



# HIV/AIDS

## Implications for Poverty Reduction



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# Introduction



HIV/AIDS is having a disastrous impact on the social and economic development of countries most affected by the epidemic. In much of Africa and other affected regions, this epidemic will prove to be the biggest single obstacle to reaching national poverty reduction targets and the development goals agreed on at the United Nations Millennium Summit.

The challenge is immense: How do countries reduce the proportion of people living in poverty when up to a quarter of households are decimated by AIDS? How do countries deliver on policies aimed at equity in access to economic opportunities and social services when AIDS widens economic differentials and undermines service delivery? How do countries deliver on promises to improve quality of life for coming generations when 40 million children will grow up orphaned by AIDS? How does a country like South Africa deliver on its goal of being a regional engine of growth with over 4 million HIV-positive people and the fastest growing infection rate in the world?

The devastation caused by HIV/AIDS is unique because it is depriving families, communities and entire nations of their young and most productive people. The epidemic is deepening poverty, reversing human development achievements, worsening gender inequalities, eroding the ability of governments to maintain essential services, reducing labour productivity and supply, and putting a brake on economic growth. These worsening conditions in turn make people and households even more at risk of, or vulnerable to, the epidemic, and sabotages global and national efforts to improve access to treatment and care. This cycle must be broken to ensure a sustainable solution to the HIV/AIDS crisis.

The response to HIV/AIDS so far has focused, rightly so, on the challenge of containing the epidemic and preventing new infections through advocacy, information and education campaigns, behaviour change communication, condom distribution, programmes targeting groups that are particularly vulnerable to infection, and other key interventions. The other part of the response is focusing on treatment and care for people living with HIV and AIDS — efforts that are expected to intensify as new treatments become more accessible and affordable. Both prevention and treatment are top priorities in not only saving lives and reducing human suffering, but also in limiting the future impact on human development and poverty reduction efforts.

**TABLE 1. SELECTED UN MILLENNIUM DECLARATION GOALS AND THE EFFECT OF HIV/AIDS**

MILLENNIUM DEVELOPMENT GOALS	EFFECT OF HIV/AIDS	IMPACT OF AIDS ON PROGRESS TOWARDS THE DECLARATION GOALS	STEPS TOWARDS PROTECTING THE DECLARATION GOALS
<b>Reduce income poverty:</b> Halve by 2015 the share of the world's people whose income is less than one dollar a day.	AIDS increases consumption needs and depletes household assets. Labour losses reduce income. <i>Can push household incomes down by 80%</i> . Increases household poverty. Weakens public infrastructures needed to reduce poverty.	Will slow or reverse progress towards the goal, least visibly at global and national level, most evidently at community and household level.	Demands investment in essential services to protect household consumption, support household production and protect social development and employment opportunities for orphans.
<b>Reduce hunger:</b> Reduce the proportion of people who suffer from hunger.	The poverty impacts may be intergenerational. Illness, reduced incomes, lower productivity of subsistence agriculture and crop shifts increase food insecurity, especially for women and children. <i>Food consumption in affected households falls by 15-30%</i> . Quality of diet important for improved survival, but more difficult to secure due to illness.	Survival with HIV makes this a critical goal, while AIDS makes it more difficult to achieve due to reduced food availability, access, intake and absorption.	Demands household inputs to ensure food production and access, and measures to meet the dietary needs of affected people, especially women and children.
<b>Increase access to safe water:</b> By 2015 halve the proportion of people who are unable to reach or afford safe drinking water.	Illness, increased labour demands for caring and lost labour reduces time for collecting water, especially for women. Human resource losses and costs in water supply services affect delivery and increase the cost of services to households.	Loss in household resources and labour time make easy access to safe water critical. The epidemic will slow or reverse progress towards this goal.	Investments needed to secure and expand delivery systems, protect household access despite cost increases, and ensure less time-consuming access to safe water.
<b>Universal primary education:</b> By 2015, children, boys and girls, able to complete a full course of primary schooling.	Education supply threatened by teacher absenteeism and deaths. Children from households facing lost income and demands for caring fall out of school. Households and schools face increased stress. <i>Can lead to 20-40% reductions in primary school enrolment</i> . Education, especially for girls, is critical in preventing infection and delaying onset of sex.	In the worst affected countries, education quality and enrolment, especially among the most vulnerable groups, have already been reduced.	Demands investments and mechanisms to secure teacher and resource inputs to education, and to ensure that children, especially female children, have access to and attend school.
<b>Improve child health:</b> Reduce under-five child mortality by two-thirds of its current rates by 2015.	Infant and child mortality will continue to increase for the next decade, and possibly longer.	Without action the target will not be met and in some countries there will be a deterioration over the period.	Increased access to ARV treatment to reduce mother to child transmission and reduce child infection and AIDS-related mortality.
<b>Achieve gender equality:</b> Girls and boys to have equal access to all levels of education.	Girl children are more likely to be kept out of school to provide care or when resources are limited. Women take on greater burdens of caring and face greater economic insecurity when wage earners fall ill. While gender equity (social and economic) is a critical factor in reducing risk, AIDS exacerbates burdens on women and gender inequalities.	Gender inequalities will not be reduced without targeted interventions that take account of the effects of AIDS. AIDS can give greater motivation to women and society at large to reduce such inequalities.	Interventions need to confront social pressures for inequity, provide access to prevention services, deal with the burdens shifted to women by the epidemic and protect female access to services, assets and incomes.
<b>Improve lives of slum dwellers:</b> By 2020, achieve a significant improvement in the lives of at least 100 million slum dwellers as per "Cities Without Slums" initiative.	AIDS reduces ability to afford even the most basic housing by the poor. It pushes new households into poverty and reduces service delivery by governments.	AIDS-related human resource and income losses can reduce capacity in support services, household savings and divert household and sectoral assets away from long term investments (like housing) into short term needs.	Demands measures to stimulate long-term savings, make housing finance accessible to poor communities, and secure housing tenure in households that have lost wage earners, particularly women. Achieving goal reduces risk environment for HIV and provides security for affected households.

However, despite intensifying efforts focused on prevention and care, the epidemic continues to spread unabatedly, and as people infected by HIV become ill and die, its devastating impact is now being felt in the worst affected countries. Assuming that life-prolonging

treatment will not be universally available in poor countries 'overnight', death rates from AIDS will continue to soar before leveling off. Recent estimates from the UN Population Division show that the population of the 45 most affected countries will be

**TABLE 2. COUNTRIES WORST AFFECTED BY HIV/AIDS****HIV/AIDS ESTIMATES IN COUNTRIES WITH HIV PREVALENCE RATES > 4% OF ADULT POPULATION, END 1999**

Country	Adult rate (%)	Adults and children	Adults (15-49)	Orphans cumulative
1. Botswana	35.80	290,000	280,000	66,000
2. Swaziland	25.25	130,000	120,000	12,000
3. Zimbabwe	25.06	1,500,000	1,400,000	900,000
4. Lesotho	23.57	240,000	240,000	35,000
5. Zambia	19.95	870,000	830,000	650,000
6. South Africa	19.94	4,200,000	4,100,000	420,000
7. Namibia	19.54	160,000	150,000	67,000
8. Malawi	15.96	800,000	760,000	390,000
9. Kenya	13.95	2,100,000	2,000,000	730,000
10. Central African Republic	13.84	240,000	230,000	99,000
11. Mozambique	13.22	1,200,000	1,100,000	310,000
12. Djibouti	11.75	37,000	35,000	7,200
13. Burundi	11.32	360,000	340,000	230,000
14. Rwanda	11.21	400,000	370,000	270,000
15. Cote d'Ivoire	10.76	760,000	730,000	420,000
16. Ethiopia	10.63	3,000,000	2,900,000	1,200,000
17. Uganda	8.30	820,000	770,000	1,700,000
18. United Rep. of Tanzania	8.09	1,300,000	1,200,000	1,100,000
19. Cameroon	7.73	540,000	520,000	270,000
20. Burkina Faso	6.44	350,000	330,000	320,000
21. Congo	6.43	86,000	82,000	53,000
22. Togo	5.98	130,000	120,000	95,000
23. Haiti	5.17	210,000	200,000	74,000
24. Dem. Republic of Congo	5.07	1,100,000	1,100,000	680,000
25. Nigeria	5.06	2,700,000	2,600,000	1,400,000
26. Gabon	4.16	23,000	22,000	8,600
27. Bahamas	4.13	6,900	6,800	970
28. Cambodia	4.04	220,000	210,000	13,000

Source: UNAIDS, 2000.

97 million smaller in 2015 than it would have been in the absence of HIV/AIDS. Most of this loss is due to sharp increases in mortality among young adults.

In the absence of national and global action to mitigate the developmental impact of HIV/AIDS, households, communities and civil society organizations will continue to bear the brunt of this tragic disaster. They are at the front lines of coping with the impact of HIV/AIDS, responding directly to the needs of people and often working with little government support. Communities are mobilizing themselves, showing great resilience and solidarity, despite their vulnerability to external shocks such as premature death of their most productive members.

The response to HIV/AIDS has tended to ignore the bigger picture of the implications for development and poverty reduction. Research has been undertaken to study the impact of the epidemic, but very little has been done about it. Discussions on the implications of HIV/AIDS among development experts and policy makers has been extremely limited, and both national and global development targets and goals have been formulated without taking into account the added challenges resulting from sharp increases in AIDS-related adult mortality rates.

With the same inevitability as the cyclonic and heavy rains which caused catastrophic floods in Mozambique twice in the last 18 months, with widespread devastation and loss of life, the current HIV prevalence forewarns an AIDS epidemic that is only beginning in many countries. The scale and scope of this epidemic over the next decade can be broadly predicted, planned for and mitigated. However, like people living on the riverbanks, we seem unable or unwilling to take action on the flood until we are knee-deep in water. This is not helped by the denial and the chronic, slow-moving and dispersed nature of both the epidemic and its impacts. It takes significant leadership to plan ahead, sometimes ahead of public perceptions, to deal with AIDS, and in so doing to divert resources from other more apparent problems.

Yet taking meaningful steps towards mitigation demands visionary leadership armed with information on the scope and nature of the epidemic, its impacts and on options for responding. Creative, albeit scattered, individual, community and national efforts provide examples of good practice. The time is overdue to apply these more widely in those areas where we **must** make a difference, put in place plans to achieve this, and back them with resources. ■

# The scope of this paper



The HIV/AIDS epidemic needs to be tackled on three fronts: (i) reducing the number of new infections and reversing the spread of the epidemic; (ii) progressively expanding access to care and treatment for people living with HIV and AIDS, and (iii) mitigating the impact of the epidemic on social and economic development by intensifying national poverty reduction efforts and providing support for those particularly affected (see box 1).

The purpose of this policy paper is to zoom in on the third component of the response to HIV/AIDS: counteracting the developmental impact of the epidemic. Firstly, the paper describes the devastating and multifaceted socio-economic impact of HIV/AIDS, well beyond the tragedy of illness and death. Secondly, it identifies five priorities for action in coping with this impact:

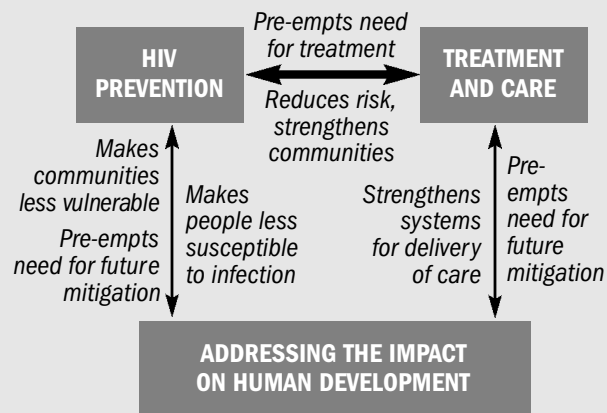
1. Preventing the collapse of essential public services,
2. Intensifying and adapting poverty reduction efforts,
3. Protecting educational achievements,
4. Mitigating the impact on labour productivity and supply, and
5. Promoting opportunities for women who carry the brunt of the epidemic. ■

## BOX 1. RESPONSE TO HIV/AIDS

**The response to HIV/AIDS includes three essential components:**

- prevention of new infection,
- treatment and care of people living with HIV and AIDS, and
- mitigation of current and future social and economic impacts of the epidemic.

**There is a virtuous circle** (pictured at right).



**Successful HIV prevention pre-empts the need for future treatment and impact mitigation; effective treatment reduces risk as well as impact, while mitigating impact makes individuals and communities less susceptible to risk. An effective response to HIV/AIDS must focus on all three areas of intervention, in the context of a broader development agenda, forming a virtuous circle that will produce real and sustainable results.**

# A devastating and multifaceted impact

## Soaring adult and child mortality

AIDS-related mortality is leading to plummeting life expectancy and climbing infant and child mortality rates, with life expectancy at birth falling to less than 1950's levels in highly affected countries.<sup>1</sup> AIDS has become the major cause of adult deaths in many African and Asian countries. AIDS now accounts for a quarter of all deaths in Sub-Saharan Africa, compared to malaria that now accounts for less than one tenth. Figures 1 and 2 (see following page) show reduced life expectancy and increased child mortality in 2000 and 2010 as a result of HIV/AIDS.

Increased deaths, fewer births and reduced fertility will slow or reverse population growth. Sub-Saharan Africa will have 71 million fewer people by 2010 because of AIDS, and populations may start contracting by 2003 in Botswana, South Africa and Zimbabwe. The increase in widows, widowers and orphans will increase dependency. The number of orphans will rise from two to up to ten in every hundred children. By 2010, about 40 million children worldwide will have been orphaned by the epidemic.

### BOX 2. GLOBAL ESTIMATES, END 2000

People living with HIV and AIDS	36.1 million
New HIV infections in 2000	5.3 million
Deaths due to HIV/AIDS in 2000	3.0 million
Cumulative number of deaths due to HIV/AIDS since the beginning of epidemic	21.8 million
Cumulative number of HIV infections	57.9 million

Source: UNAIDS, 2000

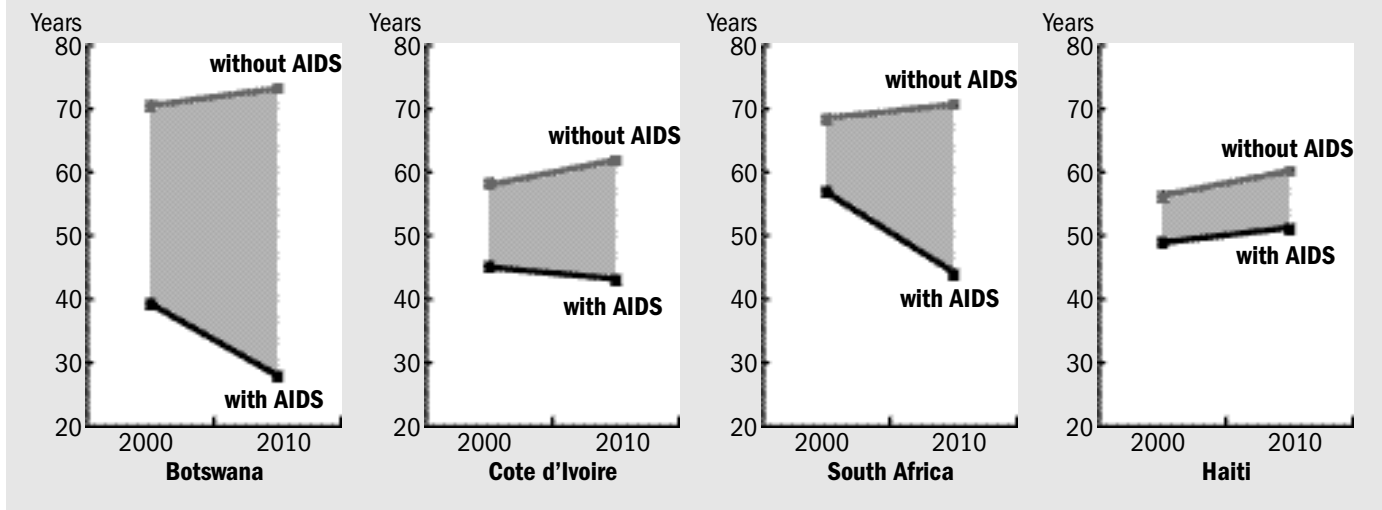
## Health services over-stretched

The epidemic has increased the burden of disease up to sevenfold in highly affected African countries, greatly increasing demand for public health care services, crowding out other conditions and doubling bed occupancy rates. Responding to AIDS distorts referral patterns, as demands for quality of care and anonymity lead people to bypass primary care facilities for more expensive tertiary services. While this is more pronounced in insured, urban populations,

1. A major problem is the lack of hard data on these real changes. Most countries base their demographic data on censuses and household surveys. Censuses are only taken every decade, and have thus been slow to pick up recent increases in mortality and do not show what is to come. In order to predict existing and future impact we have to rely on models that show demographic changes.

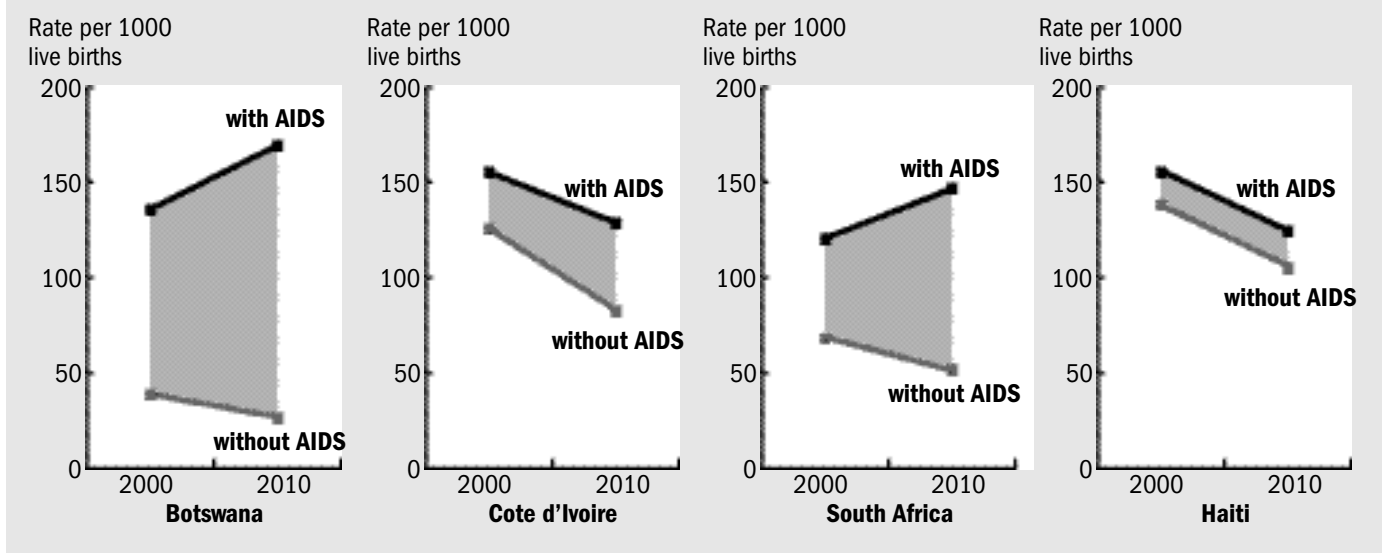


**FIGURE 1. LIFE EXPECTANCY 2000 AND 2010 (SELECTED COUNTRIES)**



Source: US Bureau of the Census, 2000

**FIGURE 2. UNDER FIVE CHILD MORTALITY 2000 AND 2010 (SELECTED COUNTRIES)**



Source: US Bureau of the Census, 2000

it significantly increases costs of care to government, and widens inequity in health expenditure.

In Malawi and Zambia, for example, five- to six-fold increases in health worker illness and death rates have reduced personnel and increased stress, overwork and fear for personal safety in remaining staff. The costs of safety procedures and of lost time and labour has made health care scarcer and more expensive, leaving households to take on a significant burden. While community care is important and complementary to health service management of AIDS, unsupported and poorly managed household care, including that given by children, increases

infection risks for the care giver, compromises quality and adds significant burdens to already stressed households.

The annual direct medical costs of AIDS (excluding antiretroviral therapy (ARV)) have been estimated at about US\$30 per capita, at a time when overall public health spending is less than US\$10 for most African countries. Per capita annual funding in Africa for HIV/AIDS was estimated to range from only \$0.03 (Nigeria) to \$1.81 (Uganda). Inadequate resources for health services, specifically for AIDS, have put unbearable pressures on health systems, eroding quality of care.

Access to affordable treatment and adequate health services has become one of the most important differentiating factors between HIV-related survival in rich and poor countries and communities. As drug prices are reduced, health service and household constraints will become more critical. Providing ARVs demands counseling and testing services to identify clients, laboratory services to identify and monitor the disease stage and progress in treatment and sustained drug access. In many countries these conditions do not exist, and use of public funds to provide ARVs for those for whom such services do exist would inequitably shift health resources away from the poor. Access to ARVs must therefore be improved **together** with the delivery of adequate, reliable health services for the poor. As yet, such basic services are not consistently provided across the board, even for the treatment of opportunistic infections, such as pneumonia, oral thrush or TB.

## Education systems collapsing

Education is crucial to national development, income growth and labour productivity. It consumes 10 to 30% of total public expenditure and is usually the largest government employer. AIDS impacts on both the availability and use of schooling. Those who survive to school age, may have to care for or work in lieu of sick parents. They may not be able to afford school fees and books, lack parental care, and face hunger and emotional distress. In the Central African Republic and Swaziland, school enrolment is reported to have fallen by 20% to 36% due to AIDS and orphanhood, with girl children most affected. In Guatemala, studies have shown that more than a third of children orphaned by HIV/AIDS drop out of school.

Even for those who do get to school, AIDS undermines their learning prospects. In some countries, tenfold increases in teacher mortality and absence due to ill health have reduced teaching time and quality, each loss rippling to 20 to 50 children. UNICEF estimates that 860,000 children in Africa have already lost their teachers to HIV/AIDS. In Botswana, death rates among primary school teachers rose from 0.7 per 1000 in 1994 to 7.1 in 1999.

These losses are not easily replaced. In Zambia and South Africa, for example, the entire output of teacher training colleges will not be enough to replace teachers lost to AIDS. Nor will it be easy to

replace losses in education administrators and planners. Added to this, the private sector will poach from the education system to replace the skills they have lost. Given the crucial role education plays in informing and promoting positive responses to HIV/AIDS in young people, these losses generate a vicious cycle of increased risk of HIV.

## Economic growth reduced

HIV/AIDS leads to falling labour quality and supply, more frequent and longer periods of absenteeism, losses in skills and experience, resulting in shifts towards a younger, less experienced workforce and subsequent production losses. These impacts intensify existing skills shortages and increase costs of training and benefits. They are felt throughout the economy, from the macro-level to the household.

HIV/AIDS is already putting a brake on economic growth in the worst affected countries through diversion of investment, deficit-creating pressures on public resources, and loss of adult labour and productivity. It is estimated that in the 1990s AIDS reduced Africa's per capita annual growth by 0.8 percent. Models suggest that in the worst affected countries 1–2 percentage points will be shaved off per capita growth in the coming years. This means that after two decades, many economies will be about 20–40 percent smaller than they would have been in the absence of AIDS.

The private sector too will be affected by HIV/AIDS. The cost per worker per year of the disease has been estimated at between US\$20 and US\$200. These costs are mainly due to lost work time and benefits. A recent study in South Africa shows the cost of AIDS for one company will be 7.2% of total salary. Large private concerns may base investment decisions on their perception of AIDS and its consequences. The potential impact of AIDS on customer purchasing power in Southern Africa led one retail firm, for example, to diversify geographically and open stores in Poland and the Czech Republic. Anecdotal evidence indicates that the consequences may be even more significant for small enterprises. They do not have the human or financial resources to weather the impact and may, as a result, collapse. Unfortunately, however, the impact of AIDS on the private sector remains poorly mapped and recognized.

### BOX 3. AIDS STRIPPING HOUSEHOLD ASSETS

In Rakai, Uganda, four percent of households with an adult death disposed of the bicycle and radio they had previously owned. In Kagera, Uganda, while households without adult deaths were accumulating assets, household *with* deaths were not. Nearly half of households (41%) in Chiang Mai, Thailand disposed of land after an adult death, and in Zimbabwe households disposed of 'cattle, goats, furniture, clothes, televisions, poultry and wardrobes'. Many families are forced to use their savings or borrow money. This depletion of assets during illness and for funerals undermines the family's future survival. For survival of rural and poor urban households it is crucial that they not dispose of the productive assets necessary to recover and rebuild. While households can sell a radio and survive, the sale of cattle reduces their ability to sustain a livelihood.

Source: World Bank, 1997; Matangadura, 2000.

## Poverty deepening

The effect of HIV/AIDS on households is profound, but neither appreciated, nor generally measured. Lost income, and the diversion of assets to caring for those affected, impoverishes families. AIDS causes labour to be lost or diverted from production to care. There is evidence of falling production in the agricultural sector. In Ethiopia, labour losses reduced time spent on agriculture from 33.6 hours per week for non AIDS-affected households to between 11.6 to 16.4 hours for those affected by AIDS. In Zimbabwe, while adult deaths from all causes led to small farm maize outputs to fall by 45%, when AIDS was the cause of death this increased to 61%.

AIDS generates new poverty as people lose housing tenure and employment. In Zambia, AIDS led to a rapid transition from relative wealth to relative poverty in many households. In two thirds of families where the father died, monthly disposable income fell by more than 80 percent. In Botswana, it was estimated in 2000 that the number of households living below the poverty line would rise by up to 8 percent over the next ten years due to AIDS, while household per capita income would fall by up to 10 percent. The poor are hardest hit: While on average every two income earners would have one extra dependent, the poorest households, those in the lowest quartile of per capita household income, would have four additional dependents as a result of AIDS, and their average incomes would fall by between 10 and 15 percent.

Household incomes fall due to loss of wage earners and rising spending, particularly on medical care and

funerals. Households are reported to spend up to 50 percent more on funerals than on medical care in both Thailand and Tanzania. Not only do outputs and household incomes decline, but family members, and particularly women, have to make hard choices on the allocation of their time between production, meeting household needs, child care and care of the sick.

Poverty resulting from AIDS interacts with other dimensions of poverty to generate a vicious downward cycle. Sub-Saharan Africa is deeply affected by this trend, with economic contraction in the past 15 years and three quarters of the continent's population surviving on less than \$2 per day. Most households lack the assets to mitigate the impacts of AIDS, including absorbing a projected 40 million orphans by 2010. These households are generally found in communities that have experienced sharp declines in public service funding and have less means to privately purchase essential services. Families may cope by sale of assets — land, bicycles, radios, cattle and other goods. If they dispose of productive assets such as cattle or land, they reduce the possibility that they will recover and rebuild. Under these conditions, AIDS not only increases poverty, but widens the gap between rich and poor (box 3).

The loss of income and assets, social marginalisation and disruption of social support networks undermine outreach of HIV interventions into affected communities. Social exclusion makes HIV/AIDS-related programmes less accessible to poor households, and information messages irrelevant to their lives, and reduces incentives for behaviour change. Risk reduction strategies need to effectively replace high risk survival mechanisms, and be backed by a supportive environment to be viable.

## Food security threatened

HIV/AIDS reduces:

- food availability (through falling production, loss of family labour, land and other resources; loss of livestock assets and implements).
- food access (through declining income for food purchases).
- the stability and quality of food supplies (through shifts to less labour intensive production).

Illness and death can disrupt the farming cycle, and reduce the ability of households to produce and buy food. Sale of assets and weakened social networks leave households vulnerable to production losses.

With lost labour, nutritional leafy crops and fruits are replaced by starchy root crops, while livestock losses reduce both manure and food supplies such as milk, eggs and meat. These losses have been found to reduce food consumption by up to 32%.

In Uganda in the late 1980s, people reduced their work on coffee which required pruning and marketing in favour of their staple, bananas. Then they cut down on the bananas and vegetables and concentrated on easily cultivated, easily stored and starchy cassava. In Kagera district, Tanzania, spending on food and food consumption declined in poor households by 32 and 15% respectively, with a move towards less varied and nutritious yams and cassava diets. Loss of livestock implies loss of manure for the farm and loss of products such as milk, meat and eggs for the family.

Falling supplies and shifts to lower quality foods are associated with chronic food insecurity, high levels of protein-energy malnutrition and micro-nutrient deficiencies, such as of iron, zinc and vitamins. This further compromises immune systems despite the fact that HIV-infected individuals have 50% higher protein and 15% higher energy requirements than normal. Diets rich in protein, energy, and micronutrients help in resisting opportunistic infections and prolong survival.

## Women severely affected

Worldwide, the HIV risk for women is rising. Younger women are particularly at risk, biologically and socially. Women are more vulnerable to HIV/AIDS because they have less secure employment, lower incomes, less access to formal social security, less entitlement to assets and savings, and little power to negotiate sex. They are more likely to be poorly educated and have uncertain access to land, credit and education. Their heavy work loads undermine the uptake of technologies and services. Women-headed households are poorer and have less control over productive resources.

HIV/AIDS worsens pre-existing gender inequities. For married women, inheritance patterns, economic subordination, and the absence of restraint on the number of sexual partners a man may have, all weaken marriage as a protective institution against HIV transmission. Many women do not have marriage certificates or wills to protect their rights to property, and have great difficulty in securing those rights that

do exist in legal and social systems. For poor and under-employed women, 'sexual networking' provides an economic strategy to sustain their families in the face of growing economic uncertainty and absence

### BOX 4. AIDS INCREASES THE BURDEN ON WOMEN TO SECURE HOUSEHOLD FOOD NEEDS

**The impact of AIDS on food security particularly affects women and children. Women contribute to over 50% of food production in Sub-Saharan Africa and Asia, and typically carry out the labour-intensive elements of farming most affected by AIDS (watering, planting, fertilizing, weeding, harvesting, marketing). Women are responsible for subsistence production, food storage, maintenance, preparation and water collection. They are, therefore, the vital link between production and food security. When production declines, women are placed under increased stress to try to sustain food security. The responses to such stresses, such as sale of land and assets to meet medical costs, taking girl children out of school, increasing workloads and reduction of off-farm activities, leave women particularly disadvantaged, and intensify female poverty.**

*Source: Muchopa and Mutangadura, 1998*

of viable alternatives. While these dimensions of gender inequity are recognised to play a role in sustaining the epidemic, many responses to AIDS do not adequately address unequal power relations that increase women's vulnerability.

## Social cohesion disintegrating

In every country, stability and progress are dependent on social cohesion. People need to believe in the rule of law; that governments will look out for their interests; and that they and their children can look forward to improving standards of living. They also need to participate in social networks within their communities and local governments to meet their needs and to interact with state and private services. This cohesion creates a climate that is conducive to investment, at household, community, national and international levels.

The loss in lives, skills and leadership, disruption of social networks and increased pre-occupation with household survival caused by AIDS undermine this cohesion. So too does the infringement of human rights through discrimination against people with HIV/AIDS, the apathy that grows in the absence of political leadership on AIDS, and the isolation of affected people and groups. Where public social services are contracting, isolated coping strategies make households further stressed.

A devastating and multi-faceted impact

11

HIV/AIDS: IMPLICATIONS FOR POVERTY REDUCTION

## **BOX 5. ORPHANS ARE VULNERABLE TO RECRUITMENT INTO CRIME**

**The boom in South Africa's orphan population during the next decade as the AIDS epidemic takes its toll is predicted to increase the risk that orphans may be recruited into crime, or be easier targets of criminal activity, unless significant intervention is put in place. "Growing up without parents, and badly supervised by relatives and welfare organisations, this growing pool of orphans will be at greater than average risk to engage in criminal activity" (Schönteich,1999). "Crime will increase because of the disintegration of the fabric of our society. It will be made worse by the lack of guidance, care and support for HIV positive people, including children. Children orphaned by AIDS will have no role models in the future and they will resort to crime to survive". (MacKay, 1999).These fears are reinforced by findings on the impact of family life on criminal activity. A series of interviews undertaken with young South African men serving jail sentences or involved in crime found that most were abandoned, kicked out of their homes, or rejected by those they lived with. They felt unloved. (Sergal, et.al., 1999).**

Increased political alienation and reduced social networking may, at worst, lead to social breakdown, conflict, increased crime and civil strife. AIDS orphans are a vulnerable group, and may be recruited into military activities or into crime with promises of food, alcohol and drugs, as well as need for 'family'. In chilling words, a recent CIA report on the threat of HIV/AIDS to national security concluded that AIDS "...will produce a huge and impoverished orphan cohort unable to cope and vulnerable to exploitation and radicalization."

In addition, the ability of the state to ensure law and order is greatly compromised, as bodies charged with maintaining stability, such as the police, army and other uniformed forces, are especially devastated by

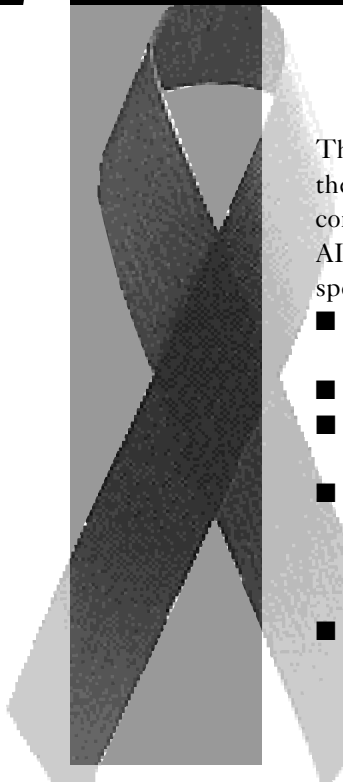
the epidemic. Although official data are hard to come by, there are suggestions that HIV prevalence in the army and other uniformed forces is twice that in the general population.

Essential services (e.g. in health, education, welfare, security) are deprived of skills at a time when these are most needed, especially by poor households. For the poorest, the impact is profound: Traditional safety nets are collapsing at a time when state support systems, rather than replacing these, are also collapsing. The mismatch between service provision and need weakens the interaction between citizens and the state and reduces social cohesion. Citizens become less willing to participate in state facilitated processes and less willing or able to pay for public services, such as health facilities.

However, HIV/AIDS, in all its tragedy, can also have a positive influence on social cohesion as people and communities join forces to face this challenge. The epidemic has mobilized community-based support networks, increased demands for improved relationships between communities and service providers, stimulated a growth in social rights groups advocating for treatment access, access to employment and other resources. These organized responses provide an important vehicle for dealing with AIDS and need to be fostered. In Uganda, for example, a national mobilisation to destigmatise the disease has created various social networks and organisations that have galvanised people around the issue of AIDS. Prevention and mitigation programmes, as well as leadership and openness on the epidemic reinforced this social cohesion. The different paths that countries follow are a matter of social choice, but leadership plays a crucial role in creating the environment in which this choice is made. ■

# IV

## Priorities for action: Mitigating the impact of AIDS



The discussion of social and economic impact highlights the growing gap between the goals that governments have committed themselves to and the devastating reality of AIDS. It is a gap that can only be closed by decisive and specific action to:

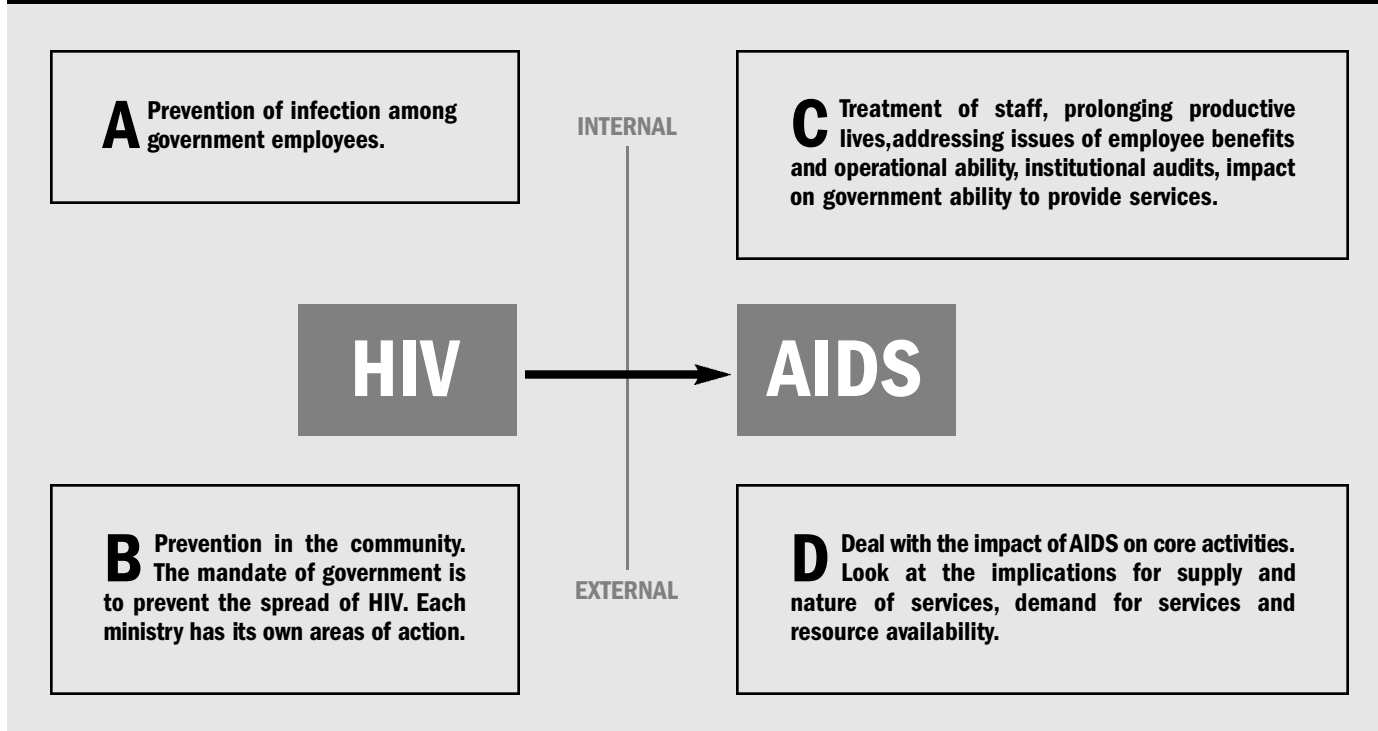
- Implement multi-sectoral interventions to reduce HIV infections.
- Progressively expand access to new HIV treatments.
- Recognise, map and plan for the social and economic impact of AIDS.
- Intensify and adjust interventions to reduce poverty, inequality, social exclusion and improve access to public services, both to mitigate impact and to improve the uptake of HIV-related interventions.
- Build an institutional framework for implementing strategies that strengthen social cohesion and networking, as well as government leadership and ability to deliver essential services.

As noted in the first section, policies and strategies aimed at mitigation form part of the virtuous circle that includes HIV prevention as well as treatment and care, with their positive effects on each other. The emphasis on which of the three components merits more attention relates to the level, stage and impact of the epidemic. In societies where the prevalence is low, prevention must be the priority. In others with high prevalence, and particularly where the epidemic is shifting from HIV infection to increasing levels of AIDS cases, prevention and mitigation go hand in hand. Treatment will increasingly play a role in both settings as access is improved through reducing drug prices and strengthening health systems. In the worst affected countries in 2001, the massive and unacceptable extent to which AIDS has impacted households and communities makes mitigation essential.

The extent and depth of impact described earlier imply that dealing with AIDS, particularly in the worst affected countries, cannot be a matter of 'adding on' components to existing policies. Neither can it be ad hoc in implementation. Impact mitigation must be part and parcel of national development plans and poverty reduction strategies.

Deeper policy review and dialogue is urgently needed to deal with the human development situation we now face with AIDS. This sections aims at contributing to this dialogue and proposes five priorities for action: (i) preventing the collapse of essential public services, (ii) adapting poverty reduction efforts to

**FIGURE 3. IMPACTS OF AND RESPONSES TO HIV/AIDS IN GOVERNMENT**



the reality of HIV/AIDS, (iii) protecting educational achievements, (iv) mitigating the impact on labour productivity and supply, and (v) promoting opportunities for women burdened with the consequences of HIV/AIDS.

## Action: Preventing the collapse of essential public services

Countries ravaged by the HIV/AIDS epidemic are facing a double jeopardy. On the one hand, their capacity for planning and implementing development strategies is greatly compromised by the loss of human capital and diversion of scarce resources due to HIV/AIDS. On the other hand, strong national capacity is becoming even more crucial as countries face the formidable challenge posed by the epidemic. Such capacity is not only essential in the health sector for coping with the added disease burden and delivering new treatments, but in all sectors of government and civil society that must be mobilized around broad-based prevention and social mobilization efforts to reverse the epidemic.

Essential services — such as health and education — make a critical difference to the ability of households

and communities to deal with the epidemic, and to its impact on development. While the cost of providing these services may be significant, the long term development costs of **not** providing them is even greater. For poor communities, these services are largely provided — or jointly provided — by the state. However, there is still little evidence of adjustments to public sector institutions to take account of AIDS in policies, strategies and operations. This calls for **significant** increased commitment from government to implement changes to ensure sustainability and relevance of essential services, both as provider and as employer.

The disease dynamic from HIV to AIDS shown in Figure 3 (the horizontal axis in the figure) provides a framework for responses to external and internal impact (the vertical axis).

- Government responses to internal impacts of HIV (Box A) include prevention of infection among the staff, including prevention measures outlined earlier. Many governments have initiated prevention programmes and identified focal persons in ministries to ensure that these are implemented. Fewer ministries have reviewed aspects of their operations that put employees at risk of HIV. The government could, for example, not post spouses apart from each other, reduce

postings away from family and cut travel time for mobile workers.

- Government also has a responsibility, beyond its own workers, to its 'clients' (Box B). HIV prevention within communities is an obvious part of government activity, and governments can, on their own or with non-governmental organizations and the private sector, provide services to wider communities. Hence, for example, where public utilities are the major employer in some peri-urban areas, they have used their infrastructure to provide services to wider communities — schools, etc. — within their area. Ministries or departments should also map where their operations generate risk: For example delays at borders due to slow customs and immigration procedures result in truck drivers spending days at border posts. Villages spring up to house, feed and entertain them. Prevention activities include education and condoms for truckers and local women, as well as getting departments in charge of immigration and customs to speed border crossings.
- Government has to deal with the impact of AIDS illness and death among government employees (Box C). In this respect, it can implement options that are used within enterprises, discussed below. Government has some comparative advantages: It is a large employer, and can buffer losses if it adopts adequate in-service and multi-skill strategies, reduce some of the hierarchical constraints to team work, decentralize decision making and build in-service learning. The scale of membership in benefit schemes offers greater possibilities for risk pooling. Governments should, however, make projections of the burden of ill health, turnover and mortality, to ensure that adequate funds are budgeted (within pay-as-you-go schemes) or saved (within partially or fully funded schemes) to meet these burdens. Government as an employer has to deal with features unique to public service — disparities between public and private remuneration which can exacerbate the attrition of personnel, greater demand by poor people on public services and thus significant stress burden for public employees.
- AIDS also impacts on governments' core business (Box D). Some responses need to be inter-sectoral: For example, where skills losses within sectors erode management and planning capacity within ministries, governments can look at

## BOX 6. HOUSING AND AIDS

**There has been an attempt by planners to anticipate the consequences of HIV/AIDS at Nkwazi on the KwaZulu-Natal north coast in South Africa. Instead of scattered box houses on grids of roads, narrow plots face articulated pedestrianised areas, with cars sharing the narrow lanes behind the houses with services. This is an attempt at co-operative housing within tight budgetary constraints. Houses share responsibility for surveillance of the common space, and because plots are narrow, there are more people to provide surveillance. The fact that people are closer together encourages networking to provide assistance to each other. The same architects have proposed building incremental ablution areas which can be improved over time and which will offer facilities at late stage illness including wheelchair access.**

*Source: Harber, 2001*

providing management units that can service across ministries, while also drawing in private sector capacities through partnership and joint venture operations. This concept has already been applied in relation to skills and technology transfer for new investments where local resources may not be adequate.

AIDS will lead to institutional losses across all these dimensions of government function. Commitment to reinvestment in government's ability to provide these essential services requires:

- Re-planning and boosting public resource allocations for essential service provision.
- Supporting increased recruitment and accelerated training of civil servants with mechanisms for retaining those in service (e.g. increasing the retirement age.)
- Ensuring safety and capacity within services to avoid risk, burnout and stress.
- Removing barriers to effective use of services through improved mechanisms for community-service interface and greater involvement of community based groups and networks.
- Ensuring that public resource allocation systems take account of deprivation and that factors such as adult death and household dependency are included in the definition of deprivation.

Effective public policy demands a deeper understanding of the systemic effects of the epidemic and a capacity to plan responses so that they integrate with household, enterprise, sectoral and national programmes. Government needs a stronger institutional capacity to plan and deliver services in a broad manner and create networks of co-operation for sharing scarce resources.



## BOX 7. INTEGRATING AIDS IN DEVELOPMENT PLANS AND POVERTY REDUCTION STRATEGIES

Responses to AIDS it have begun to be integrated into country analyses of human development and into poverty reduction strategy processes, albeit slowly. The 2000 Botswana Human Development Report sets progress 'Towards an AIDS-Free Generation' as its goal, and provides a thorough analysis of the challenges to achieving this and the strategies that must be put in place.

The Kenya Poverty Reduction Strategy Paper (PRSP) includes provision of increased resources targeted to AIDS orphans, child workers, nomadic groups, rural poor and slum dwellers, and development of a curriculum that facilitates transition from non-formal to formal education programmes. It also includes specific interventions to monitor and mitigate the impact of HIV/AIDS on family food security using village level approaches and extension service personnel.

The Burkina Faso Poverty Reduction Strategy Paper estimates the cost of confronting the challenges of HIV/AIDS at about US\$ 25 million annually. These challenges are most noted at household level in increased poverty, dependency and food insecurity, with close to 20% of rural families in Burkina Faso estimated to reduce or abandon their farms because of AIDS. This strategy is conceived within the context of a multisectoral and decentralized government plan to deal with AIDS. The plan involves the participation of civil society through community-based organizations, including People with AIDS organizations. The health and rural sectors, the army and technical ministries, have analyses completed or underway on the impact of the epidemic, and the economic sector has been integrated through large private and public companies. At the local level, districts organize themselves around a decentralized, multi-sectoral AIDS campaign plan. The PRSP aims to strengthen services (medical, condom supply, VCT), information outreach to communities, and the institutional capacities and networking needed to mount responses.

A toolkit for mainstreaming HIV/AIDS programmes into PRSPs has been developed by the UNAIDS Secretariat and the World Bank, available at [www.unaids.org](http://www.unaids.org).

Source: Govt of Botswana (UNDP 2000; [www1.worldbank.org/prsp/](http://www1.worldbank.org/prsp/))

Government planning needs to be backed by consistent generation of new knowledge and relevant evidence. The learning curve on AIDS is global, and real experience on the ground is often a better input to planning than complex modeling predictions. Government mechanisms (in both north and south) for incorporating new evidence into public policy is too slow. Experience with AIDS and agriculture signals a time lag between quantitative "evidence" and policy response that may be as long as twenty years. For example, the first FAO desk study of the impact of HIV/AIDS on agriculture was undertaken in 1988; the first field study was completed in 1994;

but programming in this area still does not take adequate account of the disease.

## Action: Adapting poverty reduction efforts to the reality of HIV/AIDS

The poverty impact of AIDS demands a twin response:

- strengthening HIV prevention, treatment and mitigation within poverty reduction strategies, and
- strengthening implementation of pro-poor policies to reduce the impact of AIDS.

In countries with advanced epidemics, AIDS amplifies existing problems of household poverty to the extent of triggering structural changes and thereby creating new problems. Hence for example, AIDS produces child headed households, a breakdown of informal rural institutions and of social safety nets. This makes wider poverty reduction strategies critical to mitigating the impact of AIDS and to reducing future vulnerability. Poverty reduction strategies need to be backed by pro-poor policies to secure the educational needs of youth and orphans, ensure access to shelter and social services, enhance food security, access to safe water and provide an adequate income security to deal with the consumption needs generated by AIDS.

Pro-poor policies direct resources in a more sustainable manner towards low income communities for these needs, and in so doing reduce their susceptibility and vulnerability to HIV/AIDS. Pro-poor policies:

- focus on the health problems of poor people, and structure health systems to serve and be accessible to poor people.
- protect poor people by limiting the impoverishing effect of health expenditures, particularly through limiting cost recovery.
- protect access to education, especially for female children.
- ensure that services are accountable to the poor.
- provide for safe water, sanitation, food security and other public health inputs to improve living and working environments for the poor.
- provide direct service support to community and household caring activities.
- promote access to credit and employment opportunities.
- promote infrastructure (transport, communications) and social organization in poor communities.

For countries affected by AIDS, sustainable poverty reduction is not easily achieved unless attention is paid in macroeconomic policies to reducing inequities, enhancing access to productive resources for a wider segment of the population, increasing the discretionary budget (by, *inter alia*, reducing the debt burden), providing a considerable improvement in public expenditure on essential services such as health, education and safe water, and strengthening social systems and infrastructures. These are not new issues: AIDS makes them more urgent.

To be effective in addressing the impact of the epidemic on poverty, interventions need to be integrated within relief strategies (whether employment creation, infrastructural development, market access or improving social service coverage). More importantly, such strategies need to deal with the social and economic impact of AIDS on poor households (see box 7).

Programmes to promote basic education need to ensure that orphans are covered, and those aimed at widening access to health services need to target youth and members of households dealing with terminal illness due to AIDS. Strategies that target food security and nutrition should specifically address issues of sustaining food production in AIDS-affected households. In addition, programmes need to take into account the fact that many farmers in areas impacted by AIDS are children or elderly.

Poverty reduction strategies also need to confront the social disruption caused by AIDS, particularly the issues of social exclusion and weakened social networking discussed earlier. There is evidence pointing to the importance, not adequately recognized, of addressing the social dimensions of poverty as part of an overall poverty reduction strategy.

Pro-poor policies strengthen community organisations that have risen to meet the challenge of AIDS, as described earlier. The investment made in strengthening, supporting and working through these networks addresses directly the social exclusion produced by AIDS, and, when genuinely representative and participatory in their operation, can ensure that relief measures and services do reach poor households. Furthermore, governments that perceive the mobilisation of citizens as a positive contribution towards realising social and economic rights, can tap such organisations for the political alliances needed to deal with equity and distributional issues within the economy and for reaching vulnerable households.

## BOX 8. SECURING FOOD PRODUCTION AND ACCESS IN POVERTY RELIEF STRATEGIES

Successful strategies in relation to food security include:

- Labour economising methods for production of staples and promotion of labour saving implements.
- Research into indigenous crops and access to and marketing of improved varieties of relish and other crops that maintain quality of diet.
- Improved food preparation and processing, food storage and storage of seeds.
- Access to small loans, especially for women.
- Introduction of non-chemical soil fertility techniques.
- Promotion of livestock breeds that require limited attention.
- Discouraging norms that deny women their right to inherit livestock.
- Promotion of birth spacing.

To a large extent these strategies imply reorienting pro-poor policies to specifically support the needs of women farmers. This is achieved through labour saving technology, especially for weeding and harvesting, promotion of threshing machines, mills, well pulleys, carts and food processing technologies, as well as through developing labour saving processes such as intercropping to reduce weeding time, zero or minimum tillage, reduced time spent fetching water and labour sharing arrangements. It also means putting in place legal and other measures to secure the inheritance rights of women.

Source: Muchopa and Mutangadura, 1998; FAO, 1995.

## Action: Protecting educational achievements

HIV/AIDS challenges the core of the education system's mission. Huge levels of "wasted investment" in individuals result from the premature death of trained and educated people. Protecting education access safeguards the rights of highly vulnerable groups, particularly female children. Moreover, education helps individuals protect themselves against HIV infection. In Zambia, surveillance data for Lusaka show that the HIV prevalence rate for women aged 15–19 dropped from 27 percent in 1993 to 15 percent in 1998. This decline was greater among those with secondary and higher levels of education than among those who had not proceeded beyond primary level. In other words, the more education, the less HIV. In the absence of a medical vaccine against HIV infection, we have at our disposal a "social vaccine," the vaccine of education.

The quality of education needs to be improved and maintained, notwithstanding the impact of HIV/AIDS. Education services need to be stabilized, so that teachers teach, children enroll and stay in school, managers and personnel, financial and professional

## BOX 9. THE EDUCATION SECTOR RESPONDS

**A 1999 assessment of the impact of AIDS on the education sector in Swaziland drew official attention to the issue and stimulated policy and planning to mitigate impacts. This led to the realisation that providing capacity, information and planning support is critical.**

**The University of Natal is developing an Education Management Systems Manual to provide data and options for response. An 'Education Mobile Task Team' has worked with Ministries of Education in Namibia, Malawi and Zambia, using regional resources to put in place locally devised plans and responses.**

## BOX 10. SUPPORTING ORPHAN EDUCATION THROUGH SURROGATE PARENTS

**The consequences of not caring for children affected by HIV/AIDS will be felt throughout society for generations. Averting this calls for an imaginative response from the public and private sectors working in partnership. One suggestion is to train surrogate parents selected by communities and church groups in conjunction with local authorities. Orphans (and here no distinction should be drawn between AIDS and non-AIDS orphans) will be housed with their surrogate parents, who are paid a small salary for supervision and be provided with sufficient funds to cover food, clothing and incidental expenses. The system could operate through Welfare Ministries, who, with non-governmental organizations, can monitor and support the fostering relationship. The costs in aggregate of implementing such a proposal may be high, but the costs of not doing it – and producing a generation of neglected young men and women – will be even higher. Moreover, it highlights the point that the extra resources required to cope with the AIDS epidemic are not just monetary. The mobilization and organization of human resources are as critical.**

*Source: Whiteside and Sunter, 2000*

systems perform. Creative measures are needed to maintain the number and skills levels of staff and to replace or buffer those ill, absent or deceased. Given that output from formal teacher training is unlikely to meet this demand, more emphasis needs to be given to in-service training, exchange of experience within schools, drawing back to service retired teachers and use of community skills. These approaches can help ensure that classes do not sit unattended, wasting time. This requires planning and management, which itself demands leadership and management skills from headmasters and education officers, support for innovative ideas and 'out-of-the-box' thinking at the highest levels.

Sustaining access to education in affected households calls for measures to reduce the costs of schooling, to reinforce norms that promote child education, and support systems to ensure that vulnerable households

do not depend on child labour for their survival. Public subsidies to schools in poor or heavily affected areas or, more directly to households, can reduce costs. However, interventions need to be comprehensive. There is no point in abolishing school fees but insisting that children wear uniforms and pay for books and stationary. Subsidies cannot be provided for orphans but exclude the impoverished natural children in families that are caring for orphans. There is an argument for geographical targeting of subsidies or targeting of support to schools in affected areas, particularly where the wider community takes on burdens of fostering, social support and home-based care. Financial support also needs to be backed by the social inputs needed for effective schooling, such as using parent-teacher bodies and other community infrastructures to provide motivational information on positive aspects of education, social support to ensure children are not withdrawn from school, and school feeding to support the nutritional and health needs of children. Indeed provision of meals provides an additional incentive for attendance. Orphans need adult mentoring and supervision, through community fostering and from guidance and counselling within schools.

Schools should provide a caring and safe environment. While education protects, the school can be a risk environment if sexual abuse and harassment of children take place, either by other children or by teachers. Policy guidelines and measures are needed to ensure zero tolerance of sexual abuse and ensure that schools are safe places for all students, especially girls and young children. If supply and access to schooling is protected, schools can themselves become a focal point for strengthening the wider community response to AIDS and for providing leadership within the community. Given the current level of dropout in many communities, there is a need to foster convergence and co-operation between in-school and out-of-school programmes, so that schools link to community outreach through institutions such as churches and NGOs, supported by wider private sector and NGO resources.

## Action: Mitigating the impact on labour productivity and supply

The impact of AIDS on production and employment has triggered many programmes that provide 'good practice' models for wider application. These include workplace-based prevention and health promotion, provision of primary health care and voluntary counselling

and testing services. Companies have implemented human resource strategies for widening the base of skills and experience, involving in-service training, team work and buffer labour for areas of bottlenecks. These strategies work better when backed by clear and negotiated industrial relations laws and policies that provide for rights and responsibilities under HIV/AIDS. They need to be backed by benefits systems that take account of increased ill health and mortality, through increased provision for ill health retirement, medical aid, housing mortgage protection, and life insurance benefits.

More recently, encouraged by reductions in ARV drug costs, a number of companies in heavily affected countries have resolved to provide ARVs to workers and, in some cases, their families. These are encouraging signs of widening medical care cover for employees. The argument of the companies is that prolonging their employees' productive lives is cost effective and makes more sense than having to recruit and train new workers. Further, treatment reduces the negative impact of morbidity and mortality on morale and productivity. Such innovations need to be implemented within agreed industrial relations standards and in a manner that sustains investment in prevention.

These enterprise-level strategies are often implemented in a scattered way, usually by companies with greater resources. A wider national and international framework is needed to support production strategies for the small enterprise sector, including securing access to credit, protecting employment and productivity, providing health care coverage and savings for survivor support. Beyond the establishment of a legal framework of rights and duties, incentives and other economic measures are also needed to stimulate the wider application of good practice. Workplaces can also promote the establishment of business coalitions or national tripartite (government, employer and labour) bodies on AIDS, as has happened in many countries. These bodies enhance co-ordination of private and public sector response, and facilitate the horizontal spread of good practice. They have produced service directories to assist workplaces to procure support services and have negotiated deals with providers of services, such as voluntary counseling and testing or home-based care services, to cover workers from a number of companies together on a fixed contract basis. This has both stimulated and strengthened community service provision, and widened the scope of HIV/AIDS services provided to companies.

Enterprise-level responses are determined largely by the business process, the business environment, the

## BOX 11. DISSEMINATING PROMISING COMPANY PRACTICES ON HIV/AIDS

**A guide to best practices on Company Action on HIV/AIDS, produced by OATUU HSEP and the UNAIDS Secretariat, provides many case studies of innovative interventions already implemented in companies in Botswana, South Africa and Zimbabwe. The guide outlines over 50 case studies of what enterprises in Zimbabwe, South Africa and Botswana are doing in relation to HIV prevention, ill health management, human resource planning and management, industrial relations, and strategic planning with regard to HIV/AIDS. The guide also highlights the Southern African Development Community (SADC) Code on AIDS and Employment, as negotiated by labour, employers and governments in southern Africa and sets the legal standard for rights and responsibilities concerning AIDS and Employment to be followed in the region.**

*Source: SADC Code on AIDS and Employment 1998, Loewenson et al., OATUU/UNAIDS 1998*

## BOX 12. COMPANY INVESTMENT IN PREVENTION AND CARE

**In 1999/2000 Botswana's diamond mining company (Debswana) carried out an institutional audit to determine how the AIDS epidemic would affect all facets of company life and operations. At the end of the process the company had a model set of policies and responses. The model was driven by experience. Between 1996 and 1999 HIV/AIDS-related morbidity and mortality increased. Ill-health retirements and AIDS-related deaths rose. In 1996 40% of retirements and 37.5% of deaths were due to HIV/AIDS. By 1999 the proportion had risen to 75% of retirements and 59.1% of deaths. The company hospitals recorded an increase in the number of patients with HIV related conditions, while in the workplaces there was anecdotal evidence of workers being absent or under-performing. It was at this stage that the company took a bold decision in co-operation with the workers to ascertain seroprevalence. The results were disturbing. HIV prevalence across all employees stood at 28.8 percent.**

**The audit looked at skill levels, ease of training and replacement of relevant skills, as well as related cost. It analysed risk reduction strategies for critical posts, estimating liabilities and costs associated with benefits, developing systems of productivity monitoring and consideration of potential treatment options and costs. The result was a landmark policy to cover 90 per cent of the cost of anti-retroviral treatment for workers and their spouses and to require suppliers of goods and services to the company to have AIDS programmes in place. In addition, prevention measures were given top priority.**

*Source: Govt of Botswana/UNDP 2000, Whiteside personal communication 2001*

employment pattern, the legal framework and the social responsibility of the enterprise. Business responses can, in their attempts to protect themselves against the impact of AIDS, shift the cost to the state and household. This has happened for example in the insurance sector, leaving high levels of unsecured risk at household level that is often borne by communities or by the state. Achieving equity in the distribution of household, private and public sector responses is an important challenge for all three sectors.

Priorities  
for action:  
Mitigating the  
impact of AIDS

19

HIV/AIDS:  
IMPLICATIONS  
FOR POVERTY  
REDUCTION

## Action: Promoting opportunities for women carrying the brunt of the burden of HIV/AIDS

Much of the discussion of the impact of HIV on women is couched in the language of “vulnerability”. It is true that women, as caregivers, are disproportionately affected by the epidemic. However, focusing on women’s vulnerabilities is not operationally useful. What is needed is to change the reality of women’s lives. This means confronting constraints such as female illiteracy, economic dependence, weak land ownership rights, weak inclusion in labour markets, significant time spent in domestic activities and inadequate supply of supportive social services.

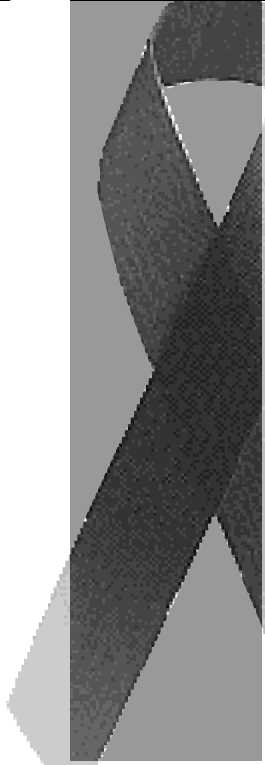
To protect themselves and their children against HIV risk and AIDS impacts, women need precisely the same things they need to strengthen themselves more generally: access to education and training, removal of restrictions on employment, access to banking services and credit on their own surety, and so on. Such changes need to be backed by shifts in laws on property rights, rights of divorced and widowed women, child custody rights and protection against physical and other abuse.

To achieve such changes in practice:

- National policies need to promote gender equity in all areas, and more specifically in relation to social norms and economic factors that perpetuate the spread of HIV, make women vulnerable to its impact, or reduce access to mitigation programmes.
- National legal frameworks should be formulated with the aim of eliminating all forms of violence against women and girls, including harmful traditional and cultural practices, abuse and rape, battering, and trafficking. Legislation must allow women to make decisions that affect their lives.
- Social norms must be cultivated to allow women to exercise control over their sexuality and promote shared responsibility of men and women in ensuring safe sex and preventing HIV infection.
- Service activities need to take account of, and put in place measures to deal with, gender-related obstacles to implementation. For example, options for risk prevention must include improving communication between men and women. Options for treatment of sexually transmitted infections (STIs) must address the norms that prevent partner notification between men and women. ■

# V

## National leadership and international support



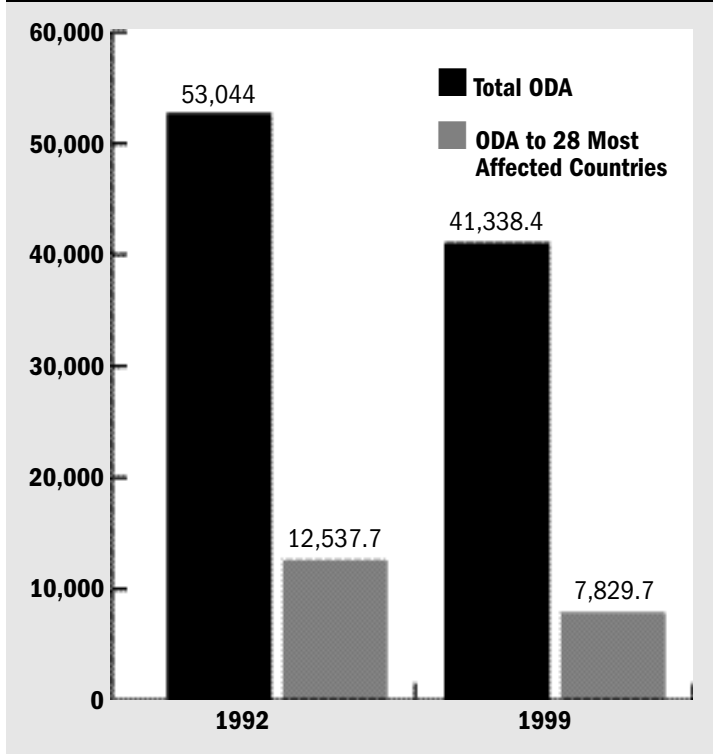
These approaches call for political leadership. Many national and community leaders still have not faced up to AIDS as a threat to their country's development agenda, and political leaderships continue to be a constraint in many countries. The necessary shifts in public policy and expenditure outlined above can only be brought about by increased political commitment and leadership at the highest level of government. Such leadership has been shown across countries as different as Botswana, Senegal, Thailand, and Uganda. National-level leadership is beginning to be responsive to demands for human rights by civil society leaders. Whether through public pronouncements or service delivery, as a bottom line, government must be able to give confidence in its basic functions, especially basic social services.

HIV/AIDS is having and will continue to have a devastating effect in the developing world. Indeed the impact of the disease is evolving and intensifying. As noted earlier, life expectancy is falling, infant and child mortality rising and poverty deepening. Countries affected by the epidemic are slipping down the Human Development Index — a trend which will continue and worsen as current HIV infections become AIDS cases. Children are orphaned and production in all sectors is declining. These effects extend beyond national boundaries. The Millennium Development Goals and global stability and security are fundamentally undermined by the HIV/AIDS epidemic. Mobilising capacities, mechanisms and resources for response require international co-operation.

This year will see the mobilisation of unprecedented quantities of aid as a response to the HIV/AIDS pandemic. The United Nations estimates that 7–10 billion dollars is required annually from national and international sources to support prevention and treatment in developing countries, the two core priorities in dealing with HIV/AIDS. If these resources materialize and help scale up effective national responses, the devastating impact described in this paper will gradually subside. In countries where the epidemic has not yet picked up speed, this impact may even be avoided altogether.

However, it is absolutely imperative that donor funding that is allocated towards HIV/AIDS prevention and care are new and additional resources, not taken from existing development assistance budgets. As this paper argues, the response to HIV/AIDS can only be successful if investments in prevention and care are combined with continued support for national poverty reduction efforts and for action to address the developmental impact of the epidemic. Without a marked reduction in poverty and sustained advances in human development, global

**FIGURE 4. OFFICIAL DEVELOPMENT ASSISTANCE (ODA) FLOWS TO 28 COUNTRIES MOST AFFECTED BY HIV/AIDS\* (US\$ MILLIONS)**



\* Countries with HIV adult prevalence rates of over four percent, excluding South Africa. Source: OECD, 2000.

mechanisms to support prevention and treatment will be built on sand.

National governments, the international community and AIDS activists need to appreciate that:

- Successful prevention means less need for future treatment and mitigation of impact. As each year sees new cohorts becoming sexually active, prevention remains a priority.
- Addressing the impact feeds into prevention and access to treatment, and vice versa in a 'virtuous cycle' (box 1).
- If the impact on development is not addressed, then increased poverty, inequity and misery will perpetuate and fuel the epidemic for the foreseeable future.

Given the importance of ensuring progress towards national poverty reduction targets and global development goals in fighting HIV/AIDS, the continuing drop in ODA for poor countries is of great concern. ODA flows to countries worst affected by AIDS (defined as having more than a four percent adult prevalence in December 1999) have fallen by a third since 1992. This is a trend that simply has to be reversed (figure 4). ■



The success of HIV/AIDS prevention and treatment is contingent on a simultaneous intensification of poverty reduction efforts. AIDS impoverishes individuals, households and communities, and these adverse conditions in turn increase the vulnerability of people and communities to the disease.

Poverty alleviation will feed into prevention of further infections: For example, improving women's incomes increases their power in all aspects of life, including control over sexuality. Education reduces risk of infection and has long-term beneficial development consequences. It should be noted that no developed country has an AIDS epidemic even approaching those of the poor world. This says something glaringly obvious about the links between AIDS and development.

The first two decades of AIDS have witnessed the burden of the epidemic on households and communities. Here innovative action has struggled against the devastating impact, often with little coherent international, state or private sector support. Two things signal the need for a vastly more intense, consistent and systematic response: Firstly, in only very few instances has the risk of infection or the mitigation of impact been managed in a decisive manner (whether at community, enterprise or national level). Secondly the 'flood waters of impact' are rising and it is urgent that resources be mobilised to reduce as far as possible the wave of debilitation, particularly for young people, women and poor households.

One of the most important, and probably biggest gaps that needs to be bridged is between global or national funds and the communities who need and can use them. The ability of such funds to make a sustained difference will be directly related to their efficiency in building or supporting systems, networks and capacities for ensuring that resources reach vulnerable households and groups. It calls for investment in community networks, strengthening their ability to plan and manage resources and generate social funds that are controlled at community level. It calls for reliable, relevant public sector services that effectively support and interface with community actions.

This paper shows that AIDS is a development crisis. While a global effort is needed to advance technical inputs, like vaccines or treatment to help control the epidemic, there are no easy answers or simple technical and scientific solutions to dealing with its spread and impact. The most effective response, or the best international 'vaccine' against this disease is sustained, equitable development. ■



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