appropriate, and support new initiatives which help both prevent the spread of HIV/AIDS and mitigate its impact.
- (l) *Vulnerability.* Workers and their organizations should ensure that factors that increase the risk of infection for certain groups of workers are addressed in consultation with employers.
- (m) *Support for confidential voluntary HIV counselling and testing.* Workers and their organizations should work with employers to encourage and support access to confidential voluntary counselling and testing.
- (n) *International partnerships.* Workers' organizations should build solidarity across national borders by using sectoral, regional and international groupings to highlight HIV/AIDS and the world of work, and to include it in workers' rights campaigns.

6. Prevention through information and education

Workplace information and education programmes are essential to combat the spread of the epidemic and to foster greater tolerance for workers with HIV/AIDS. Effective education can contribute to the capacity of workers to protect themselves against HIV infection. It can significantly reduce HIV-related anxiety and stigmatization, minimize disruption in the workplace, and bring about attitudinal and behavioural change. Programmes should be developed through consultations between governments, employers and workers and their representatives to ensure support at the highest levels and the fullest participation of all concerned. Information and education should be provided in a variety of forms, not relying exclusively on the written word and including distance learning where necessary. Programmes should be targeted and tailored to the age, gender, sexual orientation, sectoral characteristics and behavioural risk factors of the workforce and its cultural context. They should be delivered by trusted and respected individuals. Peer education has been found to be particularly effective, as has the involvement of people living with HIV/AIDS in the design and implementation of programmes.

6.1. Information and awareness-raising campaigns

- (a) Information programmes should, where possible, be linked to broader HIV/AIDS campaigns within the local community, sector, region or country. The programmes should be based on correct and up-to-date information about how HIV is and is not transmitted, dispel the myths surrounding HIV/AIDS, how HIV can be prevented, medical aspects of the disease, the impact of AIDS on individuals, and the possibilities for care, support and treatment.

- (b) As far as is practicable, information programmes, courses and campaigns should be integrated into existing education and human resource policies and programmes as well as occupational safety and health and anti-discrimination strategies.

6.2. Educational programmes

- (a) Educational strategies should be based on consultation between employers and workers, and their representatives and, where appropriate, government and other relevant stakeholders with expertise in HIV/AIDS education, counselling and care. The methods should be as interactive and participatory as possible.
- (b) Consideration should be given to educational programmes taking place during paid working hours and developing educational materials to be used by workers outside workplaces. Where courses are offered, attendance should be considered as part of work obligations.
- (c) Where practical and appropriate, programmes should:
 - include activities to help individuals assess the risks that face them personally (both as individuals and as members of a group) and reduce these risks through decision-making, negotiation and communication skills, as well as educational, preventative and counselling programmes;
 - give special emphasis to high-risk behaviour and other risk factors such as occupational mobility that expose certain groups of workers to increased risk of HIV infection;
 - provide information about transmission of HIV through drug injection and information about how to reduce the risk of such transmission;
 - enhance dialogue among governments and employers' and workers' organizations from neighbouring countries and at regional level;
 - promote HIV/AIDS awareness in vocational training programmes carried out by governments and enterprises, in collaboration with workers' organizations;
 - promote campaigns targeted at young workers and women;
 - give special emphasis to the vulnerability of women to HIV and prevention strategies that can lessen this vulnerability (see section 6.3);
 - emphasize that HIV cannot be contracted through casual contact, and that people who are HIV-positive do not need to be avoided or stigmatized, but rather should be supported and accommodated in the workplace;
 - explain the debilitating effects of the virus and the need for all workers to be empathetic and non-discriminatory towards workers with HIV/AIDS;
 - give workers the opportunity to express and discuss their reactions and emotions caused by HIV/AIDS;
 - instruct workers (especially health-care workers) on the use of Universal Precautions and inform them of procedures to be followed in case of exposure;
 - provide education about the prevention and management of STIs and tuberculosis, not only because of the associated risk of HIV infection but also because these conditions are treatable, thus improving the workers' general health and immunity;
 - promote hygiene and proper nutrition;
 - promote safer sex practices, including instructions on the use of male and female condoms;
 - encourage peer education and informal education activities;
 - be regularly monitored, evaluated, reviewed and revised where necessary.

6.3. Gender-specific programmes

- (a) All programmes should be gender-sensitive, as well as sensitive to race and sexual orientation. This includes targeting both women and men explicitly, or addressing either women or men in separate programmes, in recognition of the different types and degrees of risk for men and women workers.
- (b) Information for women needs to alert them to, and explain their higher risk of, infection, in particular the special vulnerability of young women.
- (c) Education should help both women and men to understand and act upon the unequal power relations between them in employment and personal situations; harassment and violence should be addressed specifically.
- (d) Programmes should help women to understand their rights, both within the workplace and outside it, and empower them to protect themselves.
- (e) Education for men should include awareness-raising, risk assessment and strategies to promote men's responsibilities regarding HIV/AIDS prevention.
- (f) Appropriately targeted prevention programmes should be developed for homosexually active men in consultation with these workers and their representatives.

6.4. Linkage to health promotion programmes

Educational programmes should be linked, where feasible, to health promotion programmes dealing with issues such as substance abuse, stress and reproductive health at the workplace. Existing work councils or health and safety committees provide an entry point to HIV/AIDS awareness campaigns and educational programmes. This linkage should highlight the increased risk of infection in the use of contaminated needles in intravenous drug-injection. It should also highlight that intoxication due to alcohol and drugs could lead to behaviour which increases the risk of HIV infection.

6.5. Practical measures to support behavioural change

- (a) Workers should be provided with sensitive, accurate and up-to-date education about risk reduction strategies, and, where appropriate, male and female condoms should be made available.
- (b) Early and effective STI and tuberculosis diagnosis, treatment and management, as well as a sterile needle and syringe-exchange programmes, should also be made available, where appropriate, or information provided on where they can be obtained.
- (c) For women workers in financial need, education should include strategies to supplement low incomes, for example, by supplying information on income-generating activities, tax relief and wage support.

6.6. Community outreach programmes

Employers, workers and their representatives should encourage and promote information and education programmes on prevention and management of HIV/AIDS within the local community, especially in schools. Participation in outreach programmes should be encouraged in order to provide an opportunity for people to express their views and enhance the welfare of workers with HIV/AIDS by reducing their isolation and ostracism. Such programmes should be run in partnership with appropriate national or local bodies.

7. Training

Training should be targeted at, and adapted to, the different groups being trained: managers, supervisors and personnel officers; workers and their representatives; trainers of trainers (both

male and female); peer educators; occupational health and safety officers; and factory/labour inspectors. Innovative approaches should be sought to defray costs. For example, enterprises can seek external support from national AIDS programmes or other relevant stakeholders by borrowing instructors or having their own trained. Training materials can vary enormously, according to available resources. They can be adapted to local customs and to the different circumstances of women and men. Trainers should also be trained to deal with prejudices against minorities, especially in relation to ethnic origin or sexual orientation. They should draw on case studies and available good practice materials. The best trainers are often staff themselves and peer education is therefore recommended at all levels. It should become part of a workplace's annual training plan, which should be developed in consultation with workers' representatives.

7.1. Training for managers, supervisors and personnel officers

In addition to participating in information and education programmes that are directed at all workers, supervisory and managerial personnel should receive training to:

- enable them to explain and respond to questions about the workplace's HIV/AIDS policy;
- be well informed about HIV/AIDS so as to help other workers overcome misconceptions about the spread of HIV/AIDS at the workplace;
- explain reasonable accommodation options to workers with HIV/AIDS so as to enable them to continue to work as long as possible;
- identify and manage workplace behaviour, conduct or practices which discriminate against or alienate workers with HIV/AIDS;
- enable them to advise about the health services and social benefits which are available.

7.2. Training for peer educators

Peer educators should receive specialized training so as to:

- be sufficiently knowledgeable about the content and methods of HIV/AIDS prevention so that they can deliver, in whole or in part, the information and education programme to the workforce;
- be sensitive to race, sexual orientation, gender and culture in developing and delivering their training;
- link into and draw from other existing workplace policies, such as those on sexual harassment or for persons with disabilities in the workplace;
- enable their co-workers to identify factors in their lives that lead to increased risk of infection;
- be able to counsel workers living with HIV/AIDS about coping with their condition and its implications.

7.3. Training for workers' representatives

Workers' representatives should, during paid working hours, receive training so as to:

- enable them to explain and respond to questions about the workplace HIV/AIDS policy;
- enable them to train other workers in trainer education programmes;
- identify individual workplace behaviour, conduct or practices which discriminate or alienate workers with HIV/AIDS, in order to effectively combat such conduct;
- help and represent workers with AIDS-related illnesses to access reasonable accommodation when so requested;
- be able to counsel workers to identify and reduce risk factors in their personal lives;

- be well instructed about HIV/AIDS in order to inform workers about the spread of HIV/AIDS;
- ensure that any information that they acquire about workers with HIV/AIDS in the course of performing their representative functions is kept confidential.

7.4. Training for health and safety officers

In addition to becoming familiar with the information and education programmes that are directed at all workers, health and safety officers should receive specialized training in order to:

- be sufficiently knowledgeable about the content and methods of HIV/AIDS prevention so that they can deliver information and education programmes to workers;
- be able to assess the working environment and identify working methods or conditions which could be changed or improved in order to lessen the vulnerability of workers with HIV/AIDS;
- verify whether the employer provides and maintains a healthy and safe working environment and processes for the workers, including safe first-aid procedures;
- ensure that HIV/AIDS-related information, if any, is maintained under conditions of strict confidentiality as with other medical data pertinent to workers and disclosed only in accordance with the ILO's code of practice on the protection of workers' personal data;
- be able to counsel workers to identify and reduce risk factors in their personal lives;
- be able to refer workers to in-house medical services or those outside the workplace which can effectively respond to their needs.

7.5. Training for factory/labour inspectors

The competent authority should ensure that factory and labour inspectors have sufficient means at their disposal to fulfil their supervisory, enforcement and advisory functions, in particular regarding HIV/AIDS prevention in enterprises. To achieve this, they should receive specialized training on HIV/AIDS prevention and protection strategies at the workplace. This training should include:

- information on relevant international labour standards, especially the Discrimination (Employment and Occupation) Convention, 1958 (No. 111), and national laws and regulations;
- how to provide awareness about HIV/AIDS to workers and management;
- how to incorporate HIV/AIDS topics into their regular occupational safety and health briefings and workplace training;
- how to assist workers to access available benefits (such as how to complete benefit forms) and to exercise other legal rights;
- how to identify violations, or the lack of implementation of, workers' rights in respect of HIV status;
- skills to collect and analyse data relating to HIV/AIDS in workplaces when this is for epidemiological or social impact studies and in conformity with this code.

7.6. Training for workers who come into contact with human blood and other body fluids

All workers should receive training about infection control procedures in the context of workplace accidents and first aid. The programmes should provide training:

- in the provision of first aid;

- about Universal Precautions to reduce the risk of exposure to human blood and other body fluids (see Appendix II);
 - in the use of protective equipment;
 - in the correct procedures to be followed in the event of exposure to human blood or body fluids;
 - rights to compensation in the event of an occupational incident,
- and emphasize that the taking of precautions is not necessarily related to the perceived or actual HIV status of individuals.

8. Testing

Testing for HIV should not be carried out at the workplace except as specified in this code. It is unnecessary and imperils the human rights and dignity of workers: test results may be revealed and misused, and the informed consent of workers may not always be fully free or based on an appreciation of all the facts and implications of testing. Even outside the workplace, confidential testing for HIV should be the consequence of voluntary informed consent and performed by suitably qualified personnel only, in conditions of the strictest confidentiality.

8.1. Prohibition in recruitment and employment

HIV testing should not be required at the time of recruitment or as a condition of continued employment. Any routine medical testing, such as testing for fitness carried out prior to the commencement of employment or on a regular basis for workers, should not include mandatory HIV testing.

8.2. Prohibition for insurance purposes

- (a) HIV testing should not be required as a condition of eligibility for national social security schemes, general insurance policies, occupational schemes and health insurance.
- (b) Insurance companies should not require HIV testing before agreeing to provide coverage for a given workplace. They may base their cost and revenue estimates and their actuarial calculations on available epidemiological data for the general population.
- (c) Employers should not facilitate any testing for insurance purposes and all information that they already have should remain confidential.

8.3. Epidemiological surveillance

Anonymous, unlinked surveillance or epidemiological HIV testing in the workplace may occur provided it is undertaken in accordance with the ethical principles of scientific research, professional ethics and the protection of individual rights and confidentiality. Where such research is done, workers and employers should be consulted and informed that it is occurring. The information obtained may not be used to discriminate against individuals or groups of persons. Testing will not be considered anonymous if there is a reasonable possibility that a person's HIV status can be deduced from the results.

8.4. Voluntary testing

There may be situations where workers wish at their own initiative to be tested including as part of voluntary testing programmes. Voluntary testing should normally be carried out by the community health services and not at the workplace. Where adequate medical services exist, voluntary testing may be undertaken at the request and with the written informed consent of a worker, with advice from the workers' representative if so requested. It should be performed by suitably qualified personnel with adherence to strict confidentiality and disclosure requirements. Gender-sensitive pre- and post-test counselling, which facilitates an understanding of the nature

and purpose of the HIV tests, the advantages and disadvantages of the tests and the effect of the result upon the worker, should form an essential part of any testing procedure.

8.5. Tests and treatment after occupational exposure

- (a) Where there is a risk of exposure to human blood, body fluids or tissues, the workplace should have procedures in place to manage the risk of such exposure and occupational incidents.
- (b) Following risk of exposure to potentially infected material (human blood, body fluids, tissue) at the workplace, the worker should be immediately counselled to cope with the incident, about the medical consequences, the desirability of testing for HIV and the availability of post-exposure prophylaxis, and referred to appropriate medical facilities. Following the conclusion of a risk assessment, further guidance as to the worker's legal rights, including eligibility and required procedures for workers' compensation, should be given.

9. Care and support

Solidarity, care and support are critical elements that should guide a workplace in responding to HIV/AIDS. Mechanisms should be created to encourage openness, acceptance and support for those workers who disclose their HIV status, and ensure that they are not discriminated against nor stigmatized. To mitigate the impact of the HIV/AIDS epidemic in the workplace, workplaces should endeavour to provide counselling and other forms of social support to workers infected and affected by HIV/AIDS. Where health-care services exist at the workplace, appropriate treatment should be provided. Where these services are not possible, workers should be informed about the location of available outside services. Linkages such as this have the advantage of reaching beyond the workers to cover their families, in particular their children. Partnership between governments, employers, workers and their organizations and other relevant stakeholders also ensures effective delivery of services and saves costs.

9.1. Parity with other serious illnesses

- (a) HIV infection and clinical AIDS should be managed in the workplace no less favourably than any other serious illness or condition.
- (b) Workers with HIV/AIDS should be treated no less favourably than workers with other serious illnesses in terms of benefits, workers' compensation and reasonable accommodation.
- (c) As long as workers are medically fit for appropriate employment, they should enjoy normal job security and opportunities for transfer and advancement.

9.2. Counselling

- (a) Employers should encourage workers with HIV/AIDS to use expertise and assistance outside the enterprise for counselling or, where available, its own occupational safety and health unit or other workplace programme, if specialized and confidential counselling is offered.
- (b) To give effect to this, employers should consider the following actions:
 - identify professionals, self-help groups and services within the local community or region which specialize in HIV/AIDS-related counselling and the treatment of HIV/AIDS;
 - identify community-based organizations, both of a medical and non-medical character, that may be useful to workers with HIV/AIDS;

- suggest that the worker contact his or her doctor or qualified health-care providers for initial assessment and treatment if not already being treated, or help the worker locate a qualified health-care provider if he or she does not have one.
- (c) Employers should provide workers with HIV/AIDS with reasonable time off for counselling and treatment in conformity with minimum national requirements.
- (d) Counselling support should be made accessible at no cost to the workers and adapted to the different needs and circumstances of women and men. It may be appropriate to liaise with government, workers and their organizations and other relevant stakeholders in establishing and providing such support.
- (e) Workers' representatives should, if requested, assist a worker with HIV/AIDS to obtain professional counselling.
- (f) Counselling services should inform all workers of their rights and benefits in relation to statutory social security programmes and occupational schemes and any life-skills programmes which may help workers cope with HIV/AIDS.
- (g) In the event of occupational exposure to HIV, employers should provide workers with reasonable paid time off for counselling purposes.

9.3. Occupational and other health services

- (a) Some employers may be in a position to assist their workers with access to antiretroviral drugs. Where health services exist at the workplace these should offer, in cooperation with government and all other stakeholders, the broadest range of health services possible to prevent and manage HIV/AIDS and assist workers living with HIV/AIDS.
- (b) These services could include the provision of antiretroviral drugs, treatment for the relief of HIV-related symptoms, nutritional counselling and supplements, stress reduction and treatment for the more common opportunistic infections including STIs and tuberculosis.

9.4. Linkages with self-help and community-based groups

Where appropriate, employers, workers' organizations and occupational health personnel should facilitate the establishment of self-help groups within the enterprise or the referral of workers affected by HIV/AIDS to self-help groups and support organizations in the local community.

9.5. Benefits

- (a) Governments, in consultation with the social partners, should ensure that benefits under national laws and regulations apply to workers with HIV/AIDS no less favourably than to workers with other serious illnesses. They should also explore the sustainability of new benefits specifically addressing the progressive and intermittent nature of HIV/AIDS.
- (b) Employers and employers' and workers' organizations should pursue with governments the adaptation of existing benefit mechanisms to the needs of workers with HIV/AIDS, including wage subsidy schemes.

9.6. Social security coverage

- (a) Governments, employers and workers' organizations should take all steps necessary to ensure that workers with HIV/AIDS and their families are not excluded from the full protection and benefits of social security programmes and occupational schemes. This should also apply to workers and their families from occupational and social groups perceived to be at risk of HIV/AIDS.
- (b) These programmes and schemes should provide similar benefits for workers with HIV/AIDS as those for workers with other serious illnesses.

9.7. Privacy and confidentiality

- (a) Governments, private insurance companies and employers should ensure that information relating to counselling, care, treatment and receipt of benefits is kept confidential, as with medical data pertinent to workers, and accessed only in accordance with the Occupational Health Services Recommendation, 1985 (No. 171).
- (b) Third parties, such as trustees and administrators of social security programmes and occupational schemes, should keep all HIV/AIDS-related information confidential, as with medical data pertinent to workers, in accordance with the ILO's code of practice on the protection of workers' personal data.

9.8. Employee and family assistance programmes

- (a) In the light of the nature of the epidemic, employee assistance programmes may need to be established or extended appropriately to include a range of services for workers as members of families, and to support their family members. This should be done in consultation with workers and their representatives, and can be done in collaboration with government and other relevant stakeholders in accordance with resources and needs.
- (b) Such programmes should recognize that women normally undertake the major part of caring for those with AIDS-related illnesses. They should also recognize the particular needs of pregnant women. They should respond to the needs of children who have lost one or both parents to AIDS, and who may then drop out of school, be forced to work, and become increasingly vulnerable to sexual exploitation. The programmes may be in-house, or enterprises could support such programmes collectively or contract out for such services from an independent enterprise.
- (c) The family assistance programme may include:
 - compassionate leave;
 - invitations to participate in information and education programmes;
 - referrals to support groups, including self-help groups;
 - assistance to families of workers to obtain alternative employment for the worker or family members provided that the work does not interfere with schooling;
 - specific measures, such as support for formal education, vocational training and apprenticeships, to meet the needs of children and young persons who have lost one or both parents to AIDS;
 - coordination with all relevant stakeholders and community-based organizations including the schools attended by the workers' children;
 - direct or indirect financial assistance;
 - managing financial issues relating to sickness and the needs of dependants;
 - legal information, advice and assistance;
 - assistance in relation to understanding the legal processes of illness and death such as managing financial issues relating to sickness, preparation of wills and succession plans;
 - helping families to deal with social security programmes and occupational schemes;
 - provision of advanced payments due to the worker;
 - directing families to the relevant legal and health authorities or providing a list of recommended authorities.

Appendix I

Basic facts about the epidemic and its implications

Facts about HIV and AIDS

The Human Immunodeficiency Virus (HIV) which causes AIDS is transmitted through body fluids – in particular blood, semen, vaginal secretions and breast milk. It has been established that transmission takes place in four ways: unprotected sexual intercourse with an infected partner (the most common); blood and blood products through, for example, infected transfusions and organ or tissue transplants, or the use of contaminated injection or other skin-piercing equipment; transmission from infected mother to child in the womb or at birth; and breastfeeding. HIV is not transmitted by casual physical contact, coughing, sneezing and kissing, by sharing toilet and washing facilities, by using eating utensils or consuming food and beverages handled by someone who has HIV; it is not spread by mosquitoes or other insect bites.

HIV weakens the human body's immune system, making it difficult to fight infection. A person may live for ten years or more after infection, much of this time without symptoms or sickness, although they can still transmit the infection to others. Early symptoms of AIDS include: chronic fatigue, diarrhoea, fever, mental changes such as memory loss, weight loss, persistent cough, severe recurrent skin rashes, herpes and mouth infections, and swelling of the lymph nodes. Opportunistic diseases such as cancers, meningitis, pneumonia and tuberculosis may also take advantage of the body's weakened immune system. Although periods of illness may be interspersed with periods of remission, AIDS is almost always fatal. Research is currently under way into vaccines, but none is viable as yet. Antiretroviral drugs are available that slow the progression of the disease and prolong life; at present these are very expensive and consequently unavailable to most sufferers, but the situation is changing rapidly. HIV is a fragile virus, which can only survive in a limited range of conditions. It can only enter the body through naturally moist places and cannot penetrate unbroken skin. Prevention therefore involves ensuring that there is a barrier to the virus, for example condoms or protective equipment such as gloves and masks (where appropriate), and that skin-piercing equipment is not contaminated; the virus is killed by bleach, strong detergents and very hot water (see Appendix II).

Demographic and labour force impact

At the end of 2000, over 36 million people were living with HIV/AIDS, two-thirds of them in sub-Saharan Africa. Nearly 22 million people have died from AIDS; there were 3 million deaths worldwide for the 12 months of 2000.

All regions are affected: adults and children with HIV/AIDS number over 25 million in sub-Saharan Africa; over 6 million in Asia; nearly 2 million in Latin America and the Caribbean; just under 1 million in North America; half a million in Western Europe; nearly three-quarters of a million in Eastern Europe and Central Asia; nearly half a million in North Africa and the Middle East. Although the dominant mode of transmission may vary, regions are experiencing increased rates of infection.

The consequences of AIDS deaths for total population numbers in Africa are clear: by 2010, for 29 countries with prevalence rates of over 2 per cent, the total population will be 50 million fewer than in the absence of AIDS. There are sex and age consequences as well, as in many countries women often become infected at a younger age than men; in Africa over half of new infections are among women. The age group worst affected everywhere is the 15-49 year-olds, the active population, whose contributions to the family, society and the economy are thus being lost. The ILO estimates that over 20 million workers globally are living with HIV/AIDS. 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 AIDS; 14 million children have lost one or both parents to AIDS, and many of them will be forced out of school and on to the job market, exacerbating the problem of child labour.

HIV/AIDS has an enormous impact on infected individuals and their families, as well as on the community at large. The implications are serious for the old and young dependants of infected family members. The impact at the individual and household level is mirrored at the enterprise level and, increasingly, in the national economy. The epidemic manifests itself in the world of work in many ways: disruption of production, discrimination in employment, the worsening of gender inequalities, and increased incidence of child labour; other manifestations are depleted human capital, pressure on health and social security systems, and threatened occupational safety and health.

Conditions that contribute to vulnerability

General factors

AIDS thrives where economic, social and cultural rights are violated, and also where civil and political norms are ignored. On the economic side, poverty merits highlighting as a major factor: the illiteracy and marginalization of the poor make them more vulnerable to infection, and poverty puts pressure on women to survive and support their families by engaging in unsafe sex. Poor diet, inadequate housing and lack of hygiene make HIV-infected persons even more vulnerable to AIDS-related diseases. On the social and cultural side, inequality in personal and working relations leads to unwanted sex in conditions of risk. Attitudes and behaviour should also be recognized as factors that may increase risk. HIV may be transmitted through injecting intravenous drugs with contaminated equipment. There is also evidence that drug and alcohol abuse can impair an individual's ability to practise safe sexual and injecting behaviour. The stigmatization of people living with HIV/AIDS fuels a natural desire to keep quiet about infection, thus helping its spread. Cultural pressures and denial mask the extent of infection locally and nationally, thus making it harder to plan an effective response for communities as well as individuals.

On the civil and political side, conflict situations, breakdown of law and order, poor legal frameworks and enforcement mechanisms, together with the denial of organizational rights and collective bargaining, hamper development in general and undermine essential health promotion measures in particular. In many countries, poorly resourced health systems, already weakened by debt and structural adjustment, have been unable to provide the care or the prevention needed.

In summary, a climate of discrimination and lack of respect for human rights leaves workers more vulnerable to infection and less able to cope with AIDS because it makes it difficult for them to seek voluntary testing, counselling, treatment or support; they will also not be in a position to take part in advocacy and prevention campaigns.

Factors that increase the risk of infection for certain groups of workers

Certain types of work situations are more susceptible to the risk of infection than others although the main issue is one of behaviour, not occupation. The following is an indicative list:

- work involving mobility, in particular the obligation to travel regularly and live away from spouses and partners;
- work in geographically isolated environments with limited social interaction and limited health facilities;
- single-sex working and living arrangements among men;
- situations where the worker cannot control protection against infection;
- work that is dominated by men, where women are in a small minority;
- work involving occupational risks such as contact with human blood, blood products and other body fluids, needle-stick injury and infected blood exposure, where Universal Precautions are not followed and/or equipment is inadequate.

To this list could be added “non-work”, in order to cover situations where: unemployed workers, congregating in urban centres in the hope of obtaining any kind of small income, are exposed to HIV-susceptible pressures, or displaced persons and refugee camp inhabitants, likewise unoccupied and feeling abandoned, may turn to sex or be forced into it, especially the many single mothers in such situations.

The special needs of the informal sector ¹

Informal workers are especially likely to suffer from the consequences of AIDS, first, because they cannot usually access health facilities or social protection benefits available to workers in formal employment; second, because their activities are rarely based on or lead to financial security; and third, because the transient and vulnerable nature of their work means that any absence will probably result in the loss of the means of trading or production. For informal businesses, the loss of one or more employees may have major consequences leading to the collapse of the enterprise. If the owner contracts HIV, becomes ill and dies, the diversion of the enterprise’s capital into treatment, care and funeral costs may ruin future reinvestment, cause bankruptcy, and leave dependent employees and family members bereft. In the rural informal sector, the burden of care often results in the diversion of labour away from agricultural activities, while labour losses due to AIDS lead to lower food production and declining longer term food security. Overall, the downward economic spiral is felt particularly hard by informal businesses when the following pattern emerges: markets contract as consumers die or retain minimal disposable income because of the costs of health treatment and care.

The gender dimension

HIV/AIDS affects women and men differently in terms of vulnerability and impact. There are biological factors which make women more vulnerable to infection than men, and structural inequalities in the status of women that make it harder for them to take measures to prevent infection, and also intensify the impact of AIDS on them.

- Many women experience sexual and economic subordination in their marriages or relationships, and are therefore unable to negotiate safe sex or refuse unsafe sex.
- The power imbalance in the workplace exposes women to the threat of sexual harassment.
- Poverty is a noted contributing factor to AIDS vulnerability and women make up the majority of the world’s poor; in poverty crises, it is more likely to be a girl child who is taken out of school or sold into forced labour or sex work.
- Women’s access to prevention messages is hampered by illiteracy, a state affecting more women than men worldwide – twice as many in some countries.
- Women make up a substantial proportion of migrants within countries and, together with children, they represent over three quarters of refugees; both of these states are associated

¹ According to the ILO Director-General’s Report to the International Labour Conference in 1991, the term “informal sector” [is] understood to refer to very small-scale units producing and distributing goods and services, and consisting largely of independent, self-employed producers in urban areas of developing countries, some of whom also employ family labour and/or a few hired workers or apprentices; which operate with very little capital, or none at all; which use a low level of technology and skills; which therefore operate at a low level of productivity; and which generally provide very low and irregular incomes and highly unstable employment to those who work in it. They are informal in the sense that they are for the most part unregistered and unrecorded in official statistics; they tend to have little or no access to organized markets, to credit institutions, to formal education and training institutions, or to many public services and amenities; they are not recognized, supported or regulated by the government; they are often compelled by circumstances to operate outside the framework of the law, and even where they are registered and respect certain aspects of the law they are almost invariably beyond the pale of social protection, labour legislation and protective measures at the workplace. Informal sector producers and workers are generally unorganized (although informal local associations of those engaged in specific activities may exist), and in most cases beyond the scope of action of trade unions and employers’ organizations (see ILC: *The dilemma of the informal sector*, 78th Session (1991), Report I(1), p. 4 (English text)).

with higher than average risks of HIV infection. In conflict situations there is an increasing incidence of the systematic rape of women by warring factions.

- The burden of caring for HIV-infected family and community members falls more often on women and girls, thus increasing workloads and diminishing income-generating and schooling possibilities.
- Sexist property, inheritance, custody and support laws mean that women living with HIV/AIDS, who have lost partners or who have been abandoned because they are HIV positive, are deprived of financial security and economic opportunities; this may, in turn, force them into “survival sex”; the girl child is especially vulnerable to commercial sexual exploitation.
- Studies show the heightened vulnerability of women, compared to men, to the social stigma and ostracism associated with AIDS, particularly in rural settings, thus leaving them shunned and marginalized; this again increases the pressure on them to survive through sex.
- The work that women carry out – paid or unrecognized – is more easily disrupted by AIDS: for example, women dominate the informal sector where jobs are covered neither by social security nor by any occupational health benefits.
- Fewer women than men are covered by social security or occupation-related health benefits.
- Men are often victims of stereotypes and norms about masculine behaviour which may lead to unsafe sex and/or non-consensual sex.
- Men are over-represented in a number of categories of vulnerable workers, and may also find themselves through their employment in situations which expose them to unsafe sex between men.
- Given the prevailing power relations between men and women, men have an important role to play in adopting and encouraging responsible attitudes to HIV/AIDS prevention and coping mechanisms.

Appendix II

Infection control in the workplace

A. Universal blood and body-fluid precautions

Universal blood and body-fluid precautions (known as “Universal Precautions” or “Standard Precautions”) were originally devised by the United States Centers for Disease Control and Prevention (CDC) in 1985, largely due to the HIV/AIDS epidemic and an urgent need for new strategies to protect hospital personnel from blood-borne infections. The new approach placed emphasis for the first time on applying blood and body-fluid precautions universally to all persons regardless of their presumed infectious status.

Universal Precautions are a simple standard of infection control practice to be used in the care of all patients at all times to minimize the risk of blood-borne pathogens. Universal Precautions consist of:

- careful handling and disposal of sharps (needles or other sharp objects);
- hand-washing before and after a procedure;
- use of protective barriers – such as gloves, gowns, masks – for direct contact with blood and other body fluids;
- safe disposal of waste contaminated with body fluids and blood;
- proper disinfection of instruments and other contaminated equipment; and
- proper handling of soiled linen.

B. Selected guidelines and Universal Precautions on infection control

Bednarsh, H.S.; Eklund, K.J.: “Infection control: Universal Precautions reconsidered”, in *American Dental Hygienists’ Association: Access* (Chicago, 1995) Vol. 11, No. 1.

Centers for Disease Control and Prevention (CDC)/National Center for HIV, STD and TB Prevention/Division of HIV/AIDS Prevention: *Preventing occupational HIV transmission to health care workers* (updated June, 1999).

South African Law Commission: *Aspects of the law relating to AIDS* (Project No. 85): Universal workplace infection control measures (Universal Precautions) (1997).

WHO: *WHO guidelines on AIDS and first aid in the workplace*, WHO AIDS series 7 (Geneva, 1990).

WHO/UNAIDS/ICN (International Council of Nurses): *HIV and the workplace and Universal Precautions*, Fact sheets on HIV/AIDS for nurses and midwives (Geneva, 2000).

Appendix III

A checklist for planning and implementing a workplace policy on HIV/AIDS

Employers, workers and their organizations should cooperate in a positive, caring manner to develop a policy on HIV/AIDS that responds to, and balances the needs of, employers and workers. Backed by commitment at the highest level, the policy should offer an example to the community in general of how to manage HIV/AIDS. The core elements of this policy, developed in sections 6–9 of this code include information about HIV/AIDS and how it is transmitted; educational measures to enhance understanding of personal risk and promote enabling strategies; practical prevention measures which encourage and support behavioural change; measures for the care and support of affected workers, whether it is they or a family member who is living with HIV/AIDS; and the principle of zero tolerance for any form of stigmatization or discrimination at the workplace.

The following steps may be used as a checklist for developing a policy and programme:

- HIV/AIDS committee is set up with representatives of top management, supervisors, workers, trade unions, human resources department, training department, industrial relations unit, occupational health unit, health and safety committee, and persons living with AIDS, if they agree;
- committee decides its terms of reference and decision-making powers and responsibilities;
- review of national laws and their implications for the enterprise;
- committee assesses the impact of the HIV epidemic on the workplace and the needs of workers infected and affected by HIV/AIDS by carrying out a confidential baseline study;
- committee establishes what health and information services are already available – both at the workplace and in the local community;
- committee formulates a draft policy; draft circulated for comment then revised and adopted;
- committee draws up a budget, seeking funds from outside the enterprise if necessary and identifies existing resources in the local community;
- committee establishes plan of action, with timetable and lines of responsibility, to implement policy;
- policy and plan of action are widely disseminated through, for example, notice boards, mailings, pay slip inserts, special meetings, induction courses, training sessions;
- committee monitors the impact of the policy;
- committee regularly reviews the policy in the light of internal monitoring and external information about the virus and its workplace implications.

Every step described above should be integrated into a comprehensive enterprise policy that is planned, implemented and monitored in a sustained and ongoing manner.

Appendix II

Non-exhaustive list of national HIV/AIDS laws and policies

Afghanistan	Draft national code of ethics regarding AIDS, 2007
Albania	National strategy for the prevention and control of HIV/AIDS for 2004–10
Algeria	National STI/HIV/AIDS strategic plan for 2007–11, 2006
Angola	<ol style="list-style-type: none">1. HIV/AIDS Act No. 8/04, 20032. Decree No. 43/03 to approve HIV/AIDS, employment and professional training regulations, 2003
Antigua and Barbuda	National strategic plan for 2002–05, 2002
Argentina	<ol style="list-style-type: none">1. Decree No. 1058/97 regulating section 33 of Deprivation of Freedom Act No. 24.660, 19962. National AIDS Act No. 23,798, 19983. Decree No. 1.244/91 issuing regulations under National AIDS Act No. 23.798, 1990
Armenia	Draft Labour Code, 2007
Australia	Disability Discrimination Act, 1992
Austria	<ol style="list-style-type: none">1. AIDS Act, 1993, as amended up to 20012. Equal Treatment Act No. 66/2004, as amended up to 2004
Azerbaijan	HIV/AIDS Control Act, 1996
Bahamas	Employment Act No. 27, 2001
Bangladesh	National policy on HIV/AIDS and STD-related issues, 1996
Barbados	<ol style="list-style-type: none">1. Employment Rights Bill, 20002. Code of practice on HIV/AIDS and other life-threatening illnesses in the workplace, 2004
Belarus	<ol style="list-style-type: none">1. HIV and AIDS Bill, 2007 (to replace the 1993 Act)2. Medical Examinations (Labour Relations) Act, 2003
Belgium	Anti-discrimination Act, 2003
Belize	<ol style="list-style-type: none">1. Draft HIV/AIDS policy and legislation, 20032. Tripartite policy on HIV/AIDS in the world of work, 2005
Benin	<ol style="list-style-type: none">1. National tripartite declaration on the fight against HIV/AIDS in the world of work, 20052. Act No. 2005-31 on the prevention, treatment and control of HIV/AIDS, 2006
Bolivia	<ol style="list-style-type: none">1. Ministerial resolution No. 0711 on the prevention and control of HIV/AIDS, 20022. HIV/AIDS Prevention Bill, 2006
Bosnia and Herzegovina	Gender Equality Act No. 56, 2003

Botswana	<ol style="list-style-type: none"> 1. National Industrial Relations Code of Good Practice (Annex 4), 2002 2. Public service code of conduct on HIV/AIDS, 2003 3. Ministry of Labour and Home Affairs policy on HIV/AIDS in the workplace, 2001 4. Draft national policy on HIV/AIDS and employment, 2007
Brazil	<ol style="list-style-type: none"> 1. Inter-ministerial Decision No. 3195, 1988 2. Inter-ministerial Ordinance No. 869, 1992
Bulgaria	<ol style="list-style-type: none"> 1. Public Health Act No. 23, 1974, as amended up to Act No. 144, 1994 2. Protection against Discrimination Act No. 56, 2003 3. Minister of Health Order No. 4 on conditions and procedures governing testing for HIV, 1992
Burkina Faso	<ol style="list-style-type: none"> 1. HIV/AIDS Bill, 2006 2. National tripartite declaration on HIV/AIDS and STI in the workplace, 2006 3. Draft amendments to the Labour Code, 2007
Burundi	<ol style="list-style-type: none"> 1. March 1992 Constitution 2. Sectoral action plan for 2005–09 to combat HIV/AIDS in the workplace, 2005 3. Act No. 1/018 to establish legal protection for people infected with HIV and AIDS, 2005 4. Draft amendments to the Labour Code, 2007 5. National tripartite consensus on HIV/AIDS in the world of work, 2007
Cambodia	HIV/AIDS Prevention and Control Act No. NS/RKM/0702/015, 2002
Cameroon	Draft tripartite declaration on the fight against HIV/AIDS at the workplace, 2006
Canada	Canadian Human Rights Act, 1985
Cape Verde	National strategic plan to combat AIDS for 2002–06, 2002
Central African Republic	National strategic framework to combat HIV/AIDS for 2006–10, 2006
Chad	Bill to combat HIV/AIDS/STDs and establish legal protection for people living with HIV/AIDS, 2006
Chile	Act No. 19,779 to establish rules on HIV and create a tax subsidy for catastrophic illnesses, 2001, as amended up to Act No. 20.077, 2005
China	<ol style="list-style-type: none"> 1. Infectious Disease Prevention Act, 1998, as amended up to 2004 2. Decree No. 457 to provide for regulations governing the prevention and treatment of AIDS, 2006 3. Tripartite guidelines on HIV/AIDS in the workplace (Guangdong Province), 2006
Colombia	<ol style="list-style-type: none"> 1. Decree No. 1543 to provide for rules for the management of HIV, AIDS and STDs, 1997 2. Act No. 972 to provide for rules to improve care for people affected by catastrophic illnesses, particularly HIV/AIDS, 2005
Comoros	National strategic plan to combat AIDS for 2006–2010, 2006
Congo	National strategy to combat HIV/AIDS/STI, 2002
Congo, Democratic Republic of	<ol style="list-style-type: none"> 1. National strategic plan to combat HIV/AIDS and STI, 1999 2. National tripartite declaration on the fight against HIV/AIDS in the workplace, 2006
Costa Rica	<ol style="list-style-type: none"> 1. Act No. 7771, 1998 2. Decree No. 27894-S issuing regulations under HIV/AIDS Act No. 7771, 1999, as amended up to Decree No. 33746-S, 2007
Côte d'Ivoire	National tripartite sectoral policy on HIV/AIDS, 2006
Croatia	Infectious Diseases Act, 1996
Cuba	Ministry of Health regulations on the treatment of persons infected with HIV/AIDS, 1997
Cyprus	Persons with Disabilities (Amendment) Act No. 57(I), 2004

Czech Republic	Equal Opportunities Act No. 26, 2004
Denmark	Act No. 31 to prohibit discrimination in the labour market, 2005, as amended up to Act No. 1542, 2006
Djibouti	<ol style="list-style-type: none"> 1. Resolution No. 06 to combat the AIDS epidemic and to protect people living with HIV/AIDS, 2006 2. Act No. 174 to provide protective measures for persons living with HIV/AIDS and other vulnerable groups, 2007
Dominica	National HIV/AIDS strategic plan for 2003–07, 2003
Dominican Republic	<ol style="list-style-type: none"> 1. Labour Code Act No. 16, 1992, as amended up to 1998 2. HIV/AIDS Act No. 55-93, 1993 3. Regulation No. 25 on procedures for the treatment of STDs, 2002
Ecuador	<ol style="list-style-type: none"> 1. Act No. 2000-11 on the prevention of HIV/AIDS and the provision of comprehensive assistance, 1999 2. Ministerial Agreement No. 00398 prohibiting the dismissal of workers with HIV/AIDS, 2006
Egypt	<ol style="list-style-type: none"> 1. National guidelines for the management of sexually transmitted infections, 2006 2. National guidelines for voluntary HIV counselling and testing, 2004 3. Operating procedures for the central laboratory voluntary HIV counselling and testing services, 2004
El Salvador	HIV/AIDS Prevention and Control Act No. 588, 2001, as amended by Decree No. 1016, 2002
Equatorial Guinea	National strategic framework to combat AIDS for 2001–05, 2002
Eritrea	National HIV/AIDS/STI strategic plan for 2003–07, 2003
Estonia	<ol style="list-style-type: none"> 1. Communicable Diseases Prevention and Control Act, 2003 2. Employment Contracts Act of 1992, as amended up to 2004
Ethiopia	<ol style="list-style-type: none"> 1. Labour Proclamation No. 377/2003, 2004, as amended up to Labour Proclamation No. 494/2006, 2006 2. Public sector: Federal Civil Servants Proclamation No. 515/2006, 2007 3. Private sector: Draft declaration on the prevention and control of HIV/AIDS, 2007
Fiji	<ol style="list-style-type: none"> 1. Draft Employment Bill, 2006 2. Code of practice on HIV/AIDS in the workplace, 2007
Finland	<ol style="list-style-type: none"> 1. Ordinance No. 462 on communicable diseases, 2003, as amended by Ordinance No. 1383, 2003 2. Non-Discrimination Act No. 21, 2004, as amended up to Act No. 50, 2006
France	<ol style="list-style-type: none"> 1. Public Health Code 2. Act No. 102 on equal rights and opportunities, participation and citizenship of persons with disabilities, 2005
Gabon	National HIV/AIDS strategic plan for 2001–06, 2001
Gambia	National HIV/AIDS strategic plan for 2003–08, 2002
Georgia	Labour Code, 2005 (no explicit reference to HIV/AIDS but section 54(1)(b) stipulates that rules are to be provided for testing)
Germany	General Equal Treatment Act, 2006
Ghana	National workplace HIV/AIDS policy, 2004
Greece	Equal Treatment Act No. 3304, 2005
Grenada	National HIV programme, 2002
Guatemala	Decree No. 27 to combat HIV/AIDS and promote, protect and defend the human rights of PLHIV, 2000

Guinea	<ol style="list-style-type: none"> 1. National tripartite plan to combat HIV/AIDS in the workplace, 2003 2. Act No. L/2005/025/AN on the prevention, treatment and control of HIV/AIDS, 2005
Guinea-Bissau	<ol style="list-style-type: none"> 1. National tripartite declaration on HIV/AIDS and the workplace, 2006 2. Bill on the prevention, treatment and control of HIV/AIDS, 2007
Guyana	Draft HIV/AIDS Regulations, 2006
Haiti	National strategic plan for the prevention and control of STI and HIV/AIDS for 2002–06, 2002
Honduras	<ol style="list-style-type: none"> 1. National tripartite strategy to combat AIDS, 2006 2. Decree No. 147-99 to approve the Special HIV/AIDS Act, 1999 3. Decree No. 009 to approve regulations issued under the Special HIV/AIDS Act, 2003
Hungary	Act No. CXXV on equal treatment and the promotion of equal opportunities, 2003
Iceland	<ol style="list-style-type: none"> 1. Act No. 19 on communicable diseases, 1997, as amended up to Act No. 164, 2002 2. Act No. 96 on equal status and equal rights for women and men, 2000
India	<ol style="list-style-type: none"> 1. Joint tripartite statement of commitment by the Central Trade Unions in India on the prevention of HIV/AIDS in the world of work, 2005 2. Ministry of Employment circular providing state labour departments with guidelines on mainstreaming HIV/AIDS in their activities, 2006 3. HIV/AIDS Bill, 2006 (prepared by the Lawyers Collective) 4. Draft national policy on HIV/AIDS and the workplace, 2007
Indonesia	<ol style="list-style-type: none"> 1. Tripartite declaration and commitment to combat HIV/AIDS in the world of work, 2003 2. Decree No. KEP.68/MEN/2004 on the prevention and control of HIV/AIDS in the workplace, 2004 3. Decision No. 20/DJPPK/VI/2005 providing technical guidance on the prevention and control of HIV/AIDS in the workplace, 2005
Iran, Islamic Republic of	National strategic programme for 2002–06 on the prevention and control of HIV/AIDS, 2002
Ireland	Equality Act No. 24, 2004
Israel	<ol style="list-style-type: none"> 1. Employment (Equal Opportunities) Act No. 5748, 1988 2. Regulation No. 45 of 2000 for the prevention of HIV transmission among sexual partners
Italy	<ol style="list-style-type: none"> 1. Act No. 135 on urgent measures to prevent and combat AIDS, 1990 2. Equal Opportunities Act No. 145, 2005
Jamaica	National workplace policy on HIV/AIDS, 2005
Japan	<ol style="list-style-type: none"> 1. Act No. 114 on the prevention of infectious diseases and medical care for patients with infectious diseases, 1998, as amended up to Act No. 145, 2003 2. Notification No. 89 providing guidelines for the prevention of specified infectious diseases, 2006
Jordan	National strategic plan to combat AIDS for 2004–09
Kazakhstan	<ol style="list-style-type: none"> 1. Prevention of AIDS Bill, 2007 (to replace the Act of 1994) 2. General tripartite agreement on HIV/AIDS for 2007–08, 2006
Kenya	HIV and AIDS Prevention and Control Act No. 14, 2006
Kiribati	Tuberculosis and HIV programme, 2006
Korea, Republic of	<ol style="list-style-type: none"> 1. Prevention of Contagious Diseases Act No. 308, 1954, as amended up to Act No. 7148, 2004 2. Guidelines on HIV/AIDS Prevention, 2006
Kyrgyzstan	HIV/AIDS Act No. 149, 2005
Lao People's Democratic Republic	Guidelines for the public sector on the prevention of HIV/AIDS, 2006

Latvia	<ol style="list-style-type: none"> 1. Regulations No. 328 on controlling the spread of HIV/AIDS, 1997 2. Labour Act, as amended up to 2006
Lebanon	National strategic plan for 2004–09, 2003
Lesotho	<ol style="list-style-type: none"> 1. Labour Code (Amendment) Act No. 5, 2006 2. Guidelines for the implementation of the Labour Code, 2007
Liberia	National strategic framework on HIV/AIDS, 2004
Lithuania	Equal Opportunities Act, 2003
Luxembourg	Equal Opportunities Act, 2006
Macedonia, The former Yugoslav Republic of	Programme for the protection of the population against AIDS, 2004
Madagascar	<ol style="list-style-type: none"> 1. Tripartite declaration on the fight against STI and HIV/AIDS at the workplace, 2005 2. Act No. 2005-040 to combat HIV/AIDS and to protect the rights of people living with HIV/AIDS, 2006 3. Decree No. 2006-902 to implement Act No. 2005-040, 2006
Malawi	<ol style="list-style-type: none"> 1. Draft Employment (Amendment) Bill, 2006 2. National tripartite policy on HIV/AIDS in the workplace, 2007
Malaysia	<ol style="list-style-type: none"> 1. HIV/AIDS Charter, Shared rights – Shared responsibilities, 1995 2. Code of practice on the prevention and management of HIV/AIDS at the workplace
Mali	Act No. 06-028 to establish rules for the prevention, treatment and control of HIV/AIDS, 2006
Malta	<ol style="list-style-type: none"> 1. Employment and Industrial Relations Act No. 22, 2002 2. Employment and Industrial Relations Interpretation Order, 2003
Marshall Islands	Communicable Diseases Prevention and Control Act, 1988
Mauritania	<ol style="list-style-type: none"> 1. Decree No. 027-2003 to establish national and regional committees to combat HIV/AIDS, 2003 2. Decision No. 01305 to establish a sectoral coordination unit to combat HIV/AIDS, 2003
Mauritius	HIV and AIDS Act No. 31, 2006
Mexico	<ol style="list-style-type: none"> 1. Regulations NOM-010-SSA2-1993 on the prevention and control of HIV infection, 1993, as amended up to 2000 2. Regulations NOM-039-SSA on the prevention and control of sexually transmitted infections, 2003
Moldova, Republic of	Act No. 23-XVI on the prevention and control of HIV/AIDS, 2006
Mongolia	<ol style="list-style-type: none"> 1. HIV/AIDS Prevention Act, 2004 2. Draft Tripartite Declaration on the prevention of HIV/AIDS in the world of work, 2007
Montenegro	Act on the protection of the population against infectious diseases, 2005
Morocco	National strategic plan for 2007–11, 2006
Mozambique	<ol style="list-style-type: none"> 1. HIV/AIDS and Workers Act No. 5/2002, 2002 2. Labour Code, 2007
Myanmar	National strategic plan on HIV and AIDS for 2006–2010, 2005
Namibia	<ol style="list-style-type: none"> 1. Ministry of Labour guidelines (No. 78) for the implementation of the National Code on HIV/AIDS in Employment, 1998 2. HIV/AIDS Charter of Rights, 2000 3. Labour Act No. 15, 2004

Nepal	<ol style="list-style-type: none"> 1. HIV and AIDS (Prevention, Control and Treatment) Bill No. 2063, 2007 (prepared by the Forum for Women, Law and Development) 2. National tripartite HIV/AIDS policy for workplaces, 2007 3. Tripartite Declaration on HIV/AIDS at the workplace, 2005
Netherlands	Equal Opportunities Act, 2000, as amended up to 2004
New Zealand	Human Rights Act, 1993
Nicaragua	<ol style="list-style-type: none"> 1. Act No. 238 to promote, protect and defend the human rights of people infected with HIV, 1996 2. Occupational safety and health rules regarding exposure to biological risks, especially HIV/AIDS, 2005
Niger	Draft HIV/AIDS workplace policy, 2006
Nigeria	<ol style="list-style-type: none"> 1. Labour Standards Bill, 2004 2. National workplace policy on HIV/AIDS, 2007 3. Bill to make provisions for the prevention of HIV and AIDS-based discrimination and to protect the human rights and dignity of people living with and affected by HIV and AIDS and other related matters, 2007
Norway	Act No. 4 on the protection of workers and of the working environment, 1977, as amended up to Act No. 38 of 2005
Pakistan	HIV and AIDS Prevention and Treatment Bill, 2006
Panama	STDs and HIV/AIDS Act No. 3, 2000
Papua New Guinea	<ol style="list-style-type: none"> 1. HIV/AIDS Management and Prevention Act No. 4, 2003 2. National Code of Practice for HIV/AIDS in the Workplace, 2007 3. Employment Relations Act No. 36, 2007
Peru	HIV/AIDS Act No. 26626, 1996
Philippines	AIDS Prevention and Control Act No. 8504, 1998
Poland	Labour Code, 1974, as amended up to 2003
Portugal	Equal Opportunities Act No. 18, 2004
Romania	<ol style="list-style-type: none"> 1. Decree No. 137 on the prevention and punishment of all forms of discrimination, 2000, as amended up to Act No. 53, 2003 2. Act No. 584 on measures to prevent the spread of HIV and to protect persons infected with HIV or suffering from AIDS, 2002
Russian Federation	<ol style="list-style-type: none"> 1. Federal Act on the prevention and spread of diseases caused by HIV infection, 1995 2. National tripartite agreement on HIV/AIDS and the world of work, 2005 3. Tripartite agreement between the Government of the Moscow Region, the Moscow Region Unions' Council and the Moscow Region Employers' Union for 2006–08, 2005 4. Tripartite agreement for the Murmansk Region for 2006–08, 2005
Rwanda	National strategic policy to combat HIV and AIDS for 2005–09, 2005
Saint Kitts and Nevis	Strategic plan for the national response to HIV/AIDS for 2000–05
Saint Lucia	National strategic plan for 2004–09
Saint Vincent and the Grenadines	HIV prevention and control programme, 2001
Samoa	National HIV/AIDS prevention and control programme, 1987
San Marino	Act No. 71 on the professional integration of invalids and persons with disabilities, 1991
Sao Tome and Principe	National strategy to combat AIDS for 2004–08

Saudi Arabia	(Reference is made to a national policy in the latest UNGASS report)
Senegal	HIV/AIDS Bill, 2007
Serbia	National strategic action plan to combat HIV/AIDS for 2005–2010, 2005
Seychelles	Employment Act No. 2, 1995, as amended up to Act No. 4, 2006
Sierra Leone	<ol style="list-style-type: none"> 1. Prevention and Control of HIV and AIDS Bill, 2007 2. National workplace policy on HIV/AIDS, 2006 3. Draft HIV/AIDS workplace policy for the mining sector, 2007 4. Draft HIV/AIDS workplace policy for the maritime sector, 2007
Singapore	Infectious Diseases Act (Chapter 137), 1977, as amended up to Statutory Instrument No. 7, 2003
Slovakia	Labour Code, as amended up to 2004
Slovenia	<ol style="list-style-type: none"> 1. Vocational Rehabilitation and Employment of Disabled Persons Act, 2004 2. Equal Opportunities Act, 2004 3. Employment Relations Act No. 42, 2002
Solomon Islands	Employment Relations Bill, 2006
Somalia	Strategic framework for the prevention and control of HIV/AIDS for 2003–08, 2003
South Africa	<ol style="list-style-type: none"> 1. Basic Conditions of Employment Act No. 75, 1997 2. Employment Equity Act No. 55, 1998 3. Medical Schemes Act No. 131, 1998 4. Code of practice on key aspects of HIV/AIDS and employment, 2000 5. Employment Equity Regulations No. 480, 2006
Spain	Equal Opportunities Act No. 3, 2007
Sri Lanka	<ol style="list-style-type: none"> 1. Draft national HIV/AIDS policy, 2007 2. National tripartite declaration on the prevention of HIV/AIDS at workplaces, 2007
Sudan	HIV/AIDS Bill, 2006
Swaziland	<ol style="list-style-type: none"> 1. HIV/AIDS and STD prevention and control policy, 1998 2. National multisectoral HIV and AIDS policy, 2006 3. Tripartite declaration to combat HIV/AIDS at workplaces, 2006
Sweden	Anti-Discrimination Act No. 307, 2003, as amended up to Act No. 69 of 2006
Switzerland	Ordinance on the notification of human communicable diseases, 1999
Syrian Arab Republic	National HIV/AIDS strategic plan (to be completed in 2008)
Tajikistan	<ol style="list-style-type: none"> 1. HIV/AIDS Act, 2005 2. National tripartite programme on HIV/AIDS in the world of work, 2007
Tanzania, United Republic of	<ol style="list-style-type: none"> 1. Tanzania Employment and Labour Relations Act No. 6, 2004 2. Circular No. 2 on services to public servants living with HIV and those infected with AIDS, 2006 3. Draft tripartite code of good practice on HIV/AIDS, 2007
Thailand	National code of practice on the prevention and management of HIV/AIDS in the workplace, 2005
Timor-Leste	National HIV/AIDS/STI strategic plan for 2006–10, 2006
Togo	<ol style="list-style-type: none"> 1. National tripartite declaration concerning HIV/AIDS at the workplace, 2004 2. Act No. 2005-012 to protect people living with HIV/AIDS, 2005
Trinidad and Tobago	National HIV/AIDS strategic plan for 2004–08

Tunisia	Communicable Diseases Act No. 921-71, 1992, as amended
Turkey	Act No. 5378 on disabled persons and amending certain Acts and Decrees, 2005
Turkmenistan	Prevention of HIV Infection Act, 2001
Uganda	Employment Act No. 6, 2006
Ukraine	Act No. 1972-12 on the prevention of AIDS and social protection of the population, as amended up to 1998
United Kingdom	Disability Discrimination Act, 2005
United States	Americans with Disabilities Act, 1990
Uruguay	Guidelines on sexually transmitted diseases, 2005
Uzbekistan	Prevention of Diseases Caused by AIDS Act, 1999
Venezuela, Bolivarian Republic of	<ol style="list-style-type: none">1. Decree No. 1127 to establish a Standing Presidential Committee on the control of HIV/AIDS, 19902. Act to provide for education, prevention, care and rehabilitation in respect of HIV/AIDS, 2003
Viet Nam	<ol style="list-style-type: none">1. HIV/AIDS Prevention and Control Act No. 64/2006/QH11, 20062. Decree No. 108/2007/ND-CP2 regarding the implementation of the HIV/AIDS Prevention and Control Act, 2007
Zambia	<ol style="list-style-type: none">1. Draft Employment (HIV/AIDS) Regulations, 20022. Draft national policy on HIV/AIDS and the world of work, 2006
Zimbabwe	<ol style="list-style-type: none">1. Labour Act No. 16, 1985, as amended up to Act No. 17, 20022. HIV/AIDS policy for the mining sector, 20063. HIV/AIDS policy for the transport sector, 20034. Zimbabwe Labour Relations (HIV and AIDS) Regulations, 19985. Act No. 06-28, 2006

Appendix III

National HIV/AIDS laws and policies

Countries	General HIV/AIDS laws/policies	HIV/AIDS integrated into equal opportunities legislation	HIV/AIDS integrated into public health legislation	HIV/AIDS integrated into labour legislation	Workplace HIV/AIDS rules/policy	Tripartite declarations	National HIV/AIDS policies
Afghanistan	X						
Albania							X
Algeria							X
Angola	X				X		
Antigua and Barbuda							X
Argentina	X						
Armenia				X			
Australia		X					
Austria	X	X					
Azerbaijan	X						
Bahamas				X			
Bangladesh	X						
Barbados				X	X		
Belarus	X						
Belgium		X					
Belize	X				X	X	
Benin	X					X	
Bolivia	X						
Bosnia and Herzegovina		X					
Botswana	X				X	X	
Brazil	X						
Bulgaria		X	X				
Burkina Faso	X			X		X	

Countries	General HIV/AIDS laws/policies	HIV/AIDS integrated into equal opportunities legislation	HIV/AIDS integrated into public health legislation	HIV/AIDS integrated into labour legislation	Workplace HIV/AIDS rules/policy	Tripartite declarations	National HIV/AIDS policies
Burundi	X	X		X	X	X	
Cambodia	X						
Cameroon	X					X	
Canada		X					
Cape Verde							X
Central African Republic							X
Chad	X						
Chile	X						
China	X		X		X	X	
Colombia	X						
Comoros							X
Congo							X
Congo, Democratic Republic of						X	X
Costa Rica	X						
Côte d'Ivoire						X	
Croatia			X				
Cuba	X						
Cyprus		X					
Czech Republic		X					
Denmark		X					
Djibouti	X						
Dominica							X
Dominican Republic	X		X	X			
Ecuador	X				X		
Egypt			X				
El Salvador	X						
Equatorial Guinea							X
Eritrea							X
Estonia			X	X			

Countries	General HIV/AIDS laws/policies	HIV/AIDS integrated into equal opportunities legislation	HIV/AIDS integrated into public health legislation	HIV/AIDS integrated into labour legislation	Workplace HIV/AIDS rules/policy	Tripartite declarations	National HIV/AIDS policies
Ethiopia	X			X	X		
Fiji				X	X		
Finland		X	X				
France		X	X				
Gabon							X
Gambia							X
Georgia				X			
Germany		X					
Ghana						X	
Greece		X					
Grenada							X
Guatemala	X						
Guinea	X					X	
Guinea-Bissau	X					X	
Guyana	X						
Haiti							X
Honduras	X					X	X
Hungary		X					
Iceland		X	X				
India	X				X	X	
Indonesia					X	X	
Iran, Islamic Republic of							X
Ireland		X					
Israel	X	X					
Italy	X	X					
Jamaica					X		
Japan	X		X				
Jordan							X
Kazakhstan	X					X	
Kenya	X						
Kiribati			X				

Countries	General HIV/AIDS laws/policies	HIV/AIDS integrated into equal opportunities legislation	HIV/AIDS integrated into public health legislation	HIV/AIDS integrated into labour legislation	Workplace HIV/AIDS rules/policy	Tripartite declarations	National HIV/AIDS policies
Korea, Republic of	X		X				
Kyrgyzstan	X						
Lao People's Democratic Republic					X		
Latvia	X			X			
Lebanon							X
Lesotho				X	X		
Liberia							X
Lithuania		X					
Luxembourg		X					
Macedonia, The former Yugoslav Republic of	X						
Madagascar	X					X	
Malawi				X		X	
Malaysia	X				X		
Mali	X						
Malta				X			
Marshall Islands			X				
Mauritania	X						
Mauritius	X						
Mexico	X		X				
Moldova, Republic of	X						
Mongolia	X					X	
Montenegro			X				
Morocco							X
Mozambique				X	X		
Myanmar							X
Namibia	X			X	X		
Nepal	X				X	X	
Netherlands		X					
New Zealand		X					
Nicaragua	X				X		

Countries	General HIV/AIDS laws/policies	HIV/AIDS integrated into equal opportunities legislation	HIV/AIDS integrated into public health legislation	HIV/AIDS integrated into labour legislation	Workplace HIV/AIDS rules/policy	Tripartite declarations	National HIV/AIDS policies
Niger					X		
Nigeria	X	X		X	X		
Norway				X			
Pakistan	X						
Panama	X						
Papua New Guinea	X			X	X		
Peru	X						
Philippines	X						
Poland				X			
Portugal		X					
Romania	X	X					
Russian Federation	X					X	
Rwanda							X
Saint Kitts and Nevis							X
Saint Lucia							X
Saint Vincent and the Grenadines							X
Samoa							X
San Marino		X					
Sao Tome and Principe							X
Saudi Arabia							X
Senegal	X						
Serbia							X
Seychelles				X			
Sierra Leone	X				X		
Singapore			X				
Slovakia				X			
Slovenia		X					
Solomon Islands				X			
Somalia							X
South Africa		X		X	X		
Spain		X					

Countries	General HIV/AIDS laws/policies	HIV/AIDS integrated into equal opportunities legislation	HIV/AIDS integrated into public health legislation	HIV/AIDS integrated into labour legislation	Workplace HIV/AIDS rules/policy	Tripartite declarations	National HIV/AIDS policies
Sri Lanka	X					X	
Sudan	X						
Swaziland	X					X	
Sweden		X					
Switzerland			X				
Syrian Arab Republic							X
Tajikistan	X					X	
Tanzania, United Republic of				X	X	X	
Thailand					X		
Timor-Leste							X
Togo	X					X	
Trinidad and Tobago							X
Tunisia			X				
Turkey		X					
Turkmenistan	X						
Uganda				X			
Ukraine	X						
United Kingdom		X					
United States		X					
Uruguay			X				
Uzbekistan	X						
Venezuela, Bolivarian Republic of	X				X		
Viet Nam	X				X		
Zambia				X	X		
Zimbabwe				X	X	X	