

## Status Report

# **The Poverty-HIV/AIDS-Interface**

Lessons and Needs  
in the context of the Poverty Reduction Strategy Paper  
(PRSP) - Process with a focus on the African continent

*February 2002*

*by*  
*Ekkehard Kürschner*

German Technical Cooperation (GTZ), Eschborn

## Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BMZ	German Federal Ministry for Economic Cooperation and Development
EU	European Commission
FAO	Food and Agriculture Organisation of the UN
GDP	Gross Domestic Product
GTZ	German Technical Cooperation
HDI	Human Development Indicators
HIPC	Highly Indebted Poor Countries
HIV	Human Immuno-deficiency Virus
ILO	International Labour Organisation
IMF	International Monetary Fund
OECD	Organisation for Economic Cooperation and Development
PEAP	Poverty Eradication Action Plan
PLWA	People living with HIV/AIDS (networks)
PRS	Poverty Reduction Strategy
PRSP	Poverty Reduction Strategy Paper
SADC	Southern Africa Development Coordination Conference
STD	Sexually Transmitted Disease or
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children Fund
UNIFEM	United Nations Development Fund for Women
WHO	World Health Organisation

Dr. Ekkehard Kürschner  
FAKT Consult for Management, Training and Technologies  
Contact address: Ulrichstrasse 3 | D -71364 Winnenden/Stuttgart, Germany  
Tel + (00 49) 711 -21095- 12 (Office)  
Tel + (00 49) 7195 - 910908 / - 2905 (Private)  
Fax + (00 49) 7195 - 910929  
Email: [ekkehard.kuerschner@t-online.de](mailto:ekkehard.kuerschner@t-online.de)  
[ekkehard.kuerschner@fakt-consult.de](mailto:ekkehard.kuerschner@fakt-consult.de)

---

## TABLE OF CONTENTS

Preface	4
1. The Starting Points	5
2. Questions and Researchable Issues	6
2.1 How is poverty related with HIV/AIDS?	6
2.2 The spread of HIV/AIDS in relation to poverty	7
2.3 To what extent does HIV/AIDS affect poor people?	7
2.4 How do the poor perceive HIV/AIDS?	8
2.5 Gender discrimination, social safety nets and HIV/AIDS	10
2.6 Macro- and meso-level effects of HIV/AIDS on development	10
2.7 Conclusion on poverty - HIV/AIDS-relationships	11
3. Status of HIV/AIDS mainstreaming in the PRSP process	11
4. Steps to Consider for Mainstreaming HIV/AIDS	15
5. Conclusions and Recommendations	19

### Annexes

- Annex 1: Analysis of factors of economic and human development affected by HIV/AIDS
- Annex 2: Support and Tools for Incorporating HIV/AIDS into PRSP
- Annex 3: Analysis of Selected PRSP documents
  
- Annex 4: Sources

## Preface

Is poverty causing the spread of AIDS? Are the poor and the very poor affected by HIV/AIDS and how? What are the effects of AIDS on national economies and on different sectors? What conclusions have to be drawn for developing appropriate sector policies and interventions?

Recognising poverty reduction as a global responsibility, the UN Millennium Summit in September 2000 accepted the challenge to halve poverty by 2015. Meanwhile Poverty Reduction Strategy Papers (PRSP) are becoming an important framework for planning and implementing future development measures.

To what extent and how should HIV/AIDS be included in the PRSPs? While an explicit provision had been made<sup>1</sup>, coverage of HIV/AIDS in initial PRSP documents was perceived to be inadequate. This is apparently also the case for health in general, for agriculture as well as for cross-cutting issues like gender<sup>2</sup>.

Recognising the need to answer these questions, the Sector Projects on Poverty Reduction and on HIV/AIDS Control in Developing Countries of GTZ requested this report. In supporting the PRSP process, GTZ focuses on process-support, participation of civil society and capacity building. Mainstreaming HIV/AIDS-related issues into the planning, implementation and evaluation of technical cooperation is one aim of the GTZ Sector-Project on HIV/AIDS-Control. The objective of this report is:

- 1) To contribute to the clarification of some conceptual issues related to the HIV/AIDS-link with poverty;
- 2) To analyse the status of incorporating HIV/AIDS into PRSP documents in selected countries with a focus on Sub-Sahara Africa;
- 3) To explore options for incorporating HIV/AIDS in the context of poverty reduction, in particular into PRSP processes, and to propose steps to facilitate this aim.

This paper would like to contribute to discussions of the recent PRSP review process. It is primarily addressed to senior planning and other staff of partner countries and of development organisations involved in steering and implementing support to the Poverty Reduction Strategy (PRS) process.

It is being recognised that the PRSP process is ongoing and that findings extracted from documents may be incomplete or will reflect a partial view only. The focus, therefore, is placed on key issues related to the PRSP process itself as they are evident from the relevant PRSP documents. The desk study takes note of respective constraints and requirements within the health and other sectors to develop effective responses to the HIV/AIDS epidemic.

---

<sup>1</sup> Poverty Reduction Strategy Source book. World Bank (Vol.II Chap. 3.2 on Health), 2001

<sup>2</sup> What productive resources do the poor really need to escape poverty? Keynote by Michael Lipton

## 1 The Starting Points

The level of poverty and the rate of HIV/AIDS infection are both alarming, especially across Sub-Sahara Africa. Almost half of the population is extremely poor with no signals of change. At the same time, over 28 million are HIV-infected in Africa and HIV/AIDS continues to spread at unprecedented rates. AIDS has reached the highest levels world-wide, in particular in women exceeding 30% prevalence in several parts of Southern Africa. In West Africa, at least five countries are experiencing serious epidemics, with adult prevalence exceeding 5%.

Presently, Sub-Sahara Africa accounts for close to 70 % of the five million new infections world-wide, which are taking place every year<sup>3</sup>. At the same time, the level of prevalence continues to rise in South and Southeast Asia and in the Caribbean. New and quickly emerging epidemics are being observed in the East Asia and Pacific region as well as in Eastern Europe and Central Asia. Relatively low rates in most South and Central American Countries mask the effect that the epidemic is already firmly lodged among specific population groups.<sup>4</sup>

Largely disconnected from the ongoing debate on poverty reduction, a global AIDS strategy has been recently adopted to address the HIV/AIDS problem<sup>5</sup>. This strategy calls for €7 to 10 million annually in the context of HIPC. UN Secretary-General Kofi Annan embarked on a campaign to seek a large-scale mobilisation of political commitment and resources to battle against AIDS. During the UN Special Session on HIV/AIDS in June 2001 a high consensus was reached that a new Global Fund has to be established focussing on HIV/AIDS and health<sup>6</sup>.

While the need to link poverty and HIV/AIDS-related efforts has been recognised, the poverty-HIV/AIDS link has been not well understood at both conceptual and intervention levels. In order to make notable progress in reducing poverty and poverty reduction strategies, responses to the HIV/AIDS pandemic must be integrated. Vice versa HIV/AIDS and mitigating its impact will not be possible without reducing structural poverty in Africa<sup>7,8</sup>.

The next section (Chapter 2) looks at various aspects of the poverty-HIV/AIDS-relationship and discusses causes and effects at micro, meso and at macro levels.

Chapter 3 summarises findings from analysing selected documents and outcomes of PRSP processes at country level.

Chapter 4 then outlines possible steps to facilitate incorporation of HIV/AIDS into the PRSP process.

Chapter 5 gives some conclusions and recommendations for further action.

---

<sup>3</sup> The AIDS Epidemic. Status Report 2000

<sup>4</sup> AIDS Epidemic Update. UNAIDS, 2001

<sup>5</sup> Global framework for action. UN General Assembly Special Session. 2001; G8 summit in Genua, 2001.

<sup>6</sup> <http://www.unaids.org/globalfund/index.html>

<sup>7</sup> Poverty and HIV/AIDS in Subsaharan Africa, 1998

<sup>8</sup> Conference of African Ministers of Finance. Algier, 2001

## 2 Questions and Researchable Issues

This chapter aims at providing insights into the poverty-HIV/AIDS-link. It reviews some of the known facts with regard to the HIV/AIDS epidemic. It orients the different aspects of the problem towards the poverty dimension at micro, meso and macro levels, and it makes analytical gaps transparent.

Does poverty cause AIDS? There is no simple answer to that question, as poverty and HIV/AIDS are inter-related in a more complex manner. Until now, these relations have been described largely as anecdotes<sup>9</sup>. A more analytic understanding of the

### ***The Story of Kevina, a 14-year-old village girl from Uganda***

*My name is Kevina Lubowa. I am studying in primary six. AIDS killed both my mother and father in 1992. It killed all brothers and sisters of my father. My father and mother left me with four brothers and two sisters, younger than me. I look after them, I also look after my grandfather. He is 84 years old. From school, I go to bring water from the well. I take a jerrycan on my head. I tell my brothers and sisters to collect fire wood. We cook potatoes, matooke, pumpkins and cassava. Our food is not enough. We don't have money to buy sugar or tea leaves. Every week we cut grass to use as mattresses. Sometimes we sleep in the corner of the house because our house is leaking. Our blankets get wet and we put them near the fire or in the sun to dry. There is the problem of disease. We get sick and go to the dispensary. At the dispensary they want money, but we don't have money. We foot home from the dispensary. Old woman help us and give us leaves and mululuza to chew. This helps to get rid of the fever. Because I am a girl people think I am weak. So they come home and steal our cassava and fire wood. Some people in the village are no friends. They shout at us. We feel sad when we see other children laughing. In short, this is how I find life. But other orphans have the same life. I am saying that the life of an orphan in Uganda is bad. We want good food, blankets, and many other things. So we need help. We need to grow and to be proud and happy people (cited in UNDP 1998).*

poverty-HIV/AIDS-relationships is required to more effectively link the two in formulating policies and development interventions.

Progress in explaining scientifically the relationship of poverty and HIV/AIDS is very recent<sup>10,11</sup>. Knowledge on the causes and effects of the epidemic is often fragmentary and research on health in relation to poverty has been limited<sup>12,13</sup>. This contributed in the past often to a heated and controversial debate about causes of the AIDS epidemic.

### **2.1 How is poverty related with HIV/AIDS?**

First, poor people are more vulnerable to HIV/AIDS. Disadvantaged ethnic groups or other marginalised groups have no or poor access to productive resources. As a consequence, they may turn to economic activities, which make them vulnerable to infection with a greater chance of being exposed to the virus, to contract the disease and to contribute to its spread<sup>14</sup>.

<sup>9</sup> Poverty and HIV/AIDS in Sub-Saharan Africa. UNDP Issues paper No. 27. By Cohen, 1998

<sup>10</sup> see UNDP Policy Paper, 2001

<sup>11</sup> AIDS and poverty, the links. By Whiteside. AIDS Analysis Africa 12(2), 2001

<sup>12</sup> Becoming Poverty Focused: Implications for health actors. By Fisher, Holland and James IHSD, 2001.

<sup>13</sup> HIV/AIDS implications for poverty reduction. UNDP Policy Paper, 2001

<sup>14</sup> see AIDS Analysis Africa, 2001

Second, poor people may be more susceptible to HIV. Malnutrition, a weakened immune system, the occurrence of STDs or a general poor health status make people more susceptible to HIV. They may be more likely to become infected if they are exposed to the virus.

Third, generally the access of the poor to social services, including preventive health services and education is limited. Support for pre- and post-test counselling, testing, as well as care and medical treatment to HIV-positive and their dependants is mostly inadequate.

## **2.2 The spread of HIV/AIDS in relation to poverty**

Many causes of poverty and HIV/AIDS are the same, such as the lack of and the poor access to information about HIV/AIDS, awareness about the legal situation and access to public services. However, the relationship of HIV and of AIDS and poverty is much more complex and poverty alone does not explain the epidemic.

The spread of HIV is attributed to a wide range of factors, which include behavioural factors, the quality and access to services and programmes aimed at prevention, care, social support and the mitigation of impact, as well as social and socio-economic factors.

At the outset of an epidemic, it is often the elite and the better educated in urban societies that contribute to the spread of HIV. With such target groups, subsequent prevention measures are more effective, as the example from Uganda shows<sup>15</sup>. During the course of the epidemic, HIV infection rates among the poor segments of the population are increasing, in particular in women. The disease is spreading from urban centres to rural and remote areas .

Today, prevalence rates are high in South Africa or Botswana, countries considered rich by African standards, as well as in countries considered relatively poor, such as Malawi or Zambia. Therefore, the rapid spread of the HIV/AIDS epidemic in Southern Africa is being attributed to a mixture of poverty and inequality. Where rich and poor people in one place, the epidemic is likely to spread more rapidly<sup>16</sup>. Along transport routes this contributes to geographic spread of the disease and to spread across social and cultural boundaries. The disease reached its highest levels in Southern and East Africa, but it continues to spread in a number of countries in Central and West Africa such as Cameroon, Nigeria or Guinea.

## **2.3 To what extent does HIV/AIDS affect poor people?**

HIV/AIDS is not only a consequence, but also a cause of poverty and a cause of deepening poverty. Consequences of AIDS will be much more severe for the livelihoods of the poor and the very poor compared with the better off.

---

<sup>15</sup> Kilian A. et al. "Reductions in risk behaviour provide the most consistent explanation for the declining prevalence of HIV-1 infection in Uganda." AIDS 1999, 13:3, S. 391-398

<sup>16</sup> See Whiteside, 2001

In the short term, individuals being infected by HIV will have choices to change life styles, if they are able to access and utilise information. Provided they are equipped with adequate cash resources and with a secure job, they will be able to maintain a healthy and productive life for quite some time. In the early stages of the disease, they will be in a position to continue supporting their families.

While HIV infections may occur across households of different social or economic status (in both urban centres and rural areas), the extent to which people will be affected by HIV/AIDS will differ significantly, depending on level of poverty<sup>17</sup>. In general, the better off are likely to be able to buffer short-term negative impact of HIV/AIDS

Individuals and communities living near the poverty line are facing the risk of immediate constraints in cash resources. The income situation may be constrained or become quickly insecure in times of sickness or need to care for sick family members, if an employment is on a non-permanent or non-regular basis. For the less wealthy, the portfolio of options to buy external inputs for business activities or to make other decisions in the household will be reduced. In rural areas, availability of labour and wage labour for agriculture and for small-scale enterprises could decline.

In the long-term, when symptoms of the disease appear, AIDS will affect livelihoods of both poor and better off. Cash resources decline and reduce possibilities to invest or to buy inputs for small-scale enterprises. A decline of outputs from income-generating activities will lead to reduced access to health and other services. For the better off, the capacity to save and to invest will be significantly reduced. Choices to take active decisions for improving livelihoods are likely to disappear. Increased costs for medical treatment and for hiring labour will lead to reduced savings and to dissavings.

## **2.4 How do the poor perceive HIV/AIDS?**

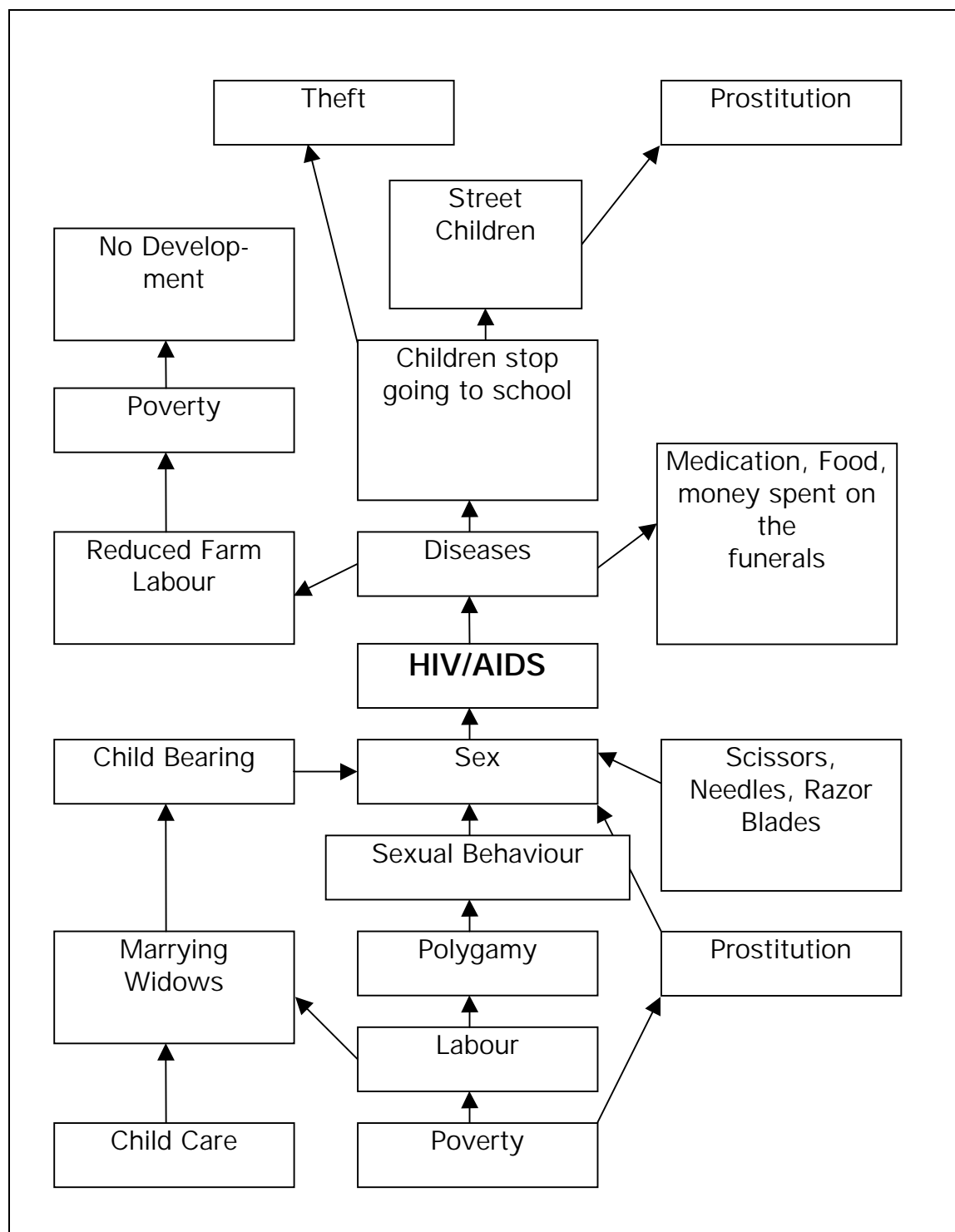
Today, members of a community in Southern Africa are ready to discuss issues arising from HIV/AIDS and to include them in the analysis of their specific poverty situation along with other problems, such as the lack of water, absence of economic and basic social services and infrastructure, the lack of credit or the lack of opportunity for education (Figure 1).

As a consequence of the fact that HIV/AIDS is increasingly becoming a reality for everybody, individuals and concerned groups, in particular in high prevalence countries, are realising the need to openly discuss issues related to HIV/AIDS, despite their sensitivity. This is true for communities, development workers as well as decision makers. However, it has to be noted that communities e.g. who had undergone a gender sensitisation based on an earlier introduction of participatory methodologies, seem to be quite effective to reflect on cultural and social matters (such as sexual behaviour of young women, widow inheritance or widow cleansing) as well as on their own role within their family and community.

---

<sup>17</sup> Typology used by Verstralen, 2001

Figure 1: Example of an HIV/AIDS Problem Tree



HIV/AIDS Workshop, Sikalongo Settlement, Choma, Zambia, August 2000

Adopted from SLE, 2000. Incorporating HIV/AIDS into Participatory Rural Extension. A multi-sectoral Approach to Southern Province Zambia by Ekkehard Kürschner et al. (Manual p.40)

## **2.5 Gender discrimination, social safety nets and HIV/AIDS**

A number of subgroups in the population are more vulnerable than others. These include children, youth, women, certain occupations such as truck drivers, migrant and seasonal workers, cross-border traders. Fishermen and fish traders, uniformed personnel, as well as prisoners, refugees and displaced people. Women, however, are disproportionately affected by HIV/AIDS<sup>18</sup>. In particular, girls and young women, are discriminated and vulnerable to HIV infection and to its impacts.

Factors such as lower social status, lower level of education, cultural and social practices increase the chance of women to contract the disease and/or increase the susceptibility to HIV, in addition to a higher physiological risk of infection<sup>19</sup>. This includes situations where early marriages are forced or where women have very limited power to refuse sex or to negotiate safe sex. Poverty is linked to sexual behaviour in different ways. The transition from commercial sex, to bartering sex to gain a job, food or gifts is blurred and may well be socially accepted. Also, women may actively seek income through sex to bridge intermittent periods of food and cash shortages. Conflict and violence multiply the threat of infection from HIV/AIDS and its negative impact.

Women are accumulating "pressures" in HIV/AIDS-affected households. Usually they care for the sick and dying, in addition to heavy workloads from agricultural and household activities. At the same time, women who fall sick are less likely than men to be admitted to the hospital and to have access to family resources, a UNAIDS survey found<sup>20</sup>. Women have fewer legal rights and limited access to land, other productive resources or credit. Gender inequalities are increased when the husband dies.

The role played by safety nets, either based on extended families or on friendship, is by far the most effective community response to the AIDS crises. Particularly in traditional rural societies, social safety networks developed successful mechanisms to cope with emergencies such as natural disasters. However, many of these safety nets are under pressure or have already been weakened. HIV/AIDS reduces the number of contributors to family income. At the same time, the rise in the number of dependants per family is accelerated, including the number of orphans. In addition to the growing number of families with single parents, widow or elderly, orphans themselves are increasingly forced to assume responsibility of heading households.

## **2.6 Macro- and meso-level effects of HIV/AIDS on development**

In addition to the impacts of HIV/AIDS at household and community levels, there is growing evidence, which suggests that HIV/AIDS is increasingly affecting human, social and economic development at meso and macro levels, in particular in African societies where prevalences are high and exceed 5%.

---

<sup>18</sup> UNIFEM, 2001. [www.reliefweb.int/IRIN/webspecials/hiv\\_aids/index.phtml](http://www.reliefweb.int/IRIN/webspecials/hiv_aids/index.phtml)

<sup>19</sup> Gender and HIV/AIDS. EU Development Programme. June 2000

<sup>20</sup> cited by IRIN (release on gender discrimination 25.6.2001)

What follows is a summary of the synthesis given in Annex 2. The impacts, which will influence the development potential and capacity of the societies concerned, are visible in various ways in terms of demography, education and food security, the availability and quality of social services, the development of key productive sectors of the national economies and the overall economic growth.

UNDP estimates suggest that the Human Development Index of South Africa, for example, could be reduced by 15% due to AIDS. During the 90ties, life expectancy at birth already dropped by 8-12 years in Southern African countries<sup>21</sup>. Child mortality in countries with highest prevalence rates is projected to be equal or to exceed 50% by 2005. At the same time, food security is predicted to be seriously affected by the change in the dependency due to the altered age and gender distribution. Research shows that female-headed AIDS-affected households faced food insecurity and malnutrition as foremost among the immediate problems<sup>22</sup>.

Formal school education is reduced as a consequence of AIDS. Families lack the cash for children to complete primary school or to continue secondary education. Also, children may be forced to take over responsibilities of their deceased or sick parents. At the same time, the quality of education is decreasing due to AIDS morbidity and mortality among teachers<sup>23</sup>.

African countries with adult prevalence of less than 5% will experience only a modest impact of AIDS on GDP growth rate. With prevalence rising to 20%, GDP growth is projected to decline by 2% per year and per capita income at 1% per year<sup>24</sup>.

A number of economic sectors are particularly vulnerable to the impact of HIV/AIDS. These sectors are often characterised by the requirement for workers to stay away from their homes for long periods, and include the transport, mining and fishing sectors. Sectors which rely on seasonal and short-term workers, such as agriculture, construction and tourism, are also particularly vulnerable to the impact of HIV/AIDS<sup>25</sup>.

Also, changes in the labour force may lead to a mismatch of human resources and labour requirements in terms of qualification, training and experience. For small firms and in the informal sectors, the loss of one or more key employees may be catastrophic, leading to the collapse of the firm. Therefore, HIV/AIDS prevention programs in private enterprises are triggered in response to high costs due to AIDS - reduced productivity, cost for new recruitment, training, increased expenditures for insurance and health care.

Another aspect of HIV/AIDS impacts on local enterprises, may be a loss of markets where the purchasing power of the population declines due to loss of income or reduced employment<sup>26</sup>. The transport industry is among the sectors most severely affected by HIV/AIDS. In Southern Africa, long distance trucking plays a critical role

---

<sup>21</sup> SADC Regional Human Development Report 2000

<sup>22</sup> The impact of AIDS on food security. FAO, 2001

<sup>23</sup> What HIV/AIDS can do to education. Kelly, 1999

<sup>24</sup> HIV/AIDS: Does it increase or decrease growth in Africa. Bonnel, 2000

<sup>25</sup> ILO, 2000

<sup>26</sup> HIV/AIDS: A threat to decent work, productivity and development. ILO, June 2000

in the national economies. Mobile populations tend to be more vulnerable to infection than local populations for reasons which may include lack of hygiene, poverty, powerlessness and the precarious family situations which accompany their status.

## **2.7 Conclusions on poverty-HIV/AIDS-relationships**

The analysis shows that poverty and HIV/AIDS are closely related both in terms of the causes and of the effects of the AIDS epidemic. HIV/AIDS significantly affects livelihoods in Africa at micro, meso and macro levels. A continuous monitoring is required to take into account effects of changes in the course of new epidemics in other regions and of changes in the medium and long-term impacts of the current epidemics.

HIV/AIDS poses a complex and difficult problem for development, since it cuts across societies, in particular in Africa, being inter-related with poverty and a number of other social, cultural and economic factors. As a consequence, HIV/AIDS response strategies, at least in high prevalence countries, include key sectors of a national economy, which are either affected by HIV/AIDS and/or which are able to contribute through policies or interventions to addressing the problem.

PRSPs, therefore, should take into account the National Strategic AIDS Plan to reflect the magnitude and dimension of the problem at national level and to be able to implement reinforcing poverty reduction and HIV/AIDS. This requires that HIV/AIDS strategies and interventions are incorporated in the overall poverty analysis as well as in the respective chapters of all the sectors concerned.

An area requiring urgent attention by policy makers, is the growing pressure on and instability of social safety nets. Increasingly, traditional safety nets are no longer able to cope with the demand arising from HIV/AIDS for care and support. In order to safeguard the basic needs of the poorest, new systems of social welfare have to be developed to address the danger of a deepening poverty situation.

## **3 Status of HIV/AIDS mainstreaming in the PRSP process**

This chapter reviews the status of incorporating HIV/AIDS by analysing selected documents and outcomes of PRSP processes at country level. The analysis was expected to give an indication of the need for improvement of the mainstreaming of HIV/AIDS in the PRSP process.

A rapid assessment of eight Interim / Draft PRSPs and of four Full PRSPs from Africa was performed (Table 1). The countries represent a range of degrees of HIV prevalence in both West and East/Southern Africa.

The analysis was based on the following criteria:

- The quality of poverty analysis in the PRSP (the depth of analysis; ideally including a range of relevant economic, social and other determinants);
- Recognition of HIV/AIDS as a development constraint related to poverty, looking at the causes and at the effects of HIV/AIDS;
- Quality of HIV/AIDS analysis (epidemic and its impact on poverty/development);
- Comprehensiveness of HIV/AIDS response as evident from the institutional framework, the budgeting approach, and the indicators outlined in the PRSP;
- Link of PRSP to an operational HIV/AIDS strategy (i.e. the National AIDS Strategic Framework);
- Mainstreaming of HIV/AIDS into sector strategies, including interfaces at conceptual and intervention levels between HIV/AIDS, cross sectoral issues such as poverty and gender as well as with the education and health sectors.

PRSP documents performed much better than it was suggested by initial reactions on the early drafts, which noted a generally poor coverage for HIV/AIDS as well as for agriculture and gender<sup>27</sup>. However, full and interim PRSP documents reflect different degrees of progress achieved in taking HIV/AIDS into consideration in the context of poverty reduction. Progress is more evident in documents presented at a later point in time and for countries with a higher level of prevalence.

**TABLE 1: Categorising low and high prevalence countries**

Region	Level of HIV Prevalence	
	Low/Moderate	High
West Africa	Chad: ↑ 2-4 <sup>1)</sup> +/- <sup>2)</sup> Guinea: ↑ 2-4 + Mauritania: ↑ 0.5 <sup>3)</sup> o Sierra Leone: ↑ 3< o	(Burkina Faso: ↑ 6-8 <sup>3)</sup> ?) Cameroon: ↑ 14 - (Ghana: ↑ 3-5 ?)
East and Southern Africa	Madagascar: → 0.5 -	Kenya: ↑ 14 - Malawi: ↑ 16 + Mozambique: ↑ 16 <sup>3)</sup> + Tanzania: ↓ 8 <sup>3)</sup> o Uganda: ↓ 8 <sup>3)</sup> + Zambia: ↑ 20 -

<sup>1)</sup> Arrows indicate the direction of trends of the HIV epidemic; figures are prevalence rates in percent; countries in brackets not included in the analysis

<sup>2)</sup> overall rating of PRSPs for incorporating HIV/AIDS (details in Table 2)

<sup>3)</sup> countries with full PRSP

<sup>27</sup> What productive resources do the poor really need to escape poverty? IFPRI, Keynote by Lipton. Bonn, 2001

HIV/AIDS has been comprehensively incorporated in the PRSPs in high prevalence countries only. Usually, the analytical part is more advanced than the implementing framework for HIV/AIDS responses within the PRSP. The findings reported here correspond to the recent review on health coverage in PRSPs prepared by WHO<sup>28</sup>. In summary, the findings are (see also Table 2):

1. Poverty analysis is substantial and multi-dimensional in most cases, including different aspects of social and human development. While analysis of cross-cutting issues such as gender, which are immediately relevant for the HIV/AIDS "diagnosis", this has not necessarily been linked to HIV/AIDS in the PRSP;
2. A number of countries recognise HIV/AIDS as national challenge, even where prevalence is moderate. This recognition is not always matched by comprehensive analysis of and responses to HIV/AIDS in the PRSP. While most documents mention AIDS, the analysis of causes and effects is often incomplete;
3. Poverty analysis is not necessarily linked to HIV/AIDS. Poverty seems more likely to be linked to HIV/AIDS where the quality of the HIV/AIDS analysis was high, which is mostly the case in high prevalence countries; in some countries there may be valid reasons such as conflict for a poor data base (e.g. Sierra Leone);
4. HIV/AIDS responses, which are reflected in PRSPs, do often seem inadequate and far from comprehensive, even in some cases with high HIV prevalence. AIDS responses were often confined to the health sector, and within health sometimes restricted to biomedical aspects. The implementation framework outlined in early PRSPs and Interim-Documents was often weak or not fully elaborated;
5. The link of PRSPs to existing HIV/AIDS strategies is mostly evident. However, HIV/AIDS responses are poorly elaborated and/or often not reflected in sectors other than health or given a low priority. Cross-sectoral links of AIDS are very weak both at policy and at intervention levels.

Even though there were a number of tools and initial support available by UNAIDS and others to facilitate the incorporation of HIV/AIDS into PRSP documents (Annex 3), their success has been limited. This may be attributed to: (1) A generally low awareness about HIV/AIDS and the role of national HIV/AIDS National Strategic Frameworks; (2) A lack of knowledge about the HIV/AIDS-poverty-link; and (3) Slow progress in incorporating HIV/AIDS into overall development strategies both at the level of developing countries as well as donor policies<sup>29 30 31 32 33</sup>.

---

<sup>28</sup> Health in PRSPs. WHO, 2001

<sup>29</sup> ODI, 2000

<sup>30</sup> Armutsminderung in der Arbeit der GTZ. Handreichung, 1999

<sup>31</sup> BMZ, 2000 and 2001

<sup>32</sup> Poverty and HIV/AIDS. Draft Policy Paper. The Netherlands, 2001

<sup>33</sup> A Toolkit. EU Commission, 1994

**TABLE 2:** Assessing PRSPs in terms of their "HIV/AIDS sensitivity"  
(Details are given in Annex 3)

Country	Quality of poverty analysis	Quality of HIV/AIDS analysis	HIV /AIDS recognised as a constraint in relation to poverty	Comprehensive HIV/AIDS response	Link of PRSP to operational HIV/AIDS strategy	Mainstreaming of HIV/AIDS into sector policies and strategies
Cameroon	-	-	-	-	-	-
Chad	+	+/o	-	+	+	-
Guinea	+	-	-	+	+	+
Mauritania	+	+	o	-	+ <sup>1)</sup>	-
Kenya	o	-	-	-	+	-
Madagascar	+	o	-	-	+ <sup>1)</sup>	-
Malawi	+	+	+	+/o	+	-
Mozambique	+	+	-	-	+	+
Sierra Leone	o	o	o	-	o	-
Tanzania	-	-	o	+	+	+
Uganda	+	+	+	+/o	+	+
Zambia	+	o	o	-	-	-

<sup>1)</sup> Link to national health strategy

Rating used: +: mainly a positive trend; o: neutral or unclear; -: mainly negative

Criteria applied:

- Quality of poverty analysis (depth; incl. a range of relevant social determinants)
- Recognition of HIV/AIDS as a development constraint related to poverty
- Quality of HIV/AIDS analysis (epidemic and its impact on poverty/development)
- Provision for implementing a comprehensive HIV/AIDS response
- Link of PRSP to operational HIV/AIDS strategy
- Evidence of mainstreaming HIV/AIDS into implementation of sector strategies

In addition, HIV/AIDS Strategic Plans so far miss the opportunity to identify windows for interfacing HIV/AIDS interventions with poverty reduction, i.e. poverty in relation to HIV/AIDS was often not identified as a key constraint within HIV/AIDS National Strategic Frameworks, therefore, relationships of HIV/AIDS with poverty were not made explicit.

This led to a situation where:

- Not all actors involved in the PRSP process were convinced of the need or of the potential benefit to fully incorporate HIV/AIDS into PRSPs.
- PRSP processes being largely disconnected from existing HIV/AIDS-strategies and their implementation;
- The emphasis given to participation in the PRSP process<sup>34,35</sup> is not matched by a respective involvement of both government and non-government organisations. While the quality of the PRSP processes varied from country to country, it appeared that key institutions involved with responses to HIV/AIDS were not systematically involved;

It should be noted that government organisations responsible for coordinating HIV/AIDS strategies at national and district levels are being located in many countries outside the traditional health administration, in particular the high-prevalence countries. In terms of involving civil society in PRSP processes, target groups concerned with HIV/AIDS should be taken into account, such as Networks of people living with HIV/AIDS (NPLWA) or home-based care groups.

- It seems that none of the processes took into consideration the specific constraints related to denial and stigmatisation, which HIV/AIDS-affected groups are facing in their environment. In some cases, marginalised groups have been identified, which are vulnerable to the spread and to the impact of HIV/AIDS and which require special attention in PRS;
- Also, there is a substantial deficit in PRSPs apparent across most sectors in mainstreaming HIV/AIDS responses into policies and strategies of relevant sectors (other than health) and to assign respective high priorities.

## **4 Steps to Consider for Mainstreaming HIV/AIDS**

This chapter outlines possible steps and options for incorporating HIV/AIDS concerns into PRSP processes and into the framework of PRSP documents. Recognising the need to improve the coverage of HIV/AIDS in the context of poverty reduction strategies and of PRSPs in particular, it is important to identify steps to address this deficit. This was confirmed by a rapid review of PRSP documents (Chap. 3; Annex 3).

---

<sup>34</sup> Eberlei, 2001. Institutionalisierte Partizipation

<sup>35</sup> Mayer et al. The Role of Participation in PRSP

As discussed in Chapter 2, HIV/AIDS requires answers, which are targeted to specific situations. The design and the scale of a national AIDS response as well as the links with poverty reduction will depend on the level of HIV prevalence in the population or its sub-populations, and the short and long-term impacts of HIV/AIDS.

In countries where the epidemic is spreading notably (>1%) in the general population, it is required to involve a range of key sectors and policy areas to be able to develop an effective response to HIV/AIDS. Therefore, it is important that multi-sectoral approaches are reflected in the PRSP-process. The steps given below may be useful to take a more systematic approach to HIV/AIDS in the context of PRSP:

#### **4.1 Classify the extent of the HIV/AIDS epidemic and magnitude of the impact**

A first step to approach HIV/AIDS related policy formulation, it is necessary to assess the magnitude of the epidemic and to classify HIV prevalence and the spread of the disease in a given country or population, taking the dynamic of HIV/AIDS in the region into consideration.

Is country X or region Z a high or a low prevalence area? What are the trends in HIV infection? The questions to ask, requirements and goals for surveillance, policies, strategies and interventions in response to HIV/AIDS differ significantly, depending on the level and type of epidemic occurring in a given country. UNAIDS distinguishes between three epidemic states<sup>36</sup>:

- Low-level epidemics are those in which HIV infection exists at low levels in sub-populations only whose behaviour carries a high risk of contracting or passing on HIV; harm in the sub-group and dissemination to the general population can be reduced by targeted interventions, such as prevention; sentinel surveillance systems can provide early warning of risks that might lead to the spread of HIV;
- Concentrated epidemic: HIV has spread rapidly in a defined sub-population, but is not well-established in the general population; targeted interventions become important both for the sub-group, as well as for the general population;
- In generalised epidemics, HIV is clearly established in the general population of sexually active adults, with over one percent of pregnant women infected; in these situations comprehensive action in prevention and cure become relevant, involving government, private sector, workers' organisations, local communities, and international agencies. This may include reforms of legislation and of support services to improve the status of women, for example. Monitoring the changes in behaviour due to interventions and of the likely impact of the epidemic at individual, community and national levels become important.

At low-level epidemics, HIV has often not been thought of as a priority. Even when HIV prevalence rises rapidly in defined sub-populations, countries may fail to recognise the danger because such populations are often overlooked or marginalised. Many countries with low-level and even with concentrated epidemics

---

<sup>36</sup> UNAIDS, 2000. Second generation surveillance for HIV: The next decade.

have virtually no systematic surveillance. But countries ignore the possibility that risk behaviour exists at their peril. Some countries have recently seen HIV explode from virtually nothing to substantial levels. For example, Kyrgyzstan currently observes a concentrated epidemic, but it is on the verge to a generalised epidemic. With no surveillance in place it is not possible to identify changes in risk behaviour which may lay the groundwork for an emerging epidemic.

#### **4.2 Identify target groups/poor affected by HIV/AIDS**

To properly orient poverty reduction and AIDS-related policies and interventions, the target groups (rural and urban) have to be analysed carefully. The foremost important two questions are: a) who is suffering now, and b) who will be suffering next, if there are no targeted interventions to prevent further spreading of the disease. In addition, specific attention should be given to the status and situation of women, youth and children, groups that are *a priori* vulnerable to a deepening of poverty and to groups that are already facing social disintegration. The assessment should include positive/negative effects of policies and interventions on the vulnerability of specific target groups to HIV and on their vulnerability to the subsequent impacts of AIDS.

#### **4.3 Poverty diagnosis/analysis**

Diagnosis and analysis of poverty will greatly enhance the transparency of the causes and effects of HIV/AIDS and of poverty, if a wide range of aspects of human development is included in the assessment. As a consequence, the relationships between the HIV/AIDS epidemic and its impacts to the different aspects of poverty, cutting across sectors, rural and urban poverty, can be assessed.

It is important to look at both HIV/AIDS as a cause and as a consequence of poverty. Projections of poverty may be influenced by (a) short-term impact of HIV/AIDS on livelihoods; (b) medium-term effects on the stability and functioning of social networks, including consequences for the capacity to recover from external shocks; and (c) long-term effect on the development potential of communities and/or the deepening of urban and rural poverty. Likewise projections of the HIV/AIDS epidemic should take effects of changes in the level of poverty into consideration.

#### **4.4 Constraints and opportunities**

Specific constraints for reinforcing poverty reduction and effective responses to HIV/AIDS should be looked at, such as gender inequalities, the status of women, structural and legal frameworks limiting access to productive resources and assets. A key constraint in effectively reducing susceptibility and vulnerability to HIV/AIDS may be the lack of participation of women in governance and decision making. Social safety nets are under pressure in many locations and are reaching a breaking point. To what extent are safety nets still able to absorb impacts of HIV and AIDS?

Here, it is important not to only look at those constraints, but to find creative ways to by-pass them in the short- and medium-term. Those constraints (like the status of women or youth within society) can hardly ever be modified fast enough to radically enough make successful interventions in HIV/AIDS prevention. Therefore, it is crucial to find ways of giving people means of self-protection, which are functioning, also under the current circumstances, such as the existing social inequalities. In the long run, things may change, but for effective HIV/AIDS prevention, general social transformation processes are often too slow.

#### **4.5 Steering the process and participation**

The steering and the involvement of actors will depend on the need and the expectations of PRSPs to provide a framework for HIV/AIDS policies and strategies. Where HIV/AIDS requires a multi-sectoral response strategy, PRSP task forces of each of the key sectors concerned should involve HIV/AIDS specialists, in addition to representatives of the health sector. In any case, focal points and working groups responsible for HIV/AIDS and for National HIV/AIDS Plans must be involved in the process, in addition to the health ministries. Special attention should be given to the problem of stigmatisation in relation to HIV/AIDS which can be counteracted e.g. by taking into consideration the views of HIV/AIDS-networks from civil society in the process.

#### **4.6 Strategic positioning of HIV/AIDS in the PRSP document**

It will be useful to take HIV/AIDS into account in each of the sections of the PRSP. Depending on the extent of the epidemic and the availability of data, HIV/AIDS should be addressed either in different sections (problem analysis, sector policies and interventions), or in addition also in special sections with other cross-cutting issues. It is important to identify relevant links between AIDS and other constraints for poverty reduction in each of the sections.

#### **4.7 Sector areas for intervention**

Depending on the type of sectors affected by HIV/AIDS and depending on the potential of the various sectors to contribute to prevention, care and to the mitigation of the impacts of HIV/AIDS, PRSPs should take into account the role of the respective sector policies and programmes to support an effective HIV/AIDS control.

The national HIV/AIDS response commonly reflects the approach outlined in the National AIDS Strategic Framework. Responses may range from a very specific approach including single sectors and target groups such as health and sex workers to more complex approaches touching on policies and strategies in different sectors such as agriculture, education and transport.

A multi-sectoral approach will pose greater challenges to the PRSP process than a confined sectoral response. For policies and interventions of poverty reduction and of

HIV/AIDS to be mutually reinforcing, appropriate entry points and links between HIV/AIDS, poverty and other cross-cutting issues such as gender need to be identified.

All formal and informal sectors can be affected by HIV/AIDS and need to be taken into consideration. Sectors, which are particularly relevant for incorporating HIV/AIDS-related action and interfaces between sector policies in terms of the PRSP are: Health and social affairs, Transport, Youth, Education, Economy, Agriculture, Rural and Community Development and Women Empowerment.

#### **4.8 Follow-up and monitoring**

In assessing the progress of incorporating HIV/AIDS into the context of PRSP, the appropriateness of institutional frameworks, of the budgeting approaches, and of the targets, intermediate targets and indicators, which are relevant to control the epidemic and to reduce the impacts of HIV/AIDS, need to be reviewed.

In order to note changes, monitoring of the epidemic and of the impacts of HIV/AIDS in relation to other criteria of human and economic development has to take place at regular intervals and feed into the annual planning and revision of operational plans.

Targets may include "maintaining or reducing a certain level of prevalence", "number of people/communities reached by campaigns", "number of people reached by home care". Further examples of indicators and targets can be found in the PRSPs of Mauritania (low prevalence country) and Mozambique (high prevalence country).

Assumptions have to be made in terms of effects of HIV/AIDS on the effectiveness of development programs as well as in terms of the potential influence of development interventions on the spread and impact of HIV/AIDS. Situations, which may completely change previous assumptions or enforce existing trends of HIV/AIDS could be state of crisis or war or events resulting refugee movements.

## **5 Conclusions and Recommendations**

Effective poverty reduction and HIV/AIDS responses require that HIV/AIDS is systematically incorporated into the PRSP and that HIV/AIDS and poverty are considered side by side in analysing causes and effects of poverty and in developing appropriate policies and interventions.

The significant progress in addressing HIV/AIDS on the political agenda<sup>37</sup>, provides a sound basis to link the cross-cutting issues of poverty and HIV at the various policy and interventions levels to make these links operational.

To ensure that HIV/AIDS-related policies and strategies are reflected in the PRSPs and that they are given the necessary priority and budget allocations within sector

---

<sup>37</sup> Global framework for action. UN General Assembly Special Session on HIV/AIDS. N.Y., June 2001.

strategies, the planning and the coordination of respective processes should be adjusted, i.e. other ongoing processes need to be taken into consideration. The recommendations are addressed to both the actors involved in the steering of PRSP processes as well as to the actors supporting related processes for responding to HIV/AIDS.

In pursuing actions for improvement, it is necessary to distinguish between: (a) a) Health-related aspects of the epidemic and the subsequent interventions; b) Mainstreaming of AIDS in other sectors; and (c) Adjustments in the PRSP documents or at the level of PRSP actors.

To be able to include a consolidated HIV/AIDS response, the PRSP process largely depends on inputs from the health and other sectors concerned with HIV/AIDS. However, responses developed within the context of national HIV/AIDS strategic frameworks have not been fully accessed and incorporated into PRSPs. It is recommended that:

1. As a first step, actors involved in steering PRSP processes significantly rise their awareness regarding HIV/AIDS; they are enabled to classify HIV/AIDS in the national development context;
2. PRSP processes are inter-linked with coordinating mechanisms, which are responsible for developing and implementing HIV/AIDS strategies at national and district levels, in particular in high-prevalence countries;
3. Immediate efforts are being made by PRSP actors to access and utilise available information from existing HIV/AIDS policies and strategies within ongoing PRSP processes to close gaps in PRSPs and to identify further needs for action;
4. Sector Projects for Poverty and HIV/AIDS of GTZ take initiative to discuss the limitation of PRSP in terms of providing a framework for HIV/AIDS responses and to discuss the need for defining different options for low, medium or high HIV prevalence countries to develop appropriate policy frameworks. Current PRSP frameworks are developed irrespective of the magnitude of the HIV/AIDS problem;
5. PRSPs processes give greater attention to development constraints and issues cutting across a number of sectors and assume a more proactive role in bringing inputs from the various sectors together.
6. HIV/AIDS coordinators (with priority at national level) are being sensitised in terms of the poverty dimension of HIV/AIDS; relevant "poverty"-windows are explored to link HIV/AIDS National Strategic Frameworks to poverty reduction;
7. A consequent mainstreaming of HIV/AIDS into respective sector policies and strategies at national level is being promoted in countries, where a generalised epidemic appears, i.e. many countries in sub-Saharan Africa; a review of existing experiences with instruments for HIV/AIDS mainstreaming could be helpful.

## **Annex 1: Analysis of factors of economic and human development affected by HIV/AIDS**

### **1 To what extent are factors of human development influenced by the epidemic (demographics, level of education, human resource)?**

In addition to the impacts of HIV/AIDS at household and community levels, there is growing evidence, which suggests that HIV/AIDS increasingly affects human and economic development at meso and macro levels, in particular in African societies. The impacts, which will influence the development potential and capacity of the societies concerned, are visible in terms of demography, education and food security, the availability and quality of social services, the development of key sectors of the national economies and the overall economic growth. While effects at target group and community levels are immediately evident, the impact on the overall economic and human development at the various levels can only be recognised after some time.

*Demographics:* HIV/AIDS is expected to significantly affect countries across the African continent. Within one decade 6.3 million lives will be lost in Southern Africa alone. UNDP estimates suggest that the Human Development Index of South Africa could be reduced by 15% due to AIDS. Life expectancy at birth dropped between 8 to 12 years between 1990 and 1998<sup>38</sup>. This drop significantly changes the age profile in populations. Particularly the most productive age groups from 15 to 50 years are severely decimated. Under five child mortality significantly increased in high and in low HIV prevalence countries<sup>39</sup>. Child mortality rates for 2000-2005 in Botswana, Zimbabwe and South Africa are projected to be equal to or greater than 50 percent<sup>40</sup>. There is a steep increase in the number of orphans. By 2010, between 20 to 35 % of all children under 15 in eleven countries of East and Southern Africa will be missing mother, father or both parents<sup>41</sup>. Southern and Eastern African regions had 6.4 million AIDS orphans by the year 2000.

*Educational level:* Formal school education of children and youth is reduced as a consequence of HIV/AIDS. According to an analytical framework developed in Zambia<sup>42</sup>, it is affecting (1) the demand for education (2) the availability of resources for education; (3) the potential clientele for education. There are fewer children enrolled, wanting to be educated or being able to complete schooling or to continue secondary education. Children are forced to earn income or take over other responsibilities from their deceased or sick parents. In the Central African Republic and Swaziland, enrolment has fallen by 20% to 36% due to AIDS. In Guatemala, more than a third of children orphaned by HIV/AIDS drop out of school<sup>43</sup>. These children may not be able to afford school fees, books, lack parental care, face hunger and emotional stress.

---

<sup>38</sup> SADC Regional Human Development Report 2000

<sup>39</sup> US Bureau of the Census 2000 cited by UNDP, 2001

<sup>40</sup> State of the World's Children 2002. UNICEF. September, 2001

<sup>41</sup> Nelson Mandela Children's Fund, 2001

<sup>42</sup> What HIV/AIDS Can Do to Education, and What Education Can do to HIV/AIDS. Kelly, 1999

<sup>43</sup> cited by UNDP 2001

The possibilities to send children to schools will be limited, either due to financial constraints or because children are replacing adult labour in the household and to undertake income generating activities. Young people lose educational opportunities such as secondary schooling and college as well as the social support from networks. If major assets are being lost, long-term impacts of HIV/AIDS can turn into a trend of deepening of poverty for the better off as well as the poor.

***Food security and nutrition:*** Food insecurity remains critical in Africa. Despite efforts and scientific advances in fighting poverty and hunger, the number of malnourished in Africa has doubled since 1970. Households are considered food secure, if food availability, equal access to food, stability of food supplies and the quality of food are in balance. At national level, a decline of food supplies and a rise of food prices could result from reduced agriculture outputs due to a reduced labour force and work productivity<sup>44</sup>. At household level, HIV/AIDS reduces household-earning power and the ability to purchase food and related goods and services<sup>45</sup>.

Food availability is predicted to be seriously affected by a change in the dependency ratio due to the altered age/gender distribution<sup>46</sup>. In general, AIDS leads to less good ratios between dependants and producers due to changes in population structure (see above on demographics). Research in Tanzania showed that per capita food consumption decreased by 15% in the poorest households when an adult died. Female-headed AIDS-affected households faced food insecurity and malnutrition as foremost among the immediate problems, according to a study in Uganda. Families coping with AIDS lack time to prepare meals. In addition to food consumption, the balance of food quality is affected by a declining diversity of nutritious food crops and reduced access or supply of livestock products. In turn, malnutrition increases susceptibility to infections and consequently worsens the severity of HIV/AIDS<sup>47</sup>.

## **2 How does HIV/AIDS affect macro economic development? At which level of infection does the economy reflect these effects?**

Growing evidence suggests that both total national income and incomes per capita fall significantly due to HIV (Figure 1). African countries with adult prevalence of less than 5% will experience only a modest impact of AIDS on the GDP growth rate<sup>48</sup>. With prevalence rising to 20%, as it is the case in a number of countries in Southern Africa, GDP growth will decline by 2% per year and per capita income at 1% per year. South Africa, which produces 40% of the economic output in Sub-Saharan Africa, is expected to observe a 17% decrease in real GNP by 2010, equivalent to €22 billion using current figures compared to a situation without AIDS<sup>49</sup>.

The costs of delayed action by African countries confronted by HIV are high. The estimated spending needed to implement prevention, care, and mitigation activities

---

<sup>44</sup> see FAO, 2001

<sup>45</sup> Health and Nutrition Emerging and Reemerging Issues in Developing Countries: HIV/AIDS. IFPRI, 2001

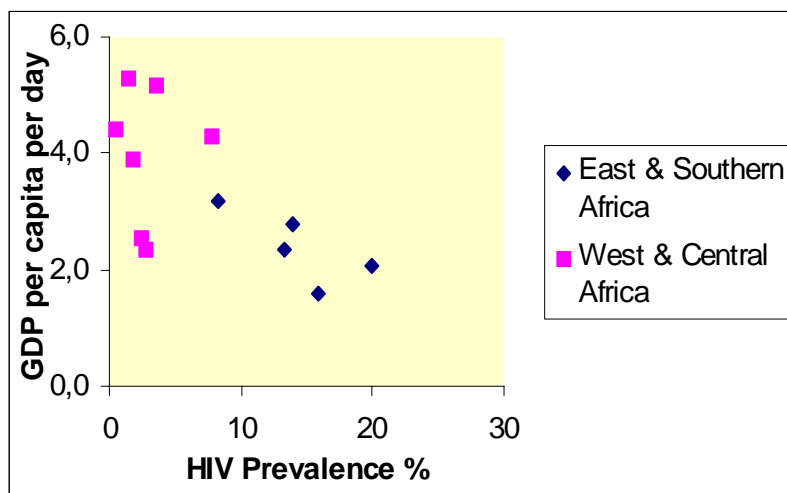
<sup>46</sup> ODI, 2000

<sup>47</sup> The impact of HIV/AIDS on Food Security. Committee on World Food Security. FAO, 2001

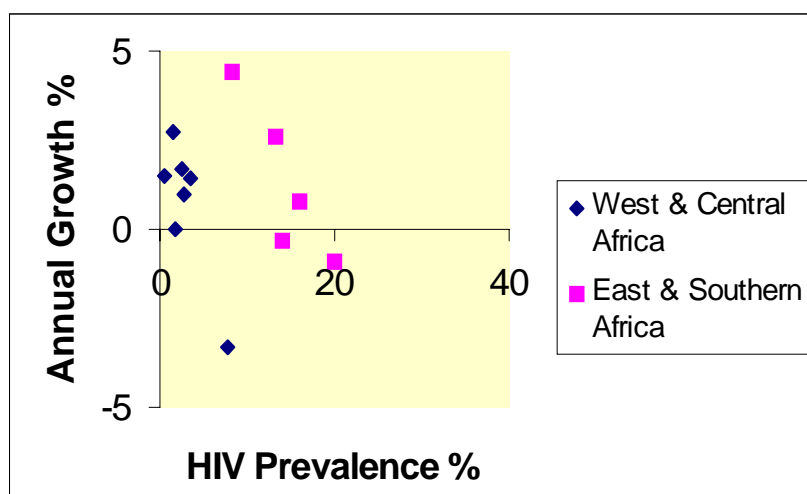
<sup>48</sup> HIV/AIDS Does it increase or decrease growth in Africa? By René Bonnel, 2000

<sup>49</sup> Study cited by UNAIDS Status Report 2000

**Figure 1: Relation of Economic Development and HIV/AIDS**  
Cause-effect relationship of coincidence?



a) **GDP per capita per day (PPP US \$), 1999 data, HDR 2001**  
**HIV/AIDS Prevalence, 1999 data, UNAIDS Status Report 2000**



b) **Annual real growth, Average 1990-97 data, World Bank,**  
**HIV/AIDS Prevalence, 1999 data, UNAIDS Status Report 2000**

increase exponentially at higher levels of HIV Prevalence. When adult prevalence is less than 5%, such comprehensive programs cost less than €3 per capita, but when prevalence exceeds 15%, HIV/AIDS program costs rise to €10 to 12 p.c. To establish the relationship between health (i.e. AIDS or malaria) and economic growth, studies used either historic data or macro-economic growth modelling. However, it is known that depending on the overall policy environment, interventions could lead to improved health promoting economic growth and reduce poverty. If the decisions taken were inappropriate poor health and poverty could become reinforcing,<sup>50</sup>.

<sup>50</sup> Estimating the Economic Impact: Potential and Limits. [www.uneca.org/adf2001/theme1.htm](http://www.uneca.org/adf2001/theme1.htm)

### 3 Which productive sectors of a national economy are particularly sensitive to impacts of HIV/AIDS?

A number of economic sectors are particularly vulnerable to the impact of HIV/AIDS. These sectors are often characterised by the requirement for workers to stay away from their homes for long periods, and include the transport, mining and fishing sectors. Sectors which rely on seasonal and short-term workers, such as agriculture, construction and tourism, are also particularly vulnerable to the impact of HIV/AIDS. Moreover, sectors which rely on highly trained personnel are also in danger of being adversely affected by HIV/AIDS because the loss of even a small number of specialists can place entire systems and significant investments at risk<sup>51</sup>.

Private Sector: The relationship between HIV/AIDS and the costs and revenue of employers has rarely been examined systematically up to now. Little data is available on how HIV/AIDS affects micro and small formal and informal enterprises. Overall there is bound to be a reduction in profits if companies do not take early measures to prevent the impact of HIV/AIDS<sup>52</sup>.

Experience from GTZ with Daimler Chrysler in South Africa shows that it is not possible as yet to quantify the starting and the cut off point for the feasibility of investments in prevention as well as the influence of the company size. Also, it is not possible to judge whether and when HIV/AIDS could lead to a transfer of production capacities<sup>53</sup>.

Health costs of four enterprises in Abidjan averaged 0.8 to 3.7% of total salary payments in 1997. In Tanzania, average health costs per employee per year increased in the mid 90ties more than three-fold in six enterprises. AIDS increases the shortage of highly qualified personnel. In Botswana, which already hires personnel abroad, salary levels will increase by 12 to 17% due to AIDS.

Employers are unlikely to be affected significantly by HIV/AIDS in situations where those employees who have to leave the labour force can be replaced without loss of productivity. The labour force is projected to decrease in Africa 2 to 20% by 2005 and up to 35% by 2020<sup>54</sup>. This may be the case in places where the unemployment rates are high. In South Africa, about 30% of the 500.000 employees in the private sector are infected with an increasing trend. In the mining sector, more than one third of the ages end of twenty to end of thirty are infected. Rates are similar in other sectors, at least in South Africa.

Changes in the labour force may lead to a mismatch of human resources and labour requirements in terms of qualification, training and experience. For small firms and in the informal sectors, the loss of one or more key employees may be catastrophic, leading to the collapse of the firm. Therefore, HIV/AIDS prevention programs in

---

<sup>51</sup> ILO, 2000

<sup>52</sup> dito

<sup>53</sup> Overview 15 years of experience. GTZ Sector Project on HIV/AIDS Control, 2001.

<sup>54</sup> The impact on the world of work. ILO, December 2000

private enterprises are triggered in response to high costs due to AIDS - reduced productivity, cost for new recruitment, training, increased expenditures for insurance and health care.

Increased costs due to HIV/AIDS prevention may affect the competitiveness of private enterprises. In Zambia, the banking sector reported a three-fold increase in training costs because highly trained staff are lost due to AIDS. To reduce costs, some enterprises change location or outsource labour to avoid paying for high social costs. One of the largest gold producers estimates current costs due to AIDS at € 10 per ounce and year, equivalent to 4% of production costs, a total of € 40 million in 2000. Another aspect of HIV/AIDS impacts on local enterprises, may be a loss of markets where the purchasing power of the population declines due to loss of income or reduced employment<sup>55</sup>.

***South Africa uses Thailand's recipe to prevent HIV/AIDS in the transport industry***

*The South African Department of Transport is pulling out all stops to prevent HIV/AIDS in the transport industry. The road freight industry is often blamed as being one of the main carriers and distributors of the disease, but Transport Minister, Mac Maharaj, has said that the time of laying blame on one sector of the population is over and action is needed. He called on South African business leaders in the transport industry to learn how Thai businesses succeeded in drastically reducing the HIV/AIDS epidemic in the transport industry. Thailand, along with Uganda, are two developing countries which have achieved some success in fighting the pandemic. The Executive Director of the Thailand Business Coalition on Aids, Anthony Pramualratana, on a visit to South Africa, described how businesses had embarked on what was called the "100 per cent condom distribution programme" in 1990 and that this had raised the figures for the use of condoms among commercial sex workers from 33 to 95 per cent.*

*Other steps taken in Thailand in the transport industry were: encouraging companies to allow drivers to take their wives or partners with them on long trips; reducing the number of long trips by drivers; and developing solidarity between workers in the industry. Maharaj said that a strategic focus was needed in South Africa and a lot could be learned from the Thai experience (cited by ILO, 2000).*

Transport sector: The transport industry is among the sectors most severely affected by HIV/AIDS. In Southern Africa, long distance trucking plays a critical role in the national economies. Trucking contributes significantly to the spread of HIV/AIDS along the transport routes. In Zambia alone, approximately 3500 drivers and assistants are away from home and their families for extended periods. Dor Farms International, one of the largest trucking companies in Zambia lost close to 30% of its drivers due to AIDS in three years.<sup>56</sup> In order to address the vulnerability of the transport sector, South Africa uses Thailand's recipe to prevent HIV/AIDS in the transport industry.

<sup>55</sup> HIV/AIDS: A threat to decent work, productivity and development. ILO, June 2000

<sup>56</sup> Zambia National HIV/AIDS Strategic Framework 2000-2002

Labour market: Mobile workers, including migrants, are another vulnerable group. A great number of persons working in the transport, fishing and tourism industry belong to this group. Mobile populations tend to be more vulnerable to infection than local populations for reasons which may include lack of hygiene, poverty, powerlessness and the precarious family situations which accompany their status. One significant source of HIV transmission is sex between men who, through their work, spend long periods away from their families in predominantly or exclusively male environments.

Migration, both permanent and temporary, are associated with the transmission of HIV, especially where family separation is involved. This is even more true for refugees and other forced migrants. People are six times more likely to contract HIV in a refugee camp than outside<sup>57</sup>. The main reason for voluntary migration (either permanent or temporary) is economic, because people seek opportunities for employment. Types of migration include rural-urban migration, seasonal workers and men who take up particular employment opportunities such as mining or construction, including also teachers and other public service personnel. Where facilities are poor for families, they may travel to another region or country, and absence may be prolonged, such as it is the case in sugar plantations in Uganda. In Africa, contacts and movements between town and village are many and complex. Rural and urban areas are tightly linked and the village remains the retreat for many working in the towns.

Agriculture and rural development: HIV is spreading at increasing rates in rural areas. Rural communities are requested to care for and support sick family members, which are returning from urban centres to traditional safety nets. Most of the poor live in rural areas. By 2020 about 50% of the population will be living in urban areas<sup>58</sup>. Rural areas are increasingly affected by the impacts of AIDS. Agriculture outputs in parts of Zimbabwe have fallen by 50% over the past five years, mainly as a result of AIDS<sup>59</sup>. The agriculture sector is affected through reduction of labour force, worker productivity and total output. FAO estimates that deaths caused by AIDS in the 10 most affected African countries will reduce labour force by 10% to 26% by 2020.

In commercial agricultural enterprises, medical costs increased two to 4.5 times due to AIDS. Illness and death make up 41% of total staff exits. Skilled workers are lost and labour productivity is declining.<sup>60</sup> AIDS-related costs are attributed to 52% to AIDS and HIV absenteeism as well as to health care, recruitment burial costs, training, labour turnover, funeral attendance and productivity loss after training.

Small holder agriculture is a key factor of economic development in many African economies. AIDS-afflicted households in Ethiopia spent 50 to 66% less time on agriculture. The loss of family and community labour leads to a decrease of area under cultivation, output per unit, abandoning of cash crops and switching to less

---

<sup>57</sup> HIV/AIDS in Africa. ILO, 2000

<sup>58</sup> World Urbanisation Prospects: The 1996 Revision

<sup>59</sup> The State of Food and Agriculture 2001. FAO, 2001

<sup>60</sup> HIV/AIDS in the Commercial Agricultural Sector in Kenya. FAO/UNDP, 1999

labour- and input-intensive crops, sale of livestock assets, and impairing of income-generating post-harvest activities.

The rural poor have limited access to care and prevention. HIV/AIDS prevention and control programs often do not reach rural communities. In the past they have been largely by-passed by HIV/AIDS campaigns or access to prevention methods (i.e. condoms). In addition, access to social services is becoming restricted and requires cash payments.

Increased costs due to AIDS limit the ability of farmers to hire labour or to buy external inputs. Continued pressure on agricultural households due to AIDS lead to dissavings and the loss of productive assets such as livestock. It also decreases the ability to recover from external shocks such as drought or flood. In addition, traditional agricultural knowledge and skills are lost. Children are deprived of learning from the parents who often divide labour and knowledge according to gender.

In rural areas, HIV/AIDS affects target groups also through changes in saving possibilities. The very poor do not have savings, as a study from rural Zambia shows<sup>61</sup>. They often rely on other people's capital and resources. These resources may disappear as a consequence of AIDS. Also, most of the poor and very poor are not likely to benefit from micro-credit, as most of the poor, to build new economic activities. For rural households, the ability to cope with external shocks, such as drought, will be reduced even for the less poor. There is a risk of losing opportunities to trade and to invest at different points in time or of losing assets such as animals. For the poor, access to animals through hiring or family ties may disappear, resulting in growing limitation of food and cash. The poor and the very poor who largely rely on their own labour and crop seeds (saved from the previous harvest) will be affected through HIV/AIDS in terms of income, food and nutrition.

Public Sector: Health, education, water and agriculture extension services are being disrupted by HIV/AIDS as staff become ill and die. At the same time, reduced economic performance will probably decrease tax income more than 20% in the next 10 years. National budgets are under strain due to the impacts of AIDS. In Botswana, for example, expenditure in the health sector alone are projected to increase more than three times in the next decade<sup>62</sup>. Health systems, which are in many cases already in a deteriorating state, are facing additional challenges. Inadequate resources for health services and increasing demands arising specifically from AIDS have put unbearable pressures on health systems, leading to an erosion of the quality of care. Burden of disease increased up to 7-fold in highly affected African countries and increases demand for health services. At the same time, death and illness reduces the capacity of the sector itself to deliver critical services. In Malawi and Zambia five-fold increases in health-worker illness and death rates reduced the personnel and increased stress among the remaining staff.

Education services are among of the services most severely affected by impacts of AIDS. They consume 10 to 30 % of total public expenditure and are usually the largest government employer. Education is affected in ten different ways by

---

<sup>61</sup> Rural Livelihood Strategies: Saving for Survival, Protection or Accumulation? Verstralen, 2001

<sup>62</sup> UNAIDS, 2000

HIV/AIDS<sup>63</sup>: the demand and supply of education, availability of resources, the potential clientele (e.g. orphans), the process of education itself, the role of education, the organisation of schools, planning and management of the education system and donor support for education. In Zambia, communities complain about the loss of teaching time due to prolonged illness of teachers. At the same time, support in kind given to schools from communities, which are affected by AIDS, will diminish. Research by UNAIDS suggests that by 2005 between 25 percent and 50 percent of today's teachers in the Central African Republic will have died from AIDS. Between 1996 and 1998 more than 100 educational establishments have been closed<sup>64</sup>.

#### **4 Do social safety nets (community or family-based), which are already at stake, become obsolete under additional pressure through AIDS? Does this development lead to the need for regional/global social welfare?**

The role played by the extended family as a safety net is by far the most effective community response to the AIDS crisis. Affected households in need of food send their children to live with relatives. Relatives are then responsible for meeting the children's food and other requirements. The preparation of food and agricultural work on the affected household's land or overseeing its livestock may well be carried out by another family member or neighbour, in addition to their own tasks. However, as the number of multi-generational households which lack a middle generation increases, the ability of families and social networks to absorb these demands is bound to decline.

Social safety networks, particularly in traditional rural societies, developed successful mechanisms to cope with emergencies such as natural disasters. Many safety nets are under pressure or have been already weakened. For example, labour migration is related to prolonged absence of one or more male family members reduces the ability of families and networks to absorb additional demands. Continuous requests for support in emergency (care, labour, food or monetary help) lead to an overstretching of networks, which may be either based on extended families or on friendship.

The initial stability of networks may differ significantly. Family networks in rural areas may be much more stable than newly established urban networks. However, rise of morbidity and mortality due to AIDS leads to collapse of nuclear families. It is driving family safety nets and information rural institutions to a breaking point<sup>65,66</sup>. HIV/AIDS is often linked with taboo and stigma, leading to social exclusion, though most individuals don't know that they are HIV positive. Therefore, social consent and openness to facilitate the mitigation of AIDS impacts and to disregard stigmatisation or social exclusion are critical to be able to acquire and to maintain network support.

---

<sup>63</sup> What HIV/AIDS can do to education. By Kelly, 1999

<sup>64</sup> Study on the impact of the spread of HIV/AIDS on the mortality of teachers in the CAR. UNICEF, 2001

<sup>65</sup> Impact of HIV/AIDS on rural households/communities and the need for multi-sectoral strategies. FAO, 1997

<sup>66</sup> see UNDP Policy Paper, 2001

Orphans, which are increasingly heading households, widows and elderly are the most vulnerable to the increasing impacts of HIV/AIDS. AIDS accelerates a downward spiral of growing dependency and reliance. Ultimately, this can lead to the withdrawal of safety nets from providing support. For example, members refuse to accept care of orphans, to safeguard their nutrition and educational needs, to give access to shelter or to contribute to funeral costs.

In Zambia, one third of the children below 15 lost a mother or father or both. More than 130.000 households equivalent to 7% are headed by children, by a girl or boy less than 13. 75 % orphans and non-orphans live below the poverty line. Half of all street children are orphans in Zambia<sup>67</sup>.

In Latin America and the Caribbean, the impact of HIV/AIDS on human development for social safety systems is increasingly realised. Due to significant changes in the relation of social security income and cost, a new strategy is being proposed. It is suggested that formal social security systems need to rethink their role beyond provision of retirement benefits due to the impacts of HIV/AIDS and based on factors that determine the viability of the social security system<sup>68</sup>.

The growing pressure and instability of social safety nets has important consequences for designing social security systems and welfare support and developing interventions. Orphans and widows are particularly vulnerable and are facing a deepening of their poverty situation. In cases, where traditional safety nets are at or close to a breaking point, new systems of social welfare are required to safeguard the basic needs of the poorest, opportunity for school, health care, growth, development nutrition or shelter.

Research on the performance and stability of networks has been neglected in the past. Findings from sociological research on networks and their capacity were not included in poverty studies. The functional logic of networks (when and how is support given, what kind of support) and strategies of risk reduction have been researched quite well in the 70ties and 80ties. However, networks are rather specific. It is not possible to make generalised statements on the delivering capacity of networks<sup>69</sup>.

---

<sup>67</sup> HIV/AIDS in Zambia. Ministry of Health. 2001

<sup>68</sup> The impact of HIV/AIDS on Social Safety Nets: What can the Caribbean Expect?, 2001

<sup>69</sup> pers. Communication Prof. Dieter Neubert

## Annex 2: Support and Tools for Incorporating HIV/AIDS into PRSP

A range of support mechanisms are available for mainstreaming HIV/AIDS in the PRSP or other processes. They provide useful guidance in the context of poverty reduction and the development of PRSP.

UNAIDS plays a key role in facilitating the incorporation of HIV/AIDS into the documents through various channels. Following policy/ strategy formulation at headquarters, UNAIDS is assisting PRSP processes through regional teams in West and Southern Africa. Electronic networking facilitates information exchange. It complements assistance by country-level technical advisors<sup>70</sup>.

To prepare and build country teams for incorporating HIV/AIDS into PRSP documents, two 2/3-day workshops were conducted in Benin (for West- and Central Africa) and Malawi (East Southern Africa) with staff from the Ministries of Finance and National HIV Programs. Process support by UNAIDS is complemented by case studies in Cameroon and Burkina Faso<sup>71</sup>. UNDP/UNAIDS carry out a regional project on HIV/AIDS and Development for Sub-Sahara Africa.

Specific sources, which can be consulted (*TABLE 1,2*):

- HIV/AIDS toolkit by UNAIDS/World Bank: This tool was specifically designed to assist PRSP/HIPC actors in the preparation of the PRSPs. It introduces to PRSP and to HIV/AIDS basic information and interventions. It gives a summary of poverty-AIDS relationship and introduces to multi-level and multi-sectoral actions. It includes initial results of incorporating HIV/AIDS into I-PRSPs at an early stage.
- The PRSP Source Book contains a chapter on health, which provides comprehensive background information and reference on health sector and policy planning. The Source Book is not designed as a practical guide.
- EU Commission: This HIV/AIDS toolkit does not specifically relate to PRSP. However, it gives a structure for mainstreaming HIV/AIDS. It is designed for actors not involved with the topic on day-to-day basis: (1) Introduction to HIV/AIDS; (2) Why is it unique; (3) National importance; (4) Sectoral checklist including education and infrastructure; (5) Guidelines for including HIV/AIDS in Project Cycle Management; (6) in consultants' Terms of Reference.
- GTZ: German gathered a range of experiences with comprehensive AIDS control programs<sup>72</sup>. Results from the Mbeya project in Tanzania (control and prevention) and from Southern Province Zambia with SLE<sup>73</sup> are available. Based on these initial results<sup>74</sup> relevant tools should be developed and made available for a wider application by development cooperation projects.

<sup>70</sup> UNAIDS Monthly Newsletter AIDS-Poverty & Debt Relief: poverty-debtrelief@unaid.org

<sup>71</sup> UNAIDS Inter-Country-Team West-/Central Africa: <http://www.onusida-aoc.org/>

<sup>72</sup> Responding to HIV/AIDS in the developing world. Overview 15 years of experience. GTZ, 2001.

<sup>73</sup> SLE, 2000. Incorporating HIV/AIDS concerns into participatory rural extension

<sup>74</sup> Multi-sectoral approach on HIV/AIDS: Constraints/opportunities for techn. coop. Hemrich & Schneider, 2001

Assessment and conclusions: Several constraints and gaps are evident to effectively facilitate the mainstreaming of HIV/AIDS into poverty reduction. The preliminary findings from the analysis of the existing tools, their use and from the processes at national and regional levels were confirmed at a recent workshop<sup>75</sup>:

1. The toolkit targets the PRSP. However, it does not serve as decision aid for actors. It is not problem- or process-oriented. The checklist of requirements is incomplete. The source book deals with the health sector in general and does not guide on the issue of mainstreaming, which is a key to developing effective AIDS responses. It is perceived as being prescriptive, focussing too much on formal requirements for the PRSP<sup>76</sup>.

The Rapid Guidelines for developing Interim-PRSPs take a broader approach with regard to health-poverty analysis and intervention. However, focus is largely on health systems and "pro-poor" health interventions. The "mainstreaming" issue as well as cross-sectoral issues are lacking<sup>77</sup>.

2. Prerequisites have not been encountered for successfully mainstreaming HIV/AIDS into poverty reduction strategies. (1) PRSP actors are not sufficiently aware that AIDS has to be incorporated; (2) The understanding about the importance and dynamics of the HIV/AIDS epidemic and the response required to fight HIV/AIDS is weak and limited to a few; (3) the toolkit assumes that actors are ready to incorporate HIV/AIDS into the documents, which is not the case.
3. Interfaces between HIV/AIDS, the health sector and poverty reduction at policy and intervention levels are not being addressed. The mainstreaming of HIV/AIDS into other sectors (such as agriculture and education) is mostly absent in the current process. Observations from selected national HIV/AIDS plans indicate that provisions in health sector policies and the National AIDS Plans are lacking to interface HIV/AIDS strategies with poverty reduction. HIV/AIDS coordinators are not aware of the need to incorporate HIV/AIDS into the PRSP.
4. Initial documents were produced under high time pressure. Further operational guidance and process support will be necessary to PRSP actors as well as to all sector specialists, which are potentially involved in mainstreaming HIV/AIDS and related issues. Beyond the development of effective interfaces between poverty reduction and HIV/AIDS, a follow-up is required to implement programs, which are mutually reinforcing. A step in the right direction is outlined by a policy paper currently being developed by the Netherlands<sup>78</sup>.
5. The establishment of a new HIV/AIDS coordination unit at the World Bank is a useful step that should be fully utilised in promoting the mainstreaming of HIV/AIDS into the PRSP process.

---

<sup>75</sup> PRS in Africa. Preparing the Implementation. Central Issues of Debate. GTZ, Eschborn, 6-10 August 2001

<sup>76</sup> Good news for the poor? Social conditionality, participation and poverty reduction. By Whaites, 2000

<sup>77</sup> Rapid Guidelines for Integrating Health, Nutrition, and Population Issues in Interim-PRSP. World Bank, 2000.

<sup>78</sup> Poverty and HIV/AIDS. Draft Policy Paper. Ministry of Foreign Affairs. The Netherlands, 2001

TABLE 1: Useful tools and guidelines for mainstreaming HIV/AIDS into the PRSP

	Targeted at PRSP	Analytical on Poverty-AIDS-link	Interfacing of poverty-AIDS interventions
A Toolkit for Mainstreaming HIV/AIDS Programs. World Bank / UNAIDS	+++	++	+
PRSP Source book. World Bank	+++	- (general to the health system only)	-
HIV/AIDS implications for Poverty Reduction. UNDP Policy Paper	+	+++	++
Rapid guidelines for integrating health, nutrition, and population issues. World Bank	+++	+	+ (health sector, poor areas & households)
Considering HIV/AIDS in Development Assistance: A Toolkit. EU Commission	-	+	+

TABLE 2: Discussions groups on HIV/AIDS, depth relief, poverty, and PRSP

AIDS Poverty & Depth Relief Newsletter <a href="mailto:Poverty-deptrelief@unaids.org">Poverty-deptrelief@unaids.org</a> <a href="http://www.unaids.org/debt/index.html">http://www.unaids.org/debt/index.html</a>	Reports on country cases and progress, relevant information and contacts
Eldis Gateway to Development Information <a href="http://www.eldis.org">http://www.eldis.org</a>	Broad range of information, analysis, contacts on HIPC, PRSP, poverty and development
International Poverty and Health Network IPHN <a href="http://www.iphn.org">http://www.iphn.org</a>	Information on poverty and health
UNAIDS Inter-Country Team West Africa <a href="http://www.onusida-aoc.org">http://www.onusida-aoc.org</a>	Experiences and strategies from specific countries
Latin America Regional Network on AIDS Strategic Planning (REDPES)	
PovertyNet Newsletter World Bank <a href="mailto:PovertyNet@forumone.com">PovertyNet@forumone.com</a>	News on the PRSP-process

## Annex 3: Analysis of Selected PRSP Documents

A rapid assessment of eight Interim/Draft PRSPs and of four Full PRSPs from Africa was performed. The countries represent a range of degrees of HIV prevalence in both West and East/Southern Africa: Kenya, Madagascar, Malawi, Mozambique, Tanzania, Uganda, Zambia and Cameroon, Chad, Guinea, and Mauritania were analysed in detail.

A synthesis of the results is given in the table in the main text. Analysis was largely based on information accessible through the PRSP process, complemented by interviews. This review was done under the premise that (1) a broad definition of poverty<sup>79</sup> is being applied and that (2) a comprehensive response to HIV/AIDS in a high prevalence country is comprised of prevention, medical treatment and care, and the mitigation of short and medium-term impacts of HIV/AIDS, based on a multi-sectoral framework<sup>80,81</sup>.

The analysis of the PRSP was based on the following criteria:

- The quality of poverty analysis (the depth of analysis; ideally including a range of relevant social and other determinants);
- Recognition of HIV/AIDS as a development constraint related to poverty, looking at causes and effects of HIV/AIDS;
- Quality of HIV/AIDS analysis (epidemic and its impact on poverty/development);
- Comprehensiveness of HIV/AIDS response as evident from the institutional framework, the budgeting approach, and the indicators outlined in the PRSP;
- Link of PRSP to an operational HIV/AIDS strategy (i.e. the National AIDS Strategic Framework);
- Mainstreaming of HIV/AIDS into sector strategies; this would for example include interfaces at conceptual and intervention levels between HIV/AIDS, cross sectoral issues such as poverty and gender as well as education and health sectors.

### 1 Cameroon (based on Interim-PRSP of 8/2000)

*What?* Cameroon prepared an Interim-PRSP giving high priority to HIV/AIDS. In parallel to the PRSP, a national HIV/AIDS strategic plan 2001-2003 was completed, which became a precondition for dept relief. About 200 million dollars will be spent to implement this plan<sup>82,83</sup>.

*Positive:* High political attention given to AIDS is flanked by the development of a multi-sectoral AIDS program. As a consequence improved HIV monitoring, prevalence is now estimated at 11 to 14%. A provision for significant support of the AIDS program was included in the PRSP.

<sup>79</sup> Understanding poverty [www.worldbank.org/poverty/mssion/upl.htm](http://www.worldbank.org/poverty/mssion/upl.htm): From the point of view of the poor, poverty consists of lack of educational opportunities, poor health and access to food, lack of economic and social infrastructure and services. This perception reflects a multi-dimensional definition of poverty, which is now widely accepted.

<sup>80</sup> Multi-Sectoral Responses to HIV/AIDS. By Hemrich & Topuzis, 2000

<sup>81</sup> Responding to HIV/AIDS in the developing world: The GTZ contribution , 2001

<sup>82</sup> Focus on Cameroon: how was it done? UNAIDS Toolkit, 2001. p. 26

<sup>83</sup> Dept reduction and HIV/AIDS control in Cameroon. UNAIDS, 2001

*Negative:* The comprehensive approach to HIV/AIDS and the priority were not reflected in the text of the document. The analysis appeared to be incomplete in terms of factors determining the spread and impact of HIV/AIDS. AIDS was not mentioned as key constraint. Policy considerations on responses were limited to the health sector and targeting of urban groups with high vulnerability. They focus largely on prevention. Links to education or rural development were not evident.

*What next?* The AIDS program is ambitious. It is intended to involve all sectors and communities and to integrate responses into the different development instruments. This will require that the AIDS Plan is operational and is fully incorporated into the PRSP. Poverty reduction interventions must establish linkages to the AIDS problem and to AIDS responses, and vice versa.

## **2 Chad (based on 2<sup>nd</sup> Draft PRSP of 7/2001)**

*What?* AIDS has been systematically incorporated into all PRSP chapters. AIDS control is included as a key objective/priority action to reduce poverty. Five major activities of prevention, treatment, and care of orphans are specified. The National AIDS Program is one of the programs in the health sector. The committee, which is steering the process, involves representation of all branches of government and civil society. Health constitutes one technical group involved in monitoring and follow-up.

*Positive:* The analysis defines poverty broadly, including access to resources and services. HIV-infected are treated as marginalised target group deserving special attention. Also, it is addressed as specific constraint. Current knowledge on the epidemic and perceptions related to AIDS/STDs are summarised. The AIDS response is reinforced by a national effort to improve the status of women, which cuts across all sectors. This includes improving the legal status of women. It is reflected by specific focus on vulnerable women (e.g. widows, unmarried women) and children in the constraint analysis, and in the chapter on sector policies and programs. HIV/AIDS is treated appropriately, considering recognition of its national significance and current prevalence estimates of 2.7-4%.

*Negative:* HIV/AIDS is not addressed as a separate theme of analysis. Poverty diagnosis does not consider impacts of AIDS or relate poverty to AIDS. Interfaces of the national AIDS plan and other sector policies are not evident. Future actions are not projected, if prevalence rates increase. Currently, AIDS is treated element in the strategy and program of the health sector. A specific population and AIDS project (credit and micro-finance) is carried out under the population fund FOSAP.

*What next?* The overall goal of reducing poverty is build on the hypothesis that "HIV is mastered". The AIDS response, however, is judged to be far from mastering the situation. It is planned to develop a multi-sectoral framework for AIDS/STDs.

### **3 Guinea** (*Based on Interim-PRSP of 10/2000*)

*What?* The Interim-PRSP identifies AIDS as a national challenge. Currently, HIV prevalence is estimated at 1.5%. Access to health services and to resources, strengthening human & institutional capacity and of responses, specifically of non-medical aspects, are the identified interventions. In 2001, about 1% of 66 million depth relief to be spend on PR programs were allocated to AIDS. Over 50% of the population have no access to health services and safe water. Poverty incidence averages 40%. In rural areas, where three fourth of the population lives, it is twice the urban poverty and nearly eight times the level in Conakry. Income inequalities differ significantly between location. Gender inequalities are substantial. Literacy in women is less than half of men. Women account for nearly 80% of the food crop production. They have limited access to productive resources and to implements, but face excessive work loads. The devote more than 60 % of their household budget to food and a marginal share to education and medical care.

*Positive:* AIDS is recognised as national challenge, at a time when HIV prevalence is still low. Poverty is analysed in depth, including social dimensions and gender, discussing interdependencies, which are relevant to AIDS. Objectives and targets to reduce the incidence and socio-economic impact of AIDS are specified. Areas to which resources will be allocated under depth relief (incl. social sectors) are made explicit. The national AIDS coordinator is member of the PRSP steering group. A working group discussed how AIDS should be incorporated into the PRSP.

*Negative:* The analysis of the AIDS dynamic is lacking. How will AIDS in the future affect the wider population, beyond truck drivers, sex workers, and the military? What is the expected influence of refugees from neighbouring countries such as Liberia? How is AIDS linked with the poverty factors?

*What next?* The final document will have to improve allocation of funds and action. Follow-up will be needed to incorporate AIDS responses into in all development programs and to achieve the gender and equity targets, including legal aspects.

### **2 Kenya** (*based on the Interim-PRSP and JSA of 7/2000*)

*What?* The poor constitute slightly more than half the population of Kenya. Three-quarters of the poor live in rural areas. Major characteristics of the poor include landlessness and lack of education. The majority of the poor cannot afford private health care (76% rural and 81% urban). Over 50% of all Kenya's households do not have access to safe drinking water. Adult HIV prevalence is estimated at 14%.

*Positive:* The PRSP consultative forum addressed HIV/AIDS as an issue affecting everybody in Kenya. While the analysis is brief and aggregate, the PRSP differentiates among the poor small farmers, pastoralists in ASAL areas, agricultural labourers, casual labourers, unskilled and semi-skilled workers, female-headed households, the physically handicapped, HIV/AIDS orphans and street children.

*Negative:* The early draft does not include figures on HIV prevalence. HIV/AIDS control is considered a central to the PRS. However, it largely appears as a health issue. Consequently actions focus on activities in the health sector to achieve the objectives of preventing transmission of HIV with a focus on vulnerable groups. The analysis of poverty does not relate to causes and effects of HIV/AIDS.

*What next?* Responding to the magnitude of the epidemic and its impacts, the documents already contains considerations of social security, the need to strengthen the traditional safety nets and targeting HIV/AIDS infected and affected persons. The early documents includes HDI indicators, which allow indirect statements on the impact of HIV/AIDS (life expectancy and infant mortality). It does not yet outline a detailed monitoring matrix with targets and indicators taking HIV into account.

### **3 Madagascar (based on Interim-PRSP of 11/2000)**

*What?* Madagascar is among the poorest countries whatever classification of indicators is used. In terms of Human Development Index (HDI), it is higher than of GDP, which is an evidence of past investment in the social sector until the early 80s. The current economic deprivation is coupled with a high level of deprivation in sectors of human life, e.g. nearly half of the school age children are not enrolled in schools. More than 70% of household expenses are devoted to food, which means that about 70 % of the population is poor. While prevalence of STI is considered high (592 in 100 000 in 1997), HIV prevalence in 1999 is reported at 0,15% for the overall population and at 0.99% in the most affected target group.

*Positive:* The analysis of poverty is broad and includes in addition to economic and social indicators environmental aspects. The specific target to fight HIV and STI is "to maintain a prevalence level below 0,99% for STI and HIV in both high risk groups and in the general population; by 2003, to reduce by 50% STI prevalence, including among the underprivileged group. The HIV-related objective lists actions including the development of essential services and campaigns to raise the awareness about HIV. The PRSP indicates a broad consultative process.

*Negative:* The analysis of the HIV epidemic is very brief and it is largely limited to the health aspects of HIV. It does not interrelate HIV with other factors of human and economic development. While the HIV coverage in relation to the magnitude seems appropriate, the PRSP does not include considerations of future development of the HIV epidemic.

*What next?* Relevant monitoring of HIV/AIDS-related concerns is largely limited to HDIs and the health sector. However, the plan includes activities to reinforce a the multi-sectorial approach in terms of education and prevention against STI/HIV-AIDS giving priority to the underprivileged and high-risk groups as well as round-tables at the policy level.

## **5 Malawi** *(based on Interim-PRSP of 8/2000)*

*What?* The Interim-PRSP contains an in-depth analysis of the HIV/AIDS epidemic and its impacts. Responses to the HIV/AIDS epidemic are presented under the National Strategic Framework for HIV/AIDS of the Ministry of Health and Population (1999). The Interim-PRSP builds on Malawi's Vision 2020 (1998) and related strategies.

*Positive:* The analysis of the epidemic and AIDS impacts is linked to the poverty and economic diagnosis. The PRSP uses gender as one of its five major criteria, which reinforces AIDS responses additionally. This analysis looks at the different dimensions of AIDS in addition to the health aspect. AIDS is looked at as cross-sectoral factor of poverty reduction. The PRSP contains an implementation framework, which includes specifically the AIDS Strategic Plan as part of the social sector. Cross sectoral links in implementing the PRSP are indicated indirectly (not explicit) through support of social safety nets (AIDS orphans), targeting of food insecure households, and through community services (addressing gender issues and women's legal rights).

*Negative:* The paper reflects the early stage in the process. It focuses on the schedule to develop the full PRSP. The paper qualifies the information basis. The implementation of AIDS responses indicates the intention to mainstream HIV/AIDS. However, it shows no link (yet) with the education sector or other important sectors (such as agriculture). The health component itself focuses too much on biomedical aspects.

*What next?* It is not clear from the preliminary document how the implementation framework will be matched with respective resources. Also, targets and indicators have to be specified. Mainstreaming HIV/AIDS into all major sectors remains to be done. Given the magnitude of the HIV/AIDS problem, this will be key to effectively addressing HIV/AIDS.

## **6 Mauritania** *(Based on Full PRSP 12/2000)*

*What?* Poverty affects nearly half of the population in Mauritania. Poverty is being assessed in terms of living conditions, education, health, access to potable water and housing. Monetary poverty is considered mostly a phenomenon in arid and rural areas (76%), the home of 57% of the population. While the prevalence level remains low at 0,5%, the PRSP notes improved access to health services from 30 to 70%.

*Positive:* The analysis of poverty is detailed and includes a range of aspects of human development. The PRSP includes specific targets related to health, demography as well as HIV/AIDS. The HIV epidemic is targeted to stabilise at 1% by 2015. Specific actions include the development of local monitoring systems and the improvement of access to health services including HIV testing. Within "Health and Nutrition" the HIV/AIDS prevention objective lists a range of specific actions.

*Negative:* Cross-sectoral links in the design and implementation of the PEAP in terms of AIDS control are not evident throughout. The costing of AIDS measures mainly refers to health and sector budgets. The IMF assessment notes deficits of gender aspects and the need to put greater emphasis on rural areas in implementing the PRS. It did not comment on the continued implementation of AIDS-related responses. However, it notes raising inequality (rural-urban, north-west of country?).

*What next?* While the PRSP includes a comparative table of HIV prevalence rates across Africa, it does not take into consideration current prevalence rates and emerging epidemics in the subregion, which are rising above 2%, Burkina Faso beyond 5%. It is not clear from the PRSP how a PRS of (1) accelerating economic growth; (2) developing the growth potential and productivity of the poor; (3) developing human resources and access to essential infrastructures; and (4) to promote true institutional development, based upon good governance and on full participation of all parties involved in poverty alleviation, would affect HIV/AIDS scenarios in Mauritania in the medium-term or how the key elements of the PRS would take into consideration the strategy to keep HIV prevalence at a level of 1% in the general population.

## **7 Mozambique (Full PRSP of 4/2001 for 2001-2005)**

*What?* Poverty is defined from the consumption perspective as the systematic inability of people to feed themselves adequately in order to conduct a healthy, productive and fulfilling life. According to this, about 70% of the population is below the line of absolute poverty, ranging from 48-88%. The degree of poverty is also reflected in health and educational indicators (close to 75% of women of 15 years and above are illiterate; 85% in rural areas) and the access to services. Prevalence of HIV/AIDS is estimated at 16%. HIV is included as one component of the health programme. The PRSP has been planned to ensure coherence with the Strategic Framework for HIV/AIDS, which included provincial and national consultations. Interventions are mainly spelled out in the education and health sectors.

*Positive:* Poverty analysis is based on a multi-dimensional understanding of poverty. The PRSP analyses the different dimensions of the impact of HIV/AIDS. A special consultation involving a broad range of actors was held to address HIV/AIDS. The monitoring matrix (2 out of 7 indicators are related to HIV) contains specific targets and actions related to HIV/AIDS (e.g. 4 Million people reached by sensitisation campaigns by 2003; HIV prevalence at 17% by 2005); as intermediate targets "no of prevention measures" and "free people reached by free distribution of condoms".

*Negative:* While the poverty analysis is in-depth and notes negative changes in demographic indicators, it does not relate this analysis to HIV/AIDS or consider HIV/AIDS as a factor of poverty.

*What next?* The PRSP outlines budget requirements including HIV/AIDS both in the health and in the education sectors, comprising 26% of the health budget and 0,21% of the education budget respectively. The HIV-related budget is being maintained throughout the planning period. The outcome of two studies is expected to provide an assessment of the macroeconomic impact of HIV/AIDS. It appears that further action will be based on the outcome of current analysis and studies.

## **8 Sierra Leone (*Interim PRSP 6/2001*)**

*What?* HD and social indicators, including illiteracy, primary school enrolments, life expectancy, maternal deaths, malnutrition, and child mortality rates, are about the worst in the world. E.g. life expectancy at birth is about 38 years compared to 45 years for Sub-Saharan Africa. About four-fifths of the population lives in absolute poverty. Major causes of poverty cited are include high unemployment and underemployment, high debt burden, poor growth performance, lack of income and access to basic social services. The PRSP notes the incidence of HIV due to the civil conflict and the lack of awareness among the population (Prevalence estimated >3%).

*Positive:* Concrete actions to intensify HIV prevention and information campaigns in the education sectors are spelled out, including support to PLWA, testing, counselling etc. Targets of the PRSP for 2002 include "to reduce HIV prevalence" and "to increase the awareness rate among women of currently 13% up to 20%".

*Negative:* Due to the post-conflict situation the PRSP process has to build on a poor data basis. While the document provides a preliminary framework only. It appears that a national HIV plan to build actions upon is not existent yet.

*What next?* TA study has been initiated on HIV/AIDS to provide projections on the demography and on the impacts for labour and on cost of fighting the disease.

## **9 Tanzania (*PRSP Progress Report of 8/2001*)**

*What?* The Report provides an update on the process and on data. It is not yet possible to make definitive statements about the level of the poverty headcount ratio or poverty depth in 2000, because of the limitations of the consumption expenditure data in the HBS preliminary analysis. However, the analysis will include both economic and social variables, such as female-headed households. AIDS prevalence has exceeded 8%. Consequently it is included as a cross-cutting issue in the PRSP. The process currently emphasises the importance of cross-cutting issues like HIV/AIDS, gender, and governance. A recent consultation emphasised the need for mainstreaming HIV/AIDS into the different sectors and other areas of the PRS. Interventions will be guided by the National AIDS Plan.

*Positive:* Specific actions in 2001 included the abolition of VAT for hospital equipment and all taxes on drugs and preventive materials (TB, HIV and Malaria). Interventions are foreseen in all sectors, except agriculture. The PRSP notes progress in HIV awareness campaigns (original target reach 75% of districts by 2003; in 2001 all districts were covered). The plan refers to the establishment of a Tanzanian Commission on HIV/AIDS, which has been budgeted for in the PRSP along with specific actions. The education sector includes a specific position on HIV control (about 2% of the budget in 2002). The plan includes 19 priority interventions in relation to HIV/AIDS, which are spelled out and budgeted for 2001-2004.

*Negative:* While the budget of the TACAIDS is included (about 1% of the overall budget), the overall programme and budget allocated to HIV/AIDS is not visible. The plan assumes that costs are mostly incorporated in the budgets of the individual ministries and departments. In the future, the health sector will be following a basket funding. The link between the PRSP and the National strategic Multi-Sectorial MTP 1998-2002 is not yet visible.

*What next?* It is planned according to the report to develop a coherent framework for rural development, including issues such as HIV/AIDS. At a recent donor meeting, an increase of HIV/AIDS related effort was agreed upon.

## **10 Uganda** (Based on PEAP of 3/2000/PRSP Progress Report)

*What?* A brief synthesis of poverty reduction is provided based on the PEAP. It uses a framework which considers all levels of analysis and planning/intervention and gives long- and short-term horizons. The analysis looks at the different dimensions of poverty. It relates to AIDS and health. Targets are set for reducing AIDS.

*Positive:* The analysis of the PEAP is sharp and clear. Targets for the AIDS-response are matched by respective indicators, which included for monitoring. AIDS and population growth are treated as cross-cutting issues. The framework, which is used, makes planning and implementation transparent. A number of indicators are included for different PEAP objectives for tracking progress in AIDS control and in reducing vulnerability (e.g. access to land and water, education, quality of life).

*Negative:* Cross-sectoral links in the design and implementation of the PEAP in terms of AIDS control are not evident throughout. The costing of AIDS measures mainly refers to health and sector budgets. The IMF assessment notes deficits of gender aspects and the need to put greater emphasis on rural areas in implementing the PRS. It did not comment on the continued implementation of AIDS-related responses. However, it notes raising inequality (rural-urban, north-west of country?).

*What next?* Uganda is often cited as successful example for the early political commitment and – as a consequence - the development and implementation of a comprehensive HIV/AIDS response. The infection rate of pregnant women in West Uganda is declining since 1995. However, this decline is confined to urban areas and more pronounced for women with secondary school education<sup>84</sup>. Specifying interventions in rural areas and emphasising gender in the poverty-AIDS-interface could be important to make further progress in implementing the PRS.

---

<sup>84</sup> Kilian A. et al. "Reductions in risk behaviour provide the most consistent explanation for the declining prevalence of HIV-1 infection in Uganda." ("Verringertes Risikoverhalten ist die wahrscheinlichste Erklärung für rückläufige HIV-1-Infektionsraten in Uganda.") AIDS, 1999, 13:3, S. 391-398

**6 Zambia** (based on Interim-PRSP 7/2000, GTZ Donor Study, CSPR analysis)  
(recent NGO analysis is included; findings were not verified in Draft PRSP)

*What?* The preliminary document analysed the nature and extent of poverty, differentiating urban and rural poverty. It indicates severe poverty among small scale farmers and female-headed households. The stagnating agriculture sector is related to high levels of poverty. HIV/AIDS are dealt with among other diseases, such as malaria, cholera, and tuberculosis. AIDS is mentioned as a factor deepening poverty.

*Positive:* The diagnosis is broad and substantive. It includes social variables in the poverty analysis (e.g. lack of safety nets).

*Negative:* The analysis did not recognise the social and economic dimension of the HIV/AIDS epidemic. The underlying poverty factors are not linked with the vulnerability against AIDS and its spread. No indication was given how PRS and AIDS responses could reinforce each. In addition, the IMF assessment noted the inadequacy of institutions and programs to handle the scale of the problem.

*What next?* While is not clear, how civil society has impacted on the PRSP, progress from discussions as reflected in the preliminary PRSP, have to be noted. Analysis by civil society groups gives attention to gender, gender imbalances in decision making and in accessing social services. It strongly suggests to address causes of gender inequalities and to make gender analysis an integral part of policy analysis. HIV/AIDS, however, is again largely looked at a health issue. While the gender focus is highly relevant for addressing HIV/AIDS, it misses the chance to link gender, poverty, and AIDS.

The proposal to monitor the impact of HIV/AIDS on food security and the progress of AIDS responses should be included. Also, proposals to specifically include men in HIV/AIDS sensitisation, traditional structures and to emphasise community and rural development should be taken up. The donor study suggests that HIV/AIDS is a significant extent looked at as cross-cutting issue. Several donors address HIV/AIDS and gender at the same time. In addition to the national AIDS strategy, donor support is being coordinated. High investments in health, agriculture, education and other sectors are a good basis for a consolidated multi-sectoral response.

## **Annex 4: Sources**

### Poverty reduction policies and approaches

World Urbanisation Prospects: The 1996 Revision. UN, New York, 1996

Human Development Report 2000. UNDP, 2000

Die Kluft Überwinden - Wege aus der Armut. Arbeitskreis Armutsbekämpfung durch Hilfe zur Selbsthilfe. Bonn, 2000

Poverty Reduction - a Global Responsibility. Program of Action 2015 The German Government's Contribution Towards Halving Extreme Poverty World-wide. Federal Ministry for Economic Cooperation and Development (BMZ). Bonn, 2001.

The State of Food and Agriculture 2001. FAO, 2001

SADC Regional Human Development Report 2000. June 2001

Poverty Report. IFAD, 2001

World Development Report 2000/2001. Attacking Poverty. World Bank, 2001

OECD Entwicklungsbericht 2000. 2001 [www.oecd.org/](http://www.oecd.org/)

### PRSP process

What good can depth relief and PRSP do? The case of Zambia. Bread for the World Institute. Depth and Development Issues #5, April 2001.

PRSP Sourcebook CD-ROM: <http://www.worldbank.org/poverty/strategies/sourctoc.htm>

### Poverty and related research studies

Nelson Mandela Children's Fund. Paper by Sibongile Mthembu-Mkhabela, South Africa, to International Forum for Child Welfare (IFCW). Ireland, 2001

Rural Livelihood Strategies: Saving for Survival, Protection or Accumulation? The Case of Southern Province, Zambia. Workshop on Livelihood, Savings and Debt. Wageningen, 14-16 May 2001. Karin Verstralen, 2001

Eberlei, Walter. Institutionalisierte Partizipation in PRS-Folgeprozessen. GTZ Studie, 2001

Mayer, Kerstin, Schmidt Annette, and Schmitt Gerald. The Role of Participation in PRSP. The Point of View of German Technical Cooperation. GTZ, 2001

PRSP and related country documents

CAMEROON: Republic of Cameroon. Interim Poverty Reduction Strategy Paper. August, 2000.

Focus on Cameroon: how was it done? UNAIDS Toolkit, 2001. p. 26.

Dept reduction and HIV/AIDS control in Cameroon. Context, challenges and perspectives. UNAIDS, 2001. <http://www.onusida-aoc.org>

CHAD: DOCUMENT DE STRATEGIE NATIONALE DE REDUCTION DE LA PAUVRETE (Deuxième draft juillet 2001). REPUBLIQUE DU TCHAD

GUINEA: DOCUMENT INTERIMAIRE DE STRATEGIE DE LA REDUCTION DE LA PAUVRETE (10/2000). REPUBLIQUE DE GUINEE

KENYA: INTERIM POVERTY REDUCTION STRATEGY 2000-2003. Government of Kenya. August 2000.

MALAWI: INTERIM POVERTY REDUCTION AND GROWTH STRATEGY PAPER - A ROAD MAP. REPUBLIC OF MALAWI. August 2000

MADAGASKAR: INTERIM POVERTY REDUCTION STRATEGY PAPER. REPOBLIKAN'I MADAGASIKARA. November 20, 2000.

MAURITANIA: POVERTY REDUCTION STRATEGY PAPER (2001-2004). 2000 and Joint Staff Assessment of IMF/IDA of 1/2001.

MOZAMBIQUE: ACTION PLAN FOR THE REDUCTION OF ABSOLUTE POVERTY (2001-2005) (PARPA). REPUBLIC OF MOZAMBIQUE, April 2001

TANZANIA: PROGRESS REPORT. POVERTY REDUCTION STRATEGY PAPER. The UNITED REPUBLIC OF TANZANIA 2000/01. 8/2001.

DONORS AND GOVERNMENT MARGINALISE CIVIL SOCIETY IN THE CG PROCESS. FEMINIST ACTIVISM COALITION (FEMACT) c/o Tanzania Gender Networking Programme (TGNP). 09/2001

Uganda: PRSP Progress Report / UGANDA's POVERTY ERADICATION ACTION PLAN. SUMMARY AND MAIN OBJECTIVES (3/2000). Ministry of Fiananca, Planning and Economic Development. Kampala

UGANDA PRSP Progress Report Joint Staff Assessment. IMF/IDA, March 2001

ZAMBIA. Interim PRSP. MoFED, Zambia. July, 2000. Text + Annexes  
Assessment of Interim-PRSP by staffs of the IM and IDA. July, 2000. 5 p.

Rural Livelihood Strategies: Saving for Survival, Protection or Accumulation? The case of South. Prov. Zambia. By Karin Verstralen, FAO. April, 2001. 19 p.

Overview over Focal Sectors of Donor Programs in Zambia. By GTZ/BMZ. June 2001

Poverty Reduction Strategy Paper For Zambia. A Document Of The Civil Society For Poverty Reduction (Cspr). Executive Summary. 2001

### HIV/AIDS epidemic

Position Paper; HIV/AIDS Control. An answer to the spreading of the disease in developing countries (BMZ Aktuell Nr. 94), Bonn (currently being revised).

ILO: <http://www.ilo.org/public/english/protection/trav/aids/>

HIV/AIDS website for Africa: <http://www.hivafrica.org> (A new website for HIV/AIDS in Africa  
For more information <mailto:info@hivafrica.org>)

The National Strategic Framework for HIV/AIDS activities in Uganda (1998-2002):  
<http://www.aidsuganda.org/>

GTZ/MOH, UR of Tanzania, 2000. Hope for Tanzania: Lessons learned from a decade of comprehensive AIDS control in Mbeya Region (Part I and II).

HIV/AIDS policy documents: The Futures Group International, USA  
Tel: 860/633-3501 Fax: 860/657-3918 [j.stover@tfqi.com](mailto:j.stover@tfqi.com)

Zambia National HIV/AIDS Strategic framework 2000-2001. Zambia HIV/AIDS/STD/TB Council (Draft 1999)

The AIDS Epidemic. Status Report 2000. UNAIDS/WHO. Geneva, 2000

UNAIDS, 2000. Second generation surveillance for HIV: The next decade.  
WHO/CDS/CSR/EDC/2000.5  
UNAIDS/00.03E. WHO/UNAIDS

Declaration 3<sup>rd</sup> UN Conference on the Least Developed Countries, UN General Assembly, Brussels, 14-20 May 2001

UN General Assembly Special Session on HIV/AIDS. Final Declaration; Global Strategy Framework for Action; Discussion Papers. New York, 25-27 June 2001

State of the World's Children 2002. UNICEF reports for U.N. General Assembly Special Session on Children (scheduled for Sept 19-21, 2001).  
<http://www.unicef.org/media/sowc02presskit/fullreport.htm>

Responding to HIV/AIDS in the developing world: The GTZ contribution - overview 15 years of experience. GTZ Sector Project on HIV/AIDS Control. [www.gtz.de/aids](http://www.gtz.de/aids)

AIDS Epidemic Update. UNAIDS/WHO, December 2001

### The PRSP process and tools for incorporating HIV/AIDS and health

Considering HIV/AIDS in Development Assistance: A Toolkit prepared to assist staff of DGVIII and consultants (by Liese Fransen and Alan Whiteside). EU Commission, 1994.

Poverty Reduction Strategy Source book. World Bank (Vol.II Chap. 3.2 on Health 35 p. by M. Claeson et al. ). April 2001.

Rapid Guidelines for Integrating Health, Nutrition, and Population Issues in Interim Poverty Reduction Strategy Papers of Low-Income Countries (prepared by A. Soucat and A. Yazbeck). Worldbank. October, 2000.

AIDS, Poverty Reduction and Dept Relief. A Toolkit for Mainstreaming HIV/AIDS Programmes into Development Instruments. Worldbank / UNAIDS Best Practice Collection (by Olusoji Adeyi et al) Geneva, March 2001. 47 p.

Poverty and HIV/AIDS. Draft Policy Paper. (prepared by Els Klinkert, Social Policy Division, Social and Institutional Development Department. Ministry of Foreign Affairs. The Netherlands, 2001

UNAIDS Newsletter AIDS-Poverty & Dept Relief: [poverty-debtrelief@unaids.org](mailto:poverty-debtrelief@unaids.org)

UNAIDS Inter-Country-Team West-/Central Africa: <http://www.onusida-aoc.org/>

#### HIV/AIDS, health, other sectors and poverty

Considering HIV/AIDS in development assistance: A Toolkit. EU Commission, 1994.  
<http://europa.eu.int/comm/development/aids/toolkit/index.htm>

HIV/AIDS as a cross-sectoral issue for technical cooperation. Focus on agriculture and rural development. GTZ, Sector Project on HIV/AIDS Control, Eschborn, 1997

The Impact of HIV/AIDS on rural households/communities and the need for multi-sectoral prevention and mitigation strategies. By Erich G. Baier. FAO, Rome, 1997

Poverty and HIV/AIDS in Sub-Saharan Africa. Issues paper no. 27 (by Desmond Cohen). UNDP, New York, 1998. 11p.

HIV/AIDS in the Commercial Agricultural Sector in Kenya. Impact, Vulnerability, Susceptibility and Coping Strategies. By Gabriel Rugalema, Silke Wigang and James Mbwika. FAO/UNDP, 1999

HIV/AIDS Does it increase or decrease growth in Africa? By René Bonnel, World Bank ACTAfrica, November 2000. 25 p.

HIV/AIDS, poverty and development. Summary of meeting held at ODI 29 November 2000 (with A. Whiteside and T. Barnett) . <http://www.odi.org.uk/speeches/booth7.html>

Health and Nutrition Emerging and Reemerging Issues in Developing Countries: HIV/AIDS. By Anthony Barrett and Gabriel Rugalema. IFPRI Vision 2020, Focus 5, Brief 3, February 2001.

AIDS, Poverty Reduction & Dept Relief: Lessons Learned and Future Steps. Conference of African Ministers of Finance. Algier, 8-10 May 2001.

Becoming Poverty Focused: Implications for health actors. Health and Poverty in a Social Context. By Eleanor Fisher, Jeremy Holland and Sarah James commissioned by IHSD. The Society for International Development 44:1:22-30, 2001.

The impact of HIV/AIDS on Food Security. Committee on World Food Security 27<sup>th</sup> Session Rome 28 May - 1 June 2001. FAO, 2001

HIV/AIDS implications for poverty reduction. UNDP Policy Paper for the UN Special Assembly on HIV/AIDS. Prepared by Rene Loewenson and Alan Whiteside. June 2001. 27 p.

AIDS and poverty the links. By Alan Whiteside. AIDS Analysis Africa Analysing the Impact of the AIDS Epidemic on Organisations, Business and the Economy. Vol. 12 (2), 2001.

Poverty, Debt and AIDS - Mainstreaming the epidemic and mobilising additional resources. UNAIDS Department of Policy, Strategy & Research. By Robert Hecht, 2001.

What productive resources do the poor really need to escape poverty? IFPRI Vision 2020, Conference on Sustainable Food Security For All. Keynote by Michael Lipton. Bonn, 4-6. Sep. 2001.

Estimating the Economic Impact: Potential and Limits. African Development Forum 2001 9-13. December Addis Ababa. HIV/AIDS and Economic Development in Sub Sahara Africa. <http://www.uneca.org/adf2000/theme1.htm>

The impact on the world of work. Africa Development Forum 2000 HIV/AIDS IN AFRICA. Addis Ababa, Ethiopia – 3-7 December 2000. International Labour Office, Geneva

HIV/AIDS: A threat to decent work, productivity and development. Document for discussion at the Special High-Level Meeting on HIV/AIDS and the World of Work Geneva, 8 June 2000 International Labour Office Geneva (ILO)

Multi-Sectoral Responses to HIV/AIDS: Constraints and Opportunities for Technical Cooperation. Journal of International Development 12:85-99. By Günther Hemrich and Daphne Topuzis, 2000

Health in PRSPs. WHO Submission to WORLD Bank/IMF Review of PRSPs. Department of Health and Development. WHO, 2001

### Social aspects, gender and HIV/AIDS

What HIV/AIDS Can Do to Education, and What Education Can do to HIV/AIDS. Sub Sahara Africa Conf. on Education (Zambia). Johannesburg Education Conf. By M.J. Kelly, 1999. 17 p.

Women - The gender connection. HIV/AIDS Action in Developing Countries. Special Report Issue no 6: Gender and HIV/AIDS. EU Development Programme. June 2000

UNIFEM Briefing Paper, 2001. [www.reliefweb.int/IRIN/webspecials/hiv\\_aids/index.phtml](http://www.reliefweb.int/IRIN/webspecials/hiv_aids/index.phtml)

Good news for the poor? Social conditionality, participation and poverty reduction. By Whaites, 2000. World Vision, Milton Keynes, UK cited in IPHN Bullentin No. 6, July 2001.

Study on the impact of the spread of HIV/AIDS on the mortality of teachers in the Central African Republic (CAR). UNICEF, 2001

The impact of HIV/AIDs on Social Safety Nets: What can the Caribbean Expect? Annual Meeting Heads of Social Security, Jamaica. By Karl Theodore and Aothea Dianne La Foucade, 2001.