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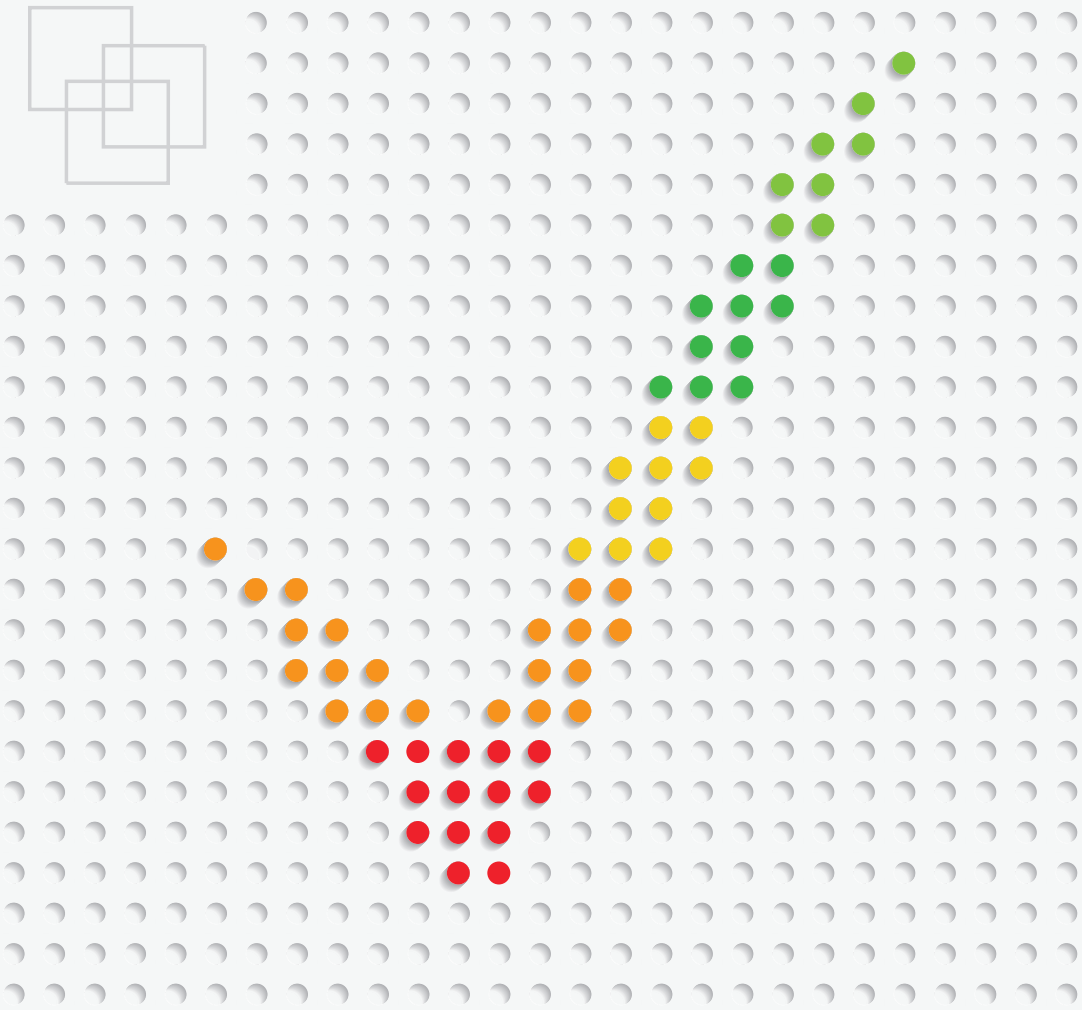
Handbook on HIV and AIDS
for labour inspectors



Handbook on HIV and AIDS for labour inspectors

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HIV and AIDS and the world of work branch (ILOAIDS)
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Preface

HIV and AIDS is a health and labour rights issue that has a profound impact on the world of work, affecting workers and their families, employers and national economies, particularly in those regions that continue to bear the highest burden of HIV. More than thirty years after the first case of HIV was diagnosed, HIV-related stigma and discrimination in workplaces remains a significant obstacle, depriving workers of their fundamental human rights and impairing the effectiveness of HIV prevention efforts.

Recognizing the devastating impact of the epidemic on the world of work, in June 2010, the International Labour Conference adopted an international labour standard aimed at preventing HIV and mitigating its impact in and through the workplace, together with a resolution to promote its effective implementation. The HIV and AIDS Recommendation, 2010 (No. 200) explicitly recognizes the vital role of labour administration services, including labour inspectorates, in optimizing the contribution of the world of work to preventing the spread of HIV, reducing the impact of the epidemic and eliminating HIV-related stigma and discrimination.

Labour administration services, including labour inspectorates, are central to national workplace HIV responses. First, inspectors have an essential role to play in ensuring compliance with national occupational safety and health legislation to help ensure a safe and healthy workplace. Second, HIV and AIDS is also a human rights issue that is relevant to inspectors empowered to safeguard labour rights. Third, given their preventive and advisory role, labour inspectors can provide needed guidance to enterprises and workers, helping them to design and implement effective workplace interventions. Working with both employers' and workers' representatives, inspectors can promote and facilitate the development, implementation and monitoring of workplace policies and programmes on HIV and AIDS and occupational safety and health to help prevent new infections, eliminate HIV-related stigma and discrimination and facilitate access to HIV-related services.

This Handbook is intended to complement the joint ILO/AIDS-LAB/ADMIN booklet on *Good Practices in Labour Inspection on HIV and AIDS*, ILO Geneva, 2012. It aims to help labour inspectors identify and address issues related to HIV, AIDS and tuberculosis (TB) in their work. The Handbook is also a flex-

ible training tool, accompanied by a CD containing learning materials and exercises that can be used in peer training activities to enhance the capacity of labour inspectorates to effectively address HIV-related issues in workplaces. The Handbook was developed by Anna Torriente and Ingrid Sipi-Johnson (ILOAIDS), in close collaboration with Joaquim Pintado Nunes and María-Luz Vega Ruiz of the Labour Administration, Labour Inspection and Occupational Safety and Health Branch (LABADMIN/OSH). Valuable contributions on draft versions of the Handbook were received from Alexander Tadion (ILOAIDS).

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Acronyms

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral treatment
HIV	Human immunodeficiency virus
ILO	International Labour Organization
MDGs	Millennium Development Goals
MSM	Men who have sex with men
OSH	Occupational safety and health
PLHIV	Persons living with HIV
PMTCT	Prevention of mother-to-child transmission
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary counselling and testing
WHO	World Health Organization

Definitions

"***HIV***" refers to the human immunodeficiency virus, a virus that damages the human immune system. HIV infection can be prevented by appropriate measures.

"***AIDS***" refers to the acquired immunodeficiency syndrome which results from advanced stages of HIV infection, and is characterized by opportunistic infections or HIV-related cancers, or both.

"***Persons living with HIV***" means persons infected with HIV.

"Affected persons" means those whose lives are changed by HIV or AIDS owing to the broader impact of the epidemic.

"Stigma" means the social mark that, when associated with a person, usually causes marginalization or presents an obstacle to the full enjoyment of social life by the person infected or affected by HIV. Stigma may or may not be acted upon, but stigmatizing attitudes toward people living with HIV can result in their isolation or segregation in the workplace as well as in the broader society.

"Discrimination" as used in this Handbook means any distinction, exclusion or preference which has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation, as referred to in the Discrimination (Employment and Occupation) Convention and Recommendation, 1958 (No. 111).

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

"Vulnerability" means the unequal opportunities, social exclusion, unemployment or precarious employment, resulting from the social, cultural, political and economic factors that make a person more susceptible to HIV infection and to developing AIDS.

1. Introduction

About this Handbook

At the end of 2013, an estimated 35 million people worldwide were living with HIV.[1] Of this number, over 90 per cent are between the ages of 15 and 49, indicating that the vast majority of those living with HIV are either working or have links to the world of work.[2] However, HIV-related stigma and discrimination is still widespread and remains a barrier to employment. One in nine people living with HIV is denied employment due to his or her HIV status.[3]

Workplaces, whether formal or informal, are settings that can provide crucial opportunities to reach people—particularly young women and men that may be at higher risk of HIV infection—with information and education on HIV prevention. Workplaces are also highly effective entry points through which information on accessing HIV-related treatment, care and support services can be provided to workers, their families and local communities.

HIV and AIDS is a complex issue that poses new challenges for labour inspection. This Handbook is a training tool that inspectorates may draw on to provide their work force with the necessary competencies to address HIV and AIDS issues in an effective, objective and holistic manner.

The Handbook also provides a reference for non-discriminatory policies and practices that labour inspectorates could develop and promote within their own workforce. It can assist labour inspectorates in developing their own internal policies on HIV and AIDS that call for inspectors to collaborate and exchange information with all relevant institutions. For example, in countries where labour inspectorates are separated by function, increased collaboration could be promoted among the different inspectorates. Collaboration between those inspectorates focussed on occupational safety and health (OSH) and those focussed on labour rights could ensure increased compliance with relevant legislation and support their advisory functions.

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[1] UNAIDS, *The Gap Report*, July 2014, p. 17.

[2] See also UNAIDS, *Global Report: UNAIDS report on the global AIDS epidemic* (Geneva, 2010).

[3] UNAIDS, *The Gap Report*, op. cit., p. 125.

Objectives and structure

The Handbook and accompanying CD are intended to be used in training activities and as a reference for policy development. They offer practical tools to help labour inspectors integrate HIV, AIDS and TB into their inspection planning and workplace visits across all sectors and at both formal and informal workplaces.

The Handbook contains:

- Background information on HIV and AIDS, including global statistics, accurate and up-to-date information on the modes of HIV transmission and how to prevent HIV infection.
- An overview of the context of labour inspection: roles, powers and functions.
- Guidelines for labour inspectorates to develop internal policies for a systematic and comprehensive approach to HIV and AIDS and strategies to promote the effective integration of HIV and AIDS into labour inspection activities.
- Concrete tools such as indicators, checklists, questionnaires and guidelines.

Chapter 10 of the Handbook provides training materials and exercises that range from a short general presentation on HIV and AIDS and labour inspection to materials and activities for a sample two-day workshop. The Handbook is designed as a flexible tool and the training materials can be adapted to the specific situation of a particular country, economic sector or region so that the materials can accommodate the specific training needs identified and the time available.

The accompanying CD contains sample presentations and exercises. The latter are formatted so that they can be printed and used as hand-outs in training activities as required. The Annexes contained in the CD also include the full texts of the HIV and AIDS Recommendation, 2010 (No. 200), the Labour Inspection Convention and Recommendation, 1947 (No. 81) and the Labour Inspection (Agriculture) Convention and Recommendation, 1969 (No. 129). The CD also contains a list of additional relevant ILO Conventions and Recommendations, guidelines on how to design and carry out an HIV and AIDS awareness campaign, how to design and carry out an inspection visit integrating HIV-related issues and a sample labour inspection checklist on HIV and AIDS.

The material contained in this Handbook may be used together with other relevant material such as the ILO/AIDS-LAB/ADMIN booklet on *Good practices on Labour Inspection and HIV and AIDS*, 2012, "*ILS on HIV/AIDS and the world of work: an education and training manual*", or the modular training course for labour inspectors developed by the ILO Turin Training Centre and LAB/ADMIN.[4]

[4] See Additional reference materials in Appendix 2 of the accompanying CD.

2. Facts about HIV and AIDS

The evolving nature of the epidemic

Since the first case of HIV was identified in the early 1980s, the epidemic has caused enormous human and economic losses. Recognizing the devastating effects of the epidemic, in 2000, the international community included HIV, AIDS and TB in the Millennium Development Goals (MDGs), a set of eight goals which provide a framework for coordinated action in working toward a range of human development objectives. Goal No. 6 includes halting and beginning to reverse the spread of HIV, malaria and other diseases and achieving universal access to HIV prevention, treatment, care and support for all those who need it.

Following the adoption of the MDGs, significant progress has been made in reaching the goal of universal access to HIV prevention, treatment, care and support services. According to the 2014 UNAIDS Gap Report, there is evidence that new HIV infections are on the decline in many countries.[5] For example, in 2013, there were an estimated 2.1 million new HIV infections, representing over 5700 new infections a day. This represents a 38% reduction in new infections compared to 2001, when there were 3.4 million new HIV infections reported.[6] Nonetheless, HIV prevention efforts continue to be of fundamental importance given that, despite a notable decline in new infections in a number of countries, new infections are on the rise in others.[7] To avoid losing ground in tackling the epidemic, it is essential to intensify and target prevention measures to meet the needs and concerns of the key populations most affected, depending upon the characteristics of the epidemic in each country and region.

Although there is still no cure for HIV, scientific and medical advances have led to the development of effective antiretroviral treatments (ART). As a result, while HIV is not curable, it is no longer a death sentence. The number of AIDS-related deaths reported declined to 1.5 million in 2013, a 35% reduction when compared to all AIDS-related deaths reported in 2005.[8]

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[5] UNAIDS, *The Gap Report*, op.cit., p. 8.

[6] Ibid, p. 4.

[7] UNAIDS, *Global Report: UNAIDS Report on the global AIDS epidemic 2013,* November 2013, p. 4.

[8] UNAIDS, *The Gap Report*, op. cit., p. 9.

As a consequence of the advances in ART, more people—35 million—are now living with HIV than ever before. There has been remarkable progress in reaching those eligible with needed treatment. As of the end of 2012, there were an estimated 9.7 million people on treatment in low- and middle-income countries.[9] While this represents continued progress toward the goal of reaching all those who need treatment, under the 2013 WHO Treatment Guidelines, this number is only 34% of the 28.3 million people eligible in 2013. There is therefore an urgent need to expand access to voluntary HIV testing and treatment while continuing to emphasize prevention efforts, particularly for young people (aged 15-24).[10] Ensuring timely access to treatment for all those living with HIV and providing sustainable treatment throughout their lives remains a challenge in many regions.

Adapting the response to meet the challenge

HIV epidemics can and do vary across regions and countries. In order to better understand the nature and characteristics of HIV epidemics in a particular region or country, it is necessary to look at both HIV prevalence (the percentage of people living with HIV in the population group) and HIV incidence (the number of new infections) in the population, including both prevalence and incidence in key at-risk populations, as well as the number of people who have died of AIDS during a specific period.

HIV epidemics are categorized as falling into one of the following categories:

- Generalized (when there is an HIV prevalence of 1% or more in the general population);
- Concentrated (when HIV prevalence is below 1% in the general population but exceeds 5% in specific at-risk populations); or
- Low level (when HIV prevalence is not recorded at a significant level in any group).

There is a great deal of data available on country epidemics that can provide an evidence base for developing informed responses, including in workplace settings. In planning actions on HIV and AIDS, labour inspectorates should consider the characteristics of the epidemic in the country and/or specific municipalities, including the main modes of transmission in the country and identification of at-risk populations. Inspectorates should be aware of whether there are key economic sectors in the country with higher HIV prevalence rates; these may be due to specific characteristics of the labour force or the living and working conditions in the particular sector.

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[9] UNAIDS, *Global Report: UNAIDS Report on the global AIDS epidemic 2013,* op. cit., p. 6.

[10] UNAIDS, *World AIDS Day Report 2012,* pp. 17 and 39.

For example, economic sectors that countries have reported as having higher HIV prevalence than the general population include:

- Transportation;
- Construction;
- Mining and logging;
- Ports and seafarers;
- Export processing zones;
- Agriculture (particularly seasonal work);
- Health care;
- Hospitality, hotels and tourism; and the
- Entertainment industry.

The more familiar labour inspectors are with the nature and causes of the epidemic in their countries, the better they will be able to develop an effective evidence-based and targeted approach to HIV and AIDS in their work. In 2008, UNAIDS undertook a campaign entitled "K*now your epidemic, know your response",* which recognized that there is not one but many epidemics, and that no single response can apply to countries as diverse as South Africa, Egypt, Russia, Thailand, or Papua New Guinea.[11]

Detailed information on country epidemics is available through Country Progress Reports submitted every two years to the UNAIDS Secretariat. In adopting the 2001 Declaration of Commitment on HIV/AIDS, United Nations member States undertook to report regularly on their progress to the UN General Assembly.[12] The UNAIDS Secretariat is responsible for accepting reports from member States and preparing regular reports for review and discussion by the General Assembly. The Country Progress Reports provide statistical information on matters such as HIV prevalence and incidence rates, identify at-risk and vulnerable groups in the country and typically indicate the measures—including legislative and policy measures—taken by the country to respond to the epidemic. Information on country epidemics is often available from the websites of national ministries of health and national AIDS authorities. Inspectors should also consult the National HIV Strategic Plan in place for the country.

In addition to familiarizing themselves with the epidemic and specific HIV risks in their country and the economic sectors in which they are working, it is essential for inspectors to have accurate and up-to-date information on HIV and AIDS (and related illnesses, such as TB). This will enable inspectors to plan their

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[11] D. Wilson and D.T. Halperin, "Know your epidemic, know your response: a useful approach if we get it right, *The Lancet*, Vol. 372, Issue 9637, pp. 423-426, 9 August 2008.

[12] United Nations General Assembly, *Declaration of Commitment on HIV/AIDS,* Resolution S-26/2 (adopted 27 June 2001) A/RES/S-26/2.

work effectively and to address HIV-related issues in the workplace context with the necessary objectivity and impartiality.

Modes of transmission

Many people have fears or misapprehensions about HIV and AIDS. Common misconceptions about the modes of HIV transmission give rise to fear, which in turn leads to stigma and intolerance in workplace settings.[13] To reduce HIV-related stigma, it is helpful to clarify the facts regarding HIV transmission.

HIV is transmitted through body fluids – blood, semen, vaginal secretions and breast milk.[14] Transmission can occur only through the following routes:

- Unprotected sexual intercourse,[15] either heterosexual or homosexual, with an infected partner (this is the most common mode of transmission). The risk of sexual HIV transmission is increased by the presence of other sexually transmitted infections, particularly ulcerative types such as herpes or syphilis;
- Mother-to-child transmission during pregnancy, labour and delivery where a prevention regimen is not followed, or through breastfeeding;[16] or
- Blood and blood products, for example:
  - ➢ Transfusion of infected blood or transplants of infected organs or tissues;
  - ➢ Sharing of contaminated drug-injecting paraphernalia, such as needles, syringes, or contaminated skin-piercing instruments;
  - ➢ Occupational injuries, including needle-stick injuries sustained by a health professional when caring for an HIV-infected patient. Other workers in the health sector, such as hospital janitors, may also be at risk of needle-stick injuries.

HIV is a fragile virus, which can only survive in a limited range of conditions. It can enter the body through mucous membranes, such as the mouth or vagina. HIV cannot enter the body if the skin is intact, but can easily enter through an open wound. Prevention therefore involves ensuring that there is a barrier to the virus – condoms or protective means such as gloves and masks, where appropriate – and that needles and other skin-piercing instruments are not contaminated.

HIV cannot be transmitted by casual physical contact of any kind, such as:

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[13] United Nations Human Rights Council, *The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS)*, Report of the Secretary-General, United Nations General Assembly (20 December 2010) A/HRC/16/69, para. 5.

[14] People cannot be infected with AIDS, but rather with HIV. Reference should therefore be made only to "HIV transmission", not to "HIV/AIDS transmission".

[15] "Unprotected" sexual intercourse refers to sexual relations without a protective barrier. For example, male or female condoms are effective barriers to infection when used correctly.

[16] Providing appropriate treatment protocols can reduce mother to child transmission, but it cannot guarantee complete avoidance of transmission in every case.

- ✓ Kissing, hugging or shaking hands
- ✓ Mosquito or insect bites
- ✓ Coughing, sneezing or spitting
- ✓ Sharing toilets or washing facilities
- ✓ Using utensils or consuming food and drink handled by someone who is infected with HIV.

In order to prevent accidental exposure to HIV, it is important to follow the standard precaution guidelines devised by the United States Centers for Disease Control and Prevention (CDC) in 1996. For additional information regarding standard precautions, please consult the CDC at *http://www.cdc.gov/*.

Know your HIV status

UNAIDS estimates that of the 35 million people living with HIV (PLHIV) globally, 19 million (54 per cent) do not know their HIV status.[17] A person may be infected with HIV for many years without developing symptoms. For this reason, HIV prevention programmes encourage people to seek voluntary and confidential HIV counselling and testing as early as possible, so that they can learn their status and take appropriate measures, both to protect themselves and to avoid transmitting the virus.[18]

Most HIV tests detect the presence of antibodies to HIV, not the virus itself. It can take some time for the immune system to produce enough antibodies for the test to detect HIV, the time period varying from person to person (between two weeks and six months). This time period is commonly referred to as the "window period", during which people can be highly infectious and yet unaware of their condition.

In order to encourage people to seek voluntary HIV testing, it is equally important to reduce HIV-related stigma and discrimination. Many of those who would benefit from voluntary HIV testing are deterred from seeking testing out of fear of being discriminated against or rejected by their families or co-workers.

Treatment as prevention

ART contributes to preventing HIV transmission: it lowers the concentration of HIV (also known as the viral load) in the bloodstream and in body fluids. Since viral load is the single greatest risk factor for all modes of HIV transmission, full

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[17] UNAIDS, *The Gap Report*, op. cit., p. 5.

[18] For instance, by using a male or female condom.

antiretroviral treatment adherence, which keeps the viral load low, also decreases the risk of HIV transmission from one person to another.[19]

Points for discussion

1. How has the HIV epidemic affected your country/region?
   a. Do you know the rate of HIV infection in your country/region?
   b. What are the main modes of HIV transmission in your country/region?
   c. How is the epidemic evolving/changing in your country/region?
2. Is ART widely available in your country or region? Is the cost of this treatment subsidized or otherwise supported?
3. In your experience, what is the level of general awareness concerning HIV and AIDS among employers and workers?
4. What do you consider to be the main challenges to raising awareness of HIV and AIDS in the workplace and what recommendations would you have for overcoming these challenges?

[19] WHO, *Consolidated guidelines on general HIV care and the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach*, June 2013.

3. Labour inspection and HIV and AIDS

The epidemic is present in all countries and in all sectors of economic activity, in both formal and informal employment. It cuts across all levels of society, although it hits vulnerable and at-risk groups the hardest. Moreover, in countries with high rates of HIV and HIV-related illness, (so-called "high burden" countries), the epidemic has placed an enormous strain on essential services and structures that are crucial to prevent HIV and reduce its impact, such as national health systems and services.[20] There is also a strong link between HIV and TB, leading to dual HIV/TB epidemics in a number of countries.

Why the epidemic is a workplace issue

HIV and AIDS has affected millions of workers and their families, leading to loss of life and sustainable livelihoods for many. It has also imposed a significant burden on employers, primarily through decreased productivity, absenteeism, loss of skills and experience and increased labour costs.[21] The epidemic has a serious impact on workplaces, particularly in high burden countries. At the same time, workplaces are also one of the most effective settings to reach the vast majority of those both infected with HIV and affected by HIV and AIDS with HIV-related services, including prevention, treatment, care and support.

The HIV epidemic also raises human rights issues. As a result of fear and stigma surrounding HIV and AIDS, PLHIV have been highly stigmatized and have faced persistent discrimination.[22]

The workplace is one of the main settings where HIV-related discrimination occurs. PLHIV, or those merely suspected of being HIV-positive, continue to be subjected to stigma and discrimination in all aspects of their daily lives, including

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[20] Ibid.

[21] See ILO, *Labour administration and labour inspection*, Report V, International Labour Conference, 100th Session (Geneva 2011), p. 23.

[22] UNAIDS, *The Gap Report*, op. cit., p. 125.

in access to health services, housing, education and employment.[23] As a result of HIV-related stigma and discrimination, PLHIV are often denied access to jobs or are excluded from specific occupations.[24] If they are already employed, they may be stigmatized, ostracized and harassed by employers and co-workers, or may be unfairly dismissed solely due to their real or perceived HIV status.

The ILO has long recognized the value of the world of work in responding to the epidemic, and the need to safeguard the labour rights of those living with or affected by HIV.

The ILO HIV and AIDS Recommendation, 2010 (No. 200) and the ILO Code of practice on HIV/AIDS and the world of work (2001) provide that the world of work should be an essential component of the HIV response:

HIV and AIDS should be recognized and treated as a workplace issue, which should be included among the essential elements of the national, regional and international response to the pandemic with full participation of organizations of employers and workers.

Recommendation No. 200, paragraph 3(b)

HIV 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 has a role to play in the wider struggle to limit the spread and effects of the epidemic.

ILO Code of practice, section 4.1.

Workplaces can help prevent the spread of HIV and reduce the impacts of the epidemic through a two-pronged response. First, workplace policies and programmes on HIV and AIDS can support prevention efforts and safeguard workers' livelihoods by protecting workplace rights. Second, workplaces can facilitate access to HIV-related information, treatment, care and support services for workers, their families and dependents. Labour inspectors can provide guidance to help employers and workers develop, implement and monitor effective workplace responses.

Integrating HIV and AIDS into labour inspection

There are many reasons why labour inspectors should integrate HIV and AIDS into their day-to-day work. These include, but are not limited to the following:

- The active engagement of labour inspectorates in working with employers and workers can contribute to more effective national HIV responses. Through

[23] *See* UN Human Rights Council, *The protection of human rights in the context of human immunodeficiency virus (VIH) and acquired immune deficiency syndrome (AIDS)*, op.cit.

[24] UNAIDS, *The Gap Report*, op.cit., p. 125.

inspectors' technical expertise, in addition to verifying compliance with national legislation on HIV and AIDS, where this exists, they can provide valuable guidance to employers, workers and their representative organizations to assist them with the development and implementation of national, sectoral and workplace policies and programmes on HIV, AIDS and TB that are aligned with relevant international law, including ILO standards, as well as with the national legal and policy framework.

- Many workplace situations and working environments may increase the risk of HIV infection for workers, particularly those in certain occupations. Risk factors may include, for example, long working hours, difficult or exploitative working conditions, exposure to contaminated blood or blood products or other specific risk factors.[25] Labour inspectors can provide guidance to employers and workers to help them take steps to prevent or reduce the risk of occupational transmission of HIV and can provide guidance on how to handle occupational transmission when it does occur. Regular inspections on health and safety can identify areas of focus for the prevention of HIV transmission, especially for workers at greater risk of occupational exposure.
- Inspections focussing on employment relations can identify indicators of possible unfair labour practices in relation to HIV and AIDS. For example, in exercising their compliance functions, labour inspectors play a crucial role in ensuring observance of the principle of equality of opportunity and treatment in employment and occupation for all persons living with or affected by HIV or AIDS.
- HIV-related stigma and discrimination threaten fundamental rights at work as well as public health interests. A positive working environment which promotes zero tolerance for HIV-related stigma and discrimination encourages workers to take action to know their own HIV status through voluntary, confidential HIV counselling and testing and to take effective preventive measures to protect themselves and others. As part of their advisory function, labour inspectors can provide expert guidance for the development of workplace policies and programmes that instil an organizational culture of respect for the labour rights of PLHIV.
- In countries where there is high TB prevalence, workers may be at risk of TB-HIV co-infection. The WHO has estimated that TB is the most common cause of illness in PLHIV, including those on ART. TB is also the leading cause of death among PLHIV, accounting for one in four HIV-related deaths.[26] The risk of TB-HIV co-infection is particularly high in certain sectors, such as mining,

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[25] For example, workers coming into contact with contaminated blood or blood products in health care facilities are at risk of HIV transmission. See ILO-WHO, *HealthWISE Action Manual: Work Improvement in Health Services*, 2014, pp. 54-55.

[26] WHO, *HIV-Associated TB Facts*, 2013.

factories, construction sites, or prisons, where workers carry out their duties in close proximity to one another and where ventilation may be poor. Labour inspectors can promote an integrated approach to address dual HIV-TB epidemics, ensuring that employers take appropriate steps to identify the hazards, assess the risks of contamination and put in place occupational safety and health measures to prevent HIV-TB related illness or death. This is particularly important given that TB is both preventable and curable.[27]

Enforcement challenges

Absence of clear legislation on HIV and AIDS

Understanding, explaining and enforcing the law is rendered more difficult where there are gaps in legislation, or where existing legislation is inconsistent or fragmented. Many countries have either enacted national legislation protecting the human rights of people living with or affected by HIV, or have interpreted existing legislation to cover real or perceived HIV status as a prohibited discrimination ground. Nevertheless, as of the end of 2012, only 61 per cent of countries reported having anti-discrimination legislation in place protecting people living with or affected by HIV.

Even where protective legislation exists, it may not explicitly apply to the employment context. In addition, some countries that have included HIV-related provisions in their employment legislation exclude certain sectors from coverage, such as public sector workers, the armed forces and uniformed services, or domestic workers.[28] To support the goal of stopping and beginning to reverse the epidemic, Recommendation No. 200 establishes a broad scope of coverage intended to cover all workers in any form of economic activity, including those who may not fall explicitly within the scope of formal labour legislation, such as workers in the informal economy, domestic workers or sex workers.[29]

Numerous countries cover HIV-related discrimination under other prohibited discrimination grounds, such as "disability"[30], "health" or "other status" , while others have included HIV status as a specific protected ground under general discrimination or equal opportunities legislation. Some countries have adopted gen-

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[27] In 2011, there were 1.4 million deaths from TB, including 430,000 deaths among HIV-positive individuals. See WHO, *Global Report on Tuberculosis*, 2012, p. 9.

[28] ILO, *HIV/AIDS and the world of work*, Report IV (1), International Labour Conference, 98th Session, Geneva, 2009.

[29] Recommendation No. 200, at para. 2.

[30] For example, the United States, which covers HIV as a disability under the Americans with Disabilities Act, 1990. The United Kingdom's Equality Act of 8 April 2010 also covers HIV as a disability rather than as a separate prohibited discrimination ground.

eral HIV or AIDS legislation[31] or provide for protection from employment discrimination on the grounds of real or perceived HIV status in their labour codes or other labour legislation.[32] A number of countries have also issued HIV policies or codes of practice, while others have included anti-discrimination clauses in collective bargaining agreements.[33]

Difficulties in relation to the labour inspection mandate

In some countries, HIV-related issues in the workplace fall outside the mandate of labour inspectors. In some others, labour inspectorates address the occupational safety and health status of workers, but are not competent to supervise compliance with anti-discrimination laws. In many countries, there is also a division between OSH inspectors and labour inspectors responsible for overseeing working conditions, including compliance with anti-discrimination legislation. There should be coordination between the different engaged institutions, as workplace policies on HIV and AIDS call for a holistic approach.

OSH inspectors typically focus on mechanical, physical and ergonomic hazards in the workplace and less on emerging risks, such as stress, harassment or mobbing. Therefore, their work may not focus on issues relevant to HIV prevention, such as stigmatization and discrimination, nor do they tend to address workplaces in the informal economy. Moreover, in some countries there is an additional division between inspectorates dealing with occupational safety and those addressing occupational health, which makes it more difficult for inspectorates to work with employers in order to help them establish a single policy to address HIV and AIDS in their workplaces.

Poor awareness raising

A main function of labour inspectorates consists of communicating relevant information to employers and workers on existing legislation and on how to comply with legal rules. The need to reach out to a multitude of individuals has led labour inspectorates in many countries and regions to integrate communication strategies into their agendas, making use of tools such as printed materials, radio and television broadcasting, written media, call centres, websites or web applications to increase awareness of labour rights. Although this approach is rapidly expanding, there are still many gaps based on less innovative visions of labour inspection

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[31] For example, Costa Rica has adopted a General AIDS Law, Law No. 7771 of 29 April 1998. Mozambique has a General AIDS Act, Act No, 5 of 5 February 2002.

[32] For example, section 5(2)(f) of Namibia's Labour Act No. 11 of 21 December 2007 or section 6 of the Bahamas Employment Act No. 73 of 2001.

[33] See ILO, *Giving globalization a human face: General Survey on the fundamental Conventions concerning rights at work in light of the ILO Declaration on Social Justice for a Fair Globalization,* Report III (Part 1B), International Labour Conference, 101st Session (Geneva, 2012), at para. 810.

or, more often, insufficient resources. Collaboration with social partners and other institutions can be extremely positive, as it strengthens social dialogue through labour inspection and multiplies results by sharing available expertise and resources.

Weak enforcement

In many countries, enforcement of existing legislation may be inadequate to protect persons living with or affected by HIV from violations of their labour rights. This is generally due to a range of factors, including a general lack of human and material resources (inadequate inspection budgets, insufficient number of inspectors, lack of adequate transportation and materials, etc.), lack of training for labour inspectors on HIV-related issues, difficulties in reaching affected workers, inexistent or non-deterrent sanctions and complex, costly and protracted judicial procedures.

Cultural obstacles

Promotion of the labour rights of those living with or affected by HIV or AIDS may encounter cultural obstacles. The organizational culture and broader society may actively discourage open discussion about sexuality, including about HIV, AIDS and sexually transmitted infections (STIs). A common problem for labour inspectors is that workers living with HIV are often reluctant to bring a claim of discrimination due to fear of disclosure and negative consequences. There may be a lack of understanding of the inspector's function and fear that if the person's HIV status is disclosed, it will be revealed to the employer and the worker will be dismissed. Prejudice may also be present among labour inspectors themselves. Where it exists, such prejudice should be addressed through non-discriminatory labour inspection policies, guidance and training.

Points for discussion

1. What do you consider the main challenges to effectively integrating HIV and AIDS into your work as a labour inspector?
2. What measures can labour inspectors in your country take to mainstream HIV and AIDS into their inspection visits and other day-to-day tasks?
3. What measures should be taken in your country so that labour inspection may address HIV and AIDS more effectively at the enterprise level?

4. International Labour Standards guiding Labour Inspection

Roles, responsibilities and functions of labour inspectors

Promoting sound, effective labour administration and inspection systems has been a priority for the ILO since it was founded in 1919.[34] The vital role of labour inspection was recognized in one of the first instruments adopted by the delegates to the International Labour Conference: the Labour Inspection (Health Services) Recommendation, 1919 (No. 5), later underpinned by the Labour Inspection Recommendation, 1923 (No. 20). Its principles were later integrated into the ILO's two governance Conventions on labour inspection: the Labour Inspection Convention, 1947 (No. 81), which regulates labour inspection in industry and commerce[35], and the Labour Inspection (Agriculture) Convention, 1969 (No. 129), which regulates labour inspection in agriculture.

Convention No. 81 is one of the most ratified ILO Conventions, serving as a model for many national laws and regulations that establish modern inspection systems.[36] It reinforces the important role of labour inspection in guaranteeing labour law compliance, workers' protection and fair competition.

The functions, duties and responsibilities of labour inspection systems are defined in Article 3 (1) of Convention No. 81 and Article 6 (1) (a) of Convention No. 129. Both of these Conventions reflect the complex nature of labour inspection, which includes diverse functions to promote the effectiveness of legislation, such as providing information and advice, monitoring workplace compliance and enforcing the law.

According to the relevant international labour standards, the functions of labour inspection are:

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[34] ILO, *Labour administration and labour inspection*, op. cit., p. 1.

[35] A Protocol of 1995 to the Labour Inspection Convention, 1947 (No. 81) extended the principles of the Convention to non-commercial services.

[36] As of October 2014, Convention No. 81 had been ratified by 145 out of 185 ILO member States.

- To secure the enforcement of the legal provisions relating to conditions of work and the protection of workers while they are engaged in their work, such as provisions relating to hours, wages, safety, health and welfare, the employment of children and young persons, and other connected matters in so far as such provisions are enforceable by labour inspectors;
- To supply technical information and advice to employers and workers concerning the most effective means of complying with the legal provisions; and
- To bring to the notice of the competent authority defects or abuses not specifically covered by existing legal provisions.

ILO Conventions Nos. 81 and 129, together with their accompanying Recommendations, establish the basis for comprehensive and efficient labour inspection systems.

Labour inspection principles

The core international principles on labour inspection are:

- Labour inspection should be organized as a system under the supervision and control of a central authority.
- Labour inspection should cover all workplaces in respect of which legal provisions relating to conditions of work and the protection of workers are enforceable.
- Labour inspectorates should have appropriate human and material resources to enable them to carry out their mandate.
- The labour inspection mandate should cover a basic number of areas, such as hours of work, wages, safety, health and welfare, the employment of children and other connected matters.
- Labour inspectorates should supply information and advice to employers and workers on how to comply with the law, and alert the competent authorities regarding any defects or abuses not covered by existing legal provisions.
- Effective cooperation with other government services engaged in labour protection, as well as collaboration with employers and workers and their organizations, should be promoted.
- Labour inspectors should be public officials assured of stability of employment and independent of changes in government and improper external influences.
- Labour inspectors should be recruited with sole regard to their qualifications and adequately trained for the performance of their duties.
- Both men and women are eligible for appointment and, if necessary, special duties may be assigned to men and women inspectors.

- Workplaces should be inspected as often and as thoroughly as is necessary to ensure the effective application of relevant legal provisions.
- Labour inspectors provided with proper credentials should be empowered to enter freely and without previous notice at any hour of the day or night any workplace liable to inspection.
- Labour inspectors should be entitled to carry any examination, test or enquiry which they consider necessary in order to assess compliance with the law.
- Labour inspectors should be empowered to take steps to remedy defects observed in plant, layout or working methods which they have reason to believe constitute a threat to the health or safety of the workers, ordering the adoption of measures, including measures with immediate executory force in the event of imminent danger.
- Labour inspectors should have discretion to give warning and advice instead of instituting or recommending proceedings.

Regardless of whether a country has a more or less comprehensive system of labour inspection, the complementary functions of enforcement and advice are a common denominator of labour inspectorates. Their balanced use seeks to ensure compliance with labour legislation and can reinforce preventive action aimed at tackling HIV and AIDS and reducing HIV-related stigma and discrimination.[37]

Labour inspectors are important actors with regard to disseminating technical information on all aspects of work and working conditions through visits to workplaces, organization of seminars and conferences, training, use of mass media, etc. They are equally essential to ensuring compliance with labour standards, protection of workers' rights, fair competition among businesses, recommending measures and imposing sanctions for violations of the law.

Points for discussion

1. In your country, does labour inspection have a mandate to supervise compliance with national legislation on HIV and AIDS in the workplace?
2. How do international labour standards on labour inspection apply to the supervision of compliance with national legislation on HIV and AIDS in your country?
3. What would you consider the main obstacles in your country (if any) to implementing the key principles of Convention No. 81, particularly in relation to addressing HIV and AIDS through labour inspection?

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[37] M-L. Vega and R. Robert, *Labour Inspection Sanctions: Law and practice of national labour inspection systems*, ILO LAB/ADM, Geneva Working Document No. 26, 2013, p. 3.

5. International Labour Standards on HIV and AIDS

Human rights at the centre of the HIV response

HIV and AIDS is an issue that profoundly affects the exercise of fundamental human rights in many settings, including health, education, privacy, freedom of movement and the right to work. The ILO, together with the other international organizations in the United Nations system, has consistently taken a rights-based approach to HIV and AIDS.[38] This means applying human rights principles to HIV and AIDS-related issues, including in the workplace.

The rights-based approach to HIV was integrated into the Declaration of Commitment on HIV/AIDS adopted by United Nations Member States at the United Nations General Assembly Special Session (UNGASS) held in New York in 2001.[39] The Declaration recognized explicitly that the realization of human rights and fundamental freedoms is essential to support effective HIV responses.[40] It called on governments to:

> *'[S]trengthen or enforce as appropriate legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups; in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support, treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic'.*[41]

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[38] ILO has been a cosponsor of UNAIDS since 2001.

[39] United Nations General Assembly, *Declaration of Commitment on HIV/AIDS,* op.cit.

[40] *Ibid.* Paragraph 13 of the Declaration of Commitment notes that "stigma, silence, discrimination, and denial, as well as lack of confidentiality, undermine prevention, care and treatment efforts and increase the impact of the epidemic on individuals, families, communities and nations and must also be addressed." Paragraph 16 recognizes that "the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic, including in the areas of prevention, care, support and treatment, and that it reduces vulnerability to HIV/AIDS and prevents stigma and related discrimination against people living with or at risk of HIV/AIDS."

[41] *Ibid.*, at para. 59.

The Declaration has recognised that workplace rights are included in the range of fundamental human rights, calling on governments to:

> *'.....[D]evelop national legal and policy frameworks that protect, in the workplace, the rights and dignity of persons living with and affected by HIV and AIDS, and those at greater risk of HIV and AIDS, in consultation with representatives of employers and workers, taking account of established international guidelines on HIV and AIDS and the workplace.'* [42]

ILO action on HIV and AIDS

The ILO's mandate includes the protection of human rights and the right of equality of opportunity and treatment, strengthening social dialogue, increased access to social protection and enhancing development through building skills, creating jobs and protecting incomes.

The ILO has been engaged in the HIV response since 1988, when a joint consultation was held with ILO and WHO, focussing on AIDS and the workplace.[43] As early as 1990, the ILO's supervisory bodies responsible for overseeing the application of ILO Conventions and Recommendations began examining HIV and AIDS-related issues in the context of a range of international labour standards in different thematic areas, including OSH, equality of opportunity and treatment, child labour, social protection and protection of certain categories of workers. [44]

The HIV and AIDS Recommendation, 2010 (No. 200)

In June 2010, the ILO adopted the first international labour standard on HIV and AIDS: the HIV and AIDS Recommendation, 2010 (No. 200). The main objectives of the Recommendation are to promote universal access to HIV prevention, treatment, care and support for workers, their families and dependents, and to protect the workplace rights of those living with or affected by HIV and AIDS.

The Recommendation builds on a set of tripartite guidelines developed in 2001: the ILO Code of practice on HIV/AIDS and the world of work. The Code, developed by a tripartite group of experts, offers practical guidance for the development and implementation of national and enterprise-level workplace policies and programmes on HIV and AIDS that integrate key human rights principles.

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[42] *Ibid*., at para. 69.

[43] WHO/ILO, *Statement from the consultation on AIDS and the workplace*, Geneva, 27-29 June 1988, Global Programme on AIDS.

[44] The ILO supervisory mechanisms referenced are the Committee of Experts on the Application of Conventions and Recommendations and the International Labour Conference Committee on the Application of Standards.

Recommendation No. 200 is intended to increase the attention paid to HIV and AIDS at the international, national and workplace levels across all economic sectors, to promote and guide united action among the key stakeholders in the area of HIV and AIDS. It is also intended to increase the impact of the ILO Code of practice, while taking into account scientific developments, particularly in terms of increased availability and effectiveness of treatment in the field of HIV and AIDS over the decade following the adoption of the Code of practice.[45] (The full texts of Recommendation No. 200 and the Code of practice are set out at Appendix 3).

As an international labour standard, Recommendation No. 200 forms part of international human rights law. It builds on the key principles affirmed in international instruments such as, for example, the principle of non-discrimination reflected in the Universal Declaration of Human Rights, 1948 and in the ILO Discrimination (Employment and Occupation) Convention, 1958 (No. 111). The Recommendation thereby provides a framework rooted in international human rights principles for developing a rights-based approach to HIV and AIDS in the workplace.

The Recommendation's primary objective is the protection of human rights at work to both prevent HIV and to mitigate its impact. HIV-related stigma and discrimination often prevent people from accessing jobs or certain occupations. In addition, those who are already employed often face the threat of job loss due to their real or suspected HIV status. While, as noted in Chapter 1, stigma and discrimination increase workers' vulnerability to HIV, discouraging voluntary testing, stigma and discrimination may also undermine access to employment-related social benefits, such as insurance and social security schemes.

Recommendation No. 200 provides comprehensive guidance for governments, employers and workers, as well as other relevant stakeholders – including national labour inspectorates – for the development, adoption, monitoring and implementation of national tripartite workplace policies and programmes on HIV and AIDS where these do not yet exist, or where they may require revision.

In particular, Recommendation No. 200 recognizes the critical role that labour inspectors play in addressing HIV-related stigma and discrimination in and through the workplace. Paragraph 37 (b) of the Recommendation provides that the labour administration authorities should be involved in the planning and implementation of national policies and programmes on HIV and AIDS and the world of work. Paragraph 44 of the Recommendation calls for the role of the labour administration services, including the labour inspectorate, to be reviewed and, if necessary, strengthened.

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[45] For example, when the ILO Code of practice was adopted, treatment options were much more limited than they are today.

Scope of application

Paragraph 2 of Recommendation No. 200 provides for the broadest possible scope of coverage, with the aim of promoting universal access to HIV-related prevention, treatment, care and support services for all workers, their families and dependants. It defines "workers" as persons working under all forms or arrangements, including:

- Persons in any employment, occupation or economic sector, including the armed forces and uniformed services;
- Persons in training (interns, apprentices and volunteers);
- Job applicants, job seekers, laid-off or suspended workers;
- Workers in both the public and private sectors and the formal and informal economies.

The Recommendation also defines "workplace" broadly, as "any place in which workers perform their activity."

Key principles of the HIV and AIDS Recommendation, 2010 (No. 200)

As mentioned previously, Recommendation No. 200 takes a rights-based approach to HIV and AIDS in the workplace. Its paragraph 3 on general principles provides that the HIV response contributes to the realization of human rights, fundamental freedoms and gender equality for all, not only for workers, but also for their families and their dependents. Recommendation No. 200 calls for the following key human rights principles to be integrated into legislation and rights-based workplace policies and programmes on HIV and AIDS:

- Recognition of HIV and AIDS as a workplace issue;
- No HIV-related stigma or discrimination in employment or occupation;
- Gender equality and women's empowerment;
- A safe and healthy work environment;
- Social dialogue;
- No mandatory HIV testing or screening for employment;
- Confidentiality of HIV-related information;
- The right to continue in employment, with reasonable accommodation if needed;
- Protection against unfair dismissal;
- HIV prevention as a fundamental priority;
- Equal access to treatment, care and support services; and
- Measures to protect workers from occupational transmission of HIV.

Other relevant international labour standards

In addition to Recommendation No. 200, there are other international labour standards that are relevant to HIV and AIDS in the workplace, providing for protection against discrimination in employment and safe and healthy working environments. Some of the most relevant standards include:

- The Discrimination (Employment and Occupation) Convention, 1958 (No. 111)
- The Occupational Safety and Health Convention, 1981 (No. 155)
- The Occupational Health Services Convention, 1985 (No. 161)
- The Termination of Employment Convention, 1982 (No. 158)
- The Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187) and its associated Recommendation (No. 197)
- The Social Protection Floors Recommendation, 2012 (No. 202)

It is useful for inspectors to be familiar with the key principles of these instruments, particularly where they have been ratified by the country concerned. (See list of relevant ILO Conventions and Recommendations at Appendix 3).

Points for discussion

1. Has your country adopted measures that integrate some or all of the key principles of Recommendation No. 200? What are these measures?
2. Are you familiar with national policies or strategies in your country that address HIV and AIDS and the rights of PLHIV? If so, which ones?
3. How do you see your role as labour inspector in addressing the following issues to which Recommendation No. 200 refers? Reflect on each of the following:
   a. Stigma and discrimination against people living with or affected by HIV in employment or occupation;
   b. Prevention of occupational risks;
   c. Social dialogue at the workplace level;
   d. Prevention of mandatory HIV testing or screening for purposes of access to or retention in employment;
   e. Unfair dismissal on the basis of real or perceived HIV status.

6. HIV-related stigma and discrimination

The 2012 PLHIV Stigma Index, a survey of the experiences reported by PLHIV in nine countries, showed persistently high levels of employment-related stigma and discrimination.[46] Similarly, a 2010 survey commissioned by UNAIDS measured HIV-related discrimination in the workplace in a range of countries, finding that from 13 to 29 per cent of workers would not be willing to work with an HIV-positive colleague.[47]

Labour inspectors can provide advice to both employers and workers' representatives to support the development and implementation of workplace policies and programmes that establish a culture of zero tolerance for HIV-related stigma and discrimination to support HIV prevention efforts.

Those living with or affected by HIV should be protected from both stigma and discrimination, phenomena that are linked, but nevertheless separate. This Chapter will introduce examples of national and regional court cases that illustrate the more common forms that HIV-related stigma and discrimination take in the workplace.

Stigma

HIV-related stigma is fuelled by fear and ignorance regarding the modes of HIV transmission as well as by cultural perspectives that associate HIV with "immoral" behaviours.[48] Stigma refers more generally to negative social attitudes directed at persons living with or associated with HIV.

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[46] Global Network of People Living with HIV (GNP+)/ILO, *Evidence brief on stigma and discrimination at work: Findings from the PLHIV Stigma Index* (Amsterdam, 2012), p. 12. The nine countries surveyed included: Argentina, Estonia, Kenya, Malaysia, Mexico, Nigeria, Philippines, Poland and Zambia.

[47] UNAIDS/Zogby International, *The Benchmark: What the world thinks about the AIDS response,* UNAIDS Outlook Report (Geneva, 2010).

[48] See United Nations Human Rights Council, *The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS)*, op. cit., para. 5.

While stigma is linked with discrimination, its effects are perhaps even more insidious. It takes many forms. People infected with or affected by HIV may be excluded from work-related social events, or may be made the subject of malicious gossip or harassment on the part of other co-workers. Managers or co-workers may isolate a colleague out of fear that shaking hands, sharing a drink or otherwise having social contact with the colleague could expose them to the virus. Stigma can have devastating effects on affected workers, influencing their morale, motivation, productivity, their mental and physical health and their livelihoods. It can also affect the organizational climate and ultimately socialization in the workplace, as it can foster a culture of non-inclusion and intolerance.

Discrimination

In contrast to stigma, discrimination generally takes the form of an act or omission. It can be a deliberate action, such as an employer's decision to refuse to hire or to terminate a worker on the basis of real or perceived HIV status. It may also be the exclusion of a certain group from a work-related benefit, such as a training opportunity or access to occupational insurance schemes.

Recommendation No. 200 defines "discrimination" with reference to ILO Convention No. 111 as:

> "[A]ny distinction, exclusion or preference which has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation, as referred to in the Discrimination (Employment and Occupation) Convention, 1958 (No. 111).[49]

Discrimination can be direct or indirect. There is direct discrimination where, in a comparable situation, a person is treated less favourably on the basis of real or perceived HIV status. For example, an HIV-positive job applicant may be denied employment following HIV screening as part of an employment interview, where the applicant may be asked about medication he or she is taking, marital status, or other elements aimed at determining HIV status. There may also be indirect discrimination where an apparent neutral provision or practice puts someone at a particular disadvantage compared to others, without a reasonable ground for the difference in treatment. For example, an internal regulation that provides for a bonus depending on the availability of workers to work overtime without taking into account the situation of those who cannot make themselves available due to sickness, parental obligations or other reasons could constitute indirect discrimination.

Discrimination need not be intentional. It is sufficient for the discriminatory act or exclusion to have the effect of impairing equality of opportunity and treatment.

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[49] See Paragraph 1 (e) of Recommendation No.200.

The following case provides an example of HIV-related stigma on the part of co-workers that prompted an employer's decision to dismiss an HIV-positive worker.

Council of Europe

European Court of Human Rights, *I.B. v. Greece*, Application No. 552/10, Judgement issued on 3 October 2013

The complainant was dismissed from his position in a jewellery business after testing positive for HIV. While the complainant was absent on sick leave, several of his co-workers, suspecting that he might have HIV, underwent HIV testing. The results were negative. Soon afterward, the complainant's co-workers learned that the complainant had tested HIV-positive. A group of co-workers immediately demanded that the employer remove him from the workplace. Approximately half the work force signed a petition urging that the complainant be removed. The employer ceded to the pressure placed upon her by her employees and dismissed the complainant. The Greek Cassation Court held that this action did not constitute discrimination, but was instead justified in the circumstances, given the pressure the employer was under and the danger posed to the smooth operation of the enterprise by the complainant's continued presence.

The European Court of Human Rights reversed the Greek Cassation Court's decision on the basis of the European Convention on Human Rights. The Court took up ILO Recommendation No. 200, referring extensively to the Recommendation's provisions on non-discrimination. The Court held that, by terminating the applicant's employment, the employer had further stigmatized a person who, even though he was HIV-positive, had shown no signs of illness. The Court also found that the co-workers' threats were irrational as they were based on no valid scientific theory. The Court held that if the applicant's HIV status was not disturbing the smooth operation of the enterprise (such as by preventing the employee from carrying out the duties of his job), his HIV status alone could not be a valid basis for terminating his employment.

Forms of HIV-related discrimination

Discrimination in employment and occupation can take many different forms, but typically occurs in three main settings:

- Pre-employment;
- During employment (in relation to terms and conditions of employment); and
- Unfair dismissal (including constructive dismissal).

Prior to employment, a job applicant may be rejected explicitly or implicitly because of real or suspected HIV status. An applicant may have disclosed his or her HIV-positive status to a prospective employer, resulting in denial of employment. An

applicant may also have been screened for HIV (screening can take place through discriminatory interview questions or through requiring applicants or employees to complete medical forms that ask for information aimed at determining whether the applicant may be living with HIV). Similarly, an applicant may have been required to take an HIV test as a pre-condition for employment.

Workers who are already in an employment relationship may also be subjected to discriminatory HIV testing. Employers may require workers to disclose their HIV status or fail to respect the confidentiality of an employee's medical data.

During the employment relationship, HIV-related discrimination may also take the form of less favourable terms and conditions of work, including:

- denial of training, advancement, or promotion opportunities;
- demotion;
- unequal remuneration;
- failure of an employer to maintain the confidentiality of an employee's personal medical data, including information regarding HIV status;
- a requirement that the employee disclose his or her HIV status or that of any other person;
- exclusion from medical or sickness benefits available to other employees in the workplace; and
- denial of reasonable accommodation necessary to enable the employee to manage HIV-related illness and continue in employment.

Finally, a worker may be unfairly dismissed on the basis of real or perceived HIV status. The dismissal may be the result of a decision taken by the employer, or the worker may be compelled to leave employment due to stigma and discrimination that creates an intolerable working environment (constructive dismissal).

Real or perceived HIV status

National legislation and policies may limit protection from employment-related discrimination to actual HIV status. In some cases, however, workers who are not HIV-positive may be stigmatized or subjected to discrimination because of their association with an HIV-positive person or for engaging in certain behaviours, such as in the case of sexual orientation discrimination.

The following decision of the Human Rights Tribunal of Ontario, Canada, provides an example of employment discrimination on the basis of perceived HIV status.

Canada

Human Rights Tribunal of Ontario/Tribunal des droits des personnes d'Ontario, *Giguere v. Popeye Restaurant*, Case No. 2008 HRTO 2, Judgement of 17 January 2008

The Ontario Human Rights Tribunal examined allegations of discrimination brought by a female worker who was HIV-negative. The complainant alleged that her employment as a waitress was terminated by her employer because her common law spouse was HIV-positive. The employer claimed that the HIV status of the spouse was known at the time that the complainant was hired and that the decision to terminate her was taken because of customer complaints related to the common law spouse's HIV status. The complaint alleged discrimination on the basis of disability (including perceived disability), association and marital status. The respondent employer and manager denied the allegations, claiming that the termination was the result of a business slowdown and financial difficulties. They claimed that customer complaints and the fact that the complainant's spouse was HIV-positive played no part in the decision.

The employer had provided the complainant with a written letter of termination, which stated:

"It is with regret that I must terminate your job due to complaints from customers of your possible contraction of the AIDS virus. The complaints were filed with me and some of your co-workers.

Some customers flat out told me that they would stop coming to the restaurant if you continued working for me.

Upon hiring you, yourself told me that your boyfriend soon to be husband was infected with the AIDS virus, and that you had been tested negative. Your honesty was greatly appreciated.

At the time I did not see this as a problem, unfortunately contrary to my beliefs, if this is going to affect business in this way, I have no other choice than to terminate your job".

The Tribunal noted that it was not disputed that the restaurant was indeed in financial difficulty. There was, however, no evidence that anyone but the complainant was terminated during the same period, nor was there any evidence that the restaurant had lost customers. The Tribunal concluded that the decision to terminate the complainant was primarily motivated by discrimination on the basis of her association with an HIV-positive person. On this basis, the Tribunal found that the employer had violated the Ontario Human Rights Code.

Denial of access to employment

Job applicants should not be denied access to employment on the basis of real or perceived HIV status alone. In the case of *Hoffmann v South African Airways (2000)*, a job applicant was denied employment as a cabin attendant due to his HIV-positive status.

Ruling in favour of the complainant, the South African Constitutional court emphasized the devastating impact of employment-related discrimination.

South Africa

Constitutional Court of South Africa, *Jacques Charl Hoffmann v. South African Airways*, Case CCT 17/00, Judgement of 28 September 2000

People who are living with HIV constitute a minority. Society has responded to their plight with intense prejudice. They have been subjected to systemic disadvantage and discrimination. They have been stigmatised and marginalised. As the present case demonstrates, they have been denied employment because of their HIV-positive status without regard to their ability to perform the duties of the position from which they have been excluded.

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The impact of discrimination on HIV-positive people is devastating. It is even more so when it occurs in the context of employment. It denies them the right to earn a living.

Denial of access to a specific occupation

While HIV-related discrimination can result in denial of access to a job, it may also result in denial of access to a specific occupation. For example, in the Hoffman decision cited above, the respondent employer argued that it was necessary for Hoffman to be HIV-negative to be able to carry out the duties of a cabin attendant. Specifically, the employer claimed that Hoffman would require a yellow fever vaccination and that his HIV-positive status would preclude him from obtaining the vaccine, while also making him more susceptible to illness. The court rejected this argument, noting that HIV status alone does not justify exclusion.

South Africa

Constitutional Court of South Africa, *Jacques Charl Hoffmann v. South African Airways*, Case CCT 17/00, Judgement of 28 September 2000

Fear and ignorance can never justify the denial to all people who are HIV-positive of the fundamental right to be judged on their merits. Our treatment of people who are HIV-positive must be based on reasoned and medically sound judgements. They must be protected against prejudice and stereotyping. We must combat erroneous, but nevertheless prevalent, perceptions about HIV. The fact that some people who are HIV-positive may, under certain circumstances, be unsuitable for employment as cabin attendants does not justify a blanket exclusion from the position of cabin attendant of all people who are HIV-positive." The Court further stated: on medical grounds alone, exclusion of an HIV-positive individual solely on the basis of HIV positivity cannot be justified…With effective treatment, they are capable of living normal lives and they can perform any employment tasks for which they are otherwise qualified." (para.14).

Mandatory HIV testing and screening

Some employers engage in the practice of mandatory HIV testing, particularly for access to certain occupations. In some circumstances, job applicants and workers may be tested for HIV without their knowledge or consent, violating their fundamental right to privacy and confidentiality. The 2012 decision of the Nigerian High Court is an illustrative example.

Nigeria

High Court of Lagos State, *Georgina Ahamefule v. Imperial Medical Centre*, Case No. ID/1627/2000, Judgement of 27 December 2012

The complainant was employed by the defendant medical centre (D1) as an auxiliary nurse since its establishment by the defendant physician (D2) in 1989. In 1995, while pregnant, she developed boils and sought treatment from D2. He carried out diagnostic tests, but did not disclose the nature or results of the tests to the complainant. Instead, she was placed on two weeks medical leave. D2 referred the complainant to a second hospital for further tests, where she and her husband were asked to provide blood samples. They were not told the reason for the request. Subsequently, the second hospital informed the complainant that she had tested positive for HIV. She was then terminated by the defendants. After suffering a miscarriage, she was denied medical care by the defendants due to her HIV status.

It was not disputed that the complainant was terminated due to her HIV-positive status; however, the defendants argued that the termination was justified because the complainant's status posed a risk to the staff and patients of the hospital. The Court rejected this argument, finding that, as an auxiliary nurse, the complainant did not pose a risk to either hospital staff or patients. The Court concluded, among other things, that the termination "was based on malice, done in bad faith and wrongful." The Court also held that the HIV testing without informed consent was a violation of her right to dignity.

HIV testing and public health

It may be assumed that requiring HIV testing before someone takes up employment protects both workers and the workplace. Apart from the human rights issues raised by the practice of mandatory HIV testing, particularly where workers may not even know they have been tested, there are many reasons why mandatory HIV testing protects neither the worker nor the enterprise:

- Workers are at no risk of HIV infection from casual physical contact with an HIV-positive colleague;
- The incubation period for HIV is between two weeks and six months (two to three months on average), so a negative test result may well be inaccurate;

- A job applicant or worker may be uninfected today but catch the virus tomorrow; therefore, mandatory HIV testing does not protect the public health; and
- In a working environment where the rights of HIV-positive persons are respected, employees are far more likely to seek voluntary testing and change their behaviour so that they take and cause fewer risks, and become advocates for HIV prevention.[50]

Recommendation No. 200 provides that HIV testing or other forms of screening for HIV should not be required of workers, including migrant workers, jobseekers and job applicants.[51] In addition, the results of HIV testing should be confidential and not endanger access to jobs, tenure, job security or opportunities for advancement.[52]

A number of countries have adopted national legislation prohibiting mandatory HIV testing for employment. Recommendation No. 200 also calls on governments to put in place easily accessible dispute resolution procedures to ensure redress for workers if these rights are violated.[53]

Where national legislation provides protections against mandatory HIV testing for employment, courts have upheld these protections. For example, on 22 February 2010, the Costa Rican Constitutional Court ruled that the National Rehabilitation Centre (CENARE) could not require job applicants to undergo HIV testing.[54]

In the case of *Gary Shane Allpass v. Mooikloof Estates (PTY) LTD and Mooikloof Equestrian Centres,* the South African Labour Court held that requiring an HIV-positive worker to respond to job interview questions regarding his sexual orientation and fill out a written form inquiring whether he was taking medication for any chronic medical condition could be deemed to constitute discriminatory screening.[55]

Promotion of voluntary HIV counselling and testing

While Recommendation No. 200 and the ILO Code of practice call for protections against mandatory HIV testing, both encourage voluntary counselling and testing (VCT). VCT is not only a diagnostic tool; it is also an essential component of a comprehensive strategy for preventing HIV and AIDS. Therefore, the Recommen-

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[50] ILO, *The Impact of Employment on HIV Treatment and Adherence* (Geneva 2013).

[51] Recommendation No 200, para. 25.

[52] Ibid, para. 26.

[53] Ibid, para. 29.

[54] Supreme Court of Costa Rica/La Corte Suprema de Justicia de Costa Rica, *XX v. Centro Nacional de Rehabilitación (CENARE),* Case No. 09-007890-0007-CO, Judgement of 29 January 2010 (available on the accompanying CD).

[55] South African Labour Court, *Gary Shane Allpass v. Mooikloof Estates (Pty) Ltd and Mooikloof Equestrian Centre,* Case No. JS178/09, Judgement of 16 February 2011(available on the accompanying CD).

dation calls for workplace prevention programmes to "encourage workers to know their own HIV status through voluntary counselling and testing."[56]

VCT empowers people to know their own HIV status so that they can take preventive measures or seek treatment if needed. The workplace can facilitate access to integrated health services for prevention, treatment and care for workers affected by HIV or AIDS, particularly by referring them to existing services.

Recommendation No. 200 calls for HIV testing to be "genuinely voluntary and free of any coercion" and for testing programmes to "respect international guidelines on confidentiality, counselling and consent".[57] Voluntary HIV counselling and testing not only protects the health of the workers concerned, it also helps to prevent the spread of HIV in that, if an HIV-positive person tests early and is placed on anti-retroviral therapy, his or her viral load will decrease, thereby decreasing the risk of further HIV transmission.

Confidentiality of HIV-related information

Employers have an obligation to respect workers' privacy and maintain the confidentiality of personal information, including medical data, relating to the HIV status of workers, their families and dependents. In addition, workers should not be required to disclose information regarding their own HIV status or that of any other person. The ILO has developed a code of practice addressing workers' rights to protection of their personal information.

An ILO code of practice: Protection of workers' personal data (1997):

Section 5.11

Employers, workers and their representatives should cooperate in protecting personal data and in developing policies on workers' privacy consistent with the principles in this code.

Section 5.12

All persons, including employers, workers' representatives, employment agencies and workers, who have access to personal data, should be bound to a rule of confidentiality consistent with the performance of their duties and the principles in this code.

Section 5.13

Workers may not waive their privacy rights.

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[56] Recommendation No. 200, para. 16 (d).

[57] Ibid., para. 24.

Where privacy rights are not respected, HIV-positive workers can be subjected to stigma and discrimination which may ultimately force them into resigning from their employment. The Canadian Human Rights Tribunal decision of *Fontaine v. Canadian Pacific Ltd*. provides an example of the harm that can be caused by a breach a of confidentiality.

Canada

Canadian Human Rights Tribunal/Tribunal canadien des droits de la personne, *Fontaine v. Canadian Pacific Ltd.*, Case No. TD 14/89, Judgement of 25 September 1990

Gilles Fontaine, an HIV-positive man, was hired by the Canadian Pacific Railroad to work as a cook for a railroad crew of close to 20 men in a camp in Saskatchewan, Canada. When he disclosed his HIV-positive status to a member of the crew, the news spread rapidly. The crew supervisor's reaction to the disclosure contributed to a hostile working environment. He refused to eat breakfast that morning, communicating in this manner to the rest of the crew that they could be at risk if they ate the meal that Fontaine had prepared for them. The supervisor also expressed concern for Fontaine's safety, implying that the crew would have a violent reaction to the news that he was HIV-positive. These actions created such a hostile atmosphere that Fontaine quickly decided that he could no longer remain in the camp. The Canadian Tribunal found that, although Fontaine had not been officially terminated, in fact the hostile atmosphere had the same result, leading to Fontaine's constructive dismissal due to HIV-related discrimination.

Discrimination in access to social protection

PLHIV may be excluded from coverage under employment–related health care and insurance plans (health, disability and life insurance). Recommendation No. 200 provides that workers living with HIV and their dependants should benefit from full access to health care, whether this is provided under public health, social security systems, private insurance or other schemes.[58] In addition, paragraph 20 of the Recommendation provides that there should be no discrimination based on real or perceived HIV status in access to social security and occupational insurance systems or benefits under those systems, including health, death, disability and survivor's benefits.

Unfair dismissal

One of the more common forms of HIV-related discrimination is unfair dismissal, which results in loss of income and livelihood for the worker concerned, but may also result in loss of access to employment-related health benefits for the worker, his or her family and dependents. Recommendation No. 200 provides that real or

[58] Recommendation No. 200, paras. 17-19.

perceived HIV status should not be a cause for termination of employment.[59] A number of countries have adopted legislation providing protection against unfair dismissal on the basis of real or perceived HIV status.

The South African Labour Court decision in *Gary Shane Allpass v. Mooikloof Estates (Pty) Ltd*, examined the issue of unfair dismissal on the basis of HIV status.

South Africa

South African Labour Court, *Gary Shane Allpass v. Mooikloof Estates (Pty) Ltd and Mooilkloof Equestrian Centre*, Case No. JS178/09, Judgement of 16 February 2011

Allpass was employed by Mooikloof Estates as a horse riding instructor and stable manager on 1 November 2008. At the time of his recruitment, he had been living with HIV for almost 20 years. Prior to being hired, Allpass underwent an interview, during which he informed the employer that he was "in good health". Shortly after his hiring, Allpass was asked to complete a form requiring him to disclose whether he was taking any "chronic medication." He complied and disclosed that he was taking, among other things, daily medication to manage his HIV condition. Upon learning of his HIV-positive status, the manager immediately fired Allpass on the grounds that he had fraudulently misrepresented his condition and that he was in fact "severely ill". In addition to the allegations of discrimination and wrongful dismissal, Allpass, who resided on the employer's estate as part of the terms and conditions of his employment contract, alleged that he had been insulted, manhandled and physically evicted from the estate.

The Court found that Allpass had been discriminated against and unfairly dismissed due to his HIV status and awarded him twelve months' pay in compensatory damages and costs. The Court considered that the dismissal violated the equality rights set out in section 9 of the Constitution of the Republic of South Africa Act, No. 108 of 1996. The Court also considered that the dismissal violated the Labour Relations Act, No. 66 of 1995 and the Employment Equity Act, No. 55 of 1998.

In the case of *XX v. Gun Club Corporation, et al.*, the Constitutional Court of Colombia reviewed a claim of unfair dismissal on the basis of HIV status.[60] The Court found that the claimant, an employee of the Gun Club Corporation, was ordered to undergo an HIV test by the employer's physician. When he tested positive, the claimant was immediately dismissed. Finding in favour of the claimant on the basis that the dismissal was discriminatory, the Court also noted the physician's disclosure of the worker's HIV status to the employer. It ordered that a copy of its judgement be transmitted to the national medical review board.

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[59] Ibid., para. 11.

[60] Constitutional Court of Colombia/Corte Constitucional de Colombia, *XX v. Gun Club Corporation et al.*, Case No. SU-256/96, Judgement of 30 May 1996 (available on the accompanying CD).

Reasonable accommodation and the right to continue in employment

Paragraph 11 of the Recommendation provides that real or perceived HIV status alone is not a valid reason to justify termination of employment. In addition, paragraph 13 of the Recommendation provides that workers with HIV-related illness should not be denied the possibility of continuing to carry out their work, with reasonable accommodation if necessary, for as long as they are medically fit to do so.

There are many reasonable measures that employers can take to accommodate workers with HIV-related illness, including providing a modified working schedule or duties, training and/or redeployment. Workers affected by HIV, perhaps due to caretaking duties for an HIV-positive relative or dependent, could be accommodated by unpaid leave or flexible hours, where this is reasonable. Employers may, however, justify a decision to dismiss a worker on the grounds that the worker can no longer perform the essential tasks of his or her job. The dismissal must be based on objective scientific and medical evidence and observe applicable procedural safeguards, such as the appropriate consultation and discussion procedures normally followed in the workplace. The following judgement of the Botswana Industrial Court is illustrative.

Botswana Industrial Court, *Monare v. Botswana Ash (Pty) Ltd*, Case No. 112 of 1998, Judgement of 28 March 2004

The applicant was employed in 1991 as a personnel officer in charge of industrial relations. In 1993, the company doctor became aware that the applicant was HIV-positive. In 1997, the applicant's health deteriorated and early symptoms of AIDS appeared. A further medical report confirmed that the applicant was in fact very ill. From July 1997, the applicant was hospitalized on different occasions. He was therefore absent from work for seventy days, i.e., until December 1997. When he came back to work in January 1998, he was only present for eight working days and was then off sick for sixteen days. At the end of January 1998, the applicant faxed his employer a sick leave note explaining that he would be off sick for the whole month of February. The employer terminated the applicant's employment on 5 February 1998.

The Court found that, even though the employer was aware of the applicant's HIV status since 1993, it did not terminate his employment while the applicant could still carry out his duties. The Court further noted that, since the applicant became ill, the employer had provided him with accommodation and transportation to the hospital, paid for his medical fees and made sure that he received the best medical care. Also, even though the applicant had overstepped his sick days' quota by fifty-two days and was at times only working half days, the employer paid him his full salary every month.

The Court referred to article 4 of ILO Convention No. 158 of 1982 which states that: " [t]he 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". The Court found that, since the applicant was very ill, he was not able to perform his duties anymore and his work was subsequently suffering from his absenteeism. In the circumstances, and taking into account the steps taken previously by the employer to accommodate his illness, the Court concluded that the termination was fair.

Key groups and employment discrimination

Certain key groups, such as men who have sex with men (MSM), sex workers or injecting drug users (IDUs), are deemed to be "at-risk" populations when they engage in behaviours or lead lifestyles that place them at higher risk of exposure to HIV. There are other groups that, due to socio-economic and cultural factors, may be more vulnerable to HIV than others, including children and young persons, women, migrant workers, persons with disabilities, refugees and internally displaced persons.[61]

Members of key groups are often subjected to multiple layers of stigma and tend to experience higher levels of discrimination than others, especially when they are also HIV-positive.[62] As a result, they often encounter barriers to accessing health services, education and employment opportunities. These barriers undermine effective HIV prevention efforts, especially in countries with concentrated epidemics where HIV prevalence rates are much higher in certain key groups, such as MSM or transgender persons, than in the general population. Two examples are set out below.

Sexual orientation

Stigma and discrimination in employment on the basis of sexual orientation is widespread. Workers may be subject to discrimination on the basis of their sexual orientation alone or discrimination may be linked with real or presumed HIV status.[63]

A number of countries have adopted legislation containing explicit protections against discrimination on the basis of sexual orientation. For example, the constitutions of South Africa and Ecuador prohibit such discrimination.[64]

The right to be free of discrimination on the basis of sexual orientation includes the right to privacy.

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[61] See also UNAIDS, *UNAIDS Terminology Guidelines,* Revised Version (Geneva, 2011), p. 30.

[62] See UNAIDS, *The Gap Report*, op.cit.

[63] Office of the United Nations High Commissioner for Human Rights (OHCHR), *Born free and equal: Sexual orientation and gender identity in international human rights law* (Geneva, 2012).

[64] See section 9, subsection 3 of the Constitution of the Republic of South Africa, No. 108, of 1996, as amended; See also Article 11, subsection 2 of the Constitution of the Republic of Ecuador, 2008.

United Kingdom

European Court of Human Rights, *Smith and Grady v. United Kingdom*, Application nos. 33985/96 and 33986/96, Judgement of 27 September 1999

The Royal Air Force had, at the time, a policy against hiring homosexuals. It carried out investigations concerning the homosexuality of a female and a male employee. They were both subsequently dismissed. They brought a complaint alleging that they had been dismissed on account of their sexual orientation, violating their right to private life under article 8 of the European Convention on Human Rights. The Court held that the investigation was a violation of the right to private life.

Gender identity and gender expression

Transgender persons, particularly male-to-female, face especially high HIV-related risks and vulnerabilities. They are often victims of the harshest forms of discrimination and stigma due to the ways they express their gender identity. According to the International HIV/AIDS Alliance, transgender persons often face abuse and violence. More than 1,123 transgender persons were murdered in 57 countries for reasons linked to their gender identity from 2008 to 2012.[65]

South Africa

South African Labour Court, *Christine Ehlers v. Bohler Uddeholm Africa (PTY) Ltd*, Case No. JS 296/09, Judgement of 13 August 2010

The complainant, a transsexual woman, brought a claim of unfair dismissal against her employer, alleging that she had been dismissed due to her gender identity.

Commenting on the facts of the case, the Labour Court noted: "This case shows what discriminated people undergo daily in the workplace. It is a sad indictment to our society that despite our discriminatory past and all the non-discriminatory laws that we have in place, discrimination in the workplace still thrives. The applicant is one such victim. Not only did she suffer discrimination and rejection in her family, but was also subjected to ridicule by some of her colleagues. Some people believed that they had the right to call her names simply because she was different. This is a rather sad state of affairs. She excelled in her workplace. She was the best. I do not understand why her changed gender would now affect her performance." The Court found in favour of the complainant, holding that the employer had unfairly discriminated against her on the grounds of her sex and gender, in violation of Article 9 of the South African Constitution and section 51.2 of the Labour Relations Act. The Court ordered that the complainant be reinstated and that the employer take measures to prevent similar discrimination from reoccurring in the future, in addition to tendering a written apology to the complainant.

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[65] United Nations Human Rights Council: *The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS)*, op.cit; see also TVT research project (2013) "Trans Murder Monitoring results: TMM March 2013 Update".

South Africa

South African Labour Court, *Quinton Atkins v. Datacentrix (PTY) Ltd*, Case No. JS 02/07, Judgement of 2 December 2009

The complainant accepted the respondent's offer of employment following a successful interview. Subsequently, he informed his employer that he intended to undergo a gender-reassignment process to change his sex from male to female. The respondent then terminated the complainant's employment on the grounds of misconduct, stating that the complainant had failed to disclose a material fact during the job interview. The Court rejected the respondent's argument that the complainant had been dishonest, noting that he was under no legal duty to have informed the respondent that he wished to undergo a gender reassignment. Noting that the claim raised issues of discrimination under both sex and gender, the Court concluded that the complainant had been discriminated against. It awarded compensation for unfair dismissal in violation of the Equality Clause in Section 9 of the South African Constitution, the Employment Equity Act, No. 55 of 1998 and the Labour Relations Act, No. 66 of.1995.

A number of countries have adopted legislation establishing the right to gender identity. For instance, on 9 May 2012, Argentina adopted a Law on the Gender Identity of Persons. In 2009, Uruguay adopted Law No. 18.620 on the Right to Gender Identity and to Change of Name and Sex on Identity Documents. On 15 March 2011, Portugal adopted Law No. 7/2011 providing for the right to gender identity and name change.[66] (For further discussions regarding gender, please see Chapter 7.)

Economic sectors at higher risk

Many workers are engaged in occupations that place them at a higher risk of HIV infection. For instance, health care workers may be exposed to needles carrying infected blood. Other workers may have jobs requiring them to work in isolated and confined situations, or to live far from their families and in segregated employer-provided housing, such as seafarers, or workers in the mining and construction sectors. Mobile workers, such as long-distance truck drivers, are vulnerable, as they are frequently far from home for extended periods and may engage in unprotected sex with casual partners or seek the services of sex workers, a group that is also at particular risk of HIV transmission. For this reason, Recommendation No. 200 calls for workplace policies and programmes on HIV and AIDS to take the characteristics of the labour force into account in addressing the needs and concerns of the target population.

[66] Copies of these laws are available at http://www.ilo.org/aids/legislation/lang--en/index.htm

Points for discussion

1. Are there protections against employment discrimination on the basis of real or perceived HIV status in your country? What form do these protections take?
2. How would you identify HIV-related discrimination in the workplace? What elements would you take into consideration?
3. Are you aware of any instances where labour inspectors (or labour courts) in your country have addressed HIV–related discrimination?

7. Gender equality and the HIV epidemic

Recommendation No. 200 stresses the importance of recognizing and addressing the gender dimensions of the HIV epidemic, including employment discrimination, gender-based violence and harassment at work. Gender equality and women's economic and social empowerment is vital to reducing the vulnerability of women and girls to HIV infection and to reduce the impact of the epidemic on their lives both at home and at work.

The Preamble to the Recommendation notes that:

> *HIV affects both men and women, although women and girls are at greater risk and more vulnerable to HIV infection and are disproportionately affected by the HIV pandemic compared to men as a result of gender inequality, and that women's empowerment is therefore a key factor in the global response to HIV and AIDS.*

Gender inequalities affect many aspects of women's lives, impairing equitable access to education and vocational training as well as equality of opportunity and treatment in paid work. Gender inequalities are also linked to increased exposure to gender-based violence and harassment. At the same time, stereotyped gender roles also increase the risk of HIV infection for men and boys, by encouraging risky behaviours.

UNAIDS, *Global Report: UNAIDS Report on the Global AIDS Epidemic*, 2012 (at page 66):

"Because of social and economic power imbalances between men and women and the associated limitations in access to services, many women and girls have little capacity to negotiate safe sex, insist on condom use or otherwise take steps to protect themselves from HIV.

Gender norms also increase men's vulnerability to HIV, encouraging high-risk behaviour and deterring them from seeking sexual health services or acknowledging their lack of knowledge about HIV. In addition, stigma and discrimination against transgender people render them highly vulnerable to HIV and impede their access to HIV services and secure livelihoods."

Promoting gender equality through targeted workplace actions facilitates the development of effective strategies that address the needs and concerns of both women and men in order to reduce their vulnerability to infection and help those infected to cope with the virus. Labour inspectors can play a vital role in providing guidance to employers and workers to support the development and implementation of effective workplace measures. Recommendation No. 200 provides concrete guidance on measures to be taken with the aim of reducing HIV vulnerabilities for both women and men.

Recognizing the need to address the gender dimensions of the HIV epidemic, Paragraph 14 of the Recommendation contains specific provisions calling for measures to be taken in the workplace to prevent HIV transmission and reduce its impact by, among other things:

- ensuring gender equality and the empowerment of women;
- preventing and prohibiting harassment and violence at work;
- involving men and women workers in the HIV response;
- empowering all workers in the HIV response regardless of sexual orientation;
- safeguarding sexual and reproductive health and rights; and
- ensuring the confidentiality of personal medical data.

The distinction between sex and gender

While this Chapter focuses on the issue of equality between women and men workers, the gender dimensions of the epidemic extend beyond male-female issues. For example, key vulnerable and at-risk groups in many national epidemics include MSM, transgender and transsexual persons. In addition, discrimination on the basis of sexual orientation and gender identity is prevalent in many countries and is often linked to HIV-related discrimination. Before turning to the issue of inequalities between men and women, it may be useful to distinguish between the concepts of "sex" and "gender":

- ➢ "Sex" refers to the biological and universal physical attributes of males and females.
- ➢ "Gender" refers to the socially-constructed roles, responsibilities and power relations between women and men and girls and boys, which are based on their sex. The concept of gender also captures norms, beliefs and practices regarding what are considered as "male" and "female" behaviours.[67]

[67] ILO, *Guide to mainstreaming gender in workplace responses to HIV and AIDS* (Geneva, 2011), p. 5.

➢ The concept of gender also includes transgender persons. This group includes men and women who may identify with a gender that does not correspond to their sex at birth. Their gender identity may therefore place them into conflict with the accepted gender norms in the society and culture in which they live. Discrimination on the basis of sexual orientation or gender identity is frequent and transgender persons often face harassment and violence, including in workplaces.[68]

Women and girls

In sub-Saharan Africa, the region most affected by the HIV epidemic, more women than men are living with HIV. According to the UNAIDS Global Report (2013), approximately 58 per cent of those living with HIV in this sub-region are women.[69] Young women (15-24) in this sub-region are twice as likely to be infected with HIV as young men.[70]

Biological risk factors

From a biological perspective, women and girls are more vulnerable to HIV infection than men and boys. The epidemic in women is overwhelmingly heterosexual, with the vast majority of women living with HIV having been infected through unprotected sex with a male partner. Women's biological vulnerability is due to the larger mucosal surface area of the vagina. Micro lesions can occur in the vaginal walls that provide entry points for the virus. The risk of such lesions is increased in cases of coerced sex or sexual assault. In addition, the mucous membranes lining the cervix and uterine walls have only a very thin layer of cells and more easily allow transmission of the virus.[71]

Another risk factor is that there is more HIV virus found in sperm than in vaginal secretions. Women are exposed to greater amounts of sperm during sex if ejaculation occurs. [72] This increased biological risk of HIV infection faced by women and girls is compounded by gender inequalities that in many countries place them in subordinate roles, both in larger society and in individual relationships, and expose them to a higher risk of sexual assault and violence.

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[68] See UN Economic and Social Council, Committee on Economic, Social and Cultural Rights, *General Comment No. 20: Non-discrimination in Economic, Social and Cultural Rights (art. 2, para.2),* Forty-second session, Geneva, 25 May 2009, E/C.12/GC/20, para. 32.

[69] UNAIDS, *Global Report* 2013, op.cit, p. 66.

[70] Ibid, at p. 17.

[71] National Institute of Allergy and Infectious Diseases, *HIV Infection in Women: An Overview*, 2008.

[72] WHO, *Women and HIV/AIDS*, Fact Sheet No. 242, June 2000.

Mother-to-child transmission

Unless women living with HIV receive timely and appropriate treatment, they risk transmitting the virus to their children during pregnancy, birth and breastfeeding. Yet mother-to-child transmission is fully preventable. Gender inequalities can pose significant barriers, however, that may prevent women from accessing needed treatment to prevent mother-to child transmission.

Subordination in sexual relationships

Societal gender norms related to "feminine" and "masculine" behaviours affect whether and how women and men access HIV information and services, their sexual behaviours and how they cope with HIV infection. Subordination in marriages or relationships reduces the ability of women and girls to protect themselves from HIV infection by negotiating condom use or refusing sex, especially unprotected sex. They face increased violence at the hands of their partners for requesting condom use, accessing voluntary HIV testing and counselling, or refusing sex within or outside marriage.[73] Harmful traditional practices in certain countries such as inter-generational marriage, wife inheritance and widow cleansing also facilitate the spread of HIV.[74]

Barriers in accessing health services

Traditional gender roles that encourage women's dependence on men, both socially and economically, may deter women from accessing HIV-related health services. Studies among women in sub-Saharan Africa showed that fear of a partner's negative reaction, including abandonment, violence, rejection, loss of economic support and accusations of infidelity were the most commonly reported barriers to HIV testing and disclosure of HIV status.

Inequalities in employment and occupation

Gender inequality in employment contributes to women's economic disadvantage. For example, women are more likely to be unemployed. They predominate in part-time and informal employment, spend more time in unpaid caregiving and earn less than men for work of equal value.[75] Women may be discriminated against due to pregnancy or as a result of their family responsibilities, resulting in diminished access to jobs or job loss. Accepted gender roles in many societies also effectively

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[73] UNAIDS, *Reducing HIV Stigma and Discrimination: a critical part of national AIDS programmes,* A resource for national stakeholders in the HIV response, December 2007, p. 12.

[74] See UN Human Rights Council, *The protection of human rights in the context of human immunodeficiency virus (VIH) and acquired immune deficiency syndrome (AIDS)*, op. cit., paras.30 through 34.

[75] UN Women/ILO, *Decent Work and Women's Economic Empowerment: Good Policy and Practice*, Policy Brief, New York, 2012.

exclude women and girls from access to certain occupations (just as they may dissuade men and boys from training for and accessing certain jobs or occupations).

Inequitable legal frameworks

Discriminatory laws and practices with regard to land ownership, inheritance, marriage and divorce increase the economic marginalization of women and can deter them from leaving abusive relationships. Where women have limited options to support themselves, they are more likely to remain in relationships where they have little or no ability to negotiate safer sex, particularly condom use. Research on impoverished communities in different regions around the world suggests that women take high sexual risks in favour of ensuring a livelihood for themselves and their families.[76] Some may be compelled to engage in unprotected transactional sex in exchange for money, food or shelter or remain in abusive relationships because they have no other economic options to support themselves or their children.[77]

Botswana

High Court of Botswana at Gaborone, EMM, *BM, JL and MKN v. MSR*, Case No. MAHLB-000836-10, Judgement of 12 October 2012

The Court examined the issue of inheritance rights under customary law, which prohibited women from inheriting the family home. This customary law meant that a woman could become homeless on the death of her parents or spouse. The case was brought by three elderly sisters who lived in the family home. Upon the death of their father, a half-nephew (the son of a half-brother of the sisters) claimed the right to inherit the property. The sisters argued that they should be allowed to inherit the family home rather than ceding it to the nephew. The Court held that the application of the customary law rule to qualify only the last-born son as an intestate heir to the exclusion of his female siblings violates Section 3 of the Constitution of Botswana, which provides for the right to equal protection under the law. In its findings, the Court considered national law, comparative judgements from other African jurisdictions and international instruments signed or ratified by Botswana, including the Universal Declaration of Human Rights and the United Nations Convention on the Elimination of All Forms of Discrimination against Women.

Men and boys

In certain regions, such as Central America, men have significantly higher HIV prevalence rates than women. HIV prevention programmes, including in work-

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[76] M. Gysels, R. Pool and B. Nnalusiba (2002) "Women Who Sell Sex in a Ugandan Trading Town: Life Stories, Survival Strategies and Risk", *Social Science and Medicine*, 1982, No. 54(2), pp. 179–192.

[77] *See* The International Association of Women Judges (IAWJ), *The Gender and Legal Dimensions of HIV/AIDS: Women's Access to Justice and the Role of the Judiciary*, 21 June 2005.

places, must take the needs and concerns of men and boys into consideration in developing effective information and education and behaviour change programmes to reduce prevalence rates among this population.

Risk-taking behaviours

Gender-based attitudes and behaviours may increase the vulnerability of men and boys, primarily by encouraging behaviours that expose them to the risk of HIV infection. Perceptions regarding "masculine" behaviours often encourage men and boys to demonstrate their virility through risk-taking behaviours, which may include unprotected sex with multiple sexual partners. These behaviours increase their risk of HIV infection.[78] Gender-based expectations also make it more difficult for men and boys to seek information about HIV and AIDS, limiting their access to prevention information, including information on the use of condoms for HIV prevention.

Barriers in accessing health services

While women and girls face barriers to accessing health services due to inequality, gender-based attitudes also deter men from accessing needed health services, including HIV testing and treatment.

UNAIDS, *Global Report: UNAIDS Report on the Global AIDS Epidemic*, Geneva, 2012 (at page 67):

"[G]ender norms of masculinity discourage men from seeking help and admitting ill health. Men have consistently lower rates of HIV testing than do women….[Their] disproportionately poorer access to antiretroviral therapy has been documented across southern Africa and in numerous other countries, including Kenya, Malawi, South Africa and Zambia."

Gender-based violence

Gender inequality and violence against women are closely linked. Inequalities facilitate gender-based violence, while violence in turn reinforces existing inequalities. Physical, sexual and psychological violence, including rape, sexual abuse, sexual harassment and other forms of gender-based violence also increase women's risk of exposure to HIV. Gender-based violence can occur within the workplace and/or the private sphere. Studies have shown that up to 40 to 50% of women in the European Union and 30 to 40% of women in Asia-Pacific countries have

[78] A. Cruz and S. Klinger, *Gender-based violence in the world of work: Overview and selected annotated bibliography*, ILO, Bureau for Gender Equality, Working Paper 2011/3, 2011, p. 21.

reported experiencing unwanted sexual advances, physical contact, verbal suggestions or other forms of sexual harassment at their workplace.[79] Men also encounter workplace harassment.[80]

Gender-based violence impacts workers through reduced motivation, loss of self-esteem and increased health and safety risks. These impacts in turn affect employers through decreased productivity, increased absenteeism and increased healthcare costs.

Domestic violence can also impact the workplace:

- 37% of women who experienced domestic violence reported that it had a negative impact on their job performance, including tardiness, absenteeism, decreased job retention and career advancement;
- women who had recently experienced domestic violence lost 26% more work time due to absenteeism and lateness than non-victims;
- a quarter of the 1 million women who are stalked each year report absenteeism as a consequence, missing an average of 11 days of work;
- 41% of perpetrators of violence are found to have job performance issues and 48% reported having difficulty concentrating as a result of their abusive behaviours.[81]

Gender-based violence and harassment should therefore be considered as a critical workplace issue and be addressed as any other occupational health and safety issue.[82]

ILO action to promote gender equality and women's empowerment

The principle of equality between men and women was affirmed in the ILO's founding document: its 1919 Constitution. Since then, the concept of equality between men and women has continued to change and evolve. For example, in the early 1900s, women were perceived as more fragile than men and therefore unsuitable for certain types of work or certain occupations, particularly in light of their reproductive functions. Thus, the first international standards took a protective stance toward women in employment and occupation. Examples of this protective approach include the Night Work (Women) Convention, 1919 (No. 4), followed by the Night Work

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[79] United Nations Secretary General's Campaign, UNITE: To End Violence Against Women, November 2011.

[80] ILO, *Sexual Harassment at Work Fact Sheet, Declaration on Fundamental Principles and Rights at Work, Work in Freedom* (Undated).

[81] Pennsylvania Coalition Against Domestic Violence, *The impact of Domestic Violence on the Workplace*,; National Coalition Against Domestic Violence, *Domestic Violence in the Workplace* (undated).

[82] ILO, *Guide to mainstreaming gender in workplace responses to HIV and AIDS*, op. cit.

(Women) Convention (Revised), 1934 (No. 41) and subsequently the Night Work (Women) Convention (Revised), 1948 (No. 89), which prohibited night work for women in industry. Subsequently, the 1990 Protocol provided for exemptions to the prohibitions on night work for women contained in Convention No. 89. The new Night Work Convention, 1990 (No. 171) now provides protections for both men and women against the dangerous effects of night work.

In the 1950s, after the Second World War, there was a progressive shift away from the notion that women required protection from workplace hazards and toward promotion of equality of opportunity and treatment for both men and women workers. The ILO adopted two key equality Conventions during this decade:

- The Equal Remuneration Convention, 1951 (No. 100), which established the principle of equal pay for men and women workers for work of equal value; and
- The Discrimination (Employment and Occupation) Convention, 1958 (No. 111), which established and defined the principle of non-discrimination in employment and occupation on seven grounds, including sex (interpreted to include sexual harassment and pregnancy discrimination).

Convention No. 111 covers equal access to vocational training (including education), access to employment and occupation, and equality in terms and conditions of employment, including protection from unfair dismissal. These two Conventions are among the eight "fundamental" human rights Conventions of the ILO and are among the most widely ratified of all ILO instruments.

More than two decades later, the Convention on Workers with Family Responsibilities, 1981 (No. 156) recognized the changing roles of men and women in society and in the family, providing protections from discrimination for both men and women workers with family responsibilities. Maternity protection has also continued to be a critical issue in the context of gender equality. The most recent Convention adopted by the ILO on this issue is the Maternity Protection Convention, 2000 (No. 183).

Gender, sex and pregnancy discrimination

Gender beliefs and attitudes affect workplace hierarchies and processes, given that people bring their cultural assumptions about gender to work with them. Gender norms often influence the assignment of tasks, responsibilities and positions in the workplace, particularly in cultures where certain roles are perceived as more appropriate for men than for women, or vice versa.

Discrimination on the basis of sex and pregnancy is still a common problem faced by many women. Sex discrimination may be compounded by an HIV-positive diagnosis, as shown by the following decision of the Industrial Court of Kenya.

Kenya

Industrial Court of Kenya at Nairobi, *Veronica Muthio Kioka v. Catholic University of Eastern Africa*, Case No. 1161 of 2010, Judgement of 8 November 2013

The Claimant, Ms. K., was employed as a telephone operator on a casual basis, while her two male counterparts hired at the same time were employed on a permanent basis. When she applied for a new position, she was asked to undergo a medical examination. An HIV test was performed. She later learned from the employer's physician that she was HIV-positive. She was not informed that she was going to be tested for HIV nor did she receive any pre- or post-counselling. After her diagnosis, Ms. K. received no information regarding the new position, and continued working on a casual basis, earning up to 4.2 less than her male colleagues. When she asked, she was refused a permanent contract. Ms. K. was informed that she was denied permanent employment and benefits due to her HIV status. She continued to work with no medical or other benefits. When she became pregnant, she did not receive any salary corresponding to her maternity leave and was kept on a casual basis when she returned to work. Ms. K. then received a letter of termination from her employer stating that her employment contract had not been renewed six months earlier. She was therefore dismissed.

The Court held that employees or prospective employees may not be deemed to be medically unfit solely on the basis of their HIV status. The Court found that Ms. K. had been discriminated against on the basis of her gender, having been denied equal remuneration for work of equal value, as well as maternity benefits. The Court also found that Ms. K. had been discriminated against on the basis of her HIV status. The discriminatory acts carried out by the employer included: refusing her recruitment on a permanent basis due to her HIV status, undertaking HIV testing without her knowledge or consent, not providing pre- and post-counselling and breaching her privacy rights by disclosing her HIV status. The Court held that the employer had violated national law and cited the principles of the HIV and AIDS Recommendation, 2010, No. 200. The Court awarded her damages, including compensation for unlawful and unfair termination and exemplary damages for discrimination and gross violation of her dignity.

Identifying and addressing the gender dimensions of the epidemic at work

As this Chapter has shown, addressing the HIV epidemic at work also implies addressing gender inequalities in the workplace. In collaborating with employers and workers to assist them in developing HIV workplace policies and programmes, labour inspectors can recommend inclusion of workplace measures to ensure greater gender equality and the active engagement of both women and men in HIV prevention. In their workplace visits, labour inspectors can identify whether or not indicators are present that suggest areas of focus for workplace programmes to address gender equality in the HIV context. To this end, inspectors can:

- determine whether there is a written policy of equality of opportunity and treatment at the workplace and whether mechanisms exist to monitor and apply this policy;
- determine whether there is a written policy prohibiting sexual harassment at work and whether or to what extent it has been applied;
- determine whether policies and practices in place afford equal treatment for both women and men workers with family responsibilities;
- enquire whether the workplace provides training or information through other means to its employees, including its management employees, to increase awareness of gender-related issues;
- assess whether and to what extent women occupy decision-making positions at the workplace;
- determine the proportion of women and men who are given opportunities for training or advancement; and
- review hiring and career advancement patterns to determine whether women are accorded equality of opportunity in all categories and at all levels in the workplace.

If, for example, women are relegated to lower-level administrative roles and are not represented in positions of decision-making authority, this may be indicative of discriminatory hiring and promotion practices. If such a pattern is present, inspectors may wish to encourage the employer to recruit qualified women and to aim for a more equal distribution of women at all levels of the enterprise, particularly in decision-making positions.

Labour inspectors can also act to promote equality between women and men workers in terms and conditions of employment by verifying that women and men receive equal remuneration for work of equal value and enjoy equal access to employment–related benefits, including occupational insurance schemes. In their enforcement role, inspectors can help to challenge inequalities and promote gender equality by verifying compliance with relevant ILO Conventions ratified by the country, such as Conventions Nos. 100, 111, 156 and 183 and with national legislation ensuring equality of opportunity and treatment in employment and occupation for men and women workers.

Points for discussion

1. Has your country ratified ILO conventions on gender equality? If so, how have these been applied?
2. What legislative protections, if any, has your country adopted to provide for protection against discrimination in employment on the basis of sex?
3. What are the main challenges to achieving gender equality in employment in your country/region and what can labour inspectors do to help meet these challenges?

8. Ensuring a safe and healthy workplace

The ILO has adopted a range of standards aimed at ensuring a safe and healthy working environment, preventing workplace accidents and occupational illnesses and diseases, especially for those workers in occupations exposed to particular hazards. It has also provided guidance for the establishment of workers' compensation schemes for workers affected by occupational accidents and illnesses. To date, the ILO has adopted more than 40 international instruments as well as over 40 codes of practice addressing occupational safety and health (OSH) issues.

The Conventions, Protocols and Recommendations adopted by the ILO fall into four broad categories:

- General provisions on preventive action to be taken at national as well as enterprise levels for all workers and in all workplaces;
- Provisions to protect against specific hazards, such as radiation, asbestos, chemicals, air pollution, noise or vibration;
- Provisions focusing on specific economic sectors, such as construction, mines and agriculture, seafarers and fishers;
- Provisions focusing on specific categories of workers, such as plantation workers, nursing personnel, hotel and restaurant workers.

HIV and AIDS and occupational safety and health

Recommendation No. 200 contains a strong focus on OSH. It emphasises the need to ensure equal access to HIV-related health services for workers, their families and dependents. It calls for the promotion and implementation of international labour Conventions and Recommendations and other international instruments relevant to HIV and AIDS and the world of work, including those that recognize the right to the highest attainable standard of health.[83]

It provides that prevention of HIV transmission is a fundamental priority and that the working environment should be safe and healthy for all workers, in order

[83] See Preamble to Recommendation No. 200.

to prevent transmission of HIV in the workplace.[84] To promote application of these principles, the Recommendation calls on governments, in consultation with organizations of employers and workers, to adopt national policies and programmes on OSH where they do not already exist.

Key occupational safety and health standards relevant to HIV, AIDS and TB

The Recommendation refers explicitly to three key ILO standards that should be taken into account and guide OSH measures taken at the national level as well as in the workplace. These are:

- *The Occupational Safety and Health Convention, 1981 (No. 155)*

Convention No. 155 provides for the formulation, implementation and periodic review of a coherent national OSH policy, as well as for action to be taken by governments and within enterprises to promote OSH and to improve working conditions. The Protocol calls for the establishment and the periodic review of requirements and procedures for the recording and notification of occupational accidents and diseases, and for the publication of related annual statistics.

- *The Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187)*

Convention No. 187 provides that Governments should promote the establishment of a preventative safety and health culture with continuous improvement of OSH. It requires ratifying States to develop, in consultation with the most representative organizations of employers and workers, a national policy system and programme on OSH. The national policy should be developed in accordance with the principles of Article 4 of the Occupational Safety and Health Convention, 1981 (No. 155), and the national systems and programmes should be developed taking into account the principles set out in relevant ILO instruments. A list of relevant instruments is contained in the Annex to the Promotional Framework for Occupational Safety and Health Recommendation, 2006 (No. 197).

- *The Occupational Health Services Convention, 1985 (No. 161)*

Convention No. 161 provides for the establishment of enterprise-level occupational health services which are entrusted with essentially preventive functions and which are responsible for advising the employer, the workers and their representatives in the enterprise on maintaining a safe and healthy working environment.

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[84] Recommendation No. 200, paras. 3 and 30.

HIV prevention measures

Recommendation No. 200 provides comprehensive guidance on HIV prevention measures that should be taken in and through the workplace. These consist of three types of measures:

- HIV-related education and information;
- Adequate safety procedures; and
- Provision of safety equipment and facilities.

Information and education for all workers

Provision of information and education is essential to enable workers to protect themselves and others from exposure to HIV. The workplace should provide all workers with accurate and up-to-date information on the modes of HIV transmission and on how they can best protect themselves from HIV as well as from other HIV-related illnesses, such as TB.

The manner in which information is presented is key to whether and to what extent it will be accessed, accepted and applied. The Recommendation therefore provides that training, safety instructions and any necessary guidance in the workplace related to HIV and AIDS should be provided in a clear and accessible form for all workers, particularly for migrant workers, newly hired or inexperienced workers, young workers and those in training. Education and training should also be sensitive to gender and cultural concerns and be adapted to the characteristics of the workforce, taking risk factors into account.[85]

Education and training on HIV and AIDS—including up-to-date scientific information—should be made available to all in the enterprise: employers, managers and workers' representatives, so that they can take appropriate action to keep the workplace safe and healthy for everyone.

Health and safety procedures

Accidents requiring first aid treatment can occur in any workplace. While the risk of infection from HIV may be small, employers are nevertheless responsible for ensuring compliance with relevant national regulations and basic procedures on standard precautions.

Standard blood and body fluid precautions were designed by the United States Centers for Disease Control and Prevention (CDC) in 1985, in response to the urgent need to protect hospital personnel from blood-borne infections. Standard precautions call for blood and body-fluid precautions to be applied to all persons regardless of their presumed HIV status. In applying these precautions, health workers are required to treat the blood and body fluids of all persons as a potential source of infection, independent of diagnosis or perceived risk.

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[85] Recommendation No. 200, para. 40.

Application of standard precautions requires:

- Careful handling and disposal of sharps (needles or other sharp objects);
- Hand washing both before and after a medical procedure;
- Routine use of protective barriers, such as gloves and other protective clothing and equipment or application of dressings to broken skin, to avoid direct contact with blood and body fluids;
- Safe disposal of waste contaminated with body fluids and blood;
- Routine disinfection of instruments and other contaminated equipment; and
- Proper handling of soiled linen.

The use of standard precautions minimizes the risk of transmission of HIV and other blood-borne infections, but cannot prevent needle-stick injuries, an occupational risk factor for health care workers.

Since it is possible for any worker to be exposed to blood, blood products or other body fluids in the event of a workplace accident, all workers should receive training about infection control procedures. All workers (including interns, trainees and volunteers) should receive awareness-raising information and appropriate training in HIV infection control procedures.

Certain conditions of work, such as long shifts, overtime and proximity to hazardous equipment or materials are all factors that may contribute to workplace accidents and increase the risk of HIV infection, particularly where these conditions are present in relation to certain occupations. For example, due to fatigue as a result of long working hours, nurses, doctors and hospital cleaning personnel may be more prone to accidental needle-stick injuries.

Those workers responsible for providing first aid should receive special training and be provided with and trained on how to use protective equipment.

Training for all workers should cover:

- Up-to-date scientific information on HIV and AIDS;
- The modes of HIV transmission, including prevention of mother-to-child transmission;
- The importance of risky behaviours;
- Information on how to access prevention, treatment, care and support measures, including VCT;
- Standard precautions;
- The use of protective equipment;
- The correct procedures to be followed in the event of exposure to blood or body fluids.

It is essential that these precautions always be followed. There are other diseases, apart from HIV, which can be transmitted through blood and body fluids. For these reasons, appropriate precautions should be taken systematically. Special training

should be provided to protect workers in occupations particularly exposed to the risk of transmission of HIV, TB and other transmittable diseases, such as health care workers.

Preventive responses

Preventive responses should include standard precautions, definition, implementation and periodical revision of preventive or control actions. These should involve adequate organizational, environmental, engineering and work practice measures, selection and availability of personal protective equipment, as appropriate, and post-exposure prophylaxis to minimize the risk of contracting HIV and TB, especially in higher-risk occupations, such as the health-care sector.

OSH measures should take into account the characteristics of the workforce. Different workplaces may require different approaches. For example, joint guidelines were developed in 2010 by ILO/WHO/UNAIDS for the health services: the Joint *Guidelines on Health Services and HIV/AIDS* in 2005 and *Policy Guidelines for improving health workers' access to HIV and TB prevention, treatment, care and support services*.[86]

Where a direct link can be established between an occupation and the risk of HIV and/or TB infection, infection should be recognized as an occupational disease or accident[87], in accordance with national procedures. These procedures provide for definitions, accident notification protocols to follow and provide for the annual publication of occupational accidents, diseases and injuries.[88]

Points for discussion

1. Has your country ratified ILO Conventions on OSH? If so, how have these been applied?
2. What legislative protections, if any, has your country adopted to provide for the right to a safe and healthy working environment?
3. How do you think that organizations in higher risk sectors, such as health services, should define and implement a policy and programme for prevention of HIV transmission? What guidance would you give them as a labour inspector?

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[86] See also ILO-WHO, *HealthWISE Action Manual*, op. cit.

[87] On 25 March 2010, the ILO Governing Body adopted a new List of Occupational Diseases that replaced the previous Annex to the List of Occupational Diseases Recommendation, 2002, (No.194). This List now includes both HIV and TB as occupational diseases.

[88] See Protocol of 2002 to the Occupational Safety and Health Convention, 1981.

9. Practical approaches for labour inspectors

When dealing with HIV-related matters, labour inspectors will primarily be involved in helping employers define and implement policies at workplace level in line with Recommendation No. 200, the ILO Code of Practice and national legislation. They will also be involved in bringing information on HIV prevention to workers – especially workers operating in remote areas which are often excluded from access to HIV-related services – and monitoring working conditions in terms of preventing exposure to HIV contamination and combating discrimination.

HIV-related discrimination is often difficult to identify, particularly given the issues of confidentiality surrounding HIV status. Workers living with HIV or those caring for a family member living with HIV may be reluctant to disclose their status or discuss their situation at work or with public authorities. This is particularly the case where workers fear a discriminatory reaction from their employer or co-workers and are not familiar with the role of labour inspection and the secrecy related to the origin of complaints which labour inspectors must respect. How then can labour inspectors best approach this issue? How can they open a space for dialogue with and between employers and workers to promote workplace action on HIV and AIDS while also verifying compliance with national legislation and policy on HIV and AIDS, where these exist?

At its 100th Session in June 2011, the International Labour Conference (ILC) recommended that labour inspectorates adopt a combination of preventive and deterrent strategies to better achieve their objectives. The ILC stated that "an appropriate mix of preventive measures such as risk evaluation, promoting a culture of leadership and best practice, implementing OSH measures, information guidance and awareness campaigns combined with sanctions should be adopted."[89] Labour inspectorates are well placed to respond to HIV through this combination of measures.

A labour inspection strategy to address HIV challenges should be based on:

- Elaboration of an internal human resources policy to prevent discrimination on the basis of real or perceived HIV status;

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[89] ILO, *Labour administration and labour inspection,* op.cit.

- Dissemination of HIV- and AIDS-related information to combat prejudice and stereotypes in workplaces;
- Identification of legal gaps in the adequate protection of workers living with HIV;
- Collaboration with the social partners and other national organizations on the definition and implementation of comprehensive national policies and programmes on HIV and AIDS;
- Increasing the capacity of labour inspectors to handle HIV-related issues, using the following indicators and promoting integration of HIV prevention in safety and health management systems.

For more detailed guidelines, please consult the publication entitled *Good Practices in Labour Inspection on HIV and AIDS,* at Appendix 2 of the accompanying CD.

Relevant indicators for workplace responses to HIV and AIDS

This Handbook proposes a number of indicators intended to assist labour inspectors and others in addressing HIV and AIDS issues in their work. These indicators represent key elements typically found in workplaces that have taken measures to provide a non-discriminatory, supportive environment of respect for the labour rights of persons living with or affected by HIV. While the presence of these indicators does not necessarily establish compliance with relevant legislation on HIV and AIDS, their presence demonstrates that enterprises/institutions have taken measures to address the epidemic in or through the workplace. On the other hand, the absence of one or more of these indicators may point to specific problem areas that the inspector may wish to explore and address in his or her workplace visits.

These indicators of effective policies and practices at the enterprise/institutional level include:

- The existence of a workplace policy and/or programme on HIV and AIDS that integrates the key principles of Recommendation No. 200 and/or the ILO Code of practice, such as the principles of prevention, non-discrimination, gender equality, confidentiality, no mandatory HIV testing and the right to continue in employment, with reasonable accommodation if necessary.
- The presence in the workplace of one or more individuals trained in HIV prevention and related issues. These persons may be HIV focal points, human resources officials, company nurses or physicians or other designated staff tasked with raising awareness at the workplace.
- The presence of a structure tasked with addressing issues related to HIV and AIDS at the workplace, such as a workplace OSH committee, a grievance committee or other designated mechanism.

- The existence of regular HIV information and education programmes for all staff, including supervisory personnel and employees at all levels and across all categories, that include a component on non-discrimination and gender equality.
- The existence of specialized training programmes or measures to assess and prevent the risks of occupational exposure to HIV, particularly among employees at higher risk of transmission.
- The availability of:
  - referral information for HIV-related services, including VCT services;
  - personal protective equipment;
  - pre- and post-exposure prophylaxis;
  - male and female condoms.
- The presence of or easy access to information on HIV and labour rights, including user-friendly information pamphlets on HIV prevention and related services, on the company's non-discrimination policy, posters or other visual media in common areas in the workplace that provide information on workers' rights in relation to HIV and employment.

Good practices

The objective of promoting the development and implementation of workplace responses to HIV and AIDS is twofold: to establish a culture of prevention and to reduce the impact of the epidemic on those affected. The protection of fundamental human rights is the foundation for effective workplace HIV prevention programmes, given that a hostile and discriminatory working environment will deter workers from coming forward to seek information and referrals to voluntary HIV testing. Such an environment would also discourage workers living with HIV from disclosing their status voluntarily. It could also have the undesirable effect of reducing their adherence to treatment.[90]

Labour inspection activities are vital to balance socio-economic development and social justice. Labour inspectorates provide important services for workers, employers and governments. Their action on HIV and AIDS should focus on a prevention-oriented approach and ensuring an adequate balance of advisory, supervisory and enforcement measures.

Ensuring access to information about HIV prevention is the first step in effectively addressing the epidemic at the international, regional and national levels to avoid the transmission of HIV and ensure universal access to HIV-related services.

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[90] ILO, *The Impact of Employment and HIV Treatment Adherence*, op.cit., concluded that, while employment improved treatment adherence by an estimated 39 per cent, employment could have a negative impact on treatment adherence in formal workplaces where workers were afraid to be seen taking their medication due to fear of stigma and discrimination, pp. 9 and 26.

Core components of any knowledge base must include—in addition to international labour standards, national legislation, technical standards, statistics and risk-assessment data, education and training tools—a systematic exchange at all levels of experience and good practice examples.

The ILO's Labour Administration, Labour Inspection and Occupational Safety and Health Branch (LABADMIN–OSH), together with the HIV/AIDS and the World of Work Branch (ILOAIDS), has compiled a collection of good practices in labour inspection. Together with this Handbook, the good practices collection can help improve labour inspectors' understanding of the linkages between labour inspection and HIV and AIDS.

Some of the good practices that labour inspectors can implement in addressing HIV and AIDS include:

- Promotion of collaboration between employers and workers on the development, adoption, implementation, evaluation and monitoring of workplace policies and programmes on HIV and AIDS;
- Promotion of voluntary HIV counselling and testing so that all workers, including management, can know their status; and
- Ensuring the sustainability and effectiveness of workplace programmes, including in the informal economy. Labour inspectors can, for instance, encourage the use of peer educators to promote prevention in workplaces.

Points for discussion

1. What experience have you had in addressing HIV and AIDS in workplaces?
2. What steps can labour inspectors take to better prevent rights violations and monitor compliance with national HIV legislation and or policy?
3. How can labour inspectors support enterprises and workers in developing workplace policies and programmes on HIV and AIDS that include workers and workers' representatives?
4. Do you have specific suggestions on approaches that you would recommend taking in dealing with cases of discrimination on the basis of real or perceived HIV status?

10. Sample training programme and learning activities

General instructions for facilitators/trainers

This section sets out an agenda and learning activities that can be adapted to make up a two-day training of trainers programme. These are only examples, and we encourage you to adapt these ideas in order to tailor them to the needs and interests of the colleagues that you work with and the time available. The numbers in brackets refer to the learning activities in the accompanying CD that support each thematic area presented in the Handbook's Chapters.

The two-day sample training programme contained in this Handbook relies on active learning methodologies. Active learning requires more from participants in training programmes than merely sitting and listening. The participants' experiences, ideas and questions are a valuable resource. Active learning is centred on the learner, not the trainer.

The activities proposed in the Handbook are intended to encourage active discussions and information sharing to facilitate active learning. These usually involve a role play or group discussions, and should take between 30 and 90 minutes. When doing exercises in small groups, these should not contain more than five to six people. Some activities can also be done in pairs. Guidance with regard to each learning activity is provided in the documents contained in the accompanying CD.

We recommend that you make notes of your work throughout the programme on post-its and/or flipcharts, which should be kept available in the meeting room. These can serve as a useful record of your discussions and you may need to refer later to what was discussed in earlier sessions. At the end of the programme, the post-its and flipcharts can also be used to write up the conclusions agreed at the workshop.

The Handbook can also be used as a reference. It can guide your working practice as labour inspectors and provide the basis for support and advice you may give to employers and workers on designing, developing and implementing workplace policies on HIV and AIDS. The Handbook will help you to become familiar with the Recommendation No. 200 and the ILO Code of Practice as well as other relevant international labour standards. It may also be useful to refer to the ILOAIDS Guidance Note on '*How Best to Develop a National Workplace Policy on HIV and AIDS*'. These additional reference documents are available on the accompanying CD.

Suggested agenda for sample two-day workshop[1]

Detailed agenda for facilitators/trainers

Day One HIV and AIDS – An Issue for labour inspectors		
Time	**Activity**	**Handbook**
8:30-9:00	Registration	
	Opening session	Chapter 1
9:00-9:30	Welcoming remarks	
9:30-9:40	Objectives of training	
9:40-10:00	*Activity No. 1 – Ice breaker*	CD
10:00 –10:30	**BREAK**	
	Test your knowledge about HIV and AIDS	Chapter 2
10:30-11:00	*Activity No. 2 – Quiz (Hand-out)*	CD
11:00-11:30	Presentation of the modes of HIV transmission	
11:30-13:00	Status of the national HIV epidemic	
13:00-14:00	**LUNCH**	
	Labour inspection and HIV and AIDS	Chapters 3 and 4
14:00-14:30	Presentation of the roles, responsibilities and functions of labour inspectors	
14:30-15:00	*Activity No. 3 – Labour inspection and HIV and AIDS*	CD
15:00-15:30	**BREAK**	
	International Labour Standards and HIV and AIDS	Chapters 5 and 6
15:30-16:30	Presentation of the key principles of Recommendation No. 200	
16:30-17:30	*Case study No. 1 (Hand-out)*	CD

[1] The agenda for facilitators is included on the accompanying CD.

Day Two Basic principles – The legal and policy framework		
Time	**Activity**	**Handbook**
8:30-8:45	Recap of day one and objectives for day two	
8:45-9:45 9:45-10:45	**HIV-related stigma and discrimination** Forms of HIV-related discrimination *Case study No. 2 or 3 (Hand-out)*	Chapters 5 and 6 CD
10:45-11:00	**BREAK**	
11:00-12:00	**Gender equality** Presentation of gender equality principles *Activity No. 4 – Ensuring gender equality at the workplace* *or* *Case study No. 4 (Hand-out)*	Chapter 7 CD CD
12:00-13:00	**Occupational safety and health** Presentation on occupational safety and health and HIV *Case study No. 5 (Hand-out)*	Chapter 8 CD
13:00-14:00	**LUNCH**	
14:00-15:30	**Practical approaches for labour inspectors** Developing indicators and good practices *Activity No. 5 – Role play*	Chapter 9 CD
15:30 –16:00	**BREAK**	
16:00-17:00 17:00-17:30	**Follow-up** *Activity No. 6 – Action planning* *Activity No. 7 – Evaluation* **Closing session**	 CD CD

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