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# AIDS, Poverty Reduction and Debt Relief

A Toolkit for Mainstreaming  
HIV/AIDS Programs into  
Development Instruments

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## Acronyms and Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CSW	Commercial Sex Worker
DfID	Department for International Development (United Kingdom)
HAART	Highly Active Antiretroviral Therapy
HIPC	Heavily Indebted Poor Country
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
IEC	Information, Education and Communication
I-PRSP	Interim Poverty Reduction Strategy Paper
NGO	Nongovernmental Organization
PLWHA	Person Living With HIV/AIDS
PRSP	Poverty Reduction Strategy Paper
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

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## FOREWORD

In the past two years we have seen unprecedented levels of political and institutional interest in reversing the course of the HIV/AIDS epidemic. Political leadership has improved significantly in some of the worst-affected countries, thus providing a more favourable environment for the fight against the epidemic and its negative effects on development. At the same time, we know that other key elements necessary for a successful response to HIV/AIDS are: (i) a concerted effort to put the HIV/AIDS agenda into major development instruments, (ii) a massive mobilization of additional resources, (iii) a multisectoral approach and (iv) a scaling up of interventions that are based on the best available evidence.

The Highly Indebted Poor Countries (HIPC) Debt Initiative provides a unique opportunity to bring together these four elements to address the threat posed by HIV/AIDS. Proposed by the World Bank and the IMF and agreed to by governments around the world in 1996, the Initiative is a coordinated approach among official creditors to bring down debtor countries' external debt to sustainable levels. An enhanced version of the Initiative was put in place in September 1999 to simplify and accelerate the process, deepen the amount of debt relief, and tighten the link to poverty reduction. The Initiative puts emphasis on structural and social policy reforms, particularly to enhance the delivery of basic health care and education services, facilitated where needed with additional financing under the HIPC Initiative. Further, governments benefiting from the debt relief are expected to make their plans for poverty reduction explicit through the preparation of a Poverty Reduction Strategy Paper (PRSP). Given the adverse effects of HIV/AIDS on poverty, plans to address the epidemic are a natural feature in most if not all PRSPs.

This toolkit adds to the knowledge base to support analysts and decision-makers in their work to: (a) mainstream HIV/AIDS as a major item on countries' development agenda, and (b) mobilize the resources needed to expand promising interventions and approaches in the fight against the epidemic. Developed by a team comprising staff from the UNAIDS Secretariat and the World Bank, the toolkit offers a unifying framework for analysing HIV/AIDS in the context of PRSPs, as well as examples of how the issue has been treated in the first generation of PRSPs, interim PRSPs and debt relief agreements. As such, it gives country officials and their partners highly relevant information that they can use in developing inputs for similar documents in their own countries.

The PRSP process is still in its infancy today and we expect that many lessons will emerge as countries adapt to this new approach in development assistance. This toolkit should therefore be viewed as a living document into which new insights and information would be incorporated as experience is gained in addressing HIV/AIDS in the context of PRSPs. This first edition of the toolkit consolidates the extensive knowledge that already exists in this regard. As such, it is a very welcome addition to the menu of practical tools that our clients, partner institutions as well as others can use to develop effective responses to the HIV/AIDS epidemic.

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## SUMMARY

The potential benefits of giving HIV/AIDS a prominent place in PRSPs and HIPC agreements are substantial. They include greater political attention to and increased domestic funding for the national HIV/AIDS programme, as well as a focus on achieving results in implementing a national HIV/AIDS programme. Crucially, it helps to forge greater consensus among stakeholders on the main strategies and medium-term goals in tackling the HIV/AIDS epidemic.

Ideally, the HIV/AIDS contents of PRSPs and HIPC documents would include the following aspects:

- HIV/AIDS as a cause of poverty, plus a discussion of poverty and income inequalities, and their contributions to conditions that make persons vulnerable to HIV infection and less able to cope with the consequences of being infected;
- the main strategies in the national HIV/AIDS plan as a central part of the overall national poverty reduction programme, justified and costed;
- medium-term goals and poverty monitoring indicators derived from the national HIV/AIDS plan; and
- short-run actions for successful implementation of the national HIV/AIDS plan, with specific and monitorable targets that form agreements for debt relief.

This toolkit will serve as a resource for training at the country and subregional levels for country teams and their partners from NGOs and donor agencies. It will enable country teams to develop useful materials on scaled-up HIV/AIDS programmes for inclusion in the PRSPs and HIPC documents. More work will be done to continually improve the toolkit and the processes for building coalitions of partners in support of national responses to HIV/AIDS.

# 1. INTRODUCTION

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Key messages in this section:

- In order to link HIV/AIDS control to Poverty Reduction Strategy Papers (PRSPs) and the enhanced Heavily Indebted Poor Country (HIPC) initiative, there is a need for credible strategies and effective negotiations. This Toolkit is aimed at facilitating both.
- AIDS induces and deepens poverty; hence it should be at the core of the poverty reduction agenda.

## 1.1. What is this Toolkit for?

This Toolkit will enable country officials and their partners to prepare and negotiate effectively the inclusion of scaled-up HIV/AIDS programmes in their PRSPs and instruments of debt relief under the enhanced HIPC initiative. PRSPs document country-owned strategies for poverty reduction and provide the basis for a wide range of development programmes to be financed from public funds and grants. Where a country is willing, a PRSP provides a basis for concessional lending by international financial institutions. The enhanced Heavily Indebted Poor Country (HIPC) Initiative adopted by the Boards of the World Bank and IMF in 1999 aimed at accelerating the delivery of HIPC Initiative assistance and linking debt relief more firmly and transparently to poverty reduction. At the same time, the enhancements more than doubled the amount of relief projected to be provided under the Initiative. It is expected that external debt servicing will be cut by approximately US\$ 50 billion. When combined with traditional debt relief, the initiative will cut by more than two-thirds the outstanding debt of more than 30 countries.

As HIV/AIDS has become recognized as a threat to development in many developing countries, so have these countries attempted to “mainstream” HIV/AIDS into instruments of development. For poor countries, where PRSPs serve as the country’s agenda for poverty reduction, it has become crucial for country-level managers and analysts to make credible proposals for the inclusion of HIV/AIDS in the poverty reduction effort. Yet, while several countries have done so effectively, many have yet to do so. For countries that are eligible for debt relief through the enhanced HIPC initiative, there is a potential for significant increases in the public financing of HIV/AIDS programmes through earmarking of funds. Only a few countries thus far have seized this opportunity. This Toolkit is intended to assist countries seeking to develop effective sections on HIV/AIDS in their PRSPs and HIPC documents.

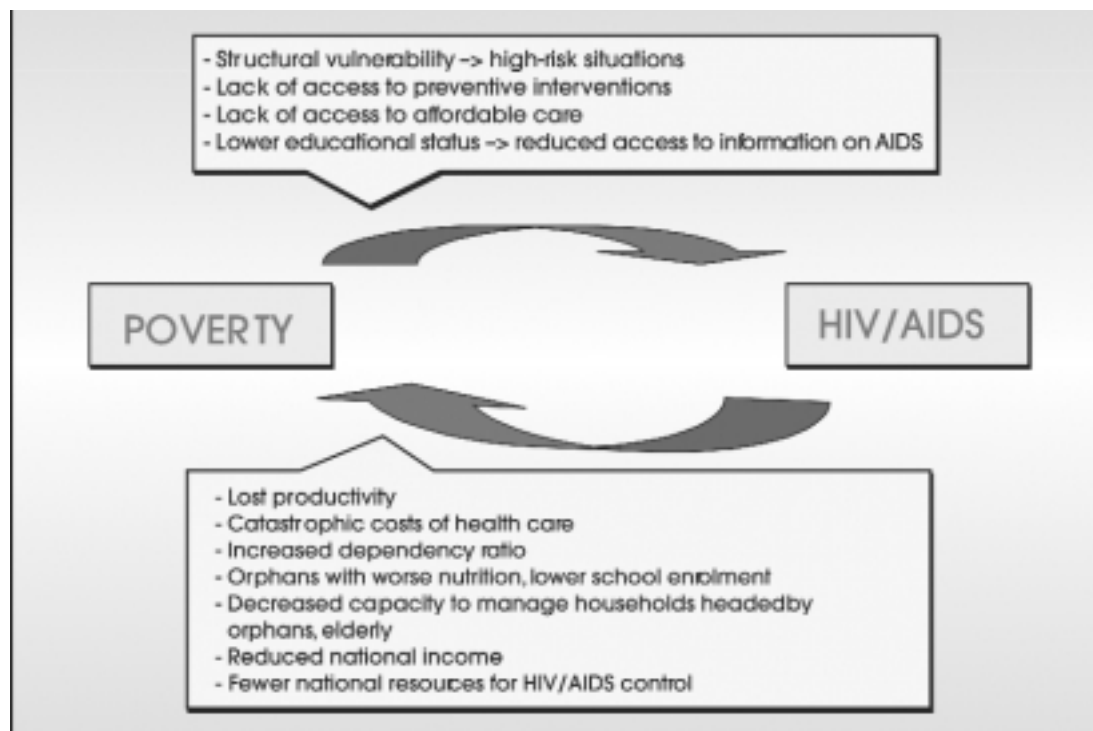
### 1.2. To whom it is addressed?

The Toolkit is addressed primarily to those with responsibilities for – or interest in – getting the HIV/AIDS agenda into the broader development efforts of each country. They include analysts and policy-makers in National AIDS Commissions or similar cross-sectoral bodies, Ministries of Finance/Economic Development and nongovernmental organizations at the country level. It is also aimed at officials of agencies that work with countries on PRSPs and HIPC documents, including NGOs, the international financial institutions, United Nations agencies with a remit that includes poverty reduction and development, foundations and bilateral development agencies.

### 1.3. Links between HIV/AIDS and poverty

There are two sets of issues: (a) AIDS as a cause of poverty or AIDS deepening poverty and (b) the combined effect of poverty and income inequalities on social transactions – including sex, patterns of vulnerability and patterns of risky behaviour in relation to HIV infection and AIDS. A simplified illustration of the links between AIDS and poverty is presented in Figure 1 below. More details are shown in Appendix 1.

Figure 1. Relationship between poverty and HIV/AIDS: a simplified view



Although some links have been demonstrated convincingly (Box 1), there are others for which the evidence is currently weak (Appendix 1). For the affected families and national policy-makers in many countries, however, the case is straightforward:<sup>1</sup> AIDS is condemning millions to misery and poverty. So far, AIDS has left behind 13.2 million orphans – children who, before the age of 15, lost either their mother or both parents to AIDS. Many of these children have died, but many more survive, not only in Africa (where 95% currently live), but also in developing countries throughout Asia and the Americas. In African countries that have had long, severe epidemics, AIDS is generating orphans so quickly that family structures can no longer cope (UNAIDS, 2000a). In the absence of effective efforts to mitigate the effect of AIDS on this generation, whole societies will become dysfunctional, with negative consequences for human development and even basic security.

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<sup>1</sup> *Poverty covers not only low income and consumption but also low achievement in education, health, nutrition and overall human development. It includes powerlessness and vulnerability.*

### Box 1: How does AIDS induce or deepen poverty?

- The few surveys of the impact of having a family member with AIDS show that households suffer a significant decrease in income and huge rises in medical care spending. Decreased income leads to fewer purchases, diminished savings and dissavings.
- In a study in Thailand, one-third of rural families affected by AIDS experienced a halving of their agricultural output, which threatened their food security. Another 15% had to take their children out of school, and over half of the elderly people were left to take care of themselves. Families spent on average US\$1,000 for medical care during the last year of an AIDS patient's life – the equivalent of an average annual income.
- In urban areas in Côte d'Ivoire, the outlay on school education was halved; food consumption went down by 41% per capita and expenditure on health more than quadrupled. When family members in urban areas fall ill, they often return to their villages to be cared for by their families, thus adding to the pressure on scarce resources and increasing the probability that a spouse or others in the rural community will be affected.
- As the number of orphans grows and the number of potential caregivers shrinks, traditional coping mechanisms are stretched to breaking point. Households headed by orphans are becoming common in high-prevalence countries. Studies in Uganda have shown that following the death of one or both parents, the chance of orphans going to school is halved and those who do go to school spend less time there than they did formerly. Other work from Uganda has suggested that orphans face an increased risk of stunting and malnutrition.
- AIDS threatens the educational system and so undermines the social capital of the country. In high-prevalence countries like Central African Republic, Côte d'Ivoire and Zambia, it is eroding the supply of teachers and thus increasing class sizes, which is likely to reduce the quality of education.
- The effects on agricultural production can be serious. In West Africa, many cases have been reported of reduced cultivation of cash crops or food products. These include market gardening in the provinces of Sanguie and Boulkiemde in Burkina Faso and cotton, coffee and cocoa plantations in parts of Côte d'Ivoire. A study in Namibia by the Food and Agricultural Organization (FAO) concluded that the impact on livestock was considerable, with a heavy gender bias: households headed by women and children generally lose their cattle, thus jeopardizing the food security of the surviving members.
- Some companies in Africa have already experienced the impact of HIV/AIDS on their balance sheets. Managers at one sugar estate in Kenya have noted increased absenteeism (8,000 days of work lost due to sickness between 1995 and 1997), lower productivity (a 50% drop in the ratio of processed sugar recovered from raw cane between 1994 and 1997) and higher overtime costs for workers obliged to work longer hours to fill in for sick colleagues. Costs of social benefits related to HIV infection have risen sharply in the same company, due to funerals and health care costs.
- A recent study estimated that Africa's income growth per capita is being reduced by about 0.7 percent per year because of HIV/AIDS. Had the HIV prevalence not reached 8.6 percent in 1999, Africa's income per capita would have grown at 1.1 percent per year – or nearly three times the growth rate of 0.4 percent per year achieved in 1990-1997 (World Bank, 2000b). A country-specific econometric model of the South African economy suggests that overall GDP will be 17% lower by 2010 than it would have been without AIDS and that average per capita income will be 7-10% lower because of AIDS (Lewis and Arndt, 2000).

Source: UNAIDS (2000a), pp. 26-36.

## 2. THE NATIONAL AIDS PROGRAMME AS A CONTRIBUTION TO POVERTY REDUCTION

Key messages in this section:

- With a rigorous national plan, it becomes easier to make a case for HIV/AIDS in poverty reduction. By using evidence of what works – where such evidence is available, country teams can be more effective advocates of the AIDS agenda.
- Effective responses take into account approaches that work (the “how”) and interventions that are effective (the “what”).
- Costed national plans make more concrete the case for increased resource allocation to fighting AIDS.

### 2.1. Rationale

Despite increasing recognition of its negative impact on development, HIV/AIDS is only one of many problems that countries will address in their PRSPs and HIPC documents. With so many ministries, sectors and civil society groups competing for attention and funding in PRSPs and HIPC documents, the case for HIV/AIDS must be highly compelling: that HIV/AIDS jeopardizes poverty reduction efforts, that by fighting AIDS poverty will also be tackled, that money can be spent efficiently to reverse the epidemic and improve people’s lives. Therefore, any effort to mainstream HIV/AIDS in the development agenda must be well articulated to ensure buy-in from multiple sectors and the highest levels of government. In order to be convincing, advocates of the use of debt relief savings for HIV/AIDS need to demonstrate that an effective national HIV/AIDS programme will contribute to the fight against poverty. They must also lay out the financial case for debt relief, including how much will it cost to implement a far-reaching HIV/AIDS programme.

### 2.2. What works against HIV/AIDS?<sup>2</sup>

In general, effective responses would address the needs of each country, taking into account the status of the epidemic, the likely impact of a range of cost-effective interventions in a given context, as well as the capacity for large-scale programme planning, funding and implementation. The range of actions would include the development or strengthening of institutions for planning and coordination, multisectoral approaches to programme development and implementation, prevention of new infec-

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<sup>2</sup> A full review of interventions against HIV/AIDS is beyond the scope of this document. Readers who wish to explore these in detail are encouraged to examine the growing literature on prevention, care and impact mitigation, including Merson et al. (2000), UNAIDS (2000a), Ainsworth and Teokul (2000), Jha et al. (2000) and Hunter (2000).

tions, affordable care for persons living with HIV/AIDS (PLWHAs), social support to mitigate the impact of AIDS on families and orphans, as well as effective monitoring and evaluation of programme efforts.

Country teams are likely to be more credible and effective advocates if their proposals are based on evidence of what works against HIV/AIDS, with clear outlines of the approaches to be taken in the national response to the epidemic and its consequences. Although a great deal remains to be understood about the evolution of the epidemic and its consequences, much has been learned regarding effective interventions for HIV prevention, cost-effective care for persons who are already infected, and actions to mitigate the impact on orphans, families and communities. When the first cases of AIDS were reported in the early 1980s, individuals and groups acted to alert people to this dangerous new disease and the steps that could be taken to protect against it. Even before HIV was isolated, safer sex and safer drug use guidelines had been developed based upon epidemiological evidence concerning patterns of transmission. However, providing people with information about how to protect against infection has proven to be insufficient in and of itself. People require enabling environments that will reduce their susceptibility and vulnerability, and allow them to modify their behaviour based on their knowledge gained through information provision (UNAIDS, 2000a).

### 2.2.1. An enabling environment across multiple sectors

At the national level, political commitment at all levels has been shown to be essential for programme success. Multilevel interventions that seek to involve a variety of partners in coordinated action have been shown to be more successful than those that work in isolation (UNAIDS, 1999, 2000a). Furthermore, coordinated economic, political and social effort are required to reduce societal vulnerability, alongside programmes and interventions operating at individual and community levels. Global experience has shown the following elements to be among those central to effective national HIV prevention efforts (Piot and Aggleton, 1998):

- *General awareness-raising activities* to provide information and counter negative reactions among the population at large
- *Focused persuasive action* to meet the needs of specially vulnerable groups and communities, with steadily expanding coverage
- *Multisectoral and multilevel partnerships* to deliver programmes and services across a range of contexts
- *Community ownership of* programmes, and building upon the will of groups and individuals to contribute to national HIV prevention efforts
- Greater *integration between prevention and care* to reduce costs and to reduce levels of discrimination and stigmatization
- Action to build *societal resistance* to HIV transmission and reduce the systematic vulnerability of particular individuals, groups and sections of society

### 2.2.2. Preventing HIV infection

There are still few systematic reviews of the evidence on preventive interventions in the published literature. Merson *et al.* (2000) reviewed the effectiveness of projects and programmes in developing countries that aim to reduce sexual transmission of HIV infection or transmission related to injection drug use. They found that behavioural change interventions are effective when targeted to populations at high risk, particularly female sex workers and their clients. Few studies have evaluated harm reduction interventions in injecting drug users (IDUs). Evidence on the effectiveness of voluntary counselling and testing programmes was mixed, and results varied according to the population being studied. STI treatment appeared highly effective in reducing HIV/STI transmission, particularly in the earlier stages of the epidemic. Structural and environmental interventions show great promise, although more evaluation is needed. Merson *et al.* concluded that:

- HIV prevention interventions can be effective in changing risk behaviours and preventing transmission in low- and middle-income countries;
- when the appropriate mix of interventions is applied, they can lead to significant reductions in the prevalence of HIV at the national level; and
- additional research is needed to identify effective interventions, particularly in men who have sex with men, youth, IDUs and HIV-infected persons.

In practice, countries will strike a pragmatic balance, based on the capacity for programme implementation, the expected effects of interventions, their political feasibility and the availability of financial resources. For practical purposes, countries would need to consider interventions aimed at reducing risk and those aimed at reducing vulnerability (Table 1).

Table 1. Interventions for prevention of HIV infection

	Factors influencing transmission of HIV	Interventions
<p>“Risk”-oriented strategies addressing immediate factors of transmission</p>	<ul style="list-style-type: none"> <li>• Sexual transmission</li>   <li>• Blood transmission</li>   <li>• Mother-to-child transmission</li> </ul>	<p>IEC for behaviour change                      School education                      Life skills                      Condoms (<i>promotion of 100% condom use among the most vulnerable, including CSWs and the military</i>)                      Voluntary counselling and testing                      Counselling                      STI treatment</p> <p>Blood safety                      Universal precautions                      Safe injections / needle exchange</p> <p>Prevention of mother-to-child transmission</p>
<p>“Vulnerability”-oriented strategies addressing underlying factors of transmission</p>	<ul style="list-style-type: none"> <li>• Sexual behaviour</li> <li>• Intravenous drug use</li> <li>• Cultural and religious factors</li> <li>• Poverty</li> <li>• Illiteracy</li> <li>• Discrimination</li>   <li>• Migration</li> </ul>	<ul style="list-style-type: none"> <li>• Behaviour change education</li> <li>• Life skills and education for in-school and out-of-school youth</li> <li>• Harm reduction,</li> <li>• IEC for behaviour change</li> <li>• Community mobilization</li> <li>• Poverty reduction</li> <li>• Education</li> <li>• Legislation</li> <li>• Human rights</li> <li>• Rural development, etc.</li> </ul>

### 2.2.3. Care, support and impact mitigation

With millions infected and many more affected by HIV, the need has become urgent for improved access to affordable care, support and mitigation of the impact on individuals, communities and countries. Table 2 shows a summary of interventions to be considered for care, support and impact mitigation.

Table 2. Care and support packages, according to resource availability

Package	Contents
The essential package	<ul style="list-style-type: none"> <li>• Voluntary HIV counselling and testing</li> <li>• Psychosocial support for HIV-positive people and their families</li> <li>• Palliative care and treatment for pneumonia, oral thrush, vaginal candidiasis and pulmonary tuberculosis</li> <li>• Prevention of infections with cotrimoxazole prophylaxis for symptomatic HIV-positive people</li> <li>• Official recognition and facilitation of community activities that reduce the impact of HIV infection</li> </ul>
The intermediate package	<p>All of the above plus one or more of the following:</p> <ul style="list-style-type: none"> <li>• Active case-finding (and treatment) of tuberculosis among HIV-positive people</li> <li>• Preventive therapy for tuberculosis for HIV-positive people</li> <li>• Systemic antifungals for systemic fungal infections (such as cryptococcosis)</li> <li>• Treatment of Kaposi sarcoma</li> <li>• Surgical treatment of cervical cancer</li> <li>• Treatment of extensive herpes with acyclovir</li> <li>• Funding for community activities that reduce the impact of HIV infection</li> </ul>
The advanced package	<p>All of the above plus:</p> <ul style="list-style-type: none"> <li>• Triple antiretroviral therapy</li> <li>• Diagnosis and treatment of opportunistic infections that are difficult to diagnose and/or expensive to treat, such as atypical mycobacterial infections, cytomegalovirus infection, multiresistant tuberculosis, toxoplasmosis and HIV-associated cancers</li> <li>• Specific public services that reduce the economic and social impacts of HIV, to supplement community efforts that reduce the impact of HIV infection</li> </ul>

Source: UNAIDS (2000a), pp. 96-98.

#### 2.2.4. Mobilization of resources

It is important to mobilize resources for all aspects of the response to HIV/AIDS described above. For sub-Saharan Africa alone, scaling up a wide range of interventions would require US\$1.5-2.3 billion per year. Providing highly active antiretroviral therapy (HAART) would add another US\$1.5-2.4 billion depending on the prices at which drugs would be available. These estimates are based on relatively conservative estimates of likely coverage that can be achieved by 2005 (World Bank, 2000c).

Country-specific estimates of the resource gaps will make the case for additional resources highly compelling. In Zambia, resources required for implementing the National HIV/AIDS Strategic Framework were estimated at US\$558.6 million for 2001-2003. A total of US\$25.5 million had been committed by October 2000, leaving a resource gap of US\$382 million (Bail and Mwikisa, 2000).

### 3. THE ESSENTIAL HIV/AIDS CONTENT IN THE PRSP AND HIPC DOCUMENTS

Key messages in this section.

Ideally, the HIV/AIDS contents of PRSPs and HIPC documents would include the following aspects:

- AIDS as a cause of poverty, plus a discussion of poverty and income inequalities, and their contributions to conditions that make persons vulnerable to HIV infection and less able to cope with the consequences of being infected;
- the main strategies in the national AIDS plan as a central part of the overall national poverty reduction programme, justified and costed;
- medium-term goals and poverty monitoring indicators derived from the national AIDS plan; and
- short-run actions for successful implementation of the national AIDS plan, with specific and monitorable targets that could form agreements for debt relief.

#### 3.1. What are PRSPs?

Poverty Reduction Strategy Papers (PRSPs) are documents that are intended to specify the issues and approaches to poverty reduction in many developing countries, most immediately in the countries receiving debt relief under the enhanced HIPC. An effective poverty reduction strategy would be expected to: (a) be prepared by the country; (b) focus on faster and broad-based economic growth; (c) reflect a comprehensive understanding of poverty and its determinants; (d) assist in choosing public actions that have the highest poverty impact; and (e) establish outcome indicators that are set and monitored using participatory processes. Most low-income countries are not immediately in a position to fully address each of the elements of a PRSP. Interim PRSPs (I-PRSPs) outline the process for producing full PRSPs, identify the gaps that need to be filled, and outline how this might be done (World Bank, 2000a). As of mid-January 2001, three countries had prepared PRSPs<sup>3</sup> while 29 had prepared I-PRSPs.<sup>4</sup>

<sup>3</sup> *Burkina Faso, Uganda and United Republic of Tanzania.*

<sup>4</sup> *In Africa: Benin, Cameroon, Central African Republic, Chad, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Madagascar, Malawi, Mali, Mozambique, Niger, Rwanda, Sao Tome and Principe, Senegal, United Republic of Tanzania, and Zambia. In Europe and Central Asia: Albania, FYR Macedonia, Georgia, Moldova, Tajikistan. In Latin America/Caribbean: Bolivia, Guyana, Honduras and Nicaragua. In Asia and the Pacific: Cambodia.*

### 3.2. An introduction to debt relief

The principal objective of debt relief for the heavily indebted poor countries (HIPC) is to bring the country's debt burden to sustainable levels, subject to satisfactory policy performance, so as to ensure that adjustment and reform efforts are not put at risk by continued high debt and debt service burdens. The process involves two key phases, the first culminating in the "decision point", and the second, in the "completion point". To reach the decision point a debtor country must have achieved a three-year period of satisfactory performance on the macroeconomic adjustment and reform programmes supported by the IMF and the World Bank. At the decision point, the Executive Boards of the IMF and the World Bank formally decide on a country's eligibility for debt relief and the international community commit to providing sufficient assistance by completion point for the country to achieve debt sustainability as assessed at the decision point.

Under the HIPC initiative, debt sustainability is usually defined as 150% of the level of export at net present value. Most eligible countries will reduce their debt-to-export and debt-to-revenue ratios (net present value) between the decision and completion points. In short, under the enhanced framework, the benefits of export and central government revenue will accrue fully to the county, allowing for greater investment in poverty reduction strategies.<sup>5</sup> At decision point, the country usually benefits from about 30% of the total amount of debt relief to be granted.

After passing the decision point, a country enters the second phase and progresses toward the completion point when the bulk of assistance under the Enhanced HIPC Initiative is delivered. Interim assistance can be made available between the decision point and the completion point, with any remaining assistance provided at the completion point. The term "floating completion point" refers to an arrangement in which the timing of completion point is tied to the implementation of policies determined at decision point. Figure 2 illustrates some of these key features of debt relief under the enhanced HIPC initiative.

Twenty-two countries<sup>6</sup> have reached their decision point under the enhanced HIPC Initiative and one country (Uganda) reached its completion point under the original HIPC Initiative. These 22 countries are now receiving relief that will amount to some \$34 billion over time.

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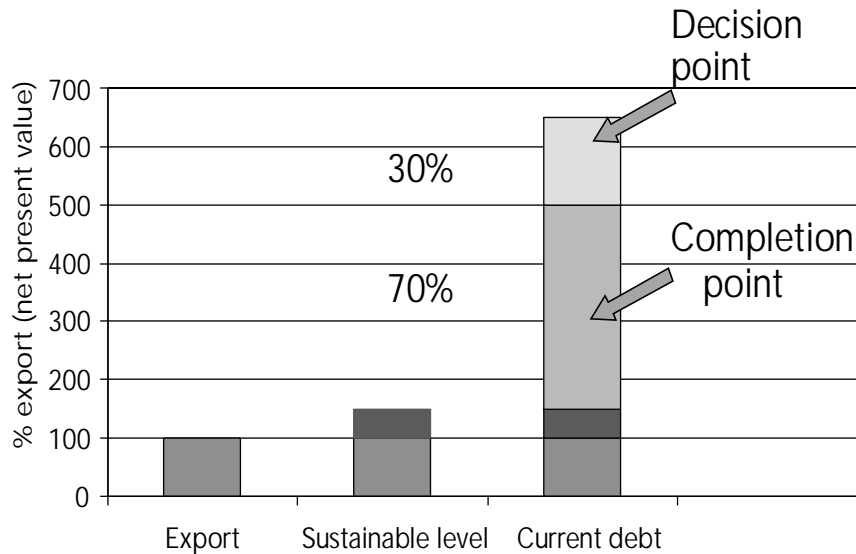
<sup>5</sup> Source: World Bank website on HIPC: <http://www.worldbank.org/hipc/about/hipcbr/hipcbr.htm>

<sup>6</sup> In Africa: Benin, Burkina Faso, Cameroon, Gambia, Guinea, Guinea-Bissau, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Rwanda, Sao Tome and Principe, Senegal, Uganda, United Republic of Tanzania, Zambia. (Source: World Bank website, News release number 2001/190/S. December 22, 2000).

In Latin American and Caribbean: Bolivia, Guyana, Honduras, Nicaragua.

(Source: World Bank website, "The HIPC Initiative: Background and Progress Through December 2000". <http://www.worldbank.org/hipc/progress-to-date/May99v3/may99v3.htm>)

Figure 2. Key features of debt relief



### 3.3. Making the case for HIV/AIDS control in the PRSP and HIPC documents

Even though there is no pre-set formula for drafting Poverty Reduction Strategy Papers and HIPC debt relief documents, in practice they have tended to follow a fairly standard format. Since teams responsible for PRSP and HIPC in each country and their World Bank/IMF counterparts are likely to use this format, it is possible for those focusing on HIV/AIDS to prepare a set of materials that fit into the main sections of the poverty and debt relief documents. These materials would cover at least four essential aspects:

- AIDS as a cause of poverty, and possibly a discussion of poverty and income inequalities as contributors to conditions that make persons vulnerable to HIV infection and less able to cope with the consequences of being infected;
- the main strategies in the national AIDS plan as a central part of the overall national poverty reduction programme, justified and costed;
- medium-term goals and poverty monitoring indicators derived from the national AIDS plan; and
- short-run actions for the successful implementation of the national AIDS plan, which could form agreements for debt relief.

In Table 3 below, the asterisks indicate the relative emphasis that county teams could put on each of these aspects in their PRSPs and HIPC documents.

Table 3. Essential sections on AIDS in PRSPs and HIPC documents

Aspects to be covered	PRSPs	Debt relief (HIPC) agreements
Country-specific analysis of the AIDS-poverty complex	***	**
Main strategies from the national AIDS plan	****	***
Medium-term goals and poverty monitoring indicators	****	**
Short-run actions, with "conditions" for debt relief	**	****

### 3.3.1. AIDS as a cause of poverty and poverty as a contributor to AIDS

Here, the general linkages between AIDS and poverty would be mentioned – and then documented with specific data and examples from the country or from neighbouring countries where similar conditions prevail. Sources of data for this analysis include household surveys such as the Demographic and Health Surveys (DHS), special studies conducted under the national AIDS programme, macroeconomic models that factor in HIV/AIDS as a variable affecting labour productivity, health spending and budget analyses that try to quantify public expenditures on AIDS.

Impact indicators that help to portray the effects of AIDS on poverty include:

- decrease in growth rate of per capita income,
- increase in number of AIDS orphans, their corresponding poorer nutrition and lowered school attendance rates,
- reductions in output and cash income in households with an AIDS death, and
- increases in household out-of-pocket health spending.

When initiating the development of a PRSP or preparing an interim PRSP for the purpose of accessing debt relief, it is important for HIV/AIDS decision-makers to be able to present an overview of the relationship between HIV/AIDS and poverty. This analysis will help as an advocacy tool to make a case for HIV/AIDS and to prepare the analytical rationale for choosing the most appropriate and cost-effective interventions in a context of poverty reduction. Basic analysis would include an assessment of the current situation, its seriousness as well as the threat it poses to the future. These subjects could be covered by means of a presentation of the evolution of the HIV epidemic countrywide and a projection of the development of the epidemic if the response is not accelerated.

An analysis of the HIV prevalence between regions of different economic development and among different vulnerable groups helps identify high-prevalence areas and link them with behaviours as well as economic exchange patterns (HIV epidemic mapping). A disaggregated analysis of the HIV prevalence by gender and age group is useful, to demonstrate that young girls are among the groups most threatened by HIV.

Vulnerability factors can also be discussed using both quantitative and qualitative information. This analysis would attempt to disentangle how some key socioeconomic determinants may affect the spread of HIV and what is the hard evidence available on this issue. Finally a rapid analysis of the response can be conducted including an assessment of the proportion of cities covered by a programme for commercial sex workers, the proportion of roads covered by a programme for truck drivers, etc.

### 3.3.2. Strategies derived from the national AIDS plan

These would include four to six well-defined strategies from the country's plan for an expanded response for prevention, care, support and impact mitigation, based on expected impact, cost-effectiveness and feasibility, with cost estimates. Even if the national AIDS plan contains many more strategies, it will probably be necessary to select the most important ones, since the PRSP is quite a brief document. Country teams might also choose to specify the incremental resources required for recurrent line items, such as for personnel, transportation, supplies and materials. In a few well-documented Poverty Reduction Strategies to date in high HIV prevalence countries, AIDS is presented in the PRSP as requiring a strategic response that cuts across the conventional sectors, spanning health, education, defence, transport, youth, communications, and others. In other words, the main lines of the national AIDS plan are first portrayed as a "supra-sectoral" or "cross-cutting" concern, and this is then reinforced in the paragraphs devoted to the main poverty-fighting sectors, where AIDS again appears as a threat requiring specific actions from each sector agency and from civil society groups and donors focusing on the sector. The Malawi PRSP is a useful example of this approach (Table 4).

### 3.3.3. Medium-term goals and poverty monitoring indicators

These also need to be selective, as only a small number of AIDS strategies are likely to be listed in the PRSP. In the ideal circumstances, these goals and indicators will have been developed with technical expertise, and negotiated among stakeholders as part of the AIDS national planning process. In many cases this will not have happened, either because the national AIDS plan is not complete or because goal/target setting was not carried out as part of the national planning process. Since the medium term covers five years or more into the future, the goals would relate to results of the national AIDS response – outcomes ideally, or at least major outputs of the AIDS programme. Each country team will need to formulate medium-term goals and targets

that are right for national circumstances. Uganda has specified a 25% decline in HIV prevalence (Table 4).

### 3.3.4. Short-run actions that could be part of agreements for debt relief

Selectivity is also required here. These actions are the agreed steps for decision and completion points, and that could be inserted into the matrix in the HIPC document. Ideally, they would have the characteristics outlined below.

- (a) Be derived from and closely linked to the key strategies in the national AIDS plan, spelled out earlier in the PRSP/HIPC document – in this sense, they should be seen as “sentinel” actions that tell us whether the AIDS plan itself is being successfully implemented.
- (b) Be relatively easy to measure. Since programme implementation will be monitored closely under HIPC by government, civil society, and international agencies, it is crucial to put in place an effective monitoring system that can generate results quickly.
- (c) Be carefully selected to match the expected timetable for HIPC, especially the trigger points for entering debt relief (decision point), and intermediate and final (completion) debt forgiveness points.
- (d) Be well understood and accepted by the political figures and programme managers who will be accountable for carrying out this series of actions.

Fortunately, there is a wide range of indicators for monitoring and assessing progress in implementing national AIDS programme strategies, which have already been developed, and for which corresponding data collection and analysis methods are fairly well established. The UNAIDS *Guide to Monitoring and Evaluation* (UNAIDS, 2000c) is a handy compendium of these indicators, an abbreviated set of which is presented in Appendix 2. At country level, too, national specialists on HIV/AIDS and international staff serving on the “technical working groups” of the United Nations Theme Groups on HIV/AIDS can help to select and validate the best performance targets for the period of HIPC debt relief.

### 3.3.5. How has HIV/AIDS been included in PRSPs?

Most I-PRSPs in sub-Saharan Africa have included HIV/AIDS as an issue to be tackled (Table 4). Yet the relationship between HIV/AIDS and poverty has rarely been examined and the strategies do not appear very well defined. In particular the vision of how the country will scale up a response to mitigate the negative effect of HIV/AIDS on human capital and economic growth has not been articulated in any of the PRSPs. However, Uganda is revising its strategy to better mainstream the issue of HIV/AIDS within its vision of poverty reduction.

### 3.3.6. HIV/AIDS conditionalities used in HIPC in 2000

As part of the policy dialogue surrounding debt relief, some countries have committed to increasing their efforts towards curtailing the HIV/AIDS epidemic. This commitment has sometimes translated into some conditionalities for the country to reach the completion point at which the bulk of debt relief will be granted. Most of these conditionalities are process-related, yet some countries have committed to triggering a real behaviour change as in Cameroon, where increased condom use among men in uniform, truck drivers and commercial sex workers was included as a conditionality.

Table 4. Selected examples of PRSPs and their HIV/AIDS contents\*

Country	Country-specific analysis of the AIDS-poverty complex	Main strategies from the national AIDS plan	Medium-term goals and poverty monitoring indicators	Short-run actions
Cameroon (Interim PRSP, August, 2000)	HIV/AIDS not mentioned under "determinants of poverty".	Subsumed under health sector: "the principal and most urgent concern is the spread of HIV/AIDS". Specific actions to slow the progression: IEC, VCT, and blood safety.  Brief mention under "Urban Poverty", focusing on commercial sex workers.  Emphasis on education campaigns.	"Rate of HIV/AIDS incidence".	Set up HIV/AIDS information and awareness campaigns in public and private media.
Malawi (Interim PRSP, August 2000)	Included as part of "Super-Sectoral Analysis", with references to country-specific statistics on seroprevalence. There are explicit notes on the effects on growth, poverty, productivity and savings. Orphans and families get specific attention. Reference to the National Strategic Framework for HIV/AIDS and the Resource Mobilization Round Table of March 2000.	Under "strategies and measures".  Mainstream HIV/AIDS into all sectors and improve orphan care.  Intensify efforts on primary prevention.  Integrate AIDS and tuberculosis control programmes.  Strengthen AIDS Secretariat.	Not specified.	Not specified.
Uganda (PRSP – Poverty Eradication Action Plan, March 2000)	Under "improving health of the people". There are notes on prevalence rates, effects on life expectancy, as well as a brief acknowledgement of interactions among AIDS, cultural factors and poverty.	Expenditures for service delivery to be included in health and other sectors.  Note: Based on its National Strategic Framework, Uganda subsequently revised its Poverty Eradication Action Plan to include AIDS in each of the four goals. The National Strategic Framework emphasizes prevention, impact mitigation and capacity building.	25% decline in HIV prevalence.	Not specified.

\* A convenience sample of three countries, for illustration. Source: World Bank Website on PRSPs. <http://www.worldbank.org/prsp/>. Accessed on 31 January 2001.

Table 5. Measures to reach the floating completion point under the HIPC Initiative\*

	Country-specific analysis of the AIDS-poverty complex	Main strategies from the national AIDS plan	Medium-term goals and poverty monitoring indicators	Short-run indicators, with "conditions" for debt relief
Cameroon	Under "overall policy framework". Based on interim PRSP.	Included explicitly. Covers coordination mechanisms, overall goal, interventions and coverage indicators. Mentions line ministries involved.	Limit infection rate to below 10%.  US\$8.9 million over 3 years from HIPC proceeds for HIV/AIDS	Prioritize HIV/AIDS in overall agenda.  Curb infection rates among population, with increased use of condoms among port workers, truckers, soldiers and commercial sex workers.
Malawi	Impact on life expectancy.  Large number of orphans.  Potential to reduce economic growth, not country-specific.	Proposed institutional framework: make National AIDS Control Programme secretariat autonomous, outside the control of any specific sectors.  Summary of interventions for prevention, care and impact mitigation.	Not explicit. "Slowing the spread of AIDS" is a floating completion point trigger.	Policy areas to be monitored include a fully staffed, functional and autonomous National AIDS Control Secretariat.
Uganda	Specific notes in the Second Decision Point Document, including prevalence, life expectancy and Human Development Index. The poor are more likely to include widows, orphans and those living with HIV/AIDS.	Poverty Reduction Strategy for 1990/2000 – 2001/2002.  Establishment of functional coordination mechanisms, at the central and district levels, for the national multisectoral response to HIV/AIDS.  Expanded outreach of education for behaviour change.	Not specified.	Government established a Poverty Action Fund, under which programmes are outcome-oriented. Outcomes are reviewed on a quarterly basis with donors and representatives of civil society.

\* A convenience sample of three countries, for illustration. Source: World Bank Website on HIPC, <http://www.worldbank.org/hipc/country-cases/country-cases.html>. Accessed on 31 January 2001.

The Cameroonian experience illustrates several elements of a successful effort to integrate HIV/AIDS into an interim PRSP and a debt relief agreement (Box 2).

### Box 2. Focus on Cameroon: how was it done?

Over the last few years, the pace of activities had stalled in Cameroon's response to HIV/AIDS. The National AIDS Control Programme included a number of projects that were considered successful. The overall response was small-scale, fragmented and incomplete, however. Meanwhile, the epidemic continued to spread, with more than 540,000 Cameroonians infected with HIV by the end of 1999 (a prevalence rate of 7.7% among adults; UNAIDS, 2000a)

The debt relief discussions and the preparation of the Interim PRSP, which started in mid-2000, helped to trigger a more vigorous response to HIV/AIDS. The I-PRSP was prepared during April-August 2000 with broad input from government and civil society, including NGOs and religious leaders, and published in September 2000. It highlighted HIV/AIDS as a factor in worsening the country's poverty and as a serious threat to overall social and economic development. Similarly, early in the debt negotiations, the government and World Bank officials identified AIDS as one of the most important areas that could benefit from additional resources from debt relief. This in turn encouraged the Government of Cameroon to accelerate the development of a nationwide plan to curtail the epidemic. An HIV/AIDS strategic planning process already under way in Cameroon was speeded up to coincide with the debt negotiations. Completing this AIDS strategic plan became a precondition for finalizing the debt relief agreement, and the plan was also needed to specify the priority actions in AIDS prevention and care that could be funded with debt relief savings.

As a result, the government completed a comprehensive national HIV/AIDS strategic plan for 2001-2003, in collaboration with UNAIDS and other partners. It was launched by the Prime Minister of Cameroon in September 2000. The plan contains a set of highly focused emergency actions costing about US\$9 million over three years, to be funded by the government using debt relief savings:

- promoting behaviour change among young people aged 15-24 through information, education and communication at the national and local levels,
- making voluntary testing and counselling widely available throughout the country and preventing HIV transmission from pregnant women to their babies, and
- supporting a 100% condom use campaign including free provision of condoms among key vulnerable groups: truckers, plantation workers, university students, military, police, workers in the customs service, prisoners, prison wardens and commercial sex workers

In parallel with the debt relief process, the government and World Bank together prepared a major project, the Multisectoral Programme to Fight against HIV/AIDS, to be funded with a combination of a US\$50 million World Bank credit (soft loan, partial grant) and national funding from debt relief savings. The World Bank credit was approved in December 2000, and the project was officially launched in February 2001. To manage the implementation of the ambitious national AIDS plan and the Bank-funded project, the government decided to establish a new Central Technical Group with a wide range of skills in managing local and sectoral AIDS responses, communications, and monitoring and evaluation.

The Cameroonian experience reflects the importance of high-level political commitment, a multi-sectoral approach, and a simultaneous focus on actions that are likely to have a significant impact on the epidemic. PRSP, HIPC, national AIDS planning, and a focus on implementation are closely intertwined.

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Several lessons can be learned from this experience, including the following:

- the need for analysts working on HIV/AIDS to develop short, simple and clear advocacy materials for political decision-makers, including success stories from other countries,
- the importance of developing a vision of a national-scale response, with precise estimates of the level of effort required to curtail the epidemic,
- the need to provide decision-makers with politically feasible options and visible short-run gains in fighting AIDS, using debt relief savings, and
- the importance of a planning process for PRSP and HIPC that is both participatory and substantive, maintaining a focus on practical and feasible actions that can be implemented to address the HIV/AIDS epidemic.



## 4. USES OF FUNDS RELEASED THROUGH HIPC – EARMARKING, CHANNELLING, AND ACCOUNTABILITY

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Key messages in this section:

- To ensure that funds go to HIV/AIDS control, consider earmarking of savings from HIPC
- Design effective approaches to get funds to community initiatives
- Ensure transparency and accountability

### 4.1. Earmarking

In growing numbers of the HIPC debt relief documents, the budgetary savings from debt relief are explicitly calculated for a number of years to come. There is thus an opportunity in the HIPC document to specify or “ earmark” how much of the savings (either as a percentage of the actual savings, or in absolute dollar terms) will be allocated to the national AIDS programme. If so, the teams working on HIV/AIDS in the HIPC process have a chance to lobby for a sizeable allocation to the national AIDS programme. This can be justified both on the basis of the estimated cost of a large-scale national response to the epidemic, and by demonstrating how fundamental the fight against AIDS is in the overall effort to reduce poverty and promote economic and social development. In high-prevalence countries, a minimum of US\$1.50-2.00 per capita is needed for a strong national AIDS programme, e.g., US\$15-20 million annually in a country with 10 million inhabitants. If one-quarter or one-half of these costs (in the above example, this would amount to say, US\$5-10 million a year) can be met through debt relief, with the balance funded from external development partners, this would constitute an important financial and political investment by the government.

Since HIV/AIDS is a cross-cutting issue that extends beyond any individual sector, a supra-sectoral budgeting/allocation is advisable. Earmarking debt relief savings for HIV/AIDS could itself be one of the HIPC conditions to be monitored for successful completion of the debt relief process. For example, “during the period from 2001-2003, the government will spend US\$xx million of debt relief savings on its national AIDS programme”.

## 4.2. Channelling funds to local initiatives

In a number of HIPC countries, there is also strong interest in seeing that a major portion of the debt relief savings assigned to AIDS – and indeed, the entire budget to support the national AIDS plan – is channelled rapidly and efficiently to local initiatives. These include local government units, local NGOs, and community organizations that are trying to carry out prevention, care and support activities.

Under these circumstances, the HIPC process can be an opportunity to develop and put in place effective mechanisms for moving financial and technical resources to local groups implementing AIDS control activities. This can be done through a variety of means that might be specified and monitored as part of national compliance with the conditions for debt relief – for example, by setting up a special “Poverty Action Fund” that receives the debt relief savings and uses them exclusively for local initiatives. These Poverty Action Funds are partly an accounting mechanism, but when combined with resource transfer features, such as matching grants for local government bodies and NGOs, they can be a way to get the resources out to the frontlines. In Uganda, the Poverty Action Fund (PAF) includes the highest-priority expenditures from the perspective of poverty eradication. The eligibility of a particular sector or programme for funding from the Uganda PAF is based on high economic and/or social returns to the expenditure, by pro-poor targeting and by the priority accorded such programmes by the poor themselves, as demonstrated by prior participatory work. In collaboration with the UNAIDS Secretariat and the World Bank, managers of the Malawi Social Action Fund (MASAF) are examining options to channel funds to communities for a more rapid implementation of activities to mitigate the impact of AIDS. Direct funding of community-based activities is a key feature of the Africa Multicountry AIDS Programme that was launched by the World Bank in 2000 (World Bank, 2000b).

Similarly, if all or part of the debt relief savings was deposited in a national social development fund or micro-projects fund with an explicit HIV/AIDS component, this could be another way to ensure that the savings reach local public and/or private institutions (e.g. youth clubs, women’s groups, NGOs assisting commercial sex workers, village AIDS committees).

The establishment of these kinds of arrangements for transferring debt relief savings to local groups could be explicitly laid out in the HIPC documents as completion point actions.

## 4.3. Accountability

Finally, the HIPC process affords an opportunity to create strong mechanisms for accountability for uses of financial resources and for results. In a number of countries, civil society groups and international donors are calling for procedures that make the

use of debt relief savings and donor funds more transparent and linked to measurable programme results. One idea has been to establish mixed bodies (composed of representatives of government, civil society, and donor agencies) to monitor progress and use of funds in parts or all of the national AIDS programme. This is the approach taken in Uganda, where quarterly reviews are carried out with representation from donors and civil society. In Malawi, the expenditure monitoring mechanisms for HIPC resources include public reporting of expenditures.

As much as possible, assessments of output, outcome and impact should be undertaken to determine the benefits of inputs through various financing mechanisms. Disbursement of funds could be accompanied by the collection of household and community-level data as part of a baseline assessment. This would facilitate the evaluation of a funding mechanisms as well as the projects financed by through the funding mechanism (Ram, 2000).



## 5. INFLUENCING POLICIES

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### Key messages in this section

- Build a coalition to ensure that HIV/AIDS gets on the PRSP and debt relief agenda
- Develop a team with the skills to manage the process

The previous sections focused on *why* HIV/AIDS belongs in PRSP and HIPC, and on *what* should go into Poverty Reduction Strategies and debt relief agreements concerning HIV/AIDS. This section deals with the *how* – the difficult process of getting HIV/AIDS issues into the PRSP/debt relief agenda. There are two key considerations: building coalitions to influence policies and developing local capacity.

### 5.1. Building coalitions

To build coalitions, it is important that the diverse groups that are already committed to fighting the HIV epidemic are brought together, and that they draw in others who are not yet fully convinced. These could include parts of government including the national AIDS secretariat or coordinating body, the national AIDS council or inter-ministerial committee, AIDS units in some ministries, civil society groups that are already active and often have one or several national umbrella organizations, associations of people living with HIV/AIDS and a wide assortment of multilateral, bilateral, and international nongovernmental agencies. To support the PRSP and HIPC process, these various individuals and institutions can be engaged as members of task forces, inter-agency working groups, etc., led by government and other national actors.

To influence the process and content of the PRSP and debt relief agreements, the HIV/AIDS “coalition” must not only articulate a strong case for including HIV/AIDS on “technical” grounds. It is also important for coalition members to be closely engaged with those responsible for overall preparation and negotiation of the PRSP/HIPC instruments. These are typically senior officials of the Ministry of Finance and/or national economics and planning agency, and technical officers from the World Bank and International Monetary Fund. Again, it is helpful to have an inter-agency committee or technical working group supporting the Ministry of Finance team, on which certain persons from the HIV/AIDS coalition can serve. Relevant ministries include those of education, social development, youth, defence, agriculture and transport. Focusing national media attention on AIDS as a poverty issue and a threat to development can also be effective in influencing national policy on AIDS in the PRSP and debt relief processes. The Uganda AIDS Commission led a process that was both inclusive and participatory, the success of which provided a basis for incorporating AIDS into all the goals of the country’s Poverty Eradication Action Plan.

Finally, PRSP/HIPC can be an opportunity to build greater technical capacity in-country to deal with a range of analytical and managerial challenges inherent in mounting and sustaining a strong national AIDS programme. As can be seen from the above, effective inclusion of HIV/AIDS in the PRSP and HIPC requires skills in analysing the impact of AIDS on poverty, programme priority setting and costing, negotiation, and monitoring and evaluation, to name just a few of the most important areas. For each of these areas, a small but critical number of capable individuals must be located in key institutions, including the national AIDS secretariat, the Ministry of Finance, and national NGO umbrella organizations and associations of people living with HIV/AIDS.

## 5.2. Strengthening capacity

As part of PRSP/HIPC, members of the AIDS “coalition” in the country should develop, fund, and implement a scenario for minimum capacity building to support the process. Such a minimum scheme should specify the required skills and the institutions to house these. For example:

- National AIDS Secretariat: one planner and one economist trained in programming, priority setting, costing, and monitoring/evaluation. In Uganda, an economist was deployed to work on HIV/AIDS in the AIDS Commission.
- Ministry of Finance: one economist tied to PRSP/HIPC who can assemble data on the poverty-AIDS linkage and articulate AIDS commitments under debt relief.
- Poverty Action Fund and/or AIDS portfolio within the national social development fund: 2-3-person management teams trained to handle both the programmatic and financial dimensions of a major transfer of resources to local AIDS initiatives.
- The umbrella NGO organization and PLWHA association: at least one person in each who can help in articulating key commitments on AIDS under debt relief and assist in monitoring compliance with AIDS conditions under HIPC.

Carrying out this capacity building could also be one of the related objectives under PRSP and debt relief, and could be explicitly financed and monitored as part of HIPC.

## 6. CONCLUSIONS

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### 6.1. PRSP, debt relief and AIDS: just another source of funding or a new opportunity?

In many countries accessing debt relief, HIV/AIDS programme managers and decision-makers have the opportunity to claim more funding for HIV/AIDS in a context of the development of poverty reduction strategies. Debt relief does not only provide the possibility of having fresh resources injected in the fight against HIV. It gives the opportunity to place HIV/AIDS at the centre of the development and aid agenda and to discuss country issues linked to policy development and budgeting. Despite the availability of external resources through various initiatives, many HIV/AIDS programmes in poor countries have not yet reached a scale that will make an impact on the epidemic. Increases in internal revenue available for the social sectors may provide the opportunity to reach that scale by:

- placing HIV/AIDS within the framework of budgetary discussions, and breaking the cycle of donor-driven programme design and financing;
- institutionalizing the response to HIV/AIDS in all activities of the government, using the new fiscal space to provide additional resources to each sector for this specific purpose;
- transforming fragmented activities into sustained programmes, thus freeing the country from extreme dependence on donors for key inputs (for example, financing drugs for tuberculosis control or condoms for the military) and ensuring a more stable supply of such commodities; and
- addressing broader issues not always directly linked to HIV/AIDS but often strongly affecting the response and contributing to dysfunction in the sectors through staff attrition, poor remuneration and lack of funds for recurrent expenditures.

Policy-makers and managers thus have a reason to think strategically about how different sources of funding can complement one another rather than compete to fund the same programmes. Debt relief funds may be used wisely to develop the capacity to exert leverage and absorb further available external funding. In Mali for example, while the health sector benefits from a large externally funded sector investment programme, HIPC funds are likely to be used to reinforce the implementation capacity by financing basic training as well as contracting of staff and providing incentives for them to deliver essential public health interventions.

## 6.2. Next steps

The record of poor countries to date in integrating HIV/AIDS in poverty strategies and debt relief has been mixed. There have been some notable successes, but also a number of failures and missed opportunities. UNAIDS and its partners stand ready to assist countries affected by the HIV epidemic to seize more fully the current and future opportunities to bring HIV/AIDS to the forefront of the analysis and national actions to combat poverty and gain maximum benefits from debt relief.

## References

Ainsworth, M., Semali, I. 1998. "Who is most likely to die of AIDS? Socioeconomic correlates of adult deaths in Kagera Region, Tanzania." In Ainsworth, M., Fransen, L., Over, M. (Eds). *Confronting AIDS: Evidence from the developing world*. Selected background papers for the World Bank Policy Research Report, *Confronting AIDS: Public priorities in a global epidemic*. European Commission, Brussels, pp. 95-109.

Ainsworth, M., Teokul, W. 2000. "Breaking the silence: setting realistic priorities for AIDS control in less-developed countries." *The Lancet*. 356:35-40.

Bail, R., Mwikisa, C. *Costing the Zambia National HIV/AIDS Strategic Framework 2001-2003*. Unpublished manuscript, October 2000, pp. 8-10.

Cowan, D. Brundage, J., Pomerantz, R. 1994. "The incidence of HIV infection among men in the United States". *AIDS* 8 (4): 505-11.

Deheneffe, J., Carael, M., Numbissi, A. 1998. Socioeconomic Determinants of Sexual Behaviour and Condom Use". In Ainsworth, M., Fransen, L., Over, M. (Eds). *Confronting AIDS: Evidence from the developing world*. Selected background papers for the World Bank Policy Research Report, *Confronting AIDS: Public Priorities in a global epidemic*. European Commission, Brussels, pp. 131-46.

Filmer, D. 1998. "The Socioeconomic Correlates of Sexual Behaviour: A Summary of Results from an Analysis of DHS Data". In Ainsworth, M., Fransen, L., Over, M. (Eds). *Confronting AIDS: Evidence from the developing world*. Selected background papers for the World Bank Policy Research Report, *Confronting AIDS: Public Priorities in a global epidemic*. European Commission, Brussels, pp. 111-30.

Halperin, D. 2000. "Is Poverty the Root Cause of African AIDS? The 'Answer' May Be More Complex Than Commonly Thought". *Global AIDSLink*, Global Health Council, 65:9.

Hunter, S. *National Systems and Strategies for Provision of Care to HIV/AIDS Affected Adults and Children*. A discussion paper presented at the UNAIDS Workshop on the Role of Debt Relief in Financing National HIV/AIDS Programmes. Lilongwe, Malawi. November, 2000. Unpublished manuscript, pp.1-2.

Jha, P., Nagelkerke, N., Ngugi, E., Rao, J., Willbond, B., Moses, S., Plummer, F. 2000. "Interventions to Reduce HIV Transmission in Developing Countries: The Lessons of Two Decades of AIDS." Unpublished manuscript.

## REFERENCES

Krueger, L., Wood, R., Diehr, P., Maxwell, C. 1990. "Poverty and HIV Seropositivity: The Poor Are More Likely to Be Infected". *AIDS* 4(8): 811-14.

Lacey, C., Merrick, D., Bensley, D., Fairely, I. Analysis of the Sociodemography of gonorrhoea in Leeds." *British Medical Journal* 314(1): 715-18.

Lewis, J., Arndt, C. 2000. The Macro Implications of HIV/AIDS in South Africa: a preliminary assessment. Paper presented at the International AIDS Economics Network Symposium. July 2000. Special submission to the *South African Journal of Economics*.

McCoy, C. B., Metsch, L., Inciardi, J., Anwyl, R., Wingerd, J., Bletzer, K. 1996. "Sex, Drugs and the Spread of HIV/AIDS in Belle Glade, Florida". *Medical Anthropology Quarterly* 10 (1): 83-93.

Merson, M., Dayton, J., O'Reilly, K. 2000. "Effectiveness of HIV Prevention Interventions in Developing Countries." *AIDS*. 14 (suppl. 2): S68-84.

Parker, R. G. 1998. 'Historic Overview of Brazil's AIDS Programmes and Review of the World Bank AIDS Project'. Family Health International/AIDSAP. Processed. In Ainsworth, M., Semali, I. "Who is most likely to die of AIDS? Socioeconomic correlates of adult deaths in Kagera Region, Tanzania." Cited in Ainsworth, M., Fransen, L., Over, M. (Eds). 1998. *Confronting AIDS: Evidence from the developing world*. Selected background papers for the World Bank Policy Research Report, *Confronting AIDS: Public Priorities in a global epidemic*. European Commission, Brussels, pp. 95-109.

Piot, P., Aggleton, P. 1998. "The Global Epidemic." *AIDS Care*, 10 (Suppl. 12) S200-208.

Ram, S. 2000. *A Summary of Resource Transfer Mechanisms*. A discussion paper presented at the UNAIDS Workshop on the Role of Debt Relief in Financing National HIV/AIDS Programmes. Lilongwe, Malawi. November, 2000. Unpublished manuscript, pp. 24-26.

UNAIDS. 1999. *Summary Booklet of Best Practice Collection*. Issue 1. Geneva.

UNAIDS. 2000a. *Report on the Global HIV/AIDS epidemic*. Geneva, pp. 26-36.

UNAIDS. 2000b. *Innovative Approaches to HIV Prevention*. Selected Case Studies. Geneva. p. 6.

UNAIDS. 2000c. *National AIDS Programmes: A Guide to Monitoring and Evaluation*. Geneva, pp. 26-27.

World Bank. 2000a. *Poverty Reduction Sourcebook*. <http://www.worldbank.org/poverty>. Accessed on 24 January 2001.

World Bank. 2000b. *Project Appraisal Document for Proposed Credits in the amount of US\$59.7 million and US\$50 million, respectively, to the Federal Democratic Republic of Ethiopia and the Republic of Kenya in support of the first phase of the US\$500 million multi-country HIV/AIDS Programme for the Africa Region*. Washington, DC, pp. 65-79.

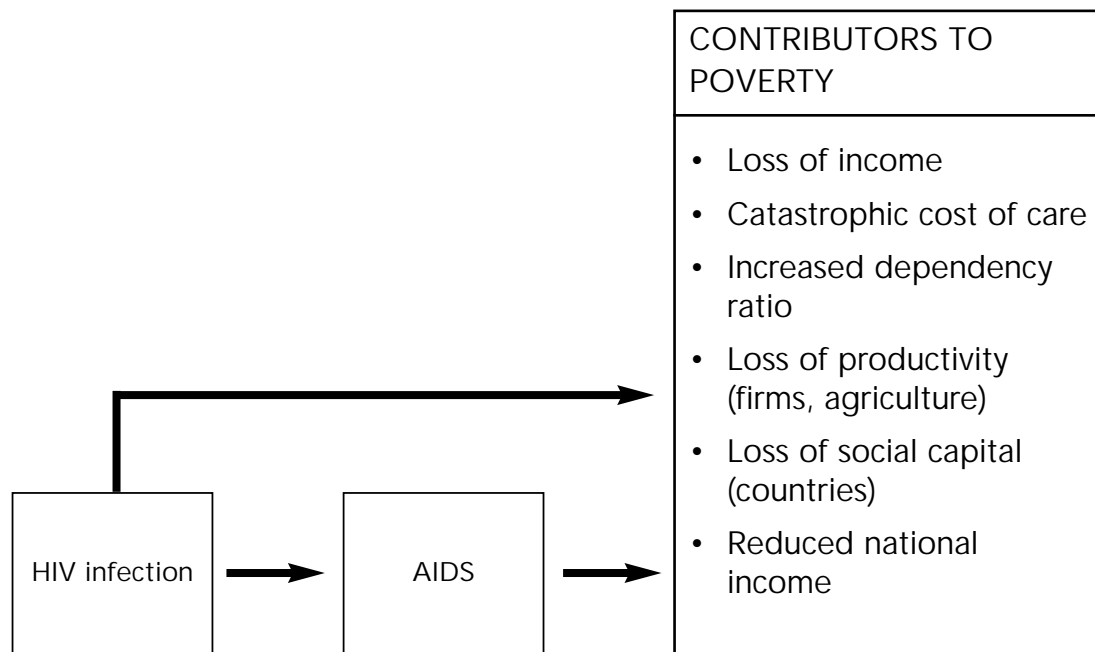
World Bank, 2000c. *Costs of Scaling HIV Programme Activities to a National Level in Sub-Saharan Africa: Methods and Estimates*. AIDS Campaign Team for Africa, pp. 1-5.

## APPENDIX 1. LINKS BETWEEN HIV/AIDS AND POVERTY

### AIDS causing or deepening poverty

The relationships are examined at the levels of the individual, the household and the national economy. Once infected, the individual faces direct catastrophic costs in terms of health and social care, plus indirect costs in terms of lost productivity. The household is more likely than not to experience reduced income. Business productivity is more likely than not to decline, due to lost productivity, high absenteeism, increased payments for treatment and funerals, as well as increased costs of training and retraining of replacements for dead workers. Figures A1 and A2 indicate the pathways from HIV infection to increased poverty.

Figure A1. HIV/AIDS induces and deepens poverty

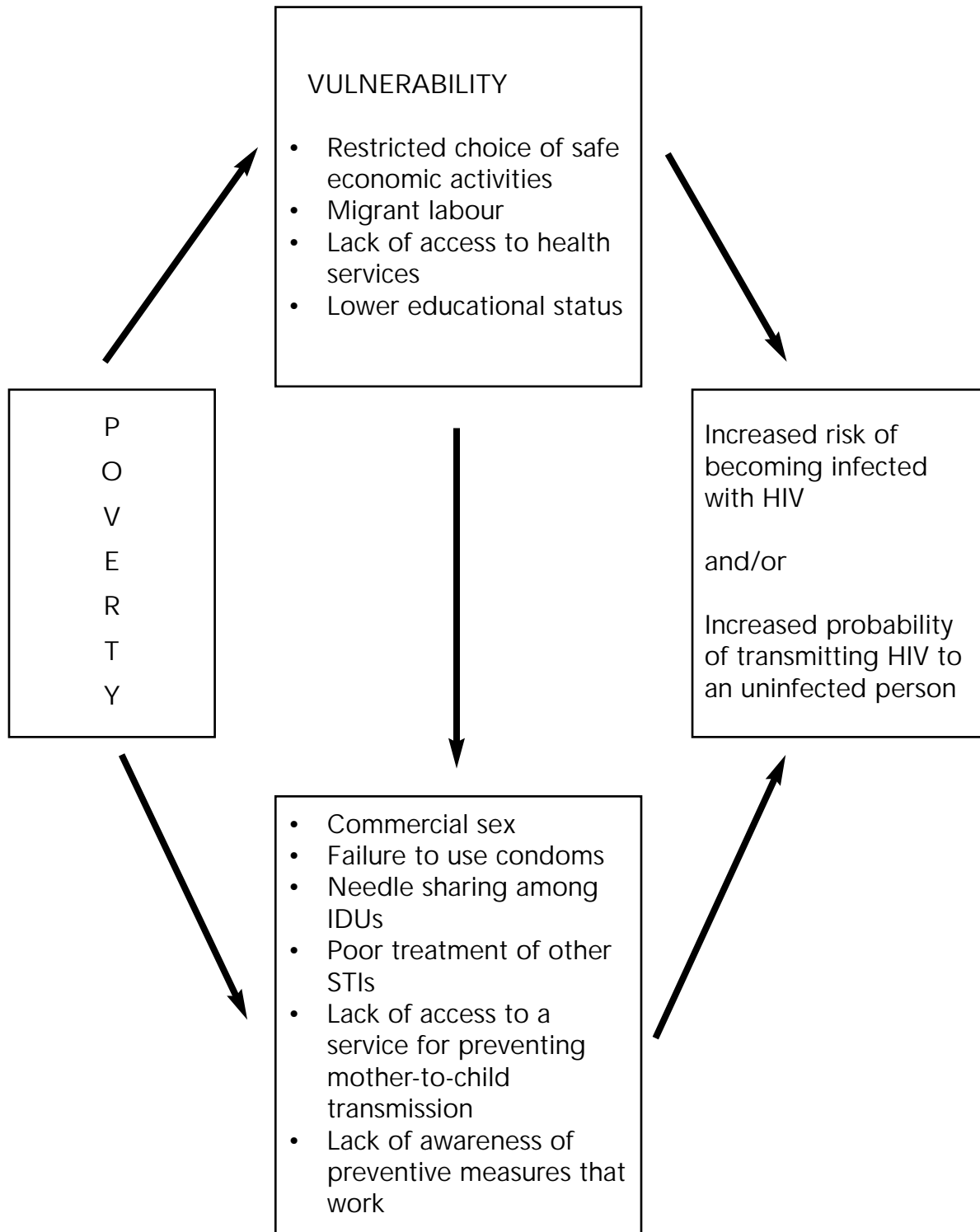


## Poverty and income inequalities increasing the likelihood of HIV infection

The plausible pathways by which poverty and income inequalities increase an individual's chances of becoming infected with HIV are perhaps indirect. ***Increased vulnerability to HIV infection is important because it increases the probability of transmitting or becoming infected with HIV.*** In this regard, poverty may reduce an individual's ability or willingness to avoid becoming infected. For example, income poverty may lead people to engage in high-risk income-generating activities such as commercial sex work. Commercial sex workers may engage in sex without condoms for the sake of higher fees. Poverty is often associated with lower education, which may in turn be associated with lower awareness of effective measures to prevent HIV infection. Figure A2 and Box A1 indicate the plausible pathways through which poverty leads to increased risks of HIV infection. As yet, there is not sufficient systematic evidence to support an assertion that poverty *causes* AIDS. While it is highly likely that some of the characteristics of poverty (e.g. lower educational level, fewer livelihood choices, lower capacity to negotiate safe sex) also increase the risk of being infected with HIV, it would be overly simplistic to see HIV purely as a "disease of the poor". Many groups and individuals at increased risk of being infected with HIV in Africa (urban elite who purchase sex, travelling businessmen who have casual sex, officers in the armed forces) are not among the poor. At this stage of the epidemic, HIV/AIDS continues to cut across household economic boundaries.

***For prevention, it is evident from the literature that in the short to medium term, the high-impact interventions are those that reduce the risk of transmitting the virus or the risk of becoming infected.*** Risk factors are those elements that increase directly the probability that an individual will become infected with HIV or transmit HIV to another person. Interventions focusing on vulnerability reduction are structural or more deep-seated development challenges. They could have indirect effects on the dynamics of the epidemic. Clearly, they need to be addressed for medium- to long-term success against HIV/AIDS. However, the dynamics of the epidemic are such that failure to act on risk reduction would result in a substantially larger number of infected persons, further limiting the gains from structural interventions against vulnerability.

Figure A2. Poverty increases the likelihood of HIV infection and AIDS



### Box A1. Does poverty increase the likelihood of HIV infection?

In the early years of the HIV/AIDS epidemic, persons of higher socioeconomic status were more likely than others to become infected with HIV. As HIV/AIDS becomes endemic in most African countries, the positive correlation between socioeconomic status and HIV infection could be expected to disappear. The evidence is mixed, as indicated in the following paragraphs. Among the issues needing attention is the combined effect of poverty and income inequalities in social transactions – including sex, patterns of vulnerability and patterns of risky behaviour in relation to HIV infection.

- UNAIDS analysed the results of studies conducted mostly among 15-19-year olds in 17 African and four Latin American countries. A risk pattern, seen in both sexes, was that better-educated individuals were generally more likely to have casual partners (UNAIDS, 2000a). The results also suggested that the best-educated people in the hardest-hit countries in Africa may be shifting towards less risky behaviour (UNAIDS, 2000a). Although it is too soon to tell, this pattern seems like that in Brazil, where there has been a shift in the socioeconomic distribution of AIDS cases: in the early 1980s, three-quarters of those newly diagnosed with AIDS had a secondary or university education; by the early 1990s this share had fallen to one-third (Parker, 1998).
- Poverty and illiteracy might be expected to raise the probability of infection with sexually transmitted diseases, including HIV/AIDS, since people with low incomes may be less able than those with higher incomes to afford condoms or STI treatment and those with little education may have less access to information about the dangers of high-risk behaviour or may be less able to understand prevention messages. This explains why, for most STIs, the poor and uneducated have higher infection rates (Lacey *et al.*, 1997). It also appears to be the case for the spread of HIV in industrialized countries (Cowan *et al.*, 1994; Krueger *et al.*, 1990; McCoy *et al.*, 1996).
- In the first decade of the HIV/AIDS epidemic in Africa, HIV infections did not follow this pattern. A number of studies showed a positive correlation between HIV infection and socioeconomic status, measured by schooling, income or occupation (Ainsworth and Semali, 1998). Analysis of data from demographic and health surveys carried out during the early 1990s and surveys of sexual behaviour sponsored by the WHO Global Programme on AIDS (GPA) conducted in 1989-1991 shows that the probability of having a non-regular or commercial sexual partner rises with education, potentially increasing exposure to contracting STIs, including HIV (Filmer 1998; Deheneffe *et al.*, 1998). The demand for commercial sex and/or the ability to support multiple partners would rise with income. Also, persons with higher education and higher incomes have more disposable cash and are more likely to travel – thus having more opportunities for casual sex. -->

- Aggregate income alone is not a predictor of trends in HIV prevalence: intra-country social and cultural factors play important roles in the dynamics of the epidemic. While well-meaning expressions like “poverty causes” AIDS may appear implicitly pro-poor, they may actually hamper condom promotion and other on-the-ground prevention efforts (Halperin, 2000).

## APPENDIX 2. INDICATORS

## 1. Overview of indicators by programme areas, tools for measurement, and priority for different epidemic states\*

(C=Core indicator; A=Additional indicator)

Note: Country teams are encouraged to refer to the full text for definitions and to be highly selective in their use of indicators.

Programme area indicator	Priority Generalized epidemic	Priority Concentrated/ low-level
Policy 1. Spending on HIV prevention	C	C
Condom availability and quality 1 Condoms available, nationwide 2 Condoms available, retail	C C	C A
Stigma and discrimination 1 Accepting attitudes toward HIV+ people 2 Employers not discriminating	C C	C C
Knowledge 1. Knowledge of HIV prevention	C	C
Voluntary counselling and testing 1 People who requested test and received results 2 Districts with VCT services 3 VCT centres with minimum conditions 4 Quality of VCT laboratories	C C C A	A  A A
Mother-to-child transmission 1 Pregnant women counselled and tested 2 Antenatal clinics offering and referring for antenatal care 3 Quality HIV counselling for pregnant women 4 Provision of antiretroviral therapy	C C A A	
Sexual negotiation and attitudes 1 Women's ability to negotiate safe sex	A	
Sexual behaviour 1 Higher-risk sex in the last year 2 Condom use at last higher-risk sex 3 Commercial sex in last year 4 Condom use by clients at last paid sex 5 Condom use by sex workers with last client	C C A A A	C C C C A

\* Part of the Behavioural surveillance surveys (BSS): Guidelines for repeated behavioural surveys in population groups at risk for HIV

## Appendix 2 (contd):

## 2. Overview of indicators by programme areas, tools for measurement, and priority for different epidemic states\*

(C=Core indicator; A=Additional indicator)

Note: Country teams are encouraged to refer to the full text for definitions and to be highly selective in their use of indicators.

Programme area indicator	Priority Generalized epidemic	Priority Concentrated/ low-level
Young people's sexual behaviour		
1 Median age at first sex	C	
2 Young people having premarital sex	C	A
3 Condom use at last premarital sex	C	A
4 Young people with multiple partners	C	A
5 Condom use at last higher-risk sex	C	A
6 Condom use at first sex	A	A
7 Age-mixing in sexual relationships	A	
Injecting drug use		
1 Injecting drug users sharing equipment		C
2 Injecting drug users never sharing equipment		C
3 Drug injectors using condom at last sex		A
Blood safety / nosocomial transmission		
1 Screening of blood units for transfusion	C	C
2 Reduction of blood transfusions	A	A
3 Districts / regions with blood bank	C	C
4 Accidental transmission in health care settings	A	
STI care and prevention		
1 Appropriate diagnosis and treatment of STI	C	C
2 Advice on prevention and HIV testing	C	C
3 Drug supply at STI care services	C	A
4 Treatment seeking for STI	A	C
Care and support		
1 Medical personnel trained in AIDS	A	A
2 Health facilities with capacity to deliver care	C	
3 Health facilities with drugs in stock	A	
4 Households helped with care of young adults	C	
5 Households helped with care of orphans	A	
Health and social impact		
1 HIV prevalence among pregnant women	C	C
2 Syphilis prevalence among pregnant women	C	C
3 HIV prevalence in sub-populations at risk	A	C
4 Prevalence of orphanhood	C	
5 Schooling of orphans	A	

Source: UNAIDS, 2000c, pp. 26-27.

\* Part of the Behavioural surveillance surveys (BSS): Guidelines for repeated behavioural surveys in population groups at risk for HIV.

## APPENDIX 3. SELECTED WEBSITES ON AIDS, POVERTY AND DEBT RELIEF

<http://www.unaids.org/publications/documents/index.html>

<http://www.worldbank.org/hipc/>

<http://www.worldbank.org/aids-econ/>

<http://www.worldbank.org/poverty/>

[http://www.oxfam.org/advocacy/human\\_f.htm](http://www.oxfam.org/advocacy/human_f.htm)

[http://www.dfid.gov.uk/public/what/strategy\\_papers/target\\_strategy.html](http://www.dfid.gov.uk/public/what/strategy_papers/target_strategy.html)

[http://www.usaid.gov/pop\\_health/aids/index.html](http://www.usaid.gov/pop_health/aids/index.html)

<http://www.j2000.usa.org>

