

Working Paper

Intersecting Risks: HIV/AIDS and Child Labour

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Foreword

In June 1998 the International Labour Conference adopted the ILO Declaration on Fundamental Principles and Rights at Work and its Follow-up. The Declaration obliges all member States of the International Labour Organization to respect, promote and realize freedom of association and effective recognition of the right to collective bargaining, the elimination of all forms of forced or compulsory labour, the effective abolition of child labour, and the elimination of discrimination in respect of employment and occupation.¹ The *InFocus Programme on Promoting the Declaration* is responsible for the reporting processes and technical cooperation activities associated with the Declaration Follow-up; and it carries out awareness-raising, advocacy and knowledge functions – of which this Working Paper is an example. Working Papers are intended to stimulate discussion of the issues covered by the Declaration. They express the views of the author, which are not necessarily those of the ILO.

Dr. Rau was commissioned by the ILO to write this working paper, as one of the inputs into preparation of the ILO Director-General's report to the 2002 session of the International Labour Conference, under the follow-up to the ILO Declaration, entitled *A Future Without Child Labour*. Based on a review of the secondary information currently available, this paper sheds new light on the direct links between HIV/AIDS and child labour, as well on the common factors, driven largely by deep inequalities between social groups, which increase children's vulnerability both to HIV infection and to being drawn into child labour, especially its worst forms. Hence the title of this Paper: *Intersecting Risks*.

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Readers are invited to share their comments and views on the paper, directly with the author and with the InFocus Programme on Promoting the Declaration.²

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¹ For the text of the Declaration, please visit our website at <http://www.ilo.org/public/english/standards/decl/declaration/text/index.htm>

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1. Introduction

The prevalence of child labour and the risk of children becoming infected with the human immunodeficiency virus (HIV) are both influenced by the socioeconomic factors that shape children's lives. An individual child does not choose to work in hazardous conditions. Similarly, an increased risk of HIV infection does not simply result from individual behaviour and choices. Rather, the acquired immunodeficiency syndrome (AIDS) pandemic is driven by the powerful inequalities that exist between social groups. Although HIV/AIDS cuts across socioeconomic groups, its transmission follows the paths created by those inequalities, particularly those that intensified during the last three decades of the 20th century.

From the outside, some of the inequalities that foster the spread of HIV/AIDS may appear mundane: no ready access to diagnosis and treatment of a sexually transmitted disease, living away from a family for many months at a time, or working at a job that pays too little to buy adequate food. These have been some of the situations so conducive to the rapid spread of HIV/AIDS. Significant changes in the global economy over the past 50 years have sharpened some of the inequalities that HIV has readily exploited. The AIDS pandemic is partly fuelled by children in the workforce, working in prostitution or as low-cost labourers who might be sexually exploited. And, as the pandemic has spread among adults, millions of children have been affected: they have been orphaned and their opportunities for a complete education seriously compromised. Many of these children have had to enter the workforce to survive.

This paper analyses the mutually reinforcing factors that, as a result of HIV infection among adults, contribute to child labour and may place child workers at risk of HIV infection themselves. In some instances, these contextual factors run parallel; in others, they intersect, thereby putting working children at greater risk of HIV infection or of suffering the consequences of infection.

2. Development, globalization and impoverishment

The nexus between child labour and HIV/AIDS results from the cumulative effect of three other factors: the inequalities that contribute to and sustain poverty, the failure of prevailing development paradigms to address fully the socioeconomic needs of all people, and the rapid expansion of corporate influence on economic models.

It is no coincidence that the HIV/AIDS pandemic spread so rapidly at the end of the 20th century. This was a period of significant and rapid changes in global economic and power relationships. It was a time when local communities and national governments in many developing countries came under intense pressure to adopt the economic structures and cultural patterns of developed countries. Two development analysts argue that "...economic and social changes over the past three decades [of the 20th century] in particular, have created an enabling environment that places tens of millions of people at risk of HIV infection and makes effective popular and governmental responses more difficult."³

³ For an overview, see Joseph Collins and Bill Rau: AIDS in the Context of Development (Geneva, UNRISD/UNAIDS, 2000).

Major lending and donor agencies legitimized these socioeconomic changes by referring to them as expected outcomes of the “development” or globalization process. Negative outcomes (e.g. growing inequalities, widening poverty) were rationalized as short-term costs that would be counter-balanced by longer term benefits derived from market-oriented economic policies. However, neither the economic reforms nor the “development” models pursued by the International Monetary Fund (IMF), the World Bank, and other bilateral agencies yielded the promised outcomes for many developing countries and major proportions of their populations.⁴ In many African countries, poverty has increased and, for the very poor, it has become more intense.

Several Asian countries recorded impressive economic growth in the 1970-1990 period, and substantial upper and middle classes were formed. But the benefits of economic growth were not equitably distributed. For example, the Indian state of Kerala has one of the lowest infant mortality rates in the developing world while the states of Orissa and Uttar Pradesh have among the highest. Thailand’s economic growth policies produced impressive results, but many rural households, and women in particular, did not share those outcomes; some of the women have been drawn into the sex industry that has helped to fuel the HIV/AIDS pandemic in the country.⁵ Globally, socioeconomic inequalities within and between countries have become more pronounced in all but a handful of East Asian countries.⁶

As a reflection of the power relations in globalization, the majority of the developing countries have only limited control over the processes of change. In contrast, developed countries are better able to manage and direct the processes for their own benefits, although not all people in developed countries enjoy the benefits of those processes or share in them in the same ways.

Globalization can be assessed from a number of perspectives. The ILO has described economic globalization as “a process of rapid economic integration between countries. It has been driven by the increasing liberalization of international trade and foreign direct investment, and by freer capital flows.”⁷ Here, we are primarily interested in the impact of this process of globalization on

⁴ Recent reviews from within the United Nations system include: Thandika Mkandawire and Virginia Rodriguez: *Globalization and Social Development after Copenhagen*, Occasional Paper 10 (Geneva, UNRISD, 2000); World Bank: *Aid and Reform in Africa: Lessons from Ten Case Studies* (Washington, DC, 2001); José Antonio Ocampo (Executive Secretary, Economic Commission for Latin America and the Caribbean): *Rethinking The Development Agenda*, (paper presented at the Annual Meeting of the American Economic Association New Orleans, January 2001; Emilio Klein and Víctor Tokman: “Globalization and Stratification”, *CEPAL Review* (Santiago, Chile), December 2000, No. 72.

⁵ Mathana Phananiramai: *Population Changes and Economic Development in Thailand: Their Implications for Women's Status*, East-West Center Working Papers, Population Series, 88-11 (Honolulu, 1997); Marjorie A. Muecke: “Mother Sold Food, Daughter Sells Her Body: The Cultural Continuity of Prostitution”, *Social Science and Medicine* (Oxford), 1992, Vol. 35, No. 7, pp. 891-901; UNDP: *Human Development Report of Thailand, 1999* (Bangkok, 1999), pp.14-15.

⁶ See A. J. McMichael and R. Beaglehole: “The changing global context of public health”, *Lancet* (London) 2000, Vol. 356, pp.495-499, for one view on the very mixed outcomes of globalization on health. Globalization is driven by corporations whose goals include expanding profits by reducing operating costs, gaining new or expanded sources of raw materials, and expanding markets. The process of globalization is often justified and guided by organizations and governments that represent or reflect strong corporate identities and/or backing. Promoters of globalization stress the value of the privatization of public-held resources, the liberalization of financial and regulatory parameters, and trade without tariff barriers or production/distribution subsidies.

⁷ ILO: *Country Studies on the Social Impact of Globalization: Final Report*, presented at the Working Party on the Social Dimensions of the Liberalization of International Trade (Geneva, Doc.GB.276/WP/SDL/1, November 1999).

socioeconomic conditions in relation to HIV/AIDS and children.⁸ Some of the key indicators that can provide insight into the impact of globalization on HIV risk are:

- trends in the ability of the national economy to provide adequate employment and revenue for social programmes;⁹
- trends in levels and forms of employment that affect people’s opportunities to earn a decent livelihood;
- the volume, direction, and living conditions of migrant workers;
- income and asset inequalities and how these reflect and contribute to gender inequities;
- the ability of nations, communities, and households to pursue social goals and improve their well-being;
- access to quality social services, especially during the 1980s and the 1990s when viable services were needed to address HIV and sexually transmitted infections (STIs).

These indicators can be used to assess, to some extent, two of the negative outcomes of globalization: hazardous forms of child labour and the risk of HIV/AIDS infection. Quantitative data are generally less available for the latter four than for the first two indicators. Data on children involved in hazardous work, children in the sex industry, and children affected by HIV/AIDS are weak or fragmented. Thus, analyses of the links between child labour and HIV/AIDS rely on short-term and small-scale field studies, area-specific data, and observer assessments of patterns of change.

The nexus between HIV/AIDS and child labour often occurs in situations of impoverishment. We use the term impoverishment to suggest conditions that contribute to people being in, or moving into, situations of poverty.¹⁰ In the context of globalization, impoverishment can result from long-term or sudden unemployment, loss of assets (e.g. land), lack of access to basic social services (e.g. education, health, security, transportation), or lack of control over everyday decision-making. Impoverishment is often characterized by inequalities between socioeconomic groups; HIV/AIDS and hazardous forms of child labour respond in positive ways to the patterns of impoverishment.¹¹

3. The impact of HIV/AIDS on the conditions in which children live

At the end of 2000, an estimated 36 million people worldwide were living with HIV; another 22 million had died of AIDS and AIDS-related illnesses.¹² The vast majority of people infected were sexually active, either by choice or by circumstance. In most cases, people do not know that they are infected with HIV. Surveillance survey findings are generally based on samples of women attending antenatal clinics. Such surveys are anonymous and it is not possible to determine when a woman was infected (although teenage girls become infected at a much higher rate than teenage boys). What is evident, however, is that many of the infected individuals are younger women (i.e.

⁸ One of the most comprehensive overviews of the impact of globalization on social well-being is a study based on the work of 50 researchers from 35 countries published by UNRISD: *Visible Hands: Taking Responsibility for Social Development* (Geneva, UNRISD, 2000).

⁹ ILO: *Eliminating the worst forms of child labour*, Report of the ILO Caribbean Tripartite Meeting on the Worst Forms of Child Labour, Kingston, Jamaica, 6-7 December, 1999.

⁸ People also move out of poverty or become less impoverished. The point is that “poverty” is not a static condition, but subject to social, economic, and political conditions and decisions.

¹¹ Paul Farmer: *Infections and Inequalities: The Modern Plagues*, (Berkeley, University of California Press, 2001).

¹² UNAIDS: *AIDS Epidemic Update: December 2000* (Geneva, 2000).

less than 40 years of age, and predominantly less than 30 years old) and many of these women have children or are pregnant. HIV infection in women of child-bearing age affects millions of children, either directly through the death of one or both parents or indirectly through the illness and death of other adults who affect their lives, such as teachers.¹³

3.1 Orphans

United Nations agencies have defined HIV-negative children under the age of 15 who have lost their mothers or both their parents as a result of HIV/AIDS as AIDS orphans. Children who have lost their fathers but not their mothers do not fall into this classification, the argument being that it is too difficult to identify children whose fathers have died as a result of HIV/AIDS.

An estimated 13 million children have lost their mothers or both parents to HIV/AIDS.¹⁴ Globally, at least 90% of those orphaned through HIV/AIDS live in Sub-Saharan Africa. As of 2000, 87% of all orphans in Zimbabwe had lost their mothers or both parents as a result of HIV/AIDS.¹⁵ Botswana and Zambia were not far behind, with 84% and 76% respectively of all orphaned children resulting from parental death associated with HIV/AIDS. HIV/AIDS accounted for over half of the orphans in Brazil. Thailand, with an estimated 900,000 people infected with HIV/AIDS, has about 90,000 orphaned children.

Before HIV/AIDS, about 2% of children in the developing world were orphans; by the end of the 1990s, the percentage had increased to about 10% in some countries. In Botswana, the number of orphaned children quadrupled between 1994 and 1997; by 1998, an estimated 5% of children under 15 were orphaned. In Malawi by the end of 1997, 6% of children under 15 were orphaned, and in Zambia by 1999, 13% of children under 15 were orphaned.¹⁶

These numbers are just the beginning of a more dramatic increase in the number of children affected by HIV/AIDS. By 2010, it is estimated that 27 million children in 34 reporting countries will be affected, using the United Nations definition of children orphaned by HIV/AIDS. Analysts who include children up to the age of 18 estimate that around 50 million children will be affected by the year 2010.¹⁷ Figure 1, using data from South Africa and Zimbabwe, indicates the emerging growth in the number of children who will be orphaned as a result of HIV/AIDS.

¹¹ Children born with HIV or who are infected as infants have very short life-spans. They may lose a parent as a result of HIV/AIDS, but without treatment, they are themselves likely to die before they enter the workforce.

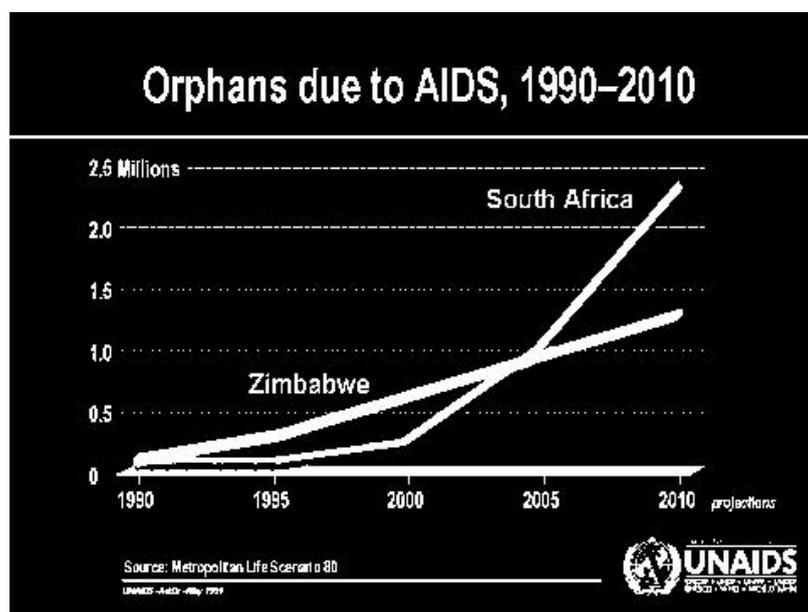
¹² UNICEF and UNAIDS: *Children Orphaned by AIDS: Front-line responses from eastern and southern Africa* (December 1999), <http://www.unaids.org/publications/documents/children/young/orphrepteng.pdf>

¹³ “as a result of HIV/AIDS” means death resulting from HIV infection, and can include death due to opportunistic infections, such as tuberculosis, as well as outcomes of full-blown AIDS.

¹⁶ *ibid.*

¹⁷ Susan Hunter and John Williamson: *Children on the Brink* (Washington, DC, TvT Associates, 2000).

Figure 1.



Source: www.unaids.org/publications/graphics/addis/sld017.htm

Other definitions of children orphaned or affected by HIV/AIDS lead to different findings. Based on research in Uganda, one analyst argues that by excluding children who have lost their fathers, young people between the ages of 15 and 18, and non-orphaned children who live in households that are also fostering orphaned children, the United Nations definition fails to take into account many of the children rendered vulnerable by the pandemic. Using this wider definition, researcher Neil Monk suggests that the number of children affected by the HIV/AIDS pandemic is three to four times greater than that based on the United Nations definition.¹⁸

Some sources do not distinguish between children orphaned by HIV/AIDS and those orphaned by other causes, arguing that all orphaned children have special needs and to focus on children orphaned by HIV/AIDS adds to the stigma and discrimination that many of them face.¹⁹ Other attempts to define orphans in the African context have taken the opposite approach. In Malawi, for example, programme managers felt that an inclusive definition would lead to such large numbers of children that provision of any services would become impractical. As an alternative, UNICEF and Malawian programme managers proposed a list of criteria to identify “needy orphans” (i.e. double orphanhood, those lacking food, shelter, and clothing, those living in a sibling-headed household or living with grandparent(s), those not attending school).²⁰ However they may be identified, children affected by HIV/AIDS face numerous constraints, ranging from reduced access to school, to seeking paid work, and to becoming heads of households in the absence of parents or guardians. These new life-shaping conditions increase the chances that children will be forced or

18 Neil Monk: “Underestimating the magnitude of a mature crisis: Dynamics of orphaning and fostering in rural Uganda” Orphan Alert: International Perspectives on Children Left Behind by HIV/AIDS, (New York, NY), 2000, pp. 7-12.

19 Susan Hunter and John Williamson: op.cit.

20 Esau Kalemba: The Development of an Orphans Policy and Programming in Malawi, unpublished paper (UNICEF Lilongwe, Malawi).

drawn into harmful or potentially harmful work situations where, in turn, their own exposure to HIV/AIDS may increase.

3.2 Loss of access to social development services and rights

Orphanhood as an outcome of HIV/AIDS exposes children to increased risks of discrimination, ill health, lost opportunities for education and training, and potentially to HIV infection.²¹ Throughout most of the 1990s, children orphaned by the death of a parent as a result of HIV/AIDS infection remained, in general, with the other parent or were placed with extended family households. However, as adult death rates increased in the 1990s, evidence from Uganda, Zambia and Zimbabwe began to show the stresses faced by these households. By 2000, the prevailing family social structures were, in many cases, unable to adequately absorb or care for children orphaned by HIV/AIDS. In these tenuous circumstances, many children lost opportunities for adequate schooling, health care, and other social services.

Education

Research from Zambia provides the most thorough assessment of the educational opportunities of children orphaned as a result of HIV/AIDS. These children are more likely to be out of school than children orphaned for other reasons.²² The reasons are usually financial (i.e. insufficient money to pay school fees) or have to do with a lack of household support for the education of fostered children. Households where one or more persons are affected by HIV/AIDS tend to reduce overall expenditure by withdrawing children from school, and seek to expand income by having children work or assume greater household responsibilities while an adult works. Even if children are not withdrawn from school, their classroom attendance may be sporadic. In Uganda, for example, breaks in attendance have lasted from five weeks to a term and a half. The most common reasons are lack of cash for school fees and that children are needed to help at home with the care of AIDS patients.²³

Michael Kelly, an education specialist at the University of Zambia, suggests that the situation of orphaned children in Zambia will only worsen over the next decade and that "...by 2010 Zambia's population of primary school age is expected to be about three-quarters of a million less than it would have been without AIDS. Currently, enrolment rates are stagnant, actual enrolments show some decline, and an increasing number of children do not complete primary school. Poverty is a major factor in this, but so also is AIDS and the way it has aggravated, and been aggravated by, that poverty."²⁴

¹⁹ Most children orphaned as a result of HIV/AIDS are themselves HIV-negative.

²² Michael Kelly: "The impact of HIV/AIDS on schooling in Zambia", *Jesuit Centre for Theological Reflection* (Lusaka, Zambia), 1999, No. 42; Michael Kelly: "Standing education on its head: Aspects of schooling in a world with HIV/AIDS", *Current Issues In Comparative Education* (New York, NY), December 2000, Vol. 3, No. 1; UNICEF: *Children Orphaned By AIDS*, op.cit.

²³ Helen Elsey, ed.: *HIV/AIDS and the Education Sector: Impacts and Responses* (London, ActionAid Education Department, 2000), p. 11, citing: *Oxfam Policy Team Access to Basic Health and Education Research and Advocacy Project, Uganda Micro Research, 2000*; Tumushabe Joseph: *Armed conflict, HIV/AIDS and child labour in Uganda*, draft report for the Government of Uganda (UNICEF Country Programme, Kampala, Uganda, 2000).

²⁴ Michael Kelly: "The impact of HIV/AIDS on schooling in Zambia", op.cit.

Schooling for all children is affected by the HIV/AIDS pandemic. Teachers (and presumably administrators and supervisors) in some parts of Africa are more heavily affected by HIV/AIDS than the general population. In 1998, in Zambia, the number of deaths of teachers was two-thirds as great as the output of teacher training colleges, and the ratio is increasing. In addition, teacher absences from the classroom because of illnesses associated with HIV/AIDS result in classroom disruptions, lowered quality of education for all students, and potentially greater student repetition.²⁵ “Communities see this as one of the factors contributing to a decline in the quality of education (and consequently, to a reduction in their preparedness to commit the time of their children to school)”, with direct consequences of children dropping out of school or being less prepared to move along in school.²⁶ Furthermore, the costs to ministries of education and the national treasury of teacher illnesses and deaths are probably significant, although studies have not been carried out to assess these costs.

Health

During the time an adult is ill with HIV/AIDS, household spending patterns shift significantly; expenditures on food may decline by 30-40%.²⁷ In Côte d’Ivoire, household medical expenses increased by four times as a result of HIV/AIDS infection and average income fell by 52-67% as income earners and caregivers withdrew from the workforce.²⁸ Thus, even before they are orphaned, children in households affected by HIV/AIDS face nutritional and other health risks. Children orphaned by HIV/AIDS are at higher risk of malnutrition and stunting than children raised in dual-parent households. Despite good intentions, foster caregivers are often overstretched to provide adequate food and other necessities for their enlarged households.

Access to health care, already limited for adolescents, is often reduced. Some orphaned children are suspected by health care providers of being HIV-positive and are discriminated against when it comes to health care. Obtaining health care for children is usually the responsibility of parents or caregivers. If one or both parents are too ill to manage such health-seeking behaviour, the children themselves are unlikely to attend a clinic unless they have a major problem. Diagnosis and treatment of malnutrition are likely to be neglected or postponed until very late. Diagnosis and treatment of STIs, already problematic in many countries and especially for teenagers, will be virtually non-existent, thereby increasing the risk of HIV transmission during any sexual encounter.²⁹ Out-of-school youth are among the hardest groups to reach with HIV/AIDS prevention information.³⁰

²⁵ Repetition rates are already high in many countries in Africa. For example, nearly one-quarter of all school children repeat grades in Mozambique.

²⁶ In South Africa, at the end of 2000, 20% of teachers in KwaZulu-Natal Province, 16% of teachers in other provinces, and between 7 and 8% of principals and heads of departments are HIV-positive. Marjolein Harvey: “Lack of government action on AIDS condemns thousands of kids to death”, 27 February 2001, <http://www.iclinic.co.za>

²⁷ UNICEF: *Children Orphaned by AIDS*, op.cit.

²⁸ *ibid*, p.3.

²⁹ “STD Control and Primary Health Care for Women: Experience and Challenges”, *Outlook* (Seattle, WA), October 1997, Vol. 15, No. 2.

³⁰ “A look at Asia’s changing youth population”, *Asia-Pacific Population & Policy* (Honolulu, HI), January 1999, No. 48; *South African Health Review 2000* (Durban, Health Systems Trust, 2000), chapter 20; “Making Reproductive Health Services Friendly for Young People”, *InFocus* (Washington, DC), December, 1997.

Loss of household structures

The death of an adult family member can have a serious impact on household and caring structures for surviving children. In Zimbabwe, a country with one of the highest national HIV/AIDS prevalence rates, two-thirds of the households in which a female adult died subsequently dissolved, leaving the children to be raised by relatives, usually grandmothers.³¹ A study in the early 1990s of 600 randomly selected households in urban and rural Mutare, Zimbabwe, looked at community coping mechanisms as the number of orphaned children increased. The research found that the majority of orphaned children were being cared for within extended families, although often in difficult circumstances. There was little evidence of discrimination or exploitation of orphaned children by extended family caregivers. However, the emergence of orphan households headed by siblings is an indication that the extended family is under stress.³²

In western Tanzania, many relatives refused to take responsibility for orphans; many of those who did were unable to look after the children adequately. As has also been found in Uganda and Thailand, while grandparents were most likely to take in orphans, they were also particularly likely to be poor and unable to offer sufficient material support for children. Some analysts view this increasing inability of relatives to provide for orphaned children as symptomatic of change in the concept of the family. Under economic pressures, related to a combination of recession and unemployment, structural adjustment reforms, drought and HIV/AIDS, responsibilities are increasingly confined to nuclear rather than to extended families.³³ In Thailand, the situation is mixed. Some grandparents assume responsibility for orphaned children. However, their own poverty and the stigma that is associated with HIV/AIDS has also resulted in children being placed in shelters or orphanages. More commonly, the government's public welfare department has assisted provincial authorities and NGOs to set up shelters for children orphaned as a result of HIV/AIDS.³⁴

Inheritance rights

In patrilineal societies, women widowed as a result of HIV/AIDS (and for other reasons) and their children risk losing household assets and any future claims to land or livestock.³⁵ Even where the law provides for inheritance of assets, cultural practices may take precedence. Thus, children orphaned as a result of HIV/AIDS often have no assets other than their labour, to bring to caretakers, to pay for their education or to begin their own livelihoods. Even where inheritance rights provide for orphaned children, the assets remaining after the death of a father (to a lesser extent after the death of a mother, as less is invested in a woman's care for HIV/AIDS) will be

³¹ G. Mutangadura: "Household welfare impacts of mortality of adult females in Zimbabwe", paper presented at the AIDS and Economics Symposium, Durban, July 2000, p. 12.

³² G. Foster et al.: "Orphan prevalence and extended family care in a peri-urban community in Zimbabwe," *AIDS Care* (London), 1995, Vol. 7, pp. 3-17.

³³ A. Tibajiuka, A. and F. Kaijage: "Patterns and processes of social exclusion in Tanzania", in G.C. Rodgers et al., eds.: *Social exclusion, rhetoric, reality, responses* (Geneva/New York, ILO/ UNDP, 1995), pp. 187-200; Caroline Harper and Rachel Marcus: "Child Poverty in Sub-Saharan Africa" (Brighton, UK, Institute of Development Studies, 1999), p.22; see also M.A. Ayiedo: "From single parents to child-headed households: the case of children orphaned by AIDS in Kisumu and Siaya [Kenya] Districts", Study Paper No. 7 (New York, UNDP, HIV and Development Programme, 1998), p. 12.

³⁴ "Helping Aids-Affected Children Live In Communities", *Bangkok Post*, August 20, 2000.

³⁵ "Making a Difference for Children Affected By AIDS" (Washington, DC, Population Council, Horizons Project Research Summary No. 3, 2000), <http://www.popcouncil.org/horizons/ressum/orphans.html>

significantly diminished. For example, in the mid-1990s, 41% of households in Chiang Mai, Thailand, reported having sold land, 57% reported some withdrawals from savings, and 24% reported borrowing from a co-operative or revolving fund to finance the adjustment to a death in the family.³⁶

Stigmatization and discrimination

Many orphaned children are stigmatized for their parents' illness and are both subtly and actively discriminated against within communities and in their access to services. UNICEF argues that "discrimination against infected youth makes it harder for them to find and keep a job and to work productively."³⁷ We can add that stigma and discrimination against affected youth reduces their opportunities for education, for vocational training, and for access to decent work, leading them instead into menial, marginal, and the worst forms of high-risk jobs.

4. HIV/AIDS and children in the workforce

HIV/AIDS has a direct impact on children's participation in the workforce. Children enter or increase their participation in the workforce to compensate for changes in household earnings or labour supply. Children orphaned as a result of HIV/AIDS are even more likely to work.

Even before one or both parents die of AIDS, the pressures on the household may result in children increasing their workload within the household or taking on work outside it. Households experiencing a member's, or members', prolonged periods of illness with HIV and related conditions and eventual death, suffer dramatic cuts in income, severe strains on cash flow, and likely loss of assets. To make up for these economic losses, children may be withdrawn from school and/or told to work. The situation in Uganda is typical of many other parts of Africa: "Guardians and parents faced with extreme situations of poverty as under AIDS and armed conflict often put in place conditions that force...girls into early marriage or the search for work at a vulnerable age."³⁸ Or, children may seek work to meet their basic needs or to acquire consumer goods, although care is needed in interpreting immediate versus structural causal factors for children's decision-making.

A growing number of children orphaned as a result of HIV/AIDS find work in the informal sector, such as petty trade and services. Initially, most children will seek work patterned on their parents' experiences. For example, a child whose parent(s) raised and sold vegetables will take on that role. Children whose parent(s) worked on a commercial agricultural estate are likely to find employment readily on the estate.³⁹ Many of these informal sector jobs are in urban areas.⁴⁰ The

³⁶ S. Pitayanon, S. Kongsin and W. Janjareon: "The Economic Impact of HIV/AIDS Mortality on Households in Thailand", in David Bloom and Peter Godwin, eds.: *The Economics of HIV and AIDS: The Case of South and South East Asia* (Delhi, Oxford University Press, 1997). See also M.A. Ayiedo: "From single parents to child-headed households: the case of children orphaned by AIDS in Kisumu and Siaya [Kenya] Districts" op.cit., p.17.

³⁷ "Youth Livelihoods and HIV/AIDS", *InFocus* (Washington, DC), citing UNICEF: *Progress of Nations 2000* (New York, 2000).

³⁸ Tumushabe Joseph: *Armed conflict, HIV/AIDS and child labour in Uganda*, op.cit., paragraph 4.1.

³⁹ ILO/IPEC: "Child Labour in Commercial Agriculture in Africa", report of a technical workshop, Geneva, 1997; Gabriel Rugalema: *HIV/AIDS and the Commercial Agricultural Sector of Kenya* (Rome, FAO/UNDP, 1999). Few adults and hardly any children working on agricultural estates have written contracts.

presence of children on the street and their need for money, food, shelter, and companionship all increase their chances of being drawn into casual sexual relationships or more formal commercial sexual exploitation. Thus, the impact of HIV/AIDS can go full circle, from affecting a child to the child becoming infected.

As noted above, children affected by HIV/AIDS have few tangible assets to bring into a guardian's home, to start a business, or to manage their own households. The lack of inherited assets is important, as there appears to be a growing trend of orphans caring for themselves and their siblings, notably in eastern and southern Africa. It is estimated that over 7% of Zambia's nearly two million households are without any adult member; instead those households are headed by a boy or a girl aged 14 or younger.⁴¹ An estimated 10% of all children orphaned by HIV/AIDS in Africa are heads of households and caring for siblings.

This is a new phenomenon in Africa, brought on by the HIV/AIDS pandemic. Child-headed households exist because there are no relatives left to care for the children or because remaining relatives are too over-burdened to care adequately for orphans. In addition, there are reports of orphaned children leaving a guardian's household because of mistreatment.⁴² Many of the children who become household heads have little option but to seek work in order to support themselves and their siblings. Stories exist of older children earning the cash to keep younger siblings in school, but continued schooling for any of the children in these households is problematic.

Are children orphaned as a result of HIV/AIDS more likely to enter the workforce, to be exploited in the workforce, and to become infected with HIV than other children? The impact of HIV/AIDS, as outlined above, suggests that children orphaned as a result of HIV/AIDS are likely to be at higher risk. Many will come from households that have recently been impoverished because of the disinvestments made as a result of the need for medical treatment and care of one or two sick adults. For children, the psychological loss of a parent is accompanied by the economic loss of household income and security.

The impact of HIV/AIDS is similar in some ways to the impact of other crises on child labour, such as the financial crisis in Asia in 1997-99. Studies by the ILO and UNDP, among others, of the impact of the crisis found that "ultra poor" and "poor" households were most severely affected. School dropout rates in Thailand appear to have been lower than in the case of HIV/AIDS-affected households in southern Africa, but such cross-national comparisons can be difficult. It is assumed, however, that many of the school dropouts in Thailand were children of laid-off workers, who had to help their parents to make ends meet, a situation paralleling the reasons for child work in HIV/AIDS-affected households. Reports suggested that some students

⁴⁰ UNICEF, Eastern and Southern Africa Regional Office: *Listening to the Children: Child Workers in the Shadow of AIDS* (Nairobi, UNICEF, 2001).

⁴¹ Government of Zambia -UNICEF: *Zambia: A Situation Analysis of Orphans* (Lusaka, USAID/UNICEF/SIDA, 1999), p. 2.

⁴² M.A. Ayiedo: "From single parents to child-headed households", op.cit.; Sandra Ali: "Community Perceptions of Orphan Care in Malawi", unpublished paper presented at the Southern African Conference on Raising the Orphan Generation, Pietermaritzburg, South Africa, June 1998; Steven Forsythe and Bill Rau, eds.: *AIDS in Kenya* (Washington, DC, Family Health International, 1996).

entered the sex industry to cope with the economic contractions.⁴³ UNDP reported that in Thailand there was an increase in parents selling their daughters to brothel owners and in prostitution of young boys, especially in the main tourist destinations. UNICEF studies confirm the seriousness of the risks. They show the correlation between child prostitution and such factors as dire poverty, increased family indebtedness, the growth of poor single-parent families, the lack of educational and employment opportunities, and broken homes and divorced and separated parents. All of these risk indicators reportedly increased in Thailand after the financial crisis.⁴⁴

In the Philippines, 1997-1999 surveillance data indicated that the HIV/AIDS pandemic was far less serious than elsewhere in South-East Asia. However, an estimated half million women and girls are in the sex industry and there is a substantial prevalence of STIs, thus establishing the potential for the spread of HIV/AIDS.⁴⁵ The economic crisis of the late 1990s could have triggered an increase in HIV/AIDS prevalence in the Philippines. School attendance declined (higher rates of decline for girls than for boys) and both urban and rural unemployment increased. More children were drawn into the informal sectors of the workforce; however, these sectors have not been monitored to assess children's involvement in the sex industry or in work where they risk being sexually exploited.⁴⁶

The impact of the economic crisis on HIV/AIDS prevalence rates is unlikely to be known for several years as most people are not tested for HIV. However, the conditions exist for an increased spread of the infection, including to and through pre-teen children and teenagers.⁴⁷

5. The socioeconomic intersection of HIV/AIDS and child labour

Many of the socioeconomic factors that contribute to the risk of HIV/AIDS co-exist with factors that contribute to hazardous and exploitative child labour. This section will outline those factors and indicate where they intersect. Four structural factors link HIV/AIDS and child labour:

- socioeconomic inequalities;
- poverty-induced labour migration and sex work;
- reduced social cohesion in and across communities;
- shocks of failed development.

Poverty, fractured societies and shocks arise out of socioeconomic inequalities and are conditions that eventually increase the risk of both HIV/AIDS infection and damaging child labour. Figure 2

⁴³ UNDP: *Human Development in Thailand 1999*, pp.129-131 and 141, citing N. Kakwani: "Poverty and Inequality During the Economic Crisis in Thailand, Indicators of Well-Being and Policy Analysis", *National Economic and Social Development Board (NESDB) Newsletter* (Bangkok), Vol. 3, No. 1 (January 1999).

⁴⁴ UNDP: *Human Development in Thailand 1999*, pp. 142-43.

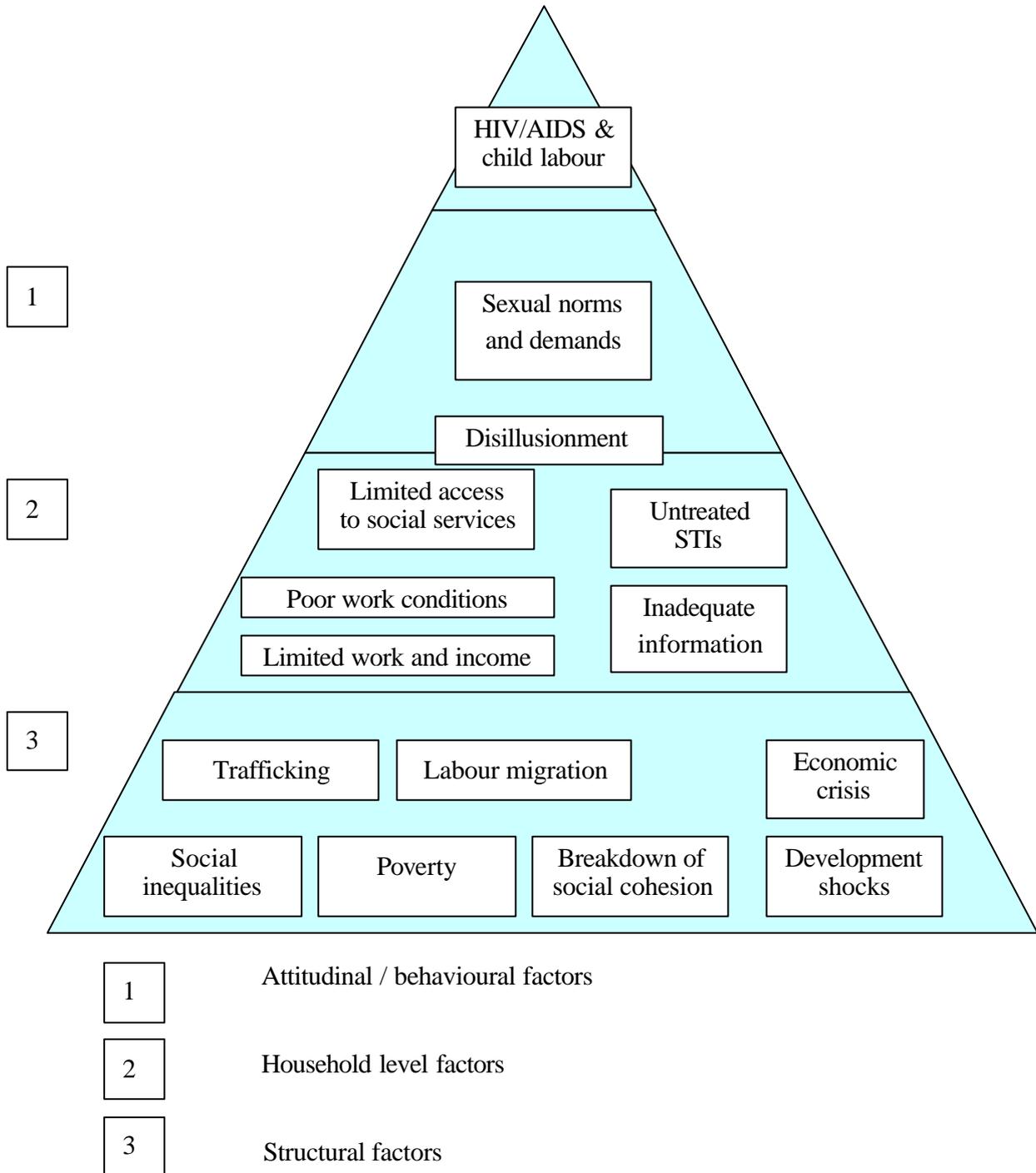
⁴⁵ The country reported an adult HIV prevalence rate of 0.07% in 1999. In Thailand, the adult prevalence was 2.15%; in Cambodia it was 4.04%. Data from UNAIDS: *Epidemiological Fact Sheets*. The fact sheets are available for each of the two countries cited, and for others. Last updated in 2000.

⁴⁶ Joseph Y. Lim: *The East Asian Crisis and Child Labour in the Philippines*, ILO/IPEC Working Paper, Geneva, 2000.

⁴⁷ The responses to HIV/AIDS in East Asia provide one of the fascinating anomalies of the pandemic. Aggressive public policies, supported by reasonable budgets, reduced the prevalence of STIs and HIV in Thailand in the latter 1990s, and the prevalence of STIs among sex workers recently in Cambodia. WHO, Regional Office for South-East Asia, STI/HIV/AIDS Surveillance Report, No. 16, November 2000.

illustrates the general hierarchy of conditions that mutually reinforce risk of HIV/AIDS infection and hazardous forms of child labour.

Figure 2. Factors contributing to HIV/AIDS and to child labour



5.1 Socioeconomic inequalities

Socioeconomic analyses by UN agencies and others of structural adjustment programmes have recorded the differential impact of adjustment on various socioeconomic groups.⁴⁸ Lower income/resource poor (LIRP) groups have had fewer resources with which to cover the increased costs of social services and have been less able to take advantage of the freer flow of capital or the reduced regulations on businesses. Most LIRP groups are workers rather than employers. They have tended to be unorganized or only loosely organized to negotiate with business owners/managers or government. Thus, they were not in a position to avoid the downward pressure on wage rates and were among the first to lose jobs in the formal private and public sectors of the economy. Likewise, these groups have been the hardest hit by the reduction or removal of food, transportation, housing, and other subsidies.⁴⁹ They have had few assets to sell or rent to offset rising prices or falling incomes.

Over the course of structural adjustment programmes, wages and income differences have widened, formal sector employment has fallen, public access to basic services has decreased, and other socioeconomic inequalities have increased in many countries.⁵⁰ These inequalities are exacerbated by, and exacerbate, other inequalities in society, such as gender,⁵¹ rural/urban,⁵² child/adult, and land holding.

Male wealth, status and HIV/AIDS

HIV/AIDS affects all socioeconomic groups, but its transmission follows the paths created by inequalities, especially those inequalities that have intensified during the last three decades of the 20th century. For example, in many rural areas of southern Africa, the regular income of teachers gives them a fairly high and secure socioeconomic status. However, they also live in isolated conditions, without their families. Male teachers use their status and income to obtain sex with school children and women of less secure means in surrounding communities. Thus, teachers have, on average, higher HIV/AIDS prevalence rates than the general population.⁵³

⁴⁸ Dharam Ghai: Structural Adjustment, Global Integration and Social Democracy, Discussion Paper No. 37, UNRISD (Geneva, October 1992); Rolph van der Hoeven: Poverty and Structural Adjustment: Some Remarks on Tradeoffs between Equity and Growth, Employment Paper 2000/4 (Geneva, ILO, 2000).

⁴⁹ Neil McCulloch, Bob Baulch, Milasoa Chereh-Robson: Globalisation, Poverty and Inequality in Zambia, Paper prepared for the OECD Conference on Poverty and Income Inequality in Developing Countries: A Policy Dialogue on the Effects of Globalisation (Paris, 2000).

⁵⁰ Rolph van der Hoeven: Poverty and Structural Adjustment, op.cit. Van der Hoeven notes that where evidence is available, half (6 out of 12) of adjusting countries in Asia and two-thirds (4 out of 6) in Africa, and nearly two-thirds (9 of 14) of countries in Latin America recorded increases in wage and income inequality in the 1980s, World Bank: Social Dimensions of Adjustment World Bank Experience 1980-93 (Washington, DC, World Bank, 1996) provides evidence of reductions in government spending on education and health, notably in Africa and Latin America.

⁵¹ H. Afshar and C. Dennis: Women and Adjustment Policies in the Third World (Basingstoke, Macmillan, 1992); Nazneen Kanji and Niki Jazdowska: "Structural Adjustment and the Implications for Low-Income Urban Women in Zimbabwe", Review of African Political Economy (Sheffield, UK), Vol.20, No.56 (1993), pp.11-26. Poverty rates for households headed by women tend to be 50-90% higher than those for households headed by men. See Mercedes González de la Rocha and Alejandro Grinspun: "Private adjustments: Households, crisis and work", in Choices for the Poor (New York, UNDP, 2001). [NB: the editor asked if this is a book—the answer is, yes]

⁵² A.E. Sommerfelt and A.L. Piani: "Childhood Immunization: 1990-1994", Demographic and Health Surveys Comparative Studies, No. 22 (Calverton, MD, Macro International, 1997). The study documents higher immunization rates for children in urban vs. rural areas.

⁵³ Michael Kelly: "The impact of HIV/AIDS on schooling in Zambia," op.cit.

Socioeconomic inequalities play out in cultural and social patterns that define male prerogatives. Added to these are the prerogatives that come with having income to spend on sex. Whether children are in the sex industry or are secondary school girls enticed by consumer goods, they are subject to the power and wealth that men can use to gain sexual advantage. A study in Kenya found that the important reason for high infection rates among girls is the frequency of sexual intercourse with older men. “Sugar daddies”, as they are known around the world, seduce young, impressionable and inexperienced girls with cash, consumer goods and supposed status.

Older men are able in many instances to display their wealth, power, or position.⁵⁴ In the oil-rich Niger Delta region of Nigeria, the regular wages provide oil workers with great wealth in contrast to the deep poverty of the local population. Oil workers, especially in remote production locations, regularly use their income to buy sex from young women and girls.⁵⁵

Male behavioural norms have helped shape and sustain socioeconomic inequalities. Those norms also mark where the intersection of HIV/AIDS and child labour is most distinctly evident. The intersection begins at the widest levels, with approaches to economic development that have been shaped and fostered by men. It includes the inequalities in wealth and wages that men use to buy sexual pleasure for themselves. It is seen in the predominately male ownership of businesses in the sex industry. Children in need of work or children coerced into work are susceptible to sexual exploitation in these male-dominated structures. Some analysts argue that the “globalization of economics...perpetuates female child prostitution because it is financially rewarding to those [e.g. owners of sex establishments, etc.] who participate in the activity.”⁵⁶

Commercial sexual exploitation of children

Asia is widely reported to have the largest number of children in the sex industry. In Africa, less evidence is available, and although commercial and survival sex are extensive in most countries, sexual exchanges occur more frequently in less formalized settings than in Asia, making data collection all the more difficult.⁵⁷ Estimates of the number of children in the sex industry cover a wide range: 200,000-800,000 in Thailand alone, 65,000 in the Philippines, and 400,000-500,000 in India.⁵⁸ Some 40,000 children under the age of 14 are believed to be involved in the sex industry

⁵⁴ George Odipo: “Adolescent Aids Epidemic in Kenya: Lessons from Child Abuse Proportion”, paper presented at East Cape Training Centre, Port Elizabeth, South Africa, October 2000, p.8.

⁵⁵ B.L. Faleyimu et al.: “Sexual networking and AIDS education in the workplace and the community: the case of oil locations in Nigeria”, abstract prepared for the National HIV Prevention Conference, 1999. Faleyimu et al. argue, unlike in this paper, that oil workers are at risk of HIV/AIDS because of the economic/sexual survival strategy of community women. Also “Niger Delta Strategic Plan: Addressing the HIV/AIDS Epidemic”, unpublished report (Nigeria, Port Harcourt, 2001).

⁵⁶ Laurie Nicole Robinson: “The globalization of female child prostitution”, *The Indiana Journal of Global Legal Studies* (Bloomington, UN), Fall 1997: Volume 5, Issue 1, <http://ijgls.indiana.edu>

⁵⁷ The most recent collection of evidence of the number of children in the sex industry is found in *Out of the Shadows: A Worldwide Report on the Worst Forms of Child Labour* (New Delhi, Global March Against Child Labour, 2000). Brothel-based sex is far less common in African than in Asian countries.

⁵⁸ Recent figures are to be found in *Out of the Shadows: A Worldwide Report on the Worst Forms of Child Labour*, op.cit. Other sources for figures are *Forced Labor: The Prostitution of Children* (Washington, DC, United States Department of Labor, 1996); United Nations: *Promotion and protection of the rights of children: Sale of children, child prostitution and child pornography*, Note by the Secretary-General (United Nations General Assembly Report A/52/482), 16 October 1997. National estimates are generated by organizations such as the Children’s Rights Protection Centre in Thailand.

in Manila, in the Philippines, where demand is driven by local men, American military personnel, Japanese businessmen and other foreign sex tourists.⁵⁹

Trafficking of women and children for the sex industry is prevalent in Asia, and increasingly so in the new states of central Asia, in southern Africa, Europe and Central America. From 1990-97, 80,000 women and children were reportedly trafficked to Thailand for prostitution — from Myanmar, Yunnan province in China and Laos. At least 3,000 girls from south Viet Nam have been trafficked to Cambodia for prostitution, more than 15% of them younger than 15.⁶⁰ The number of Nepalese women and girls trafficked to India (primarily Mumbai, Calcutta and smaller cities) is estimated at 5,000-7,000 per year, with 20% of these under 16 years of age. Of the estimated 100,000 women and girls in prostitution in Mumbai, half are Nepalese; of the 40,000 women and girls in prostitution in Calcutta, the majority are Nepalese.

The trafficking of Nepalese girls for sexual purposes is driven by several poverty-related factors: low literacy among girls and their families, limited access to health care, significant gender disparities, and rural deprivation so deep that for some girls and young women migration to India is seen as a viable alternative to remaining in their home areas.⁶¹ Other girls and young women are drawn into the carpet-making factories to earn a limited cash income. From there, recruitment into international sex networks, especially in India, is facilitated. In other instances, orphaned girls living with relatives are more likely to be trafficked.⁶²

AIDS only perpetuates conditions of household and national poverty and stress, keeping in motion the links between HIV/AIDS, child labour and poverty. Some people have characterized Nepal as “a dumping ground” for HIV infections bred elsewhere. It is estimated that at least half, and possibly as many as two-thirds, of Nepalese girls and women returning from sex work in India are HIV-positive.⁶³

In South Africa, the child rights’ group Molo Songololo has documented an increase in trafficking of children for sexual exploitation. This is the result of increased demand, including amongst the increased number of tourists in Cape Town.⁶⁴ In other large cities of South Africa, the “child sex industry has become increasingly organised, with children either being forced into prostitution or being exploited by their parents to earn money for the family. An increase in the number of children living on the streets has contributed to the growing number of child prostitutes”, according to a report by the information and advocacy group, Global March Against Child

⁵⁹ UNICEF: Commercial Sexual Exploitation of Children in the Philippines: A Situational Analysis (Manila, 1998).

⁶⁰ ILO/IPEC: Trafficking in children for labor exploitation in the Mekong sub-region: A framework for action, paper presented at a sub-regional consultation, Bangkok, 1998.

⁶¹ Nepal South Asia Centre: Nepal Human Development Report 1998 (Katmandu, UNDP, 1998).

⁶² Evidence can be found in United Nations High Commissioner For Human Rights: Sale of children, child prostitution and child pornography, report by Vitit Muntarbhorn, Special Rapporteur, New York (Doc.E/CN.4/1994/84/Add.1), 20 January 1994, paras. 52 and 53.

Also ILO and FESC: Situation analysis of child labour in Nepal, cited by Nepalnews.com <http://www.nepalnews.com.np/contents/englishweekly/telegraph/2000/feb/feb23/national.htm>

⁶³ Soma Wadhwa: “For sale childhood”, Outlook in India (Delhi), 1998. This unofficial account is substantiated by HIV/AIDS prevention programmes supported by USAID and by the United States Department of State: Nepal Country Report on Human Rights Practices for 1998 (Washington, DC, United States Government Printing Office, 1999).

⁶⁴ Molo Songololo: The Trafficking of Children for Purposes of Sexual Exploitation - South Africa (Cape Town, 2000).

Labour.⁶⁵ Trafficking in women and girls is also increasing in Europe and the new states of central Asia.

Half a million children are prostituted in Brazil. Costa Rica's capital, San José, counts some 2,000 girls who are prostituted and who are especially sought by tourists and wealthy nationals.⁶⁶ One of the signs of the inequalities between countries is expansion of the tourism-based sex industry in developing countries, as law enforcement against paedophiles increases in developed countries.

It is becoming increasingly common for men to seek younger and younger girls for sex, as they believe that younger girls are free from HIV. According to the child rights' organization ECPAT International, "the average age of girls trafficked in India has dropped from ages 14-16 to ages 10-14. This is a direct result of the demand for young girls."⁶⁷ Girls from the mountain areas of Viet Nam are in demand in Cambodia "because they are perceived to decrease the risk for HIV/AIDS or other STD's [sic]."⁶⁸ In Latin America, too, younger children are being drawn into the sex industry at an increasing rate. A 1994 study by the City of Bogotá Chamber of Commerce, Colombia, found that prostitution among 8-13 year olds had increased by 500% between 1986 and 1993. A study commissioned by UNICEF in 1995 discovered that almost half of the girl prostitutes in El Salvador, Guatemala, Honduras and Nicaragua entered prostitution between the ages of nine and thirteen. As elsewhere, there appears to be a trend towards more and younger children in the sex industries of the Latin American and Caribbean countries that collect such data.⁶⁹

The risk of HIV infection is much higher for girls than for boys and men. Invariably, HIV prevalence rates among girls and women working in the sex industry who are treated are far higher than those of the general population. For example, in Guyana in 1997 HIV prevalence among blood donors was 3.2%, while 46% of urban female sex workers were HIV-positive.⁷⁰ In the community around one of South Africa's mines, HIV prevalence among female sex workers was 70%, twice the prevalence of 37% among resident women.⁷¹ Figure 3 illustrates the disparity in HIV infection rates between boys and girls (aged 15-19 years) in Kenya.

⁶⁵ Out of the Shadows: A Worldwide Report on the Worst Forms of Child Labour, op.cit.

⁶⁶ Bruce C. Harris: Presentation to the Inter American Commission on Human Rights on the Subject of the Commercial Sexual Exploitation of Children in Costa Rica, March 2000, <http://www.casa-alianza.org/EN/human-rights/sexual-exploit/docs/0003audiencia.shtml>

⁶⁷ Social Implications of Child Prostitution, Texas Association Against Sexual Assault, <http://www.taasa.org/currentissues/chldprostit.htm>, citing an unidentified ECPAT document. [the editor asked if this is the correct reference. The answer is, yes.]

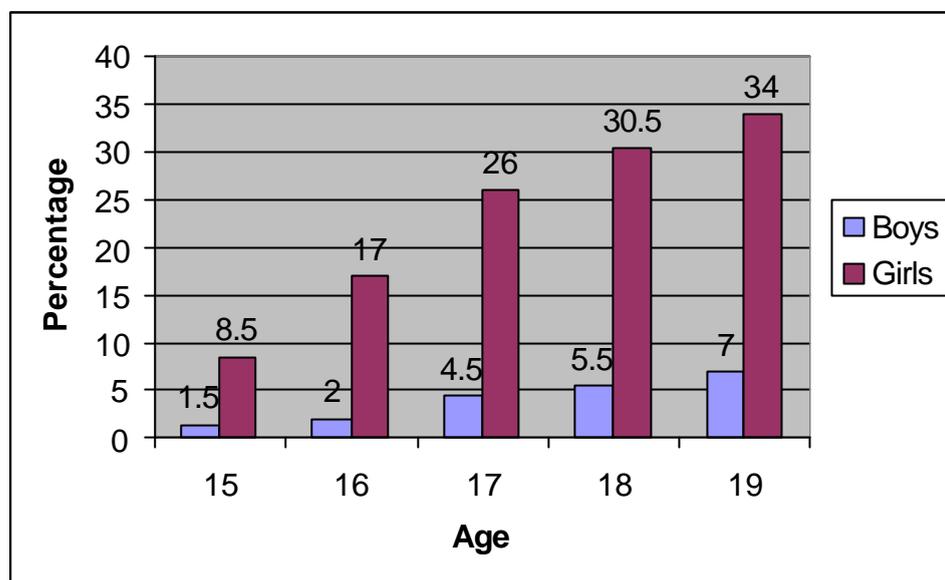
⁶⁸ ILO/IPEC: Trafficking in children for labor exploitation in the Mekong sub-region: A framework for action, op.cit.

⁶⁹ Social Implications of Child Prostitution, op.cit.; Peggy McEvoy: "Caribbean Crossroads", Caribbean Voice (Bronx, NY), <http://www.caribvoice.org/Health/aids.html>

⁷⁰ HIV/AIDS: A threat to decent work, productivity and development, document for discussion at the Special High-Level Meeting on HIV/AIDS and the World of Work, Geneva, ILO, June 2000, p.6.

⁷¹ Denise Gilgen, Catherine Campbell et al.: The Natural History of HIV/AIDS in South Africa: A Biomedical and Social Survey in Carletonville (Johannesburg, Council for Scientific and Industrial Research, 2000).

Figure 3. HIV-infection rates among Kenyan boys and girls (aged 15-19 years) (rounded percentages, six districts, 1999)



Source: George Odipo: *Adolescent Aids Epidemic in Kenya: Lessons from Child Abuse Proportion* (University of Nairobi, Population Studies and Research Institute, 2000).

Added to the gender bias is poverty. Poverty and gender are inextricably intertwined. Women and children are disproportionately represented among the poor. Some 70% of the world's poor are women. It is poor women (and within that group, young women aged 12-20 years) who are most susceptible to HIV infection,⁷² because of the income and decision-making inequalities between men and women, because of the biases in education, food supply, and health care against girls, and because of fewer opportunities for gainful employment for young women. Bangkok masseuses (commercial sex workers in massage parlours) are reported to say that their presence in the sex industry was an entrepreneurial decision, "a perfectly rational decision within the context of their particular social and economic situation."⁷³

5.2 Poverty: labour migration and sex work

The relationship between poverty and HIV/AIDS is bi-directional.⁷⁴ Poverty contributes to situations in which people face higher risks of HIV infection, such as the migration of both men

⁷² Paul Farmer: "On Suffering and Structural Violence: A View from Below", *Daedalus* (Boston, MA), Vol. 118, 1989, p 275.

⁷³ Ronald Skeldon: *Population Mobility and HIV Vulnerability in South East Asia: An Assessment and Analysis* (Bangkok, UNDP, 2000). Skeldon cites P. Podhista et al., "Socio-cultural context of commercial sex workers in Thailand: an analysis of their family, employer, and client relations", in J. Cleland and P. Way, eds.: "AIDS impact and prevention in the developing world: demographic and social science perspectives", *Health Transition Review* (Canberra, ACT), Vol. 4, 1994, pp.297-320, and P. Phongpaichit: *From Peasant Girls to Bangkok Masseuses* (Geneva, ILO, 1982). Podhista et al. state that the sex workers interviewed for their study told them that "they do not insist on condoms because their fear of poverty is greater than their fear of AIDS."

⁷⁴ The term is used in several publications of the UNDP HIV/AIDS programme.

and women to areas that offer greater opportunities for employment and income. In turn, HIV infection becomes a major financial and asset drain on households, communities, businesses and countries, leading to increased poverty.

Migration is a key livelihood strategy for many millions of people across the world. The dislocation of so many millions of people from their homes stems from prevailing inequalities generated, in part, by socioeconomic development efforts. In many countries, the development paradigm, which was often imposed by and for colonial powers and has been pursued since independence by political authorities and local economic upper classes, in association with transnational corporations and international development agencies, has focused on the export of agricultural products and minerals. The plantations, mines and industries, though development enclaves from one point of view, have required and attracted massive quantities of labour drawn largely from the countryside. Heavy concentration in urban centres of both formal and informal sector employment has also drawn millions of young people into the cities.⁷⁵

Being away from regular sexual partners, living in the context of different social norms, lacking adequate recreational facilities, using alcohol and drugs, and other factors all contribute to higher risk situations for migrant workers. Using 1993 data, a study of migrants in Kenya concluded that “Independent of marital and cohabitation status, social milieu, awareness of AIDS, and other crucial influences on sexual behaviour, male migrants between urban areas and female migrants within rural areas are much more likely than non-migrant counterparts to engage in sexual practices conducive to HIV infection. In rural areas, migrants [returning] from urban places are more likely than non-migrants to practice high-risk sex.”⁷⁶ Labour migrants have higher infection rates than those who do not move, independent of the HIV prevalence at the site of departure or the site of destination.⁷⁷ High HIV prevalence rates in areas of high out-migration have been documented in Ecuador, Kenya,⁷⁸ Mexico,⁷⁹ Nepal, Senegal,⁸⁰ and in the southeast of Ghana.⁸¹ Higher HIV prevalence rates are common among truckers, trucker helpers, and other users of major transportation routes and people living along those routes (e.g. Mombasa-Kampala, Highway One in Vietnam, Nepal-India).⁸² Likewise, high prevalence rates are found around many construction sites, mines, and other points where men may be working in isolation.

There is little evidence on the number of girls involved in recognized migration. The International Labour Office estimated in the mid-1990s that around 1.5 million Asian women were working overseas either legally or illegally, but the number below the age of 18 was not given. The relationship between migration and HIV is real, however. In the 1990s, the ILO estimated that at least 80% of those who entered Japan as legal migrants were “entertainers”. Thailand, Brazil, the

⁷⁵ A recent detailed study is Eric Beauchemin: *The Exodus: The Growing Migration of Children From Ghana's Rural Areas To the Urban Centres* (Accra, Catholic Action for Street Children and UNICEF, 1999).

⁷⁶ M. Brouckerhoff and A.E. Biddlecom: “Migration, Sexual Behavior and the Risk of HIV in Kenya”, *International Migration Review* (New York, NY), Vol. 33, 1999.

⁷⁷ Josef Decosas and Alix Adrien: “Migration and HIV”, *AIDS* (London), Vol. 11, Suppl. A, 1997, p. S78.

⁷⁸ M. Brouckerhoff and A.E. Biddlecom: “Migration, Sexual Behavior and the Risk of HIV in Kenya”, op.cit.

⁷⁹ A. Santarriaga et al.: *HIV/AIDS in a Migrant Exporter Mexican State*, paper presented at the XI International Conference on AIDS, Vancouver, July 1996.

⁸⁰ G. Pison et al.: “Seasonal Migration: A Risk Factor for HIV Infection in Rural Senegal”, *Journal of Acquired Immuno Deficiency Syndromes* (New York, NY), Vol. 6, 1993, pp. 196-200.

⁸¹ Josef Decosas: “HIV and Development”, *AIDS* (London), Vol. 10, Suppl. B, 1996, pp. S69-S74.

⁸² “India’s long-distance truckers average 200 sexual encounters each year; at any given time, 70 percent of them have STDs.” Quote from *Harvard AIDS Review* (Boston, MA), Fall 1995.

Philippines, and the Dominican Republic, in that order, have the highest populations of women working overseas in the euphemistically labelled “entertainment” industries. Over half a million Dominican women are abroad as “entertainers”.⁸³ It can be assumed that a significant proportion of women migrant entertainers are under 18.

Boys, too, are involved in sex work and the United Nations and other sources report that the demand for boys is increasing.⁸⁴ However, in most countries, boys represent only a small proportion, usually no more than 10% (for example, in Bangkok, males represent 34% of all prostitutes), of children involved in prostitution.⁸⁵ In Sri Lanka, that proportion is reversed and of the estimated 20,000-30,000 children involved in commercial sexual exploitation, an estimated 80% are boys. Like girls, boys are often recruited into the sex industry at an early age. In Jamaica, girls as young as 12 and boys as young as 9 are involved in sex tourism and the street sex trade.⁸⁶ Jamaican “beach boys” cater to the tourism trade. South African “rent boys” serve homosexual or bisexual clients and work off the streets and in their clients’ motorcars.⁸⁷

Some analysts argue that boys become engaged in the sex industry for different reasons than girls. For example, research in Sri Lanka on children in prostitution revealed that 80% of the children surveyed were still at school and that the majority of them were not responding to situations of poverty.⁸⁸ Male prostitutes in Bangkok (presumably including boys, but this is not specified) are said to enter the trade on the introduction of a friend or through job advertisements. “For male sex workers, choosing this job is mainly their own decision.”⁸⁹ Elsewhere, different motivations are seen. The involvement of boys and girls in sex work in Jamaica is driven, according to Peter Weller, a psychologist and HIV/AIDS behavioural specialist, by the dire economic conditions in the country.⁹⁰ In other cases, boys flee abusive situations at home, finding street life more tolerable.

In Zimbabwe, the loss of adult labour on commercial agricultural estates as a result of HIV/AIDS increases demand from both the estates and working households for child labour; in South Africa, child labour on estates is expected if the child lives with parents on the compound.⁹¹ The recent invasions of white-owned farms in Zimbabwe have affected children, according to news reports.

⁸³ Aida F. Santos: *Emerging Issues: Reproductive health and HIV vulnerability of migrant and mobile populations*, paper presented at the Fifth International Congress on AIDS in Asia and the Pacific, Kuala Lumpur, 1999.

⁸⁴ An increased demand for boys for sexual purposes in Kathmandu is noted by a Special Rapporteur (see footnote 80); “Child Sex Tourism is Flourishing in Sri Lanka”, *Coalition Report* (New York, NY), newsletter of the Coalition Against Trafficking in Women, Vol. 4, No. 1, 1997; ILO/IPEC: *Mainstreaming Gender in IPEC Activities* (Geneva, 1999).

⁸⁵ In Mexico, the Center for Research and Advanced Study in Social Anthropology found that 10% of children in the sex industry were boys. United States Department of State: *Human Rights Report, 1999* (Washington, DC, United States Government Printing Office, 2000).

⁸⁶ ECPAT International: *Bluebook 2000* (Bangkok, 2000).

⁸⁷ Robert C-H. Shell: *Yangen’inkonmo endlwini; The cow enters the hut: AIDS in the poorest province of South Africa, 1976 to 2001*, paper presented at DEMSA conference, 2000.

⁸⁸ Local HIV/AIDS authorities and activists in Indonesia, Nigeria, and Kenya told the author that schoolgirls sold or exchanged sex to gain material benefits, such as CDs and clothes. The author is not aware of studies that confirm such statements.

⁸⁹ Chumrurtai Kanchanachitra: *Reducing Girls’ Vulnerability to HIV/AIDS: The Thai approach* (Geneva, UNAIDS, 1999).

⁹⁰ Leith L. Dunn: *Child Prostitution in Jamaica*, draft of an ILO Rapid Assessment (Port of Spain, Trinidad and Tobago, ILO, 2000); Neville Johnson: *Poverty Driving Boys into the Sex Trade*, Inter Press Service, 20 June 1998.

⁹¹ ILO/IPEC: “Child Labour in Commercial Agriculture in Africa”, *op.cit.*, paras. 15 and 18.

Children and teachers reported being harassed by occupiers, farm schools closing, and farm workers' children dropping out of school because they were afraid of strangers as they walked along the road to school. Particularly vulnerable were AIDS orphans, especially girls, who had a higher dropout rate, which generally took place within three years of being orphaned.⁹²

5.3 *Degree of social cohesion*

Social cohesion has gained recognition as a factor, albeit intangible, that relates to both child labour and HIV. Increased levels of social cohesion arise from social structures offering opportunities for people to pursue social goals and improve their well-being. Two well-established analysts of HIV/AIDS argue that a society's susceptibility to HIV infection and its vulnerability to the impact of HIV/AIDS are determined by the degree of social cohesion *and* by the overall level of wealth. Societies with low social cohesion and low wealth will be the most susceptible and vulnerable, according to this hypothesis.⁹³ Communities sending out large numbers of migrant workers are likely to be less cohesive than those where almost everyone works and socializes locally. Likewise, the areas where migrants settle are often transitory in nature or lack many of the features of home societies (the mine compounds of southern Africa are obvious examples). Without the influence of the social norms of a home society, migrant workers are "free" to engage in behaviours that may place them at risk.

Initial evidence from Uganda suggests that much of the information about AIDS and about persons affected by AIDS is transmitted through socially accepted personal communication networks. As these networks are deemed credible, people feel they can apply the information to their own behaviour. One element contributing to social cohesion has been very active civil society leadership in promoting prevention and care, reinforced by high-level political support in openly communicating the facts about AIDS risk and prevention to the population.⁹⁴

The degree of social cohesion is also relevant in assessing options for children affected by HIV/AIDS. The breakup of a family by the death of a parent and the potential placement of children in foster care causes, at least over the short to medium term, a break with the established social order. Children are likely to feel uncertain about their future, excluded from the security they had known, and adrift from mainstream society. For many adults in African societies, the loss of social relations is seen as a much worse calamity than the reduction or loss of income.⁹⁵ Children, too, must feel the stresses of the unravelling of their lives.

5.4 *Socioeconomic shocks*

The HIV/AIDS pandemic comes on top of a series of "shocks" that have confronted countries, and especially lower income groups in those countries, over the past three decades. The hopes of

⁹² "Children victims of land crisis, AIDS in Zimbabwe", Associated Press, 14 September 2000.

⁹³ Tony Barnett and Alan Whiteside: *The Jaipur Paradigm: A Conceptual Framework for Understanding Social Susceptibility and Vulnerability to HIV*, unpublished paper, 1998.

⁹⁴ World Bank: *Adapting to Change*, electronic newsletter No. 3, January 2001; Werasing Sittitjai: *HIV Prevention Needs and Successes: a tale of three countries. An update on HIV prevention success in Senegal, Thailand, and Uganda* (Geneva, UNAIDS, 2001).

⁹⁵ Sophie Bessis: *From social exclusion to social cohesion: towards a policy agenda*, Management of Social Transformations Policy Paper No. 2 (Paris, UNESCO, 1995).

positive development have been steadily eroded by economic crises and prolonged economic downturns in many countries.

These economic shocks have drained countries in Africa, Asia and Latin America of human, financial and natural resources and have made effective planning nearly impossible. Shocks range in size from communities not receiving fertilizers on time for planting, thereby limiting yields and incomes, to national currency devaluations and health sector reforms. Few people have escaped the impact of these shocks, and, as previously mentioned, it is the lower income/resource poor groups that have suffered most.

Zimbabwe is one of the countries hardest hit by the HIV/AIDS pandemic. The country has also been exposed to sustained and severe economic shocks for over a decade. An assessment by the World Bank argues that “Higher costs for food and social services, combined with declining formal sector wages and the lingering effects of severe drought in 1991-92, have left many of the poor worse off than before adjustment began. Although both the government and the Bank tried to protect spending for health and education, large budget deficits fuelled inflation and led to growing interest payments, which contributed to declines in real health spending and real wages for health workers.”⁹⁶ The extent of health budget cuts was dramatic: a decline of 14% in 1991-92 and another 15% in 1992-93.⁹⁷ Thus, at a time when a vibrant health system was needed to deal with the emerging HIV/AIDS pandemic, and with drought-induced malnutrition, it was being defunded in a devastating way.

The alternatives to these economic shocks and restructurings are often as negative as the shocks themselves. For example, in Nepal, the World Bank has encouraged the government to expand tourism in order to expand sources of foreign exchange and employment.⁹⁸ One outcome, however, has been increased demand for sex from tourists. Another aspect of economic restructuring is a greater focus on export promotion. Yet some commentators claim that this has been at the expense of worker rights and wage rates within, for example, the carpet industry, thus perpetuating the harsh working conditions from which girls and women are recruited into the sex industry.⁹⁹

These economic shocks have added to the shocks faced by young people, including the failure of the promise that development will help improve their lives. Development as envisioned in the 1960s and 1970s has been replaced by disillusionment, among development professionals as well as the intended beneficiaries. Widely practiced economic activities, such as agriculture, offer young people inadequate and inconsistent returns.¹⁰⁰ In one district of Tanzania, mean annual household income from agriculture declined by 71% between 1979 and 1992.¹⁰¹ Even in countries

⁹⁶ World Bank: “Meeting the Health Care Challenges in Zimbabwe”, *Precis* (Washington, DC), No. 176, Operations Evaluation Department, January 1998.

⁹⁷ Caroline Harper & Rachel Marcus: *Child Poverty in Sub Saharan Africa*, Institute of Development Studies, Brighton, 1999, p.14 (a background paper for the 1999 Africa Poverty Status Report, published by the World Bank).

⁹⁸ World Bank: *Nepal 1997 Economic Update*, Report 17034-NEP (Washington, DC, 1997).

⁹⁹ Suman Pradhan: *Labour-Nepal: Carpet Industry Under Scrutiny For Flouting Laws*, Inter Press Service, January 13, 1999, http://www.oneworld.org/ips2/jan99/09_00_012.html.

¹⁰⁰ Deborah Fahy Bryceson: *Sub-Saharan Africa Betwixt and Between: Rural Livelihood Practices and Policies*, ASC Working Paper 43/1999 (Leiden, Afrika-Studiecentrum, 1999), pp. 4-6.

¹⁰¹ C.G. Mung'ong'o: *Coming Full Circle: Agriculture, Non-Farm Activities and the Resurgence of Out-Migration in Njombe District, Tanzania* (Dar es Salaam, Institute of Resource Assessment and Leiden, Afrika-Studiecentrum Working Paper, 1998), Vol. 26.

with rapid economic growth, such as Thailand, small-scale agriculture has become steadily less advantageous as a source of livelihood. According to UNDP, "In 1960, the average income of agricultural households [in Thailand] was estimated to be around one-sixth of the average income in other sectors. By the 1990s the difference had grown to one-twelfth, implying that 60 percent of the population has been disadvantaged by income trends."¹⁰² Young people, in particular, have expected, or more rightly, imagined, opportunities for wage employment in urban areas, a phenomenon seen throughout south-east Asia, in China, across much of Sub-Saharan Africa and in Latin America. But even in urban areas, opportunities for improving one's life have been severely limited. Survival rather than livelihood has become the norm for many young people. In such circumstances, street children in Delhi, and in most urban centres "found it difficult to relate to HIV/AIDS when, for many of them, the priority was day-to-day survival." Sale of sex was one way to survive in difficult circumstances. Rural Nepalese girls are said to be "desperate enough to do anything to escape their hopeless situation in the villages."¹⁰³ In Morocco, the United Nations estimates that up to 48% of street children have been sexually abused in return for food and shelter.¹⁰⁴ So desperate are some children in South Africa that they are induced into the sex industry with promises of food or material goods.¹⁰⁵ Paul Richards, an agro-technician with a strong anthropological bent, has looked closely at the attitudes of young people in Africa. He writes that "HIV/AIDS cuts short the normal life expectation, and already [c.1999] young people in Tanzania make it clear that they have to work with the space they will get. Life has to be lived to the full but perhaps over 30-40 years rather than a normal three score years and ten."¹⁰⁶

6. Initiatives to address HIV/AIDS and child labour

Numerous NGO, community, and some national programmes have emerged to address children affected by HIV/AIDS. Most of these are direct service programmes, seeking to fill some of the gaps that have occurred in the children's lives as a result of the death of a parent.

Very few of these programmes go beyond direct service to address the socioeconomic factors driving the pandemic, and most of the programmes are already overwhelmed by the magnitude of the number of children affected by HIV/AIDS. There are a handful of programmes supported by bilateral donors, USAID and GTZ for example, to improve work opportunities for youth affected by HIV/AIDS. Some vocational training programmes, usually targeting boys have incorporated HIV/AIDS information, but the programmes rarely address male sexual norms and associated behaviours.

¹⁰² UNDP: Human Development Report of Thailand, 1999, op.cit., p. 14.

¹⁰³ David Holmstrom: "One Woman's Efforts to Stop the Trade in Girls for Brothels", Christian Science Monitor (Boston, MA), 14 April 1999.

¹⁰⁴ Peter Kandela: "Marrakesh: Child prostitution and the spread of AIDS", Lancet, Vol. 356, 2000, p. 1991. The author of this article provides no statistics on the number of street children in Morocco, but does cite government sources reporting over half the country's population is living in poverty and that number is increasing. See also papers on street children in Nairobi, Kenya including Alison Mott and Philip Kilbride: Street girls in Nairobi: Patterns of Survival for Homeless Teen Mothers (Athens, OH, Ohio University, 1999); Catherine D. Cutcher: Survival At The Periphery Of Underdevelopment: Street Children in Nairobi, Kenya (Athens, OH, Ohio University, 1999).

¹⁰⁵ Molo Songololo: op.cit, pp. 28-30; Steven Swindells: "Child sex trafficking on rise in South Africa", 26 November 2000, <http://www.antichildporn.org/news>

¹⁰⁶ Paul Richards: Hurry, We are All Dying of AIDS: Linking Cultural and Agro-Technical Responses to the Challenge of Living with HIV/AIDS in Africa, paper presented to a conference on AIDS, Livelihood and Social Change in Africa (The Netherlands, Wageningen Agricultural University, 1999).

In Peru, the local affiliate of the International Planned Parenthood Federation collaborated with a local NGO specializing in business training to provide 30,000 poor urban youth with reproductive health services and business training over a two-year period.¹⁰⁷ Evaluation showed increased knowledge about reproductive health and improved attitudes toward responsible sexual behaviour.

There are experiments with micro-savings/micro-credit initiatives (mostly in southern Africa) to help cover the education expenses of children orphaned by HIV/AIDS and to include such children in small business financing. Various community groups in South Africa and Uganda, for example, use informal savings programmes to help pay school fees and other expenses for orphaned children. Some long established programs, such as The AIDS Service Organization (TASO) in Uganda, are working with parents infected with HIV to help them make arrangements for their children and to prepare them for when death comes. In Uganda, UNDP also supports a small-scale credit fund that includes provisions for orphan care and involvement.¹⁰⁸

The relationship between child labour and HIV/AIDS is appearing more frequently in the literature, including that of the United Nations system. At the national level, there is a reliance on existing and new national legislation and international mandates for addressing the sexual exploitation of children. However, most governments have only recently begun fully to address the HIV/AIDS pandemic. They are either overwhelmed by the extent of the problem or unable to address effectively the impact of the epidemic on children. In Africa, several governments have instituted reductions in, or elimination of, school fees for orphaned children.¹⁰⁹ However, little has been done to implement and strengthen programmes, policies, or legislation to reduce the likelihood of children orphaned by HIV/AIDS from being drawn into hazardous forms of work. Instead, NGOs have taken the lead in addressing these issues and they provide much of the impetus for moving governments to focus their resources on these issues.

At the international level, the ILO has taken the lead in increasing the understanding of the situations that contribute to placing children in high-risk situations for HIV infection and hazardous work. The UNDP South-East Asia office is sponsoring research and publications on the relationship between migration, including the trafficking of children, and HIV/AIDS. That work is to be encouraged, including a greater focus on working with member States and organizations to expand understanding at national and local levels. International advocacy groups, such as Global March Against Child Labour and ECPAT International, have begun to make linkages between HIV/AIDS and child labour.

7. HIV/AIDS and the future dimensions of child labour

What does HIV/AIDS mean for the future dimensions of child labour? The millions of adults of working age who are likely to lose their lives will leave a major gap in national workforces. Will this lead to a demand for younger people to fill some of the places? The prevailing demand-side

¹⁰⁷ E. Segil and A. Sebastiani: "An Integrated Reproductive Health and Business Training Program for Youth", *FOCUS Project Highlights* (Washington, DC), FOCUS on Young Adults, 1999.

¹⁰⁸ J. K. Bejjuka: *A Study on the Revolving Fund/Credit Schemes - Final Report, UNDP Micro-Projects Programme to Combat AIDS* (Kampala, Uganda, 1994).

¹⁰⁹ It is not known, however, how many children know about such subsidies and take advantage of them. Usually, the programmes are for all orphaned children, so as to avoid focusing attention on children orphaned by HIV/AIDS.

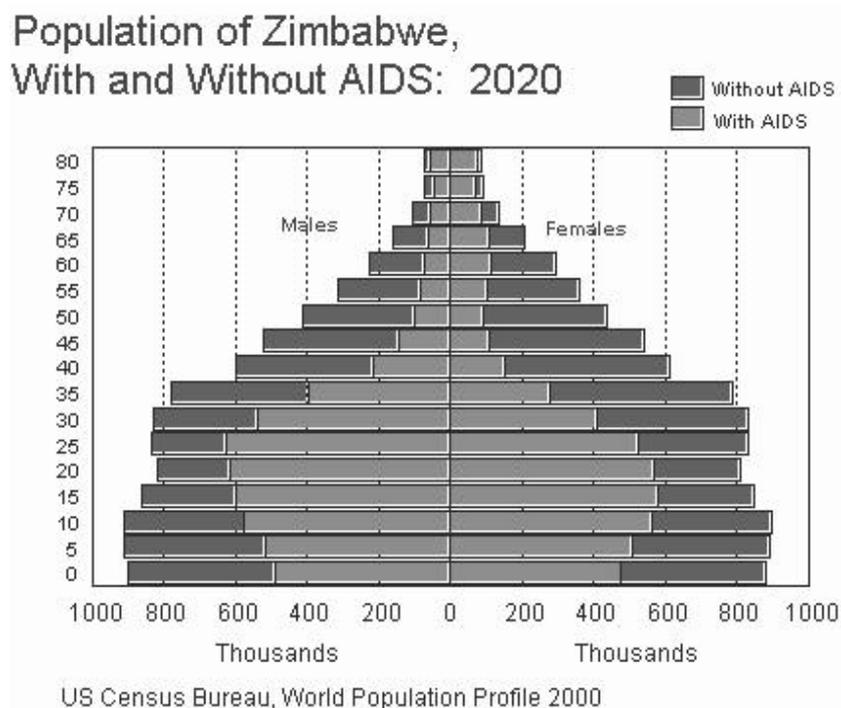
reasons for using children in the workforce (i.e. less costly than adults, more compliant to difficult workplace conditions) will continue, but it is unclear whether children will fill places formerly held by adults. As noted, the pandemic has increased demand for younger children in the sex industry. The consequences and risks of HIV/AIDS are also placing millions of children in situations where they are likely to have to work more and at an earlier age, and often without the benefits of adequate education or training, than has been the case for most children in the past. Thus, both demand and supply factors are increasing.

Demographic changes resulting from HIV/AIDS are likely to have very mixed implications for child labour. On the one hand, the deaths of millions of working adults in the general 18-45 year age group, the age group most affected by HIV/AIDS (see Figure 4, for the example of Zimbabwe), will leave vast gaps in the labour force over the next two decades. Will there be a greater demand for younger people to help fill these gaps? Will children be recruited in some cases, and most likely in some sectors (agriculture, informal manufacturing, informal sales and services), but not in others (formal sector manufacturing, finance/insurance, public service)?

Projections made in the early 1990s of the impact of HIV/AIDS on selected countries indicated that formal sector workers had disproportionately higher rates of infection. For example, in Malawi wage earners in firms with more than nine employees represented 6% of the country's population, but accounted for 19% of all new AIDS cases.¹¹⁰ If that trend had continued (in fact, HIV prevalence came to reflect more closely the national demographic structures), formal sector employers would have been actively searching for employees, or perhaps young trainees, to fill vacant posts.

¹¹⁰ S. Forsythe et al.: *Projecting the socio-economic impact of HIV/AIDS in Malawi*, abstract for the International Conference on AIDS, 1993.

Figure 4.



Source: www.census.gov/ipc/www/idbnew.html

An analysis of future demographic and economic trends in Botswana, a country with a HIV prevalence rate of about 36% of the adult population, by the International Institute for Applied Systems Analysis indicates a stagnation in the total population but a decrease in rural and an increase in urban populations. The rural labour force will decline more rapidly than the rural population and will be very imbalanced toward young and elderly people. At the same time, the modelling exercise suggested that the high levels of unemployment and underemployment of the past two to three decades would change over the next two decades. “Although it seems like wishful thinking today, an important labor market concern will become the short supply of unskilled labor”, as that segment of the labour force will lose a disproportionate number of people to HIV/AIDS. “Assuming the 1991 rates of labor force participation (economic activity), the more-educated labor force will grow by around 80% from 2001 to 2021, while the less-educated labor force will shrink by around 18%.”¹¹¹ The study did not specifically indicate trends for children or children orphaned as a result of HIV/AIDS as they become teenagers and joined the labour force, but the suggestion is that work opportunities will become more available over time. What is not known is how children who are orphaned as a result of HIV/AIDS will be situated to take advantage of these changes.

¹¹¹ Warren C. Sanderson, Molly E. Hellmuth and Kenneth M. Strzepek: *Botswana's Future: Modeling Population and Sustainable Development Challenges in the Era of HIV/AIDS* (Laxenburg, Austria, International Institute for Applied Systems Analysis, 2001), pp. vi and 10. The same conclusion is drawn in a companion study on Namibia.

7.1 Resources to address child labour and HIV/AIDS

The ability of countries to respond effectively to the HIV/AIDS pandemic and its impact on child labour depends, in part, on adequate resources. One of the great dilemmas of the pandemic is that it diverts household, business, and national resources from savings and social and economic investments to health and medical care for members of society who are sick. Projections of the future impact of HIV/AIDS on resources indicates that business and national resources will become more constrained, as more people become ill and die.

By 2010, it is estimated that approximately 15% of highly skilled employees in South Africa will have contracted HIV, with the potential of great losses to the public service, private enterprise, and households. A projection by Metropolitan Life Insurance Company in South Africa suggested that the cost of benefits for businesses would nearly triple between 1995 and 2005 as a result of HIV/AIDS in the workforce.¹¹² Another assessment estimated total direct costs of HIV/AIDS reaching 3.6 and 8% of current GNP by 2005, depending upon the assumptions used.¹¹³ An assessment by the Botswana Institute for Development Policy Analysis projected HIV/AIDS to reduce the growth rate of GDP in that country by 1.5% per annum, with the economy being 31% smaller by the year 2025.¹¹⁴ Recent decisions by large mining companies and the Botswana government to provide anti-retroviral drugs to HIV-infected workers and citizens will obviously influence these projections. The ILO refers to studies from Cameroon, Kenya, Swaziland, Tanzania and Zambia that project reductions in rates of economic growth by as much as 25% over a 20-year period as a result of the HIV/AIDS pandemic.¹¹⁵ A study of the impact of HIV/AIDS on India's economic situation indicated that the equivalent of one year's GNP would be lost across sectors if current trends of HIV/AIDS infection continue into the 21st century.¹¹⁶ The pandemic has been projected by the Health Economics Unit of the University of the West Indies to cost the Caribbean region at least \$80 million (6% of the region's GDP) by the year 2020 in direct (for patient care and support) and indirect (lack of productivity) costs.¹¹⁷

7.2 Children in the future labour force

Given past trends and the prevailing social and economic conditions that relate to HIV/AIDS and child labour, some of the changes likely to occur that will influence child labour are:

- a continuing increase in the number of child-headed households in which one or more of the older children participate in the labour force;
- marginal livelihoods for millions of orphaned children fostered to LIRP adults;

¹¹² Alan Whiteside, Mary O'Grady and Anita Alban: *How Will AIDS Impact on Your Business?*, paper prepared for the 1998 Southern Africa Economic Summit, Update Session, 4th July 1999. Alban is a staff member of UNAIDS, although the paper is not an official United Nations document.

¹¹³ Lori Bollinger and John Stover: *The Economic Impact of AIDS in South Africa* (Washington, DC, The Futures Group International (Policy Project), 1999) pp.11-12. The publisher has produced similar studies for other countries.

¹¹⁴ R. Greener, K. Jefferis and H. Siphambe: *The macroeconomic impacts of HIV/AIDS in Botswana*, abstract prepared for the International Conference on AIDS, Durban, July 2000.

¹¹⁵ ILO: *HIV/AIDS: A Threat to Decent Work, Productivity and Development* (Geneva, ILO, 2000), p.12.

¹¹⁶ C.N. Pandav et al.: "Economic Consequences of HIV/AIDS in India", *National Medical Journal of India* (New Delhi), Vol. 10, No. 1, 1997, pp. 53-59.

¹¹⁷ The figures are cited in World Bank: *The Caribbean Regional Strategic Plan of Action for HIV/AIDS* (Washington, DC, World Bank, 2000), p.4.

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- increased out-migration by both boys and girls from rural settings where they have few, if any, assets and livelihood opportunities;
 - potentially significant increases in child morbidity due to malnutrition, parasitic infections, etc., which will compromise their future roles in the workforce.

In households where one or more adults are ill with HIV/AIDS, children will probably be required to assume new and/or additional household tasks. Girls will probably be expected to assume a major role in caring for adults and younger siblings who are sick. In agricultural households, children will probably be expected to compensate, to some extent, for the loss of labour of women in farming tasks.¹¹⁸ Some households affected by HIV/AIDS, as was found in Côte d'Ivoire, will hire labour, perhaps at increased wage rates for workers, for agricultural tasks.¹¹⁹ The loss of inherited work knowledge that occurs between generations, whether through running a farm or acquiring a vocational skill, will have implications for individual children and for society as a whole.

The estimated 50 million children orphaned as a result of HIV/AIDS over the next two decades will enter the workforce with many disadvantages: gaps in education, psychological problems associated with the trauma of a lost parent or parents, lack of social structure to guide effective decision making, and the stigma and discrimination surrounding people affected by HIV/AIDS. They will not be the first choices of formal sector employers, unless such young people have been able to complete their schooling.

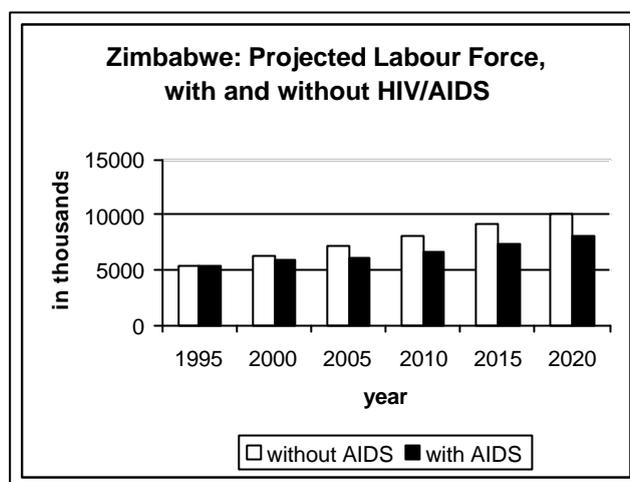
In countries heavily impacted by HIV/AIDS and with fragile economies, the prospects for non-decent work for young people are not good. In Zimbabwe, for example, young people are already the most affected by unemployment. The ILO observes that “The impact of HIV/AIDS has affected the highly qualified people and, therefore.....obviously deepening the skills shortages which are already existing, dealing a big blow on competitiveness.”¹²⁰ Figure 5 shows projections of the labour force of Zimbabwe with and without the impact of HIV/AIDS.

¹¹⁸ Gabriel Rugalema: *Adult Mortality & Entitlement Failure: AIDS and the Crisis of Rural Livelihoods in a Tanzanian Village*, Ph.D. dissertation, Institute of Social Studies, The Hague, The Netherlands, 1999.

¹¹⁹ FAO: *The Rural People of Africa Confronted with AIDS* (Rome, FAO, 1997); A.K. Tibaijuka: “AIDS and economic welfare in peasant agriculture”, *World Development* (Oxford), Vol. 15, No. 6, 1997, pp. 963-975.

¹²⁰ ILO: *National Child Labour Survey Country Report Zimbabwe-1999* (Geneva, ILO, 1999), <http://www.ilo.org/public/english/standards/ipecc/simpoc/zimbabwe/report/page1-1.htm#population>

Figure 5.



Source: ILO: *HIV/AIDS: A Threat to Decent Work, Productivity and Development*, 2000.

Although the labour force will not grow as fast given the influence of HIV/AIDS, the implications for all forms of child labour are likely to be mixed. With tens of thousands of children affected by HIV/AIDS unable to gain quality education or training, there is only limited likelihood that they will be able to step into positions of existing employees infected by HIV/AIDS. And, as business productivity, competitiveness and profitability are compromised by HIV/AIDS in the workforce, those businesses will be less able to hire new employees and will offer smaller tax revenues to governments, which will in turn affect investment in training and employment creation. Zimbabwe's "...poor economic performance", argues the World Bank, "has also led to decreased [public] spending on the social sectors, just at the time when the services are most needed."¹²¹

A similar situation exists for South Africa. One-third of African men and nearly half of African women are unemployed. The country has lost over half a million formal sector jobs in the past decade. Since 1994, almost 10% of non-agricultural jobs have disappeared, and people are turning to low-income, insecure, informal sector work.¹²² For children affected by HIV/AIDS or at risk of infection, the labour market does not offer short, or likely medium, term hope for achieving economic security. And Kenyan employers, including those involved in small-scale agricultural employment, are unable to absorb a growing labour force; even in the 1990s the employment gap was particularly vast for young people and even worse for "youth that drop out of school", a situation that describes many children affected by HIV/AIDS.¹²³

¹²¹ World Bank: *Zimbabwe-Multi-Sectoral AIDS Project*, Report No. PID9727, (Washington, DC, 2000). One can also argue that such social investment was needed early in the 1990s, at a time when Zimbabwe was collaborating with the World Bank to hold down public sector spending.

¹²² *Highlights of Current Labor Market Conditions in South Africa*, prepared by the National Labour & Economic Development Institute, Johannesburg, and published by Global Policy Network, Washington, DC and Johannesburg, 2000.

¹²³ *Highlights of Current Labour Market Conditions in Kenya*, prepared by the Congress of Trade Unions, Kenya, and published by Global Policy Network, Washington, DC and Johannesburg, 2000.

8. Conclusion

The relationship between HIV/AIDS and child labour has only recently become a focus for study. However, the socioeconomic context in which both of these conditions exist is fairly well known. The analytical concepts that have illuminated other socioeconomic conditions provide a basis for effectively linking HIV/AIDS and child labour. A review of the socioeconomic inequalities in societies is a starting point for understanding both the patterns of HIV/AIDS spread (e.g. along labour migration centres and transportation routes, in communities fractured by heavy out-migration or conflict) and the related outcomes of HIV/AIDS infection. Inequalities in income, assets, gender, and access to social services form the framework that fosters situations of risk of HIV infection. The potential for children to be placed in those situations of risk is both an outcome of HIV/AIDS infection and of their own inequitable status in society.

The programme and analytical work of both the HIV/AIDS and the child labour communities can be shaped and applied to bring greater focus to the role of inequalities in shaping risk. From the HIV/AIDS prevention and mitigation communities, it is possible to learn about the conditions of children affected by the epidemic. From child labour groups, information and analyses are available about the variety of hazardous working conditions that place children at risk of HIV infection. Thus, there are opportunities to build upon existing studies to clarify the linkages and to create more comprehensive analyses of the socioeconomic context of child labour. Further analyses of the socioeconomic relationships between child labour and HIV/AIDS risk can provide greater impetus to national and local responses to target factors that expose children to hazardous work. Such analyses can help donor and advocacy organizations to approach more comprehensively what have, until now, been treated largely as separate and independent issues.

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