



HIV/AIDS

AND POVERTY REDUCTION STRATEGIES

POLICY NOTE

August 2002

Executive Summary

UNDP Policy Notes are intended to inform and strengthen the delivery of policy and programme support to countries. This note provides policy guidance on the important challenge of integrating HIV/AIDS priorities into poverty reduction strategies, including Poverty Reduction Strategy Papers (PRSPs).

Poverty reduction strategies are becoming the main development planning instrument in many countries, determining national priorities and domestic as well as external resource allocation. In the case of HIPC countries, poverty reduction strategies shape the speed of debt relief, and the allocation of debt relief savings. Integrating HIV/AIDS into poverty reduction strategies therefore helps to create the necessary policy and planning environment for a comprehensive, multi-sectoral and adequately funded response to the epidemic.

The Policy Note provides a synthesis of cutting-edge thinking on the interface between poverty reduction strategies and efforts to reverse the spread of HIV/AIDS. It proposes nine policy areas that UNDP and its partners must focus on as a matter of priority.

At the core of the Policy Note is a checklist with specific guidance on how to integrate HIV/AIDS into poverty reduction strategies, relevant for all countries regardless of their current HIV prevalence rates. The Note concludes by bringing the discussion to the global level. It recommends that UNDP—in the context of the Millennium Development Goals Campaign—step up its advocacy for placing HIV/AIDS at the centre of the international development agenda, capitalizing and building on its work at country level.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral drug
BDP	Bureau for Development Policy
CIS	Commonwealth of Independent States
HIPC	Heavily Indebted Poor Countries
HIV	Human Immunodeficiency Virus
HPI-1	Human Poverty Index (developing countries)
IMF	International Monetary Fund
MDG	Millennium Development Goal
MTEF	Medium Term Expenditure Frameworks
NEPAD	New Partnership for Africa's Development
NGO	Non-governmental organization
ODA	Official Development Assistance
OECD	Organization for Economic Cooperation and Development
PLWHA	People Living With HIV and AIDS
PRS	Poverty Reduction Strategy
PRSP	Poverty Reduction Strategy Paper
STD	Sexually Transmitted Disease
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme

1. Introduction

The purpose of this paper is to provide policy guidance on the important challenge of integrating HIV/AIDS priorities into poverty reduction strategies, including Poverty Reduction Strategy Papers (PRSPs). The current and projected socio-economic impact of the epidemic is so devastating that fighting AIDS and fighting poverty become one and the same battle. Achieving the Millennium Development Goals (MDGs)—and nationally determined poverty targets—will not be possible without an effective response to the AIDS crisis.

Poverty reduction strategies are becoming the overarching national planning instrument in many countries, providing an important opportunity for placing AIDS at the centre of national development planning and budget allocation processes—to facilitate the creation of an enabling policy and resource environment for a comprehensive, multi-sectoral and scaled-up response.

UNDP is in a privileged position to help countries ensure synergy between efforts to reverse the epidemic and strategies to reduce poverty. And there is much to be done. In the case of PRSPs, a recent review by the World Bank and IMF acknowledges that attention paid to the HIV/AIDS pandemic has tended to be weak in most strategy papers. Depending on the point of reference, only a handful of poverty reduction strategies adequately integrate HIV/AIDS. Examples of countries where HIV/AIDS priorities are at least partly integrated into poverty reduction strategies include Malawi, Mozambique and Uganda. But the great majority of strategies make only occasional reference to HIV/AIDS, under the health section—ignoring its impact in analyses of causes and consequences of poverty, and missing an opportunity to make HIV/AIDS a key priority requiring cross-sectoral action with time-bound targets, and adequate resources. In the case of many HIPC/PRSP countries, the result is that little or no money from debt-relief savings is being specifically allocated to HIV/AIDS. According to a survey of 10 countries where debt-relief has been allocated, these resources amount on average to less than 5% of total debt relief proceeds.

UNDP is stepping up its efforts to ensure that poverty reduction strategies, in both PRSP and non-PRSP countries, reflect the reality of the epidemic and its socio-economic impacts. This Policy Note is a key step in implementing UNDP's *Corporate Strategy on HIV/AIDS*, specifically the component (service line) that focuses on mainstreaming HIV/AIDS into development planning. In addition, the Note builds on UNDP's overall approach for supporting poverty reduction strategies as outlined in the Policy Note titled "*The Role of Economic Policy in Poverty Reduction*".

The challenge of mainstreaming HIV/AIDS into poverty reduction strategies is given further importance through the Declaration of Commitment made by member states at the UN General Assembly Special Session on HIV/AIDS, to "*By 2003, integrate HIV/AIDS prevention, care, treatment and support and impact-mitigation into the mainstream of development planning, including in poverty eradication strategies, national budget allocations and sectoral development plans.*" (Paragraph 38) Given its role and mandate in poverty reduction and HIV/AIDS, UNDP will be held accountable for providing effective support to countries in their efforts to fulfil this commitment.

2. The HIV/AIDS Crisis: A Brief Update

At the end of 2001, 40 million people were estimated to be living with HIV and AIDS, and 28 million had already died of the disease. The number of people infected is likely to reach 100 million (cumulatively) within less than a decade if a massive response does not take effect immediately.

HIV/AIDS is the leading cause of death in Sub-Saharan Africa, accounting for a quarter of all mortality while malaria now accounts for less than one tenth. The Caribbean and some Central American countries are experiencing an epidemic approaching the magnitude of that in Africa. However, the fastest increase in HIV infection is now occurring in Asia and Eastern Europe and the CIS. A wide range of societal factors is making these regions greatly vulnerable to a generalized epidemic. Even at relatively low prevalence rates, millions of people are infected and affected by HIV/AIDS, given the large population sizes. India today has the second largest number of people living with HIV/AIDS (PLWHA), after South Africa.

The statistical magnitude of the epidemic is presented in **Annex Table 1**. Below is a summary:

- Fifty-seven countries world-wide have reached an HIV adult prevalence rate of over 1%—the point at which the epidemic is believed to take hold and begin to spread throughout the general population.
- Twenty-eight have reached prevalence rates of over 4%—believed to be the level above which the epidemic spins out of control.
- Thirteen countries have surpassed 10% of adults infected by HIV.
- Seven countries have moved above the 20% mark, with Botswana and Zimbabwe going beyond what experts believed to be possible—prevalence rates of 39% and 34% respectively.
- India will soon have the highest number of HIV-positive citizens, and China is close behind; the two countries combined will have at least 10 million people infected with HIV by 2005.
- Ukraine (1%) and Russia (0.9%) have the fastest growing epidemics in the world, and the trend in Russia is for registered cases to double every year. The Russian Health Ministry estimates that 5-10 million men and boys between the ages of 15 and 20 will be HIV-positive in five years time.

It must be remembered that these rates cannot take account of people who have already died of AIDS, or include those who will become infected in the future. Also, given the delay between HIV infection and the onset of AIDS, mortality rates among young adults are expected to continue to increase for quite some time. Without progress in prevention and treatment, and assuming constant risk levels, the lifetime likelihood of an AIDS death for a 15-year-old boy is 50% in Kenya, 60% in Zambia, nearly 70% in South Africa, and nearly 90% in Botswana.¹

¹ Report on the Global HIV/AIDS Epidemic, UNAIDS, June 2000

3. Impact on Poverty Reduction Efforts

The HIV/AIDS crisis has far-reaching implications for the attainment of the MDGs and related nationally-determined poverty targets. One of the goals is to reduce HIV prevalence in persons aged 15-24 by 25% by 2005 in the worst affected countries, and by 2010 globally. Given the unique devastation of the epidemic, reversing HIV/AIDS becomes the most important MDG. Without progress in tackling HIV/AIDS, the prospect of achieving any of the other goals is in great jeopardy. **Annex Table 2** provides an analysis of the impact of HIV/AIDS on the attainment of the MDGs.

The impact of HIV/AIDS is unique because AIDS kills adults in the prime of their lives, thus depriving families, communities, and entire nations of their young and most productive people. Adding to an already heavy disease burden in poor countries, the HIV/AIDS epidemic is deepening and spreading poverty, reversing human development, worsening gender inequalities, eroding the capacity of governments to provide essential services, reducing labour productivity, and hampering pro-poor growth. For example:

- As a result of HIV/AIDS, the proportion of people living in poverty in Burkina Faso will increase from 45% to nearly 60% by 2010, according to the UNDP National Human Development Report 2001.
- Life expectancy in Haiti will be 50 years instead of 60 in 2010 as a result of HIV/AIDS. According to the UN Population Division, life expectancy is expected to drop below 35 years in the worst affected countries.
- The under five mortality rate in South Africa will increase to nearly 150 per 1,000 live births by 2010, instead of falling to around 50 in the absence of HIV/AIDS, according to the US Census Bureau.
- School enrolment in the Central African Republic and Swaziland has already fallen by 20-36% as a result of AIDS orphans dropping out of school, according to government reports.
- In Trinidad and Tobago, according to the UNDP National Human Development Report 2000, HIV rates are five times higher for girls aged 15-19 than for boys—testament to the discriminatory impact of AIDS on young women.
- Public revenues will be reduced by 20% in Botswana as a result of the economic impact of the epidemic, according to Botswana Human Development Report 2000—crippling efforts to reduce poverty and achieve the MDGs.

These staggering aggregate statistics reflect the devastating impact at the household level. As families lose their breadwinners and caretakers, income is lost, agricultural output declines, nutrition worsens, spending on health care increases, funeral costs soar, savings turn into debt, children drop out of school, the health status of individuals deteriorates, and so on. Studies of rural families in Thailand show that farm output and income fell between 52% and 67% in households affected by AIDS. A study in Zambia shows that two-thirds of urban households that lost their main breadwinner to AIDS experienced a loss of income of 80%. The same study found that 61% of these households moved to cheaper housing, 39% lost piped water, and 21% of girls and 17% of boys dropped out of school.²

Of crucial importance is the fact that the brunt of the burden is borne by women in their multiple roles as caretakers, breadwinners and subsistence farmers. Poverty, gender and HIV/AIDS seem to be closely intertwined. It has also been observed that the social

² Namposya Nampanya-Serpell, "Social and Economic Risk Factors for HIV/AIDS-Affected Families in Zambia", 2001.

epidemiology of AIDS is changing over time. In the early stage of the pandemic, the better educated and better-off are more vulnerable to HIV infection, mainly because of higher resources and greater mobility. But once information and knowledge about the disease become available, they change their behaviour and protect themselves against HIV, while the less educated become more vulnerable as the virus spreads.³

4. Placing HIV/AIDS at the Centre of the Development Agenda

Poverty reduction strategies are becoming the main development planning instruments in many countries, determining national priorities and domestic as well as external resource allocation, and in the case of HIPC countries, the speed of debt relief and allocation of debt relief savings. This is the primary reason for integrating HIV/AIDS into poverty reduction strategies, thus ensuring that adequate resources are allocated to programmes aimed at reversing the epidemic and managing its impact. Viewing the response to HIV/AIDS as an isolated, narrowly defined public health intervention, separate from the mainstream of development efforts, will guarantee that it continues to be under-funded, fragmented and inadequate.

Mainstreaming HIV-related priorities into poverty reduction strategies helps create an *'enabling policy and resource environment'* for an effective response to the epidemic, thus achieving synergy between diverse interventions across many sectors, and ensuring adequate financing for HIV/AIDS. Experiences in those few countries where measurable results have been achieved in reversing the epidemic—Uganda, Senegal, Thailand, Cambodia and Brazil— indicate the importance of such an enabling policy and resource environment.

Mainstreaming HIV/AIDS priorities into poverty reduction strategies is likely to produce the following crucial outcomes/results:

- HIV/AIDS priorities become an integral part of a government's development agenda, giving the epidemic greater political visibility and leadership.
- HIV/AIDS is more likely to feature prominently in the priorities of the Ministries of Finance/Planning—a prerequisite for full government mobilization in the fight against HIV/AIDS and its socio-economic impact.
- The government takes charge firmly of the national AIDS programme, which enjoys stronger national ownership and the oversight necessary for real and sustained results.
- The response to HIV/AIDS becomes properly institutionalized and integrated into all activities of government, across all sectors. This helps ensure that HIV/AIDS is not the reserved domain of the ministry of health and charity-focused NGOs. The response becomes truly multi-sectoral and multi-level, with better co-ordination

³ In the most affected countries, the pattern for people with education follows an inverted U-shape as the epidemic progresses from the nascent stage to the concentrated phase and subsequently to the generalized stage. The pattern for those without education follows a more gradual curve during the nascent and concentrated stages, but grows exponentially in the generalized stage. Even in countries where the overall HIV prevalence rate is high and rising, the level of HIV infection among the better educated has started to decline during the 1990s. The 'education vaccine' against HIV seems to be taking effect as awareness about the pandemic increases. Evidence shows that HIV infection is not random, and that new infections are increasingly concentrated among the illiterate and the poor, especially among young, poor and illiterate women.

- between various sectors and actors, and between national and local-level interventions, resulting in a scaled-up and sustained nation-wide response.
- Domestic resources are allocated to the national HIV/AIDS strategic plan, avoiding too much dependency on donor-driven programme design and financing, while not ignoring the fact that much more donor support is required to bridge the gap between available resources and resource needs.
 - Debt relief savings are more likely to be earmarked for HIV/AIDS interventions, as part of the national poverty reduction strategy, providing an important opportunity to increase the level of public spending on HIV/AIDS. (Of the 42 countries eligible for HIPC debt relief, 30 are seriously affected by HIV/AIDS)
 - The national AIDS programme can benefit from accountability frameworks developed in the context of budget planning and poverty reduction strategies, thus producing a clear division of labour between various government institutions, and transparent allocation and disbursement of resources.

5. HIV/AIDS and Poverty Reduction Strategies: Nine Policy Areas

In view of the interface between HIV/AIDS, poverty and gender inequality—and the socio-economic devastation caused by the epidemic—UNDP must now play a pivotal role in helping countries place HIV/AIDS at the centre of poverty reduction strategies. To this end, the paper proposes nine areas for UNDP intervention and support. These areas can also be seen as entry points for South-South networking, and for building partnerships with other UN agencies, multi-lateral lending institutions and NGOs.

5.1. Putting HIV/AIDS Prevention and Treatment at the Centre of Poverty Reduction Strategies

As the epidemic is becoming the single biggest obstacle to reducing poverty, HIV/AIDS prevention and treatment need to take centre stage in national poverty reduction strategies. Poverty reduction strategies need to include specific commitments, medium-term goals, and short-term action targets related to HIV prevention and treatment, and to managing the socio-economic impact. Mainstreaming HIV/AIDS into poverty reduction strategies is becoming a key opportunity for ensuring a multi-sectoral and multi-actor response to HIV/AIDS that includes, but moves well beyond, health sector-based interventions. HIV/AIDS needs to feature in poverty reduction strategies as a cross-sectoral concern, specifying the respective roles and accountabilities of all sectors and levels of government, as well as civil society groups and the private sector.

To ensure that poverty reduction strategies reflect the realities of the epidemic as experienced by people, it is essential to have dynamic consultations between government and with civil society—with special recognition of the leading role of communities affected by the epidemic and PLWHA. This is also of paramount importance in order to address the prevailing stigma and denial surrounding the HIV/AIDS epidemic—a major obstacle for placing HIV/AIDS at the centre of development and poverty reduction dialogues. In countries where the political leadership is still unable to face the facts of the current reality or the future threat of the epidemic, civil society and the media play a leading role in liberating the issue from the shackles of denial.

5.2. Special Efforts in Low-prevalence Countries

Integrating HIV/AIDS prevention and care into poverty reduction strategies is just as important in high-prevalence as in low-prevalence countries. In countries with low HIV prevalence rates, the challenge of integrating a *proactive response* to the epidemic into development planning is of utmost urgency. Many countries in Asia and the Pacific, in Eastern Europe and the CIS, in Latin America, and in the Arab States, still have a window of opportunity for stopping the epidemic before it becomes as prevalent as in Africa or the Caribbean, thus avoiding its devastating socio-economic impact.

Placing HIV/AIDS at the centre of the national development agenda in countries yet to witness the devastation of the epidemic can be problematic. It requires special efforts in terms of engaging government decision-makers and civil society leaders in a dialogue about the factors that make countries and communities vulnerable to a full-fledged epidemic and the importance of preparedness and early action. Solid analysis and scenario building is required to predict the potential course and impact of the epidemic in order to convince policy makers that the epidemic merits immediate attention, resources and a clear expression of priority.

5.3. HIV/AIDS and Macro-economic Frameworks

Critical to mainstreaming HIV/AIDS within poverty reduction strategies is the costing of truly multi-sectoral national HIV/AIDS strategic plans, which should then be placed at the centre of budget allocation decisions and within the Medium Term Expenditure Frameworks (MTEF). A survey at the end of 2000 showed that in no country does the MTEF account for HIV/AIDS-related expenditure across the different sectors involved. This is a missed opportunity to track HIV-related expenditure and to show government commitment to a multi-sectoral and multi-level response. And in virtually all countries, it is currently impossible to obtain reliable information on public expenditure on HIV/AIDS. Many countries therefore need to build capacity in the area of sectoral planning and budgeting and in particular with regards to cross cutting issues such as HIV/AIDS. In PRSP countries, it is essential that national HIV/AIDS strategic plans are costed within the macro-economic framework of the PRSPs, rather than added on as costing that is not integral to resource envelope projections.

In the seriously affected countries, the issue of integrating HIV/AIDS into macro-economic frameworks extends well beyond the need to ensure the adequate financing of national HIV/AIDS strategies. As AIDS-related illness strikes a significant portion of the adult population, demand for health and social welfare services rises sharply. This has budgetary implications that must be taken into account in macro-economic planning, especially as the escalating costs of caring for people dying of AIDS may divert resources from other human development priorities. In addition, the socio-economic impact of HIV/AIDS is so severe that the revenue base of the public sector is gradually being eroded. In Botswana, for example, UNDP has estimated that public sector revenues will fall by 20% by 2010 as a direct result of HIV/AIDS.

5.4. Counteracting the Socio-economic Impact of HIV/AIDS at the Household Level

In seriously affected countries, poverty reduction efforts need to be scaled up to counteract the deprivation-creating effect of the epidemic, notwithstanding efforts to prevent its spread and provide treatment for those infected. Poverty strategies must be 'calibrated' to meet the

special needs of households and communities devastated by HIV/AIDS, improving their access to essential social services, income generation and employment programmes, and where necessary, interventions to alleviate hunger and extreme deprivation. Special attention needs to be given to poor households already vulnerable to external shocks, the needs of women, and support for orphaned children.

In countries affected by growing HIV/AIDS-related mortality among young adults, a number of key questions need to be raised as poverty reduction strategies are developed and implemented: Does targeting of poverty reduction programmes need to shift so that they benefit those households falling below the poverty line as a result of HIV/AIDS? How can income and employment generation programmes, credit schemes, and rural development projects be adjusted to the specific needs of households and communities impacted by high adult mortality? How can the coverage of these programmes be expanded given the resource constraint? What policies and resources are required to ensure access to basic social services for AIDS-affected households? How can the delivery of these services better meet the specific needs of PLWHA and affected communities?

Over the years, UNDP has supported many individual initiatives specifically aimed at alleviating the socio-economic impact of HIV/AIDS on people and communities. Many of these projects, however, are fragmented efforts in specific locations and with very limited coverage, and do not form part of the overall national poverty reduction strategies. One example where this is not the case is Uganda, where the national Poverty Eradication Plan (which also serves as the PRSP) tackles the devastating impact of HIV/AIDS on households and communities in a more systematic way. Resources from the Poverty Action Fund are channelled down to the district and village level to support surviving members of households affected by the epidemic through income generating activities, nutritional support, training, and improved access to schooling for orphans.

5.5. Mitigating the Impact of AIDS on Essential Public Services

Within the framework of poverty reduction strategies, concrete action and additional resources are required to counteract the devastating impact on the public sector, in particular to ensure the maintenance of essential public services notwithstanding the loss of teachers, nurses and other civil servants, and the diversion of public resources to address the AIDS epidemic. For example, resources are needed for the accelerated recruitment and training of service providers and to meet the growing demand for health care and poverty relief generated by high AIDS morbidity and mortality.

In this area, UNDP is undertaking cutting edge work in Malawi, where it is supporting a major review of the impact of HIV/AIDS on human resources in the public sector. The government is setting up a system to better track morbidity, mortality and absenteeism in the public service, fast-tracking training and recruitment of replacement staff, adjusting human resource management policies and succession-planning activities to ensure continued functioning of essential services and maintain acceptable levels of productivity. Efforts are already underway to ensure support to employees affected by the epidemic and to step up workplace prevention and care activities.

5.6. Action to Alleviate the Heavy Burden on Women

Of particular importance is the fact that poverty reduction strategies will need to be adjusted to respond to the special needs of women who bare the brunt of the impact of HIV/AIDS—as caretakers, breadwinners and those who are most vulnerable to HIV infection. The unique

impact on women is often poorly understood and analysed, and needs to be given special attention when poverty reduction strategies are formulated and implemented. As women struggle to support families, earn income, produce food and care for the sick, while suffering from HIV-related illness themselves, a mix of community solidarity, support programmes and public services become absolutely essential. Special efforts are needed to ensure access to social services, land, credit, employment opportunities, markets and improved agricultural techniques. Poverty and powerlessness render women vulnerable to infection. Disempowerment of women makes it more difficult for them to protect themselves from being infected by their partners, exposes them to sexual abuse and rape, limits their access to knowledge about how to protect themselves, and increases the incidence of other STDs that raise susceptibility to HIV infection. This vicious circle of gender inequality, poverty and voicelessness is at the core of the relentless spread of the epidemic.

5.7. Addressing Poverty as a Source of Vulnerability to HIV and AIDS

Success in preventing HIV and expanding access to care hinges on progress in reducing income poverty and inequality, tackling gender inequality and social exclusion, and addressing lack of access to essential services—especially basic education and literacy. These conditions, and other sources of human deprivation, are important “co-factors” fuelling the epidemic because they render people vulnerable to infection and put those who are disadvantaged at high risk. HIV/AIDS is not strictly speaking a “disease of poverty” since it affects people at all income levels, but evidence from some countries at advanced stages of the epidemic shows that new HIV infections disproportionately affect poor people, unskilled workers and those lacking literacy skills—especially young women in each of these categories. The relationship between poverty, gender and vulnerability to HIV/AIDS has important policy implications that require special attention in the context of both poverty reduction and HIV/AIDS programmes. Programmes aimed at empowering people politically, socially and economically in the context of poverty reduction strategies obviously contribute greatly to reducing vulnerability to HIV/AIDS. Opportunities to combine tools and methodologies to develop community responses to both HIV/AIDS and poverty must be further explored.

5.8. The Arrival of Antiretroviral Drugs

The discriminatory impact of the epidemic on poor people and poor countries is even more striking in terms of AIDS mortality. Access to antiretroviral drugs (ARVs) is now universal in most OECD countries. While not a cure, the treatment delays the onset of AIDS and has resulted in a sharp fall in AIDS mortality in rich countries. In developing countries, ARVs are gradually becoming available to the highest income groups who have access to, and can afford treatment. For the vast majority, however, they are not available. Out of the 38 million PLWHA in developing countries, a mere 200,000 have access to ARVs. In Africa it is estimated that 30,000 people, or a minuscule 0.1% of PLWHA are benefiting from these medical advances. Improving access to ARVs in developing countries is of extreme urgency, but will have major policy dimensions and budgetary implications that will need to be addressed not only in health sector planning, but also in the context of poverty reduction strategies, MTEFs and national budgets. A full scale ARV programme is a multi-sectoral undertaking, involving not only ministries of health, but also ministries of finance (to ensure adequate funding), local government (to ensure actual delivery of services to individuals), the

private sector (to extend access to employees), and civil society organizations (to ensure awareness raising and community mobilization in support of programmes).

5.9. Poverty Monitoring and HIV/AIDS

The reality of HIV/AIDS makes it imperative that more attention be paid to monitoring the socio-economic impact of the epidemic, especially in the context of MDGs and nationally determined poverty targets. UNDP is already helping countries to focus on the current and projected impact of HIV/AIDS in the context of national MDG reports, as well as in its support for poverty monitoring in the context of poverty reduction strategies. In addition, UNDP is supporting an increasing number of countries in preparing NHDRs that focus on HIV/AIDS. The Reports provide policy-relevant analysis of the multi-faceted impact on human development, and are tools for monitoring trends in human development indicators as they are affected by the sharp increases in mortality caused by the epidemic. UNDP will now further step up its efforts to integrate HIV/AIDS impact analysis into its support for national poverty monitoring, as well as monitoring of the attainment of the MDGs at country level.

6. Checklist for Mainstreaming HIV/AIDS into Poverty Reduction Strategies

Below is a checklist that provides more specific guidance on how to integrate HIV/AIDS into poverty reduction strategies. It is by no means exhaustive, but provides illustrative examples of the types of questions/criteria that can be used to determine the extent to which HIV/AIDS has been integrated into such strategies.

The checklist is divided into two categories (i) actions that are needed in all countries, irrespective of the level of HIV prevalence. This category usually pertains to proactive strategies to prevent the spread of the epidemic, and (ii) additional actions required in countries that are already seriously impacted by HIV/AIDS. The second category includes countries with high HIV prevalence and AIDS mortality rates and countries with low prevalence rates but, due to large populations, a high absolute number of PLWHA.

Checklist for Mainstreaming HIV/AIDS into Poverty Reduction Strategies

<i>All Countries</i>	<i>Seriously Affected Countries</i>
<input checked="" type="checkbox"/> Has the impact of HIV/AIDS (current and/or projected) on poverty reduction efforts been analysed, showing the centrality of HIV/AIDS in understanding the dynamics of poverty, and the contribution that successful HIV prevention and treatment can make in terms of fighting poverty?	<input checked="" type="checkbox"/> Has accelerating HIV/AIDS mortality among young adults been factored into the calculation of poverty reduction and economic growth targets, and projections for reaching the Millennium Development Goals (proportion of people living below the poverty line, primary school enrolment, child mortality rates, malnutrition levels, etc.)?
<input checked="" type="checkbox"/> Have gender disaggregation and analysis been incorporated to reflect the gender dimension and socio-economic and cultural implications for women?	<input checked="" type="checkbox"/> Has the poverty reduction strategy been appropriately adapted, accelerated and scaled-up to address the generalized human development impact of HIV/AIDS?
<input checked="" type="checkbox"/> Does the poverty reduction strategy include specific commitments, targets, medium-term goals, short-term action targets related to HIV	<input checked="" type="checkbox"/> Has the poverty reduction strategy been adapted to respond to the more specific needs of people

<p>prevention, care and impact mitigation?</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> In the case of PRSPs, is HIV/AIDS reflected as a cross-sectoral, "Goal-Level" priority? <input checked="" type="checkbox"/> Do HIV/AIDS strategies figure only in the health section of the poverty reduction strategy, or is it treated as a supra-sectoral concern (as is done in Uganda)? <input checked="" type="checkbox"/> Are the poverty reduction strategies and the national strategic HIV/AIDS plans properly linked, complementing each other, sharing common targets and priorities, etc? <input checked="" type="checkbox"/> Has the multi-sectoral national HIV/AIDS strategic plan been fully costed and is it included within the Medium Term Expenditure Framework and reflected in the national budget? <input checked="" type="checkbox"/> Do Medium Term Expenditure Frameworks account for all HIV/AIDS-related expenditures, including resources expended by the central National AIDS coordination unit, as well as line ministries, district authorities, and community organizations? <input checked="" type="checkbox"/> Do HIV/AIDS concerns figure prominently in debt-relief negotiations and HIPC documents, and are debt relief savings being earmarked for HIV interventions? <input checked="" type="checkbox"/> Have adequate public resources been allocated (in accordance with a multi-sectoral National Strategic HIV/AIDS plan) to the various government sectors, or alternatively have ministries been instructed to set aside a certain percentage of their existing budgets to HIV/AIDS? <input checked="" type="checkbox"/> Are public resources available for province, district and village-level HIV/AIDS activities, or have province, municipal, and district authorities been instructed to use a certain percentage of their existing budgets for HIV/AIDS? What proportion of these units are covered by effective programmes? <input checked="" type="checkbox"/> Are there adequate institutional linkages and collaboration between the National HIV/AIDS coordinating body and the Ministry of Finance/Planning, in order to facilitate all of the above? 	<p>and communities particularly affected by HIV/AIDS, especially the needs of orphans, and the elderly, ensuring maximum coverage of social services, access to livelihood opportunities, etc?</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Has the poverty reduction strategy been adjusted to respond to the special needs of women affected by HIV/AIDS, as caretakers and breadwinners, in terms of support, social services, access to livelihood opportunities, etc. <input checked="" type="checkbox"/> Has the impact of HIV/AIDS disease and mortality on public revenues been properly analysed and have adjustments in macro-economic planning been made accordingly. <input checked="" type="checkbox"/> Has the impact on all sectors been addressed in budget allocation decision-making, such as the need to recruit and train skilled public servants to replace those that have died of HIV/AIDS, coping with greater demands on poverty relief programmes, avoiding collapse of the health sector over-burdened with AIDS patients, etc? <input checked="" type="checkbox"/> Are poverty action funds, social action funds, or other financing mechanisms that reach districts and community organizations (thus bypassing central bureaucracies) being used to fund HIV/AIDS prevention, care and impact mitigation programmes, as part of national poverty and social development strategies? (as is done in Uganda and Malawi)
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7. The Global Dimension

For UNDP, the MDG campaign is a key opportunity to ensure that HIV/AIDS is firmly placed at the centre of the global development agenda. One of the millennium goals aims at reversing the spread of HIV/AIDS by 2010, and given the current and projected impact of the epidemic on development, progress towards this particular goal will be a precondition for

reaching all other MDGs (see **Annex Table 2**). The MDG campaign will become an entry point for marshalling international support for countries grappling with the socio-economic impact of HIV/AIDS, and UNDP is in a privileged position to provide leadership in this endeavour.

To enable countries to effectively address the challenge of arresting the spread of HIV/AIDS, improving access to treatment, and managing the socio-economic impact, the international community will need to further intensify its support. HIV/AIDS and its impact must take centre stage in global discussions on reducing poverty, achieving the MDGs, financing development, providing debt relief, and negotiating trade and investment agreements to ensure universal access to drugs. The inadequate attention given to HIV/AIDS at the 2002 Monterrey Conference on Finance for Development and in the New Partnership for Africa's Development (NEPAD) is symptomatic of the inability to get to grips with the wider development implications of the worst epidemic in modern history.

The United Nations has estimated that by 2005, \$10 billion a year will be needed for prevention and care in low and middle-income countries. In poor countries, nearly 80% of these resources will need to come from external sources. However, these estimates do not include the cost of managing the socio-economic impact of the epidemic, notwithstanding efforts to stem the spread of AIDS and keep those who are infected alive through medical treatment. Addressing the broader impact as countries are devastated by rapid increases in AIDS mortality among young adults has major implications for international cooperation and financial support to development and poverty reduction efforts.

Over and above resources required for HIV/AIDS prevention and care, ODA for the worst affected countries needs to be increased by substantial amounts to support poverty reduction strategies that address the devastating impact of the epidemic. ODA flows to the 28 countries most seriously affected by AIDS (those countries with adult HIV prevalence ranging from 4% to 39%) have fallen by a third since 1992, from \$12.5 billion to \$7.8 billion. Given the developmental impact of HIV/AIDS outlined in this paper, this trend must be reversed. More than ever, ODA needs to be allocated to the social sector and in support of national poverty reduction targets in order to help counteract the poverty-creating and gender-discriminating effects of HIV/AIDS.

An issue that has received virtually no attention to date is the need for accelerated debt relief for countries seriously affected by HIV/AIDS. Sixteen African countries are both 'heavily indebted' and 'highly infected', with unsustainable debt burdens and HIV adult prevalence rates well above the critical threshold of 4%. While accelerated debt relief is focusing on countries that suffer from more eye-catching and short-term external shocks, such as floods and hurricanes, no such special treatment is given to countries crumbling under the weight of HIV/AIDS—indefinitely more devastating than any natural disaster. Debt sustainability analysis at HIPC completion point must take into account the developmental impact of HIV/AIDS, as well as the resource requirements for responding to the epidemic. Multilateral lending agencies and creditors may need to consider the impact of the epidemic on countries' debt sustainability, and if necessary, explore the possibility of debt relief well beyond HIPC for those countries that are experiencing a dramatic reversal of human development achievements. Countries that are not eligible for HIPC, but are seriously affected by the HIV/AIDS epidemic, must also be given debt relief consideration.

In the context of the MDG campaign, UNDP will now step up its global advocacy for placing HIV/AIDS at the centre of the international development agenda as described above, capitalizing on the credibility earned by working on these issues at country level.

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Annex Table 1: HIV Prevalence and Poverty

HIV Rank ¹	Country	Adults (15-49) living with HIV/AIDS (%) ²	Adults and children living with HIV/AIDS ²	Women (15-49) living with HIV/AIDS ²	Human Poverty Index (HPI-1) value	Population below national poverty line (%)	PRSP Country
1	Botswana	38.8	330,000	170,000	...	...
2	Zimbabwe	33.7	2,300,000	1,200,000	36.1	25.5	
3	Swaziland	33.4	170,000	89,000	...	40	
4	Lesotho	31.0	360,000	180,000	25.7	49.2	✓
5	Namibia	22.5	230,000	110,000	34.5	...	
6	Zambia	21.5	1,200,000	590,000	40	86	✓
7	South Africa	20.1	5,000,000	2,700,000	...	...
8	Kenya	15.0	2,500,000	1,400,000	31.9	42	✓
9	Malawi	15.0	850,000	440,000	42.5	54	✓
10	Mozambique	13.0	1,100,000	630,000	47.9	...	✓
11	Central African Republic	12.9	250,000	130,000	45.2	...	✓
12	Cameroon	11.8	920,000	500,000	30.7	40	✓
13	Djibouti	11.8 ³	37,000 ³	19,000 ³	34.3	45.1	✓
14	Cote d'Ivoire	9.7	770,000	400,000	42.3	36.8	✓
15	Rwanda	8.9	500,000	250,000	44.3	51.2	✓
16	Burundi	8.3	390,000	190,000	...	36.2	✓
17	Tanzania, United Rep. of	7.8	1,500,000	750,000	32.7	41.6	✓
18	Congo	7.2	110,000	59,000	30	...	✓
19	Sierra Leone	7.0	170,000	90,000	...	68	✓
20	Burkina Faso	6.5	440,000	220,000	...	...	✓
21	Ethiopia	6.4	2,100,000	1,100,000	56.5	...	✓
22	Haiti	6.1	250,000	120,000	42.3	65	
23	Togo	6.0	150,000	76,000	37.9	32.3	✓
24	Nigeria	5.8	3,500,000	1,700,000	34.9	34.1	✓
25	Angola	5.5	350,000	190,000	...	...	✓
26	Uganda	5.0	600,000	280,000	40.8	55	✓
27	Congo, Dem. Republic of	4.9	1,300,000	670,000	39.7	...	✓
28	Gabon	4.2 ³	23,000 ³	12,000 ³	...	...
29	Chad	3.6	150,000	76,000	50.5	64	✓
30	Benin	3.6	120,000	67,000	46.8	33	✓
31	Bahamas	3.5	6,200	2,700	...	...
32	Equatorial Guinea	3.4	5,900	3,000	...	...
33	Ghana	3.0	360,000	170,000	28.7	31.4	✓
34	Guinea-Bissau	2.8	17,000	9,300	49.3	48.7	✓
35	Eritrea	2.8	55,000	30,000	42.9	53	✓
36	Liberia	2.8 ³	39,000 ³	21,000 ³	...	...
37	Cambodia	2.7	170,000	74,000	43.3	36.1	✓
38	Guyana	2.7	18,000	8,500	11.4	43.2	✓
39	Sudan	2.6	450,000	230,000	32.7	...	
40	Dominican Republic	2.5	130,000	61,000	14	20.6	
41	Trinidad and Tobago	2.5	17,000	5,600	7.9	21	
42	Belize	2.0	2,500	1,000	11	...	
43	Myanmar	2.0 ³	530,000 ³	180,000 ³	27.2	...	
44	Thailand	1.8	670,000	220,000	14	13.1	
45	Mali	1.7	110,000	54,000	47.3	...	✓
46	Honduras	1.6	57,000	27,000	20.5	53	✓
47	Gambia	1.6	8,400	4,400	48.5	64	✓
48	Guinea	1.5 ³	55,000 ³	29,000 ³	...	40	✓
49	Panama	1.5	25,000	8,700	8.4	37.3	
50	Niger	1.4 ³	64,000 ³	34,000 ³	62.5	63	✓
51	Jamaica	1.2	20,000	7,200	13.2	18.7	
52	Suriname	1.2	3,700	1,800	...	...
53	Barbados	1.2	...	...	...	...

HIV Rank	Country	Adults (15-49) living with HIV/AIDS (%)	Adults and children living with HIV/AIDS	Women (15-49) living with HIV/AIDS	Human Poverty Index (HPI-1) value	Population below national poverty line (%)	PRSP Country
54	Guatemala	1.0	67,000	27,000	23.5	57.9	
55	Somalia	1.0	43,000	....	...	...
56	Estonia	1.0	7,700	1,500	...	...
57	Ukraine	1.0	250,000	76,000	...	...
58	Russian Federation	0.9	700,000	180,000	...	...
59	India	0.8	3,970,000	1,500,000	33.1	35	
60	Argentina	0.7	130,000	30,000	...	17.6	
61	Brazil	0.7	610,000	220,000	12.2	17.4	
62	Papua New Guinea	0.7	17,000	4,100	37.5	...	
63	El Salvador	0.6	24,000	6,300	18.1	48.3	
64	Costa Rica	0.6	11,000	2,800	4	22	
65	Mauritania	0.5 ³	6,600 ³	3,500 ³	47.9	57	✓
66	Senegal	0.5	27,000	14,000	45.2	33.4	✓
67	Nepal	0.5	58,000	14,000	43.4	42	
68	Venezuela	0.5	...	...	8.5	31.3	
69	Colombia	0.4	140,000	20,000	8.9	17.7	
70	Latvia	0.4	5,000	1,000	...	...
71	Peru	0.4	53,000	13,000	12.8	49	
72	Malaysia	0.4	42,000	11,000	...	15.5	
73	Viet Nam	0.3	130,000	35,000	27.1	50.9	✓
74	Chile	0.3	20,000	4,300	4.1	21.2	
75	Ecuador	0.3	20,000	5,100	16.1	35	
76	Uruguay	0.3	6,300	1,400	3.9	...	
77	Madagascar	0.3	22,000	12,000	36.7	70	✓
78	Mexico	0.3	150,000	32,000	9.4	10.1	
79	Belarus	0.3	15,000	3,700	...	...
80	Bahrain	0.3	<1000	150	...	...
81	Cyprus	0.3	<1000	150	...	...
82	Libyan Arab Jamahiriya	0.2	7,000	1,100	16.2	...	
83	Moldova, Republic of	0.2	5,500	1,200	...	...	✓
84	Brunei Darussalam	0.2 ³	<100 ³	...	...	...
85	Nicaragua	0.2	5,800	1,500	24.4	50.3	✓
86	Singapore	0.2	3,400	860	6.5	...	
87	Yugoslavia	0.2	10,000	...	...	...
88	United Arab Emirates	0.2 ³	...	...	...	...
89	Armenia	0.2	2,400	480	...	...	✓
90	Kuwait	0.1 ³	...	...	...	...
91	Comoros	0.1 ³	...	...	31.9	...	
92	Yemen	0.1	9,900	1,500	41.8	19.1	✓
93	Paraguay	0.1 ³	3,000 ³	520 ³	10.2	21.8	
94	China	0.1	850,000	220,000	14.9	4.6	
95	Pakistan	0.1	78,000	16,000	41	34	✓
96	Oman	0.1	1,300	200	32.1	...	
97	Indonesia	0.1	120,000	27,000	18.8	27.1	
98	Bolivia	0.1	4,600	1,200	16.3	...	✓
99	Mauritius	0.1	700	350	11.3	10.6	
100	Morocco	0.1	13,000	2,000	35.8	19	
101	Hong Kong	0.1	2,600	660	...	...
102	Kazakhstan	0.1	6,000	1,200	...	...
103	Lithuania	0.1	1,300	260	...	...
104	Fiji	0.1	300	<100	21.3	...	
105	Maldives	0.1	<100	...	15.8	...	
106	Hungary	0.1	2,800	300	...	...
107	Poland	0.1	...	...	...	...
108	Algeria	0.1	...	...	23.4	22.6	
109	Iran, Islamic Republic of	<0.1	20,000	5,000	17	...	

HIV Rank	Country	Adults (15-49) living with HIV/AIDS (%)	Adults and children living with HIV/AIDS	Women (15-49) living with HIV/AIDS	Human Poverty Index (HPI-1) value	Population below national poverty line (%)	PRSP Country
110	Bangladesh	<0.1	13,000	3,100	42.4	35.6	
111	Philippines	<0.1	9,400	2,500	14.6	36.8	
112	Egypt	<0.1	8,000	780	31.2	22.9	
113	Romania	<0.1	6,500	...	...	...
114	Sri Lanka	<0.1	4,800	1,400	17.6	25	
115	Republic of Korea	<0.1	4,000	960	...	...
116	Cuba	<0.1	3,200	830	4.1	...	
117	Lao People's Dem. Rep	<0.1	1,400	350	39.1	46.1	✓
118	Azerbaijan	<0.1	1,400	280	...	...	✓
119	Iraq	<0.1	<1000	150	...	...
120	Jordan	<0.1	<1000	150	8.2	11.7	
121	Georgia	<0.1	900	180	...	...	✓
122	Uzbekistan	<0.1	740	150	...	...
123	Czech Republic	<0.1	500	<100	...	...
124	Kyrgyzstan	<0.1	500	<100	...	...	✓
125	Slovenia	<0.1	280	<100	...	...
126	Croatia	<0.1	200	<100	...	...
127	Tajikistan	<0.1	200	<100	...	...	✓
128	Macedonia TFYR	<0.1	<100	<100	...	...	✓
129	Slovakia	<0.1	<100	<100	...	...
130	Turkmenistan	<0.1	<100	<100	...	...
131	Bhutan	<0.1	<100	...	...	...
132	Korea, Dem. Peo. Rep. of	<0.1 ³	<100 ³	...	...	...
133	Mongolia	<0.1	<100	...	19.4	36.3	✓
134	Afghanistan	<0.1 ³	...	...	...	...
135	Albania	<0.1 ³	...	...	...	...	✓
136	Bosnia and Herzegovina	<0.1	...	...	...	...
137	Bulgaria	<0.1	...	...	...	...
138	Lebanon	<0.1 ³	...	...	9.9	...	
139	Qatar	<0.1 ³	...	...	...	...
140	Saudi Arabia	<0.1 ³	...	...	16.9	...	
141	Syrian Arab Republic	<0.1 ³	...	...	19.3	...	
142	Tunisia	<0.1 ³	...	...	...	14.1	
143	Turkey	<0.1	...	...	12.7	...	

¹ Countries are ranked by Adult HIV prevalence rate, then by number of Adults and children living with HIV/AIDS.

² HIV data refers to end 2001 unless otherwise noted.

³ Data refer to end 1999.

Source: UNAIDS 2002; UNDP Human Development Report 2002; World Bank website.

Annex Table 2: Selected Millennium Development Goals and the Effect of HIV/AIDS

Millennium Development Goals	Effect of HIV/AIDS	Impact of AIDS on Progress towards the Declaration Goals, with examples
Reduce income poverty: Halve by 2015 the share of the world's people whose income is less than one dollar a day.	AIDS increases consumption needs and depletes household assets. Labour losses reduce income. <i>Can push household incomes down by 80%</i> . Increases household poverty. Weakens public infrastructure needed to reduce poverty.	Will slow or reverse progress towards the goal. For example, in Burkina Faso the proportion of people living in poverty is projected to increase from 45% to nearly 60% by 2010 as a result of HIV/AIDS.
Reduce hunger: Reduce the proportion of people who suffer from hunger.	The poverty impacts may be intergenerational. Illness, reduced incomes, lower productivity of subsistence agriculture and crop shifts increase food insecurity, especially for women and children. Quality of diet important for improved survival, but more difficult to secure due to illness.	Survival with HIV makes this a critical goal, while AIDS makes it more difficult to achieve due to reduced food availability, access, intake and absorption. Studies in Thailand have found that food consumption in affected households falls by 15–30%.
Increase access to safe water: By 2015 halve the proportion of people who are unable to reach or afford safe drinking water.	Illness, increased labour demands for caring, and lost labour reduce time for collecting water, especially for women. Human resource losses and costs in water supply services affect delivery and increase the cost of services to households.	Loss in household resources and labour time make easy access to safe water critical. The epidemic will slow or reverse progress towards this goal.
Universal primary education: By 2015, children, boys and girls, able to complete a full course of primary schooling.	Education supply threatened by teacher absenteeism and deaths. Children from households facing lost income and demands for caring fall out of school. Households and schools face increased stress. Education, especially for girls, is critical in preventing infection and delaying onset of sex.	In the worst affected countries, education quality and enrolment, especially among the most vulnerable groups, have already been reduced. For example, in the Central African Republic and Swaziland, school enrollment is reported to have fallen by 20% to 36% due to AIDS and orphanhood
Improve child health: Reduce under-five child mortality by two-thirds of its current rates by 2015.	Infant and child mortality will continue to increase for the next decade, and possibly longer, due to mother-to-child HIV infection and the more general poverty-creating effects of the epidemic.	Without action the target will not be met and in some countries there will be a deterioration over the period. For example, under-five mortality in South Africa will increase to 160 per 1000 live births by 2010, instead of falling to 44/1000 (as per Millennium Development Goal) by 2015.
Achieve gender equality: Girls and boys to have equal access to all levels of education.	Girl children are more likely to be kept out of school to provide care or when resources are limited. Women take on greater burdens of caring and face greater economic insecurity when wage earners fall ill. While gender equity (social and economic) is a critical factor in reducing risk, AIDS exacerbates burdens on women and gender inequalities.	Goal cannot be met in seriously affected countries. In some of the worst affected countries, nearly 50% of children who lose their parents to HIV/AIDS drop out of school, the majority of whom are girls.
Improve lives of slum dwellers: By 2020, achieve a significant improvement in the lives of at least 100 million slum dwellers as per "Cities Without Slums" initiative.	For the poor, AIDS reduces ability to afford even the most basic housing. It pushes new households into poverty and reduces service delivery by governments.	Goal cannot be met without addressing impact of HIV/AIDS. A study in Zambia found that urban households affected by HIV/AIDS lost 80% of their income.

Adapted from: UNDP, "HIV/AIDS: Implications for Poverty Reduction", 2001

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