HIV/AIDS

human resources

and sustainable development

World Summit on
Sustainable Development
Johannesburg 2002

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HIV/AIDS, human resources and sustainable development

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1. Making the links

At the heart of sustainable development lies the integration and balancing of social, economic and environmental priorities. In a world where pockets of privilege exist amid vast deprivation, such a quest fundamentally requires improving the well-being of those who are poor, marginalized or excluded, and sustaining those improvements. None of this is possible unless human resources are placed at the centre of sustainable development.

Despite welcome progress in many respects since the end of the Cold War, the world remains cleaved by grave inequalities, deep deprivation and continuing environmental degradation. Those features are hardening in the ever-larger areas of the world that find themselves in the grip of the HIV/AIDS epidemic. Hard-hit parts of the world are seeing socio-economic progress wane and, in some cases, reverse. By robbing communities and nations of their greatest wealth—their people—AIDS drains the human and institutional capacities that fuel sustainable development.

These are not just temporary setbacks. AIDS is sapping vital components and attributes of potentially successful development strategies. By draining human resources, the epidemic distorts labour markets, disrupts production and consumption, and ultimately diminishes national wealth. Some countries bearing the brunt of such effects now face the prospect of 'un-developing'—of seeing their development achievements dissolve in the wake of the epidemic.

Allowed to spread unchecked, HIV/AIDS weakens the capacity of households, communities, institutions and nations to cope with the social and economic effects of the epidemic. Productive capacities—including in the informal sector—are eroded as workers and managers fall prey to the disease. Flagging consumption, along with the loss of skills and capacities, in turn drains public revenue and undermines the State's ability to serve the common interest of development and human well-being. The cycle is dynamic and vicious. Typically, it is the poor who are edged further towards the margins and exclusion, as revealed by worsening social indicators in countries with serious AIDS epidemics.

A complex interplay occurs between such negative development and the spread of HIV/AIDS. The epidemic flourishes especially among people and communities that are deprived of the elementary benefits of successful development (public social services such as education and health care, secure employment, shelter, and social safety nets essential for sustaining livelihoods).

Choices and opportunities—hallmarks of successful human development—shrink as the epidemic gains a foothold in an environment of inequality and exclusion. Negative development and HIV/AIDS lock into a dynamic relationship, whereby one feeds on the other. A growing number of countries are becoming trapped in this cycle. And their ranks will grow unless other countries act now to hold their emerging epidemics in check.

The flux of rapid development can also become a factor in the epidemic's advance. In some countries where vigorous growth and development have occurred (but the benefits have been spread unevenly), HIV/AIDS has taken hold in unanticipated ways. In Botswana, the epidemic gained a foothold during a period of political stability, sustained economic growth and human development. One of the most vigorous economic performers in the world, China is now also home to a rapidly spreading epidemic. Thailand's encounter with a seriously expanding epidemic in the early 1990s coincided with a period of dramatic growth and development. Labour migration to economic growth zones along improved transport networks, and the dismantling of traditional livelihoods can all render people and communities more susceptible to HIV transmission.

The AIDS *cul-de-sac*

With its global reach, HIV /AIDS is blocking progress towards the Millennium Development Goals that the international community has committed to reach by 2015. In heavily-affected countries, the epidemic is erasing hard-earned gains—a sign of what potentially lies in store for other countries that fail to prevent or control such a dynamic epidemic.

- As HIV prevalence levels rise, **poverty** deepens. The incomes of the poorest quarter of households in Botswana are projected to drop by 13% by 2010. A study in neighbouring Zambia has shown that two-thirds of urban households that have lost their main breadwinner to AIDS have experienced an income loss of 80%.

  Cutting the incidence and prevalence of HIV/AIDS is a prerequisite for sustainable poverty eradication.

- HIV/AIDS undermines **food security**. In combination with other setbacks, AIDS can trigger food crises, even famine. As many as 13 million people face possible starvation in southern Africa in 2002. Causing this is a mix of adverse weather conditions, policy mistakes, environmental degradation and AIDS. Each of the affected countries is in the midst of a long-standing, severe HIV/AIDS epidemic, with prevalence rates exceeding 10%.

  Reversing the epidemic is necessary to defuse the threat of food insecurity and lift the burden of hunger.

- The epidemic stands squarely in the path of achieving education for all. **Schooling** is suffering as enrolment rates drop, poor families remove their children from school, and teachers and support staff succumb to the epidemic. A cornerstone of development—education—is being undermined.

  Youth- and school-focused prevention programmes, along with steps to safeguard and extend education, especially to the millions of children orphaned by AIDS, could put the goal of achieving universal primary education back within reach.

- An estimated 330 000 children under the age of five died of AIDS in sub-Saharan Africa in 1999. That toll has risen in subsequent years. Vertical transmission of HIV/AIDS from mother to child is further increasing **maternal and child mortality** rates, causing the goals set in these areas to slip further from reach.

  Greater efforts to prevent mother-to-child transmission, including the provision of antiretroviral treatment to HIV-infected pregnant women, could reverse the rising levels of child mortality.

In many cases, countries face an uphill battle as they try to overcome such drawbacks, especially when AIDS arrives in the slipstream of other setbacks. Many States' capacities for providing public goods and services have been weakened in the midst of conflict, poor governance, economic austerity and misconceived restructuring programmes. The administrative capacity of many States, as well as the effective functioning of democratic institutions in economic and social policy-making, is set to suffer further setbacks because of AIDS.

The distribution of opportunities and resources—patterns of inequality, in other words—can operate as the dynamic undertow of the AIDS epidemic. Indeed, the HIV/AIDS epidemic can be seen as a glaring symptom of the ways in which social and economic relations are organized.

The sum effects of a rampaging epidemic on sustainable development are grave and long-lasting. Just *how* long-lasting, the world does not yet know, for the epidemic is still in its early stages.

But we know from experience that HIV/AIDS epidemics can be prevented and subdued. And it is clear that such achievements are more likely when countries' responses draw on, develop and conserve the capacity of people, communities and institutions.

New studies show that immediate implementation of a full prevention package could avert 29 million new infections by 2005. Access to antiretroviral drugs and other HIV medicines can also greatly reduce the predicted death toll, as high-income countries, as well as middle-income countries such as Brazil, have shown. It is neither just nor sustainable to deny access to such treatment opportunities to the millions of people who urgently need them in resource-poor countries.

An effective response on all these fronts must engage all stakeholders. If the epidemic is to be stemmed, and its threat to humanity and sustainable development defused, HIV/AIDS needs to feature centrally in the political priorities and development agenda of countries everywhere.

Meaningful and sustainable development cannot occur if the AIDS epidemic is allowed to drain human resources.

2. Chain reaction—the impact of HIV/AIDS on human resources and development

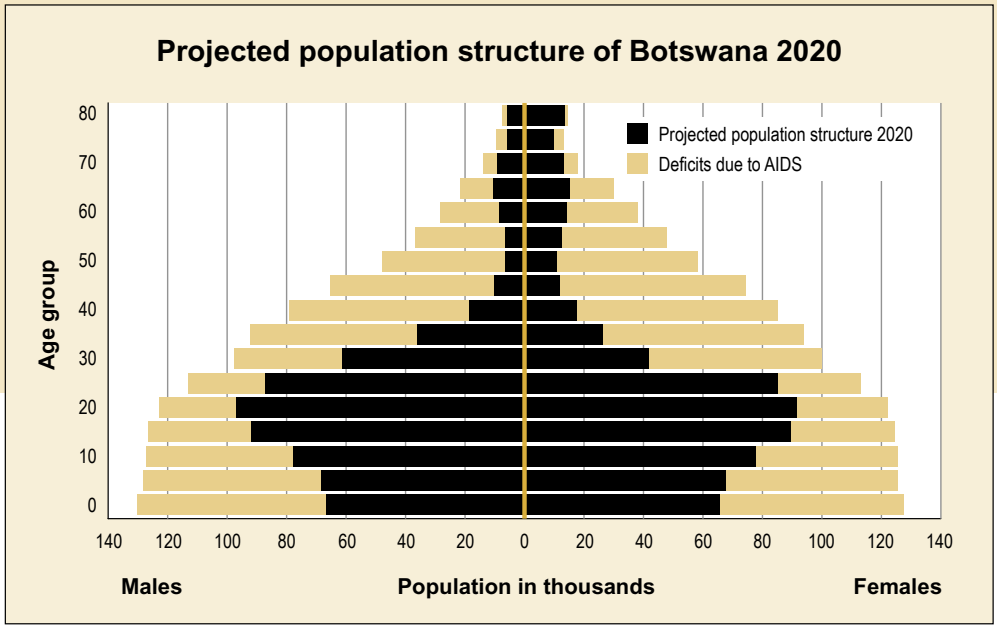
The hard fact is that the global HIV/AIDS epidemic is still in its early stages.

In countries that are currently hardest hit, the epidemic and its effects will churn on for many years. Those countries have had the misfortune of encountering the early advance of AIDS. But, in many dozens more, including some of the most populous in the world, HIV/AIDS is now also demonstrating its ability to rapidly adapt and spread in new settings.

In our increasingly interdependent world, the widening spread and cumulative impact of the AIDS epidemic mean that development everywhere is threatened.

Bent out of shape

As illustrated in this graph showing Botswana's projected population structure in 2020, in badly affected countries the population size can shrink radically among women in their early 30s and among men in their late 30s. In Botswana's case, among people in their early 20s to late 30s, there will be significantly fewer women than men alive, profoundly affecting gender roles and relations. As a result, the burden of caring for the growing numbers of orphans will increasingly fall on the elderly and on adolescents, with females being most affected.



Source: US Census Bureau 2000

A plunge in life expectancies

Average life expectancy in sub-Saharan Africa is now 47 years, when it would have been 62 years without AIDS. As shown in UNAIDS' *Report on the Global HIV/AIDS Epidemic, 2002* (available at www.unaids.org), life expectancy at birth in Botswana has dropped to a level not seen in that country since before 1950. In South Africa, life expectancy in 2000–2005 is projected to be 18 years less than it would have been in the absence of AIDS; in Ethiopia, the difference is 10 years, in Haiti 6 years, and in Cambodia it is 4 years.

The graph below shows the steep drop in life expectancy in three high-prevalence countries, compared to the steady increase in countries with significantly lower HIV prevalence.

Fourteen million children living today have lost one or both parents to AIDS. Their numbers are set to almost double to 25 million by the end of the decade, if current trends are allowed to continue.

Close to a million children under the age of 15 have been orphaned by AIDS in both Ethiopia and Nigeria. In South Africa, an estimated 660 000 children have been orphaned by AIDS—a number that could rise to 1.5 million by 2010. The total in Asia could be even higher than projected if HIV prevalence in populous countries such as China, India and Indonesia continues to rise.

Increases in the number of children orphaned by AIDS, 2001–2010

Global
- **2001 – 14 million**
- **2010 – 25 million**

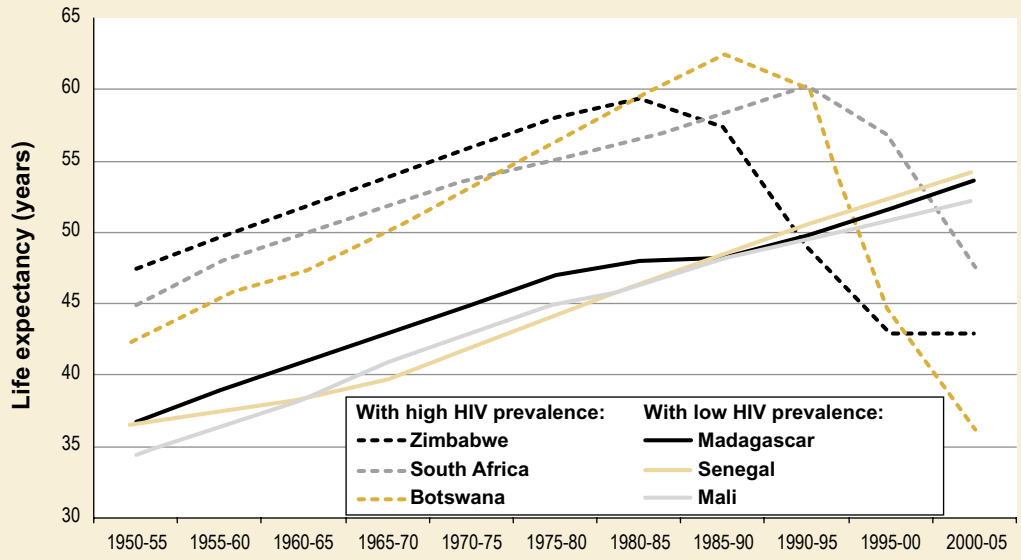
Africa
- **2001 – 9 million**
- **2010 – 20 million**

Asia
- **2001 – 1.8 million**
- **2010 – 4.3 million**

Latin America/The Caribbean
- **2001 – 578 000**
- **2010 – 898 000**

Source: USAID, UNICEF, UNAIDS (2002)

Changes in life expectancy in selected African countries with high and low HIV prevalence: 1950–2005



Source: UN Department of Economic and Social Affairs (2001) *World Population Prospects, the 2000 Revision*

Hitting where it hurts: the impact on health systems

Vital in its own right, the improvement of human resources is essential for development. In particular, improved health and educational levels become pathways for moving out of poverty and cementing long-term economic growth. But the added demands for treatment and care are putting health budgets and systems under huge strain, just when the epidemic is claiming its heaviest toll among health workers and related resources.

A concerted global effort is needed to increase affordable access to health services. Yet, in countries hard hit by HIV/AIDS, the need for health care is expanding massively just when the capacity of health systems to provide that care is being drained.

In hard-hit countries, many hospitals are reporting a shortage of beds, for example, which means that people tend to be admitted only in the later stages of illness, putting their recovery in jeopardy. Rising rates of HIV infection among health workers lead to more absenteeism, reduced productivity and higher training and recruitment costs. Some countries have been experiencing five-to-six-fold increases in health-worker illness and death rates. The increased workloads and stress might further spur the departure of health workers into the private sector or even abroad. The quality of care suffers, as does the capacity to provide essential HIV/AIDS services, such as voluntary counselling and testing.

Beyond the increased strain on hospitals and health-care facilities, the cost of providing basic health care soars as the epidemic expands. Partially in response to that reality, African governments committed themselves in Abuja in April 2001 to increase their health spending to 15% of government revenue. Even reaching that target (a long haul for many countries) would not match the needs generated by the epidemic, especially if treatment access is to expand beyond the mere 30 000 Africans who were receiving antiretroviral therapy in early 2002.

An estimated 6 million people in developing countries are in urgent need of antiretroviral treatment. WHO estimates that it should be feasible to provide that treatment to about 3 million people by 2005. With antiretroviral drug prices having dropped from US$10 000 to around US$300 (for a year's treatment), treatment should be reaching many, many more people.

Treatment access is not only a human rights imperative. It prolongs a healthy life and enables people living with HIV to remain productive, thereby reducing the stigma and discrimination to which people are so frequently exposed. Treatment access is an investment in human development for the broader good of society.

In some countries, nongovernmental organizations deliver a significant proportion of accessible care and support for HIV-infected and -affected populations. Community-rooted home-care initiatives, often organized by people living with HIV/AIDS themselves, have become an outstanding feature of the epidemic. But if home-based care is to be sustainable, it requires support from formal health, welfare and other social sectors.

Learning the hard way: the impact on education systems

Not only do higher education levels improve access to employment and income security, boost the status of women and lead to improved health indicators, they also feature prominently in the fight against AIDS. But the epidemic creates a double-jeopardy situa-

tion. On the one hand, it reduces the quality of training and education that can be provided by institutions. On the other, it leaves fewer people able to receive the benefits of learning. AIDS is depleting societies' overall stock of human capital—in some cases, in conjunction with a serious brain drain of professionals.

Already, school enrolment is shrinking in some countries; children are being taken out of school to care for parents and family members and to avoid unaffordable schooling costs. AIDS-related infertility, resulting in a decline in the birth rate, is further depleting family resources. More and more children and young people are themselves infected and do not survive their schooling years. In some countries in Africa, school enrolment is reported to have fallen by 20–36% due to AIDS and orphanhood, with girls most affected. These discriminatory effects of the epidemic on the poor, and especially on girls, in terms of enrolment and completion of schooling, can be countered with special incentives—for example, subsidies or the waiving of fees.

AIDS is also undermining the ability of education systems to perform their basic social mandates, as more teachers and administrative staff are lost to the disease. The implications can be dramatic in rural areas, where schools can depend heavily on one or two teachers, the loss of whom can deprive an entire community of students of their schooling.

In developing countries, the education sector can rarely cope with the additional costs associated with training and replacing teachers. So, budgets tend to be reshuffled—by cutting spending on maintenance of buildings and infrastructure, or learning materials and teaching aids, for example. The effect, though, can be the same: a slump in the quality of teaching and learning.

Equipping young people with the knowledge, skills and capacity to protect themselves against HIV/AIDS is a prerequisite for turning the epidemic around. There is evidence that greater educational achievements correlate strongly to reduced risky behaviour in places where the epidemic is well entrenched. Yet, as schooling deteriorates, an ideal venue for prevention programmes that reach young people and put them at the centre of the response can be lost also.

With their formal education cut short, boys and girls may have to resort to survival strategies that include sexual transactions that expose them to higher risks of HIV transmission.

Bringing health systems into line with the needs sparked by HIV/AIDS (in terms of prevention, treatment and care) rank among the most far-sighted and far-reaching investments a society can make.

Advance human resource planning is vital to prevent such collapse.

Just as important as training more teachers is the need to prevent and, where necessary, replace the sudden losses of experience and institutional memory—by, for example, expanding access to HIV/AIDS medicines that can keep teachers alive and productive, and by re-enlisting retired teachers.

Home is where the hurt is: the impact on households

Households are the first social safety net in all societies. They demonstrate remarkably strong resilience in the face of setbacks. But to expect households to cope with HIV/AIDS without support from the broader society is unrealistic.

The loss of family breadwinners to HIV and AIDS strips households of hard-earned income and assets. Available resources are spent on care, funerals and sustaining a bare minimum of standard of living. Deeper debt

for a while slows the slide towards destitution. Without support, poor households eventually risk imploding.

Studies in AIDS-affected countries in Africa and Asia indicate that income in AIDS-affected households can be less than half that of the average household. The sale of land—one of the prime assets of poor rural households—is particularly frequent in such situations, as is chronic debt.

Once deprived of their productive assets, such as land and livestock, households battle to recuperate sustainable livelihoods. The transition from relative well-being to extreme poverty can be quite rapid in AIDS-affected households. Botswana provides an example of a country where, as a result of HIV/AIDS, per capita household income for the poorest quarter of households is projected to drop by 13% this decade.

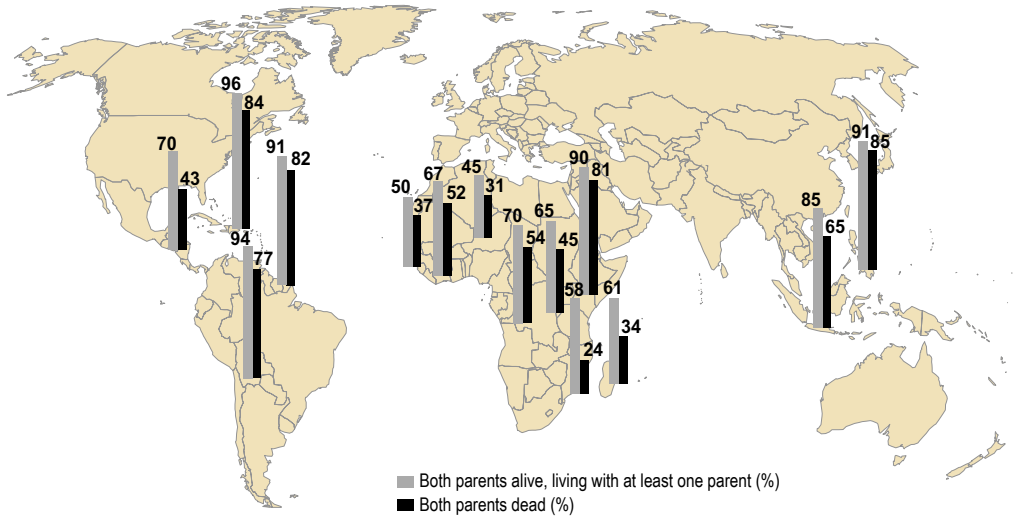
Typically, women are saddled with most of the coping burden, as demand increases for their income-earning labour, household maintenance, child-care and nursing work. Because of this dependency, worsening female mortality undermines the well-being of households and communities. A survey in Zambia in 2000 revealed that 65% of households disintegrated and dispersed after losing a key adult female family member. Women represent a growing proportion of people living with HIV/AIDS and new infections are disproportionately concentrated among poor and illiterate young women. In the era of HIV/AIDS, promoting gender equality and empowering women are more vital than ever.

In already impoverished settings, the vestiges of family- and community-based social safety nets fray further. Many of the millions of orphans left in the epidemic's wake are deprived of the parental emotional and physical security so vital in the formative years of childhood. As the graph below shows, young teenagers who have lost both parents are also more likely to be deprived of an education than peers who have not lost a parent.

Going hungry: the impact on rural livelihoods

In a world of plenty, some 800 million people are under-nourished and thousands die of hunger every day. These numbers are rising

Percentage of children aged 10–14 who are still in school, according to whether their parents are alive: selected countries, 1997–2001



Sources: UNICEF (1997–2001) Multi-Indicator Cluster Surveys; Macro International (1997–2001) Demographic and Health Surveys

as the food crisis in southern Africa escalates, and the AIDS epidemic is further aggravating this situation.

The Food and Agriculture Organization (FAO) has estimated that, since the early days of the AIDS epidemic, seven million farm workers have died from the disease. Another 16 million may die in the next 20 years if effective HIV/AIDS responses are not implemented.

The agricultural output of community-based farming—so vital to food security in many developing countries—and the supplementary incomes from wage labour cannot be sustained if AIDS is allowed to rage unabated.

Illness and death in farming households leave fewer people available to work in the fields. When one or two key crops must be planted and harvested at specific times of the year, losing even a few workers during the crucial planting and harvesting periods can scuttle production. As extension workers and other staff fall ill, a breakdown in agricultural support services exacerbates the problem.

As the availability of labour lessens, a smaller range of crops is grown on smaller plots of land, with the remainder surrendered to the elements and degradation. Maintenance work suffers—on irrigation ditches, tree planting, drainage run-offs or fencing—causing the farming operation to become less sustainable.

As people die or are forced to abandon rural communities, valuable local knowledge (about soils, local fauna, climatic patterns, ways to improvise in times of hardship, etc.) is lost. The effects on rural economies and food security can be severe and long-lasting.

Fleeing hunger and insecurity, people face new adversities—among them the heightened risk of HIV transmission. Women, in particular, may find themselves in circumstances where they are more susceptible to HIV transmission, as a result of sexual violence, or having to trade sex for food and other basic necessities.

Whether and how people cope depends on the distribution of power, assets and income. In many regions, women are the linchpins of rural

AIDS and the food crisis in southern Africa

The food emergencies sweeping through southern Africa highlight how vulnerable many countries are to shocks that disrupt food production and consumption. In each of the affected countries, HIV/AIDS constitutes a shock of considerable proportion.

Almost 13 million people are at risk of starvation in six southern African countries: Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe. The crisis stems from a combination of mishaps that beset these countries. Drought or floods, a lack of extension and other support services for stricken farmers, lack of consumer protection (allowing food prices to rocket as an emergency worsens), the selling of food reserves, misguided governance and political instability are among the factors involved. So is the AIDS epidemic.

Where the resulting lack of availability or affordable access to food is greatest, the prevalence of HIV is also alarmingly high: adult HIV prevalence rates range from 15% in Malawi to a staggering 33% in Swaziland and Zimbabwe.

At a point where human and productive capacity is especially critical, that of farmer and farm-worker households, as well as agricultural extension workers and other State personnel, is being stripped bare by HIV/AIDS.

This unfolding tragedy underlines the need to tackle rural development, food security and agricultural policies in concert with fighting the AIDS epidemic.

A cut above the rest?

An institutional audit done by Botswana's diamond mining company, Debswana, in 1999/2000 revealed that retirements due to ill-health and AIDS-related deaths had risen steeply. In response, the company gauged its vulnerability to the epidemic (in terms of productivity, skill availability, employee benefits, etc.), and decided to establish a new HIV/AIDS strategy.

One step, for example, was to pinpoint specialized workers, the loss of whom might create a bottleneck in the company's operations. Workers in key positions are now targeted with specific HIV/AIDS risk-reduction programmes. As part of an improved workplace-wide prevention strategy, managers now have to pass HIV/AIDS-competence exams. Also in place is a 'contractor assurance' policy, which compels companies providing Debswana with goods and services to have workplace HIV/AIDS prevention and education programmes (which Debswana aims to audit regularly).

Another breakthrough came with the decision to provide antiretroviral treatment to workers living with HIV/AIDS, as well as to their spouse; Debswana pays 90% of the drugs' cost and the related expenses of monitoring viral loads and CD4 counts, for as long as the worker is employed by the company.

economies, both as farmers and wage-earners. Yet, access to productive resources, such as land, credit, knowledge and skills, training and technology, is typically determined along gender lines. Usually, women lose out. The death of a husband might leave a widow in even more precarious circumstances—deprived of access to the land, house, livestock and other assets she helped develop and maintain. A rights-based approach to HIV/AIDS must address these and other forms of discrimination, which worsen poverty.

Other opportunities for action include:

- developing AIDS-awareness programmes that are tailored for rural communities
- introducing microcredit schemes that can help sustain female-headed households
- equipping agricultural extension workers with HIV/AIDS knowledge and skills
- ensuring that farming and other essential life skills are passed on to young people
- strengthening rural cooperatives
- supporting home- and community-based care in rural areas

Also shaping the interplay between AIDS and food insecurity are broader factors, such as international trade relations and other economic policies. The new round of trade negotiations agreed to in Doha in November 2001 represents one opportunity to rectify such imbalances.

Moves that remedy these inequalities can go a long way towards safeguarding rural livelihoods and bringing the AIDS epidemic to heel. Fairer access to global markets for low- and middle-income countries is one obvious corrective. Boosting sound environmental practices is another.

The epidemic at work: the impact on enterprises and workplaces

A thriving production and trade sector is the engine of sustained economic growth. That, in turn, can be a boon for human development. The business sector itself is recognizing that AIDS takes a huge toll on workers and managers of enterprises—formal and informal—and that it can ruin efforts to achieve growth. The epidemic:

- cuts the supply of labour and skills
- increases business costs
- disrupts production and undermines productivity

- cuts incomes and reduces the market for goods and services
- erodes savings and discourages investment
- reduces revenue from taxation, just as spending on health and social services needs to increase.

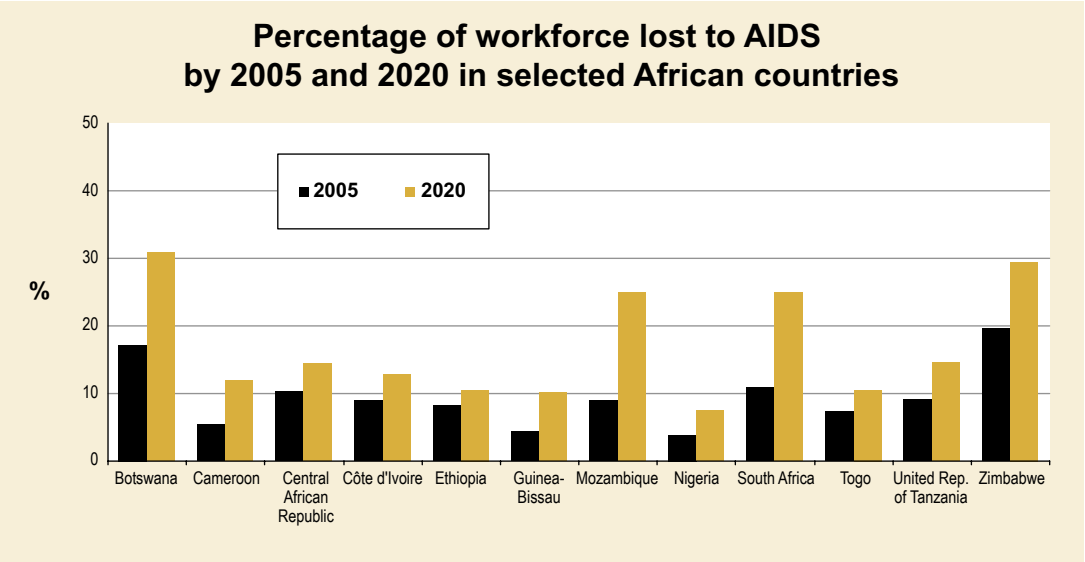
HIV/AIDS affects productivity mainly through increased absenteeism, disrupted production, weakened workforce morale and the loss of skills and organizational memory—all of which forces costs up and drives productivity down. Comparative studies of East African businesses have shown that absenteeism due to HIV and AIDS can account for as much as 25–54% of company costs.

In small and medium-sized companies, typically the backbone of local economies in many developing countries, these kinds of effects become amplified. Even in high-unemployment areas (with an apparently bottomless pool of un- or semi-skilled labour), the drain on skills and knowledge is considerable.

Losing supervisory workers can be especially damaging. A general shortage of skilled workers and management-level staff in areas hard hit by the epidemic means that positions stay unfilled for long periods—at significant cost in terms of productivity. The effects can be particularly harsh on young workers who lose the opportunity to benefit from the skills and experience of more experienced colleagues.

Investing in prevention programmes in the workplace, and ensuring the greater involvement of people living with HIV/AIDS, makes good business and developmental sense. So, too, does provision of treatment and care. The fact that migrant and mobile workers can be at special risk of infection calls for special steps, built on solid research and understanding, to protect them against the epidemic.

Enterprises and workers can now draw on comprehensive guidelines for acting against HIV/AIDS in the workplace, developed by the International Labour Organization (ILO). Based on international standards, this *Code of Practice on HIV/AIDS and the World of Work* outlines the rights and responsibilities of governments, employers and workers in responding to the HIV/AIDS epidemic. Rights-based, it applies to a wide range of settings, including international partnerships, national action plans, enterprise agreements and work in the informal economy. As a voluntary instrument, it can be adapted to the needs of specific situations, sectors and regions (see www.ilo.org/).



Sources: ILO (2000) POPILO population and labour force projection; UN Department of Economic and Social Affairs, Population Division (1998) *World Population Prospects: the 1998 Revision*

A drag on growth: the macroeconomic impact

Through its combined impact on the labour force, households, communities, institutions and enterprises, HIV/AIDS can become a powerful brake on economic growth and sustainable development.

For those countries where national HIV/AIDS prevalence rates exceed 20%, annual gross domestic product growth has been estimated to drop by an average 2.6 percentage points. Sub-Saharan Africa's growth rate is estimated to have fallen by 2–4% as a result of AIDS. There are concerns that, in areas with rapidly expanding epidemics, such as the Russian Federation, economic output might also shrink as a result of HIV/AIDS, while the demand for greater public expenditure swells. In the Caribbean, another area with high prevalence, GDP in 2005 could be around 4.2% lower than it would be in the absence of the epidemic.

Economic powerhouses are not escaping this fall-out. By the beginning of the next decade, South Africa, which represents about 40% of Africa's economic output, faces a real GDP 17% lower than it would have been without AIDS. Studies also indicate that, for some high-prevalence countries, AIDS will discourage foreign and domestic investments that are vital as countries embark on sustainable development strategies.

It is important to distinguish the role AIDS plays in weakening economies from other negative factors such as declining terms of trade, debt burdens, volatile capital movements, weak governance systems, political instability, and violent conflict. But it might be that current modelling underestimates the impact on economic growth. It is still difficult, for example, to capture the interplay between economic growth and dysfunction in public institutions, or the long-term economic effects when the supply and distribution of knowledge and skills become severely distorted.

More research is needed to probe more deeply the complex interplay between HIV/AIDS and sustainable development. More generous support for such research and analysis could help countries hone their understandings of the epidemic, and contribute to sound development planning, effective governance and a wider appreciation of the merits of investing in prevention, care, treatment and support.

Holding it together: the impact on institutions

The quality and range of public services and regulatory functions (from education, health and the justice system, to water and sanitation, telecommunications and transport) depend on flows of finance, and on the stock of public employees with the requisite skills and expertise. The AIDS epidemic threatens to eat away at all these assets.

A recent study, in one badly affected country, provides a snapshot of the impact on the public sector. Total annual attrition in 1999–2000 rose almost six-fold in the period under review. Death was the highest cause of attrition. Across the public sector, mortality increased by a factor of 10 during the period of the study, with deaths disproportionately high among young adults of both sexes—a sign that HIV/AIDS is primarily responsible.

In the country's Ministry of Agriculture, the study found excess mortality in all occupational categories, with the rate highest among professional and junior technical staff. Many of the posts remained unfilled for long periods, with vacancies higher in rural than in urban areas—a sign that the epidemic's impact on public services is worse in rural areas, which are often already under-serviced.

By loading more pressure on national budgets and by weakening public institutions, the epidemic makes it even more difficult for States to perform their primary duties—protecting citizens against human suffering, including hunger, disease and destitution. As the provision of essential services falters, the poor and most vulnerable households endure the worst of the consequences. The impact on social protection systems (such as public sector

pensions and social security) can be significant. As fewer public sector employees reach retirement age, contributions by employers decline. At the same time, expenditures on sickness and death-related benefits and pensions for surviving dependants increase as a share of the government wage bill.

What has proved crucial is the mobilization of all sectors—across the State, civil society and business—amid the consistent and visible commitment of leaders. The public and private sectors need to lead from the front.

In many countries, too, the epidemic is provoking new forms of mobilization as social networks and organizations emerge to confront AIDS, and this, in turn, is invigorating civil society. Community-based support networks are mobilizing, and social rights groups are advocating treatment access, human rights-protection and improved socioeconomic conditions. The activism and advocacy work of people living with HIV/AIDS has been central to boosting political commitments to fight the epidemic, and is a cornerstone of an effective response to AIDS.

All is not gloom. There are many examples of AIDS responses having achieved a 'critical mass' and begun turning the tide against the epidemic.

Successful development also requires that citizens trust the rule of law, that they believe the State protects their most basic interests, and that they can anticipate improved standards of living for themselves and their children. The AIDS epidemic weakens these and many other pillars of social cohesion. This is especially important in light of the fact that many countries in both the region with the fastest-growing epidemic (Eastern Europe) and the region with the highest national HIV prevalence rates (sub-Saharan Africa) are fledgling democracies, where governments are trying to foster the trust of citizens. The AIDS crisis has the potential to stymie these democratic transitions.

More information on the impact of HIV/AIDS can be found in the *Report on the Global HIV/AIDS Epidemic, 2002,* available at www.unaids.org

3. Ways forward

The impact of HIV/AIDS—whether global, societal, familial or individual—is primarily a *human* impact. Fighting AIDS successfully is a people-centred quest, with solid human resource development as one of its key elements.

Success in bringing the global AIDS epidemic under control occurs when policies, resource allocation and action reflect this essential fact: the fight against AIDS is inseparable from the broader agenda of realizing people's rights, safeguarding human resources and moving towards sustainable development.

Countries on the brink of serious AIDS epidemics have to be able to prevent further HIV spread and to provide adequate treatment and care for those already infected. Countries already in the grip of serious epidemics face an even greater challenge: they have to bring the epidemic under control, while mitigating its impact. Paramount in all cases is the need to protect and build human resources in line with the principle of non-discrimination.

This requires tracking and assessing the impact of the epidemic on workforces, planning ahead to avert or compensate for the toll

Especially valuable are strategies that tackle the underlying socioeconomic factors that leave people vulnerable to HIV/AIDS, as well as the vulnerabilities that arise from gender inequalities, the denial of human rights, and the stigma and discrimination directed at marginalized groups.

It can be done

The evidence shows that prevention works, and that treatment and care can be provided on a much larger scale.

- A number of African countries continue to register success in fighting the epidemic. HIV prevalence continues to drop in Uganda—down to 5% at the end of 2001. In Zambia, HIV prevalence is falling among young urban and rural women, while Senegal's multi-pronged prevention efforts are still holding that country's epidemic at bay.
- Elsewhere, Cambodia, like Thailand, is proving that the 'natural' course of the epidemic can be changed. Strong political commitment and large-scale prevention programmes have helped lower HIV prevalence among pregnant women in urban areas from 3.2% in 1996 to 2.7% at the end of 2000 in Cambodia.
- In Eastern Europe, the Polish Government has successfully curtailed the epidemic among injecting drug users, preventing it from gaining a foothold in the wider population.
- From Latin America and the Caribbean comes proof that middle- and low-income countries *can* provide treatment and care through the public sector. In Brazil, more than 100 000 people are receiving free HIV/AIDS medication. The number of AIDS deaths in 2000 was a third lower than in 1996, with an estimated 230 000 hospitalizations having been avoided. At the same time, prevention programmes are bringing success—for example, HIV prevalence among injecting drug users has fallen sharply in several of Brazil's larger cities.

AIDS takes on institutions and workplaces, and setting in place treatment and care programmes for those infected.

Wider public health and development strategies can considerably enhance the impact of prevention.

When buttressed by well-supported community responses that include people living with HIV/AIDS, religious groups, and traditional and trusted leaders, the positive impact is even greater.

The basic principles

The way forward is to promote a three-pronged approach:

- *Drastically reduce the number of new infections (and thus reverse the epidemic's spread)*
- *Expand access to treatment and care to all who need it*
- *Reduce the impact of AIDS on social and economic development*

These endeavours are interlinked. Underpinning them all are five priorities:

1. **Leadership commitment**. Mobilizing high-level support is essential—not just in political circles but among business, religious, cultural, sports and entertainment luminaries, too. These leaders bear a special responsibility to set examples that

A framework for accountability: the Declaration of Commitment on HIV/AIDS

At the United Nations General Assembly Special Session on HIV/AIDS in June 2001, the world's governments adopted a series of benchmark targets in the fight against the epidemic.

Those targets now provide a common platform for accountability.

Recognizing that HIV/AIDS responses are not add-ons, countries agreed to integrate HIV/AIDS prevention, care, treatment, support and impact mitigation into the mainstream of development planning by 2003.

Countries pledged to make every effort—urgently—to provide the highest attainable standard of treatment for HIV/AIDS, including treatment for opportunistic infections and antiretroviral medicines. Prominent among the many other targets, are the following:

- A 25% reduction in HIV prevalence among young people globally is to be achieved by 2010, along with a 50% reduction in the proportion of infants infected by HIV.
- By 2005, 90% of young people (aged 15–24) should have the information, education, services and life skills they need to reduce their vulnerability to infection.
- By 2005, strategies should be in place to create supportive environments for orphans, as well as for girls and boys infected and affected by HIV/AIDS.
- Strategies that promote the advancement of women and safeguard their human rights are to be implemented by 2005.
- By 2003, legislation, regulations and other measures are to be enforced to halt discrimination against people living with HIV/AIDS and vulnerable groups, and to ensure that their rights are protected.
- By 2003, countries should evaluate the economic and social impact of the epidemic and develop strategies to address it at all levels.

(The entire *Declaration of Commitment on HIV/AIDS* is available at http://www.unaids.org/UNGASS/index.html)

spur others into action. Their consistent commitment is needed if national plans are to operate effectively and if sufficient resources are to be channelled into AIDS responses. Growing political leadership is becoming evident in the lengthening list of national HIV/AIDS strategies, which have been developed in almost 100 countries, and in the almost three dozen countries where heads of government or their deputies now head national AIDS commissions.

2. **Community mobilization.** Initiatives mounted by community and popular forces—and supported by the State and private sector—have proved critical in those countries that are making headway against the epidemic. The best of them closely involve people living with HIV/AIDS, and pay special attention to the roles and needs of young people and women. In many countries, new forms of mobilization, such as social networks and organizations, have emerged to confront AIDS and invigorate civil society. When civil society organizations have been able to participate in policy-making, AIDS strategies and activities have generally benefited.

3. **Involve people living with HIV/AIDS**. The involvement of people living with HIV/AIDS is an indispensable part of an effective response. Through example and activism, those living with HIV/AIDS have spearheaded many of the successes achieved against the epidemic. Their courage has inspired countless similar efforts to counter the epidemic and its effects. In countries around the world, people living with HIV/AIDS have helped draft national plans and ensured that they match grass-roots realities. Their involvement is vital, too, in overcoming the barriers of stigma, discrimination and denial. But if they are to choose candour over secrecy, people living with the virus need to have an environment that protects them and safeguards their human rights.

4. **Overcome stigma and discrimination**. Stigma, discrimination and human rights violations form a vicious circle, reinforcing and perpetuating each other. They increase people's vulnerability and, by isolating people and depriving them of treatment, care and support, worsen the impact of infection—which is why the 2002–2003 World AIDS Campaign is focusing worldwide efforts on removing those barriers. Some key steps? Urge leaders at all levels, and in all walks of life, to visibly challenge HIV-related discrimination, spearhead public action and act against the many other forms of discrimination that people face in relation to HIV/AIDS. Create an appropriate legal environment for fighting discrimination and other human rights violations, and ensure that prevention, treatment, care and support services are accessible to all.

5. **Protect women and young people**. If it is to be effective, an AIDS response (in terms of prevention, treatment, care and support) has to benefit those who are most vulnerable, particularly women and young people. And special care is needed to shield them against the impact of the epidemic. Orphans and children with HIV-infected relatives need access to education, health care and other social services. More intensive prevention activities are needed, and they should reach young people before the latter become sexually active. Efforts to reverse women's low economic and social status need to be redoubled. Income-generation schemes, improving women's employment opportunities and microfinance schemes are among the potential options. A rule of thumb? Experience shows that programmes are more likely to succeed when women and young people are closely involved in designing and implementing them.

There is ample evidence in countries around the world that these approaches can be turned into reality. The following are some concrete suggestions for developing effective HIV/AIDS responses.

Broadening the scope of prevention programmes

If human resources are to be safeguarded and developed, people must be protected against HIV infection. Despite the progress of recent years, there are still huge gaps on the prevention front.

- Fewer than one in five people at risk of HIV infection receive even basic prevention services—proof that prevention programmes are not being mounted on a broad enough scale.
- New research shows that the vast majority of the world's young people have no idea how HIV/AIDS is transmitted or how to protect themselves from the disease.
- It is estimated that there will be up to 45 million new HIV infections by 2010 in low- and middle-income countries if the world fails to mount a drastically expanded, global prevention effort.
- The heavy toll can be avoided. Implementation of a full prevention package by 2005 could cut the number of new infections by 29 million (63%), lowering the number of adults infected each year in low- and middle-income countries from about 4 million, currently, to approximately 1.5 million.
- The target of reducing HIV prevalence levels among young people by 25% by 2010 (set in the Declaration of Commitment on HIV/AIDS) can therefore be met. The course of the epidemic can be drastically changed. But even a three-year delay in implementing a full prevention package could slash the potential gains by half.
- Preventing HIV transmission requires also that people's susceptibility to infection be reduced. Fighting poverty and exclusion—and safeguarding human rights—are powerful elements of successful prevention programmes.

Expanding treatment, care and support

As with prevention, access to adequate treatment and care is both a moral necessity and a precondition for building human resources and reviving development progress. The Declaration of Commitment on HIV/AIDS thus regards access to treatment as a fundamental step towards achieving the right of everyone to the highest possible standard of physical and mental health.

Yet, huge gaps remain in treatment and care.

- Antiretroviral and other drugs are now much cheaper in many countries, but they

A world out of balance

Analysis of access to treatment shows that, of the estimated 6 million people in low- and middle-income countries in need of antiretroviral drug therapy, just 230 000 (less than 4%) were receiving antiretroviral drugs at the end of 2001.

In high-income countries, where an estimated 500 000 people were receiving antiretroviral treatment in 2001, 25 000 people died of AIDS that year. In Africa, however, where only some 30 000 people infected were receiving antiretroviral treatment, AIDS killed 2.2 million people.

Latin America and the Caribbean are showing that the treatment gap can be closed. Eleven countries in that region now have policies that guarantee antiretroviral therapy for HIV-infected citizens. Across the region, about 170 000 people now receive antiretroviral treatment, more than half of them in Brazil.

As these countries work to expand treatment access, other related services, including treatment for opportunistic infections, counselling and social support, are also improving.

remain unaffordable for the majority of people living with HIV/AIDS. As a result, only a small fraction of those in need of HIV/AIDS medications currently receive them. Prices, though, do not represent the same barrier to expanded treatment access as they did two years ago. As the World Health Organization's *Scaling Up Antiretroviral Therapy in Resource-Limited Settings* shows, considerable expansion of treatment access is feasible (see www.who.int/).

- More effort is needed to ensure that essential medicines are available to low-income countries at near-production cost, and that countries' health systems are capable of delivering these treatments to people in need.
- Antiretroviral treatment generates powerful collateral benefits, not least for the health system. Each HIV-infected person who does not progress to AIDS acquires extra years of good-quality and productive life, and saves the health system several hundred dollars per patient-year in averted palliative and opportunistic infection care.
- Greater availability of treatment can boost prevention efforts. Thus, more people are likely to come forward for voluntary counselling and testing, which could bring about behavioural change among those already infected.

Unequal access to life-saving HIV/AIDS treatments is a glaring human rights issue. It also helps keep stigma alive, since HIV/AIDS-related stigma and discrimination are fuelled largely by the fact that HIV/AIDS is so closely associated with ailing health and early death. Increasing access to medication therefore not only helps in the realization of the right to health and in overcoming inequities due to poverty, it also changes attitudes.

Protecting global public goods

An effective response to HIV/AIDS, and other diseases that particularly affect the poor, requires substantial investments in global public goods—services and products that potentially benefit people everywhere.

- The **fruits of research and development** aimed at diseases that predominate in developing countries are a global public good. Yet the quest for such medicines is rare in the handful of high-income countries where most pharmaceutical R&D is concentrated. A mix of financial incentives and regulatory guidelines, along with other mechanisms, could help ensure that the priorities and products of that research answer to the principle of global equity.
- A key challenge is to ensure that the guarantees of the Doha Declaration on TRIPS (the Agreement on Trade-Related Aspects of Intellectual Property Rights) in November 2001 are respected. Concerted action might be needed to ensure that countries have the knowledge and capacity to invoke their right to **respond to public health emergencies**, as stipulated in this declaration.
- World Trade Organization (WTO) member governments can also move to ensure that countries that lack local **pharmaceutical production capacity** (and therefore cannot directly benefit from compulsory licensing arrangements) are, in emergencies, allowed to import essential medicines from a low-cost producer in a third country.
- **Vaccine research** needs to address the entire range of HIV subtypes spreading in different parts of the world. Recent initiatives mounted by low- and middle-income countries are valuable steps in that direction. Once available, vaccines need to be accessible to all who need them.
- **Expanded surveillance programmes** are required, together with strengthened epidemiological data collection and analysis. Though highly valuable, sound research into health economics and health systems and policies is seldom available to low-income countries.

The challenge of governance

How well countries govern, manage and coordinate their national responses will determine whether they achieve success against the epidemic and preserve their human resources.

- In a world of AIDS, one of the indicators of good governance is the willingness of leaders and governments to visibly promote the fight against the epidemic. Thus, the successes in Brazil, Thailand and Uganda drew heavily on their respective governments' visionary and courageous leadership in the early stages of the epidemic. This created the ideal conditions for the mobilization of government, communities, businesses, and other civil society groups.
- The twin goals of struggling for development and fighting against HIV/AIDS are more likely to be achieved in settings where States are accountable to their citizens, and are capable of safeguarding their human rights and providing them with the conditions for secure livelihoods, with basic services. These, ultimately, are the truest yardsticks of good governance.
- Governance needs to be inclusive and democratic. Social dialogue with civil society is an indispensable aspect of democratic governance and a fundamental part of an effective HIV/AIDS strategy. A hallmark of success to date has been the strong roles played by civil society organizations—from grass-roots community groups to national NGOs and research institutions. Incorporating the experiences and insights of community responses into policies has proved especially valuable.
- The principles of sound governance—not least those of transparency and accountability—extend also to relations between donor countries and multilateral institutions, on the one hand, and low-income countries on the other.

Reviving the public sector

In many low-income countries, the eroded capacity of the public sector has seriously undermined the sector's ability to rise to the dual challenge of fighting AIDS and fulfilling its pivotal role of enhancing and safeguarding human resources and development.

- The impact of HIV/AIDS on public services must be taken into account and addressed in ways that anticipate the epidemic's effects. The ability to replace skilled professionals is a top priority, especially in low-income countries where governments depend heavily on a small number of policy-makers and managers for public management and core social services.
- Human resource planning needs to take account of an advancing and long-term epidemic. Crucially, time frames have to reflect the inexorable manner in which HIV/AIDS can spread, and the initially imperceptible ways in which its effects accumulate in society.

Planning ahead

Supported by UNDP, the Malawi Government has launched a major review of the impact of HIV/AIDS on human resources in the public sector. It is now devising measures to maintain productivity and ensure that workers affected by the epidemic are supported.

The government is considering setting up a system to better track morbidity, mortality and absenteeism in public services. It also plans to establish a fund to help staff with funeral costs, introduce fast-track training and recruitment of replacement staff, adjust human resource management policies to ensure continued functioning of essential services, and step up workplace prevention and care activities.

- Donor-imposed limits on public sector spending need not pit fiscal responsibility against the need for sustained investment in an AIDS response. Stronger, responsible public investment in line with a cogent HIV/AIDS strategy will reap huge long-term benefits—not just in steeling society against the epidemic, but also in spurring development processes.
- It is not enough to have sufficiently large budget allocations. Services and interventions must reach all who need them. Especially where the public sector has been sapped by cutbacks, institutional capacity needs to be replenished.
- In some cases, national capacities for management and implementation need to be boosted. Sound budgeting systems and strong accountability frameworks are important if funding is to be disbursed smoothly. Equally important is the capacity for accurate monitoring and evaluation.

Integrating HIV/AIDS into wider development strategies

A step forward occurs when the HIV/AIDS response is made everybody's business. AIDS-alertness should be part of the remit of public institutions, nongovernmental organizations and private companies if human resources are to be protected from the epidemic. Just as mobilization around environmental concerns has made environmental impact assessments a key part of policy-making, AIDS impact assessments need to become commonplace.

Persistent and, in many cases, deepening poverty has revived the emphasis on poverty reduction, with donor countries now focusing aid and debt relief on countries with good poverty reduction strategies, and solid systems of governance. Poverty reduction strategies are more likely to yield lasting benefits if they also include specific commitments and targets that relate to HIV prevention, care and impact mitigation.

Making HIV/AIDS everybody's business

There are countless ways in which the AIDS response can be liberated from the pigeonhole of the Ministry of Health and slotted into the agenda of other government sectors.

- Ministries of Labour, for example, can promote workplace prevention and care programmes in the public and private sectors, as well as assess and prepare for AIDS-related labour market shifts.
- Ministries of Defence can use their budgets to implement prevention and care programmes in the military, particularly among young recruits.
- Ministries of Education can introduce HIV/AIDS education, including reproductive health information, into school curricula, and devise ways to broaden access to education (especially for orphans and other vulnerable children).
- Ministries of Agriculture can use their networks of extension workers to bring AIDS-related skills to rural communities, and to ensure that necessary resources and support are available to help people cope with the epidemic's impact.
- Ministries of Land Affairs can improve land tenure arrangements that discriminate against women and marginalize sectors of the population.
- Ministries of Finance can factor into their economic policy frameworks the long-term costs and benefits of mounting an effective AIDS response, and prevent vital public spending priorities from being sacrificed.
- All ministries and departments can assess and plan for the human resource impact of the epidemic.

Social and economic strategies are more likely to achieve the goals of poverty eradication and sustainable development if they measure up to the challenge of HIV/AIDS.

- Poverty-reduction strategies also hold the potential for better aligning economic policies with the broader imperatives of reducing poverty, boosting equity and fighting AIDS. Especially for countries badly affected by AIDS, macroeconomic policies can be geared more acutely towards reducing deprivation, enhancing access to productive resources for wider segments of populations, improving public provision of essential services, and strengthening infrastructures. These are not new issues, but AIDS certainly makes them more urgent.
- Pro-poor policies can strengthen community organizations, which, in turn, can help reduce social exclusion. When these organizations operate along genuinely representative and participatory lines, they can help ensure that resources and skills reach poor households—all valuable elements of long-term success against the epidemic.
- Keeping or introducing cost-recovery measures in the education system needs to be weighed against the effects of such measures on AIDS prevention efforts and the long-term vulnerability of communities.
- Programmes to promote basic education, for example, need to ensure that orphans benefit. Those aimed at widening access to health services need to target youth and members of households who are affected by the epidemic.
- Steps that promote gender equality and that counter the overlapping forms of legal, economic and social discrimination that marginalize groups (such as minorities, migrants, displaced persons and refugees) are as valuable in the fight against HIV/AIDS as they are in the struggle for sustainable development.

Forging new partnerships

One of the best ways to enhance human resources is to harness them in the form of partnerships.

- A strong case exists for moulding social compacts around the dual challenge of countering the AIDS epidemic and achieving sustainable development. Countries that have expanded their responses to include all fields of economic and social life have seen their national response bolstered. An important role for governments is to pave the way for all sectors of society to contribute to the response.
- The strongest responses have been achieved when a broad network of partnerships has been forged—involving people living with HIV/AIDS, community-based organizations, non-governmental organizations, faith-based organizations, businesses, the media, and sports and cultural bodies.
- AIDS also represents an ideal opportunity for combining the strengths of the government, trade unions and the private sector. Labour ministries, for example, have a central role to play, both in gauging and addressing the effects of the epidemic on the labour market and in ensuring that workplace programmes become widespread realities. Unions and businesses share those responsibilities.
- Despite progress, too many businesses still shirk such duties, too many unions allow AIDS to slip off their agenda, and too many governments (despite claims to the contrary) still handle AIDS mainly as a public health issue. As a result, in many places, the impact of a potentially powerful social partnership is not being felt.

Good policies make the difference

The fight to preserve human resources against AIDS could benefit from a wider rethink of policy choices, too.

- At the heart of a quest for sustainable development lie often-difficult economic policy choices that, in complex ways, might mesh with the HIV/AIDS epidemic. Measures that enable countries to reduce the impact of the epidemic at all levels can dramatically enhance their development prospects. Likewise, policies that end up narrowing people's access to secure employment, incomes and essential services—policies that exacerbate human poverty, in other words—can help ingrain the conditions of insecurity in which the epidemic thrives.
- Under the Declaration of Commitment, governments agreed to evaluate, by 2003, the economic and social impact of the epidemic and develop strategies at all levels for reducing that impact. Steps could include poverty eradication strategies and development policies to counter the impact of HIV/AIDS on economic growth, economic services, labour, government revenues and public resources.
- Equally important are policies and programmes that reflect the importance and value of social cohesion and equity. This implies approaches that are rights-based and that actively counter discrimination and social exclusion.
- By analysing more closely the linkages between policy shifts and the socioeconomic conditions in which the epidemic thrives, countries can more finely hone their AIDS responses. There is considerable scope for further research and deeper analysis on this front.
- More research is needed, for example: to assess the impact on basic service access if certain public services are shifted into poorly regulated private control; to test whether moves towards deeper trade liberalization reinforce or sap the livelihoods of the poor; to assess the outcome of a particular policies on the financial and social status of women; and to probe the effects of cost-recovery mechanisms on the provision of health care and education available to the poor.
- Steps are needed also to protect health care and other social services against economic shocks and subsequent budgetary cuts. Particularly important are pre-emptive efforts to protect the poor in such situations.
- As the debates around TRIPS have shown, a strong case exists for ensuring that trade and other agreements struck at the international level do not impede States' efforts to fulfil their essential mandates—such as safeguarding public health or protecting human security. For example, the possible effects on health-care provision and other basic services of new rounds of negotiations to liberalize trade in services deserve scrutiny.

Paying the bills

Strong commitment, sound governance, lucid strategies and policies, and inventive partnerships all help make an HIV/AIDS response effective. But these efforts come to nought if sufficient funding is not available.

Where could the funding come from?

A calculation of the estimated total financial need in low- and middle-income countries for HIV/AIDS, done by an international team convened by UNAIDS, has shown that, by 2005, US$10 billion will be required to mount a minimum, credible response. (These projections are based on conservative estimates of expansion costs for each of 18 prevention, treatment and care interventions used in the calculations of overall resource needs, and do not include costs for building up infrastructure.)

The amount is several times larger than the spending projections for 2002 in low-

and middle-income countries. A sustained increase of 50% annually in total funding for HIV/AIDS programmes has to be achieved. This is a modest amount.

The additional funding needs to come from five main sources, each of which brings its own advantages to a comprehensive human resource-centred HIV/AIDS response.

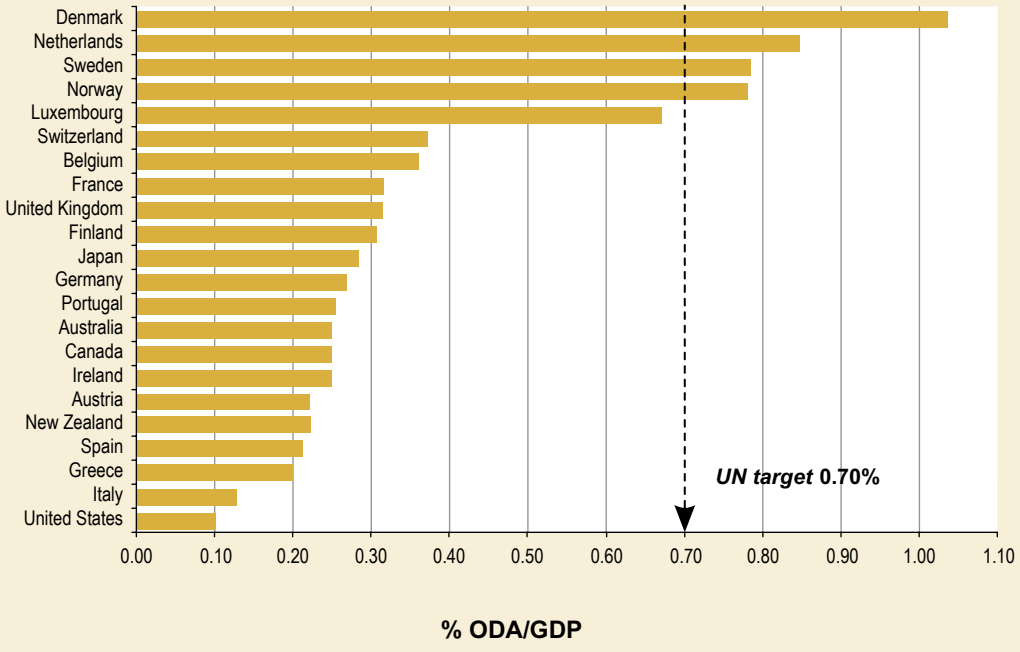
1. The affected countries themselves have a special responsibility

- Increasing health spending is one way of slowing the spread of the epidemic and reducing its impact—as African governments showed in April 2001 by agreeing to increase their health outlays to 15% of total budget spending.
- Increased public investment should be considered, including for programmes aimed at eradicating extreme poverty, improving the status of women, and boosting the education and livelihood prospects of young people, among others.
- More countries (including some of the poorest) are devoting significant funds towards combating the epidemic. But the most commonplace reality is that many interventions do not reach the poor. A weak public sector, and consequent mismanagement, is only partly to blame. The poor lack the financial resources to access these services, and their governments lack the resources to provide the necessary coverage.

2. International assistance must increase exponentially

- Even with more efficient allocation, the levels of funding necessary to cover essential health services hover far beyond the reach of poor countries and of many middle-income countries with high HIV prevalence rates. Bridging the shortfall is a duty that rests with the international community.
- Stronger commitment from bilateral donors would be one valuable move. Their

Net Official Development Assistance (ODA) as percentage of gross domestic product (GDP): 2000



Sources: For GDP data, OECD, *National Accounts of OECD Countries*, Volume 1, for ODA data, OECD

comparative advantage lies in being able to draw on domestic technical resources (for example, within their universities and national programmes), and their capacity to build solidarity directly between their own communities at home and those in the recipient countries (for example, through networks of non-profit organizations).

- Greater donor assistance is needed, particularly to boost public investments that help overcome poverty, improve health and other public services, and mitigate the effects of the epidemic. As the Commission on Macroeconomics and Health (2001) has stressed, a lack of donor funds should not be the factor that limits the capacity to provide health services to the world's poorest people.
- Not only have **Official Development Assistance** (ODA) flows been thinning significantly, but ODA flows to the 28 countries most seriously affected by AIDS (countries where HIV adult prevalence exceeds 4%) have fallen by a third since 1992 (from US$12.8 billion to US$8.4 billion).
- Recent steps by the United States of America and the European Union, announced at the Monterrey Conference on Financing for Development in March 2002, point in the right direction. At the conference, they raised their ODA levels by US$12 billion in total over several years. The Organization for Economic Cooperation and Development (OECD) and the Development Assistance Committee (DAC) estimate that (calculating an average growth in donor countries of 2.5%) an increase from the present ODA level of some 0.2% to the 0.3% level of some years ago could raise the overall aid resources by US$46 billion annually.
- **Debt relief** needs to reach a lot deeper. Half of the 26 countries receiving debt relief under the enhanced Heavily Indebted Poor Countries (HIPC) Initiative were still spending 15% or more of government revenue on debt repayments in early 2002, 'crowding out' vital public investments in health, education and other areas.
- Debt relief also needs to extend much wider. Ineligible for debt relief under the HIPC Initiative are 16 countries where adult HIV prevalence exceeded 1.5% in 2001, including several sub-Saharan African countries where HIV prevalence exceeded 20%.
- Given the multiple difficulties experienced by many low- and middle-income countries—not least those facing serious HIV/AIDS epidemics—a case exists for relaxing the eligibility criteria for debt relief in their favour.

3. Multilateral channels should be expanded

- Multilateral organizations are well placed to ensure that internationally accepted scientific and technical standards are applied, and to help harmonize approaches to complex social issues. United Nations agencies, in particular the eight Cosponsors of UNAIDS, are making valuable contributions towards the protection of human resources against the epidemic.
- The United Nations Children's Fund (UNICEF) works extensively on protecting vulnerable children, including orphans, against HIV/AIDS. Incorporating HIV/AIDS into broader development strategies has become a focus of UNDP's work against the epidemic, while the United Nations Population Fund (UNFPA) has taken the lead on condom provision and reproductive health programmes for young people. The United Nations International Drug Control Programme (UNDCP) is acting to break the link between injecting drug use and the epidemic, while the ILO's international guideline for workplace programmes reflects its focus on AIDS and the world of work.
- Meanwhile, the United Nations Educational, Scientific and Cultural Organization (UNESCO) is marshalling strong efforts

in the education and culture sectors. The World Health Organization (WHO) lays special emphasis on strengthening health-care systems' responses to HIV/AIDS, and provides normative guidance for health interventions. Along with supporting donor agencies and national governments in their bids to counter the epidemic, the World Bank provides concessional funding, including US$1 billion under the Multi-country HIV/AIDS Program (MAP) for Africa.

4. The Global Fund to Fight AIDS, Tuberculosis and Malaria requires sustained support

- Operating since January 2002, the **Global Fund to Fight AIDS, Tuberculosis and Malaria** adds the comparative advantage of focusing new resources on programmes in countries with the greatest need.
- Total pledges to the **Global Fund** stood at more than US$2 billion in August 2002, and UNAIDS estimates that a considerable share of the funding will go towards AIDS. Were that figure to grow significantly, many countries would have a better chance of preventing the epidemic from spreading and of providing citizens with the treatment, care and support they need. This funding should be additional and *new*, and not have been diverted from other valuable development activities.

5. The private sector needs to play its part

- Greater support from businesses is crucial. They are often best placed to reach workers and their communities, not least in the cases of mobile workers. Approximately 7% of the total resource need is for workplace prevention programmes, which private enterprises can fund.
- Workplace prevention programmes are multiplying, and more businesses are recognizing the value of investing in treatment and care for workers. But the scale and range of business involvement in the fight against AIDS is still only a fraction of its potential. For example, more can be done to harness key business strengths (such as distribution networks and marketing savvy) in HIV/AIDS responses.
- Foundations and philanthropies are becoming increasingly valuable allies as they incorporate HIV/AIDS into the health, education and other development initiatives they support.

Conclusion

HIV/AIDS is ravishing the world's most valuable resource: its people.

In two decades, AIDS has killed more than 20 million people. By 2020, another 68 million face premature death in the 45 most affected countries, unless concerted and effective action is taken now.

By targeting mainly the working-age population (15–49)—people with vital social and economic roles in their communities and societies—AIDS depletes human resources, saps productive capacity, and deepens poverty and hardship.

AIDS makes developmental recovery, let alone *progress*, inestimably more difficult. It simultaneously entrenches the conditions in which the epidemic thrives, creating a vicious, downward spiral.

At the same time, it is clear that wide and equitable access to education, health and other essential services, and effective steps to eradicate poverty and achieve social and economic equity, increase the odds of holding an AIDS epidemic in check.

Because of this, the mutual struggles of controlling the epidemic, while shielding people against its effects, and making stronger progress towards sustainable development are inseparable.

Prevention works. Treatment and care save lives. The world knows what it takes—strategically, institutionally, financially—to set effective responses in place everywhere they are needed.

An effective, long-term response to the epidemic hinges on recognizing and protecting people's rights. Individuals and communities who are able to realize their rights to information, education, health, shelter and viable livelihoods, and who are protected against discrimination and violence, are less vulnerable to the epidemic and more able to cope with its impact.

The Declaration of Commitment on HIV/AIDS agreed to by governments in June 2001 provides a benchmark for action and accountability. It cannot be allowed to turn into another empty promise. Living up to it will bring the dual benefits of reversing the global AIDS epidemic and sustaining development.

The challenge now is to act.

Annex: A brief overview of the global HIV/AIDS epidemic

The disease is striking the poor the hardest: more than 95% of people living with HIV/AIDS are in low-income countries, and 70% of them are in sub-Saharan Africa. In high-income countries, poor and marginalized groups account for an increasing share of new infections. Women and young girls are increasingly affected, reflecting persistent and glaring gender inequalities, despite political commitments to the contrary.

New data compiled in UNAIDS' *Report on the Global HIV/AIDS Epidemic, 2002* [www.unaids.org] highlight troubling trends:

- The global epidemic is still in its early stages. It is growing further, including in countries that, to date, have been spared the brunt of its impact.
- HIV prevalence is climbing higher than previously believed possible in the worst-affected countries. In some, more than one-third of the adult population is HIV-infected.
- The epidemic is spreading rapidly into new populations and areas in Africa, Asia, the Caribbean and Eastern Europe (especially in countries of the former Soviet Union).

In parts of the world where the epidemic had appeared relatively stable, new data show sudden, rapid increases in prevalence.

- In parts of Western and Central Africa, where HIV infection rates have been high but relatively stable, there is now evidence of rapidly accelerating HIV spread. In Cameroon, for example, the adult prevalence rate, which remained in the low single digits from 1988 through 1996, now stands at almost 12%. Some states in Nigeria, Africa's most populous nation, are already experiencing prevalence rates as high as those now found in Cameroon.

Some of the world's most populous countries, such as China and Indonesia, are examples of just how suddenly an epidemic can emerge, even if, initially, it might take years for HIV spread to become apparent. In such cases, even a relatively low HIV prevalence rate would mean many millions of people are infected.

- In China, where almost all cases of HIV/AIDS were previously transmitted through injecting drug use and unsafe blood practices, the epidemic is increasingly spreading through heterosexual contact. Countrywide, reported HIV infections rose nearly 70% in just the first six months of 2001.
- Indonesia hardly saw HIV for more than a decade. Infection rates are now rising steeply among injecting drug users and sex workers, and among blood donors (a sign of HIV spread in the wider population).
- And in India, already home to almost 4 million people living with HIV/AIDS, the virus is spreading beyond high-risk groups into the wider population.

Several countries that have undergone dramatic political and economic changes (such as those in Eastern Europe and in the former Soviet Union) are now home to the world's fastest-growing HIV/AIDS epidemics.

- The cumulative number of reported cases in the Russian Federation has increased more than 15-fold in just three years (from 11 000 in 1998 to 177 000 at the end of 2001). In Estonia, reported infections have soared from 12 in 1999 to 1474 in 2001.
- HIV has begun spreading swiftly in the countries of central Asia, including Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan.

In conflict zones in Africa, a rise in HIV prevalence is being detected.

- HIV prevalence is rising in urban areas of Angola, for example, and there is reason to fear a similar trend in the Great Lakes region, where the massive displacement of people and disruption of social structures and governance worsen people's vulnerability to the epidemic.

No region is being left unscathed.

- Some Caribbean countries have infection rates second only to those in Africa. In Haiti, adult HIV prevalence exceeds 6%, and in the Bahamas it is almost 4%. In 10 other countries in Latin America and the Caribbean, at least 1% of the adult population is estimated to be living with HIV.
- In the Middle East and North Africa (where 500 000 people were living with HIV/AIDS at the end of 2001), HIV infection rates are increasing.
- In many high-income countries, prevention efforts are stalling and the epidemic is moving into disadvantaged communities, with women making up a larger proportion of new infections than before.

Contrary to earlier expectations, the epidemic is not yet 'levelling off' in heavily affected countries, with severe consequences for their demographic structures.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) is the leading advocate for global action on HIV/AIDS. It brings together eight United Nations agencies in a common effort to fight the epidemic: the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations International Drug Control Programme (UNDCP), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO) and the World Bank.

UNAIDS both mobilizes the responses to the epidemic of its eight cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV/AIDS on all fronts: medical, public health, social, economic, cultural, political and human rights. UNAIDS works with a broad range of partners—governmental and NGO, business, scientific and lay—to share knowledge, skills and best practice across boundaries.

Produced with environment-friendly materials

The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together eight United Nations system organizations. These UNAIDS Cosponsors are:

For 56 years, the United Nations Children's Fund (UNICEF) has been working with partners around the world to promote the recognition and fulfilment of children's human rights. This mandate, as established in the Convention on the Rights of the Child, is achieved through partnerships with governments, nongovernmental organizations and individuals in 162 countries, areas and territories. It brings to UNAIDS this extensive network and an effective communication and advocacy capacity. UNICEF's priorities in addressing HIV/AIDS include prevention among young people, reducing mother-to-child transmission, care and protection of orphans and vulnerable children, and care and support for children, young people and parents living with HIV/AIDS.

As a development agency with strong country presence, the United Nations Development Programme promotes an enabling policy, legislative and resource environment for an effective response to HIV/AIDS. Areas of work include: mobilizing actors and institutions well beyond the health sector to facilitate the social transformation needed to achieve a HIV-free future; promoting strong leadership and capacity for a coordinated and enhanced response; helping governments raise domestic and international resources; placing HIV/AIDS at the centre of national development agendas; and promoting the rights of people living with HIV/AIDS through advocacy and legislation.

The United Nations Population Fund (UNFPA) applies its 30 years' experience in reproductive health to prevent HIV and sexually transmitted infections. As a priority within 150 country programmes, UNFPA focuses on HIV prevention among young people, comprehensive condom programmes for both male and female condoms, and prevention of infection among pregnant women. UNFPA supports: advocacy efforts; improving access to information and education, including voluntary counselling and testing; strengthening capacity of service providers across sectors; and provision of commodities for the prevention of HIV and sexually transmitted infection, such as STI/HIV test kits, male and female condoms and infection prevention and control supplies.

The United Nations International Drug Control Programme (UNDCP) is entrusted with exclusive responsibility for coordinating and providing effective leadership for all United Nations drug control activities. In this context, UNDCP actively supports HIV/AIDS prevention in programmes to reduce the demand for illicit drugs. Its primary focus is on youth and high-risk groups. UNDCP operates from its headquarters in Vienna, Austria, as well as from a field network currently serving 121 countries and territories.

The International Labour Organization (ILO) works to promote social justice and equality, set standards in employment, and improve working conditions. The ILO's particular contribution to UNAIDS includes: its tripartite membership, encouraging the mobilization of governments, employers and workers against HIV/AIDS; direct access to the workplace; long experience in framing international standards to protect the rights of workers; and a global technical cooperation programme. The ILO has produced a code of practice on HIV/AIDS and the world of work—an international guideline for the development of national and workplace policies and programmes.

Within the UN system, the United Nations Educational, Scientific and Cultural Organization (UNESCO) has a special responsibility for education. Since ignorance is a major reason why the AIDS epidemic is out of control, preventive education is at the top of UNESCO's agenda. The need for such education flows from the types of ignorance associated with HIV/AIDS, particularly in the most affected developing countries: most of those infected do not know it; there are widespread misconceptions about possible remedies; and there is sparse and unfounded knowledge about the disease itself, leading to prejudice and discrimination.

The World Health Organization (WHO) supports countries in strengthening their health systems' responses to HIV/AIDS and other sexually transmitted infections. WHO promotes partnerships, provides technical and strategic support to countries and regions, and develops normative guidelines and other resources on key health interventions, including prevention of mother-to-child transmission; management of HIV/AIDS, sexually transmitted infections and related conditions, including use of antiretroviral therapy; blood safety; universal precautions; vaccine development; safe injection; voluntary counselling and testing; and interventions targeting vulnerable populations. WHO also contributes to the global HIV/AIDS knowledge base by supporting monitoring and surveillance, reviewing the evidence for interventions and promoting research.

The mandate of the World Bank is to alleviate poverty and improve the quality of life. Between 1986 and early 2002, the World Bank committed nearly US$2 billion for HIV/AIDS projects worldwide. Most of the resources have been provided on highly concessional terms, including US$1 billion under the Multi-Country HIV/AIDS Program (MAP) for Africa. To address the devastating consequences of HIV/AIDS on development, the Bank is strengthening its response in partnership with UNAIDS, donor agencies and governments. The Bank's response is comprehensive, encompassing prevention, care, support, treatment, and impact mitigation.

Joint United Nations Programme on HIV/AIDS
UNAIDS
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