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To Michael Iskowitz
From Tom Stillitano



AMERICAN CENTER
FOR INTERNATIONAL
LABOR SOLIDARITY

February 9, 1999

Mr. Tom Stillitano
Labor Advisor
United States Information Agency
301 4th Street, SW
Washington, DC 20547

Dear Tom:

Thanks again for your help in securing funding for the AFL-CIO's Solidarity Center/South African trade union HIV/AIDS workplace education program.

BOARD OF DIRECTORS

JOHN J. SWEENEY

RICHARD L. TRUMKA

LINDA CHAVEZ-THOMPSON

As you know a part of that program will be devoted to generating greater HIV/AIDS awareness through a campaign that will include public service announcements on South African radio and television and in the print media.

Once again, we would appreciate your input and assistance. I will soon be communicating with my brother and sister trade unionists in South Africa to discuss a unified approach to securing radio and television time in the South African media and in soliciting mutually acceptable corporate sponsors to the South African trade union centers and the Solidarity Center, to help supplement the grant award.

Your willingness to approach your U.S. corporate contacts in this regard would be most appreciated. In addition, we welcome any suggestions you may have as to American performers who are union members and are well known in South Africa, as well as members of our affiliated unions in the entertainment industry (Screen Actors Guild, American Guild of Musical Artists, etc.)

I look forward to meeting with you after I return to the country. Again, our special thanks for your continued support and assistance.

EXECUTIVE DIRECTOR

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Working Paper Series

"HIV/AIDS and Labor Force Productivity in Africa"

Ita I. Ekanem

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'HIV/AIDS AND LABOR FORCE PRODUCTIVITY IN AFRICA'

Text of an Address Delivered

by

**Dr. Ita I. Ekanem
Population Division
United Nations Economic Commission for Africa**

**On the Occasion of the Conferment on him of the
DISTINGUISHED GRADUATE ALUMNUS AWARD**

by

Brown University, Providence, R. I. (USA)

Monday, 27 May 1996

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The Chairperson

Distinguished Colleagues, Ladies and Gentlemen

I. INTRODUCTORY REMARKS

1. At the onset, let me say how delighted I am to be here on this historic occasion. I left Brown University early in January 1971, on completion of my Graduate studies which started in September 1967. I left with a great deal of satisfaction and brim-full with ideas, having been ushered into a new challenging and exciting world of academia. Unfortunately, I could not even attend the Commencement in May 1971 to receive my Diploma as I would have wished owing to pressing circumstances which demanded my presence in my home country, Nigeria before the Commencement date. Little did I know that an occasion, as eventful and glorious as this, would provide the much-needed opportunity for me to return to the Institution that nurtured my early interest and efforts in the population and development field.

2. I wish therefore, to express my profound gratitude to all the members of the Brown University Community including, in particular, Professor Emeritus, Sidney Goldstein, my much revered mentor; Professor Dennis Hogan, Director of the Population Studies and Training Center; Dean Michael Difilly, Chairman of the Faculty Committee responsible for approving the nominations; and, most importantly, President Vartan Gregorian, for his kind approval of my nomination for the

DISTINGUISHED GRADUATE ALUMNUS AWARD OF BROWN UNIVERSITY.

3. Let me first observe that I was requested to speak on the Theme: **"HIV/AIDS AND FAMINES IN AFRICA"**. Although this is an exciting and intriguing subject, I decided to amend it a little to read **"HIV/AIDS AND LABOR FORCE PRODUCTIVITY IN AFRICA"** principally because, although "the era in which we live has the odious distinction of being the period when more people will die of famine than in any

previous century, yet in no previous era has famine been more preventable than the present, through unparalleled communication and transport possibilities and world grain reserves, as well as the existence of international capability to detect and remedy food shortages anywhere, before famine results" [1].

4. The pertinence of the chosen theme is predicated not only on its topicality in terms of contemporary socio-economic realities of the African region but also because of the apparent causal linkage between the HIV/AIDS pandemic and labor force productivity.

5. It is common knowledge that currently, the human immuno-deficiency virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS) are life long infections without a vaccine for prevention. Just about fifteen years ago, few if any people were aware that a new epidemic disease was on the move. A decade later, it has become clear that HIV/AIDS is a pandemic of global reach and concern.

6. Because the disease and its pathogens have been under scientific study for only a short period of time, their natural history is as yet inadequately understood. It is a disease that thrives on human ignorance, fear, resistance to change and poverty. It differs from other diseases in several ways: it affects people who are responsible for the care and support of others; it affects adults in their economically and socially active years; and, because there is no cure, its potential to lower labor force productivity, can in fact, ultimately lead to famine especially in the rural areas of Africa.

7. World-wide, there are three distinct patterns in the incidence of the disease [2]. In the first (Pattern I) which includes Western Europe, North America, some areas of South America, Australia and New Zealand, most cases occur among homosexual and bisexual men and intra-venous drug users. Infection through blood and perinatal transfusion are no longer serious in this pattern. The second (Pattern II) involves parts

of central, eastern and southern Africa and Latin America (especially parts of the Caribbean). Common transmission modes in this pattern include heterosexual encounters, improperly sterilized syringes if used for immunization in children, treatment of malaria through blood transfusion. In the third (**Pattern III**) which includes Asia, parts of the Pacific, west Asia and western Europe, most cases occur in homosexual persons or blood recipients.

8. The Chairperson, Distinguished Colleagues, Ladies and Gentlemen, to provide leads for our discussion, I would wish to focus on four aspects of the HIV/AIDS pandemic, albeit briefly. The first will be in the form of a background covering the prevalence of the disease, its spread, transmission modes and the unfavorable economic climate in Africa. The second will focus on the impact of HIV/AIDS particularly on labor force productivity. In the third and fourth, I will address respectively, the challenges posed by and the responses towards confronting the pandemic.

II. BACKGROUND

- Prevalence and spread

9. Although in retrospect, the sub-Saharan African HIV/AIDS pandemic may well be regarded as the major event of our time because the sub-region may well lose as many people to the disease over the next half century as the Black Death killed in 14th century Europe [3], it is important to bear in mind that,

- first, given the difficulties in accurately assessing levels of HIV infection in normal populations, estimates of HIV prevalence are provisional and are intended to provide indications of the magnitude of the pandemic;**

- secondly, the knowledge that has so far guided us originates with a small number of researchers who have examined a limited number of cases; and,
- finally, given the magnitude of the sub-Saharan African HIV/AIDS crisis, it has been necessary to base generalizations on such a tenuous fabric of proven social science findings. A great deal is being written but much of it is based on the continuous recirculation of a small number of research findings [4].

10. With those precautionary remarks, I note that the World Health Organization (WHO) estimated that globally, by the end of 1994, about 17 million adults were living with HIV infection; the majority of these (11.2 million or 66 percent) were in sub-Saharan Africa [5]. Following country-by-country review of the data, WHO revised its 1994 estimate of adult HIV prevalence to 16.9 million.

11. WHO further maintains that as of 15th December 1995, about 1,291,810 cumulative AIDS cases in adults and children had been reported to its Global Program on AIDS (WHO/GPA) from 193 countries. This represented a 26 percent increase from the 1,025,073 cases reported in its weekly epidemiological record of 13th January 1995. As at June 1995, this number of cases reported to WHO/GPA by 41 out of the 46 sub-Saharan African countries for the 1978-1992 period totalled about 270,475. Of these, over 70 percent were in 12 of the 16 countries that constitute the Eastern sub-region of Africa. For 1993 alone, this number was 81,667 (75 percent in the Eastern sub-region); and increased to 126,607 (83 percent in the Eastern sub-region) by 1994 [6].

12. These reported cases indicate that the prevalence of the HIV/AIDS pandemic has been most severely felt in countries of the Eastern, Central and Southern sub-region of Africa. This observation is also substantiated by the findings from recent

studies in Rwanda, Tanzania, Uganda and Zambia [6] by the ILO Eastern Africa Multi-disciplinary Advisory Team in Addis Ababa. The ILO studies indicate that about 80 percent of the reported **TYPE I** cases of the disease [6] are concentrated in the 10 countries of **EASTERN CENTRAL AND SOUTHERN AFRICA** namely Burundi, Central African Republic, Kenya, Malawi, Rwanda, Tanzania, Uganda, Zaire, Zambia and Zimbabwe. These constitute what has been designated, the **AIDS BELT**.

13. In contrast to the experiences of countries within the belt, other countries in the West African sub-region such as Burkina Faso, Cote D'Ivoire and Ghana as well as those in the Northern and Southern sub-regions, still record relatively lower levels of the **TYPES I and II** strain of the disease [6]. In the North, there are worrying indications of a steady spread of the pandemic in southern Sudan, to take one example. Given these trends, WHO/GPA projects that the annual number of new HIV infections in sub-Saharan Africa will continue to rise in the coming years.

14. Aside from WHO, Way and Stanecki (cited in the ILO studies under reference) estimate that as of 1994, out of the 19.5 million infected people worldwide, 11 million (about 55 percent) were in sub-saharan Africa [6]. They maintain that if a cure for the disease is not found, there will be about 70 million infected persons in Africa by the year 2015.

15. Regardless of the need for caution, these estimates and projections are not only of serious concern in themselves; they also underline the urgent need to take more seriously, the search for a cure for this dreadful and repulsive disease.

- Transmission modes

16. **BUT WHY DOES THE AFRICAN REGION HAVE SUCH A HIGH PREVALENCE RATE OF THE HIV/AIDS PANDEMIC.** Stephens maintains that among the possible factors are (i) the poorer socio-economic performance in sub-Saharan Africa compared

to other world regions; (ii) the unfavorable health environment; (iii) the high fertility; and, (iv) a number of traditional practices that elevate the risk of exposure to the HIV virus.

17. Despite marked improvements in overall health conditions and reduction in mortality since the 1950s, sub-Saharan African region still has the world's poorest demographic and health indicators [7]. Based on the latest population estimates and projections by the United Nations Economic Commission for Africa [15], annual population growth rate for the region (1990-95) was 2.9 percent; the corresponding estimates of infant mortality rate, average life expectancy at birth and average family size were 95 per 1000 live births, 51.4 (males) and 54.6 (females) years and 6.0 respectively. The associated projections for the 1995-2000 period are 2.8 percent, 87 per 1000 live births, 52.8 (males) and 55.9 (females) years and 5.6 respectively.

18. Equally, the proportion of sub-Saharan African urban population is lower than in other world regions (e.g. in 1995, sub-Saharan African urban population proportion was 31 percent as against 37.6 for the Least developed Countries together). Even then, sub-Saharan urbanization implies increased growth of squatter settlements and possibly higher exposure of the population to various health risks as against the normal growing access of the population to basic services in the developed world. Access to health services, to education and to safe water are also lowest in sub-Saharan Africa. The level of expanded program of immunization (EPI) for the basic diseases is low. Warm and humid temperatures and poor sanitation, coupled with poor quality and access to curative health services, promote the dominance of infectious and parasitic diseases. By providing a host of pathogens to capitalize on the immune-deficient status of HIV patients, Stephens further maintains that the endemicity of diseases of infectious and parasitic origin creates a fertile context for the progression of HIV to AIDS in sub-Saharan Africa.

19. The prevailing high frequency of child-bearing in the region also imposes further strains on an already difficult health environment. For many women, prenatal care and

medical assistance at delivery are poor thus subjecting them to increased risks of maternal mortality or post-partum infection including sexually transmitted diseases (STDs) and HIV. As Hunter, Kapiga and others [8 and 9] have reported, the lack of treatment for various STDs and genital ulcers in both sexes, increase the chance of HIV infection.

20. Caldwell and others maintain that Africans probably have no more sexual partners than some sections of the industrialized societies but the latter are protected because their higher levels of health services mean that STDs are continually being cleared up and that there are not long periods of ulcerating diseases. Because STDs persist in Africa, they serve not only as carriers for HIV infection but as foci of infection for maintaining the high levels of STDs themselves [4]. With poverty, prostitutes and clients often go for long periods or indefinitely without having STDs treated while continuing to have sex [3].

21. Besides, sub-Saharan Africa was and still is characterized by (i) uniquely high levels of polygyny partly because farming and economic strength depend solely on the size of the work force; (ii) prolonged post-partum sexual abstinence of one to two years duration; (iii) the belief that postpubertal male continence is unnatural and even unhealthy; and, (iv) the substantial surplus of males in the urban areas. Although all of these forces do not exert themselves with equal intensity across the continent, they have obvious negative implications in the HIV/AIDS dynamics [3].

22. Additionally, there are a variety of traditional contexts in sub-Saharan African countries in which sexual encounters are sanctioned beyond individuals who are not in a mutually monogamous sexual relationship [10]. Such traditions include widow inheritance (i.e. a form of social security for widows without rights of inheritance to the land or property of their husbands); wife sharing (among brothers as in western Uganda) or in the form of polyandry (among some tribes in Kogi and Plateau States in Nigeria); sexual hospitality (whereby a husband offers to a visitor or friend the sexual services of his wife and in some cases, his daughter); ritualistic cleansing (by

which a spouse of a deceased person has sex with a family member in order to be cleansed or to be freed of the spirit of the deceased); and, the breaking of a girl's virginity among the Maasai warriors in Tanzania as a prerequisite for breast development.

23. Mr. Chairperson, Distinguished Colleagues, Ladies and Gentlemen, So much for the basis of the high prevalence and spread of the pandemic in sub-Saharan Africa. Let me then turn some attention to

- The unfavorable economic climate for HIV/AIDS prevention

24. Sub-Saharan Africa already carries the heaviest burden of other diseases apart from having the weakest economies in the world. "During the 1980s, nine African countries fell from the middle-income group of developing countries to the group of least developed countries. In 1993, Africa accounted for 33 of the 47 least developed countries. For many individual African countries, per capita income fell continuously during the decade and was lower in 1989 than it was in 1980. The total debt of the region, a mere USD 48.3 billion in 1978 increased to USD 265 billion in 1989 and USD 285 billion in 1993, an amount representing over 96 percent of the combined gross domestic product (GDP) of the region". Even more worrying, Africa is suffering from a crisis in food and agricultural production. According to the Food and Agricultural Organization (FAO), the proportion of under-nourished people in Africa - based on food availability, the distribution of income and its relation to food consumption - is increasing. By the year 2010, the absolute number might have increased from its current level of about 180 million to some 300 million, 32 percent of the total population" [11].

25. The crisis formed the ex-post rationalization for the structural adjustment programs (SAPs) introduced by the World Bank to make national economies more efficient, more flexible and better able to use resources. Contrary to these expectations, the massive devaluation of national currencies, the repayment of debts

and the reduction of public expenditure on health and education consequent upon SAPs, have really hit hard, especially at African populations at the lower echelons of civil society.

26. It is well known that the majority of African countries that have adopted SAPs have not experienced sustained economic performance and social development. For example, based on a World Bank sponsored study in Malawi, the policy reform leading to an increase in primary school fees, reduced primary school enrolment by as much as 26 percent [see ECA in 11]. Such a policy, upon implementation, could "alienate the vast majority of people on the poverty line from the benefits of these services; strengthen traditional tendencies; and, reduce the scope for effective grassroots participation in the development process.

27. Indeed, from the point of view of long term development, the reduction in public expenditure in education necessitated by SAPs, has meant a reversal of the process of heavy investment in human resources development initiated in the early 1960s to forge structural transformation in African economies" [12].

28. Additionally, according to United Nations Children's Fund (UNICEF), given the economic crisis, many African children are "growing in circumstances under which they may never fulfil the mental and physical potential with which they were born; will not be able to derive maximum benefit from the educational opportunities available; and, their abilities to work productively and be rewarded accordingly, might be restricted" [13].

29. One of the saddest aspects of the HIV/AIDS pandemic is that it has occurred just as structural adjustment and cost recovery programs are being implemented. These programs have actually blunted the ability of the medical system to give help with HIV/AIDS let alone to extend their services further into the STD field. They make it more imperative for school girls to secure the money for school fees or for their mothers to earn this money. Indications are that transactional sex has increased

during the structural adjustment period, thus accelerating the spread of the HIV/AIDS pandemic [4].

30. According to William Drapper III, the former Administrator of the United Nations Development Program (UNDP), the impact of the pandemic in the region has to be understood in the context of the critical social and economic problems already experienced by these countries: poverty; food shortage; inadequate sanitary and health care; the subordination of women; and, adjustment policies that allocate insufficient resources to the social sectors [14].

31. So much for what I consider as background information. No doubt, it sounds depressing. Let me move on to the main part of our discussion:

III. IMPACT OF HIV/AIDS

32. As the first epidemic, **THE EPIDEMIC OF HIV INFECTION**, continues its spread, Africa is suffering the impact of the second epidemic, **THE EPIDEMIC OF HIV-RELATED ILLNESS AND AIDS**. This second epidemic is a double tragedy. It is a tragedy, first of all, because of the personal suffering it brings to people with HIV and AIDS. It is a tragedy, secondly, because these people, mostly young and middle-aged adults, are the ones on whom society depends to take care of the young and old, to farm the land, to work in the mines, to teach in schools, to run hospitals.

33. In those parts of Africa where the second epidemic is already well advanced, families and communities are reeling from the loss of these people. Many children are being left orphaned on their parents' death from AIDS. The WHO/GPA estimates that there will be 10 million such orphans worldwide by the year 2000, most of them in sub-Saharan Africa. Their suffering is terrible particularly as they struggle for the bare necessities of life...food, shelter, and nurture. Not surprisingly, AIDS often deprives these children of schooling too, either because families impoverished by AIDS can no

longer afford school fees or because they need the children at home to perform tasks that sick or dying adults are no longer able to handle. The neglect of the orphans' health, educational, nutritional and emotional needs, is a real possibility; not to mention the additional pressures on the adopting families exacerbating the poverty situation.

WHEN I THINK OF THESE CHILDREN, I FEAR GREATLY FOR THE FUTURE DEVELOPMENT OF AFRICA.

- Population loss and increased mortality.

34. This is more so because the 1994 population estimates and projections prepared by the United Nations Population Division (Department for Economic and Social Information and Political Analysis), showed a devastating toll from AIDS with respect to population loss and increased mortality in **15 sub-Saharan African countries** in which HIV seroprevalence was estimated to exceed one percent in the adult population . These countries are Benin, Burkina Faso, Burundi, Central African Republic, Congo, Cote D'Ivoire, Kenya, Malawi, Mozambique, Rwanda, Tanzania, Uganda, Zaire, Zambia and Zimbabwe [15].

35. A disturbing case in point is the fact that for all the 15 countries together, the population by the year 2005, is expected to be 11 million less than what it would have been without HIV/AIDS. The corresponding picture in some of the 15 countries is equally startling. Whereas, by the year 2005, the population of Uganda and Kenya, would each experience about 1.5 million additional deaths due to AIDS; the corresponding estimates for Tanzania and Zaire would be 1.1 and 1.2 million respectively. The corresponding proportional difference for Uganda would be 6.1 percent while for Zambia and Zimbabwe, it will each be 6.9 percent.

36. For these 15 countries still, the estimated crude death rate (CDR) for the 1990-95 period, was 15.4 deaths per 1000 (as against 13.7 without AIDS) with a

corresponding average life expectancy at birth of 50 years instead of 53 years without AIDS. Indeed a loss of at least 5 potential years of life has already occurred in Kenya, Uganda, Zambia and Zimbabwe as a result of AIDS. Furthermore, indications are that a new born child in Zimbabwe will have an average life expectancy at birth of 51 years (2000-2005) with AIDS as against 66 years without; in Zambia, the corresponding estimates are 47 and 67 years respectively.

37. Of course, as I hinted earlier, these estimates and projections are indications and we should not overdramatize the problem. That does not imply either, that all is well. Indeed, on the contrary, although the overall findings from the projections by the United Nations Population Division (New York) reveal that population growth rates for all Africa would remain high and positive, indications are that no sector of the inflicted economies will escape the scourge of HIV/AIDs.

- Health

38. But if the social repercussions of the pandemic are so destructive, what of the economic impact ? One such impact is the direct cost of health care. I hardly need to remind this audience that in some African cities, at least 80 percent of all adults admitted to medical wards have HIV-related disease. The cost of providing them with hospital and ambulatory treatment is enormous, given their need for care during repeated episodes of illness. And tuberculosis, the most serious of the opportunistic infections to which HIV-infected people are prone, is on the march. In some areas, 50 percent of all Africans infected with HIV, also have tuberculosis.

39. This parallel resurgence of tuberculosis is sometimes described as the **THIRD AIDS RELATED EPIDEMIC**. We need only to look at sub-regions where the second and third pandemic are already well advanced (e.g. the AIDS-belt) to see what the future holds. It is indeed a grim sight.

40. HIV/AIDS patients absorb an increasingly large proportion of the hospital system's resources and take up the bed space of patients with curable diseases [see Karanja in 15]. In some of the severely affected countries, as much as 80 percent of the beds in several hospital wards are occupied by AIDS patients.

41. The real scare is that the hospital system in most of such countries is increasingly losing some of its workers as a direct result of the pandemic; thus affecting the supply of quality medical care. Cases in point include first, a study in Kinshasa (Zaire) in the mid 1980s which revealed that 6.4 percent of a sample of 2,384 hospital workers at the Yemo hospital were seropositive [17]; and second, mortality rates among nurses in two hospitals in Southern Zambia which rose from 0.5 percent per annum in 1980 to 2.7 percent in 1991 presumably due to the HIV/AIDs epidemic [16].

- Education

42. Besides Health, let us think of Africa's skilled and highly educated people who have not escaped infection and on whom Africa is counting to emancipate the continent from underdevelopment. Ainsworth has reported that "the high risk of contracting HIV among the educated may also lower the return to education from the household point of view, resulting in low schooling investment" [17]. If the spread of the epidemic is not halted, the demand for schooling might drop simultaneously with a smaller cohort size entering school than would have been without AIDS [Karanja in 15]. School enrollment rates would decline simultaneously with an increase in the number of drop-outs because of the inability of the affected parents or surviving relatives to pay for schooling.

43. As in the case of the hospital workers, HIV/AIDS will reduce the number of teachers in the schools, and the efficiency of the entire system. In this regard, the African Development Bank, at its 1993 Symposium on AIDS and Development in Africa, maintained that this scenario "will leave some countries like Tanzania with

about 14,460 teachers less by the year 2010 and 27,000 by the year 2020; the training of replacement teachers will cost the country about USD 37.8 million [Karanja in 15].

- The African family and women

44. Let me also touch briefly on the family and women in relation to the pandemic. As a mechanism for providing comprehensive care, the African family has been stretched to the limit by the HIV/AIDS scourge. The vast majority of care provided for AIDS victims in Africa is provided by the family. Caldwell and others [4] have argued that although the family has provided the care and coping structure, the provision of care has been almost wholly an undertaking of the women.

45. Because the women are the mainstay of the care that is given within the traditional extended family, any disruption of their lives affects the stability of the family as well as its ability to recuperate. Through tending to sick husbands, children, co-wives and orphans of diseased family members, the demands of the disease further burden the already overloaded female work schedule; thus taking a toll both emotionally and financially on the women.

46. Two effects of this may be identified: first, given the growing volume of female headed households, this impacts on the nutritional and educational well-being of households; and, second, income insecurity predisposes the women to sexual harassment with deadly implications.

- Labor Force Productivity

47. Although these other impacts are aspects of labor force productivity, it is necessary to highlight the main impact of the HIV/AIDS on labor force productivity.

48. According to the ILO [Ruigu in 15], the effect of HIV/AIDS on the labor force is first felt by employees (micro level); gradually it spreads through enterprises and organizations (intermediate level); and, through this build up, it destabilizes the national economy (macro level). Thus "from the chronic illness and death of workers, through lowered productivity in enterprises to declining gross domestic product (GDP), the HIV/AIDS pandemic has the potential of sinking a nation".

49. In Zambia for example, institutions have been experiencing rising medical costs since about 1989. In 1993, data from a petroleum refinery revealed that the medical expenses incurred were about 1.2 times the net profits. Although the findings from other studies in Rwanda, Tanzania and Uganda also indicated imminent reduced productivity as an aftermath of AIDS, the margin of loss was not significant as at the time.

50. The real problems identified from the studies [6] relate to the potentially explosive issues of job security for employees and employers' policy of discrimination against seropositive job applicants as well as existing staff. The applicants are unable to get employment; the staff face dismissal and financial ruin; and organizations struggle to 'keep afloat' in the face of dwindling profits.

51. Despite laws that protect workers [6], there are no binding international standards that address the specific problems raised by HIV/AIDS in relation to work, at least I am not aware. Dismissals of several seropositive employees are therefore being implemented by the organizations but these are subsumed within the ongoing retrenchment exercises sweeping across Africa in response to the deepening economic crisis.

52. Such dismissals have ripple effects throughout the system given the associated reduced urban remittances. Beyond remittances, in a situation where female labor force participation rate in the urban wage sector of the economies is low, and most women depend on husbands' employment benefits, the dismissals are doubly

unfortunate against the background of existing discriminatory employment policies directed at women and an increasing number of female-headed households.

Formal Sector

53. Indications from the ILO Studies [6] are that the individuals employed are generally between ages 15 and 55; over 80 percent of infected persons are aged between 20 and 49. Thus AIDS is killing the most productive, skilled and experienced workers within the formal sector. The death of even one employee can reduce efficiency within a unit even when an equally skilled person joins the team immediately because the newcomer needs to learn the ropes before old levels of productivity can be reached.

54. Because the years of experience are difficult to replace, HIV/AIDS not only reduces the stock of skilled labor, but productivity is also affected directly or indirectly. The direct impact on labor is on the cost of medical services, early retirement, funeral benefits and additional training programs. The indirect impact is the cost in lowered productivity emanating from sickness, absenteeism and staff turnover.

Informal Sector

55. A distinguishing feature of the informal sector is the preponderance of women operators. The majority among them trade in perishable goods such as vegetables and fruits. Their businesses collapse when illness either of the woman herself or those to whom she is obligated, disrupts the normal schedule of activities [Ruigu in 15]. Financial ruin following the HIV/AIDS episode, generally means the women are unable to resume business.

56. Informal sector activities also involve "illegal trading across national borders" [Ruigu in 15]. This contraband trade increases population mobility and the spread of HIV/AIDS [18 and 19].

Rural Labor

57. There are three discernible stages in the rural sector demise. The first comprises seropositive individual returnees from urban centers many of whom arrive with declining health. In time, these returnees infect the local residents (i.e. second stage). The third stage is marked by the HIV/AIDS impact on farming systems as farmers begin to die [Ruigu In 15]. When a producer dies, the impact is on the remaining work force for the farm in terms of the division of labor, authority structure, physical output and resource exchange.

58. A related but important change is that consequent upon the reduced work force size in the face of the AIDS onslaught, in many countries, farmers are switching from more nutritious but labor intensive crops to less labor intensive ones. Similarly, food crops are being substituted for cash crops. This downward adjustment which began with the economic recession, is now intertwined with the impact of HIV/AIDS [Ruigu in 15].

IV. THE CHALLENGES

59. So much on the impact of HIV/AIDS on labor force productivity. These various impacts just outlined are aspects of the challenges that face individuals, families, organizations and governments in Africa. A key additional challenge posed by the HIV/AIDS scourge is that the trauma of grieving death after death induces a feeling of powerlessness, an inability to act, and seemingly endless demands to existing support systems. The difficulty of replacing lost labor and the concomitant loss of output, skills, experience and aspirations can discourage investment, force the closure of enterprises and reduce national income.

60. A related additional challenge is financial. Because African governments experience financial difficulties, there has been heavy reliance on external sources of

funds. In this regard, there have been complaints over pressures from donors who have plans that conflict with the stated national priorities.

61. This attitude towards finances is viewed differently by some African leaders. For example, President Museveni of Uganda, speaking at the International Conference on STDs and AIDS in Africa (ICASA), held at Kampala (Uganda) in December 1995, condemned this "AIDISM" SYNDROME (as he called it). For him, African bureaucrats can do more to help themselves by fighting illiteracy, gender imbalance and the cultural practices that facilitate the spread of HIV/AIDS [10].

62. There is also the lack of coordination in HIV/AIDS related activities from the national to local levels. This has impeded the effectiveness in the implementation of HIV/AIDS programs. Civil unrest also disrupts the coordination and execution of programs. Projects are often slowed down by the very nature of HIV/AIDS work; this is heavy and resources are scarce, emotional toll is enormous, and there is a high level of burnout and staff turnover.

63. Another challenge lies in preventive measures geared to alleviation of poverty, misinformation, dangerous socio-cultural practices such as circumcision, economic and rapid community-based techniques in screening of STD/HIV, access to counselling and management, as well as collaboration with traditional healers and NGOs who represent some of the hopes and challenges to STD and AIDS epidemic in Africa.

64. In the long run, there is the possibility of the disintegration of communities and abandoned children turning to socially disruptive survival strategies. The extent and seriousness of the consequences of this particular challenge depends directly on the timeliness and effectiveness of prevention programs and of policies adopted to respond to the needs of the infected, the ill and the survivors.

V. THE RESPONSE

65. Mr. Chairperson, Distinguished Colleagues, Ladies and Gentlemen, given the aforementioned and other challenges, several pertinent questions can be raised:

- what should be done to confront the pandemic**
- is there a way forward to the HIV/AIDS scourge**
- how has the international community reacted to the scourge**

66. A lot is being done to combat the HIV/AIDS pandemic. But more needs to be done until some preventive vaccine for the HIV virus is provided and/or a cure for AIDS is found. The scientific work to master AIDS, like the disease itself, is now firmly and irrevocably international.

67. As we know, a Global Program (or Strategy) on AIDS (GPA) was drawn up by the WHO in 1985-86 and approved by (i) the 40th World Health Assembly (May 1987); (ii) the Venice Summit of the Heads of State and Government (June 1987); and, (iii) the United Nations General Assembly in October 1987 [20].

68. A significant event in the global struggle to combat the pandemic was the World Summit of Ministers of Health on programs for AIDS prevention held early in 1988. The Summit adopted the London Declaration on AIDS Prevention, which called for the full opening of channels of communication in each society, the forging of a spirit of social coherence through information, education and social leadership and the protection of human dignity in AIDS prevention programs. The Summit declared 1988 a year of communication and cooperation about AIDS; the first World AIDS Day (1st Dec. 1988) was commemorated (to promote information and education in the fight against AIDS) throughout the world.

69. At the regional level, African Heads of State and Government have adopted the Dakar (1992) and Tunis (1994) Declarations and the Cairo Guidelines for Action

(1993) on HIV/AIDS. These Declarations focus on many issues including care for HIV/AIDS patients; prevention of infection in youths; protection of women against infection; and, care for orphans. The Organization of African Unity (OAU), the International Donor Community including the World Bank and the WHO have been involved with the implementation of these Declarations [21]. The OAU secretariat is expected to monitor the national efforts aimed at the implementation of these Declarations. In July this year (1996), the African Heads of State and Government will be meeting in Cameroon to discuss (among others), an evaluation of national efforts at implementing the Declarations.

70. National Programs to confront the HIV/AIDS pandemic which were started during the latter half of the 1980s involved the development of emergency and medium term plans in the areas of monitoring and research; prevention; and, coping with AIDS with the assistance of international organizations, the WHO/GPA being the principal agency [22].

71. Beyond National Structures, various provincial and district organizations and projects have been inaugurated to execute the national activities generally under the Ministry of Health; the goal is to foster inter sectoral planning. Aside from the public sector, support structures have been established by international and local non governmental organizations (NGOs), private business and religious agencies.

72. Locally, there are numerous educational institutions, trade unions, community-based clubs/associations or civil society and the media. Among these organizations are urban-based non-denominational charitable bodies which provide counselling, information, training in skills for personnel in HIV/AIDS work and outreach programs. They provide material needs and alleviate suffering, education, advocacy and specific attempts to improve the economic and social situation of specific categories of people. Some have set up home-based care, care for orphans and educational projects; others work to raise HIV/AIDS awareness within the public.

73. The Chairperson, Distinguished Colleagues, Ladies and Gentlemen, I am aware that you have heard these facts about AIDS in Africa many times before. If I have repeated them today, it was not with the intention of creating despair and hopelessness. On the contrary, my aim is to stress the urgency of getting to work on the African AIDS agenda. WHAT IS THIS AGENDA ?

74. Probably, the best description of it is to be found in the OAU Declarations on AIDS [21] adopted in Dakar (1992) and Tunis (1994) by the OAU Heads of State and Government. Given the epidemiological situation in Africa, the African AIDS agenda encompasses both prevention and health care. Let me share some thoughts with you on each of these two goals. I will begin with prevention.

75. With an audience as sophisticated as this one, there is no need to spell out the specifics of prevention. We all know by now what is needed..... mass media campaigns, condom promotion, peer education and other interpersonal interventions. We also know that at this stage in Africa's HIV/AIDS pandemic, there is little point in focussing only on narrow "risk groups". What makes epidemiological sense in contemporary Africa is to "alter the risk environment" and transform it into a safe, supportive one. The need is to ensure that the AIDS prevention activities take root and flourish. What kind of environment will protect the many millions of Africans who have escaped infection so far ?

76. To my mind, such an environment is one that gives the people the power to avoid infection. Powerless people are vulnerable people. But power is a relative term. People who have subordinate status are powerless relative to others. In this era of HIV/AIDS, the subordination of women is perhaps the most dangerous example. Many men unfortunately, not all, feel that they have a natural dominion over women, a delusion of superiority that is similar in many ways to the delusion of racial superiority

we call racism. We see in these male attitudes, the root of phenomena such as seeking younger women as sex partners, prostitution, and rape, all of which facilitate the spread of HIV.

77. Women's powerlessness relative to men makes it difficult for women to raise the subject of safe sex, no less demand that their partner should refrain from casual encounters or use a condom. And a mother who is financially dependent on a man is the most vulnerable of all. Even if he refuses safe sex, she has little freedom to leave home, although, if she stays, it is at the risk of death for her and orphanhood for her children. So how can women be empowered to avoid infection ?

by supporting women's groups and organizations that are trying to raise women's status;

by improving women's legal position particularly vis-a-vis inheritance and property ownership; and,

by maximizing their access to credit and their income generating ability.

78. The men also have a responsibility:

They should examine their attitudes towards women; rethink their own behavior and if it is unsafe, decide whether it is really worth dying for.

The men who understand the link between women's powerlessness and the spread of HIV should be peer educators to fellow men by serving as behavioral role models.

79. Besides the women and men, how can we make the environment safe for our children and adolescents ? How can we empower them to avoid infection ? This can be done by:

by giving them knowledge since knowledge is power; and,

by giving young people skills...especially, the skill to say no to unsafe sex, the skill to set their own sexual limits and to insist that these limits should be respected.

80. As for adults, girls are in specially great need of empowerment so that they stand up not only to boys but to adult men.

81. Empowering women and empowering youngsters will transform the AIDS risk environment into one that is far more supportive of prevention. So much on prevention.

82. Regarding Care, President Museveni has emphasized that fighting AIDS in Africa necessitates a focus on prevention, medical and psychological care. For him, since there is no cure for AIDS as yet, there must be a broad definition of care which is not synonymous with cure [10].

83. Care should focus on the alleviation of pain, discomfort, and treatment of opportunistic infections. In resource poor sub-Saharan Africa, care makes for economic efficiency as it eases off the congestion in hospitals.

84. Care should entail integrated counselling for behavioral change through day-care clinics, mobile program visits, home-based care (where patients can continue to live among friends and relatives and share their experiences with others with the same plight) and delegation of medical care to lower level health workers like dispensaries and community workers.

85. African Governments however, cannot possibly shoulder the health care burden alone and neither can communities. They need each other. This underlines the efforts

by the WHO, the United Nations Partners and their bilateral partners to bring all parties together to discuss HIV/AIDS matters in the spirit of ensuring the sustainability of community-based care. The international community is in "this for a long haul but at least, we are in it together".

Proposed Recommendations

86. The Chairperson, Distinguished Colleagues, Ladies and Gentlemen, the reality is that in the light of the foregoing responses [23]:

- (i) there is need to review marital, educational and work environments and understand the contexts in which sexual activities occur. There is need for a strong women's movement to empower women in such a way that spousal relationships are strengthened rather than weakened;**
- (ii) there is need to review the laws governing abortion, marital rape, land tenure, rights of widows, property distribution, sexual harassment, monitoring donated blood, divorce, levirate, and ritual cleansing;**
- (iii) there is a major need for the massive creation of female urban employment opportunities so that the towns can house as many women as men and wives as well as husbands. There is also a need to modify farming practices so that it is not predominantly a female occupation as far as labor inputs are concerned;**
- (iv) there is need to develop innovative strategies combining indigenous methods and western modes in order to reach informal sector workers.**
- (v) there is need for research to focus on the double impact of the AIDS pandemic on women, as infected persons and providers of care, and on**

the complex links between women's personal vulnerability to infection and their social status;

- (vi) there is need for innovative studies on how best to invest the scarce medical resources and deliver health care. International coordination of HIV/AIDS research is vital to create a research environment conducive to the sharing of information and experience, which will help speed scientific progress; and, to accelerate the development of strategies and technologies appropriate for use in developing countries (including training and the transfer of technology);**
- (vii) the existing gap between the resources available and those needed is bound to widen as the pandemic evolves. To narrow this gap, resources must be identified from within national budgets, while the international donor community responds to meet the remaining needs;**
- (viii) more testing would certainly bring home the message about the dangers of the epidemic and might protect some spouses and other sexual partners from danger; and,**
- (ix) there is need to popularize and implement the ILO/WHO Guidelines on HIV/AIDS in the work place which are aimed at maximizing the contribution of HIV/AIDS infected persons in the labor force through the avoidance of discrimination against them by employers and fellow workers.**

MR. CHAIRPERSON, WE CAN CARRY ON ALMOST INDEFINITELY WITH THIS VERY DISCUSSION. BUT HAVING OUTLINED THE PREVALENCE AND TRANSMISSION MODES OF THE HIV/AIDS PANDEMIC IN THE AFRICAN REGION, THE UNFAVORABLE ECONOMIC CLIMATE, SOME OF THE IMPACT ON THE LABOR

FORCE, THE CHALLENGES, THE RESPONSE AND SOME OF THE RECOMMENDATIONS THAT COULD BE AND HAVE BEEN PROPOSED, LET ME END ON THE NOTE THAT FOR THE SAKE OF OUR COMMON SURVIVAL, WE MUST ACT WITH COURAGE AND URGENCY. THIS IS BECAUSE, WITH EVERY PASSING DAY, HIV/AIDS IS CLAIMING THOUSANDS OF LIVES WORLDWIDE GENERALLY AND IN AFRICA IN PARTICULAR. THE ONLY EFFECTIVE RESPONSE LIES IN GLOBAL SOLIDARITY.

THEREFORE I LIKE TO CALL ON THE BROWN UNIVERSITY TEACHING AND RESEARCH COMMUNITY, IN ITS RECENT BID TO FOSTER LINKS WITH AFRICAN UNIVERSITIES, TO INTENSIFY THEIR EFFORTS IN THE SEARCH FOR A PREVENTIVE VACCINE FOR THE HIV VIRUS AND/OR CURE FOR AIDS OR MORE EFFECTIVE WAYS IN THE PREVENTION OF OR LIMITING THE SPREAD OF THE HIV/AIDS. I THANK YOU ALL FOR ATTENTION.

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Examples of laws that are designed to protect employees include the Employment and Occupation Convention No. III (1958); the Termination of Employment Convention No. 158 (1982); and the Occupation Health Services Recommendation No. 171).

According to Ruigu, matrilineal systems in sub-Saharan Africa are under stress. Couples are not sure where to live and death or divorce leaves a woman quite vulnerable. On returning to her natal home, she merely swells the number of single parents struggling to survive. The strength of patrilineal systems appears to be the ability of the patriach to organize labor and material within the extended family. Paramount is the labor of men. Male labor has consequences for the size of plots. In addition, women in

matrilineal systems are to attend only to their own unit of mother and child and engage less in cooperative work in extended groups [Rulgu in 15].

There is also tremendous confusion resulting from all the changes occurring since the colonial period. In a single country there could be several tenure systems in operation as in Tanzania where government leaseholds, right of occupancy, customary tenureship and the collective system are all legal. These interact with different marital or lineage systems with important consequences for the property claims of women and children. In addition, land tenure systems are intertwined with systems of farming like mono-cultural or diversified farming. The outcome of all this is that levels of resource endowment differ, particularly for women [Rulgu in 15].

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effective treatment for other STDs, which are now known to increase the risk of HIV transmission; a reduction of the special vulnerability to HIV infection of women and their offspring through an improvement of women's health, education, legal status and economic prospects; (iv) the creation of a more supportive social environment for AIDS prevention through the removal of legal and other barriers to grant messages about sexual transmission and to people's ability to act on such information; (v) immediate planning in anticipation of the socioeconomic impact of the pandemic; and, (vi) a greater focus on communicating effectively the compelling public health rationale for overcoming stigmatization and discrimination.

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[23]. Among the guiding principles for these recommendations are:

- an integrated and comprehensive approach to the pandemic should be based on an understanding of the way it affects personal, social and economic development;
- programs must take into account each culture's ability to evolve and change in response to the challenge posed by the pandemic;
- the power imbalances and interpersonal relationships and in society which create women's subordination must change if women are to be able to protect themselves from infections.

* Stacey Groeman
AIDS in the workplace
219-6127.X175

The Positive Workplace

a different approach

November 1, 1999

Ms. Elena Carr
U.S. Department of Labor Policy Center
via electronic mail and facsimile

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL

of pages = 10

To Tom Skilleforn	Stacey Groeman
Company ph. 260-2102	Phone 219-6197 X175
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NGN 7640-01-317-7260	6099-101 GENERAL SERVICES ADMINISTRATION

Dear Ms. Carr,

As I promised in our telephone conversation this morning, I am sending via electronic mail a one-page resume and a curriculum vitae that will give you more information about my own background and the resources of The Positive Workplace. If you have any difficulty with either file, please just let me know, and I will fax both.

The Positive Workplace's reputation is built on its partners' reputations. Lynne Gabriel and I have submitted every project to our clients on time and on budget. Lynne is an excellent researcher and trainer who brings several years in the field of workplace HIV to the task. I have thirteen years' experience in workplace HIV/AIDS and have sought to contribute to the field by helping to frame HIV/AIDS in the workplace for domestic and international employers. We draw in on our projects several subject matter experts as needed, including B.J. Stiles, until recently the president of the National AIDS Fund, and Peter Petesch, attorney with Ford and Harrison, LLP in Washington, D.C., who specializes in HIV as a labor issue. Should you seek a proposal, it will represent not only my own skills but also those of our company and its associates.

The enclosed materials do not list an article for *Workforce* that awaits publication, tentatively titled "How AIDS Will Affect Your Global Business," which I submitted in fulfillment of an assignment from *Workforce* late in the spring this year.

Whatever direction you and your colleagues choose to take, we are thrilled that domestic and global business and labor issues of the AIDS epidemic are among the Secretary of Labor's concerns. We would be glad to assist you in any way during the process of framing and addressing this present and emerging challenge.

Yours sincerely,


Nancy A. Breuer
Partner

① Background for sec.
② Public document so
that out.

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COMPETENCIES

- Writer, researcher, consultant and speaker on HIV/AIDS as a business issue since 1986
- Skilled interviewer of subject matter experts on difficult health and political issues for purposes of framing the issue for readers
- Curriculum developer for domestic and international workplace HIV education seminars: AIDS in the Workplace course for the International Federation of Red Cross and Red Crescent Societies (1989), American National Red Cross prototype AIDS in the Workplace curriculum (1987)
- Facilitator trainer in AIDS in the Workplace for the National AIDS Fund, American National Red Cross, Hollywood Supports (AIDS education organization of the entertainment industry)
- Conference organizer and speaker on AIDS as a workplace issue for the Centers for Disease Control and Prevention
- Designer of interactive website materials on AIDS as a domestic and international workplace issue (projects of The Positive Workplace)
- Award-winning writer for video scripts on aspects of HIV/AIDS
- Co-founder of a successful women-owned business providing HIV-related consulting, writing and training to clients
- Community leader on HIV-focused task forces and commissions in Los Angeles for the U.S. Centers for Disease Control and Prevention and for Mayor Riordan's office

RESOURCES

The Positive Workplace, Inc. offers clients the skills of Nancy Breuer and Lynne Gabriel, who served until December 1997 as national director of the Hollywood Supports AIDS in the Workplace training program, as well as associates with expertise in other aspects of workplace HIV/AIDS. Clients include the Centers for Disease Control and Prevention; Ogilvy Adams Rinehart, Washington, D.C.; National AIDS Fund; Business for Social Responsibility; government and business clients.

EDUCATION

B.A. cum laude, Middlebury College, Vermont

M.A. Fuller Theological Seminary, California Fields: theology and management

Certificate in Management and Quality Improvement in Multicultural Work Environments, California State University, Fullerton

REFERENCES

- Victor Barnes, Associate Director for International HIV Prevention, Centers for Disease Control and Prevention, 404.639.5204
- Jeff Monford, Account Supervisor, Hill & Knowlton, New York, 212.885.0623 (Until July, Jeff served as Director, Workplace Resource Center, National AIDS Fund)
- Allan Halcrow, Publisher and Senior Editor, *Workforce* magazine, 714.751.1883, ext 248
- Yolán LaPorte, Senior Vice President, Ogilvy Public Relations Worldwide, Washington, D.C., 202.452.9412

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EDUCATION

B.A. cum laude, Middlebury College, Vermont	1969
M.A. Fuller Theological Seminary, California	1983
Fields: theology and management	
Certificate in Management and Quality Improvement in Multicultural Work Environments, California State University, Fullerton	1995

CAREER HISTORY

FOUNDING PARTNER, THE POSITIVE WORKPLACE, Los Angeles, CA consulting and training company focusing on HIV as a workplace issue	1999-
CONSULTANT AND WRITER, Los Angeles, CA	1991-
AMERICAN RED CROSS, Los Angeles, CA	1984-1991
Director, Contract Educational Services	1987-1989
Director, HIV/AIDS Education	1989-1991
FULLER THEOLOGICAL SEMINARY, Pasadena, CA	1979-1984
Assistant Director, Extended Education	
REGAL BOOKS, Glendale, CA	1977-1979
Writer	
NEW ENGLAND SCHOOL DISTRICTS	1969-1977
Instructor in English and Adult Education	

PROFESSIONAL EXPERIENCE AND ACCOMPLISHMENTS

PUBLICATIONS

Website on HIV/AIDS as a workplace issue for the non-profit business organization Business for Social Responsibility, San Francisco, CA. Under development now as a project of *The Positive Workplace*. Associate on the project: ~~Dr. Nancy L. Breuer~~ former President, National AIDS Fund. Website will include descriptions of international business impact and solutions.

National AIDS Fund Website Visibility Project: Website materials on HIV/AIDS as a workplace issue for the National AIDS Fund, including pages on disclosure, managing the HIV-positive employee, workplace injury and reasonable accommodation. A product of *The Positive Workplace*, in final review before going online by 12/99.

Managing Returning Disabled Employees: What Every Employer Should Know, guidebook for the National AIDS Fund, funded by CIGNA, 1999.

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What You Should Know About Returning to Work Before Talking with Your Disability Provider, guidebook for the National AIDS Fund, funded by CIGNA, 1999.

Employee Attitudes About AIDS, 1998. A National Survey. What Working Americans Know and Think About HIV/AIDS, report for the National AIDS Fund, 1998.

Course developer and video scriptwriter, with Burt Pearl, for *The Positive Workplace: Managing HIV at Work*, a video-based workplace HIV education course. Award-winning video distributed by the National AIDS Fund.

Editor, curriculum written by 12 subject area experts on aspects of HIV and AIDS for a 12-week training program targeting people living with AIDS, released during 1998 by Glaxo Wellcome as T.H.E. Course.

What About My Rights? Guidelines for Employers and Employees Living with HIV/AIDS, guidebook for the National AIDS Fund and the Westchester County (NY) AIDS Council, 1997.

L. A. Shanti PLUS Weekend: A Manual for Coordinators, (editor), Summer 1996.

Hollywood Supports AIDS in the Workplace Facilitator's Manual, published October 1993 by Hollywood Supports; 111 pages.

A Guide to Self Care for HIV Infection, published December, 1991 by AIDS Project Los Angeles; 160 pages.

Curriculum writer, *AIDS in the Workplace* curriculum for the International Federation of Red Cross and Red Crescent Societies in Geneva, 1989. Seminar in use by 20 countries by 1991.

Los Angeles Project Manager for course development and trainer of 200 trainers for American National Red Cross in the workplace AIDS education program of the American Red Cross. Clients of program include Southern California Gas, Prudential Insurance, 3M, Internal Revenue Service, U.S. Justice Department, and Los Angeles Times, all at multiple sites. 1986-1991.

TRAINING

Trainer of AIDS in the Workplace facilitators for The National AIDS Fund, 1997 to present. Facilitators trained at TCI, Inc. and DuPont Pharmaceuticals, and for community organizations in Washington, D.C., Chicago, San Francisco and New York.

Trainer of facilitators and curriculum writer for Hollywood Supports, an organization formed by the entertainment industry to provide workplace HIV education within the industry. Wrote 40-hour curriculum and have trained 92 entertainment industry volunteer facilitators since spring, 1992.

Corporate trainer in managing AIDS at work for Los Angeles area and national clients including ARCO, Avon Products, Walt Disney Company, Giorgio Beverly Hills, Morrison & Foerster, J. Paul Getty Museum, Prudential Insurance, Teradyne Inc., UCLA Medical Center Chaplains. June 1991 to present.

Journal Editing

Curriculum Vitae: Nancy L. Breuer

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Editor, *Pacific Center Journal*, quarterly publication of the Pacific Center for HIV/AIDS Counseling and Psychotherapy, Los Angeles, Fall 1991 to Summer 1994.

Selected Articles

"Will You Hire Lazarus?" (challenges facing persons with AIDS returning to work), *Workforce*, June 1998.

"Must HR Diagnose Mental Disabilities?" *Workforce*, October 1997.

"Offer Long Term Care Insurance: Uncle Sam No Longer Has His Hand Out," *Workforce*, July 1997.

"Honor Their Last Will: When Terminally Ill Employees Choose to Work," cover story, *Workforce*, May 1997.

"When Employees Seek Pastoral Advice--How Will You Answer Them?" *Workforce*, April 1997.

"AIDS: Why Let the Courtroom Become Your Classroom?", *Management Review* (journal of the American Management Association), November 1995.

"Emerging Trends for Managing AIDS in the Workplace," *Personnel Journal*, June 1995.

"Revealing the Dark Secret of Clinical Depression," *Personnel Journal*, April 1995.

"Helping Your Clients Through Tough Times," *Life Association News*, September 1994, with Peggy S. Wallace, CFP.

"Resources Can Relieve ADA Fears," *Personnel Journal*, September 1993.

"Financial Help for Terminally Ill," *Personnel Journal*, January 1993.

"AIDS Issues Haven't Gone Away," *Personnel Journal*, January 1992. This article is reprinted in Simon & Schuster's 1994 book, The Simon & Schuster Guide to Writing.

Video Scripts

"The Positive Workplace: Managing HIV at Work," with Burt Pearl, comprehensive 28-minute HIV in the workplace training video, Fall 1997.

Video segments (7-12 minutes each) for ten sessions of a training course on living with AIDS for Glaxo Wellcome released during 1998.

"Help is Very Near," four public service announcements recorded by Shirley MacLaine, Liza Minelli, Tom Goodman, Wynton Marsalis, Clint Black, Miss America, Billy Joel, et al. for AIDS Project Los Angeles. (30-second PSA's released January, 1993) Winner of 1993 Pro Award for Best Public Service Campaign, Publicity Club of Los Angeles.

"This Stuff Can Save Your Life," produced for Office of Forensics, Department of Mental Health, State of California. HIV risk reduction video by and for persistently and severely mentally ill adolescents and adults. (Video released in English December 1992, in

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Spanish 1994.)

"Loving Well: Caring for the HIV+ Child," produced for a consortium of three Los Angeles agencies training caregivers and foster parents. Video and companion educational brochure for caregivers. Third place winner, medical category, international industrial video competition in Chicago, April 1992. (Video released June 1991)

CONFERENCES, WORKSHOPS, CONSULTING

The Positive Workplace is under contract with the Centers for Disease Control and Prevention to develop the business track for the Year 2000 conference of the Business and Labor Responds to AIDS program. In 1999 we have delivered the keynote address and a workshop for the CDC's AIDS in the Workplace conference in Charlotte, North Carolina. In 1998 we developed and organized the CDC's AIDS in the Workplace conference for Los Angeles in cooperation with United Way and the Mayor's Task Force on Employment Issues for People with AIDS.

"How to Create the HIV-Comfortable Workplace--For Everyone," address at HIV & Employment: New Trends, New Duties, conference co-sponsored by United Way of Greater Los Angeles and Mayor Riordan's Task Force on Employment Issues for People with AIDS, Los Angeles, September 17, 1998.

"Managing and Accommodating Employees Living with HIV/AIDS: What's New in the Era of Return to Work," Society for Human Resource Management 1998 Diversity Conference, Washington, D.C., October 28, 1998.

"Is AIDS Your Business?" opening address at conference on HIV/AIDS for employers sponsored by the HIV/AIDS Workplace Alliance of Charlotte, N.C., July 31, 1998.

"Managing and Accommodating Employees Living with HIV/AIDS: What's New in the Era of Return to Work," with Jeff Monford of the National AIDS Fund, Society for Human Resource Management 50th Annual Conference, Minneapolis, MN, June 16, 1998.

"Is AIDS Your Business?" Keynote speech for United Way of Anchorage, Alaska AIDS Conference sponsored by United Way of America and the Centers for Disease Control and Prevention, May 21, 1998.

"AIDS in Today's Workplace: Is Your Organization Prepared for the Return to Work of Employees Living with AIDS?" American Management Association, 69th Annual Human Resources Conference, New York, New York, April 7, 1998.

"Managing HIV and AIDS in the Workplace," California Public Employers Labor Relations Association, Monterey, CA, November 12, 1997.

Expert witness (background), *EEOC v. General Electric*, October 1997.

"Reasonable Accommodations for Employees with HIV," workshop for The Workplace in a New Era, conference of the Centers for Disease Control and Prevention, Washington, D.C., September 29 and 30, 1997.

"Working with HIV/AIDS in the Workplace," workshop with Andrew Foster for California Public Administration Safety Management Association, San Diego, CA, September 16, 1997.

"Whose Rights? Planning for Productivity When an Employee has AIDS," workshop for 49th

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Annual Conference of Society for Human Resource Management, San Diego, CA, June 23, 1997.

"Managing HIV and AIDS in the Workplace," workshop for California Public Employers Labor Relations Association (CALPELRA) Annual Conference, Monterey, CA, November 6, 1996.

"Whose Rights? Whose Responsibilities?" workshop for 48th Annual Conference of Society for Human Resource Management, Chicago, IL, June 25, 1996. Rated among top ten presenters for 1996 conference.

"Managing the Employee with HIV," speech for Southern California Personnel Management Association, Glendale, CA, May 15, 1996.

"AIDS/HIV in the Workplace," speech for The Employers Group, South Bay Human Resources Roundtable, April 18, 1996.

"When an Employee has HIV," workshop for California League of Cities Employee Relations Institute, Newport Beach, CA, February 29, 1996.

"Managing HIV at Work," Public Administration Safety Management Association, Southern California chapter, January 11, 1996.

"Shared Rights, Shared Responsibilities," workshop for the Westchester County AIDS Council World AIDS Day event, Westchester County, New York, December 1, 1995.

"Workplace Consulting Skills: Legal Basics for Educators, Case Managers and Advocates," with Jeff Monford of the National AIDS Fund, for the 1995 AIDS National Skills Building Conference, Century City, CA, October 20, 1995.

"Workplace Consulting Skills: Marketing Your Program to Business and Labor," with Richard Jennings of Hollywood Supports, for the 1995 AIDS National Skills Building Conference, Century City, CA, October 21, 1995.

"Avoiding Liability from HIV-Infected Employees under the ADA," June 21, 1995 for PIHRA, West L.A.

"When Your Co-Worker Has AIDS," workshop for the Continuing Administrative Education Committee, Ernst & Young LLP, March 22, 1995.

"Visiting the Person with AIDS in the Hospital," workshop for Greater Bethany Community Church, South Central Los Angeles, January 15, 1995.

"Managing HIV in the Workplace," speech for Management and Safety Association, Riverside, CA, November 22, 1994.

"AIDS and the Hospital Chaplaincy," continuing education seminar for the chaplains of Kaiser Permanente, Fuller Theological Seminary, November 9, 1994.

"Managing HIV Effectively," workshop for 37th Annual PIRA Conference, Long Beach, CA, September 29, 1994.

"The Role of the Business Community in Facilitating Community-Wide AIDS Education," workshop for first annual Westchester County AIDS Council Conference, White Plains, New York, July

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18, 1994.

"The Challenge of AIDS in the Workplace," speech for Riverside Area PIRA meeting, April 14, 1994.

"AIDS Update," workshop for American Management Association's 65th Annual Human Resources Conference and Exposition, San Francisco, April 12, 1994.

Expert witness (background) on managing an employee with HIV/AIDS in the case of *Sullivan v. Delta Airlines*, March and April, 1994.

"How to Talk With Your Children About AIDS," workshop for national conference, American Journal of Health Promotion, Colorado Springs, February 22-25, 1994.

"When the Church Has AIDS," seminar for employees and students at Fuller Theological Seminary, Pasadena, CA, February 11, 1994.

"AIDS in the Church Workplace," seminar for national convention of National Episcopal AIDS Coalition, Santa Monica, February 4, 1994.

"Managing HIV at Work," speech for Pomona Area PIRA meeting, January 18, 1994.

"AIDS in the Workplace: New Initiatives, New Concerns," presentation at American Public Health Association Annual Conference, San Francisco, October 1993.

"When Your Colleague Has AIDS: Managing HIV Effectively," seminar at 36th Annual Conference, PIRA (Association of Human Resource Professionals), September 1993.

"Managing HIV in the Workplace: Models that Work," speech for Helpmates Personnel Services 1993 Seminar Series, September 1993.

"Working with Colleagues with HIV," speech for Orange County Wellness Coalition, August 1993.

"AIDS: The Human and Financial Impact," speech for the West Los Angeles Chapter of the Institute of Management Accountants, July 1993.

"When Your Co-worker Has AIDS," workshop for 7th Annual Health Education Conference, Health Net, Burbank, June 1993.

"Working with HIV," speech for the Continuing Administrative Education Seminar, ARCO Tower, Los Angeles, May 1993.

"Working with HIV," management retreat speech for the vice presidents of human resources, the ARCO companies, April 1993.

"HIV and the Americans with Disabilities Act," workshop for Western Compensation and Benefits Conference, Los Angeles, March 1993.

"Managing AIDS at Work," speech for clients of AppleOne, Cerritos, March 1993.

"Working with HIV," speech for Association of Legal Administrators, Century City, January 1993.

Guest trainer of trainers, AIDS Project Los Angeles training for facilitators of AIDS education in the workplace, January 1993.

"AIDS and Shame," workshop for Fuller Theological Seminary Continuing Education conference, "Shame and Grace," February 1993.

"Managing AIDS at Work," speech for Western Compensation and Benefits Conference, Los Angeles Chapter, September 1992.

"HIV as a Human Resources Issue," speech for Los Angeles Human Resources Association, September 1992.

"HIV and Wellness," speech for Downtown Wellness Consortium, Los Angeles, August 1992.

"Managing AIDS at Work," speech for Brea Rotary Club, Brea, CA, July 1992.

"Human Resources Management of HIV," speech for Personnel and Industrial Relations Association, Orange County Chapter, Irvine, CA, June 1992.

"A Pastoral Response to Persons with HIV," seminar for students and faculty, Fuller Theological Seminary, Pasadena, CA, May 1992.

"The Americans with Disabilities Act: Impact on Training," panelist for Los Angeles Chapter meeting of American Society for Training and Development, April 1992.

"Human Resource Management of HIV," speech for Orange County Employment Managers' Association, Newport Beach, CA, April 1992.

"HIV and Wellness," speech for Health Net Wellness Team, Woodland Hills, CA, April 1992.

"Managing AIDS at Work," speech for Association of Legal Administrators, Los Angeles Chapter, March 1992.

"HIV Education: Psychosocial Basics for Facilitators," workshop for facilitator trainees for Roman Catholic Archdiocese of Southern California, Los Angeles, January 1992.

"When Your Co-worker has AIDS," speech for Kellogg Training Center, United Way of Greater Los Angeles, December 1991.

"Workplace HIV Management," workshop for Hunt-Wesson Safety Conference, Garden Grove, CA, November 1991.

"AIDS in the Workplace," speech for Association of Legal Administrators, Los Angeles Chapter, October 1991.

"Working with HIV: Training for A Healthy Workplace Response," workshop for annual conference, American Society for Training and Development, Los Angeles Chapter, October 1991.

"Working Beyond Fear," seminar for Los Angeles City Personnel Department, September 1991.

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"HIV Education: Psychosocial Basics for Facilitators," workshop for facilitator trainees for Roman Catholic Archdiocese of Southern California, Los Angeles, June 1991.

COMMUNITY SERVICE

Member, Mayor's Task Force on Employment Issues for People with AIDS, City of Los Angeles, February 1997--present.

Commissioner, Los Angeles County AIDS Commission, July 1989-June 1991.

Chair of the AIDS in the Workplace Committee and member, Community Issues Council, Greater Los Angeles United Way, July 1989--present.

AIDS Project Los Angeles volunteer, Neighborhood Network, AIDS-related lobbying group, February 1992-1994.

Executive Committee, Board of Directors, American Lung Association of Los Angeles County, 1984-87.

Founder, American Red Cross Southern California Business Forum. First chair, 1985.

PROFESSIONAL MEMBERSHIPS

American Management Association

National AIDS Fund

American Society for Training and Development

AWARDS AND HONORS

1996 Spirit of Hope Award, Being Alive (largest organization of and by people with HIV and AIDS in the United States), Los Angeles, November 1996.

Listing in Who's Who Of American Women, 19th Edition, 1995.

PRO Award for Outstanding public service campaign of 1993, Los Angeles Publicity Club, 1993.

Third place winner, medical category, international industrial video competition in Chicago, April 1992. ("Loving Well: Caring for the HIV-Positive Child," June 1991.)

Tiffany Award for employee excellence, American Red Cross, 1987.

PERSONAL INFORMATION

Married November 1988 to S. Scott Bartchy, Ph.D.