

FACT SHEETS ON HIV/AIDS

Fact Sheet #1: Update on the HIV/AIDS epidemic

This section covers:

- The history of the HIV/AIDS epidemic
- The current situation globally and in Africa

As the world enters the third decade of the AIDS epidemic, the evidence of its impact is undeniable. Wherever the epidemic has spread unchecked, it is robbing countries of the resources and capacities on which human security and development depend. In some regions, HIV/AIDS, in combination with other crises, is driving ever-larger parts of nations towards destitution.

UNAIDS; AIDS epidemic update: December 2002 (p3)

Key points

- ⌘ HIV/AIDS is a "new" disease – the first cases were diagnosed in the early 1980's.
- ⌘ In sub-Saharan Africa HIV/AIDS is primarily a heterosexual disease.
- ⌘ In the worst affected countries in Africa, HIV/AIDS is reversing life expectancy gains.
- ⌘ It is a disease that mostly affects younger people. Gender differences are also pronounced, with women at highest risk between the ages of 15 and 20, while the highest incidence in men is some years later.
- ⌘ At the end of 2002, 29.4 million adults and children were living with HIV/AIDS in sub-Saharan Africa.

1.1 Historical, scientific and human rights landmarks

The HIV/AIDS epidemic is a new epidemic and its origins have not been positively identified. Important historical and scientific landmarks mark not only the progress of the epidemic but also the progress in understanding the disease, in recognising the links between human rights abuses and vulnerability and in developing responses including treatments for those who are infected.

- ⌘ In 1981, the Morbidity and Mortality Weekly Report from the Centres of Disease Control (CDC) in the United States reported a sudden increase in the diagnosis of Pneumocystis carinii pneumonia and Kaposi's sarcoma in gay men. Not long after this, health care workers in Central Africa began to notice a new disease characterised by diarrhoea and severe weight loss. They called it 'Slims Disease'.
- ⌘ In 1982, the name Acquired Immune Deficiency Syndrome (AIDS) was given to this new disease.

- ⌘ In 1983, the Human Immunodeficiency Virus (HIV) – the virus that causes AIDS – was discovered by scientists in France and the routes of transmission were confirmed.
- ⌘ In 1985, the first blood tests to identify antibodies to HIV were developed.
- ⌘ In 1987, the World Health Organisation (WHO) set up its Global Programme on AIDS (GPA) and the first antiretroviral drug – AZT – was approved by the US Food and Drug Administration (FDA).
- ⌘ In 1989, the first international consultation on HIV/AIDS and human rights was organised by the then UN Centre for Human Rights in co-operation with GPA. The report of that consultation highlighted the public health rationale for the prevention of HIV-related discrimination and the promotion and protection of human rights in the context of HIV/AIDS.

... recognition of and respect for human rights does not impede prevention and containment of HIV, but actually enhances it

Justice Michael Kirby
High Court of Australia
- ⌘ In 1992, the first clinical trial using combination therapy started to enrol patients and, in 1993, a new classification system used CD4 cell counts in defining AIDS.
- ⌘ On 1 July 1994, the Dakar Declaration was developed and endorsed by the African Network on Ethics, Law and HIV. It sets out ten principles, including non-discrimination, confidentiality and privacy, ethics in research and prohibition of mandatory HIV testing.
- ⌘ In 1996, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Office of the High Commissioner for Human Rights convened the Second International Consultation on HIV/AIDS and Human Rights, which produced a set of guidelines on the promotion and protection of human rights in the context of HIV/AIDS (published in 1998). The Guidelines emphasise the critical role of not only Governments but also non-governmental organisations.

... in each society, those people who were marginalised, stigmatised and discriminated against – before HIV/AIDS arrived – have become over time those at highest risk of HIV infection.

Jonathan Mann
1996
- ⌘ In 1996, HAART (Highly Active Antiretroviral Therapy) was shown to be effective in treating HIV disease and limiting morbidity and mortality.
- ⌘ In 1997, the US President issued a challenge to develop an HIV vaccine within a decade.
- ⌘ In June 2001, the United Nations Special Session on HIV/AIDS set in place a framework for national and international accountability with

benchmark targets relating to prevention, care, support and treatment, impact alleviation and children orphaned and made vulnerable by HIV/AIDS.

UNGASS TARGETS

Leadership:

- By 2003, develop and implement multisectoral national strategies and financing plans.

Prevention:

- By 2005, reduce HIV prevalence amongst young men and women aged 15-24 by 25% in most affected countries, and by 25% globally by 2010.
- By 2005 reduce the proportion of infants infected by 20%, and by 50% by 2010.

Care, support and treatment:

- By 2003, ensure national strategies to strengthen health care systems.
- By 2005, develop and make progress in implementing comprehensive care strategies.

HIV/AIDS and human rights:

- Enact, strengthen or enforce legislation, regulations and other measures to eliminate all forms of discrimination.
- By 2005, develop and accelerate the implementation of national strategies that promote the advancement of women.

Reducing vulnerability:

- By 2003, have in place policies and programmes that identify and begin to address factors that make individuals vulnerable.

Children orphaned and made vulnerable by HIV/AIDS:

- By 2005, implement policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for OVC.

Alleviating social and economic impact:

- By 2003, develop multisectoral strategies to address the impact at the individual, family, community and national levels.
- By 2003, develop a legal and policy framework that protects, in the workplace, the rights and dignity of PLWHAs, and those at greatest risk of HIV/AIDS.

Research and development:

- Increase investment in and accelerate research on the development of vaccines.
- By 2003, ensure that all research protocols for the investigation of HIV-related treatment are evaluated by independent committees of ethics.

HIV/AIDS in conflict and disaster-affected regions:

- By 2003, develop and begin to implement comprehensive HIV/AIDS strategies that respond to emergency situations.
- By 2003, have in place strategies to address the spread of HIV among national uniformed services.

Resources:

- By 2002, launch a worldwide fundraising campaign.
- By 2005, reach an overall target of annual expenditure on the epidemic of between US\$7 and 10 billion in low- and middle-income countries.
- Integrate HIV/AIDS actions in development assistance programs and poverty eradication strategies.

Follow-up:

- Conduct national periodic reviews of progress achieved, with full participation.
- By 2003, establish or strengthen effective monitoring systems for the promotion and protection of human rights of PLWHAs.

1.2 A global and African overview

The epidemic continues to spread around the world. Estimates from the Joint United Nations Programme on HIV/AIDS (UNAIDS) track the epidemic in time and in different parts of the world.

UNAIDS estimated at the end of 2002, that 29.4 million adults and children were living with HIV/AIDS in sub-Saharan Africa, representing an 8.8% adult prevalence rate. Of the infected adults, 58% were women. Approximately 3.5 million new infections occurred in sub-Saharan Africa in 2002, while the epidemic claimed the lives of an estimated 2.4 million Africans in the same year. Ten million young people (aged 15–24) and almost 3 million children under 15 were living with HIV/AIDS.

In sub-Saharan Africa the epidemic is primarily a heterosexual epidemic with more women than men infected.

Adult HIV prevalence of over 1% - the point at which the epidemic begins to spread through the general population.

Adult prevalence rate of over 4% - the level at which the epidemic spins out of control.

In the worst affected countries steep drops in life expectancies are beginning to occur, most drastically in sub-Saharan Africa, where four countries, (Botswana, Malawi, Mozambique and Swaziland) now have a life expectancy of less than 40 years.

Though sub-Saharan Africa heads the list as the region with the largest annual number of new infections, there may be a new trend on the horizon – HIV incidence appears to be stabilising. Because the long-standing African epidemics have already reached large numbers of people whose behaviour exposes them to HIV, and because effective prevention measures in some countries have enabled people to reduce their risk of exposure, the annual number of new infections has stabilised or even fallen in many countries. These decreases have now begun to balance out the still-rising infection rates in other parts of Africa, particularly the southern part of the continent.

Fact Sheet #2: Basic facts on HIV/AIDS

This section covers:

- The basic facts about HIV/AIDS
- Related diseases – facts about TB and STIs
- Diagnosis and treatment

Key points

- ⌘ HIV is the virus that causes AIDS – by progressively compromising the immune system.
- ⌘ Anybody who has unprotected sex is at risk – regardless of race, religion or sexual orientation.
- ⌘ There is no risk of HIV transmission from everyday contact with an infected person either at work or socially.
- ⌘ TB is the most common opportunistic infection in people living with HIV/AIDS.
- ⌘ The presence of untreated STIs increases the risk of HIV transmission.
- ⌘ It is a well-established fact that living positively can delay the onset of symptoms and extend the period of wellness in a person who is infected.
- ⌘ Options such as antiretroviral therapy, which are widely used in the developed world to treat people living with HIV/AIDS are not routinely available in workplaces in developing countries.

2.1 Facts about HIV/AIDS

HIV stands for the **H**uman **I**mmunodeficiency **V**irus
AIDS stands for **A**cquired **I**mmune **D**eficiency **S**yndrome

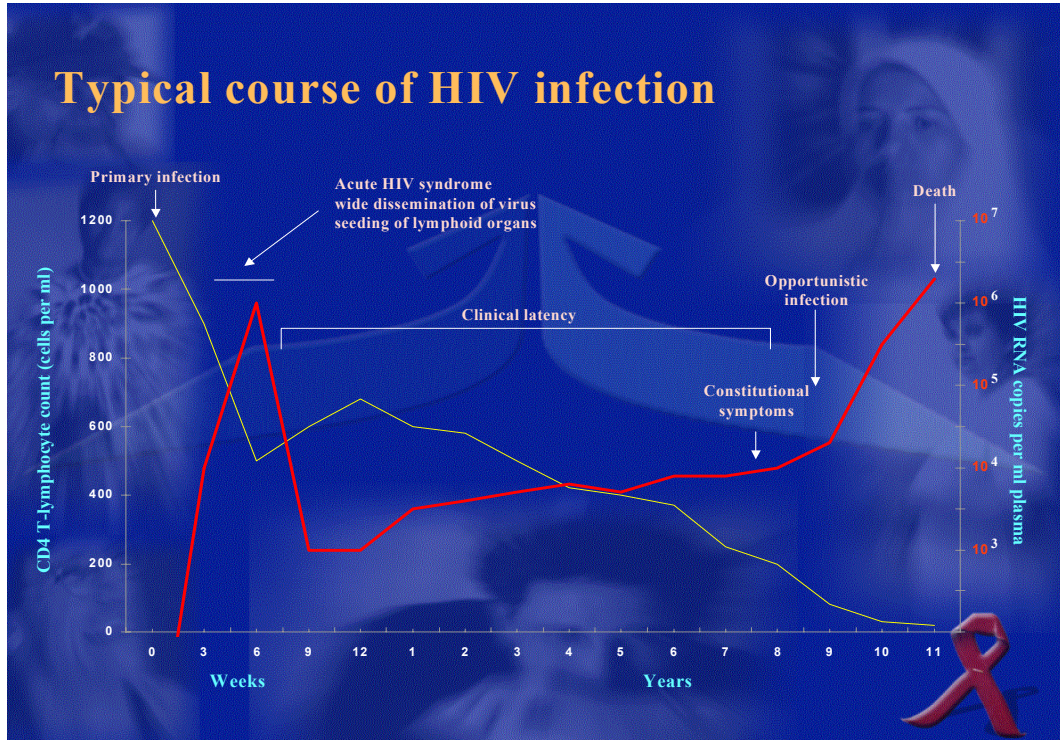
There are two types of HIV:

- ⌘ HIV-1, the most common type
- ⌘ HIV-2, found mostly in West Africa

→ HIV and the immune system

HIV affects the body by affecting the immune system. The immune system is the body's defence against infection by micro-organisms (bacteria and viruses) that cause disease.

Amongst the cells that make up the immune system is one called a CD4 lymphocyte. HIV is able, by attaching to the surface of the CD4 lymphocyte, to enter, infect and eventually destroy the cell. Over time this leads to a progressive and finally a profound impairment of the immune system, resulting in the infected person becoming susceptible to infections and diseases such as cancer.



In **adults**, the typical course from HIV infection to AIDS is as follows:

- ⌘ About 6 weeks to 3 months after becoming infected a person will develop antibodies to HIV. At this time some people will experience a flu-like or glandular fever-like illness.
- ⌘ There is usually thereafter a long 'silent' period – up to 8 years – during which the person may have no symptoms.
- ⌘ Following that, almost all (if not all) infected persons progress to HIV-related disease and AIDS. They may develop skin conditions, chronic diarrhoea, weight loss or they might develop one or more opportunistic infections such as tuberculosis, pneumonia, fungal infections, meningitis and certain cancers.
- ⌘ Death occurs as a result of one or more of these diseases or infections.

➔ **Transmission**

HIV is a weak virus that cannot survive outside the human body. Although present in all body fluids, HIV is only present in sufficient concentrations to cause infection in:

- ⌘ Blood
- ⌘ Sexual fluids (semen and vaginal secretions)
- ⌘ Breast milk

HIV can only be transmitted from an infected person by the following routes:

- ⌘ Sexual intercourse (vaginal, anal or oral). This is the most frequent mode of transmission.
- ⌘ Contact with infected blood, semen, cervical or vaginal fluids – in situations where the infected body fluid is able to enter a person's body.
- ⌘ From an infected mother to her child – during pregnancy or birth, or from breastfeeding.

→ Prevention

Because the major route of HIV transmission is unprotected sex, the safest form of prevention is abstinence. However, in many instances, this is neither realistic nor desirable. Options such as limiting the number of sexual partners and/or using barrier methods can reduce the risk. Barrier methods commonly include the male and female condom.

In the workplace, prevention of HIV transmission in a health care or accident situation requires that universal infection control procedures are followed. Where exposure to infected blood does take place, the administration of post-exposure prophylaxis (PEP) can significantly reduce the risk of actual infection.

2.2 Related diseases – TB and STIs

It is important to understand the close associations between HIV/AIDS and diseases such as TB and infections such as other sexually transmitted infections.

→ Tuberculosis (TB)

TB is a disease caused by a bacillus. TB is a serious public health problem. TB kills more people every year than any other infectious disease – yet it is curable. Correct TB treatment not only cures TB and saves lives but also prevents the spread of infection and the development of drug-resistant TB.

TB is the most common opportunistic infection and the most frequent cause of death in people living with HIV in Africa. In 1997, there were an estimated 2.2 billion people infected with *Mycobacterium tuberculosis* (the germ that causes TB). In 1996, there were an estimated 9.4 million people in the world infected with both HIV and TB. Of those people, 6.58 million (70% of the global total) lived in sub-Saharan Africa. In South Africa, approximately 50% of TB patients are infected with HIV.

HIV and TB interact in the following way. In people with healthy immune systems, only 10% of those who are infected with TB ever become sick from TB. HIV, by destroying the immune system, increases the risk of progression from TB infection to TB disease from 10% per lifetime to 10% per year. This means that over 50% of people who are co-infected with TB and HIV will get sick with TB before they die. TB also accelerates HIV disease. It is important to realise that although HIV increases the risk of developing TB, not all HIV infected people have TB and not all people with TB are HIV infected.

People with TB or HIV face similar problems of stigmatisation, fear and discrimination and have shared needs for counselling, care and support. HIV/AIDS is common in socio-economically-stressed communities, and these same communities are also vulnerable to TB.

The symptoms of TB are the same in HIV-positive and HIV-negative people: cough for more than 3 weeks, loss of appetite and weight loss, night sweats, tiredness, chest pain and coughing blood.

TB is spread through coughing. A person who is sick with TB and is not on appropriate treatment coughs TB germs into the air and another person breathes them into their lungs. TB patients who are on appropriate treatment are not infectious and therefore it is safe to work with them, socialise with them and live near them.

The important fact is that TB can be cured as effectively in HIV-positive as in HIV-negative people using the same drugs for the same amount of time.

The DOTS (Directly Observed Treatment, Short-course) approach is the cornerstone of South Africa's approach to the management of TB. As part of DOTS, it is important that a treatment supporter encourages the patient to complete their TB treatment and observes them taking their treatment. Treatment supporters can be health workers, employers, co-workers, shopkeepers, traditional healers, teachers, and community or family members.

The risk of getting sick with TB can be decreased in people living with HIV/AIDS by taking TB preventive therapy using a TB drug called isoniazid.

→ Sexually transmitted infections (STIs)

STIs are diseases transmitted during unprotected sex with a person who has one or more STIs. They are very common – in Africa as many as 1 in every 10 people will get an STI every year.

The same behaviours that place people at risk for STI infection also place them at risk of HIV infection – both are transmitted during unprotected sex.

STIs can be categorised as curable and incurable. The common curable STIs are gonorrhoea, chlamydial infection, syphilis, trichomoniasis and lymphogranuloma venereum. The STIs that are not curable are the viral STDs such as HIV, human papilloma virus, hepatitis B virus and herpes simplex virus.

Untreated STIs can cause serious health problems in both men and women. Fortunately, however, most STDs can be cured.

The signs and symptoms of STIs may be one or a combination of discharge, lower abdominal pain (in women), scrotal swelling (in men), dysuria, itching, warts, blisters, ulcers, lice and inflammation. Not all clients with STIs will experience symptoms and, in women in particular, STIs are often asymptomatic or 'hidden'.

Following infection with an STI, immune system cells that can be the host cells for HIV are present in large numbers, thus providing an opportunity for HIV infection to become established. Where the STI causes a break in the skin or mucous membrane, this can become an entry point for HIV. Therefore, where STIs are present, it is 5 to 10 times more likely for HIV to be transmitted from one person to another, particularly when there are ulcers present.

The presence of HIV infection in a person with an STI may result in the STI condition being more severe and treatment being less effective.

The best way of treating STIs is known as the 'syndromic approach'. It recognises that groups of STIs produce similar symptoms and that people commonly have multiple infections. The treatment therefore is given for a group of STIs, rather than trying to isolate and then treat the exact STI or STIs.

2.3 Diagnosis of HIV infection and treatment

→ **Diagnosis of HIV infection**

A test, called an HIV test, or HIV antibody test, is the usual way in which a diagnosis of HIV infection is made. The test identifies antibodies to HIV (antibodies are produced in response to infections). Typically it takes about 6 weeks following infection with HIV for a person to develop antibodies. This period is called the window period – the period between infection and the production of antibodies.

Usually HIV antibody testing is done using an ELISA test (Enzyme Linked ImmunoSorbent Assay). The test can be done using a number of body fluids, but is usually done using blood. The ideal testing process involves two tests, if the first is positive. This re-testing, using a different test, allows for the positive test to be confirmed and excludes the possibility that the first test was a false positive.

- ⌘ A positive test result means that HIV antibodies were detected – the person is infected.
- ⌘ A negative test result means that HIV antibodies were not detected – the person is not infected, or may be infected, but be in the window period.

Pre- and post-test counselling are universally regarded as necessary accompaniments to all HIV testing where the person concerned will receive his or her test result. The 3 'C's' are the standards for ethical HIV antibody testing:

- ⌘ **Informed Consent**
- ⌘ **Counselling**
- ⌘ **Confidentiality**

→ **Treatment**

HIV/AIDS treatment and care may be defined within the following framework:

- ⌘ For asymptomatic HIV-positive individuals

- ⌘ For those with early HIV disease
- ⌘ For those with late disease or AIDS
- ⌘ For those with terminal illness

Treatment, care and support needs are very different at different stages and are not restricted only to the infected person. The primary objectives therefore are:

- For the infected person
 - to reduce suffering and improve quality of life
 - to provide appropriate treatment of acute intercurrent infections
- For affected families
 - to render practical support
 - to lend bereavement support

The health interventions for a person who is HIV infected are numerous and may include:

- ⌘ Treatment for STIs and TB
- ⌘ Treatment of opportunistic infections
- ⌘ Prophylaxis for opportunistic infections
- ⌘ Immune boosting therapies
- ⌘ Palliative care
- ⌘ Antiretroviral therapy

Positive living is central to effectively coping with HIV disease. Positive living means an infected person taking control of aspects of his/her life such as:

- ⌘ Eating a good diet whenever possible
- ⌘ Staying as active as possible
- ⌘ Getting sufficient rest and sleep
- ⌘ Reducing stress as far as possible
- ⌘ Staying occupied with meaningful activities
- ⌘ Meeting and talking to friends and family
- ⌘ Seeking medical attention for any health problems

Antiretroviral therapy (ART) means using antiretroviral drugs to treat HIV disease and in some instances to prevent HIV infection. There are different classes of drugs but all act to prevent replication or reduce the rate of replication of the virus and so slow the progression of the disease and prolong the survival of infected persons.

Vaccines are substances that teach the immune system to recognise and protect against a disease caused by an infectious organism or virus. Some experimental HIV/AIDS vaccines are in development, but the widespread availability of an effective vaccine is still many years away.

Fact Sheet #3: The relationship between HIV/AIDS and development

This section covers:

- The links between the HIV/AIDS epidemic, poverty and development
- The impact on individuals, families, communities and society
- The gender dimension of the epidemic

Key points

- ⌘ HIV/AIDS poses a serious threat to human development and social and economic security. In developing countries, HIV/AIDS is already reversing decades of hard-won development gains in improving the quality of people's lives and reducing poverty.
- ⌘ Unlike many infectious diseases, which affect either the very young or elderly, HIV/AIDS has a different impact. While infants account for approximately 10% of cases, young adults aged between 15 and 45 make up the majority of the remaining infections. This results in the massive loss of people in the prime of their lives – when they are the providers and parents.
- ⌘ The impact of HIV/AIDS occurs in all sectors and from the macro to the micro level. The impact at the household level can be devastating, increasing poverty, compromising childrearing and undermining household coping strategies.

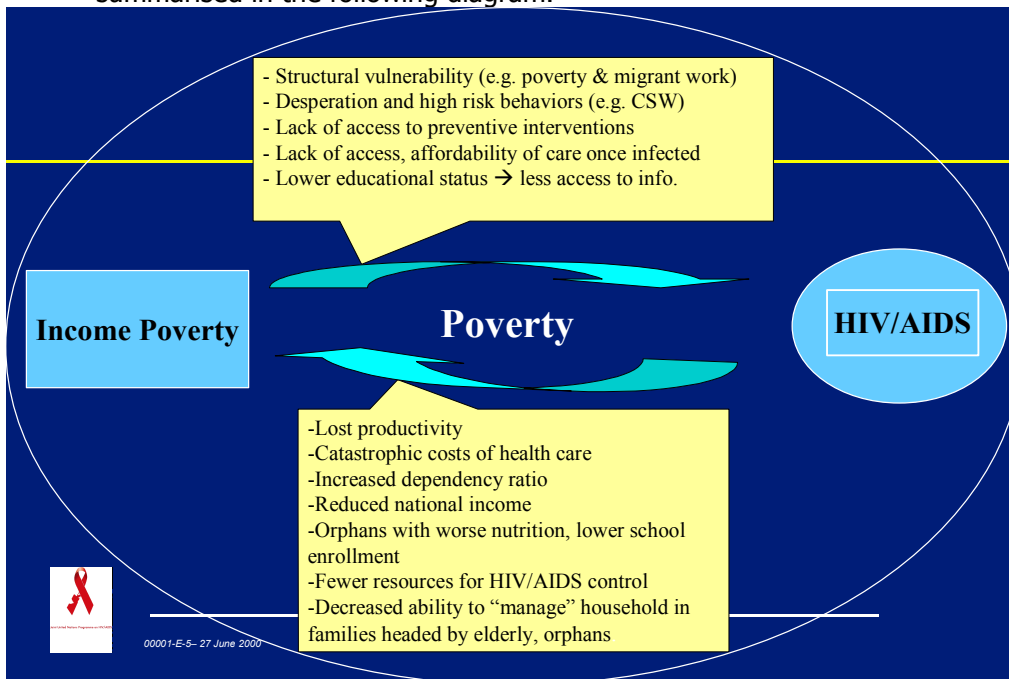
3.1 HIV/AIDS, poverty and development

By killing so many people in the prime of their lives, HIV/AIDS poses a serious threat to development. By reducing growth, weakening governance, destroying human capital, discouraging investment and eroding productivity, AIDS undermines countries' efforts to reduce poverty and improve living standards.

Concepts that are useful in understanding the epidemic

Risk:	The probability that a person may acquire HIV.
Risk behaviour:	Either individual or group behaviour which increases the chance of HIV transmission.
Risk environments:	Those environments in which the chances of HIV transmission are increased as a result of social, economic and/or cultural factors.
Susceptibility:	Those factors determining the rate at which the HIV epidemic is propagated at an individual, group or societal level.
Vulnerability:	The features of a social or economic entity which make it more or less likely that excess morbidity and mortality associated with HIV will have a negative impact upon that unit.

The links between HIV/AIDS and poverty are well established and are summarised in the following diagram.



3.2 Macro and micro impacts

Major channels of HIV/AIDS impact on the economy¹

For firms:

- Insurance/benefits up → affects costs, profits, savings
- Disruption/absenteeism → affects overall productivity
- Worker experience down/morbidity → affects labour productivity

For government:

- AIDS spending up → affects other spending, deficit
- Production structure shifts → affects revenue from VAT, trade taxes
- Household incomes, spending shift → affects income tax receipts, transfers

For households:

- Loss of income/orphans → vulnerable households require transfers
- Caring for HIV/AIDS → changed expenditure patterns, reduced savings, asset sales, lower investment in human capital

For the macro economy:

- Lower physical & human investment → reduced growth trajectory
- Class biased impacts → uneven welfare effects

From studies done in developing countries, the following facts have been established:

¹ Arndt, A & Lewis, JD; The macro implications of HIV/AIDS in South Africa: a preliminary assessment (August 2000) p3

→ **Impact on economies and livelihoods**

- ⌘ HIV/AIDS has a profound impact on growth, income and poverty. It is estimated that the annual per capita growth in half the countries of sub-Saharan Africa is falling by 0.5-1.2% as a direct result of HIV/AIDS. By 2010, per capita GDP in some of the hardest hit countries may drop by 8% and per capita consumption may fall even farther.
- ⌘ People at all income levels are vulnerable to the economic impact of HIV, but the poor suffer most acutely. HIV/AIDS pushes people deeper into poverty as households lose their breadwinners to HIV/AIDS, livelihoods are compromised, and savings are consumed by the cost of health care and funerals. In some countries, conservative estimates indicate that the number of people living in poverty has already increased by 5% as a result of the epidemic.
- ⌘ With less access to jobs, health care and other services, impoverished people are more likely to resort to survival strategies such as commercial sex, which may put them at risk of HIV infection, thus creating a vicious cycle.

→ **Impact on governance**

- ⌘ Governments are losing valuable skilled employees and are confronted with mounting expenses for health and orphan care, reduced revenues and lower return on social investment.
- ⌘ Governments in a number of low-income countries depend heavily on a small number of policy-makers and managers whose skills are often scarce in important areas of public management and core social services. In heavily affected countries, the ranks of such personnel are being thinned further as more civil servants fall prey to the epidemic.

→ **Impact on the social sectors**

- ⌘ AIDS overburdens social systems and hinders health and educational development. The current number of children who have lost their mothers or both parents to the epidemic poses unprecedented social welfare demands for countries already burdened by huge development challenges.
- ⌘ Teachers and students are dying or leaving school, reducing both the quality and efficiency of educational systems. Faltering education services will also diminish human capital in every other sector.
- ⌘ Health care systems in many countries are overstretched as they deal with a growing number of AIDS patients and the loss of health care personnel.

→ **Impact on the agricultural sector**

The relationship between HIV/AIDS and agriculture is multidirectional.

- ⌘ HIV/AIDS reduces food production, and inadequate nutrition further weakens those who are infected with HIV.
- ⌘ There is loss of labour in the most productive age cohorts, and consequently higher involvement of children and the elderly in agricultural activities. Labour time is further reduced by sickness or the need to care for sick family members.
- ⌘ In sub-Saharan Africa, women and girls are responsible for 50–80% of food production, including the most labour-intensive work, such as planting, fertilizing, irrigating, weeding, harvesting and marketing. Their work also extends to food preparation, as well as nurturing activities. The epidemic upends this division of labour – often with disastrous results.
- ⌘ Assets such as land, equipment and livestock are sold to raise funds for health care. Livestock serve multiple functions in most rural areas including a source of food, traction, fertiliser, income and savings.
- ⌘ Specific impacts include reductions in planted area, yield and diversity of crop and livestock enterprises; shifts towards less labour intensive crops; weeding is neglected, infrastructure (such as fences and irrigation ditches) falls into disrepair, and pest-control becomes too expensive.
- ⌘ As a result of declining crop variety, food supplies are less varied, with a negative impact on the nutritional quality of the diets of affected households.
- ⌘ Post-production, food storage and processing are impaired. Thus, the security of food and other raw materials between harvests are at risk, including the availability of seed for subsequent cropping.
- ⌘ There is loss of agricultural knowledge and farm management skills. In terms of rural development it is clear that many traditional systems of social learning that pass skills and knowledge from generation to generation are no longer functioning because of the increasing mortality of parents in their prime working ages.

→ **Impact on the mining sector**

Mining is a key source of foreign exchange for many African countries, and the impact HIV/AIDS is having on this sector is of major concern.

- ⌘ Miners are particularly at risk for HIV because, like soldiers, police officers, and truckers, miners often live far from population centres, apart from their families, and earn regular wages. This increases their opportunity to have multiple casual sexual partners.
- ⌘ Some employees, such as highly-trained mining engineers, can be very difficult to replace².

² ICG; HIV/AIDS as a security issue (June 2001) (p18)

- ⌘ In South Africa, experts believe that the industry hardest-hit by HIV/AIDS will be mining – one that is of central importance both for employment and revenue. Studies of the sector show HIV infection rates from one-quarter to almost one-half of the country's miners.
- ⌘ Zambia has a similar problem, where copper accounts for 75% of the country's export earnings, and 18% of the copper miners (again, a skilled workforce) are estimated to be HIV positive.
- ⌘ In Botswana, where diamonds account for 80% of export earnings and half of the government's total revenue, a third of the industry's employees are estimated to be HIV-positive.

➔ **Community and household-level impacts**

In a typical community affected by HIV/AIDS:

- ⌘ Economically productive adults leave work due to illness or to attend funerals or to care for sick family members – the financial impact of HIV/AIDS on households is as much as 30% more than when the death is due to other causes.
- ⌘ Children are kept away from school to care for adults or sent to work, exacerbating child labour problems.
- ⌘ There are increasing numbers of orphans – most of whom have less access to education and to adult role models.
- ⌘ Limited family resources are spent on care and funerals. Food production declines, malnutrition increases and poverty increases.
- ⌘ Disruption to family and community life emerges.
- ⌘ People with HIV become stigmatised and face harm and discrimination.

3.3 The gender dimension of the epidemic

Worldwide the risk of HIV infection for women is rising. Where transmission of HIV is predominantly heterosexual, women have a greater incidence of infection than men do. The reasons for this are multiple.

- ⌘ The risk of becoming infected with HIV during unprotected vaginal intercourse is 2-4 times higher for women than for men. In addition, an untreated STD increases the risk of HIV transmission during unprotected sex by up to 10 times, and women with STDs are often unaware of them because the infections are 'invisible'.
- ⌘ Young girls are at even greater biological risk – their physiologically immature reproductive tracts constitute ineffective barriers to HIV and other STDs. Older women also become biologically more vulnerable after menopause.

- ⌘ Many young girls become sexually active earlier than their male counterparts; and, at a young age, they lack the knowledge and power to control their sexual encounters, and also what happens about protection.
- ⌘ The financial dependence of women on men is especially entrenched in the developing world, leaving them with little or no control over how and when they have sex. Traditionally women play the passive role in sexual encounters, which means they are unable to be assertive and negotiate safer sexual practices with their partners. In Africa, simply being married is a major risk factor for women who have little control over abstinence or condom use at home or their husband's sexual activity outside the home.
- ⌘ Condoms are incompatible with pregnancy and fertility is a powerful prerequisite to social acceptance in many societies.
- ⌘ Women have less access to information and prevention measures, which are available and/or distributed at work places, schools and social organisations.
- ⌘ Where their lives have been disrupted by war, migration, divorce or widowhood, or where they have lost their property because of inequitable laws and customs, women, in the absence of other viable alternatives, may be forced to have transactional sex or to turn to commercial sex work, with the attendant risks of infection, in order to survive.
- ⌘ Women are more likely to know their HIV status than men, as women and young girls are often tested for HIV during pregnancy.
- ⌘ Women are often seen as 'carriers' of HIV, and many experience severe forms of stigma and discrimination as a result of some association with HIV/AIDS.
- ⌘ High levels of rape, sexual abuse and domestic violence have been linked to increased risk of HIV infection.
- ⌘ Pregnant women who are infected carry the burden and risk of possibly transmitting HIV to their unborn children.

The demands on women resulting from the epidemic are also significant.

- ⌘ Women are the caregivers – of infected spouses, often whilst being infected themselves, of infected children, and of 'AIDS orphans'.
- ⌘ They are also predominantly the educators and health professionals who have to spearhead and staff AIDS prevention and care programmes.
- ⌘ There is a great burden on elderly women to care for and bring up grandchildren whose parents have died of AIDS.

Fact Sheet #4: The impact of HIV/AIDS on the workplace

This section covers:

- Facts about HIV/AIDS and the workplace
- The impact of HIV/AIDS at an organisational level
- The impact on the informal sector
- Predictions of the future impact of HIV/AIDS on workplaces
- A checklist (of vulnerability and susceptibility) for the informal sector

Key points

- ⌘ A number of factors will influence the susceptibility of organisations, and of classes of employees. These include the location of the place of business, the location of employees' families in relation to the place of business, the travel requirements of employment, the level of knowledge of HIV and individual risk behaviour.
- ⌘ All workplaces will be impacted by HIV/AIDS, though the extent and nature of the impact will differ from workplace to workplace, related to factors such as labour intensity and markets for products produced.
- ⌘ Typically the impact is described in areas such as morbidity, mortality, absenteeism, staff morale, the cost of benefits, products and services and investment. Indirect costs will, in all instances be more significant than direct costs.

Only fifteen years ago, if one had called business, labour, government and non government representatives together to discuss how to deal with the AIDS epidemic, most would not have even more than a fleeting idea of what it was, let alone why they should discuss it. Today, companies have lost top managers, workers have lost colleagues and huge amounts of time, energy and emotion have been spent pre-occupied with issues of illness and loss. Whole families have collapsed, while companies struggling against a background of chronic poverty have taken on deeper burdens of dependency.³

4.1 Facts about HIV/AIDS and the workplace

- ⌘ The epidemic primarily affects working age adults and far exceeds any other threat to the health and well-being of employees.
- ⌘ Certain working situations are associated with vulnerability to HIV infection, especially where workers have to stay away from their homes for long periods or where men are in single-sex accommodation.
- ⌘ Because HIV/AIDS has increased the burden of ill health and mortality in the 15 – 50 year age group two to three fold, according to the ILO,

³ Loewenson, R. 1998. Towards a framework for mobilisation and support of company interventions on HIV/AIDS

an average of 15 years of working life will be lost per employee due to HIV/AIDS.

- ⌘ The vulnerability of businesses to HIV/AIDS will vary, depending on factors such as the type of business and production processes. Businesses may also be susceptible to inadequate responses to HIV/AIDS by key suppliers – eg water and electricity, telecommunications and basic government services suppliers.
- ⌘ Productivity growth may be cut by as much as 50% in hard-hit countries. Combined with the erosion of human capital and loss of skilled and experienced workers, this is likely to result in a mismatch between human resources and labour requirements.
- ⌘ The indirect costs to a workplace of HIV/AIDS are greater than the direct costs. The costs of lost time have been consistently shown to be the most significant costs to organisations. Each HIV infection is likely to cost the organisation between 1 and 6 times the employee's annual salary.
- ⌘ HIV/AIDS will affect the growth of many markets for goods and services.
- ⌘ HIV/AIDS is reducing the ratio of healthy workers to dependants.
- ⌘ HIV infected persons have 5 - 10 years on average of asymptomatic productive working life. This period can be lengthened by health promotion and positive living.
- ⌘ There are specific occupational risks in certain sectors, such as the health and emergency services. Otherwise the transmission of HIV poses little or no risk in most work settings.

4.2 The impact of HIV/AIDS at an organisational level

Organisations will experience the impact of HIV/AIDS in many areas, such as:

- ⌘ **Morbidity**
As infected employees become ill they will take additional sick leave; this will disrupt the operation of the institution for which they work. The disruption will be amplified when the more qualified and experienced employees are absent, as finding a temporary replacement is that much more difficult.
- ⌘ **Mortality or retirement**
The impact of the death or retirement of an infected employee is similar to morbidity, although the problems are permanent. The loss of an employee requires an appropriate replacement to be selected and trained. For highly qualified staff this is often difficult, particularly in developing economies with skill shortages. Training and recruitment are costly and disrupt operations.

- ⌘ Absenteeism
As the HIV/AIDS epidemic advances, increases in deaths will lead to increased absenteeism or compassionate leave, if this is available, as employees attend funerals for family members, friends and colleagues.
- ⌘ Staff morale
The epidemic has a negative impact on morale in the workplace. There is a fear of infection and death, which may lead to increased suspicion of others as well as resistance to shouldering the additional responsibilities for colleagues who are off sick, away from work or newly recruited and not yet fully functional.
- ⌘ Benefits
Employers and employees will feel the impact as the cost of employee benefits increases.
→Death payments, early retirements, funeral payments and pensions paid to families after the contributor's death will all lead to an increase in the cost of group cover. This is partly offset by a reduced demand for normal pensions.
→Medical aids are the most obvious area on which the epidemic will impact. The cost of treating HIV and related illnesses is substantial. Even if the treatment of HIV is excluded, the treatment of the symptoms can still have a significant impact on costs. Such exclusions further encourage non-disclosure, thereby reducing the use of prophylactic treatments - which may in the long run reduce costs.
- ⌘ Products and services
Changing levels of disposable income will affect the markets for luxury items and the profile of customers may also change with the intensifying epidemic. If the organisation provides services the demand for these could increase (eg health and welfare) at the same time as the ability to deliver is affected due to the loss of key personnel.
- ⌘ Investments
All enterprises require investment (from reinvested profits, money raised through financial institutions or stock markets) to maintain or increase capital stocks. Local capital may be reduced as assets are used to meet immediate health needs. Foreign investors may be concerned about the HIV/AIDS situation in a country when contemplating investment.

4.3 The informal sector workplace

Informal enterprise operators and workers are especially vulnerable to the consequences of HIV/AIDS.

- ⌘ HIV/AIDS poses a particularly serious threat to informal enterprises because of their inherent dependence on a small labour base.
- ⌘ Employers and workers in the sector lack access to health facilities

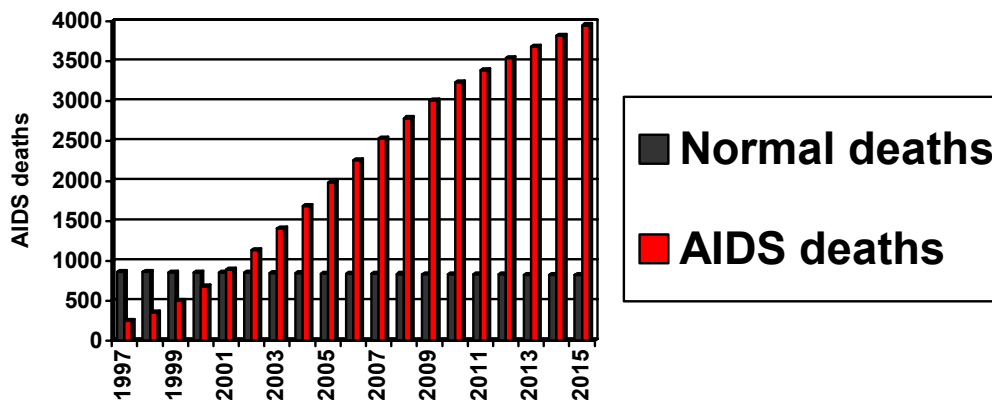
and social protection.

- ⌘ Their activities depend heavily on their own labour and rarely lead to financial security.
- ⌘ Informal workers can easily lose their precarious livelihoods when they are infected or forced to withdraw from work to care for family members.

4.4 Predictions of the future impact of HIV/AIDS on workplaces⁴

The following 2 studies illustrate the potential impact of the HIV/AIDS epidemic on workplaces – in terms of mortality and costs.

Projected AIDS deaths among employees in a South African workforce



Cost as a percentage of salary for a typical scheme

	2000	2005	2010
Lump sum on death	2%	3.8%	5.7%
Spouse's pension	4.7%	6.3%	7.8%
Disability pension	1.8%	2.3%	2.8%
Medical (per month)	R400	R800	R1 200

4.5 Checklist for the informal sector

→ Susceptibility

- ⌘ What is the degree of poverty of enterprise operators and workers?
- ⌘ What is the education level of enterprise operators and workers?
- ⌘ Do women in the sector have low status and limited economic independence?

⁴ Sources: Abt Associates – Impending catastrophe revisited (2001) and Metropolitan Life

- ⌘ Does business involve long-distance travel?
- ⌘ Is risky sexual behaviour common?

→ Vulnerability

- ⌘ What is the health burden of poor working conditions?
- ⌘ What is the health burden associated with alcohol/substance abuse?
- ⌘ How will early onset of illness and death affect the business?
- ⌘ Is the operator's family also employed in enterprise?
- ⌘ What is the effect of enterprise time diverted to care for sick family members?
- ⌘ Will orphans be left in the care of extended family?
- ⌘ Is there any access to social protection schemes?
- ⌘ What is the strength of business associations?
- ⌘ To what extent is there dependence on business networks for resources, joint production and markets?
- ⌘ To what extent is there dependence on family and/or rotating savings and credit associations for finance?
- ⌘ To what extent will consumer spending be reduced by HIV/AIDS?

The costs of inaction are potentially enormous. Policymakers who demonstrate commitment, by working in creative ways with people most severely affected by HIV/AIDS, have a unique opportunity to contain a global epidemic and save millions of lives.

World Bank