MAINSTREAMING HIV/AIDS AND GENDER INTO THE TRADE POLICY DEVELOPMENT PROJECT

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Submitted to:
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Gaborone, Botswana

February 2005

USAID Contract No. 690-M-00-04-00309-00 (GSA No. GS 10F-0277P)
**Context**

- The Trade Policy Development (TPD) Project was conceived to contribute to achieving SO 14: A more competitive Southern African economy. The TPD Project’s strategic objective is to increase economic growth by making the Southern Africa economy more competitive in world markets.
- The TPD Project addresses two IRs under SO 14, namely:
  - IR 14.1: Improved policy and regulatory environment for competitiveness and free trade; and
  - IR 14.3 Key transaction costs reduced.
- The TPD Project works closely with the Trade Competitiveness Component (TCC) Project, which is the project responsible for addressing IR 14.2: Strengthened capacity of targeted clusters to produce and market competitive goods and services.
- USAID policy requires that gender issues are addressed as appropriate in all USAID-funded activities (TPD Project Statement of Work).
- Also, the contractor must incorporate interventions to mitigate the effects of HIV/AIDS on the capacity of government ministries and regional institutions to participate effectively in trade negotiations and to conduct effective trade policy development and implementation (TPD Project Statement of Work).

**Purpose of the concept note**

To present a framework for mainstreaming HIV/AIDS and gender into the TPD Project’s 4-year work plan by:

- Making the economic and business case for mainstreaming HIV/AIDS and gender into any trade initiative.
- Analysing the TPD Project’s core activities for areas of comparative advantage to mainstream HIV/AIDS and gender.
- Proposing activities – primarily the amendment of planned activities – that will ensure HIV/AIDS and gender mainstreaming.
- Developing indicators to monitor and measure HIV/AIDS and gender mainstreaming in the TPD Project.

**Point of departure**

1. The emphasis is on HIV/AIDS mainstreaming; with gender mainstreaming being a secondary, albeit important, consideration. The reality is that the links between HIV/AIDS and gender are so profound that it is often impossible to separate the two.

2. There is an assumption that the components and activities in the TPD project year-one work plan will form the basis for subsequent years and so the proposed areas for HIV/AIDS and gender mainstreaming are restricted to those.

3. The majority of TPD Project initiatives are regional (as opposed to working with individual countries or companies).
4. The emphasis at all times is on the policy level, as opposed to the programme level (which is more the domain of the TCC Project).

**Understanding HIV/AIDS mainstreaming**

There are many definitions of HIV/AIDS mainstreaming. For this purpose the following one will serve as a definition for the TPD Project:

**Mainstreaming HIV/AIDS** means determining (i) how the spread of HIV is caused or contributed to by the Project; (ii) how the epidemic is likely to affect its objectives, activities and outputs; and (iii) where the Project has a comparative advantage to respond – to limit the spread of HIV and to mitigate the impact of the epidemic.

**Gender and HIV/AIDS**

Gender refers to the differences in social roles and relations between men and women. The HIV/AIDS epidemic compounds gender inequalities, inequities and discrimination in multiple ways.

- Women and girls are commonly discriminated against in terms of access to education, employment, credit, health care, land and inheritance.
- With the downward trend of many African economies increasing the ranks of people in poverty, relationships with men (casual or formalised through marriage) can serve – for women and girls – as vital opportunities for financial and social security, or for satisfying material aspirations.
- The combination of dependence and subordination can make it very difficult for girls and women to demand safer sex (even/especially from their husbands) or to end relationships that carry the threat of infection.
- These patterns of social, economic and cultural inequality make women more susceptible to HIV infection than men. The situation is worsened further by the physiological differences between men and women.
- As the epidemic spreads, women are faced with the double burden of having to work and cope with the additional responsibilities of caring for family and community members who fall ill.
- It is important to recognise that men, too, are subject to social and cultural pressures that increase their susceptibility to HIV infection and their likelihood of spreading it further. Multiple partners and sexual infidelity are condoned for men in many societies.
- Finally, certain occupations tend to encourage risk-taking behaviour, especially those that involve men spending long periods away from their families. This in turn increases the risk of infection for their partners when they return home.

**The economic and business case for mainstreaming HIV/AIDS**

The impact of the epidemic can be described in different ways and it is useful to consider this according to the framework below, or alternatively within three spheres, namely microeconomic impacts, macroeconomic impacts, and sectoral impacts.
Major channels of HIV/AIDS impact on the economy

For firms:
- Insurance/benefits up → affects costs, profits, savings
- Disruption/absenteeism → affects overall productivity
- Worker experience down/morbidity → affects labour productivity

For government:
- AIDS spending up → affects other spending, deficit
- Production structure shifts → affects revenue from VAT, trade taxes
- Household incomes, spending shift → affects income tax receipts, transfers

For households:
- Loss of income/orphans → vulnerable households require transfers
- Caring for those with HIV/AIDS → changed expenditure patterns, reduced savings, asset sales, lower investment in human capital

For the macro economy:
- Lower physical and human investment → reduced growth trajectory
- Class biased impacts → uneven welfare effects

1. One of the most significant features of the epidemic is its concentration in the working age population (aged 15-49) such that those with critical social and economic roles are disproportionately affected.

2. The loss to the economy of skilled and experienced workers results in both direct and indirect costs. Direct costs relate to recruitment and training, to reduced productivity and are associated with demands on health care and other benefits. Indirect costs include absenteeism due to illness or funeral attendance, recruitment and training costs to replace employees lost due to HIV/AIDS, reduced work performance and lower productivity, and lost skills, loss of institutional memory and decreased staff morale.

3. At the macroeconomic level, there will be negative changes to GDP, though the extent of these is still hotly debated. Certainly the diversion of household resources to health care and the inability of affected households to save can result in a shortage of resources available for investment at the national level.

4. At the same time, the loss of investment in human capital at the household level can also have long-term consequences. If families don’t have the resources needed to invest in the education of their children, the nation as a whole may find that it lacks the human capital it requires. And, if the poor are disproportionately affected by HIV/AIDS, then a quickly spreading epidemic may produce greater economic disparities between the rich and the poor.

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2 Cohen, D; Human capital and the HIV epidemic in sub-Saharan Africa (June 2002)
5. In addition, issues of international competitiveness are very relevant within the African context. Countries inevitably compete against one another to attract investors. In turn, investors seek to locate their businesses in a country that has the most productive, lowest-cost workforce. HIV/AIDS affects the international competitiveness of an economy when there is a reduction in the number of workers available and possibly a shortage of workers or of specific skills, leading to higher wages, higher training costs and higher domestic production costs.

6. In short, the epidemic is affecting the size, growth rate, and age and skill composition of both current and future labour forces. At the same time, HIV/AIDS is raising the cost of labour in all Southern African countries and diminishing the competitiveness of African business in the global marketplace.

7. Finally, the existence of orphans, while often dealt with as a social issue, also represents a significant economic issue as children are considered, by many, as Africa’s most vital long-term economic investment.

HIV/AIDS should therefore be an issue that is acknowledged, analysed and addressed in the same way as any other significant challenge to a government, sector, or organisation. This implies applying the same management principles and strategies as would be applied to any other strategic priority. The rationale would be to:

- Ensure an uninterrupted labour supply – the right people, in the right place, at the right time.
- Minimise the impact of the epidemic on productivity.
- Contain costs.
- Manage demand and supply fluctuations or changes resulting from HIV/AIDS.
- Contribute to broader societal initiatives to address the epidemic.

**HIV/AIDS, gender and mobility**

Borders, customs and corridors are an area where the TPD Project has the greatest potential to mainstream HIV/AIDS and gender, and so an understanding of HIV/AIDS, gender and mobility and of the various points of entry for mainstreaming is relevant. The International Organisation for Migration (IOM) defines a framework for HIV/AIDS interventions based on four stages of mobility:

- **Source**: where people come from, why they leave, and the relationships they maintain at home while away.
- **Transit**: the places people pass through, how they travel and their behaviour while they travel.
- **Destination**: where people go, the attitudes they encounter and their new living and working conditions.
- **Return**: the changes that have occurred in people’s lives and the conditions they find upon their return.

Factors that increase the vulnerability of mobile populations to HIV/AIDS include:
- Work involving mobility, in particular the obligation to travel regularly and live away from spouses.
- Separation from socio-cultural norms that regulate behaviour in stable communities.
- Work in isolated environments with limited recreation and easy access to commercial sex workers (CSWs), drugs and alcohol.
- Limited access to health facilities, including treatment for sexually transmitted infections (STIs) and HIV/AIDS prevention and care programmes.
- Types of accommodation such as single-sex, overcrowded living quarters or having to sleep in trucks.
- Difficult and dangerous working conditions, with high risk of physical injury.
- Workplaces dominated by men.
- For women and girls, transactional sex, sexual abuse and sexual violence.
- A sense of anonymity, which allows for more sexual freedom.
- Xenophobia and discrimination.
- Lack of legal rights and legal protection.

**Scope**

The TPD Project covers the following countries: Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania and Zambia.

**Country comparative analysis**

There are both important similarities as well as some key distinctions between the TPD Project countries – in terms of economic, development and HIV/AIDS data.

**Table 1: Basic demographic data**

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>AREA (KMP)</th>
<th>POPULATION</th>
<th>POPULATION GROWTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>1 246 700</td>
<td>10 978 552</td>
<td>1.93%</td>
</tr>
<tr>
<td>Botswana</td>
<td>582 000</td>
<td>1 561 973</td>
<td>-0.89%</td>
</tr>
<tr>
<td>Lesotho</td>
<td>30 355</td>
<td>1 865 040</td>
<td>0.14%</td>
</tr>
<tr>
<td>Malawi</td>
<td>118 484</td>
<td>11 906 855</td>
<td>2.14%</td>
</tr>
<tr>
<td>Mozambique</td>
<td>801 590</td>
<td>18 811 731</td>
<td>1.22%</td>
</tr>
<tr>
<td>Namibia</td>
<td>825 418</td>
<td>1 954 033</td>
<td>1.25%</td>
</tr>
<tr>
<td>South Africa</td>
<td>1 225 815</td>
<td>42 718 530</td>
<td>-0.25%</td>
</tr>
<tr>
<td>Swaziland</td>
<td>17 363</td>
<td>1 169 241</td>
<td>0.55%</td>
</tr>
<tr>
<td>Tanzania</td>
<td>945 087</td>
<td>36 588 225</td>
<td>1.95%</td>
</tr>
<tr>
<td>Zambia</td>
<td>752 614</td>
<td>10 462 436</td>
<td>1.47%</td>
</tr>
</tbody>
</table>

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3 Data from CIA; World Fact Book, UNDP; Human Development Report, UNAIDS; 2004 Report on the Global AIDS Epidemic
Table 2: Key economic data

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>GDP</th>
<th>INFLATION</th>
<th>FOREIGN DEBT</th>
<th>UNEMPLOYMENT RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>$20.42 billion</td>
<td>76.6%</td>
<td>$9.164 billion</td>
<td>+50%</td>
</tr>
<tr>
<td>Botswana</td>
<td>$14.2 billion</td>
<td>9.2%</td>
<td>$392 million</td>
<td>40%</td>
</tr>
<tr>
<td>Lesotho</td>
<td>$5.583 billion</td>
<td>6.1%</td>
<td>$735 million</td>
<td>45%</td>
</tr>
<tr>
<td>Malawi</td>
<td>$6.845 billion</td>
<td>9.5%</td>
<td>$3.026 billion</td>
<td>?</td>
</tr>
<tr>
<td>Mozambique</td>
<td>$21.23 billion</td>
<td>11.4%</td>
<td>$1.04 billion</td>
<td>35%</td>
</tr>
<tr>
<td>Namibia</td>
<td>$13.85 billion</td>
<td>7.3%</td>
<td>$180 million</td>
<td>30-40%</td>
</tr>
<tr>
<td>South Africa</td>
<td>$456.7 billion</td>
<td>5.9%</td>
<td>$25.9 billion</td>
<td>31%</td>
</tr>
<tr>
<td>Swaziland</td>
<td>$5.702 billion</td>
<td>7.3%</td>
<td>$320 million</td>
<td>34%</td>
</tr>
<tr>
<td>Tanzania</td>
<td>$21.58 billion</td>
<td>4.4%</td>
<td>$6.549 billion</td>
<td>?</td>
</tr>
<tr>
<td>Zambia</td>
<td>$8.596 billion</td>
<td>21.4%</td>
<td>$5.281 billion</td>
<td>50%</td>
</tr>
</tbody>
</table>

Table 3: Development data

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>INFANT MORTALITY (PER 1,000 LIVE BIRTHS)</th>
<th>LIFE EXPECTANCY (YEARS)</th>
<th>LITERACY</th>
<th>HUMAN DEVELOPMENT INDEX (OUT OF 177 COUNTRIES)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MALE</td>
<td>FEMALE</td>
<td>M: 74.5%</td>
<td>F: 94.5%</td>
</tr>
<tr>
<td>Angola</td>
<td>192.5</td>
<td>36.06</td>
<td>37.55</td>
<td>42%</td>
</tr>
<tr>
<td>Botswana</td>
<td>69.98</td>
<td>30.99</td>
<td>30.53</td>
<td>79.8%</td>
</tr>
<tr>
<td>Lesotho</td>
<td>85.22</td>
<td>36.81</td>
<td>36.81</td>
<td>M: 74.5%</td>
</tr>
<tr>
<td>Malawi</td>
<td>104.23</td>
<td>37.08</td>
<td>37.88</td>
<td>62.7%</td>
</tr>
<tr>
<td>Mozambique</td>
<td>137.08</td>
<td>37.83</td>
<td>36.34</td>
<td>47.8%</td>
</tr>
<tr>
<td>Namibia</td>
<td>69.58</td>
<td>42.36</td>
<td>38.64</td>
<td>84%</td>
</tr>
<tr>
<td>South Africa</td>
<td>62.18</td>
<td>44.39</td>
<td>43.98</td>
<td>86.4%</td>
</tr>
<tr>
<td>Swaziland</td>
<td>68.35</td>
<td>39.1</td>
<td>35.94</td>
<td>81.6%</td>
</tr>
<tr>
<td>Tanzania</td>
<td>102.13</td>
<td>43.2</td>
<td>45.61</td>
<td>78.2%</td>
</tr>
<tr>
<td>Zambia</td>
<td>98.4</td>
<td>35.19</td>
<td>35.17</td>
<td>80.6%</td>
</tr>
</tbody>
</table>
Table 4: HIV/AIDS data (end 2003)

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>ADULTS AND CHILDREN LIVING WITH HIV/AIDS</th>
<th>ADULTS (15-49 YEARS) HIV PREVALENCE RATE</th>
<th>ORPHANS DUE TO AIDS ESTIMATED NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LOW ESTIMATE</td>
<td>HIGH ESTIMATE</td>
<td></td>
</tr>
<tr>
<td>Angola</td>
<td>97 000</td>
<td>600 000</td>
<td>3.9%</td>
</tr>
<tr>
<td>Botswana</td>
<td>330 000</td>
<td>380 000</td>
<td>37.3%</td>
</tr>
<tr>
<td>Lesotho</td>
<td>290 000</td>
<td>360 000</td>
<td>28.9%</td>
</tr>
<tr>
<td>Malawi</td>
<td>700 000</td>
<td>1 100 000</td>
<td>14.2%</td>
</tr>
<tr>
<td>Mozambique</td>
<td>980 000</td>
<td>1 700 000</td>
<td>12.2%</td>
</tr>
<tr>
<td>Namibia</td>
<td>180 000</td>
<td>250 000</td>
<td>21.3%</td>
</tr>
<tr>
<td>South Africa</td>
<td>4 500 000</td>
<td>6 200 000</td>
<td>21.5%</td>
</tr>
<tr>
<td>Swaziland</td>
<td>210 000</td>
<td>230 000</td>
<td>38.8%</td>
</tr>
<tr>
<td>Tanzania</td>
<td>1 200 000</td>
<td>2 300 000</td>
<td>8.8%</td>
</tr>
<tr>
<td>Zambia</td>
<td>730 000</td>
<td>1 100 000</td>
<td>16.5%</td>
</tr>
</tbody>
</table>

**Legal and policy frameworks**

Increasingly the main international and national policy frameworks that guide country responses to HIV/AIDS are development and poverty reduction policies and strategies, namely the Millennium Development Goals, the PRSPs and National Development Plans (NDPs). In addition, the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) targets apply to all signatory countries, as do those defined in their national HIV/AIDS strategies.

MDGs 1, 3 and 8 have particular relevance in the context of mainstreaming HIV/AIDS and gender into the TPD Project.

**MDG 1. Eradicate extreme poverty and hunger**
Target for 2015: Halve the proportion of people living on less than a dollar a day and those who suffer from hunger.

**MDG 3. Promote gender equality and empower women**

**MDG 8. Develop a global partnership for development**
Targets:
- Develop further an open trading and financial system that includes a commitment to good governance, development and poverty reduction – nationally and internationally.
- Address the least developed countries’ special needs, and the special needs of landlocked and small island developing States.
- Deal comprehensively with developing countries’ debt problems.
- Develop decent and productive work for youth.
- In co-operation with pharmaceutical companies, provide access to affordable essential drugs in developing countries.
- In co-operation with the private sector, make available the benefits of new technologies – especially information and communications technologies.

Further, selected extracts from the UNGASS declaration on HIV/AIDS (June 2001) provide the context and focus for HIV/AIDS interventions.

- **Leadership** by Governments in combating HIV/AIDS is essential and their efforts should be complemented by the full and active participation of civil society, the business community and the private sector.
- Realisation of **human rights and fundamental freedoms** for all is essential to reduce vulnerability to HIV/AIDS.
- **Empowering women** is essential for reducing vulnerability.
- By 2005 **reduce HIV prevalence among young men and women** aged 15 to 24 in the most affected countries by 25% and by 25% cent globally by 2010.
- **Care, support and treatment** are fundamental elements of an effective response.
- The HIV/AIDS challenge cannot be met without **new, additional and sustained resources**.

The main international, regional and national trade policy frameworks – which are detailed in the TPD Project work plan for year one – reflect a focus on improving national economies, increasing competitiveness and removing barriers to trade; all of which have significant potential to reduce poverty.

**International best practice**

At the AGOA forum held in Washington DC in 2001, the following were identified as some key economic and trade responses to HIV/AIDS:

- Address challenges to trade and commerce posed by the epidemic in areas of intellectual property rights, trade practices, tourism, the workplace and international competitiveness.
- Enhance employment opportunities for youth, particularly young women, while incorporating HIV/AIDS education and prevention programmes into their training and job preparation programmes.
- Generate employment through the expansion of export opportunities via co-ordination amongst private and public sectors, NGOs and donors.
- Improve customs regulations and speed up transit of long-distance trucks to lessen risks of long stays at border crossing areas.
- Enhance workplace programmes in those industrial sectors that benefit most from trade liberalisation and increased exports.
- Ensure provision of effective HIV/AIDS services in cross-border areas.
TPD Project areas of comparative advantage to mainstream HIV/AIDS and gender

An analysis of the TPD Project year-one work plan suggests the following opportunities to mainstream HIV/AIDS and gender:

Component 1: Capacity building and policy reform for trade and competitiveness

- Finalise work plan – mainstreaming HIV/AIDS and gender into the plan, and developing appropriate indicators (1.1).
- Capacity building – linked to support for implementation of regional agreements (1.3) and trade negotiation training (1.4) – incorporate sessions/modules on HIV/AIDS and gender.
- Policy analysis, reform and/or development – ensure that HIV/AIDS and gender are included in all policy activities.

Component 2: Trade facilitation

- Include HIV/AIDS and gender in any outstanding transport or corridor audits and diagnostic studies (2.1).
- Include HIV/AIDS and gender in any training and in stakeholder meetings (2.1).
- Transport-related risk reduction along corridors and at transit point controls – HIV/AIDS and gender mainstreaming will be effected, not as a direct intervention, but as an indirect one, where rapid processing at border posts, uniform practices across countries, etc will have the potential to decrease HIV risk. Examples where this will/could be done are the Trans Kalahari Corridor (TKC), the Dar es Salaam (Dar) Corridor and at the Lebombo-Resano Garcia post in Mozambique (2.3).
- Formal coordinating committees that are established should include HIV/AIDS and gender in their mandate, and in their business plans.
- Include HIV/AIDS in training for customs officials and border personnel and in outreach to key government ministries and the private sector.
- Collaborate with TCC Project in their identified HIV/AIDS focus areas.

Component 3: Financial services for trade and competitiveness

- Include HIV/AIDS-related aspects, such the impact of HIV/AIDS on financial services, and on SMEs, and on women in SMEs, in the one-country study (3.1).

Component 4: Dialogue for competitiveness

- Include HIV/AIDS in the flagship and other training events (4.1; 4.2; 4.5).
- Mainstream HIV/AIDS into other knowledge management and sharing initiatives, like abstracts (4.2; 4.3; 4.4).
- Document and disseminate lessons learned on HIV/AIDS mainstreaming (4.3).

Other potential HIV/AIDS and gender mainstreaming opportunities may be:

- HIV/AIDS and gender capacity development for the Programme Advisory Group, regional experts and others.
- Ensuring that partnerships and PR for trade are partnerships for HIV/AIDS and gender too:
Requiring that HIV/AIDS is included in every SOW.

**TCC position on mitigating the effects of HIV/AIDS**

The TCC plans to mainstream HIV/AIDS in three ways:

1. **Supporting core business operations by:**
   - Incorporating HIV/AIDS risk assessments into the package of business development services offered to target beneficiaries; and developing cost-effective ways to mitigate the risks.
   - Increasing awareness of HIV prevention, care and treatment, and mitigation amongst entrepreneurs, employees and business association members
   - Establish workplace HIV/AIDS policies (covering rights, benefits and protection from stigma).

   This will take the form of TA and training for selected SMEs and agribusinesses.

2. **Linking with service providers to improve access for HUB clients to HIV/AIDS-related services and to opportunities to participate in national events and fora.**

   This will take the form of coordination, facilitation and support.

3. **In 2004/5, focusing on three sectors/sub-sectors, namely:**
   - Exportable agricultural products – to mitigate the numerous impacts of the HIV/AIDS epidemic, on labour, productivity, knowledge loss, and so on; and specifically to develop a fortified sorghum drink for consumption by infected persons.
   - Textiles/apparel – to develop workplace HIV/AIDS policies and human resource plans (multi-skilling, rapid training, alternatives to assembly lines, and so on) and to assist companies to develop funding proposals.
   - Tourism – to identify the main financial and economic effects, devise strategies and implement these.

**Indicators**

Some examples of indicators to mainstream HIV/AIDS and gender into the TPD Project four-year work plan are detailed in the year-one work plan. They are:

- Number of organisations addressing HIV/AIDS in manpower planning.
- Increasing the percentage of districts with information systems tracking the impact of HIV/AIDS on economic activities.
- The number of people trained in HIV/AIDS workplace policy analysis and related analysis.
- The number of alliances forged with public/private partners for addressing HIV/AIDS issues.

Others could be developed relating to the main areas in which TPD Project HIV/AIDS and gender mainstreaming will take place, namely:
- Advocacy and awareness raising.
- Information dissemination and knowledge sharing.
- Capacity building and training.
- Improved systems and processes at borders and along corridors.

**Possible areas for additional/future TA on HIV/AIDS and gender mainstreaming**

- TA on request by the team, for specified activities.
- Article/s on HIV/AIDS and/or gender for “Trade Matters”.
- Abstract on HIV/AIDS and/or gender.
- Meeting with P Craviolatti (TCC Project) to explore joint initiatives.
- Literature search for HIV/AIDS and gender materials for the website.
- HIV/AIDS workplace policy brief and examples.
- Development and piloting of HIV/AIDS module for inclusion in training courses.
- HIV/AIDS and gender mainstreaming session for TPD (and TCC) teams.