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# **PERCEPTIONS OF INDIAN EMPLOYERS ABOUT HIV/AIDS IN THE WORLD OF WORK**

**(An ILO Project, conducted by CEC)**

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**CENTRE FOR EDUCATION AND COMMUNICATION**

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# CONTENTS

Executive Summary (Key Findings)	05
Chapter One	12
Introduction	
Chapter Two	20
Methodology	
Chapter Three	27
General Profile of the Sample	
Chapter Four	34
Health and Social Security Status of Firms	
Chapter Five	42
Awareness Level of Employers about HIV/AIDS	
Chapter Six	49
Threat of HIV/AIDS at Workplace, Impact on Industry, and Action Taken Information	
Chapter Seven	58
Elements of HIV/AIDS Policy in the World of Work	
Chapter Eight	63
Expectation of Employers: Level and Agencies of Implementation of HIV/AIDS Policy in the World of Work	
Chapter Nine	69
Key Parameters for Advocacy and Intervention	
Annexures	72

# PREFACE

HIV/AIDS in the world of work would have been a neglected theme, had ILO not taken the lead in the matter. The present study, Perceptions of Indian Employers about HIV/AIDS in the World of Work, is part of a larger project taken up by ILO, namely, Prevention of HIV/AIDS in the World of Work: A Tripartite Response, and implemented in close co-operation with NACO, Ministry of Labour and the V. V. Giri National Labour Institute.

CEC is pleased to undertake this study for ILO as the External Collaborator. This is a research study of a larger scale that involved survey of 1,058 firms in the private sector during April-June 2002 in 21 States and 71 districts all over India. The study depended on the interviews of employers. No special emphasis was given to industrial sectors and geographical areas where higher incidence of HIV/AIDS is reported.

The study reiterated the need for an HIV/AIDS policy at workplace as only 0.2 per cent of firms were reported to follow a positive policy though 0.5 per cent of firms claimed to have one. The impact of HIV/AIDS was reported in terms of increase in medical cost, workforce stability, absenteeism on medical grounds, loss of productivity, discrimination of affected staff. Ten firms and 0.01 per cent of workforce in sample were HIV-affected. The study found a gap between the general awareness level of employers with regard to HIV/AIDS and their attitude towards the HIV affected labor. So the study recommends sensitization measures to focus this awareness-attitudinal gap in translating it into proactive steps. Health and social security measures have to be linked with the new HIV/AIDS policy. Fishing sector needs special attention.

Around 70 per cent of employers suggested 3 elements of HIV/AIDS policy, and they are education and awareness programs, sex education and condom promotion, and counseling and treatment. Employers expected active support from government in implementing the policy and showed willingness to take it up at enterprise level; they also expect support from employers' associations. As implementing agencies, besides and after government, preference went to NGOs and private sponsors in general; media also elicited preference as implementing agency in the case of education and awareness programs.

The present Report incorporates the changes suggested by ILO on two earlier drafts as well as some of the suggestions from two external evaluators, Dr Swapna Mukhopadhyay of Institute of Social Studies Trust and Dr Ritu Priya of Jawaharlal Nehru University. Executive Summary gives the key findings of the study, and the last chapter (nine) suggests the recommendations. We thank the leaders of the business enterprises all over the country who collaborated with us in this study. Obviously, we could not have completed this study without their cooperation and willingness to divulge with information.

Mr. Nasir Ateeq, Dr. Sugathan R., Mr. Jalees Ahmed, Ms. Paulamee Mistry and Mr. Sandeep Sahu were the team leaders from North, South, Central, West & East Zones respectively. Minimum of three researchers was attached to the Zonal Co-ordinators for field data collection. These researchers were Sukhendu Bhattacharya, Subhransu Priyadarsini, Ratan Pani, Anthony Gardia, Rohan Sinha, Ketan Gandhi, D K Gajandekar, Kumar

Abhishek Pratap, Susil Aparajit, Abdul Thaha, Sambasiva Vatti, Kannan K, Sivasankar, Swapna David, Soumya Venkatesan, Sunila Singh, K M Ziyauddin, Neeraj Kumar, Pallavi Chauhan, Sujana Krishnamoorthy and Srinivas Rao.

Mr. Nasir Ateeq coordinated the project. Dr. Sugthan R did the data analysis and writing of the report with the support from Mr. Nasir Ateeq and J John. Mr. Graceson Mathew C helped Dr. Sugthan in the management of SPSS database. Ms. Pallavi Chauhan and Mrs. Anitha Prakash too helped Dr. Sugthan in data entry and cleaning. Mrs. Anitha Prakash did most of the tables and part of the typing, while Mr. Mukesh helped in printing and binding.

We acknowledge with thanks the technical contribution given by Dr. Biswajit Nag in arriving at the appropriate sample for the study.

In coming with this report, we got tremendous support, guidance and patience from the side of ILO. We acknowledge with thanks the support and timely guidance given by Mr. S. M. Afsar, National Project Co-ordinator and Mr. Ravi Subbiah, Programme Officer-Research & Documentation of the ILO. Mr. Afsar provided us with the opportunity to interact with Dr. Rajen Mehrotra, Employer Representative at the ILO and the evaluators of the project from the USA. These interactions helped us to sharpen the methodology and analysis. We gained also from two consultative meetings on the key findings in which Mr. Maurizio Bussi, Dy. Director, ILO-India participated among others.

The ILO has taken the initiative to evolve a tripartite response to the problem of HIV/AIDS at work at the opportune time. We are proud to be part of this exercise by way of conducting this research as ILO's external collaborator. We hope the findings and recommendations of the study will help the ILO in working with the Government of India, employers and trade unions in evolving a meaningful policy and viable programs on HIV/AIDS at work. Such an effort will necessarily contribute to positive workplace practices, non-discrimination of workers, enhanced worker satisfaction, prevention of unanticipated costs, and increased productivity.

J John  
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# EXECUTIVE SUMMARY

Studies have shown a possible comparative decrease in labor force because of the increased mortality of workers with HIV/AIDS in high prevalence countries. Studies done on business showed that the absence of a comprehensive health policy (including HIV/AIDS prevention) affects the industry, the employers as well as employees and thus the total economy. In developed countries, HIV/AIDS at workplace has been taken note of as an issue to be handled, and the employers have started introducing definite policy. In India also, attempts are made by corporate sector. For instance, CII has attempted to develop guidelines on HIV/AIDS at workplace in 1996. However, much remains to be done.

The ILO has increasingly recognized and responded to the threat to the world of work posed by HIV/AIDS. ILO developed a Code of Practice on HIV/AIDS and the World of Work that was discussed and adopted at a tripartite meeting of experts held in Geneva in May 2001. The ILO in consultation with its Indian constituents and NACO developed a three-phased strategy aimed at establishing a sustainable national program on the prevention of HIV/AIDS in the world of work.

## **Objectives of the Study**

The main objective of the study is to capture the perceptions of Indian employers about the HIV/AIDS in the world of work. This is meant to determine the key parameters that could be used to undertake appropriate advocacy/intervention strategies in the world of work vis-à-vis HIV/AIDS. The study aims to present the employers' view on HIV/AIDS in the world of work, specifically of the private sector.

The Centre for Education and Communication (CEC), a Delhi-based labor resource center, has executed the present study as the external collaborator for ILO.

## **Methodology**

Available data sources such as NSSO (1999-00), ASI (1996), Economic Census (2001), Economic Survey (2001-02), and Annual Report of Department of Company Affairs (2000-01) and data sources on small industry were reviewed. Owing to specific limitation of these data sources, relevant information from multiple data sources was used to determine the total sample as well as its distribution across States and sectors.

For classifying size of industry, official method of basing on investment size was adopted. On this basis tiny, small, medium and large industries were considered, and random survey was followed. Manufacturing included 8 and plantation 5 sub-sectors, and here also, random method was adopted in the survey.

## **Strengths and constraints of the study**

In covering the economic activities and workforce, the sample of the survey is strong enough to represent the universe of the study. The selected sectors excluding fishery and plantation cover around 63.4 per cent of economic activities, and have 44 per cent of workforce including fishery and plantation. The total sample is adequate enough to give results with minimum margin of error.

No special emphasis was given to industrial sectors and geographical areas where higher incidence of HIV/AIDS is reported. As the study is to capture the perception of employers, the study depended on the interviews from employers. There may be under-reporting on size of investment, on strength of total workers, migrant workers, and short-term and

contract workers, and on the incidence of HIV.

### **Sample profile**

Sample is drawn from all the four geographical zones of India i. e., South, West, North and West, proportionate to the presence of industries as per data sources. 21 States and 71 districts were covered.

Respondents in the sample mainly consist of 51.4 per cent owners, 20.4 per cent CEOs, and 12 per cent HR heads and 16.2 senior level functionaries designated by the management for the interview. In fishing, plantation and trade, respondents are mostly owners. Only 4.3 per cent of respondents are women. Of the total (46) female respondents, 34.8 per cent are owners, 26.1 per cent CEOs and 21.7 per cent HR leaders.

The sample included 53.6 per cent formal and 46.4 per cent informal segments of industry. It is found that as the investment size increases the size of informal segment decreases. The final sample covered around two-thirds tiny and small industry and one-third medium and large industry.

The firms under study cover a total of 160,947 workers. Around one-third of total workers are from the category of short-term and contract workers (51,854). They include casual labor, temporary employees and trainees. While men are found more among the regular category, women are more in the category of short-term and contract workers. In the occupational category, men are more found in the skilled segment (73,446) while women are least employed in the managerial segment (2,175). The strength of seasonal workers (7,871) is found higher than that of the migrant workers (5,560) in the sample of total workers. However, more firms employ migrant workers. While 110 firms employ migrant workers, only 102 firms employ seasonal workers. Total migrant workers constitute around 3.5 per cent of the workforce in the sample, and male migrant workers (3,868) constitute 69.6 per cent of the total migrant workers.

### **MAJOR FINDINGS**

#### *Health and social security status of firms*

- Only 9.5 per cent of firms claim to have health policy. Such policies are not available in firms in the sector of plantation; they are least available in trade, construction, IT and mining. Chances of availability of health policy increases, as the investment of the industry increases from tiny to large.
- Though 53.6 per cent of the total industries surveyed are from the formal segment, only 41.5 per cent of firms provide provident fund for regular workers, and a maximum of 43.0 per cent provide the minimum health facility of ESI.
- 8.6 per cent firms provide some direct or indirect facilities for family planning, condom promotion or for both. While 4.2 per cent of firms conduct some classes or programs for sex education of staff, 1.1 per cent provide STD clinics for its staff. It is significant that 4.7 per cent of establishments give AIDS counseling. Fifteen firms (1.4 per cent) are common among those providing sex education and AIDS counseling. Only four firms (0.4 per cent) provide all these four facilities.
- There is no special category of facilities for short-term or women workers. For regular workers, two transport units provide accident insurance but only for drivers.
- 22.6 per cent (239) of firms provide some benefits to the families of employees who die of sickness. Only 22.2 per cent (235) of sample specified the scheme of benefit. While quizzed on the issue of a policy in this regard, only 9.2 per cent (97) have agreed to have one. Some of the respondents have mixed up schemes like ESI and EPF and also workers' support with benefits to family members of the deceased employees from the side of employers and management. Of these firms, 2.9 per cent (31 firms) earmark a part of their budget for providing benefits.

- Except maternity benefits, no other special facilities are given to women workers. Our data showed that 11.8 per cent of firms provide maternity benefits to women workers.

#### *Awareness level of employers*

- The overall general awareness level about HIV/AIDS is found high, as 52.5 to 73.8 per cent of employers identified at least one correct answer as the source of HIV. Majority of respondents took risky/unprotected sexual intercourse, blood transfusion, sharing needle for injectable drugs, mother to child, and sharing of blades/razors as the right sources of HIV/AIDS.
- Fifteen (1.4 per cent) employers pointed out other sources of HIV/AIDS such as careless use of needles and syringes in injections, exchange of body fluids, saliva, eye moisture, open wound, sexual kissing, virus, and using same toothbrush.
- Risky/unprotected sexual intercourse has been taken least seriously by construction sector (88.5 per cent) followed by mechanized fishing (92 per cent) and trade (92.3 per cent). Social kissing is most misunderstood in hotel sector. Lack of knowledge about the source of HIV is most noticed in fishing (4 per cent) sector and least in manufacturing.
- Wrong options as sources of HIV were more ticked by employers in the informal industry. Regarding the right answers, formal industry has recorded majority of answers except in the case of the option, *risky/unprotected sexual intercourse*.
- Distribution of answers across investment size shows the pattern of wrong answers being mostly given by employers in tiny industry and then by those in small industry, while right answers are largely given by medium and large industry. As exception to this pattern, risky unprotected sexual intercourse is given comparatively high importance by the tiny industry (95 per cent compared to the average of 93.4 per cent). Among the other right answers, most of them showed a pattern of progressive increase in importance as they go from tiny to large. The percentage of employers who had no idea of the disease was found more in tiny industry than in any other size.
- No firm claimed that incidence of HIV at unit level was high, and 0.5 percent of employers considered this to be significant. When their knowledge level on the source of HIV was analyzed, 100 per cent was found to have ticked right answers along with wrong ones. However, this pattern was found not different from the general trend.
- Respondents showed a tendency to underestimate the chance of incidence of HIV/AIDS at the level of sector, and more or less deny it at unit level. When 82.7 per cent of employers denied existence of HIV/AIDS at unit level, 34.1 per cent of them denied it at sector level. This denial strengthens progressively from the level of country to that of unit. This shows that general awareness need not go along with right attitude.
- As per studies including NACO reports, India has still an average of less-than-one (0.4) per cent HIV population in general, with exceptional percentage rates in some States. When the situation is so, only 24 per cent of employers interviewed have got a general idea of the actual incidence of HIV in India, and 16.5 per cent has expressed that they have no idea about it. 59.2 per cent has exaggerated the incidence, while 24.6 per cent have highly exaggerated it.
- The attitude of employers toward recruitment of HIV-affected persons is negative, as 67.1 per cent of them are not ready to employ HIV positive persons. However, majority (55.3 per cent) was ready to allow them continue with the employment. Though a good majority (71.6 per cent) was ready to offer treatment, most of them were not clear on who would foot the bill.
- IT sector showed greatest readiness to recruit and it came highest in non-discrimination, while the sector of

construction stood lowest-ranked in both the issues. At the same time IT showed least interest in offering treatment. Finance and real estate stood highest in the scale of comparison with regard to issues of allowing the HIV affected to continue in job and offering treatment. Mechanized fishing showed least interest in allowing the infected to continue in job.

- In non-discrimination, allowing continuation in job, and offering treatment, formal sector stood in forefront, while informal sector fared better in showing readiness to recruit the HIV infected. Tiny industry stood at the lowest rung in matters of non-discrimination and treatment.
- When the attitude of employers in all the 10 firms with HIV affected persons are selected and studied, it was found that there is perceptible change recorded as far as the attitude of non-discrimination in giving training. Only 20 per cent of employers in the affected firms agreed for non-discrimination, when 41 per cent of employers in general agreed for it.
- When the possible reaction of coworkers was assessed from the perception of employers, it was found most of them gave negative opinions. 24.2 to 36.5 per cent of employers felt that coworkers will refuse to work, neglect or avoid the worker, or will protest. Only 12.9 per cent thought that workers will support the HIV affected coworkers.
- The perception of employers on this matter is varied. Finance and real estate, manufacturing, and trade and commerce are least supportive. Fishing, hotel, IT and transport sectors were found more supportive. Formal sector was found less supportive in comparison to informal one.

#### *Impact of HIV/AIDS on industry*

- A total of 16 proven and 6 perceived cases of HIV infected workers (22 in total) were reported respectively from 7 and 3 firms in our sample. 10 firms (0.9 per cent) are affected in total, from 4 zones and 4 States (Maharashtra, Tamil Nadu, Madhya Pradesh and West Bengal). Except one, all are from formal sector (90 per cent). The informal sector firm is a trade and commerce unit from MP. Only skilled and unskilled male workers from regular category are affected. None of them are seasonal or migrant. 0.1 per cent of workforce (22 of 160,947) is affected by HIV/AIDS.
- The threat of opportunistic infection is very visible over and above the impending threat of HIV to the industry. The total workers infected with STD, opportunistic and related diseases are 265 in 70 firms (6.6 per cent). Of them, TB infected alone is 144. Hepatitis affected 83, hepatitis B two, and STD 36 workers. Firms with disease-affected persons are found in almost all the major States and all sectors in the sample. Tiny, small, medium and large industries are all affected, medium industry leading over other sectors. As far as higher incidence is concerned, manufacturing sector is mostly affected, followed by construction and trade.
- The impact of HIV/AIDS on industry is not very substantial. However, the available results are a pointer to the impending danger. The results showed that no impact is reported in terms of social security cost, output, replacement and training cost, negative influence on procurement of orders, and stigmatization of enterprise. In terms of medical cost, marginal increase was reported in 3 enterprises in Maharashtra and high increase in 1 enterprise in Haryana. 0.5 per cent increase in medical cost is recorded in an enterprise in Maharashtra. Workforce stability was affected marginally in 1 enterprise in Maharashtra. Absenteeism on medical grounds affected marginally 3, and significantly 1 enterprise. Loss of productivity was reported marginally in 1 enterprise and significantly in another. Discrimination of affected staff was also reported in one enterprise.
- Hotel, mechanized fishing, manufacturing, trade, and finance & real estate are the sectors that suffered the impact

of HIV/AIDS. By nature of industry, the impact in terms of all factors reported has affected the formal industry. In terms of size, every industry irrespective of size is affected by HIV/AIDS.

- The response of the coworkers toward the affected, as reported by the employers, was studied for the select firms with HIV affected persons. 57.1 per cent of coworkers positively supported while 14.3 per cent did not bother. No percentage of the workforce is reported to have gone against the affected, though in another context (while measuring impact of HIV/AIDS) 0.1 per cent of firms (equivalent to 14.3 per cent of the affected firms in terms of HIV impact) reported marginal discrimination of the affected.
- Action taken information is available with 7 firms (0.7 per cent) affected with HIV-infected workers. Management came to know about the HIV cases in the company through various means – co-workers, medical check up, company doctor, frequent illness and family member. In the case of skilled workers, one firm (hotel) has given counseling and treatment and then changed their duty. In two cases, the management came to know very late and nothing could be done. In a case in Tamil Nadu, the management came to know about the problem only two years after the worker left. In the case of unskilled workers, one firm asked the worker to leave, one gave financial assistance, and another sent one worker to treatment.
- Regarding policy, only 5 respondents (0.5 per cent of total firms) have said that they have HIV policy at enterprise level. On close scrutiny, it was found that two of them do not recruit the affected staff, another appoints only workers with moral character, and two others take medically related steps. One of the latter gives medical guidance and counseling while the other has mediclaim policy for its workers, and it could not be ascertained whether the specific mediclaim policy covered AIDS or not. Uninformed medical check-up at the stage of recruitment is the policy followed by one firm that does not recruit infected staff.
- Some firms follow certain steps with the objective of preventing HIV among their staff. Some of the steps are: aids awareness camps and classes, character monitoring, discussion and distribution of available information, education of workers, encouraging workers to discuss the issue, medical steps like giving Hepatitis B shot, sex education, etc.

#### *Elements of a possible HIV/AIDS policy in the world of work*

- In the list of ten policy components given in the interview schedule, few objected to linking up sex education and condom promotion. When some suggested voluntary test and confidentiality of identity, there are few, who suggested compulsory HIV test and linking it with marriage, job and license. It is also suggested that implementation of an HIV/AIDS policy at unit level will go against the confidentiality of the affected staff. Besides these ten components, some of the other elements suggested, such as identifying right job for the affected and giving financial support, are important but not adequately supported. Segregation of HIV affected workers into separate enclaves of economy is also suggested.
- Among the policy elements, education and awareness programs (73.5 per cent), sex education and condom promotion (71.3 per cent), and counseling and treatment (69.4 per cent) were the maximum suggested elements. Voluntary test (57.9 per cent) and confidentiality of identity (43.2 per cent) followed these three elements in order. As 19.2 per cent of the respondents (203 employers) supported all the 10 suggested elements, the least supported policy element, i.e., *incapacity and survivors' benefits* also got the support of 22.4 per cent of employers interviewed.
- IT scored the highest in percentage support to eight of the ten policy elements, emerging itself the progressive-minded sector compared to other sectors. Finance and real estate is the second highest scorer. Except the element

of sex education and condom promotion, all the other policy elements are preferred more by formal industry than by the informal one. Large industry is the highest scorer in all elements of HIV/AIDS policy. The larger the industry, the higher is the comparative importance given to counseling and treatment. Industry is unanimous, irrespective of size, in giving least importance to incapacity and survivor's benefits.

#### *Expectation of employers with regard to nature, level and implementing agencies of policy*

- 47.1 per cent of the respondents want to make use of the existing health facilities and thus link the HIV policy with a general integrated health policy. Majority of the respondents (48.4 per cent) treats HIV as special case that needs more attention and wants to keep it independent of the existing health policy. Majority in construction, hotel, IT, plantation and transport sectors wants the policy to be independent and separate. Majority in the informal sector wants a separate HIV policy. When majority in tiny and large industries favors an integrated policy, that in the small and medium sector supports separate policy. Firms employing less than 100 workers have majority support for a separate dealing of the HIV policy. Those employing 100 and above workers gave a majority support for integrating the policy with the existing health policy.
- While 86.7 per cent of employers went in favor of implementing the policy at government level, 42.7 per cent opted at enterprise level and 44.3 per cent at the level of employers' association. That means, a minimum of 42.7 per cent of employers are ready to bear responsibility at enterprise level, and 44.3 per cent want co-operation from employers' association. At the same time, 86.7 per cent of them expect active intervention from the side of government. This reflects clear willingness of employers to have an HIV/AIDS policy in the world of work, though they expect active support of government. In addition, 4.1 per cent of employers preferred the implementation of the policy at other levels also. For instance, 1.3 per cent preferred NGOs, 0.6 per cent TUs, 0.4 per cent independent bodies of experts and 0.2 per cent chose the clubs.
- As far as the implementing agencies are concerned, majority of respondents preferred government as the implementing agency with regard to education and awareness programs (61.9 per cent), sex education and condom promotion (62.9 per cent), and counseling and treatment (59.7 per cent). NGOs followed this (42.5 per cent, 41.7 per cent and 42.2 per cent respectively).
- In workers' participation, workers committee was preferred (38.8 per cent), followed by workers' union in the unit (19.1 per cent). In fact, 48.8 per cent of employers in total preferred trade unions of some kind as the implementing agency for the policy element of workers' participation, as workers' representative from local TU (16.4 per cent) and trade union centers (13.3 per cent) were the third and fourth preferences. Thus, the three union-related options together overtake the option of workers' committee in the case of workers' participation. However, TU fared as the last option in the case of other three policy elements.

#### ***Recommendations***

- The survey reiterated the need for an HIV/AIDS policy at workplace. ILO could work with the Government, employers and trade unions to evolve a comprehensive policy on HIV/AIDS in the world of work and suggest model policies at the enterprise level.
- The three major policy elements supported by most of the employers are 'education and awareness programs,' 'sex education and condom promotion,' 'counseling and treatment.' Therefore, it is very important to arrive at measures directly or indirectly linked to the above three policy elements.
- Employers preferred simultaneous action at the levels of government, employers' association, and enterprises.

This reflects clear willingness of employers to have an HIV/AIDS policy in the world of work, though they expect active support of government. They expect also the support of NGOs, private sponsors, media and trade unions. Majority of respondents prefers government as the implementing agency with regard to education and awareness programs, sex education and condom promotion, and counseling and treatment. NGOs, private sponsors and media are the other important agencies suggested. Lobbying is needed to persuade Government to take initiative.

- Stronger opinion has emerged with regard to the interlinkage of a new HIV/AIDS policy in the world of work with the existing health policy. A national comprehensive policy is needed in this context.
- The relatively high level of awareness found among employers with regard to HIV and AIDS has to be utilized to develop a realistic assessment of HIV/AIDS and to devise proactive steps. The focus of the translation of awareness shall intend (1) to evolve preventive measures, (2) to persuade employers to acknowledge the rights of HIV positive workers, and (3) to enable the employers to assess the impact of HIV/AIDS at enterprise level and evolve necessary measures with the cooperation of the workers.
- Measures should be initiated against discriminatory practices.
- Best practices have to be documented and disseminated for emulation and learning.

Fishing sector needs special measures, as it emerged as the sector with low awareness levels on various counts and also as the sector more affected with HIV and other diseases. Discrimination of HIV-affected coworker is also reported from this sector. Both the workers and employers need crash measures of sensitization and also health and social security measures.

# CHAPTER ONE: INTRODUCTION

AIDS has become the most devastating disease humankind has ever faced since the first clinical evidence of Acquired Immune Deficiency Syndrome (AIDS) was reported two decades ago. Since the pandemic began, more than 60 million people have been infected with the Human Immunodeficiency Virus (HIV). HIV/AIDS is now the fourth biggest killer worldwide and the leading cause of death in sub-Saharan Africa.

Nine tenths of all people living with HIV/AIDS are in poor countries. Two thirds of the total infected are in sub-Saharan Africa. Eastern Europe, especially the Russian Federation, continues to experience the fastest-growing epidemic in the world. Of particular concern are the marked increases registered in some of the world's most heavily populated countries like China, India and Indonesia. The epidemic on a larger scale threatens to develop in the high-income countries. Republic of South Africa and India stand first and second in holding largest number of HIV infected persons. An estimated 40 million people globally were living with HIV by the end of 2001.

Irrespective of classes and communities, the danger of HIV/AIDS has become a common issue now. However, as studies point out, the spread of HIV infection is found poverty-related and affects men and women differently. Studies could link HIV/AIDS with sexually transmitted infections (STI) and tuberculosis, the latter being the main opportunistic infection. As on 31 August 2002, India is reported to have 39,742 AIDS cases of which 29,907 are males and 9,835 are females. With 18,276 AIDS cases, Tamil Nadu tops the list, followed by Maharashtra with 8,262 cases. Many companies are now introducing HIV testing for their employees, albeit in a surreptitious manner. Violation of human rights is noticed in AIDS cases. Pre-natal transmission is also a cause for concern, as one in every four infected person is a woman.

The management of hospital waste has become a matter of serious concern in developing countries. Waste handlers and healthcare workers have become victims of HIV infection. As far as occupational health is concerned, the existing legislation in India would be obviously inadequate in an HIV/AIDS scenario.

## **HIV/AIDS in the World of Work**

In a document, ILO (2000) has analyzed the impact of HIV/AIDS at workplace. The labor force in the high prevalence country in 2020 is estimated to be about 10-22 per cent smaller than it would have been if there had been no HIV/AIDS. Though labor force is still expected to grow, there will be about 11.5 million fewer persons at the workplace because of increased mortality. In Zimbabwe, AIDS related reduction in the production of maize has reached 61 per cent, cotton 47 per cent, vegetable 49 per cent and ground nuts 37 per cent. In another study (UNAIDS, 2000) it is found that Central African Republic lost 85 per cent of 300 teachers due to AIDS related deaths in 2000. By the nineties the toll had forced the closure of more than 100 educational establishments in that country.

Studies done in India show that HIV/AIDS has become already an issue at workplace. For instance, the study done by CEC on HIV/AIDS and workers' vulnerability taking Wazirpur Industrial Area and linking the issue with

labor rights. The study (CEC, 1999) found Wazirpur Industrial Area as a case representing a larger reality, of a dangerously porous environment for HIV/AIDS transmission. It pointed out that the cost of the HIV/AIDS epidemic would be very high for a population already operating within perilously over-stretched margins. In the absence of any security net provided by the state or the workplace, this 'heavy cost' will have to be borne by the affected individuals and families, leading to their further impoverishment. Though the study recommends measures and roles to be taken and performed by employers, state, unions and social groups, the study was mostly centered on the issue of labor rights. However, the questions of absenteeism and loss of persondays have been pointed out.

That how the absence of a comprehensive health policy (including HIV/AIDS prevention) affects the industry, the employers as well as employees and thus the total economy has been done in other countries. A study done on business in Côte d'Ivoire by Laurent Aventin and Pierre Huard (Aventin and Huard, undated) points out two kinds of impact of HIV/AIDS on firms. One is the easily observable economic loss and other empirical features of the impact, as confirmed by micro-economic or sectoral studies. The second aspect of the impact is the less visible one, working slowly on the organization and operational structures of industries. At the moment, managers are concerned only about the visible effects, and that too only in the context of their own business. Absence of a proper HIV/AIDS policy would only encourage discriminatory practices and speed up the processes of the disorganization of work. What is now needed is to seek a transitional solution to the problems that will be applicable to most industries and at the same time tackle the root cause of staff turnover. It may be posited that, while opting for a health policy may entail costs for a firm, it has its advantages also, one of them being that it reduces absenteeism on health grounds, which also puts a burden on the firm.

Some public and private sector enterprises contribute in varying proportions to the payment of employees' health insurance and continues to be willing to allocate large amounts to medical aid. Before the emergence of HIV/AIDS, this policy helped give the international-type of firms a positive social image in the eyes of both staff and consumers. It recognizes the relationship between the physical health and morale of the staff on the one hand and productivity on the other. The quality of social benefits, especially the offer of medical cover, in a country where health care is expensive is highly appreciated by employees. This policy, which is of benefit to the staff as a whole, narrows hierarchical gaps and strengthens social ties and work cohesion among employees.

The study carried out in Abidjan did not directly take into account increases in employee productivity in relation to the quality of the medical aid, since it is a relation that is difficult to prove. It concluded that, nevertheless, there probably is a relation, especially considering the often-difficult organizational and working conditions under which industries in Africa have to operate. A socio-medical policy could help mitigate the organizational dysfunction caused by HIV/AIDS. Inevitably there will be significant differences between an establishment which plays no part in its employees' health and one which employs a full-time doctor and partly funds its employees' health insurance. Given the situation, the question therefore is to ascertain whether, in terms of costs and also of production capacity, prioritizing medical aid is more efficient than failing to make any contribution to the medical care of employees (Aventin and Huard).

All these measures are of benefit to not only the employees, but also to the employer, for there will be less absenteeism on medical grounds. This is true for all pathologies, including those associated with HIV. The

study notes that the lack of effective treatment against HIV/AIDS in Africa indirectly affects economic activity, since such treatments would prolong the life expectancy of HIV-infected persons and affect the mortality and morbidity of a company's workforce and hence its turnover and all the attendant organizational consequences. In near future, this is going to be true of any country, and for that matter, India also.

In developed countries, HIV/AIDS at workplace has been taken note of as an issue to be handled, and the employers have started introducing definite policy either as separate or as part of an integrated health policy. For instance, in USA, the Business Responds to AIDS Program by CDC (Centers for Disease Control and Prevention) is designed to help businesses across the country develop and implement comprehensive workplace-based HIV and AIDS prevention education programs. CDC has developed materials and technical assistance to assist business and unions in forming comprehensive HIV and AIDS workplace programs.

Businesses that have addressed the HIV/AIDS issue suggest that it is useful to have a written policy stating the company's position and procedures that tell employees what is expected of them. An HIV/AIDS policy is the foundation for the entire HIV/AIDS program, and it establishes consistency within the company. The policy works as the standard for communication about HIV/AIDS, sets standards of behavior expected of all employees, and lets all employees know where to go for assistance. Some small businesses do not have formal, written policies. Instead, these businesses follow established "business practices." Such standard practices guide the managers and employees, and lead to consistent, predictable and desired behavior. However, standard practices come about through repeated experience (CDC, undated).

A study by the Institute of Economic Growth, New Delhi shows that, on average, an HIV positive person spends approximately Rs.6,600 every month on consultation, diagnosis, medication, hospitalization and transport. For people with full-blown AIDS, the expenses could be up to Rs.35,000 a month (India Today, 15 March 1997). For an average middle class family in India an HIV positive patient is a major catastrophe since, in most cases, the main breadwinner is the patient himself.

There is growing evidence that the private sector is taking an active role in the fight against HIV/AIDS at workplace. For example, Larson and Toubro in India has established a policy to prevent discrimination and give training to its employees. A study by Daly (2000) observes that over the years, the company has involved 85 trainers and social workers and conducted more than 200 programs covering 10,000 employees out of total workforce of 26,000. Likewise, Teddy Export, a company with only 287 employees in Madurai in Tamil Nadu has taken an extensive program through street plays, slide shows and stickers. The UK Department for International Development has identified the work of Teddy Export as a model to replicate in other areas.

Tata Tea is working with tea plantation workers in Kerala, providing them with information on HIV and related services. Federation of Indian Chambers of Commerce and Industry (FICCI) has also suggested the sugar mills to take up prevention not just within their own workforce but also with the migrant laborers employed by cane growers. One company is already spending over Rs 5 lakh in footing the medical bills of five employees with HIV (The Times of India, New Delhi, 9 May 2002). TELCO is one company that has started its own program on HIV.

A study (The Times of India, New Delhi, 14 January 1999) has estimated a whopping loss of Rs.23,500

crores (Rs.235,000 million) to Indian economy, if the AIDS epidemic is not checked. According to this report there are more than 5000 full blown AIDS cases in the corporate sector. Among those seriously concerned by this information is the Confederation of Indian Industry (CII) which has initiated a program to create awareness about the prevention of AIDS among its members.

CII has attempted to develop guidelines on HIV/AIDS at workplace in 1996. The main objectives of the CII program are the following:

- To sensitize industry on issues related to HIV/AIDS.
- To implement behavioral change programs by giving the right input and direction to employees at the workplace with essential information on STD/HIV/AIDS, transmission, care and control, and promotion of safer sexual behavior including consistent condom use.
- To mobilize industry to implement non-discriminatory policies toward employees with HIV/AIDS.
- To provide acceptable and accessible good quality clinical services which do not stigmatize, and guarantee privacy and confidentiality.
- To arrange facilities for STD diagnosis and treatment.
- To develop good referral centers outside the organization.
- To make available condoms at the workplace set up.

CII has conducted a specific study of the program implementing non-discriminating policies towards employees with HIV/AIDS and providing acceptable and accessible clinical services, which do not stigmatize. There are some successful examples of the program.

- (i) An employee in a high-risk job was transferred to another department in the interest of other employees.
- (ii) In another case, an employee who worked in the canteen faced great resistance from his colleagues till the management called an expert to clear misconceptions about the disease.
- (iii) In an instance where an employee's services were not being fully utilized, the manager of the department was counseled and the employee was able to continue his work without any stigma attached.
- (iv) In another case an employee received financial assistance from the company and in the final stages of the disease, his colleagues contributed.

The study, however emphasized that the industry should not stop at preventive steps but should also shoulder some responsibility for caring for the infected and help in providing an alternative source of income for the affected family.

### **ILO's Intervention and Participation**

ILO has analyzed the probable impact of HIV/AIDS on the labor force in fifteen countries, thirteen of which are in Africa, one in Asia, and one in the Americas. The age and sex distribution of the labor force is expected to change, due to the rising number of people with AIDS in the age group of 20-40 years. This would result in early entry of children into the active labor force and the early withdrawal of people with AIDS and the retention of older person in the labor force due to the economic need. The labor force in the high prevalence countries in

the year 2020 is estimated to be about 10-22 per cent smaller than it would have been if there had been no HIV/AIDS. Though labor force is still expected to grow, there will be about 11.5 million fewer people in the workforce because of the increased mortality. In the case of lower prevalence countries, the impact is significant but smaller. The labor force is expected to be between 3 and 9 per cent smaller (except for Thailand where the difference is just over 1 per cent) than it would have been without HIV/AIDS.

The ILO has increasingly recognized and responded to the threat to the world of work posed by HIV/AIDS. ILO estimates that out of 36 million people infected with HIV worldwide, at least 23 million (three quarters) are working people aged 15-49.

The Regional Tripartite Workshop on the labor and social implications of HIV/AIDS (Windhoek, October 1999) adopted a platform for action on HIV/AIDS in the context of world of work in Africa. This received later the unanimous approval from the Ministers of Labor attending a regional meeting in Abidjan in December 1999. This paved the way for the Special high level meeting on HIV/AIDS and the World of Work, held in conjunction with the International Labour Conference in June 2000, at which the Co-operation Framework Agreement between the ILO and UNAIDS was signed.

ILO developed a Code of Practice on HIV/AIDS and the World of Work that was discussed and adopted at a tripartite meeting of experts held in Geneva in May 2001. The ILO Code of Practice will provide workers, employers and governments with new global guidelines based on international labor standards to address HIV/AIDS and its impact at the enterprise, community and national levels.

The ILO, in consultation with its Indian constituents and NACO developed a three-phased strategy aimed at establishing a sustainable national program on HIV/AIDS prevention in the world of work. First phase intends to establish infrastructure for mobilization of the tripartite partners for the prevention of HIV/AIDS in the world of work, and prepare a plan of action for the second phase. The second phase would cover implementation, completion and evaluation of a pilot tripartite plan of action for the prevention of HIV/AIDS at workplace in six States. The focus will be on (1) documenting the impact of HIV/AIDS on the labor force, (2) combating discrimination and social exclusion and (3) launching prevention, protection and assistance programs.

The third phase intends to put in place a national plan for the prevention of HIV/AIDS in the world of work on a sustainable basis, fully integrated into the relevant programs of the government and organizations of employers and workers, including enterprises in public, private and informal sectors. In this context, ILO envisaged a number of consultations with the stakeholders involved. The nodal agency of the ILO project is VGNLI that houses the Technical Resource Group set by NACO for the prevention of HIV/AIDS at the workplace. Research and documentation is another key component of the ILO project in this regard.

### **Project on Perceptions of Indian Employers about HIV/AIDS in the World of Work**

Indian employers are one of the stakeholders of the present project. The objective of the present research is to capture the perception of employers in India on the issue of HIV/AIDS in the world of work. However, the employers' perspective of the private sector alone is brought under the purview of the present inquiry. This is meant to determine some key parameters that could be used to undertake appropriate advocacy/intervention programs related to HIV/AIDS. The objectives of the study are set, situating on the context of deliberation so far done.

### **Objectives of the Study**

The main objectives of the study are:

- To capture the perceptions of Indian employers about the HIV/AIDS in the world of work.
- To identify the key parameters in relation to the above that could be used to undertake appropriate advocacy/intervention strategies at the world of work vis-à-vis HIV/AIDS.

In accomplishing these objectives, the study would consider the following specific issues in its analyses.

- Awareness of Indian employers about HIV/AIDS in general.
- Awareness of Indian employers about the importance of HIV/AIDS at workplace.
- Their awareness about the “opportunistic” diseases associated with HIV/AIDS like Tuberculosis, Hepatitis C, Hepatitis B and sexually transmitted infections (STIs).
- Magnitude and pattern of their workforce, having or perceived to be having HIV/AIDS.
- Magnitude and pattern of their workforce, having or perceived to be having “opportunistic” diseases associated with HIV/AIDS like TB, STIs, Hepatitis, etc.
- Company's existing health policy (schemes and efforts) to assess how far it has integrated schemes such as sex education for staff, family planning and condom promotion, STD clinics and HIV/AIDS counseling.
- Special elements needed in the health policy for women workers including maternity health vis-à-vis the existing policy and its reflection on the HIV/AIDS at workplace.
- Fatalities as regards HIV/AIDS and “opportunistic” diseases associated with it like TB, STIs, etc., and the social security measures taken by the enterprise to support the families of employees who died of severe sicknesses.
- Existing policy and the actions taken based on the existing policy or otherwise as regards to HIV positive persons (in terms of offering employment, continuing with employment, treatment, etc.).
- The inadequacies of the existing policy on occupational health and safety, to see how it can relate with the emerging HIV/AIDS scenario at workplace, and to find the legislative needs and make suggestions thereof.
- The pattern of how HIV/AIDS has affected their organization at different dimensions (workforce stability, loss of persondays due to medical reasons, stigma on particular workers, problems in procuring orders, turnover, productivity, extra expenditure on recruiting and training new staff, change in expenditure on health and social security).
- The cost-benefit sense of the employers to have a health policy.
- Willingness of employers to have an HIV/AIDS policy at enterprises level or not, and the reasons thereof. In addition, their interest to have a separate HIV/AIDS policy or their interest to integrate it with the existing health policy.
- Elements of HIV/AIDS policy in employers' view.
- Nature of support required by employers to initiate programs for combating HIV/AIDS.

- Suggestions based on the expectation of employers, on the HIV/AIDS policy at workplace, from the public institutions and state in terms of institutional and infra-structural support on the one hand, and from the workers and unions on the other.
- Over and above, the threat of HIV/AIDS to the enterprises in terms of sector, size and nature of industry, and general composition, migrant component, gender composition, skills and education level of workforce.
- The intention of the research to suggest, basing on the study, the measures that can be taken to contain the HIV/AIDS in the world of work in general, and from the employers' perspective in particular.

### **About CEC, the external collaborator of the present study**

The Centre for Education and Communication (CEC), as the external collaborator, is executing the present study for ILO. CEC was founded in 1982 with a new vision on labor. Now, the Centre critically understands the changes in the world of work in the context of new economic policy changes, and evolves appropriate resolving strategies at national and international levels, in collaboration with trade unions, labor support organizations and peoples' movements. CEC has its office equipped with qualified and committed staff, and communication and data processing facilities. The Documentation and Information Services (DIS) of CEC has a large collection of books, documents and reports, besides all standard journals on economy, industry and labor, and newspaper clippings on labor issues. CEC has been involved in research on various aspects of labor. CEC places the findings of its studies in the public domain through roundtables, and seeks the co-operation and collaboration of workers' organizations, women and child rights activists, NGOs, academics and policy makers, government agencies, employers' associations, and all the concerned citizens to transform the situation. Beyond research, it engages in advocacy and campaign on labor rights and undertakes capacity building programs.

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## CHAPTER TWO: METHODOLOGY

This section deals mainly with sampling (justification of sample size, selection and distribution of sample with data sources), interview schedule (including the pre-testing – pilot study), training of zonal co-ordinators and research investigators, monitoring, and strengths and constraints of the study.

### Data Sources

Data of National Sample Survey Organization (1999-00), Annual Survey of Industries (1996),<sup>1</sup> Economic Census (2001),<sup>2</sup> Economic Survey (2001-02), and Annual Report of Department of Company Affairs (2000-01)<sup>3</sup> and data sources on small industry were reviewed. Relevant data from ASI, Economic Census and NSSO were used for arriving at an optimum sample and distribution of sample across States and sectors. Wherever calculations related to primary sector sample were involved, other sector-specific data sources had to be used.

ASI data was used to understand State-wise distribution of registered manufacturing establishments. Statement 31 of ASI 1993-94 (p. 50) provides State-wise division of number of factories (sample) along with other information for 17 States. Therefore, ASI data was used as the basis for distributing firms at State level in the sample under study. Neither Department of Company Affairs nor Economic Survey gives detailed sectoral distribution of enterprises. Economic Survey 2001-02 records sector-wise information on employment. Though this data is a pointer for the share of samples in each sector, there is no information on the number of factories in each sector. As Economic Census gives this data, the figures of Economic Census 1998 were used to arrive at sectoral distribution of firms. Thus, the Economic Census 1998 (2001) and ASI 1993-94 (1996) were taken as bases for distribution of sample at sectoral and State levels respectively.

Selection of sectors is based on factors of coverage and employment. NSSO data was used to comprehend the distribution of employment across the sectors. Industrial significance weighed in the selection of some sub-sectors in manufacturing, as in the instance of automobiles and auto-ancillaries.

Central Marine Fisheries Research Institute (1996) data on State-wise mechanized fishing boats and statistics on State-wise mining as percentage of GDP provided by the Indian Minerals Year book 2000 were used for distributing respectively the samples for fishing and mining across States. Plantation employment was estimated on the basis of average employment per hectare for five major plantation crops – tea, coffee, rubber, cotton and sugarcane. Distribution was arrived at on the basis of data available in the website agristat.org on total land used for these crops in each State. Assam and West Bengal were not getting sizeable samples. Therefore, the samples were ceiled by a significance of 1. The additional samples were equally distributed among Assam & West Bengal.

1. CSO (1996): Annual Survey of Industries – 1993-94, Summary Report (Factory Sector), Central Statistical Organisation, Department of Statistics, Ministry of Planning, New Delhi.

2. CSO (2001): Economic Census 1998: All India Report (New Delhi: Central Statistical Organisation, Ministry of Statistics and Programme Implementation, Government of India).

3. Annual Report 2000-2001, Department of Company Affairs, Ministry of Law, Justice and Company Affairs, Government of India.

## Sampling

### Derivation of the Sample size for Manufacturing Sector

- It is assumed that on an average there are 6 per cent of total manufacturing establishments in each State. The assumption is based on ASI data (see table 2.1).
- Considering this as null-hypothesis, it would be rejected with respect to the exact share of each State.
- A two-tailed test is considered for sample proportion for each State. The test statistic is  $z = (p - 0.06) / [(p \cdot q) / n]^{1/2}$  where  $p$  = exact sample proportion in each State.  $q = 1 - p$ , and 'n' is the sample size. 0.06 is the average sample proportion across the States.
- To make the test significant at 10 per cent level, the sample size for each State is calculated. Then they are summed and got it as 250 (246 exactly).

### Other States considered

Two more States other than those listed in table 2.1, i.e., Goa and Nagaland are considered for the survey. Chattisgarh and Jharkhand are the new States carved out of MP and Bihar respectively. These two States together make it a total of 21 States in the present study.

**Table 2.1 Percentage Share of Factories by States (ASI 1993-94)**

States	Number of factories (sample)	Percentage share (out of 17 States)
Maharashtra	18,710	16
Tamil Nadu	18,522	15
Gujarat	11,821	10
Bihar	3,763	3
Uttar Pradesh	10,335	9
Madhya Pradesh	4,011	3
West Bengal	5,881	5
Andhra Pradesh	15,227	13
Karnataka	6,094	5
Punjab	6,099	5
Rajasthan	4,173	3
Haryana	3,509	3
Kerala	4,035	3
Orissa	1,611	1
Delhi	4,350	4
Assam	1,435	1
Himachal Pradesh	341	0.3
Total for 17 States	119,917	100
All India	121,594	

Source: Annual Survey of Industries 1993-94, p. 50

### Derivation of Sector-wise All India Distribution

- The all India figures provided by Economic Census are considered to get the percentage distribution of other sectors such as trade (30%), transport (2.5%), restaurants & hotels (5.2%), communications (1.5%), real estate (4%), IT & Communication (1.5%), construction (negligible) and mining & quarrying (0.2%). These, including manufacturing sector, come roughly around 63.4% of total establishments.
- The sample size for other sectors (excluding fishing and plantation) is arrived at, by extrapolating the

derived sample size of 250 for manufacturing sector, which represent 20% of all establishments as per the economic census. Hence, 793 establishments will cover 63.4% of total establishments roughly.

- Even though a sample of 793 suffices, taking a total of 1050 is considered for the survey that includes samples for fishing and plantation.

### **Distribution of Additional 257 Samples**

The distribution of additional 257 establishments  $[(1050-793)=257]$  has been made in the following way.

- The percentage distribution of employment across the sectors as per NSSO (1999-2000) and the estimated figure for plantation has been taken into consideration for this.
- The additional 257 establishments were distributed proportionately to all the sectors following percentage distribution as described earlier. This has been added to the original sample, sector-wise.
- It was noticed that mining & quarrying and fishing have not been allocated adequate number of establishments. Considering the subjective understanding and the gravity of the problem, the allocated size of manufacturing and trade (together by 40) was shortened and this number added equally (20 each) to fishing and mining & quarrying. After revision, the sample size of manufacturing is 300 and that of trade is 401. They are still more than their respective sample size in the original sample distribution of 793. In the sample of 793, the allocation to manufacturing was 250 and that to trade was 373.
- Needed adjustment and revision were made on total sample in each State. Minor revision was done on the total sample in each sector and also on its distribution across States.

### **The Final Industry wise Distribution of Samples**

The final distribution of the sample across the sectors is provided in the table 2.2.

**Table 2.2 Sectoral Evolution of Sample**

	Original	Original + Additional	Revised
Mining & Quarrying	3	5	25
Construction	3	28	28
Trade	373	426	401
Hotel & Restaurants	65	72	72
Transport	31	53	53
IT (Communication)	19	19	19
Finance & Real Estate	50	58	58
Manufacturing	250	315	300
Fishing		2	22
Plantation		71	71
Total	(794) 793	(1,049) 1,050	(1,049) 1,050

### **State-wise Distribution of Samples**

State-wise distribution of these sectors in total followed the same pattern of ASI data distribution in the case of manufacturing. For instance, 16 per cent of total sample was earmarked for Maharashtra. A cluster approach was used in distributing Primary Sector Samples (Mining & Quarrying, Fisheries and Plantations) across different States considering the fact that the concentration varied among States.

## **Other Important Points**

- Random survey was preferred without predetermining the distribution of samples among tiny, small, medium and large industries (based on total investment). More thrust was given on small, medium and large establishments during the survey.
- As far as activities like mechanized fishing and plantation are concerned, clusters were chosen to distribute the sample.
- The unit of this survey is one establishment.
- Manufacturing consists of 8 industrial sectors. The total sample was distributed among these eight sectors, but selection was at random. In some cases, the cluster approach was also considered.
- Plantation consists of 5 major plantation crops.

## **Coverage**

Selected sectors cover around 63.4 per cent of the economic activities excluding fishery and plantation, as per Economic Census 1998. The selected sectors have 44 per cent of total workforce including fishing and plantation, as per NSSO (1999-2000). Sectors included mining and quarrying (25), construction (28) trade and commerce (401), hotel and restaurants (72) transport (53), IT (19), finance and real estate (58), manufacturing (300), mechanized fishing (22) and plantation (71). The total sample was 1,050 (1,049 to be exact). Cluster approach was used in distributing primary sector sample (mining, fishing and plantation) across States considering the fact that concentration varied among States. State-wise and sectoral distribution had led the sample to a total of 1,063. Final accepted sample after survey is 1,058, and the study is based on this sample.

## **Explanation for Classification by Size of Industry**

In India, the industrial/official definition of small-scale sector is in terms of investment. Dr. S. P. Gupta Study Group (Interim Report on the 6 July 2000) on Development of Small Enterprises recommended considering the SSEs into a three-tier definition - tiny, small and medium. At the same time, medium scale sector is differentiated as having investment of Rs. 10 to 100 million, and excluded from the fiscal and other policy support given to SSIs.

The new policy initiatives in 1999-2000 reduced the investment limit in the small scale and ancillary units from Rs.3 crore to Rs.1 crore (from Rs.30 million to 10 million). The investment limit for the Tiny Sector continues to be Rs. 25 lakh (2.5 million) as per the Comprehensive policy package for Small Scale Industries and Tiny Sector announced on 30th and 31st August 2000.<sup>4</sup> Medium scale units have the range of investment from 1 to 10 crore rupees (10 to 100 million). Those with an investment of above Rs. 10 crore (above 100 million) are in the large industry. Nevertheless, some products are de-reserved from such limits for promoting export. The question of using power or not is also linked to the definition of small-scale units. Based on the consideration of investment size of firms as on April 2002, units are classified into tiny, small, medium and large industries.

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4. Ministry of SSI & ARI (2000): Comprehensive policy package for Small Scale Industries and Tiny Sector (Announced on 30th and 31st August 2000 by Government of India), Internet (SIDO online).

The size of plantation firm is considered in terms of its acreage. In investment or acreage terms, tiny industry or plantation is therefore with an investment up to Rs. 2.5 million or with land up to 12 acres. Small is with Rs.2.5 million to 10 million or with more than 12 and less than 30 acres, and medium is of Rs.10 to 100 million or of 30 to 100 acres. A firm is considered large if it is with an investment of more than Rs.100 million, or the plantation is large if it has a holding of above 100 acres.

### **Explanation for Classification of Firms by Nature of Industry**

Industries are divided into two categories, formal and informal. Almost similar equivalents are the organized and unorganized, as is used in India. At the 15th International Conference of Labour Statisticians, the ILO postulated that the urban informal sector can be characterized as a range of economic units in the urban areas, which are mainly owned and operated by individuals either alone or in partnership with members of the same household and which employ one or more employees on a continuous basis in addition to the unpaid family worker and / or casual employee. Typically, these units operate on a small scale, with a low level of organization and little or no division between labor and capital. They are engaged in production and distribution of goods and services with the main objective of generating employment and a basic income to the persons concerned.

In fact, the use of the term 'unorganized sector' is more limited to India and referred in our five-year plans. The Central Statistical Organisation (CSO) has differentiated the organized and unorganized enterprises. According to CSO, all enterprises which are either registered or come under the purview of any of the Acts and / or maintain annual accounts and balance sheets are 'organized' enterprises. The unorganized enterprises are all unincorporated enterprises and household industries other than the organized ones and which do not maintain annual accounts and balance sheets.

The present survey excludes the Own Account Worker Establishments (OAWEs), which do not hire any worker on a regular basis. So also, our survey interviewed only those firms with at least two workers including one worker outside the family. We did not adopt any mechanism to see whether the firm surveyed maintains annual accounts and balance sheets. Therefore, the availability of any one of benefits to workers on the basis of any Labor Act such as bonus, ESI, EPF, gratuity, maternity benefits and pension was considered a determining factor to consider a firm as formal, except in establishments with fairly large workforce.

### **Interview Schedule**

- The interview schedule was structured and partly open-ended.
- Interview schedule at the stage of proposal was thoroughly reorganized after accommodating the suggestions from ILO office.
- The same was subjected to in-house discussion before the research and campaign staff in Centre for Education and Communication, and relevant changes were made.
- The suggestions of the program officer, research and documentation, for the related project from the side of ILO were again considered.
- Meanwhile, interview schedule was subjected to pre-testing. The pilot study was basically centering on

the possible changes, if needed. For this reason alone, project co-ordinator and the main researcher directly went to field for the pilot survey. In fact, changes of the nature of ambiguity in questions could be made and thus the interview schedule was revised.

Following are details of five schedules that were piloted for the project. All were piloted in and around Delhi during 25 March-18 April 2002.

1. Manufacturing (automobile accessories); formal; workforce 575 (Sahebabad, UP)
2. Manufacturing (pharmaceuticals); formal; workforce 350 (Sahebabad, UP)
3. Service – health (hospital); formal; workforce 230 (Delhi)
4. Manufacturing (garment embroidery); informal; workforce 10 (Delhi)
5. Manufacturing (metal products, machinery & equipment); informal; workforce 5 (Delhi)

A designated zonal co-ordinator and one research investigator visited the last (fifth) firm, but the results and the message of the interview were discussed and used. Two interviews, one each from garment sector (Gurgaon) and IT enabled industry (NOIDA) were denied at the pilot stage, despite pursuit. The revised and final schedule used in the survey is appended (Annexure 1).

### **Training and monitoring**

Initially 5 co-ordinators were given training on 24 April 2002 in CEC, attended by the program officer, research and documentation, for the related project from the side of ILO. Investigators were trained at Indian Social Institute on 25 April in the presence of the National Co-ordinator and the program officer concerned from ILO, researchers from CEC and zonal co-ordinators. Later, some more investigators had to be additionally appointed who were given informal training either by the respective zonal co-ordinators or by the CEC research team. Another researcher from CEC had to additionally do some field interviews. Interviews were done during April-June 2002. Though five zones were initially planned, the central zone is distributed between East and North zones and the data were processed as belonging to 4 zones.

Training modules included discussion on interview schedule, methodology and sample distribution, nature of sectors selected for survey, and information materials on HIV/AIDS. Monitoring of survey included examination of first two interview schedules done by every investigator and suggestions based on them by co-ordinators. Necessary corrections and further vigil was kept. Active telephonic conversations and email communications were also used to monitor the survey, besides occasional field visits by co-ordinators to places where the investigators were working.

### **Sample planned and done**

Taking 1,050 as the statistical sample, sample was distributed sector-wise, then State-wise and center-wise. In this process, the sample arrived at has become 1,063. Table 2.3 shows the break-up. Table 2.4 gives the break-up of actual sampling done, which are 1,058. Tables 2.3 to 2.4 are appended (Annexures 2 to 3). In the process of survey, some of the centers initially planned were changed due to practical reasons. To sample and approach employers in most of the centers, the research investigators used directories, help of

merchants' associations, and even web-sites in some cases. The details of the sample are dealt in the chapter on profile of sample (chapter three).

### **Strengths and Constraints of the Study**

- In covering the economic activities and workforce, the sample of the survey is strong enough to represent the universe of the study. The selected sectors cover around 63.4 per cent of economic activities excluding fishery and plantation, and have 44 per cent of workforce including fishery and plantation.
- The total sample is adequate enough to give results with minimum margin of error.
- The main objective of the study is to capture the perception of employers on an HIV/AIDS policy at workplace, its elements and their expectation from others in implementation of such a policy. Therefore, no special emphasis was given to industrial sectors and geographical areas where higher incidence of HIV/AIDS is reported.
- As the study is to capture the perception of employers, the study depended on the interviews from employers. The intention is not to study the living and working conditions of workers, though the assessment on the health and social security policies and measures is needed as supplement to the perception of an HIV/AIDS policy at workplace. Therefore, the study did not intend to adopt any effective crosscheck (except observing the workers wherever possible and reporting on their apparent health, etc.) on the information gathered from the employers.
- There may be under-reporting on size of investment, total strength of workers, and incidence of HIV.
- Options given the interview schedule led to some questions. For some employers, it is impossible to implement an HIV/AIDS policy at the level of enterprise, as it would break the confidentiality of identity of the worker patient, and distance the enterprise from clients. So another set up is needed. Some respondents suggested compulsory test, linking with recruitment, continuation of job, marriage, and license. However, these were not the views aired by a substantive cross section.
- As far as workers' participation is concerned, workers' committee was given as an option of implementing agency along with options of trade unions. However, as a single choice, it emerged as the topmost one vis-à-vis three options of trade unions, i.e., union in the enterprise, local union, and trade union center. It seems that employers who are against unions also preferred workers' committee to unions, though their firms might not have such set up.

## CHAPTER THREE: GENERAL PROFILE OF THE SAMPLE

The general profile of the sample gives coverage as well as the distribution of sample on the basis of some general variables and their inter-relation. Following variables are taken into account.

1. Zones
2. States
3. Gender of respondents
4. Status of respondents in the firm
5. Sector of industry
6. Nature of Industry
7. Investment size or size of acreage in case of plantation
8. Workforce size

### Geographical Distribution of enterprises (Zones, States, Districts and Areas)

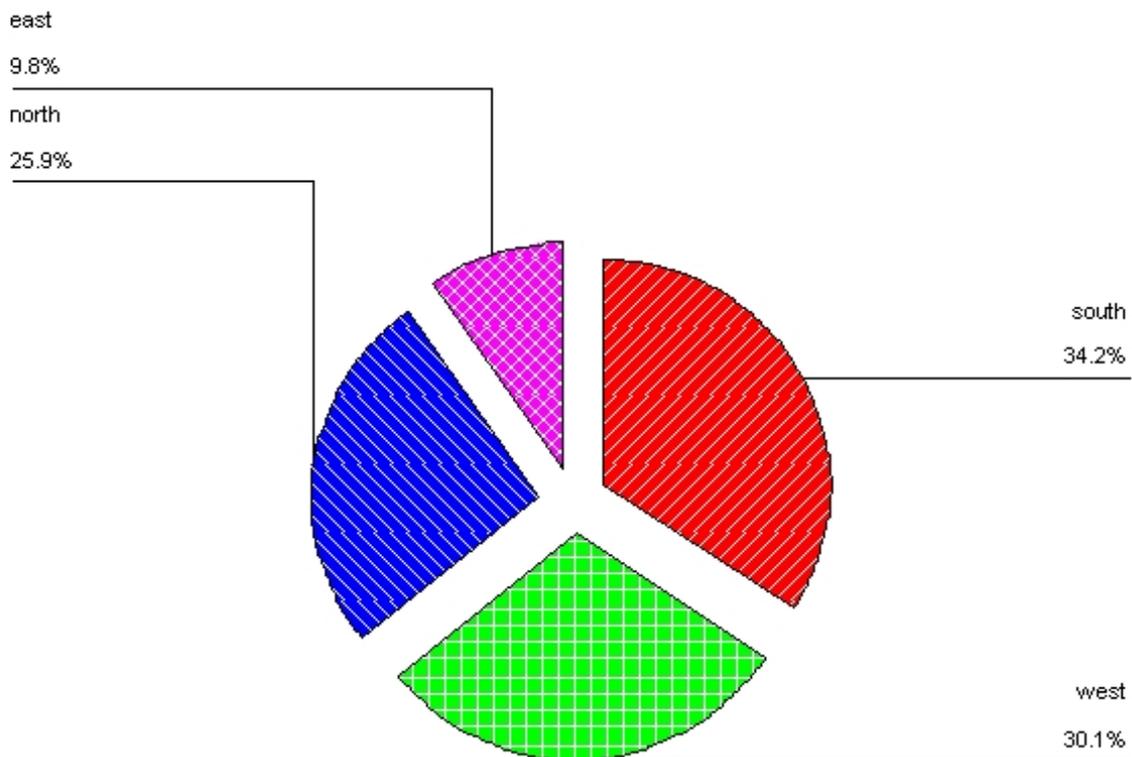
Sample is drawn from all the four geographical zones of India. A total of 1,058 firms were surveyed. Twenty-one States, 71 districts and 140 areas/centers were covered in the survey. South and West share major portions of the sample, while east zone has the least representation. As per the Annual Survey of Industries data, south and west zones represent maximum industries, and that explains the larger presence of firms from these zones. South zone represents 34.2 per cent, west 30.1, north 25.9, and east 9.8 per cent of our sample (chart on zonal distribution). Maharashtra shares the largest percentage of the sample (16.5 per cent), followed by TN (13.6 per cent), AP (13.1 per cent), UP (10.7 per cent) and Gujarat (10.2 per cent).

### Sectoral Distribution of Enterprises

For the survey, 10 sectors were selected within which plantation had 5 and manufacturing 8 sub-sectors. In total, 21 sectors were covered and analysis is done for the 10 major sectors that account for all the sub-sectors. Following is the sectoral coverage.

<b>Sector</b>	<b>Number</b>	<b>%</b>
Plantation	75	7.1
Mechanized Fishing	25	2.4
Mining & Quarrying	25	2.4
Manufacturing	303	28.6
Construction	26	2.5
Trade & Commerce	388	36.7
Hotels & Restaurants	76	7.2
Transport & Auxiliary Activities	57	5.4
IT Enabled Industries	22	2.1
Finance & Real Estate	61	5.8

## zonal distribution of sample



N = 1058

Trade (36.7 per cent) and manufacturing (28.6 per cent) have major coverage in the sample (65.3 per cent in total). However, this is more or less in proportion to the actual existence of firms. Table 3.1 gives the sectoral distribution of firms with diaggregates for sub-sectors within plantation and manufacturing. Sugarcane is most covered (4.3 per cent of the total sample) and rubber (0.3 per cent of total) is least covered among the sub-sectors in plantation. Among the sub-sectors in manufacturing, metals & machinery is most covered (8.0 per cent of total) and tobacco is least covered (0.2 per cent of total).

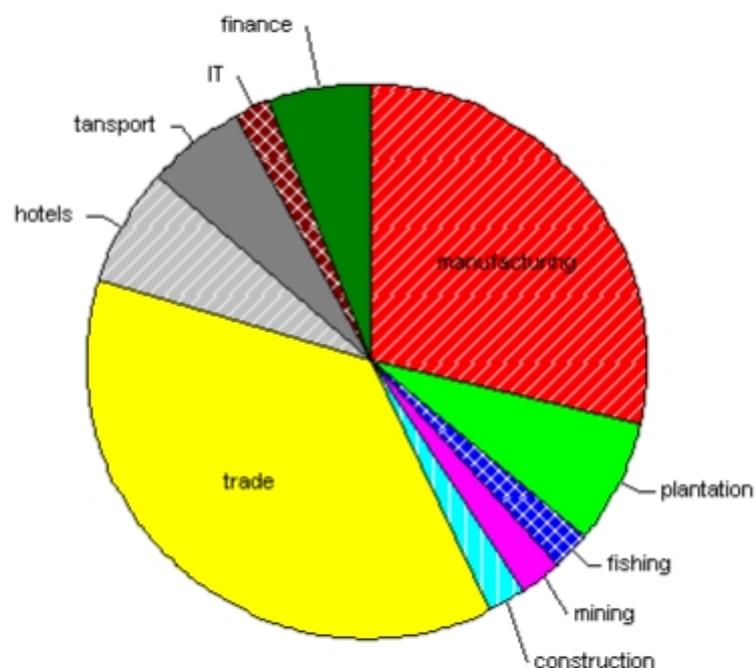
Sectoral distribution by nature of industry showed that mechanized fishing and plantation (primary) sectors have proportionately very high presence of informal enterprises. The sector of mining and quarrying is also mostly informal. There are no formal enterprises for sugarcane and cotton plantations in the sample. In trade and commerce also, informal sector has substantial presence (260 out of 388, 67.0 per cent). In manufacturing sector, informal enterprises are comparatively less with only 15.5 per cent of it (47 firms). The same trend is visible with less intensity in sectors of hotels & restaurants and finance & real estate. All sectors of industry in the sample except the primary sectors (plantation, fishing and mining), IT enabled industries, and trade and commerce record a greater presence of formal enterprises. In terms of presence of formal and informal enterprises, there is parity in the case of IT enabled industries (50 per cent each). Within the manufacturing sector covered, electrical and electronic goods industry has the least proportion of informal enterprises with only 6.8 per cent (3 out of 44 enterprises), followed by chemicals and pharmaceuticals (8.2 per cent, with 4 out of 49), and garments and textiles (8.3 per cent, 4 in 48).

**Table 3.1 Sectoral distribution of firms**

**(With Manufacturing and Plantation Disaggregates)**

Sectors and sub-sectors	Frequency	Percentage
Mechanized Fishing	25	2.4
Mining & Quarrying	25	2.4
<b>Manufacturing</b>	303	28.6
<i>Food Processing</i>	42	4.0
<i>Garments &amp; Textiles</i>	48	4.5
<i>Chemicals &amp; Pharmaceuticals</i>	49	4.6
<i>Metals &amp; Machinery</i>	85	8.0
<i>Electrical and Electronic Goods</i>	44	4.2
<i>Automobiles &amp; Auto-ancillaries</i>	25	2.4
<i>Tobacco &amp; Tobacco Products</i>	2	.2
<i>Wood Products &amp; Furniture</i>	8	.8
Construction	26	2.5
Trade & Commerce	388	36.7
Hotels & Restaurants	76	7.2
Transport & Auxiliary Activities	57	5.4
IT Enabled Industries	22	2.1
Finance & Real Estate	61	5.8
<b>Plantation</b>	75	7.1
<i>Cotton</i>	11	1.0
<i>Tea</i>	9	.9
<i>Coffee</i>	6	.6
<i>Rubber</i>	3	.3
<i>Sugarcane</i>	46	4.3
Total	1058	100.0

**sectoral distribution of sample**



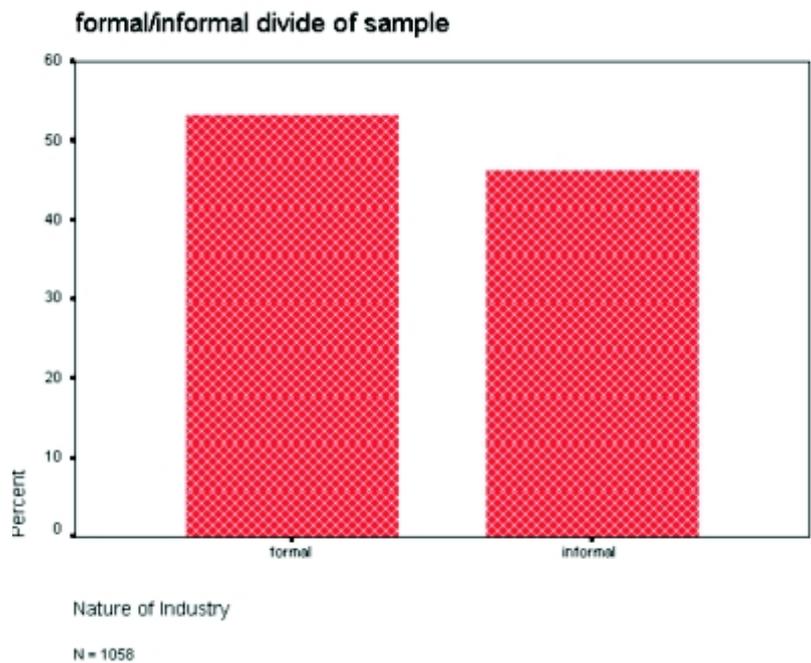
N = 1058

## Nature of Industry

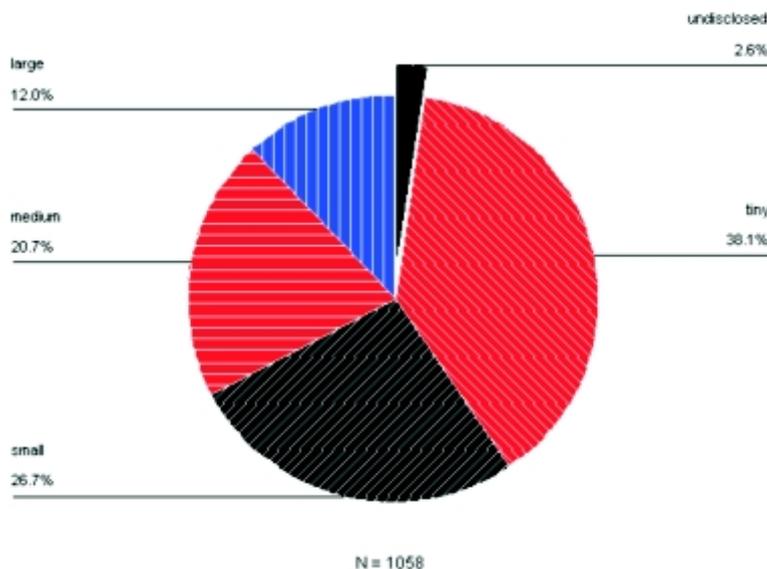
The sample recorded 53.6 per cent formal enterprises and 46.4 per cent informal enterprises. South zone and Kerala State in the zone has proportionately less presence of informal enterprises, while UP in north zone has the largest proportionate presence of informal enterprises, as far as the total sample under study is concerned. Analysis found that as the investment size increases the size of the informal segment decreases. Out of total 2.6 per cent of enterprises, which did not disclose investment size, 55.6 per cent are from the informal sector. 70.8 per cent of firms with workforce of 2-24 are from the informal sector, and all firms employing 500 and more workers are from the formal sector.

## Firms by investment/acreage size

There is comparatively high proportion of tiny firms (38.1 per cent), while large enterprises are only 12 per cent. Small sector constitutes 26.7 per cent and medium sector 20.7 per cent of the sample. Tiny and small firms together constitute around 65 per cent of the sample. Large and medium together constitute around one third of the sample. There are about 2.6 per cent of enterprises, which did not disclose their investment size. Zonal distribution of enterprises by investment size points at the fact that while small and medium industries are more available in the sample of south zone, the west, north and east zones have dominant presence of tiny sector in



**distribution of sample by investment size**



terms of number of firms. North zone shares a greater part of establishments that did not disclose the investment size (88.9 per cent, 24 out of 27). While UP hosts the largest share of samples from tiny sector at all-India level, Maharashtra, followed by AP, has the largest share of samples from the large sector.

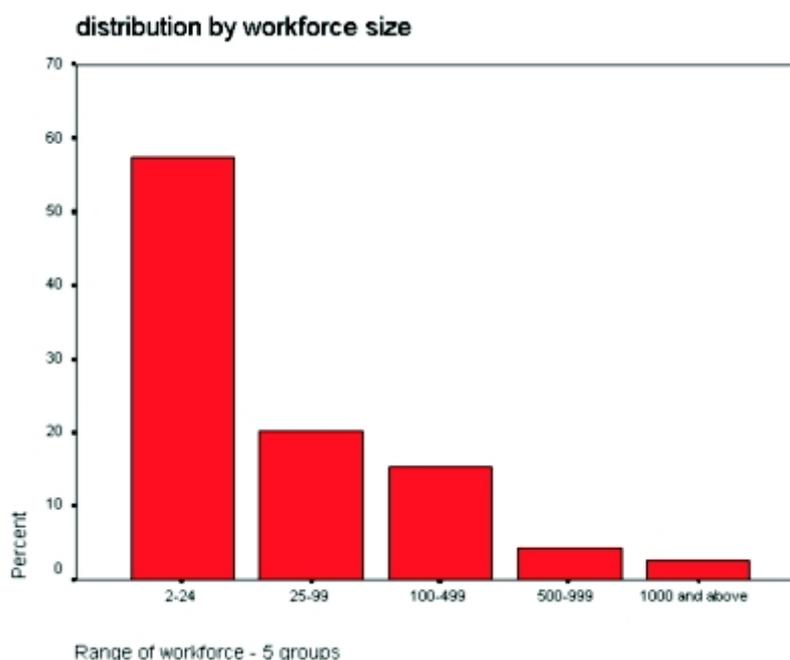
## Workforce Size

Five classes of workforce size are considered for analysis, and they

are 2-24, 25-99, 100-499, 500-999, and 1000 and above. 57.6 per cent of firms are from the workforce size of 2-24, while only 2.6 per cent have employed a workforce size of 1,000 and above. Three large enterprises employ more than 5,000 workforce each, one of which having more than 10,000 workers. 20.2 per cent of firms are from the workforce size of 25-99, and 15.4 per cent employ 100-499 workforce group, while 4.3 per cent have employed a workforce size of 500-999. Crosstabulation with State revealed that the largest employed unit (more than 10,000 workers) in the sample is from West Bengal (east zone), while smallest employed units are mostly from UP.

### Status profile of Respondents

Respondents in the sample (table 3.2) consist of 51.4 per cent owners, 20.4 per cent CEOs and 12 per cent HR Heads. Others (16.2 per cent) were senior level functionaries designated by the management for the interview. The senior level functionaries included project engineers, branch managers in case of units, administrative officers, etc. In fishing, plantation and trade, respondents are mostly owners, and most of them handle firms with 2 to 24 workers. In the informal sector, 80.7 per cent of respondents are owners.



**Table 3.2 Status of respondents in Firms**

Status of respondents	Frequency	Percentage
Owner/Proprietor	544	51.4
CEO	216	20.4
HR Head	127	12.0
Others	171	16.2
Total	1058	100.0

Analysis showed that owners/proprietors are highest in proportion, and 256 (47.1 per cent) of them represent trade and commerce sector alone. Respondents were mostly owners not only in the case of trade and commerce (66 per cent), but also in small manufacturing units. In the case of mechanized fishing and plantation, almost all were owners. In the informal sector, 80.7 per cent of respondents, i.e., 396 out of 491 are owners. No specific point emerged in the crosstabulation of status of respondents with size of investment and acreage. Big majority of owner respondents handles a workforce size of 2 to 24.

### Gender profile of Respondents

The male-female ratio of respondents is 95.7:4.3. Only 4.3 per cent (46) of respondents are women. Of the

total female respondents, 34.8 per cent are owners, 26.1 per cent CEOs and 21.7 per cent HR leaders. 1.9 per cent (20) in south zone, 0.9 per cent (10) in west zone, 1.1 per cent (12) from north and 0.4 per cent (4) from east are female respondents. The States such as Assam, Bihar, Chattisgarh, Goa, Himachal Pradesh, Jharkhand, Madhya Pradesh, Orissa, Punjab and Rajasthan do not have any female respondent in the sample. Tamil Nadu and Maharashtra recorded highest representation of female respondents (0.9 per cent each of the total sample) on an all-India level. All the States in the south zone have women respondents in the sample.

There are no women respondents in sectors of fishing, construction and transport in our sample. Women respondents are more or less uniformly spread across tiny, small, medium and large industries. Half (50 per cent) of them are handling firms with 2 to 24 workers. Of the 46 total female respondents, 65.2 per cent are in formal sector while only 34.8 per cent are in informal sector. They are equivalent to 2.8 per cent and 1.5 per cent of the total sample.

### **Coverage of workforce**

The total coverage of workers by employment category (regular and short-term & contract), nature of workforce (migrant and seasonal), and occupational category (managerial, skilled and unskilled), and also by gender in each of the above sets is given in tables 3.3, 3.4 and 3.5.

### **Total coverage of workers and the problem of average**

A total coverage of 160,947 workers in 1058 firms means an average of 152 workers per firm (table 3.3). However, if this average is taken as a basis it can lead to wrong conclusions and assumptions. When 57.6 per cent of firms have employed only 2-24 workers, and 20.2 per cent employ 25-99 workers, the average of 100 plus can give a misguided picture. This can be definitely so when 27 firms (2.6 per cent) have 1,000 and above workforce size, and three firms among them alone employ together more than 20,000 workers (see section on workforce size). These two extremes of the spectrum dim out the average figure of 150 plus. As per investment size also, it is found that around two thirds of firms are in the small sector including tiny ones.

**Table 3.3 Distribution of Workforce by Employment Category  
(Count, Column % and Table %)**

Category	Male	Female	Total
Regular Employees	97655	11438	109093
	71.1	48.6	67.8
	60.7	7.1	67.8
Short-term & Contract workers	39746	12108	51854
	28.9	51.4	32.2
	24.7	7.5	32.2
Total	137401	23546	160947
	100.0	100.0	100.0
	85.4	14.6	100.0

### **Workforce by employment and occupation**

Around one-third of total workers (32.2 per cent) are from the category of short-term & contract workers. They include also casual labor, temporary employees and trainees. While men are found more among the regular category (60.7 per cent), women are more in the category of short-term & contract workers (7.5 per cent) than in regular category. When 71.1 per cent of men work as regular employees, 51.4 per cent of women are engaged as short-term & contract workers (table 3.3).

**Table 3.4 Occupational Distribution of Workforce  
(Count and Table %)**

Category	Male	Female	Total
Managerial	18085 (11.2)	2175 (1.4)	20260 (12.6)
Skilled	73446 (45.6)	11130 (6.9)	84576 (52.5)
Unskilled	45870 (28.5)	10241 (6.4)	56111 (34.9)
Total	137401 (85.4)	23546 (14.6)	160947 (100.0)

Skilled category accounts for the major share of workforce (52.5 per cent) in the sample. In the occupational category, men are more found (45.6 per cent) in the skilled segment while women are least (6.4 per cent) in the managerial segments (table 3.4).

### **Seasonal and Migrant workers**

There are a total of 7871 seasonal workers and 5560 migrant workers. Seasonal workers are found more than migrant workers, as some sectors like plantation, fishing and hotels employ seasonal workers. However, more firms employ migrant workers. While 110 firms (10.4 per cent) employ migrant workers, only 102 firms (9.6 per cent) employ seasonal workers. It should also be noted that migrant component of workforce can be very much part of regular, short-term and seasonal workers. However, percentage wise, female migrant component is greater than the seasonal female workers are. Male workers constitute 69.6 per cent of the total migrant workers, while seasonal male component is high as 73.2 per cent (table 3.5).

**Table 3.5 Seasonal and Migrant Workers:  
Gender Distribution (Row %)**

Category	Male	Female	Total
Seasonal Workers	5763 (73.2)	2108 (26.8)	7871 (100.0)
Migrant Workers	3868 (69.6)	1692 (30.4)	5560 (100.0)

Total migrant workers (5,560 out of 160,947) constitute 3.5 per cent of the workforce in the sample. Correlation of the migrant component with other variables would be done as and when needed while doing the major findings.

## CHAPTER FOUR: HEALTH AND SOCIAL SECURITY STATUS OF FIRMS

In this chapter, we include the health policy, its elements, existing health and social security status of workers, special health policy elements if any for women, and other measures existing in the establishments. The other measures include facilities for sex education of staff, counseling on HIV/AIDS, etc. The opportunistic infections are dealt along with HIV/AIDS in chapter six. However, here, it is possible to state that the total workers infected with STD, opportunistic and related diseases are 265. Of them, TB infected alone is 144. Hepatitis affected 83, hepatitis B two, and STD 36 workers. In total, 70 firms (6.6 per cent) are affected.

### Health policy

Only 9.5 per cent (101) of firms stated that they have a health policy (table 4.1). The north zone hosts only 17.8 per cent of firms with health policy (18 out of 101), a very low share compared to its share of sample (25.9 per cent). The sample from States of Goa, Chattisgarh, Bihar, Jharkhand and Nagaland was found to have no firms with health policy. Maharashtra has 20.8 per cent of firms with health policy, while Kerala hosts 15.8 per cent and AP 13.9 per cent of them, as shown in table 4.2. Plantation has no firms with health policy. Manufacturing shares the larger part of firms with health policy (58.4 per cent). As the table 4.3 on sectoral distribution shows, health policy is comparatively least available in trade, construction, IT and mining. Chances of availability of health policy increase, as the investment size of the industry increases from tiny to large. Analysis found that most of them (90.1 per cent) are from the formal sector (table 4.2). Firms with health policy are more available in larger workforce groups.

**Table 4.1 Firms and Health policy**

Policy	Frequency	Per cent
Without policy	957	90.5
With policy	101	9.5
Total	1058	100.0

**Table 4.2 Enterprises with health policy by Nature of Industry State and zonal distribution**

Zone	State	Nature of Industry		Total
		Formal	Informal	
South	Andhra Pradesh	11	3	14 (13.9%)
	Karnataka	4		4 (4%)
	Kerala	16		16 (15.8%)
	Tamil Nadu	5	1	6 (5.9%)
West	Gujarat	8	1	9 (8.9%)
	Maharashtra	19	2	21 (20.8%)
	Rajasthan	2		2 (2%)
North	Delhi	3		3 (3%)
	Haryana	2		2 (2%)
	Himachal P	1		1 (1%)
	Madhya Pradesh	2		2 (2%)
	Punjab	1		1 (1%)
	Uttar Pradesh	8	1	9 (8.9%)
East	Assam	1		1 (1%)
	Orissa	1		1 (1%)
	West Bengal	7	2	9 (8.9%)
Total		91 (90.1%)	10 (9.9%)	101 (100%)
Grand Total		n = 567	n = 491	N = 1058

**Table 4.3 Sectoral Distribution of firms with health policy**

Sectors	Frequency	Per cent
Construction	1	1
Finance and real estate	6	5.9
Hotels and restaurants	10	9.9
IT enabled industry	1	1
Manufacturing	59	58.4
Mechanized Fishing	5	5
Mining and quarrying	2	2
Trade and commerce	14	13.9
Transport	3	3
Plantation	0	0
Total	101	100.0

**Following are some of the elements of health policy besides, ESI, medical insurance and other facilities and schemes.**

#### **Health check-up**

Medicclaim

Health card

Regular safety and health audit for all employees

Hospitalization for the expense of maximum of Rs.2 lakh (Rs.0.2 million)

Bhavishya arogya after 10 years of service

In-house and private sponsored healthcare

High-risk job allowance

Health counseling center

Family medical expenses

Accident insurance

Free medicine

#### **Mobile ambulance**

Health benefit scheme

#### **Health and social security facilities**

The study reveals that health and social security facilities are not made available in some of the industries where these are mandatory. 41.5 per cent of firms provide provident fund for regular workers, and a maximum of 43.0 per cent provides minimum health facility (ESI). This is in spite of the fact that 53.6 per cent of industries surveyed are from the formal segment. Data showed that 5 per cent of firms give maternity benefits to regular workers, though the percentage figure for women workers is found higher (11.8 per cent). Bonus is given to regular workers in 3.5 per cent of firms and to short-term workers in 0.6 per cent of firms. Only 4.9 per cent of firms provide EPF to short-term workers. Table 4.4 gives details of health and social security schemes and the percentage of firms providing them by category of employment (regular or short-term).

**Table 4.4 Availability of health and social security facilities**

Facility	Regular workers		Short-term workers	
	Available	Percentage	Available	Percentage
ESI	455	43.0	59	5.6
EPF	439	41.5	52	4.9
Gratuity	345	32.6	34	3.2
Pension	88	8.3	0	0.0
Maternity benefits	53	5.0	0	0.0
<b>Bonus</b>	37	3.5	6	0.6
Medical reimbursement	27	2.6	6	0.6
Group Insurance	188	17.8	35	3.3
Medical Insurance	186	17.6	24	2.3
Medical allowance	313	29.6	42	4.0
Family health scheme	35	3.3	7	0.7
Company hospital	32	3.0	11	1.0
Company doctor	83	7.8	26	2.5
Referral hospital	83	7.8	21	2.0

Other special health-specific facilities provided in units

Survey tried to find whether the firms provide facilities of family planning and condom promotion, sex education for staff, STD clinics, and HIV/AIDS counseling. Results are tabulated in table 4.5.

**Table 4.5 Special health-specific facilities provided in Units**

Provisions	Count	% Responses	% Cases
Sex Education for staff	44	3.9	4.2
Family planning and condom promotion	91	8.1	8.6
STD Clinics	12	1.1	1.1
HIV/AIDS counseling	50	4.5	4.7
Others	41	3.7	3.9
No provisions	879	78.7	83.1
Total Responses	1117	100	105.6

As table 4.5 suggests, 8.6 firms provide some direct or indirect facilities for family planning, condom promotion or for both. While 4.2 per cent of firms conduct some classes or programs for sex education of staff, 1.1 per cent provide STD clinics for its staff. It is significant that 4.7 per cent of establishments give AIDS counseling.

Further analysis showed only two per cent (21) firms provide sex education, and family planning and condom promotion. 0.5 per cent (five) firms provide sex education and STD clinics. 1.4 per cent (15) firms are common among those providing sex education and AIDS counseling. Two per cent (21) firms provide family planning and condom promotion, and AIDS counseling. Only 0.4 per cent (four) firms provide all these four facilities together.

Fifty-one (4.8 per cent) firms provide other similar facilities. Most of them are related to awareness programs. Some are direct health check-up, related training and camps. General counseling, awareness about AIDS, family planning, etc. also find place.

### **Special Health Policy elements**

There is no special category of facilities for short-term or women workers. For regular workers, two transport units provide accident insurance but only for drivers. These two transport firms belong to the medium

industry, one formal and other informal, one from Andhra Pradesh in south zone and the other from Maharashtra of west zone, and both have a workforce size of 25-99.

### **Benefits to families of deceased employees**

Out of 239 firms, only 235 firms (22.2 per cent of the total sample) specified the schemes providing benefits to the families of diseased employees. It should be noted that some of the respondents have mixed up schemes like ESI and EPF and also workers' support with benefits to family members of the deceased employees from the side of employers and management. The benefits included financial support, employment to family member, equal contribution from employees and employer, funeral expense, education of children, medical expense, no recovery of pending loan, medical facility to dependants, lump-sum from family welfare fund, food grains to the family, etc.

### **Limits of Measurement in Capturing the Health Status of Firms**

The survey tried to measure the health situation in firms through certain variables such as disease-related fatalities, staff left on health grounds, etc. However, the survey had certain limitations. For instance, no in-depth interviews could be done with employers of firms where fatalities occurred or staff left on health grounds on a larger scale or in large numbers. Similarly, of these casualties, the interview schedule could not specifically count the migrant or seasonal workers. It could only find whether there is any relation established.

### **Reported Disease-related fatalities since 1998**

The survey tried to capture the quantum of health related fatalities excluding injury-related ones. Four per cent of firms were found affected. 210 disease related fatalities occurred in 42 firms. As the table 4.6 states, 1016 firms (96 per cent) in the sample were not affected by disease-related fatalities. One case each of 70, 18, 12, 9, 8 and 7 workers, three cases of 10, two cases of 5, three cases of 3, nine cases of 2, and 19 cases of 1 each are the recorded disease related fatalities in the sample (table 4.6).

**Table 4.6 Reported Disease Fatalities since 1998**

Number of workers (fatalities)	Frequency	Per cent
0	1016	96.0
1	19	1.8
2	9	.9
3	3	.3
5	2	.2
7	1	.1
8	1	.1
9	1	.1
10	3	.3
12	1	.1
18	1	.1
70	1	.1
n = 210	N = 1058	100.0

While 70 people died in a firm in West Bengal, 18 lost life in another firm in AP due to obvious disease related problems. State-wise, West Bengal (91 deaths, 43.3 per cent) is most affected, followed by Maharashtra, and then by AP and Delhi. East zone was affected mostly (94 deaths in total, 44.8 per cent) and the zone was

followed in order by north (21.0 per cent), west (18.6 per cent) and south (15.7 per cent) zones. Of the disease related fatalities reported from east zone, West Bengal alone holds 96.8 per cent of cases.

Analysis found that, except women in short-term category, all categories of workers are affected by disease related fatalities. Formal segment of the industry shares 97.1 per cent (204 out of 210) of disease related fatalities since 1998. There also, medium and large industries, especially the large ones, record most of the fatalities. Sector wise, 79.5 per cent (167) of disease-related fatalities are recorded by manufacturing. Similarly big majority of the fatalities has been found occurred in firms employing 500 and above workers, especially in those employing 1,000 and above.

#### **Reported disease-related fatalities among migrant and seasonal workers**

Analysis showed fatalities of migrant workers, in hotel and construction. All of them were found to be male workers. Hoteliering and construction are employing noticeable proportion of migrant workers. Among the seasonal workers fatalities occurred in three firms, involving both male and female workers. All of them were from manufacturing sector.

#### **Reported disease-related fatalities in firms with death-related family benefit policy**

It is important to link up disease related fatalities with firms having policy to provide family benefits to the deceased. Of the 97 firms (9.2 per cent) which stated to have a policy regarding this, 17 firms recorded 133 fatalities.

**Table 4.7 Reported Disease-related Fatalities in Firms with Fatality-related Family benefit policy**

No. of fatalities	Frequency	Per cent
0	80	82.5
1	7	7.2
2	2	2.1
3	1	1
5	1	1
7	1	1
8	1	1
9	1	1
10	2	2.1
70	1	1
n = 133	n = 97	100.0

**Table 4.8 Reported disease-related fatalities since 1998 in Firms with death-related Family benefit policy**

State	Total
Andhra Pradesh	1 (0.8)
Bihar	1 (0.8)
Delhi	20 (15.0)
Kerala	1 (0.8)
Maharashtra	27 (20.3)
Orissa	1 (0.8)
Tamil Nadu	4 (3.0)
Uttar Pradesh	1 (0.8)
West Bengal	77 (57.9)
Total	133 (100)

State-wise distribution of disease related fatalities in select cases of firms with fatality related family benefit policy showed West Bengal leading with majority of deaths (57.9 per cent in this case), followed by Maharashtra and Delhi (table 4.8). The gender divide showed that the case of 3 fatalities from Maharashtra is of women and the rest was related to male fatality.

Sectoral distribution showed that there occurred 110 fatalities in manufacturing sector, 10 in finance, and 10 in trade. Manufacturing was found the most affected sector, as it accounted for 82.7 per cent of fatalities. The case of 3 female fatalities was also from manufacturing sector. Distribution by nature of industry showed that all the disease related fatalities in select cases of firms with fatality related family benefit policy are from the formal sector. This included also the female fatalities.

Large industry accounted for 76.7 per cent (102) of the select fatalities. This was followed by medium, small and tiny industries in descending order. It is found that the larger the industry, greater the rate of fatalities. Distribution by workforce showed that the firms employing 1,000 and above workers accounted for 75.9 per cent (101) of select fatalities.

**Reported disease-related fatalities in Firms earmarking budget for fatality-related family benefit policy**

The survey found that 2.9 per cent (31) of firms earmark specific budget for supporting families of the deceased employees. However, only 1.1 per cent of employers could specify the percentage of annual budget earmarked for this purpose. 80.6 per cent of these firms (25 firms) were found not affected. A total of 45 fatalities occurred in 19.4 per cent of firms. Of this, the female fatality was 6.7 per cent.

57.8 per cent of fatalities occurred in Maharashtra in the select firms. Madhya Pradesh had 22.2 per cent and Delhi 20 per cent of fatalities. This also means that West Bengal, that fared with highest percentage of fatalities when analyzed for fatalities in firms with fatality related family benefit policy, do not earmark any budget for this purpose. All the female fatalities were reported from Maharashtra. Distribution by Sector showed manufacturing taking the share of 77.8 per cent of the select fatalities. Trade shares the rest. Women fatality was reported in manufacturing. Large industry recorded 48.9 per cent of the select fatalities, followed in order by medium (28.9 per cent) and small (22.2 per cent) industries. All the reported fatalities are from the formal industry. Distribution by workforce size showed that all the referred fatalities are from workforce size of 500 and above workers. The group with 1,000 and above workers had accounted for 71.1 per cent of the said fatalities.

### **Reported disease-related fatalities in firms providing ESI and EPF**

ESI and EPF are the most common health and social security schemes available in firms engaged in economic activities. In total, 41.5 per cent of firms provided EPF and 43 per cent gave ESI. Here, the firms providing the most common schemes of ESI and EPF to the regular employees are selected and analyzed for fatalities. A total of 199 fatalities occurred in these select firms. Of them, three per cent were female fatalities.

West Bengal (44.7 per cent) and Maharashtra (16.1 per cent) share together more than 60 per cent of the fatalities in firms providing ESI and EPF to their regular employees. AP and Delhi hold 11.1 per cent each and MP accounts for eight per cent of the select fatalities. 66.7 per cent of women fatality in this case went to Maharashtra; and AP and HP equally shared rest.

Manufacturing accounted for 76.9 per cent of the select fatalities, followed by trade (8 per cent) and finance and real estate (7 per cent). Manufacturing shared 83.3 per cent of female fatalities and the rest went to finance and real estate. Large industry accounts for 74.9 per cent of the select fatalities. Medium sector took the second largest share (13.1 per cent) of fatalities, while small industry accounted for 10.6 per cent. Tiny industry had 1.5 per cent of the select fatalities. Here also, we find that as the size of industry increases, the rate of this specific fatality tends to increase. Fifty per cent of female fatalities were from medium sector, and 33.3 per cent was from large industry.

All the select fatalities are reported from the formal industry. All the workforce size groups were found affected. Firms employing 500 and above workers share 85.4 per cent of fatalities. Firms with a workforce size of 1,000 and above alone accounted for 70.9 per cent. 66.7 per cent of female fatalities were reported from the 500-999 workforce group. As far as the results go, the scheme of things here is also more or less similar to the just two previous lines of analyses done.

In general, West Bengal and Maharashtra, manufacturing sector, formal industry, large industry and large workforce size coincide with majority of disease related fatalities.

### **Staff left on grounds of health since 1998**

The survey tried to take stock of the diseases affecting the staff. Mostly, the HIV/AIDS and opportunistic infections were studied; an analysis of these is provided in the chapter on threat to industry (chapter six). However, data on the specific health ground that led to the staff leaving the firm were not collected and studied in particular. Analysis found that 441 workers left their job on reasons of health grounds from 4.3 per cent of the firms under study. No staff had left on health grounds from 1013 firms (95.7 per cent) since 1998. One each left from 16 firms, 2 each from ten, 150 staff from one, and 126 from another firm. The rest of the pattern has cases of 3, 4, 5, 8, 15 and 20 as number of workers leaving on health grounds.

It is found, on an average, 0.3 per cent of workforce retreat on health grounds (441 of 160,947). An analysis taking the break-up of workforce as various categories has shown that there is no case of short-term managerial female and short-term skilled female leaving the firm on the ground of health. Regular skilled male workers are found to be the section mostly affected by staff leaving on health ground, followed by regular unskilled male workers.

In general it is true to say that almost all the zones are affected with staff leaving on health grounds. 35.1 per cent of them were from Gujarat, and 30.2 per cent were from AP. No worker had to leave the enterprise in the sample from States of Assam, Bihar, Chattisgarh, Goa, Haryana, Himachal Pradesh, Karnataka, Kerala, Nagaland, Orissa and Punjab. One hundred and fifty workers have left a firm in Gujarat and 126 left a firm in AP. Twenty workers each from one firm in Tamil Nadu and another in Jharkhand have left on the same ground. Fifteen workers each from a Delhi firm and an MP firm also had to leave. Single worker leaving a firm can be found in four cases in south and west zones, while this is so in six cases in north and two cases in east. Eight workers left a firm in Rajasthan on health ground. One can observe two cases of five workers leaving a firm in north zone, while four such cases were seen in east zone.

Staff leaving on health grounds largely affected formal sector and the large industry. All sizes of workforce are affected. There is no direct proportionate relation found between number of workers leaving on health ground and the size of workforce. Sector wise, manufacturing is the most affected segment, followed by hotel and restaurants and trade and commerce.

Thus, the phenomenon of staff leaving on health grounds has mostly affected Gujarat and Andhra Pradesh, formal sector, large industry, manufacturing, and firms of all workforce sizes.

### Health and Social Security measures for Women

The data under study showed that women are not given a fair deal compared to men. The number of firms giving health and social security facilities to women workers is less in comparison to those giving to regular workers including men. Table 4.9 shows the health and social security status of women workers in the surveyed enterprises. Data on common facilities available for both short-term and regular women workers are collected separately for women with an intention for comparison.

Our data showed that 11.8 per cent of firms provide maternity benefits to women (table 4.9). On all other counts, women are given a raw deal (compare with table 4.4). If 14 per cent of firms give ESI facilities, 13.5 per cent give EPF to women. Six per cent give medical insurance, 5.8 per cent group insurance, 10.8 per cent gratuity, 4.2 per cent pension, 2.2 per cent family health scheme and 9.5 per cent provide medical allowance to women workers. When 1.4 per cent of firms provide for company hospital and 4.4 per cent company doctor, four per cent give the facility of referral hospital (table 4.9).

**Table 4.9 Health and social security Status of Women**

Facilities	Women workers	
	Available	Percentage
ESI	149	14.1
EPF	144	13.6
Gratuity	115	10.9
Pension	44	4.2
Maternity benefits	125	11.8
<b>Bonus</b>	6	0.6
Medical reimbursement	2	0.2
Group Insurance	60	5.7
Medical Insurance	62	5.9
Medical allowance	100	9.5
Family health scheme	22	2.1
Company hospital	14	1.3
Company doctor	46	4.3
Referral hospital	41	3.9

Comparison has shown that less number of firms provides facilities for women, except in the case of maternity benefits. However, women in general are placed better than the short-term workers, except in the case of medical reimbursement. There are no special health policy elements provided specifically to women except maternity benefits. One textile firm in Pune was reported to give paternity benefits to its male workers.

## CHAPTER FIVE: AWARENESS LEVEL OF EMPLOYERS ABOUT HIV/AIDS

The main mechanism used in the survey to measure the awareness level of employers is to assess their knowledge in identifying the right choices on source of HIV/AIDS given along with wrong ones. Two other variables used are the perception of employers on the incidence of HIV/AIDS and their attitude toward the HIV-affected workers and job applicants. Employers' perception on the possible reaction of co-workers toward the HIV affected is also used to measure the awareness level of employers.

Perception on the source of HIV/AIDS

Right choices given in our list of options as the source of HIV/AIDS are the following:

- Risky/unprotected sexual intercourse
- Mother to child
- Sharing needle for injectable drugs
- Blood transfusion
- Sharing of blades/razors

Oral communication, physical touch, sharing of towel, using same toilet, eating together, from dirt, social kissing, and sharing of telephone/computer are the wrong choices given in the interview schedule. They were also given option to suggest any other sources they consider right.

The table 5.1 shows that 1.0 per cent of employers did not have any idea about the source, and 0.5 per cent chose not to answer this question. Many employers gave mixed combination of infection sources. However, 52.5 per cent to 93.4 per cent of employers have identified at least one correct answer, and so the overall general awareness level is rated high.

**Table 5.1 Source of HIV as Perceived by Employers**

Source of HIV	Count	% of Responses	% of Cases (Respondents)
No Answer	5	.1	.5
Oral Communication	20	.5	1.9
Physical touch	60	1.4	5.7
Sharing of towel	52	1.2	4.9
Using same toilet	46	1.0	4.3
Eating together	45	1.0	4.3
Risky/unprotected sexual intercourse	988	22.6	93.4
Mother to child	664	15.2	62.8
Sharing needle for injectable drugs	867	19.8	81.9
Blood transfusion	910	20.8	86.0
From dirt	34	.8	3.2
Social kissing	92	2.1	8.7
Sharing of telephone/computer	17	.4	1.6
Sharing of blades/razors	555	12.7	52.5
Others	15	.3	1.4
Do not know	11	.3	1.0
<b>Total Responses</b>	<b>4381</b>	<b>100.0</b>	<b>414.1</b>

Fifteen (1.4 per cent) employers have pointed out other sources of HIV/AIDS. Other sources included careless use of needles and syringes in injections, exchange of body fluids, saliva, eye moisture, open wound, sexual kissing, virus, and sharing the same toothbrush as possible sources of the disease. Here

also, the choices point at a high level general awareness among employers.

Analysis takes one to the reading that variables such as risky/unprotected sexual intercourse, blood transfusion, sharing needle for injectable drugs, mother to child, and sharing of blades/razors are taken as the right sources of HIV/AIDS by the majority of respondents (table 5.1). For instance, 93.4 per cent of employers understand that the risky/unprotected sexual intercourse can cause HIV. Of course, some of them have combined this with wrong choices. Sharing of blades/razors as a right source of HIV got comparatively less support (52.5 per cent) than the other four right sources. Among the wrong choices, majority of employers chose social kissing (8.7 per cent), followed by physical touch (5.7 per cent). A close look at table 5.1 reveals that the percentage figures for employers who ticked wrong answers are very low compared to those for right options. Thus, the overall general awareness level of employers is found high.

Further, we shall see the perceptions of employers, on the source of HIV/AIDS, across industries by sector, nature, and investment/acreage size. Tables 5.2 to 5.4 giving the relevant distribution are given as annexures 4 to 6.

Table 5.2 (annex 4) gives sector-wise break-up. All sectors have put up the five correct answers, but in varying degrees. Risky/unprotected sexual intercourse has been taken least seriously by construction sector (88.5 per cent) followed by mechanized fishing (92 per cent) and trade (92.3 per cent). Social kissing is most misunderstood in hotel sector. Lack of knowledge about the source of HIV is most noticed in fishing (4 per cent) sector and least in manufacturing. All sectors have shown problems in understanding the right sources of HIV. However, the sector of fishing needs more attention.

Regarding the right answers, formal industry (table 5.3, annex 5) has recorded majority except in the case of the option, risky/unprotected sexual intercourse. In this case also, the formal industry registered a higher absolute number (529, compared to 459 in informal sector). However, these 459 answers constitute 93.5 per cent of the opinions registered by the informal industry, while the same variable in the formal sector is only 93.3 per cent. The comparative high variation found for this variable in the informal industry shows the simple sex related linkage to AIDS in the perception of employers in the informal sector. This coupled with their greater share in wrong answers put them to relatively less level of awareness, compared to the employers in the formal sector. Among employers who had no idea of the source of HIV, more are from informal sector (table 5.3).

Distribution of answers across investment size (table 5.4, annex 6) shows the pattern of wrong answers being mostly given by employers in tiny industry and then by those in small industry, while right answers are largely given by medium and large industry. As exception to this pattern, risky unprotected sexual intercourse is given comparatively high importance by the tiny industry (95 per cent compared to the average of 93.4 per cent). Small and medium industry (only 90.4 per cent and 90.9 per cent respectively) does not give this factor the importance attained as average. Among the other right answers, mother to child and sharing of blades and razors showed a pattern of progressive increase in importance as they go from tiny to large. The remaining right answers such as sharing needles for injectable drugs and blood transfusion also showed more or less the same pattern with minor exceptions at stages. The percentage of employers who had no idea of the disease was found more in tiny industry than in any other size.

Knowledge level (on the Source of HIV) of employers who consider the incidence of HIV as Significant at Unit Level

No firm claimed that incidence of HIV at unit level was high. Those who claimed this to be significant was 0.5 percent of employers. Their knowledge level as far as source of HIV is analyzed here (table 5.5).

All answers in the table include right choices. Some are along with wrong choices. Risky unprotected sexual intercourse, sharing needle for injectable drugs, and blood transfusion, are the sources common in all the answers. So, 100 per cent of these select respondents gave all the above three sources. The respondents chose sixty per cent to 100 per cent of right answers here. They ticked 20 to 40 per cent wrong answers. This pattern is found not substantially different from the general trend.

**Table 5.5 Source of HIV/AIDS in the Perception of Employers  
Who considered HIV incidence Significant at Unit level**

Source of HIV	Count	% responses	% cases
Physical touch	1	3.7	20
Using same toilet	1	3.7	20
Risky unprotected sexual intercourse	5	18.5	100
Mother to child	4	14.8	80
Sharing needle for injectable drugs	5	18.5	100
Blood transfusion	5	18.5	100
Social kissing	2	7.4	40
Sharing of telephone/computer	1	3.7	20
Sharing of blades/razors	3	11.1	60
Total responses	27	100.0	540

Perception on the incidence of HIV/AIDS at various levels

Another variable indirectly used is to know their perception on the incidence of HIV/AIDS, at various levels – country, State, area, sector and unit. Respondents showed a tendency to underestimate the chance of incidence of HIV/AIDS at the level of sector, and more or less deny it at unit level.

**Table 5.6 Perception on the Incidence of HIV**

Level	Non-existence (%)
Country	0.3
State	0.9
Area	13.2
Sector	34.1
Unit	82.7

From the table 5.6, it is obvious that when 82.7 per cent of employers denied existence of HIV/AIDS at unit level while 34.1 per cent of them denied it at sector level. This denial strengthens progressively from the level of country to that of unit, as can be seen in the above table. This shows that general awareness need not go along with right attitude.

As per studies including NACO reports, India has still an average of less-than-one (0.4) per cent HIV population in general, with exceptional percentage rates in some States. When the situation is so, only 24 per cent of employers interviewed have got a general idea of the actual incidence of HIV in India, and 16.5 per cent has expressed that they have no idea about it. 59.2 per cent has exaggerated the incidence, while 24.6 per cent have highly exaggerated it (table 5.7).

The three (0.3 per cent) respondents who perceived non-existence of HIV/AIDS in India were from Haryana.

The States of UP and Punjab in the north zone host a high ratio of the respondents who have no idea about the incidence of the disease at the country level. Most of them are drawn from Uttar Pradesh (47.8 per cent State-wise), while Punjab holds 37.7 per cent of them within the State.

On this count, the general awareness level of employers is found comparatively less than what is measured through their ability to identify the right sources of HIV. Moreover, the awareness level is found less in the north zone, compared to other States and zones, though east zone took this place when analyzed through their ability to identify the right sources of HIV.

**Table 5.7 Perception on Incidence of HIV/AIDS (in % of employers)**

Level	Non-existent	Negligible (<1%)	Significant (1 to 5%)	High (>5%)	No Idea
Country	0.3	24.0	34.6	24.6	14.5
State	0.9	30.0	32.3	18.0	18.9
Area	13.2	32.3	21.7	7.4	25.3
Sector	34.1	27.6	8.1	2.5	27.7
Unit	82.7	4.2	0.5	0.0	12.7

#### Attitude toward the HIV-affected

Attitude of employers on specific issues was confronted when another variable was used to know their attitude towards recruitment, job continuation, training and treatment of HIV-affected persons. Analysis (table 5.8) found that the attitude of respondents is negative, as 67.1 per cent of them are not ready to employ HIV positive persons. However, majority (55.3 per cent) was ready to allow them continue with the employment. Though a significant majority (71.6 per cent) was ready to offer treatment, number of them expressed that the schemes like ESI, insurance, etc. subscribed by the firms would take care of the treatment.

**Table 5.8 Attitude of Employers toward persons identified HIV positive**

	No Answer (%)	Yes (%)	No (%)
In terms of recruitment	38 (3.6)	310 (29.3)	710 (67.1)
Non-discrimination in giving training	93 (8.8)	434 (41.0)	531 (50.2)
In continuing with employment	66 (6.2)	585 (55.3)	407 (38.5)
In offering treatment	74 (7.0)	758 (71.6)	226 (21.4)

The employers in north zone showed more readiness to recruit HIV affected, compared to other zones. South zone is found rated lowest in matters of non-discrimination in training, allowing continuing in job, and offering treatment. East showed least readiness in recruitment, but stood highest in offering treatment. Overall, west zone has stood high, but fared highest in non-discrimination and allowing continue job.

Sectorally, IT showed greatest readiness to recruit and came highest in non-discrimination, while the sector of construction stood lowest in both the issues. At the same time IT showed least interest in offering treatment. Finance and real estate stood highest in the scale of comparison with regard to issues of allowing the HIV affected to continue in job and offering treatment. Mechanized fishing showed least interest in allowing the infected to continue in job (table 5.9).

**Table 5.9 Attitude of Employers: sectoral distribution (in %)**

Sector	Readiness to recruit	No discrimination in training	Allow to continue in job	Readiness to give treatment
Construction	11.5	23.1	42.3	76.9
Finance	37.7	60.7	73.8	80.3
Hotels	18.4	32.9	43.4	68.4
IT	50.0	63.6	72.7	59.1
Manufacturing	27.1	45.5	62.0	77.6
Fishing	40.0	28.0	20.0	80.0
Mining	48.0	32.0	56.0	72.0
Plantation	34.7	25.3	50.7	76.0
Trade	31.4	43.9	51.5	65.2
Transport	28.1	40.4	61.4	71.9
Total	29.3	41.0	55.3	71.6

In non-discrimination, allowing continuation in job, and offering treatment, formal sector stood in forefront, while informal sector fared high in showing readiness to recruit the HIV infected (table 5.10).

**Table 5.10 Attitude of Employers: distribution by nature of industry (in %)**

Nature of Industry	Readiness to recruit	No discrimination in training	Allow to continue in job	Readiness to give treatment
Formal	28.4	45.7	58.2	74.4
Informal	30.3	35.6	51.9	68.4
Total	29.3	41.0	55.3	71.6

As per table 5.11, tiny industry stood at the lowest rung in non-discrimination. Small industry has recorded a similar lowest position in allowing the affected to continue work. Medium sector on the question of recruitment and large industry on all the other three aspects stood comparatively on a high status. However, large industry showed least interest in recruiting the affected.

**Table 5.11 Attitude of Employers: distribution by Investment size (in %)**

Investment size	Readiness to recruit	No discrimination in training	Allow to continue in job	Readiness to give treatment
Tiny	29.3	36.5	52.9	73.0
Small	28.7	37.6	50.7	68.8
Medium	32.4	44.7	56.6	68.5
Large	26.0	55.9	72.4	81.9
Total	29.3	41.0	55.3	71.6

#### Attitude of employers of the HIV-affected firms

The seven firms with proven HIV cases and the three firms with perceived cases were selected and analyzed to capture the attitude of the employers (tables 5.12 and 5.13). The analysis found that the latter group scored high in all the four parameters used, when compared with the former group. Percentage figures are listed in the tables 5.12 and 5.13.

**Table 5.12 Attitude of Employers in firms with Proven HIV cases (in %)**

YES to attitude	Frequency	Per cent
In terms of recruitment	1	14.3
In giving training	1	14.3
In continuing with employment	4	57.1
In offering treatment	3	42.9
Total	7	100

**Table 5.13 Attitude of Employers in firms with Perceived HIV cases (in %)**

YES to attitude	Frequency	Per cent
In terms of recruitment	2	66.7
In giving training	1	33.3
In continuing with employment	3	100.0
In offering treatment	3	100.0
Total	3	100

When the attitude of employers in all the 10 firms with HIV affected persons are selected and studied, it was found that there is perceptible change recorded as far as the attitude of non-discrimination in giving training. Only 20 per cent of employers in the affected firms agreed for non-discrimination, when 41 per cent of employers in general agreed for it (compare table 5.14 with 5.7).

**Table 5.14 Attitude of Employers in firms with HIV positive persons**

Attitude toward HIV positives	Yes (%)	No (%)
In terms of recruitment	3 (30)	7 (70)
Non-discrimination in giving training	2 (20)	8 (80)
In continuing with employment	6 (60)	4 (40)
In offering treatment	7 (70)	3 (30)

#### Employers' Perceptions on the possible reaction of Coworkers toward HIV-affected Employees

When the possible reaction of coworkers was assessed from the perception of employers, it was found most of them gave negative opinions. 24.2 to 36.5 per cent of employers felt that coworkers will refuse to work, neglect or avoid the worker, or will protest. Only 12.9 per cent thought that workers will support the HIV affected coworkers. 15.5 per cent said that workers would not bother about the situation (table 5.15).

**Table 5.15 Employer's Perception in the possible reaction of Coworkers toward HIV affected staff**

Reaction of Coworkers	Count	% Responses	% Cases
Will not bother	164	12.7	15.5
Will Protest	386	30.0	36.5
Will refuse to work	256	19.9	24.2
Will neglect/avoid	257	20.0	24.3
Will support	137	10.6	12.9
No answer	22	1.7	2.1
No idea	66	5.1	6.2
Total Responses	1288	100.0	121.7

Sectoral analysis (table 5.16, annex 7) showed that finance and real estate, manufacturing, and trade and commerce are least supportive (as their respective column percentages – will support column – are less than their respective row totals that represent the total sectoral coverage). Fishing, hotel, IT and transport sectors were found more supportive.

**Table 5.17 Employer's Perception in the possible reaction of coworkers toward HIV affected staff: Distribution by nature of industry (Count, and Column %)**

Nature of Industry	Will not bother	Will Protest	Will refuse to work	Will neglect /avoid	Will support	No answer	No idea	Row Total
Formal	86 52.4	229 59.3	138 53.9	123 47.9	68 49.6	12 54.5	29 43.9	567 53.6
Informal	78 47.6	157 40.7	118 46.1	134 52.1	69 50.4	10 45.5	37 56.1	491 46.4
Column Total	164 15.5	386 36.5	256 24.2	257 24.3	137 12.9	22 2.1	66 6.2	1058 100.0

Formal sector was found less supportive, as only 49.6 per cent of employers belonged to the sector when it holds 53.6 per cent of firms in the sample (table 5.17). Whereas 50.4 per cent of those who thought in support of HIV affected workers came from 46.4 per cent of the sample, i.e., from informal sector. Regarding refusal to work also, formal sector put up 53.9 per cent of the opinion when its presence in the sample was 53.6 per cent, less than its share of the opinion to refuse to work.

## **CHAPTER SIX: THREAT OF HIV/AIDS AT WORKPLACE, IMPACT ON INDUSTRY AND ACTION TAKEN INFORMATION**

As specifically stated already in the methodology (chapter two), no special weightage was given to industrial sectors and geographical areas of higher incidence of HIV/AIDS. As the issue of STD and opportunistic diseases like TB is an important matter while studying the threat of HIV/AIDS to the industry, here, along with HIV/AIDS, we examine also the threat of STD/STI and opportunistic diseases to the industry.

Besides the proven cases of HIV/AIDS there are few perceived cases in the sample. These are not formally reported in the enterprise, but the employers are informed of them through informal means. Besides examining the status on all these aspects, the impact of HIV/AIDS on the industry, the action taken on the HIV/AIDS cases and the existing HIV/AIDS policy are also studied in this chapter.

### **Threat of HIV/AIDS**

A total of 16 proven and 6 perceived cases of HIV infected workers were reported respectively from 7 and 3 firms in the sample. 0.1 per cent of workforce (22 of 160,947) is affected by HIV/AIDS. As shown in table 6.1, 10 firms (0.9 per cent) are affected in total from 4 zones and 4 States (Maharashtra, Tamil Nadu, Madhya Pradesh and West Bengal). Except one, all are from formal sector (90 per cent). The informal sector firm is a trade and commerce unit from MP. 40 per cent of the affected firms are from the hotel sector, while 20 per cent each is from mechanized fishing, manufacturing (garments), and trade. Size-wise, 30 per cent each of the affected firms belong to small and large industries, while 20 per cent each represent tiny and medium industries. Thirty per cent of the firms have a workforce size of 2-24 each, while another 30 per cent are from 100-499 group, and 40 per cent have 1000 and above workers each.

The profile shows that size of firm and size of workforce does not matter as far as the industry and workers getting infected by AIDS are concerned. However, 90 per cent of the cases found in our sample turned out to be from formal industry, which goes against the commonplace linkage of AIDS with informal sector in India.

The table 6.1 shows that when 5 of the firms are affected with one worker each, one firm is with 2 workers, one firm with three, and three firms with four workers each. In total 22 workers are affected. All of them (100 per cent) are regular employees. Of them, 45.5 per cent (10) are skilled and the rest of them unskilled (54.5 per cent). It is important to note that the workers affected are all regular workers and invariably all of them are male workers.

As the table on infected workers by employment status, gender and occupational status (table 6.2) points out, no short-term workers are affected. All the HIV-infected workers are regular workers. No female workers are affected. No one from managerial category is affected. All the workers affected are either skilled or unskilled male workers from regular category.

**Table 6.1 Threat of HIV/AIDS: Profile of Firms and Workers**

firm = 10	Zone	State	Nature of firm	Sector	Size	Workforce size	Workers affected n=22	Employment status	Skill level	Sex
ROVEY cases – 1 <sup>st</sup> to 7 <sup>th</sup>										
firm 1	South	Tamil Nadu	Formal	Hotel	Medium	100-499	1	Regular	Skilled	Male
firm 2	West	Maharashtra	Formal	Mechanized fishing	Medium	2-24	1	Regular	Unskilled	Male
firm 3	West	Maharashtra	Formal	Mechanized fishing	Tiny	100-499	1	Regular	Skilled	Male
firm 4	West	Maharashtra	Formal	Hotel	Tiny	100-499	2	Regular	Unskilled	Male
firm 5	West	Maharashtra	Formal	Manufacturing/ garments	Large	1,000 and above	3	Regular	Skilled	Male
firm 6	West	Maharashtra	Formal	Hotel	Large	1,000 and above	4	Regular	Skilled	Male
firm 7	West	Maharashtra	Formal	Trade	Small	1,000 and above	4	Regular	Unskilled	Male
PERCEIVED cases – 8 <sup>th</sup> to 10 <sup>th</sup>										
firm 8	East	West Bengal	Formal	Manufacturing/ garments (leather)	Large	1,000 and above	1	Regular	Skilled	Male
firm 9	North	Madhya Pradesh	Informal	Trade	Small	2-24	1	Regular	Unskilled	Male
firm 10	North	Madhya Pradesh	Formal	Hotel	Small	2-24	4	Regular	Unskilled	Male

**Table 6.2 HIV/AIDS affected workers by Employment, Gender and Occupational Status (%)**

Employment and occupational status	Male	Female	Total
Total	22 (100.0)	0	22 (100.0)
Regular total	22 (100.0)	0	22 (100.0)
Regular Managerial	0	0	0
Regular Skilled	10 (45.5)	0	10 (45.5)
Regular Unskilled	12 (54.5)	0	12 (54.5)
Short-term total	0	0	0
Short-term Managerial	0	0	0
Short-term Skilled	0	0	0
Short-term Unskilled	0	0	0

### HIV and migrant and seasonal workers

In our study, none of the HIV-infected workers is migrant or seasonal. This may or may not be an exceptional situation. However, it is not fair to draw generalization on linkages of HIV with migrant nature of workforce from the sample where only 22 cases of HIV/AIDS are found.

### STD and Opportunistic diseases

Glossary of Medical, Statistical, and Clinical Research Terminology (National AIDS Treatment Activist Forum: Carlton Hogan and University of MN, 1995) defines ‘Opportunistic Infections’ as follows:

An infection in an immune compromised person caused by an organism that does not usually cause disease in healthy people. Many of these organisms are carried in a latent state by virtually everyone, and only cause disease when given the opportunity of a damaged immune system.

TB is the main opportunistic disease found linked so far with AIDS. There are other such diseases too. Fits and even diarrhea can be opportunistic in killing AIDS patients. Though many diseases are reported in the survey as part of the health status of workers, we are analyzing a select number of diseases that are some way or other related to HIV and AIDS. They are TB, hepatitis, hepatitis B and STD/STI, and it was found that all sectors are affected.

The total workers infected with STD, opportunistic and related diseases are 265. Of them, TB infected alone is 144. Hepatitis affected 83, hepatitis B two, and STD 36 workers. 70 firms (6.6 per cent) are affected, though disaggregate frequencies together show 80 (7.6 per cent) of firms affected. This is because of the incidence of some diseases as common to some firms. Table 6.3 gives the gist of information regarding the diseases being discussed.

**Table 6.3 STD, Hepatitis B, Hepatitis and TB**

Diseases	Infected workers	Number of firms	Percentage of firms
STD/STI	36	5	0.5
Hepatitis B	2	2	0.2
Hepatitis	83	24	2.3
TB	144	49	4.6
Total	265	70*	6.6*

\*Disaggregate figures total 80 and 7.6.

The diseases concerned affected firms in almost all the major States. Nine out of 362 firms (2.5 per cent) in south, 22 out of 318 firms (6.9 per cent) in west, 27 out of 274 (9.6 per cent) in north and 12 out of 104 firms (11.5 per cent) in east zone are affected. As percentages to the total affected firms, these figures are respectively 12.9 for south, 31.4 for west, 38.6 for north and 17.1 for east. The zonal percentage figures point out that south is least affected and east is most affected in terms of number of firms (table 6.4). South has 47 (17.7 per cent of the total affected workers) workers affected, west 106 (40.0 per cent), north 85 (32.1 per cent) and east has 27 (10.2 per cent) affected, making a total of 265 being affected by STD and opportunistic diseases.

**Table 6.4 Firms and Workers affected by STI and Opportunistic Infections**

Zone	Firms (%)	Zonal % of firms	Workers (%)
South	9 (12.9)	9/362 (2.5)	47 (17.7)
West	22 (31.4)	22/318 (6.9)	106 (40.0)
North	27 (38.6)	27/274 (9.6)	85 (32.1)
East	12 (17.1)	12/104 (11.5)	27 (10.2)
Total	70 (100)	70/1058 (6.6)	265 (100)

Analysis found that tiny, small, medium and large industries are all affected, medium industry leading over other sectors. Similarly, all sectors are also affected. As far as higher incidence is concerned, manufacturing sector is mostly affected, followed by construction and trade in order. Comparatively, formal enterprises are more affected by these four types of infections and diseases than the informal ones are. When 7.8 per cent (44 out 567) of formal sector firms are affected, 5.3 per cent (26 of the 491) of informal sector firms got affected. STD and opportunistic diseases affected firms with all classes of workforce size.

## STI and Opportunistic Infections among Seasonal and Migrant workers

The crosstabulation does not give the count of migrant workers infected; but it establishes the linkage. As there is no exact count, the results cannot be tabulated. The interview schedule and the data had no provision to take care of this. However, the crosstables on seasonal and migrant workers established that opportunistic diseases and STD dog the seasonal and migrant workers, though HIV did not affect them.

### Impact of HIV/AIDS on the industry

Before going to analyze the impact of HIV on firms, it is important to note the linkage, with regard to HIV, opportunistic infection, fatality and staff leaving the firm on grounds of health, with firms/employers who considered HIV incidence is significant at unit level. 0.5 per cent of firms come under this category.

### Impact on Units where employers consider HIV incidence is significant

Profile of firms and affected workers of these 0.5 per cent of units (5 firms) are tabulated in table 6.5. Of these, only 3 firms (60 per cent of the select firms) are found affected in some or the other way. In 20 per cent of these select firms, staff had to leave on health grounds (West Bengal), and fatality of 10 regular unskilled male workers took place (Maharashtra). The same firm where 10 workers died of health reasons had 4 HIV-infected workers. None of the firms have any perceived but unconfirmed case of HIV. 40 per cent of these select firms had STI and opportunistic diseases (Haryana with 5 workers and Maharashtra with 16). Analysis found that no one of these affected workers is migrant or seasonal.

All the affected firms (60 per cent of the select firms in total) from among the 5 select firms are from formal industry. Transport, finance and real estate, and trade and commerce are the sectors affected. Except medium industry, all sizes of investment are affected. HIV and opportunistic diseases are reported from firms with workforce size of 500 and above. Only 20 per cent (One firm) of select firms had HIV, as the employer feared.

**Table 6.5 Profile of firms and affected workers of Units where employers consider that HIV incidence is significant**

Subject	No. of Firms	Zone	State	Nature of firm	Sector	Size	Work-force size	No. of Staff	Employment status	Skill level	Sex
Staff left on health ground	1 out of 5 (20%)	East	West Bengal	Formal	Transport	Tiny	100-499	5	Short-term	Skilled	Male
STI and opportunistic infection	2 (40%)	North, West	Haryana, Maharashtra	Formal	Finance and Real Estate, Trade	Large, Small	500-999, 1,000 and above	5, 16 (total 21)	No info	No info	No info
Disease-fatality	1 (20%)	West	Maharashtra	Formal	Trade	Small	1000 and above	10	Regular	Unskilled	Male
HIV incidence	1 (20%)	West	Maharashtra	Formal	Trade	Small	1000 and above	4	Regular	Unskilled	Male

### Staff left on the ground of HIV/AIDS

Three firms (0.3 per cent) recorded seven staff leaving on the grounds of HIV/AIDS. All are from Maharashtra in west zone. All workers are regular and male, four skilled and three unskilled. All these firms reported incidence of HIV. No relation could be established between these firms and any role of migrant and seasonal workers.

**Table 6.6 Staff left on the ground of HIV/AIDS**

No. of firms	Zone	State	Nature of firm	Sector	Size	Work-force size	No. of affected	Employment status	Skill level	Sex
Firm 1	West	Maharashtra	Formal	Mechanized Fishing	Medium	2-24	1	Regular	Unskilled	Male
Firm 2	West	Maharashtra	Formal	Hotel	Tiny	100-499	2	Regular	Unskilled	Male
Firm 3	West	Maharashtra	Formal	Hotel	Large	1000 and above	4	Regular	Skilled	Male
n=3							n=7			

The same issue of staff leaving on the grounds of HIV/AIDS was subjected to analysis for the ten firms (0.9 per cent) that reported incidence or perceived cases of HIV/AIDS among the staff. However, the results were the same as the general output given in table 6.6. That is, three firms and 7 workers were affected. This means that no firms other than the firms with HIV affected workers have reported any case of staff leaving because of HIV/AIDS.

### **Impact of HIV on the firms in general**

Attempt was made to measure the impact in terms of medical cost, social security cost, output, replacement and training cost, workforce instability, absenteeism on medical grounds, loss of productivity, discrimination of affected staff, stigmatization of enterprise, and negative influence on procurement of orders. The options given on quantifying the impact if any are 'marginal,' 'significant' and 'high,' keeping this a bit subjective without giving a scale. Therefore the responses also need not be objective to the extent of giving a measurement as such, but definitely reflect a trend. However, in the case of first four variables (medical and social security costs, output, and replacement and training cost), attempt was done to get actual quantification if possible.

Analysis shows that the impact of HIV/AIDS on industry is not very substantial. However, the available results are a pointer to the impending danger. The results showed that no impact is reported in terms of social security cost, output, replacement and training cost, negative influence on procurement of orders, and stigmatization of enterprise.

Impact is reported in 70 per cent (7 firms) of the firms with HIV affected workers. So, the threat perceived industrially is felt in 0.7 per cent of firms in the sample. The profile of the affected firms is given in table 6.7. In terms of medical cost, marginal increase was reported in 3 enterprises in Maharashtra and high increase in 1 enterprise in Haryana. 0.5 per cent increase in medical cost is recorded in an enterprise in Maharashtra. Workforce stability was affected marginally in 1 enterprise in Maharashtra. Absenteeism on medical grounds affected marginally 3, and significantly 1 enterprise. Loss of productivity was reported marginally in 1 enterprise and significantly in another. Discrimination of affected staff was also reported in one enterprise (table 6.7).

The impact of HIV/AIDS is noticed in sectors of hotels (2 firms), mechanized fishing (2 firms), manufacturing (1 firm), trade (1 firm), and finance and real estate (1 firm). Of the affected, 28.6 per cent (2 firms) each was from hotels and mechanized fishing, and 14.3 per cent (1 firm) each was from manufacturing, trade, and

finance and real estate (table 6.7). The impact of HIV/AIDS in terms of medical cost is greater in the sector of finance and real estate where it is reported high; the same is marginal in hotel and fishing. Instability of workforce is reported in the hotel sector. Absenteeism on medical grounds is reported in four sectors – hotels, manufacturing, trade and fishing. However, it seems that there may be a factor of mixing absenteeism in matters of general health with that of HIV. Loss of productivity is reported in manufacturing and trade. A mechanized fishing firm has encountered discrimination of affected staff.

**Table 6.7 Profile of Impact of HIV/AIDS on industry**

No. of firms	Zone	State	Nature of firm	Sector	Size	Workforce size	Affected with
Firm 1	West	Maharashtra	Formal	Mechanized Fishing	Medium	2-24	☐ Marginal medical cost.
Firm 2	West	Maharashtra	Formal	Mechanized fishing	Tiny	100-499	☐ Marginal absenteeism on medical ground. ☐ Marginal discrimination of the affected staff.
Firm 3	West	Maharashtra	Formal	Hotel	Tiny	100-499	☐ Marginal medical cost. ☐ Quantified it as 0.5% increase.
Firm 4	West	Maharashtra	Formal	Hotel	Large	1000 and above	☐ Marginal medical cost. ☐ Marginal workforce instability. ☐ Marginal absenteeism on medical ground.
Firm 5	West	Maharashtra	Formal	Manufacturing (garments)	Large	1000 and above	☐ Marginal absenteeism on medical ground. ☐ Marginal loss of productivity.
Firm 6	West	Maharashtra	Formal	Trade	Small	1000 and above	☐ Significant absenteeism on medical ground. ☐ Significant loss of productivity.
Firm 7	North	Haryana	Formal	Finance and real estate	Large	500-999	☐ High medical cost.

By nature of industry, the impact in terms of all factors reported has affected the formal industry. This as a generalization can be disputed. However, the data is establishing link with formal establishments as 100 per cent, as far as the impact of AIDS on industry is concerned.

Tiny, medium and large industries are equally affected by HIV/AIDS in terms of increased medical cost. Large industry is affected by instability of workforce. Absenteeism on medical ground has affected two large industries, one tiny and one small industry. Loss of productivity was the impact in one small and one large industry. One tiny industry encountered discrimination of affected staff. In general, in terms of size, every industry irrespective of size is affected by HIV/AIDS. However, large industry (3 firms, i.e., 42.9 per cent) is comparatively more affected, followed by tiny (2 firms, i.e., 28.6 per cent) and other classes of investment (1 firm, i.e., 14.3 per cent each for small and medium).

Impact of HIV/AIDS is reported greatest in workforce size of 1000 and above workers (42.9 per cent, followed by 100-499 (28.6 per cent). 14.3 per cent affected was from firms employing 2-24 workers and 500-999 workers each (table 6.7).

**Table 6.8 Impact of HIV/AIDS on Firms (%)**

Factors of Impact	Marginal	Significant	High	Total
Increase in medical cost	3 (0.3)		1 (0.1)	4 (0.4)
Workforce instability	1 (0.1)			1 (0.1)
Absenteeism on medical ground	3 (0.3)	1 (0.1)		4 (0.4)
Loss of productivity	1 (0.1)	1 (0.1)		2 (0.2)
Discrimination of the affected staff	1 (0.1)			1 (0.1)
Total firms affected	5 (0.5)	1 (0.1)	1 (0.1)	7 (0.7)

Note: The hotel employer from tiny sector quantified the increase in marginal medical cost as 0.5%.

In nutshell, 0.7 per cent of industry are affected in total. When 0.4 percent each got affected by increase in medical cost and absenteeism on medical grounds, 0.1 per cent each was affected by workforce instability and discrimination of the affected staff. 0.2 per cent of industry experienced loss of productivity. When 0.5 per cent of industry was marginally affected, the impact was significant and high in 0.1 per cent each (table 6.8).

### Action Taken Information

Action taken information is available with 7 firms (0.7 per cent) affected with HIV-infected workers. Management came to know about the HIV cases in the company through various means – co-workers, company doctor and family member. In 28.6 per cent of cases, medical check up has revealed the infection. Frequent illness was also a pointer (14.3 per cent). The firm had no information about one case (14.3 per cent) till they came to know 2 years after the employee left (table 6.9).

The details of action taken are put together in table 6.10. In the case of skilled workers, one firm (hotel) has given counseling and treatment and then changed their duty. In two cases, the management came to know very late and nothing could be done. In a case in Tamil Nadu, the management came to know about the problem only two years after the worker left. In the case of unskilled workers, one firm asked the worker to leave, one gave financial assistance, and another sent one worker to treatment.

**Table 6.13 Source of information about HIV status of worker**

Source of information	Frequency	Percentage
Came to know 2 years after he left the job (1 worker) – Tamil Nadu	1	14.3
Coworkers informed the employer (1) – Maharashtra	1	14.3
Company doctor, close monitoring (3) – Maharashtra	1	14.3
Frequent illness, paleness, blood check-up (4) – Maharashtra	1	14.3
His family member informed about his status (1 worker, he died) – Maharashtra	1	14.3
Medical check-up (2) – Maharashtra	1	14.3
Medical check-up (4) – Maharashtra	1	14.3
Total	7	100.0

**Table 6.10 Action taken Information**

Category of workers	Nature of Industry	Sector, State	Size of Industry	Work-force size	Action taken
Regular Skilled	Formal	Hotel, Maharashtra	Large	1000 and above	Counseling, treatment and change of duty
Regular Skilled	Formal	Hotel, Tamil Nadu	Medium	100-499	No Action – Came to know 2 years after he left
Regular Skilled	Formal	Manufacturing, Maharashtra	Large	1000 and above	No Action – Came to know at the last stage
Regular Skilled	Formal	Mechanized Fishing, Maharashtra	Tiny	100-499	No Action – Came to know with death
Regular Unskilled	Formal	Trade and Commerce, Maharashtra	Small	1000 and above	One worker sent for treatment
Regular Unskilled	Formal	Hotel, Maharashtra	Tiny	100-499	Asked one worker to leave
Regular Unskilled	Formal	Mechanized Fishing, Maharashtra	Medium	2-24	Gave financial assistance

Here, the action taken includes also no action because of certain circumstances. All is about cases of regular workers, skilled as well as unskilled. 42.9 per cent of action was no action. Same percentage of positive action was also reported – counseling and change of duty, treatment, and financial support (14.3 per cent each). 14.3 per cent of action was retrenchment. For 50 per cent each of large and medium industry and 100 per cent of small industry, the action taken was in favorable direction as far as the worker is concerned. Tiny industry behaved cent per cent unfavorably to the worker.

It was seen already that a mechanized fishing firm had encountered discrimination of affected staff. In this context it would be pertinent to observe the general response of the co-workers toward the affected, as reported by the employers. Information is studied for 0.9 per cent of HIV affected firms, and it is available for 0.7 per cent of firms (or 70 per cent of the affected firms). 57.1 per cent of staff seem to positively support while 14.3 per cent did not bother (table 6.11). No percentage of the workforce is reported to go against the affected, though in another context 0.1 per cent of firms (equivalent to 14.3 per cent of the affected firms in terms of HIV impact) reported marginal discrimination of the affected. However, as such the issue seems attention.

**Table 6.11 Reaction of Coworkers towards HIV infected In firms with HIV infected workers**

Reaction	Frequency	Percent
No information/no response	1	14.3
Did not bother	1	14.3
Supported	4	57.1
Not informed	1	14.3
Total	7	100.0

### HIV Policy in Firms

Regarding policy, only 5 respondents (0.5 per cent of total firms) have said that they have HIV policy at enterprise level. On close scrutiny, it was found that two of them do not recruit the affected staff, another appoints only workers with moral character, and two others take medically related steps. One of the latter gives medical guidance and counseling while the other has mediclaim policy for its workers, and it could not be ascertained whether the specific mediclaim policy covered AIDS or not. Uninformed medical check-up at the stage of recruitment is the policy followed by one firm that does not recruit infected staff. Two firms (0.2 per cent) have not responded to this particular question, while 99.3 (1051 firms) per cent have no policy (table 6.12).

**Table 6.12 Elements of Existing HIV/AIDS Policy**

Elements of existing HIV/AIDS policy	Frequency	Percentage
No recruitment of HIV positives (1 uninformed)	2	.2
Appointing people with moral character	1	.1
Medical guidance, counseling	1	.1
Medicclaim	1	.1
No answer	2	.2
No Policy	1051	99.3
Total	1058	100.0

However, some firms follow certain steps thinking that those steps would help preventing HIV among their staff. Some of the steps are: aids awareness camps and classes, character monitoring, discussion and distribution of available information, education of workers, encouraging workers to discuss the issue, medical steps like giving Hepatitis B shot, sex education, etc.

The readings of the break-up by State and sector, size of industry, nature of industry and workforce size on the existing HIV policy are summed up in table 6.13. Only two zones and four States have claimed to have policy; and the firms (hotel, manufacturing and IT) are in both formal and informal industry and they belong to all sizes of industry (investment) except the tiny sector.

**Table 6.13 Existing HIV policy with industry details**

Policy element		State, Zone	Sector	Nature of Industry	Size of Industry	Workforce size
No Recruitment	Medical Step					
Appointment of people with moral character		Kerala, South	Hotel	Formal	Medium	100-499
Uninformed HIV test		Kerala, South	Manufacturing	Formal	Small	100-499
No recruitment of HIV+		Karnataka, South	IT	Informal	Small	2-24
	Medicclaim	Tamil Nadu, South	Hotel	Formal	Medium	100-499
	Counseling	Jharkhand, East	Manufacturing	Formal	Large	1,000 and above

The survey tried to find whether the firms provide facilities such as family planning and condom promotion, sex education for staff, STD clinics, HIV/AIDS counseling and similar kind of services. Results are tabulated in the chapter on health and social security (Chapter Four, table 4.5). It should be recollected that 8.6 firms provide some direct or indirect facilities for family planning, condom promotion or for both. While 4.2 per cent of firms conduct some classes or programs for sex education of staff, 1.1 per cent provide STD clinics for its staff. It is significant that 4.7 per cent of establishments reported that they give AIDS counseling. Further analysis showed that fifteen firms (1.4 per cent) are common among those providing sex education and AIDS counseling. Though some of these facilities are linked to HIV redress, they are not part of stated policy by employers.

## **CHAPTER SEVEN: ELEMENTS OF HIV/AIDS POLICY IN THE WORLD OF WORK**

The survey tried to find the elements/components of an HIV policy at workplace by giving ten closed choices and one open option (12 in total, including the option of all the above 10 elements) and allowing the respondents to choose multiple answers. The following are the 10 given variables as options:

Voluntary test

Confidentiality of identity

Non-discrimination of the affected

Sex education and condom promotion

Counseling and treatment

Education and awareness programs

Workers' participation

Incapacity and survivors' benefits

Specific budget allocation by enterprise

Right to work of the affected people

The results showed that 19.2 per cent of the respondents (203 employers) suggested all the 10 elements listed above. This acceptance of all elements is very significant. So, even the least supported policy element, incapacity and survivors' benefits got the support of 22.4 per cent of employers interviewed.

Among these policy elements (table 7.1), education and awareness programs (73.5 per cent), sex education and condom promotion (71.3 per cent), and counseling and treatment (69.4 per cent) were the maximum suggested elements. Voluntary test (57.9 per cent) and confidentiality of identity (43.2 per cent) followed these three elements in order. Some have not responded properly to this particular query and some did not have any idea, all of them together constitute 2.3 per cent of employers in the sample.

Some employers objected to linking up sex education and condom promotion. When some suggested voluntary test and confidentiality of identity, there are some others who suggested compulsory HIV test and linking it with marriage, job and license. It is also suggested that implementation of an HIV/AIDS policy at unit level will go against the confidentiality of the affected staff. The other elements suggested are exceptional but not sufficiently supported; though some of them such as identifying right job for the affected and financial support are important. Segregation of HIV affected workers into separate enclaves of economy is also one among the other elements suggested.

**Table 7.1 HIV/AIDS Policy Elements**

HIV/AIDS policy elements	Count	% Responses	% Cases
No Answer/No idea	24	.5	2.3
Voluntary test	613	12.5	57.9
Confidentiality of identity	457	9.3	43.2
Non-discrimination of the affected	441	9.0	41.7
Sex education and condom promotion	754	15.4	71.3
Counseling and treatment	734	15.0	69.4
Education and awareness programs	778	15.8	73.5
Workers participation	318	6.5	30.1
Incapacity and survivors benefits	237	4.8	22.4
Specific budget allocation by enterprise	259	5.3	24.5
Right to work of the affected people	285	5.8	26.9
Others	9	.2	.9
Total Responses	4909	100.0	464.0

The distribution of choices on policy elements by sector, nature of industry, size of industry (investment size) is to be examined to notice difference if any in pattern from the general trend.

### **Sectoral Priorities of HIV/AIDS Policy Elements**

Table 7.2 gives the sectoral distribution of HIV policy components. An analysis of this table will help us in identifying the sectoral priorities. Following are the major readings.

- The first three preferences of all sectors are invariably education and awareness program, sex education and condom promotion, and counseling and treatment, hinting at these elements as the major areas of intervention.
- The opinion on the issue of discrimination is divided. Voluntary test, confidentiality of identity, and non-discrimination occupy the fourth, fifth and sixth preferences of the industry in general. This considerate approach is getting undone when one sees that the right to work of the affected people is among the last two preferences in five sectors: of construction, fishing, mining, manufacturing, and hotel.
- IT sector has given 36.4 per cent (specific budget allocation) to 86.4 per cent (education and awareness programs) support to all the elements. IT scored the highest in percentage support to eight of the ten policy elements, emerging itself the progressive-minded sector compared to other sectors. Finance and real estate is the second highest scorer (31.1 to 78.7 per cent).
- Incapacity and survivor's benefit, specific budget allocation by enterprise, and right to work of the affected people are the elements that appeared as the last two preferences in different sectors. Incapacity and survivor's benefit is one of the last options in all the sectors except IT and construction. The low preference to these policy elements shows that large majority of sectors feels burdensome to bear the expenses involved.
- Workers' participation is a last preference for the sector of mechanized fishing.
- Right to work of the affected people needs consideration foremost in sectors of construction and mining and then in hotel, fishing, and manufacturing.

**Table 7.2 Elements of HIV policy: Sectoral distribution by respondents (Count and Column %)**

Elements of HIV Policy	Manuf acture	Plant ation	Fishin g	Minin g	Constr uction	Trade	Hotel	Trans port	IT	Fina nce	Row total
No Answer/No idea	4 1.3	6 8.0	3 12.0	0 .0	1 3.8	9 2.3	1 1.3	0 .0	0 .0	0 .0	24 2.3
Voluntary test	174 57.4	32 42.7	13 52.0	14 56.0	16 61.5	229 59.0	53 69.7	32 56.1	12 54.5	38 62.3	613 57.9
Confidentiality of identity	145 47.9	22 29.3	8 32.0	9 36.0	9 34.6	162 41.8	33 43.4	25 43.9	11 50.0	33 54.1	457 43.2
Non-discrimination of the affected	140 46.2	19 25.3	9 36.0	7 28.0	11 42.3	153 39.4	31 40.8	25 43.9	13 59.1	33 54.1	441 41.7
Sex education and condom promotion	213 70.3	53 70.7	18 72.0	18 72.0	21 80.8	269 69.3	55 72.4	41 71.9	18 81.8	48 78.7	754 71.3
Counseling and treatment	218 71.9	41 54.7	16 64.0	15 60.0	19 73.1	266 68.6	55 72.4	41 71.9	18 81.8	45 73.8	734 69.4
Education and awareness programs	231 76.2	42 56.0	15 60.0	17 68.0	17 65.4	296 76.3	54 71.1	41 71.9	19 86.4	46 75.4	778 73.5
Workers' participation	106 35.0	12 16.0	5 20.0	6 24.0	5 19.2	109 28.1	24 31.6	14 24.6	11 50.0	26 42.6	318 30.1
Incapacity and survivors' benefits	75 24.8	8 10.7	5 20.0	2 8.0	4 15.4	87 22.4	17 22.4	11 19.3	9 40.9	19 31.1	237 22.4
Specific budget allocation	89 29.4	9 12.0	5 20.0	4 16.0	3 11.5	92 23.7	17 22.4	12 21.1	8 36.4	20 32.8	259 24.5
Right to work of the affected people	89 29.4	15 20.0	6 24.0	2 8.0	3 11.5	104 26.8	18 23.7	13 22.8	10 45.5	25 41.0	285 26.9
Others	6 2.0	2 2.7	0 .0	0 .0	0 .0	0 .0	1 1.3	0 .0	0 .0	0 .0	9 .9
Column Total	303 28.6	75 7.1	25 2.4	25 2.4	26 2.5	388 36.7	76 7.2	57 5.4	22 2.1	61 5.8	1058 100.0

### Distribution of HIV/AIDS policy elements by nature of industry

The distribution of choices on policy elements by nature of industry is given in table 7.3. When the formal-informal divide in the industry was considered, conspicuous difference was found in the general order of preference. Education and awareness program is the most preferred policy element, followed by sex education & condom promotion and counseling & treatment. However, this order of preference changes in the consideration of the divide. Following are the main readings:

- Except the element of sex education and condom promotion, all the other policy elements are preferred more by formal industry than by the informal one.
- Education & awareness program and counseling & treatment are equally preferred by formal industry (74.3 per cent each).
- Both the types of industry prefer least the element of incapacity and survivor's benefit, 26.1 per cent by formal industry and 18.1 per cent by the informal one, the latter being the least interested.

**Table 7.3 Elements of HIV policy: Distribution by Nature of industry (Count and Column %)**

Elements of HIV/AIDS Policy	Formal	Informal	Row Total
No Answer/No idea	6 1.1	18 3.7	24 2.3
Voluntary test	361 63.7	252 51.3	613 57.9
Confidentiality of identity	287 50.6	170 34.6	457 43.2
Non-discrimination of the affected	274 48.3	167 34.0	441 41.7
Sex education and condom promotion	394 69.5	360 73.3	754 71.3
Counseling and treatment	421 74.3	313 63.7	734 69.4
Education and awareness programs	421 74.3	357 72.7	778 73.5
Workers' participation	201 35.4	117 23.8	318 30.1
Incapacity and survivors' benefits	148 26.1	89 18.1	237 22.4
Specific budget allocation by enterprise	160 28.2	99 20.2	259 24.5
Right to work of the affected people	175 30.9	110 22.4	285 26.9
Others	8 1.4	1 .2	9 .9
Column Total	567 53.6	491 46.4	1058 100.0

Distribution by Size of Industry (investment size)

**Table 7.4 gives the percentage of preference of policy elements by size of industry. Following are the readings.**

- The elements, education and awareness programs, sex education and condom promotion, and counseling and treatment are the three major choices, given in the order of importance, preferred by employers in general. This order of preference remains same only in the case of tiny industry.
- Large industry is the highest scorer in all elements of HIV/AIDS policy.
- The larger the industry, the higher is the comparative importance given to counseling and treatment.
- Industry is unanimous, irrespective of size, in giving least importance to incapacity and survivor's benefits (table 7.4).

**Table 7.4 Distribution of Elements of HIV/AIDS Policy by investment size**

Policy elements	Undisclosed	Tiny	Small	Medium	Large	Row Total
No Answer/No idea	0 .0	19 4.7	3 1.1	2 .9	0 .0	24 2.3
Voluntary test	13 48.1	225 55.8	161 57.1	131 59.8	83 65.4	613 57.9
Confidentiality of identity	10 37.0	150 37.2	118 41.8	100 45.7	79 62.2	457 43.2
Non-discrimination of the affected	8 29.6	152 37.7	113 40.1	93 42.5	75 59.1	441 41.7
Sex education and condom promotion	21 77.8	283 70.2	203 72.0	151 68.9	96 75.6	754 71.3
Counseling and treatment	12 44.4	260 64.5	194 68.8	155 70.8	113 89.0	734 69.4
Education and awareness programs	27 100.0	293 72.7	203 72.0	155 70.8	100 78.7	778 73.5
Workers' participation	8 29.6	103 25.6	91 32.3	61 27.9	55 43.3	318 30.1
In capacity and survivors' benefits	7 25.9	81 20.1	63 22.3	44 20.1	42 33.1	237 22.4
Specific budget allocation	9 33.3	89 22.1	68 24.1	49 22.4	44 34.6	259 24.5
Right to work of the affected people	8 29.6	89 22.1	81 28.7	58 26.5	49 38.6	285 26.9
Others	0 .0	1 .2	3 1.1	3 1.4	2 1.6	9 .9
Column Total	27 2.6	403 38.1	282 26.7	219 20.7	127 12.0	1058 100.0

## CHAPTER EIGHT: EXPECTATION OF EMPLOYERS: LEVEL AND AGENCIES OF IMPLEMENTATION OF HIV/AIDS POLICY

The willingness of employers to have an HIV/AIDS policy in the world of work, links and levels of the policy, and the agencies of implementation in select cases of policy elements/components as expected by the employers are the aspects dealt in this chapter. The willingness of majority of employers is adequately revealed through the choices they preferred, and one witnesses this as we go ahead in the analysis.

### **Policy: separate or integrated with the existing health policy?**

Respondents are more or less equally divided on having an HIV/AIDS policy either as integrated with the existing health policy or as separate (table 8.1). Still, majority is of the opinion to keep it separate (48.4 percent). As 4.5 per cent of the employers in the sample did not respond to this question with a clear answer, this majority opinion is set below 50 per cent. 47.1 per cent of the respondents want to make use of the existing health facilities and thus link the HIV policy with the general health policy. Majority of the respondents treats HIV as special case that needs more attention and wants to keep it independent of the existing health policy.

**Table 8.1 HIV Policy at workplace**

Nature of policy	Frequency	Percent
No proper answer	48	4.5
Integrated with existing health policy	498	47.1
Separate	512	48.4
Total	1058	100.0

The break-up of the opinion on the policy by sector, nature of industry, investment size, and workforce size is studied. Among the employers who want a policy integrated with the existing health policy, 55.6 per cent belong to the formal sector. The informal sector has 47.7 per cent of employers, who like it separate, while the sector has only 46.4 per cent of presence in the sample. That means majority in the informal sector wants a separate HIV policy.

Sectorally, majority in construction, hotel, IT, plantation and transport wants the policy to be independent and separate. Finance and real estate is more or less equally poised. When majority in tiny and large industries favors an integrated policy, that in the small and medium sector supports separate policy. Firms employing less than 100 workers have majority support for a separate dealing of the HIV policy. Those employing 100 and above workers gave a majority support for integrating the policy with the existing health policy.

### **Implementation level of HIV/AIDS policy at workplace**

Analysis found that 33.9 per cent of employers chose all the three multiple options – enterprise, association of employers and government as levels of implementation of HIV policy. Table 8.2 gives the frequency of preference of employers. 1.7 per cent either did not respond or did not have any idea about the issue. While

86.7 per cent of employers went in favor of implementing the policy at government level, 42.7 per cent opted at enterprise level and 44.3 per cent at the level of employers' association (table 8.2).

**Table 8.2 Implementation level of HIV policy**

Policy Level	Count	% Responses	% Cases
No answer/No idea	18	.9	1.7
Enterprise	452	23.8	42.7
Association of employers	469	24.7	44.3
Government	917	48.3	86.7
Other level	43	2.3	4.1
Total Responses	1899	100.0	179.5

In addition, 4.1 per cent of employers preferred the implementation of the policy at other levels also. For instance, 1.3 per cent preferred NGOs, 0.6 per cent TUs, 0.4 per cent independent bodies of experts and 0.2 per cent chose the clubs.

### **Willingness of employers**

One reading that emerges out of the combination of these choices (table 8.2) is that a minimum of 42.7 per cent of employers are ready to bear responsibility at enterprise level, and 44.3 per cent want co-operation from employers' association. At the same time, 86.7 per cent of them expect active intervention from the side of government. This reflects clear willingness of employers to have an HIV/AIDS policy in the world of work, though they expect active support of government.

### **Implementation levels of HIV Policy as preferred by sector, nature and size of firms**

Sectorally, the general combined trend prevails with minor exceptions. For instance, the preference shown by construction, hotel and IT sectors to government is comparatively higher than other sectors. A comparatively higher preference for enterprise and association of employers as levels of policy implementation can be seen in sectors such as hotels, IT, finance & real estate, manufacture, and mining.

Informal industry's preference to government is slightly less than that of formal industry. When 86.8 per cent of employers in the formal industry preferred government, 86.6 per cent of employers in the informal industry preferred it. In the formal industry 50.1 per cent of employers are ready to bear the share of responsibility in implementing the HIV policy at enterprise level. The figure for the same in informal enterprises is 34.2 per cent. In choosing employers associations, the readiness of employers in formal industry is 50.4 per cent while it is 37.3 per cent in informal sector.

The preference of tiny sector to government is the highest (87.6 per cent). The preference to enterprise and association of employers increases from tiny to large with the exception of medium industry, where the preference is highest for these two levels. In absolute terms, the preference for government is high, irrespective of size.

### **Implementing agencies**

The survey tried to find which agencies were preferred as implementing agencies for the following HIV/AIDS policy elements.

- Education and awareness programs
- Counseling and treatment
- Sex education and condom promotion
- Workers' participation

The options given included government, employer, employers' associations, TUs, NGOs, private sponsors, media, workers' committee, etc. Every policy element is given different list of options as implementing agencies.

Majority of respondents preferred government as the implementing agency with regard to education and awareness programs (61.9 per cent), sex education and condom promotion (62.9 per cent), and counseling and treatment (59.7 per cent) followed by NGOs (42.5 per cent, 41.7 per cent and 42.2 per cent respectively). Media was the third choice (38.2 per cent) preferred by employers in education and awareness programs, for which private sponsors emerged as the fourth choice. In the latter two policy components, third choice went to private sponsors. Employers and employers' association have also emerged as important choices, fourth and fifth places in counseling & treatment and sex education & condom promotion, and fifth and sixth places in the case of education & awareness programs. In workers' participation, workers committee was preferred (38.8 per cent), followed by workers' union in the unit (19.1 per cent). In fact, 48.8 per cent of employers preferred trade unions of some kind as the implementing agency for the policy element of workers' participation. Because, workers' representative from local TU (16.4 per cent) and trade union centers (13.3 per cent) were the third and fourth preferences. Thus, the three union-related options together overtake the option of workers' committee in the case of workers' participation. However, TU fared as the last option in the case of other three policy elements.

### **Other implementing agencies**

Besides the closed options, space for open-ended options was given as other choice in all the four cases.

Besides these four cases, additional space for suggesting new policy elements and implementing agencies as well was given. The results of all the five other cases were analyzed. The additional choices of implementing agencies given by respondents in all the four cases are mostly the same. They include new specialized department, body of experts, religious and caste/community organizations, medical bodies, unions, volunteers, clubs, etc. More or less same suggestions came up in the fifth additional case.

### **Education and Awareness Programs – Implementing Agencies**

As the table 8.3 puts it, 6.1 per cent of employers did not respond to the query on the implementation agency for education and awareness program, and 1.9 per cent had no idea on the issue. Employers chose the agencies in the order of government (61.9 per cent), non-governmental organizations (42.2 per cent), media (38.2 per cent), private sponsors (17.4 per cent), employers (16.4 per cent), employers' association (13.9 per cent) and trade unions (10.2 per cent). NGOs, media and private sponsors emerged as important agencies, besides government, in the implementation of education and awareness programs on HIV/AIDS in the world of work.

**Table 8.3 Implementing Agencies: Education and Awareness programs**

Implementing Agencies	Count	% Responses	% Cases
No Answer	65	2.9	6.1
Employer	174	7.8	16.4
Employers Association	147	6.6	13.9
Trade Unions	108	4.9	10.2
Government	655	29.5	61.9
NGOs	450	20.3	42.5
Private sponsors	184	8.3	17.4
Media	404	18.2	38.2
Others	14	.6	1.3
Don't Know	20	.9	1.9
Total Responses	2221	100.0	209.9

A sectoral consideration has shown that construction and plantation sectors do not prefer trade unions. Finance and real estate, mining, and manufacturing gave comparatively higher importance to trade unions. IT and hotels gave high preference to NGOs and private sponsors.

Finance & real estate, and manufacturing preferred employer as an agency of implementation for HIV policy than by any other sector. Manufacturing, finance, mining and trade, in that order, gave higher importance to employers' association compared to other sectors. No other sector gave importance to media than by finance, manufacturing, IT and transport sectors. Fishing and manufacturing gave least importance to government. However, government remained the most favored agency for all sectors, as far as the policy element of education and awareness program is concerned.

Employers' association and government are preferred comparatively more by informal sector than by formal sector firms, and the rest of agencies are preferred more by formal sector. Tiny industry has shown the highest preference to government, and large industry showed the least. NGOs are preferred least by the tiny and most by large industry. Tiny and Small industry give less importance to private sponsors and trade unions than by medium and large industry. Medium industry has shown comparative preference to media than other sectors do. Large industry gave comparatively the highest preference to employers. Tiny and medium preferred employers' association more than the other sectors did.

### **Sex education and Condom promotion – Implementing Agencies**

Table 8.4 gives frequency of implementing agencies for the HIV policy component, namely, the sex education and condom promotion. 8.1 per cent of employers gave no answer and 0.6 per cent did not have any idea about the issue. The preference goes in the order of government first (62.9 per cent) and trade unions last and sixth (7.2 per cent). NGOs, private sponsors, employer and employers' association took the positions from second to fifth in order.

**Table 8.4 Implementing Agencies: Sex Education and Condom Promotion**

Implementing agencies	Count	% Responses	% of Cases
No answer	86	5.0	8.1
Employer	126	7.3	11.9
Employers' Association	106	6.2	10.0
Trade Unions	76	4.4	7.2
Government	666	38.7	62.9
NGOs	441	25.6	41.7
Private Sponsors	195	11.3	18.4
Others	18	1.0	1.7
Don't know	6	.3	.6
Total responses	1720	100.0	162.6

In implementing the policy of sex education and condom promotion, sectoral analysis showed that the sectors of plantation and IT do not prefer trade unions at all. Fishing, mining and construction prefer trade union than by other sectors. Mining does not prefer employers or enterprises as implementing agency. Mining sector does not want to take any responsibility, and expects more from government. Transport and manufacturing thought in favor of employer than other sectors did it. Fishing, mining and manufacture preferred employers' association than by other sectors. NGOs are least preferred by plantation and fishing and then by transport and mining. IT is the sector that gave highest importance to private sponsors and NGOs. Fishing sector expected least from the government. Here also government remained the highest preferred agency.

Except government, all other agencies are more preferred by formal sector. Though informal industry is found more inclined to have government as implementing agency, in absolute terms, both the sectors prefer government as the main implementing agency. Trade unions and private sponsors are preferred more by medium industry than by others. In the case of employer, employers' association, and NGOs, the preference increases progressively from tiny to large, while this decreases in the case of government.

### **Counseling and Treatment – Implementing Agencies**

Regarding counseling and treatment (table 8.5), 8.4 percent of employers did not participate and 0.6 percent had no idea. Employers chose the agencies in the order of preference of government (59.7 percent), NGOs (42.2 percent), private sponsors (20.2 percent) employer (15.4 percent), employers association (10.7 percent) and trade unions (8.1 per cent).

**Table 8.5 Implementing agencies: Counseling and Treatment**

Implementing agencies	Count	% Responses	% cases
No answer	89	5.0	8.4
Employer	163	9.2	15.4
Employers Association	113	6.4	10.7
Trade Unions	86	4.9	8.1
Government	632	35.8	59.7
NGOs	446	25.3	42.2
Private Sponsors	214	12.1	20.2
Others	14	.8	1.3
Don't know	6	.3	.6
Total Responses	1763	100.0	166.6

The general preference is reflected even when analyzed across sectors. Besides this reflection, sectoral variation can also be witnessed. For instance, there is preferential variation advantageous to NGOs in the sector of construction and then in finance and IT. Plantations have zero-preference to trade unions. Mining and construction gave importance to trade unions. IT, manufacturing and transport have shown employer preference. Here also, fishing showed least preference to government. Fishing and mining showed comparative preference to employers' association as an agency in implementing counseling and treatment. Transport prefers private sponsors than by other sectors.

Informal sector employers are found more in preferring government, and all other agencies are more chosen by formal sector compared to informal one. Distribution by investment size has shown that employer preference increases progressively from tiny to large. Medium industry showed the highest preference to

employers' association and private sponsors than by other groups of investment size. Tiny and medium industry gave less importance to trade unions compared to medium and large industry. Large industry has given least importance to government and highest importance to NGOs when compared to other sectors. As far as counseling and treatment as a policy component is concerned, government lost its topmost position to NGOs in the case of large industry.

### **Workers' Participation – Implementing Agencies**

The participation of employers in choosing implementing agencies in the case of workers' participation as an HIV policy element is significantly low. 22.8 per cent of employers did not answer the query, while 4.7 per cent had no idea (table 8.6). As a single agency, workers committee is mostly preferred (38.8 per cent). The rest of choice favored trade unions of some kind (48.8 per cent). Of these options, trade union in the unit got 19.1 per cent of support, while local trade union and trade union center got respectively 16.4 per cent and 13.3 per cent of support. As choices given, the union component is divided into 3 options. This is one factor in workers' committee emerging as the most-favored singular option. It should be remembered that employers, without any set up or any vision of workers' committee, have also preferred it as an option, perhaps in opposition to trade union.

**Table 8.6 Implementing agencies: Workers' Participation**

Implementing agencies	Count	% Responses	% Cases
No answer	241	19.3	22.8
Workers' Committee	410	32.8	38.8
Workers' union in the unit	202	16.2	19.1
Workers' representative from local TU	174	13.9	16.4
Workers' representative from TU centers	141	11.3	13.3
Others	31	2.5	2.9
No idea	50	4.0	4.7
Total	1249	100.0	118.1

Sectorally, substantial section of employers in plantation (60 per cent), fishing (28 per cent) and trade (27.1 per cent) did not participate in the selection of agencies. 28 per cent of employers in the sector of mechanized fishing did not have any idea about the issue. Finance, IT, manufacturing, construction, and mining showed comparative preference for workers committee. Formal sector employers dominated all the four options given. If variation by investment size is considered, the choice of workers' committee can be seen progressively getting favored from tiny to large sector. Medium and large industry favors union in the unit and small industry prefers local union. Workers' representative from TU centers is mostly voted by medium industry. This is despite the fact that all the classes of investment size have chosen workers' committee in absolute terms.

## CHAPTER NINE: KEY PARAMETERS FOR ADVOCACY AND INTERVENTION

### A. Policy Intervention

1. The survey reiterated the need for an HIV/AIDS policy at workplace. ILO could work with the Government, employers and trade unions to evolve a comprehensive policy on HIV/AIDS in the world of work and suggest model policies at the enterprise level. Only 0.5 per cent of the firms claimed to have an existing policy. A close look at the claim of enterprise level policy on HIV/AIDS has boiled down positively to medical steps in 0.2 per cent of enterprises. Owing to HIV impact, the industry has recorded increase in medical expense, workforce instability, absenteeism on medical ground, loss of productivity, and discrimination of the affected. Industry, and thus the economy, is affected and workers are also affected. The existing HIV policy in the industry is sparse and weak.

2. The three major policy elements supported by most of the employers are:

Education and awareness programs

Sex education and condom promotion

Counseling and treatment.

Incidentally, when the remedial measures at all levels (country, State, area, sector and unit) suggested by employers who considered incidence of HIV/AIDS significant at unit level is studied, it is found that they also gave importance to measures similar to these three policy elements. The measures were awareness generation, sex education and condom promotion, education, and health measures like health camps, in the given order of importance. Therefore, it is very important to arrive at measures directly or indirectly linked to the above three policy elements, which got substantive acceptance among employers, as well as are important on their-own. All possible and practical means of communication should be used to provide general information about HIV/AIDS regarding source of infection and prevention in a manner and language easily understood by the workers, these be provided at working and living places.

3. Employers preferred simultaneous action at the levels of government, employers' association, and enterprises. The preferential order is also the same. This reflects clear willingness of employers to have an HIV/AIDS policy in the world of work, though they expect active support of government. They expect also the support of NGOs, private sponsors, media and trade unions.

4. Majority of respondents prefers government as the implementing agency with regard to education and awareness programs, sex education and condom promotion, and counseling and treatment. NGOs, private sponsors and media are the other important agencies suggested. Next preference went to employers and employers' association. As government has been suggested the main implementing agency for the above suggested policy elements, government has to obviously take lead in involving the employers associations,

NGOs, etc. to implement the policy components at workplace, though the employers are ready to bear responsibility at enterprise levels.

5. Stronger opinion has emerged with regard to the interlinkage of a new HIV/AIDS policy in the world of work with the existing health policy. 47.1 per cent of the respondents want to make use of the existing health facilities and thus link the HIV policy with a general integrated health policy. However, opinion remains divided, as 48.4 per cent of respondents consider HIV as special case that needs more attention and wants to keep it independent of the existing health policy. Majority in the sectors of fishing, mining, manufacturing, trade, and finance and real estate, majority in the formal sector, majority in tiny and large industries, and firms employing 100 and above workers want the policy to be integrated with the existing health policy.

## **B. Sensitization**

1. The relatively high level of awareness found among employers with regard to HIV and AIDS has to be utilized to develop a realistic assessment of HIV/AIDS and to devise proactive steps. The focus of the translation of awareness shall intend (1) to evolve preventive measures, (2) to persuade employers to acknowledge the rights of HIV positive workers, and (3) to enable the employers to assess the impact of HIV/AIDS at enterprise level and evolve necessary measures with the cooperation of the workers. In this context, the following sensitization and policy measures are suggested:

a. As the existing trend is against recruitment of the HIV-affected workers and also discriminatory, as shown by employers' attitude, the action taken information, and the existing stated policy on HIV at workplace, we can see the all-important need for sensitization of employers to change their negative attitude toward the affected. A policy on HIV formulated for employers could help in the sensitization process. But the employers must get perceptible support from government and other agencies in order to feel enthused to adopt the policy in their own enterprise.

b. Education and awareness programs, sex education and condom promotion, counseling and treatment as policies got fair acceptance, while policies of voluntary test, confidentiality, and non-discrimination got only second level acceptance. Worker's participation and right to work of the affected got relatively low level of acceptance, while the policies on benefits to the affected are more or less rejected. Therefore, advocacy moves should enhance the acceptance of the above second and third level policies.

c. Fear of getting the firms stigmatized tells on the need of further creation of social awareness among the masses as consumers, and also among the other business dealers. The probable fears of employers suggest the need for apex level sensitization measures among workers, their settlements, their family and thus involving the broader society. In fact, a number of employers suggested awareness measures of similar nature.

d. The impact of HIV on the affected staff being discriminated in mechanized fishing unit in west zone shows the necessity of educating the workers on the issue of AIDS.

## **C. Human Rights**

1. Measures should be initiated against discriminatory practices. The uninformed HIV test in a manufacturing unit brings in rights issues – human rights, and the right to confidentiality. The retrenchment of worker brings in labor

rights. The recruitment is mostly of screening away the affected. Action taken information also corroborated this. The discriminatory practices such as compulsory medical test either at the time of recruitment and periodical discriminatory treatment to the infected workers have to be discouraged by legislation, encouraging formulation of an ideal HIV policy to be adopted by employers on the lines of the ILO code of practices.

#### **D. Priority Areas**

1. The present study found that at least some percentage of formal establishments are not fulfilling the mandatory health and social security measures as per legislation. Ninety per cent of firms with HIV-affected persons are from formal industry. Though HIV is low as reported, STI and opportunistic infection like Tuberculosis and Hepatitis have affected the industry intensely. These infections are a foreground for HIV. Health and social security policy and measures needed changes in this context.

a. Employers have to be sensitized and instilled of a cost benefit sense, whereby better health policy can bring higher profit and health. The health condition of the workers and social security given are poor. The employers are to be educated and convinced of the increasing vulnerability of workers to HIV/AIDS created by such working conditions, which in turn will affect the productivity and increase the industrial cost of overall input. In many of the reported cases of HIV, the employers came to know about the infected at a very late stage or at the stage of death. This shows that there is no health monitoring, and that a lack of cost-benefit sense exists among employers in matters of health of the staff. The initial impact reported on medical cost should inspire them to take note of this issue. The existing worse health situation where STD and opportunistic diseases dog all the sectors further shows the need for an improved health policy in the industry. Otherwise, the present health situation would provide a wide open door for the impending danger of HIV/AIDS at workplace. A national comprehensive policy on health and social security linking it with HIV/AIDS is needed.

b. Maharashtra, Tamil Nadu, Madhya Pradesh and West Bengal are the States where firms with HIV-affected firms are found. West Bengal has recorded highest number of disease-related fatality, and Gujarat and Andhra Pradesh reported substantial cases of staff leaving on health grounds. Therefore the above six States may need special attention.

c. Hotels and restaurants, mechanized fishing, trade and commerce, and garment manufacturing sectors are affected by HIV/AIDS and so need special attention.

2. Best practices have to be documented and disseminated for emulation and learning. Use positive examples for sensitization. There is also positive example emerging from the survey where the management of a hotel rearranged the duty of the workers affected. Negative example is where the affected worker is asked to leave the job. Such selective information without loosing confidentiality can be used for awareness creation.

3. Fishing sector needs special measures, as it emerged as the sector with low awareness levels on various counts and also as the sector more affected with HIV and other diseases. Both the workers and employers need crash measures of sensitization and also health and social security measures. Discrimination of HIV-affected coworker is also reported from this sector.

# ANNEXURES

Annexure 1

## Interview Schedule

### PERCEPTIONS OF INDIAN EMPLOYERS ABOUT HIV/AIDS IN THE WORLD OF WORK

(An ILO Project, conducted by CEC)

#### I. GENERAL INFORMATION

No:                      Date:

Name of Respondent:

1. Sex:              a. Male              b. Female

2. Status in the Organization: (encircle)

a. Owner/Proprietor	b. CEO	c. HR head	d. Others (name of post)
Specification, if needed:			

Telephone:

Fax:

Email:

Mailing Address of the respondent:

Name and Address of the Enterprise:

Area/District:

State/UT:

3. Industry/Sector: (encircle)

a. Plantations & horticulture	b. Fishing (mechanized)	c. Mining & Quarrying	d. Food Processing	e. Garments & Textile
f. Chemicals & Pharmaceuticals	g. Metals, Metal Products, Machinery & Equipments	h. Electrical & Electronic Goods	i. Automobiles & Auto-ancillaries	j. Tobacco & tobacco products
k. Wood products & furniture	l. Construction	m. Trade & Commerce	n. Hotels & Restaurants	o. Transport & Auxiliary Activities
p. IT Enabled Industries	q. Finance & Real Estate			

4. Nature of industry: (encircle)              a. Formal / organized              b. Informal / unorganized

5. Size by total investment (in Rs.) up to 2000-2001: (encircle)

a. up to 25 lakh	b. 25 lakh to 1 crore	c. 1 to 10 crore	d. more than 10 crore
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## II. NATURE AND STRUCTURE OF THE WORKFORCE AT THE ENTERPRISE LEVEL

6. Size by workforce during 2000-2001: (encircle)

a. 2 to 9	b. 10 to 24	c. 25 to 49	d. 50 to 99
e. 100 to 249	f. 250 to 499	g. 500 to 999	
h. 1000 to 4999	i. 5000 to 9999	j. 10000 & above	

7. Strength of workforce (for the last ONE month):

Total:	
Male:	Female:
1. No. of regular employees	Total:
	Male:   Female:
2. No. of short term & contract workers	Total:
	Male:   Female:
Approximate %ge of seasonal workers	Total:
	Male:   Female:
Approximate %ge of migrant workers	Total:
	Male:   Female:

8. Occupational category of workforce (total number or percentage):

1. Professional/ managerial	Total:	
	Male:	Female:
2. Skilled/ technical	Total:	
	Male:	Female:
3. Unskilled	Total:	
	Male:	Female:

## III. HEALTH AND SOCIAL SECURITY

9. Profile of different social security & medical schemes (tick the available):

	Regular Staff	Short term / contract	Women
<i>Medical allowance</i>			
<i>Medical Insurance</i>			
<i>Group Insurance</i>			
<i>Paternity/Maternity benefits</i>			
<i>Family Health scheme</i>			
<i>Referral hospitals</i>			
<i>Company hospital</i>			
<i>Company doctor</i>			
<i>Other (name)</i>			
<i>ESI</i>			
<i>EPF</i>			
<i>Gratuity</i>			
<i>Pension</i>			
Other specialized categories (specify)			

(Available material to be collected in support of the above)

10. Number of health-related cases reported in the unit since 1998:

Diseases	Regular Staff		Short term / contract workers		Managerial & Professional Staff		Skilled & Technical Staff		Unskilled	
	M*	F*	M	F	F	F	M	F	M	F
TB										
STD/STI										
Hepatitis										
Hepatitis B										
HIV/AIDS										
Others (specify)										

\*M = Male; F = Female

11. Number of staff who left the unit on health grounds since 1998:

Total:							
Male:				Female:			
Regular	Managerial/ Professional			Skilled /Technical		Unskilled	
	Total:			Total:		Total:	
	M*	F*		M:	F:	M:	F:
Short term / contract workers	Total:			Total:		Total:	
	M:	F:		M:	F:	M:	F:

\*M = Male; F = Female

12. Number of health related fatalities reported since 1998:

Total:							
Male:				Female:			
Regular	Managerial/ Professional			Skilled /Technical		Unskilled	
	Total:			Total:		Total:	
	M:	F:		M:	F:	M:	F:
Short term / contract workers	Total:			Total:		Total:	
	M:	F:		M:	F:	M:	F:

6. Do you provide benefits to families of employees who have died? (encircle)

- a. Yes                      b. No

1. If yes, what specific benefits are provided?

14. Do you have any policy to support the families of employees, who have died of sicknesses? (Encircle)

- a. Yes                      b. No

1. If yes, can you specify the policy/policies?

15. Do you earmark specific amount in the budget for such expense? Yes / No

1. If yes, what percentage of the total budget:

**IV. BASIC ISSUES RELATED TO HIV / AIDS**

16. In your perception, the incidence of the HIV/AIDS: (encircle one choice in each line)

In the Country	a. <i>Non-existent</i>	b. <i>Negligible</i> *	c. <i>Significant</i>	d. <i>High</i>	e. <i>No idea</i>
In the State	a. <i>Non-existent</i>	b. <i>Negligible</i>	c. <i>Significant</i>	d. <i>High</i>	e. <i>No idea</i>
In the Area	a. <i>Non-existent</i>	b. <i>Negligible</i>	c. <i>Significant</i>	d. <i>High</i>	e. <i>No idea</i>
In the Sector	a. <i>Non-existent</i>	b. <i>Negligible</i>	c. <i>Significant</i>	d. <i>High</i>	e. <i>No idea</i>
In the Unit	a. <i>Non-existent</i>	b. <i>Negligible</i>	c. <i>Significant</i>	d. <i>High</i>	e. <i>No idea</i>

\*Negligible = less than 1%; Significant = 1 to 5%; High = above 5%

17. What remedial measures would you like to suggest at each level?

Levels	Remedial Measures
The Country	
The State	
The Area	
The Sector	
The Unit	

18. Can you identify the source of HIV/AIDS? (Encircle more than one choice, if needed):

a. oral communication	b. physical touch	c. sharing of towel
d. using same toilet	e. eating together	f. risky / unprotected sexual intercourse
g. mother to child	h. sharing needle for injectable drugs	i. blood transfusion
j. from dirt	k. social kissing	l. sharing of telephone /computer
m. sharing of blades/ razors	n. all the above	o. any other (specify)
p. don't know		

## V. HIV/AIDS AT ENTERPRISE LEVEL

19. Has there been any case of HIV/AIDS infected worker in your unit since 1998?

a. Yes                      b. No

1. If yes, how many?

Total:						
Male:			Female:			
Regular	Managerial/ Professional		Skilled /Technical		Unskilled	
	Total:		Total:		Total:	
	M:	F:	M:	F:	M:	F:
Short term / contract workers	Total:		Total:		Total:	
	M:	F:	M:	F:	M:	F:

2. What did you do about the case/cases?

Action taken in each case			
Regular	Managerial/professional	Skilled /Technical	Unskilled
Short term/ contract workers			

3. What was the reaction of the co-workers towards the infected workers

a. didn't bother	b. protested	c. refused to work
d. neglected /avoided	e. supported	f. were not informed

20. What was the source of information for knowing about worker(s) HIV status?

21. Number of staff who left the unit on the grounds of HIV/AIDS since 1998:

Total:					
Male:			Female:		
Regular	Managerial/ Professional		Skilled /Technical		Unskilled
	Total:		Total:		Total:
	M:	F:	M:	F:	M: F:
Short term / contract workers	Total:		Total:		Total:
	M:	F:	M:	F:	M: F:

22. Steps taken in general by the employer to prevent HIV/AIDS among the workers:

Details:

23. Workers perceived to be affected by HIV/AIDS in your unit:

Total:					
Male:			Female:		
Regular	Managerial/professional		Skilled /Technical		Unskilled
	Total:		Total:		Total:
	M: Age:	F: Age:	M: Age:	F: Age:	M: Age: F: Age:
Short term / contract workers	Total:		Total:		Total:
	M: Age:	F: Age:	M: Age:	F: Age:	M: Age: F: Age:

24. What would you like to do to address it?

25. Is your enterprise affected by incidence of HIV/AIDS in terms of increase in medical costs? (encircle)

a. No            b. Marginally            c. Significantly            d. Highly

1. Can you quantify the increased cost? If yes, the percentage of the total expense:

26. Is your enterprise affected by incidence of HIV/AIDS in terms of increase in social security costs? (encircle)

a. No            b. Marginally            c. Significantly            d. Highly

1. Can you quantify the increase in cost? If yes, the percentage of the total expense:

27. Is your enterprise affected by incidence of HIV/AIDS in terms of output? (encircle)

a. No            b. Marginally            c. Significantly            d. Highly

1. Can you quantify the decrease in output/turnover? If yes, the percentage of decrease:

28. Is your enterprise affected by incidence of HIV/AIDS in terms of replacement and training cost of workers? (encircle)

a. Not affected            b. Marginal increase in replacement cost

c. Significant increase in replacement cost            d. High increase in replacement cost

1. Can you quantify the increase in cost? If yes, the percentage of the total expense:

29. Other impacts of HIV/AIDS in the enterprise? (encircle)

1. Workforce instability:			
a. No	b. Marginal	c. significant	d. High
2. Absenteeism on medical grounds:			
a. No	b. Marginal	c. significant	d. High
3. Loss of productivity:			
a. No	b. Marginal	c. significant	d. High
4. Stigmatization/discrimination of the affected staff:			
a. No	b. Marginal	c. significant	d. High
5. Stigmatization of the enterprise:			
a. No	b. Marginal	c. significant	d. High
6. Negative influence on procurement of orders:			
a. No	b. Marginal	c. significant	d. High
7. Any other (specify):			
a. No	b. Marginal	c. significant	d. High

## VI. HIV / AIDS POLICY AT THE ENTERPRISE LEVEL

30. What will be your attitude to a person identified HIV positive? (encircle)

1. in terms of recruitment:	a. <i>Do not recruit</i>	b. <i>Offer employment</i>
2. in giving training:	a. <i>Do not send</i>	b. <i>Do not discriminate</i>
3 in continuing with employment:	a. <i>Allow</i>	b. <i>Terminate</i>
4 in offering treatment:	a. <i>Give</i>	b. <i>Do not give</i>
5 Any other (specify):		

31. What are the likely reactions of the co-workers if you offer employment to the HIV positive worker(s)? (encircle more than one, if necessary)

a. will not bother	b. will protest	c. will refuse to work
d. will neglect / avoid	e. will support	

32. Does your unit provide the following? (encircle more than one option, if needed)

a. Sex education for staff	b. Family planning and condom promotion
c. STD clinics	d. HIV/AIDS counseling
e. Others (specify):	

33. Do you have a health policy and scheme at the enterprise level? Yes / No

1. If yes, what are the elements of the health policy?
2. How do you implement them?

34. Does your unit have an HIV/AIDS policy at the enterprise level? Yes / No

1. If yes, what are the elements of the HIV/AIDS policy?
2. How do you implement them?

35. A policy on HIV/AIDS at workplace should be: (encircle)

- a. Integrated with the existing health policy    b. Separate

36. An HIV/AIDS policy would be needed at level of: (encircle more than one option if needed)

a. Enterprise	b. Association of employers
c. Government	d. Other level (specify)
e. all	

35. In your/company's view, what should be the elements of the policy on HIV/AIDS at workplace? (encircle more than one option if needed)

a. Voluntary test	b. Confidentiality of identity
c. Non-discrimination	d. Sex education and condom promotion
e. Counseling and Treatment	f. Education and awareness programs
g. Workers' participation	h. Incapacity and survivor's benefits
i. Specific budget allocation	j. Right to work of the affected people
k. All of above	l. Other (specify):

38. Implementing agency in case of: (encircle more than one option if needed)

1. Voluntary test:							
a. workers' committee	b. <u>TUs</u>	c. employer	d. employers' association	e. government	f. NGOs	g. any other	
2. Sex education & condom promotion:							
a. employer	b. employers' association	c. <u>TUs</u>	d. government	e. NGOs	f. Private sponsors	g. any other	
Counseling & Treatment:							
a. employer	b. employers' association	c. <u>TUs</u>	d. government	e. NGOs	f. Private sponsors	g. any other	
4. Education & awareness program:							
a. employer	b. employers' association	c. <u>TUs</u>	d. government	e. NGOs	f. Private sponsors	g. media	h. any other
5. Workers' participation:							
a. workers' committee	b. workers' union in the unit	c. workers' representative from local TU		d. workers' representative from TU centers		e. any other	
6. Others (specify):							

35. In your opinion how can HIV/ AIDS be eradicated fast from the World of Work?

- a.
- b.
- c.
- d.

36. Remarks of the respondent:

37. Remarks of the Researcher:

Interview done by Researcher (name and signature):

Verified and received by Zonal Co-ordinator (name and signature):

No.      Date:

# ANNEXURE 2

Table 2.3 Sampling Plan

State	Center	Industry/Economic Activities										Total State/Center
		1	2	3	4	5	6	7	8	9	10	
		Manufacturing	Construction	Trade and Commerce	Hotels and Restaurants	Transport and Auxiliary	IT Enabled Industries	Finance and Real Estate	Mining and Quarrying	Mechanized Fishing	Plantations	
Kerala	Kochi	9	1	12	2	2		2		2		30
	Munnar										3	3
Tamil Nadu	Chennai	9	1	12	2	2	0	2	0	2	3	33
	Tiruppur	25	3	37	7	5	3	6		3		89
	Nilagiri	10		5				1				16
	Coimbatore	10	1	15	2	2		2			3	32
Andhra Pradesh	Hyderabad	45	4	60	11	8	3	9	0	3	3	146
	Visakhapatnam	32	3	41	6	5	6	7				100
	Anatapur	7	1	9	3	2		1		1		24
	Prakasham								3			3
Karnataka	Bangalore	39	4	52	9	7	6	8	3	1	6	135
	Mangalore	13	1	16	3	2	5	3				43
	Coorg	2		4	1	1				2		10
	Goa	15	1	20	4	3	5	3	0	2	6	59
Maharashtra	Goa	1		1	1	1				1		4
	Mumbai	1	0	1	1	0	0	0	0	1	0	4
	Pune	12	2	22	6	3	2	4		6		57
	Nasik	18	2	19	3	2		3			7	54
Gujarat	Nagpur	12		10	3	1					5	31
	Surat	6	4	64	12	8	2	9	0	6	18	171
	Baroda	12	2	12	3	2		3				27
	Porbandar	1		6	3	2		3		4		34
												11



Jharkhand	Jamshedpur	6	1	8	1	1	0	1	0	0	0	0	18
	Noamundi										5		5
<b>Bihar + Jharkhand</b>		<b>6</b>	<b>1</b>	<b>8</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>5</b>	<b>0</b>	<b>23</b>
Orissa	Keonjhar										3		3
	Paradeep	1		2					1				4
	Bhubaneswar	1	1	1				1					4
	Rourkela	1		1		1							3
West Bengal	Kolkata	13	1	18	1	1	1	1	2	2	3	1	39
	Asansol	2				1							3
	Darjeeling			2	3	1							10
Assam	Gauhati	15	1	20	4	3	1	3	2	2	0	3	52
	Tinsukia	3		3	1	1							9
				1									5
Nagaland	Dimapur	3	0	4	1	1	0	1	0	0	0	4	14
		1		1				1					3
<b>Total</b>	<b>All India</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3</b>
<b>Economic Activity</b>		<b>300</b>	<b>27</b>	<b>399</b>	<b>74</b>	<b>56</b>	<b>21</b>	<b>61</b>	<b>25</b>	<b>22</b>	<b>78</b>	<b>1063</b>	

## Annexure 3

**Table 2.4 Sample Surveyed: Break-up**

State	Industry/Economic Activities										Total State
	Manuf cture	Constru ction	Trade	Hotels	Transpo rt	IT	Finance & Real Estate	Mining	Mechaniz ed Fishing	Plantat ions	
Kerala	9	1	12	2	2	1	2	0	2	3	34
Tamil Nadu	55	4	52	11	7	3	10	0	0	2	144
Andhra Pradesh	35	3	47	11	8	7	7	6	8	7	139
Karnataka	11	0	15	3	2	3	3	0	2	6	45
Goa	0	0	1	1	0	0	0	0	0	0	2
Maharashtra	53	5	63	12	8	2	10	0	6	16	175
Gujarat	32	2	43	7	5	0	6	5	4	4	108
Rajasthan	8	1	13	2	2	1	0	3	0	3	33
Haryana	10	1	11	2	1	1	2	0	0	3	31
Delhi	12	1	17	3	2	1	2	0	0	0	38
Punjab	16	1	20	4	4	0	3	0	0	5	53
Himachal Pradesh	1	0	1	1	0	0	0	0	0	0	3
Madhya Pradesh	6	1	8	1	1	0	1	2	0	0	20
Chattisgarh	4	0	4	1	1	0	1	5	0	0	16
<b>MP + Chattisgarh</b>	<b>10</b>	<b>1</b>	<b>12</b>	<b>2</b>	<b>2</b>	<b>0</b>	<b>2</b>	<b>7</b>	<b>0</b>	<b>0</b>	<b>36</b>
Uttar Pradesh	22	4	44	7	8	2	7	0	0	19	113
Bihar	3	0	4	1	1	0	1	0	0	0	10
Jharkhand	5	1	7	1	0	0	1	1	0	0	16
<b>Bihar + Jharkhand</b>	<b>8</b>	<b>1</b>	<b>11</b>	<b>2</b>	<b>1</b>	<b>0</b>	<b>2</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>26</b>
Orissa	3	0	4	1	1	0	1	3	1	0	14
West Bengal	14	1	19	4	3	1	2	0	2	3	49
Assam	3	0	2	1	1	0	1	0	0	4	12
Nagaland	1	0	1	0	0	0	1	0	0	0	3
<b>Total Industry/Economic Activities</b>	<b>303</b>	<b>26</b>	<b>388</b>	<b>76</b>	<b>57</b>	<b>22</b>	<b>61</b>	<b>25</b>	<b>25</b>	<b>75</b>	<b>1058</b>

## Annexure 4

**Table 5.2 Source of HIV by Respondents: Sectoral distribution  
(Count and Column %)**

Source of HIV	Manuf acture	Pla ntat ion	Fish ing	Min ing	Cons tructi on	Trad e	Hot el	Tra nsp ort	IT	Fin anc e	Row Total
No Answer	0	0	1 4.0	0	0	4 1.0	0	0	0	0	5 .5
Risky/un protected sex	282 93.1	72 96.0	23 92. 0	25 100 .0	23 88.5	358 92.3	71 93. 4	54 94. 7	21 95. 5	59 96. 7	988 93.4
Mother to child	208 68.6	39 52. 0	8 32. 0	10 40. 0	17 65.4	233 60.1	53 69. 7	33 57. 9	19 86. 4	44 72. 1	664 62.8
Sharing needle	258 85.1	55 73. 3	18 72. 0	18 72. 0	22 84.6	312 80.4	66 86. 8	44 77. 2	21 95. 5	53 86. 9	867 81.9
Blood transfus ion	269 88.8	61 81. 3	20 80. 0	19 76. 0	22 84.6	326 84.0	65 85. 5	50 87. 7	21 95. 5	57 93. 4	910 86.0
Sharing of blades	172 56.8	33 44. 0	9 36. 0	12 48. 0	11 42.3	186 47.9	47 61. 8	29 50. 9	16 72. 7	40 65. 6	555 52.5
Oral commu n...	3 1.0	0	1 4.0	1 4.0	0	11 2.8	2 2.6	1 1.8	1 4.5	0	20 1.9
Physical touch	14 4.6	3 4.0	2 8.0	1 4.0	0	26 6.7	3 3.9	4 7.0	2 9.1	5 8.2	60 5.7
Sharing of towel	11 3.6	4 5.3	1 4.0	2 8.0	0	25 6.4	3 3.9	3 5.3	1 4.5	2 3.3	52 4.9
Using same	9 3.0	3 4.0	2 8.0	2 8.0	0	18 4.6	6 7.9	4 7.0	1 4.5	1 1.6	46 4.3

Eating together	6 2.0	5 6.7	0	3 12. 0	2 7.7	19 4.9	3 3.9	3 5.3	1 4.5	3 4.9	45 4.3
From dirt	6 2.0	5 6.7	1 4.0	3 12. 0	2 7.7	11 2.8	2 2.6	2 3.5	1 4.5	1 1.6	34 3.2
Social kissing	18 5.9	8 10. 7	2 8.0	3 12. 0	2 7.7	34 8.8	11 14. 5	6 10. 5	2 9.1	6 9.8	92 8.7
Sharing phone...	5 1.7	0	0	0	0	6 1.5	2 2.6	2 3.5	2 9.1	0	17 1.6
Others	3 1.0	1 1.3	2 8.0	0	1 3.8	6 1.5	1 1.3	1 1.8	0	0	15 1.4
Don't know	3 1.0	2 2.7	1 4.0	0	0	3 .8	2 2.6	0	0	0	11 1.0
Column Total	303 28.6	75 7.1	25 2.4	25 2.4	26 2.5	388 36.7	76 7.2	57 5.4	22 2.1	61 5.8	1058 100. 0

## Annexure 5

**Table 5.3 Source of HIV/ AIDS in Nature of industry  
(Count and column %)**

Source of HIV	Formal	Informal	Total
Oral Communication	7 1.2	13 2.6	20 1.9
Physical touch	28 4.9	32 6.5	60 5.7
Sharing of towel	22 3.9	30 6.1	52 4.9
Using same toilet	26 4.6	20 4.1	46 4.3
Eating together	14 2.5	31 6.3	45 4.3
Risky/unprotected sexual intercourse	529 93.3	459 93.5	988 93.4
Mother to child	389 68.6	275 56.0	664 62.8
Sharing needle for injectable drugs	489 86.2	378 77.0	867 81.9
Blood transfusion	510 89.9	400 81.5	910 86.0
From dirt	9 1.6	25 5.1	34 3.2
Social kissing	43 7.6	49 10.0	92 8.7
Sharing of telephone/computer	8 1.4	9 1.8	17 1.6
Sharing of blades/razors	323 57.0	232 47.3	555 52.5
Others	9 1.6	6 1.2	15 1.4
Don't know	3 .5	8 1.6	11 1.0
No Answer	2 .4	3 .6	5 .5
Column Total	567 53.6	491 46.4	1058 100.0

## Annexure 6

**Table 5.4 Source of HIV/AIDS by Investment/Acreage size (count and column %)**

Source of HIV	Undisclosed	Tiny	Small	Medium	Large	Total
Oral Communication	0 .0	12 3.0	5 1.8	1 .5	2 1.6	20 1.9
Physical touch	1 3.7	30 7.4	13 4.6	7 3.2	9 7.1	60 5.7
Sharing of towel	1 3.7	26 6.5	12 4.3	8 3.7	5 3.9	52 4.9
Using same toilet	1 3.7	20 5.0	15 5.3	7 3.2	3 2.4	46 4.3
Eating together	1 3.7	27 6.7	13 4.6	3 1.4	1 .8	45 4.3
Risky/unprotected sexual intercourse	27 100.0	383 95.0	255 90.4	199 90.9	124 97.6	988 93.4
Mother to child	22 81.5	220 54.6	180 63.8	148 67.6	94 74.0	664 62.8
Sharing needle for injectable drugs	25 92.6	325 80.6	224 79.4	181 82.6	112 88.2	867 81.9
Blood transfusion	26 96.3	328 81.4	244 86.5	198 90.4	114 89.8	910 86.0
From dirt	1 3.7	20 5.0	7 2.5	5 2.3	1 .8	34 3.2
Social kissing	0 .0	43 10.7	27 9.6	11 5.0	11 8.7	92 8.7
Sharing of telephone/computer	0 .0	7 1.7	4 1.4	2 .9	4 3.1	17 1.6
Sharing of blades/razors	13 48.1	197 48.9	141 50.0	127 58.0	77 60.6	555 52.5
Others	2 7.4	4 1.0	3 1.1	3 1.4	3 2.4	15 1.4
Don't know	0 .0	8 2.0	1 .4	2 .9	0 .0	11 1.0
No Answer	0 .0	1 .2	2 .7	2 .9	0 .0	5 .5
Column Total	27 2.6	403 38.1	282 26.7	219 20.7	127 12.0	1058 100.0

## Annexure 7

**Table 5.16 Employer's Perception in the possible reaction of coworkers toward HIV affected staff: Sectoral distribution (Count and Column %)**

Sectors	Will not bother	Will Protest	Will refuse to work	Will neglect /avoid	Will support	No answer	No idea	Row Total
Manufacturing	47 28.7	121 31.3	85 33.2	71 27.6	33 24.1	5 22.7	19 28.8	303 28.6
Plantation	9 5.5	20 5.2	22 8.6	18 7.0	8 5.8	2 9.1	8 12.1	75 7.1
Fishing	0 .0	7 1.8	6 2.3	10 3.9	5 3.6	2 9.1	2 3.0	25 2.4
Mining & Quarrying	5 3.0	6 1.6	6 2.3	7 2.7	4 2.9	0 .0	0 .0	25 2.4
Construction	2 1.2	10 2.6	6 2.3	6 2.3	4 2.9	0 .0	2 3.0	26 2.5
Trade & Commerce	69 42.1	141 36.5	94 36.7	91 35.4	48 35.0	10 45.5	21 31.8	388 36.7
Hotels & Restaurants	8 4.9	25 6.5	15 5.9	24 9.3	13 9.5	3 13.6	6 9.1	76 7.2
Transport	7 4.3	29 7.5	10 3.9	12 4.7	12 8.8	0 .0	2 3.0	57 5.4
IT Industry	8 4.9	6 1.6	0 .0	2 .8	5 3.6	0 .0	2 3.0	22 2.1
Finance & Real Estate	9 5.5	21 5.4	12 4.7	16 6.2	5 3.6	0 .0	4 6.1	61 5.8
Column Total	164 15.5	386 36.5	256 24.2	257 24.3	137 12.9	22 2.1	66 6.2	1058 100.0