

The mounting impact



The mounting impact

Twenty years after the world first became aware of AIDS, it is clear that humanity is facing one of the most devastating epidemics in human history—one that threatens development in major regions of the world.

Since the 1960s, most countries have made impressive strides in human development. However, such achievements are being undermined as countries lose young, productive people to the epidemic, economies stumble, households fall into deeper poverty, and the costs of the epidemic mount. Despite this devastation, however, it is clear that the epidemic is still in its early stages.

Countries that fail to bring the epidemic under control risk becoming locked in a vicious circle as worsening socioeconomic conditions render people, enterprises and communities even more vulnerable to the epidemic. The impact of AIDS on societies and economies, however, can be dealt with. Whether through community action or national programmes, institutions can be retooled and capacity can be built to defend societies' from the worst ravages of AIDS.

The demographic impact

Since the epidemic began, more than 60 million people have been infected with the virus. HIV/AIDS is now by far the leading cause of death in sub-Saharan Africa, and the fourth-biggest global killer. In 2001, the epidemic claimed about 3 million lives.

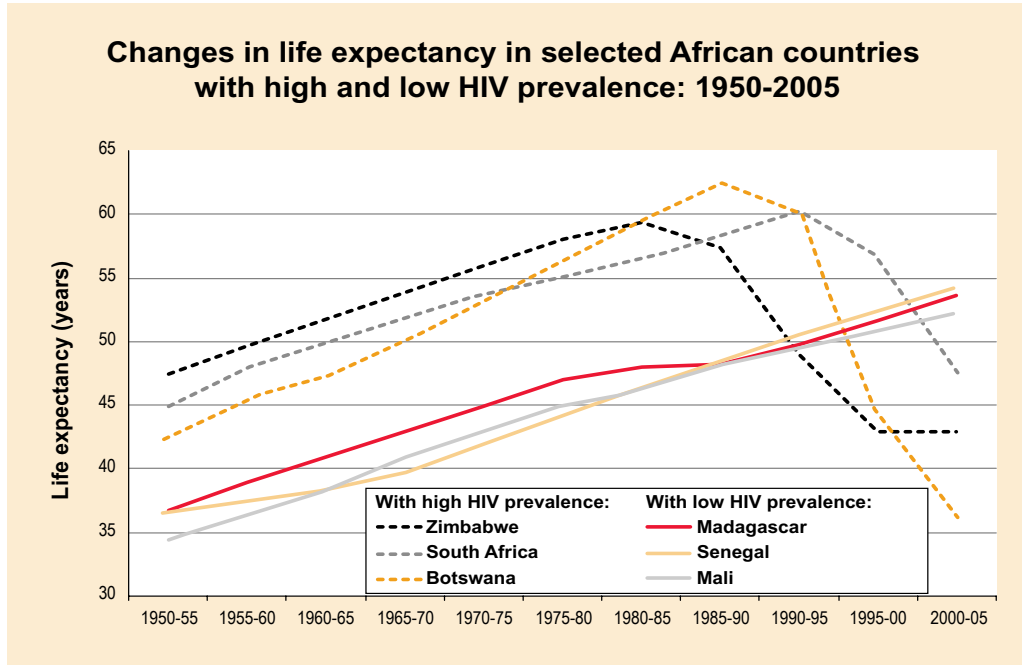
Life expectancy is still falling

In many countries, AIDS is erasing decades of progress made in extending life expectancies. Average life expectancy in sub-Saharan Africa is now 47 years, when it would have been 62 years without AIDS. Life expectancy at birth in Botswana has dropped to a level not seen in that country since before

1950. In other African countries, life expectancy has dropped less severely, but it is still significantly below what it would have been without AIDS. Figure 8 illustrates the steep drop in life expectancy in three high-prevalence countries, compared to the steady increase in countries with significantly lower HIV prevalence.

The impact of AIDS on life expectancy, which signifies a major blow to a society's development, has spread beyond Africa. Haiti's life expectancy in 2000–2005 is nearly six years less than it would have been in the absence of AIDS. In Asia, Cambodia has experienced a reduction of four years.

Figure 8

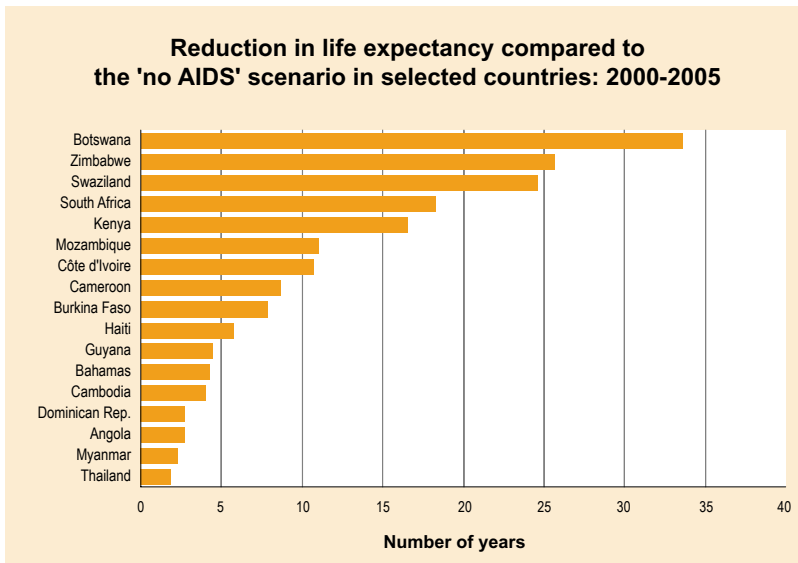


Source: UN Department of Economic and Social Affairs (2001) *World Population Prospects, the 2000 Revision*

Current HIV prevalence levels merely hint at the much greater lifetime probability of becoming infected with HIV. In Lesotho, for instance, it is estimated that a person who turned 15 in 2000 has a 74% chance of becoming infected

with HIV by his or her 50th birthday. Even relatively low prevalence today can mean high odds of contracting HIV. In Guyana, where adult prevalence is 2.7%, the probability of contracting HIV between the ages of 15 and 50 in 2000–2035 is 19%. High as they are, these estimates are conservative, and assume that HIV infection rates will decline in the future, as stronger prevention efforts bear fruit.

Figure 9



Source: UN Department of Economic and Social Affairs (2002) *World Population Prospects, the 2000 Revision*

The death toll rises

In the 45 most affected countries, it is projected that, between 2000 and 2020, 68 million people will die earlier than they would have in the absence of AIDS. These projections are based on the assumption that prevention, treatment and care programmes will have a modest effect on the growth and impact of the epi-

demic in most countries over the next two decades. The assumptions do not include a reduction in the annual number of newly infected people, which would result from vaccination with a possible future vaccine or from use of other possible future technological advances. Nor do they include the potential effect of large-scale future access to antiretroviral therapy on the survival of people living with HIV/AIDS.

The projected toll is greatest in sub-Saharan Africa, where 55 million additional deaths can

be expected—39% more deaths than would be expected in the absence of AIDS.

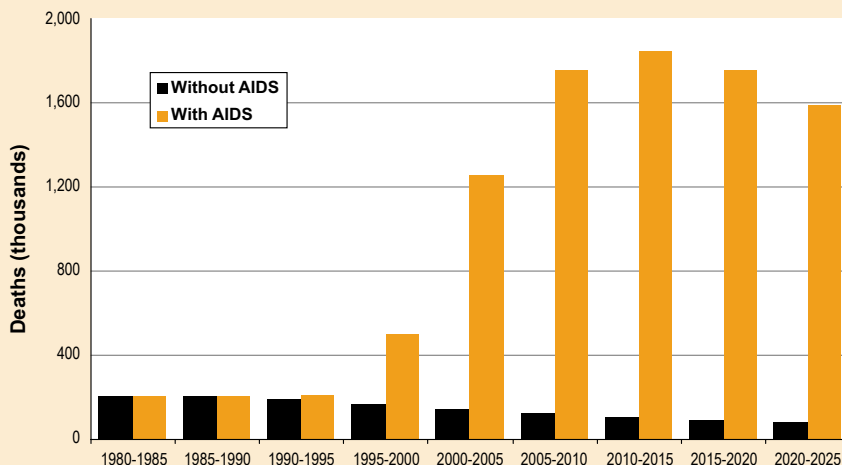
AIDS has a particularly strong impact on mortality among children between the ages of one and five. Most children who are infected at birth or through breastfeeding will develop AIDS and die before their fifth birthday. In the worst affected countries, HIV/AIDS has had a major impact on child survival. In seven countries in sub-Saharan Africa, under-five mortality has increased by 20–40% due to HIV/AIDS.

The future is not what it used to be

In the young democracy of South Africa, where HIV prevalence rose swiftly in the 1990s, the number of AIDS-related deaths among young adults is projected to peak in 2010–2015. It is estimated that there will be more than 17 times as many deaths among persons aged 15–34 as there would have been without AIDS, as Figure 10 illustrates.

Even in countries where the prevalence of HIV/AIDS is lower, the number of deaths among 15–34-year-olds is high in relation to the number that would have occurred in the absence of AIDS. Thus, it is approximately 2.5 times higher in the Bahamas and Guyana, and twice as high in the Dominican Republic and Thailand.

Figure 10
Estimated and projected deaths at ages 15-34, with and without AIDS in South Africa: 1980-2025



Source: UN Department of Economic and Social Affairs (2002) *World Population Prospects, the 2000 Revision*

Declaration of Commitment

By 2003, evaluate the economic and social impact of the HIV/AIDS epidemic and develop multisectoral strategies to: address the impact at the individual, family, community and national levels; develop and accelerate the implementation of national poverty eradication strategies to address the impact of HIV/AIDS on household income, livelihoods and access to basic social services [...] (paragraph 68).

United Nations General Assembly Special Session on HIV/AIDS, June 2001, New York

3

The impact on households

The toll of HIV/AIDS on households can be very severe. In many cases, the presence of AIDS means that the household will dissolve, as parents die and children are sent to relatives for care and upbringing. A study in Zambia revealed that 65% of households in which the mother had died had dissolved. But much happens to a family before this dissolution occurs; HIV/AIDS strips the family of assets and income-earners, further impoverishing those already poor.

In Zambia, AIDS has led to a rapid transition from relative wealth to relative poverty in many households. Research shows that, in two-thirds of families where the father had died, monthly disposable income fell by more than 80%. A study in Côte d'Ivoire revealed that income in affected households was half that of the average household income. This was often the result not only of the loss of income due to illness among household members, but also because other members had to divert more time and effort away from income-generating activities. A study of three countries (Burkina Faso, Rwanda and Uganda) has calculated that AIDS will not only reverse efforts to reduce

poverty, but will increase the percentage of people living in extreme poverty from 45% in 2000 to 51% in 2015. In Botswana, per capita household income for the poorest quarter of households is expected to fall by 13%, while every income-earner in this category can expect to take on four more dependents as a result of HIV/AIDS.

Loss of income, additional care-related expenses, the reduced ability of caregivers to work, and mounting medical fees and funeral expenses collectively push affected households deeper into poverty. According to a study in Côte d'Ivoire, health-care expenses rose by up to 400% when a family member had AIDS. The hardship does not end there. Studies in Thailand and the United Republic of Tanzania show that the financial burden of death can be far greater than that of illness. Households there have reported spending up to 50% more on funerals than on medical care. Traditions in many societies require that relatives and community members gather (sometimes for several days) at the home of the deceased to mourn and support the bereaved. In many cases, lengthy journeys are required to reach a burial place.

Three main coping strategies appear to be adopted among affected households. Savings are used up or assets sold; assistance is received from other households; and the composition of households tends to change, with fewer adults of prime working age in the households.

Tapping into savings and taking on more debt (often in the form of cash transfers or loans from extended family members and local community) are usually the first recourse by households that struggle to pay for medical treatment or funeral costs. In an ongoing study in the Free State Province of South Africa, households used up, on average, 21 months of savings to pay for medical expenses and funerals. In the United Republic of Tanzania, a case study has revealed that, in households where one person was ill because of AIDS,

29% of savings were redirected to cope with the illness.

As debts mount, precious assets, such as bicycles, livestock and even land, are sold. Once households are stripped of their productive assets, the odds of them recovering and rebuilding their livelihoods grow ever slimmer. A study in Chiang Mai, Thailand, revealed that 41% of AIDS-affected households reported having sold land, 57% used up their savings and 24% had borrowed from a cooperative or other type of locally-run fund. In response, many households restructure themselves: dependent children might be sent to live with relatives, or relatives may join the household to assist in household or farming tasks. One of the more unfortunate responses to a prime-age-adult death in poorer

Making a difference

Social protection programmes that support people, households and communities hard hit by the epidemic make a huge difference. Given the heavy burden the epidemic places on women as caretakers and breadwinners, new safety nets are needed. Microcredit schemes that take account of women's special needs can be important tools that also help make local social relations more equitable. Microfinance programmes, such as the African Microenterprise AIDS Initiative, have provided opportunities for women to operate business ventures and to fashion relatively autonomous livelihoods. This helps them to generate enough household income to organize their work schedules around HIV-related care demands. Equally valuable are subsidy and bursary initiatives that enable girls to attend school and pursue their education.

Extraordinary efforts are needed to provide for children orphaned by the epidemic, especially in the form of measures that afford them access to education, food, health care and other social support (see 'Focus: AIDS and orphans'). Chikankata Health Services, a church-based organization in central Zambia, is one of many projects that have stepped into that breach. Staff set up the Community-Based Orphan Support Project in 1995, with support from the United Nations Children's Fund (UNICEF), to offer educational and medical support to orphans from five communities. It now assists 1500 orphans, and facilitates local income-generating projects for other residents. In Malawi, meanwhile, the country's National Orphan Task Force developed guidelines for the care of orphans as early as 1992. Operating in the ambit of those guidelines are several initiatives that link nongovernmental and community-based organizations with government structures and district authorities as they plan and introduce orphan programmes. Government extension workers belong to Community Orphan Care Committees, and help communities set up or maintain small farming operations.

households is that of removing the children (especially girls) from schools as school uniforms and fees become unaffordable and the girls' labour and income-generating potential are required in the household.

Almost invariably, the burden of coping rests on women as the demands for their income-earning labour, household work, child-care and care of the sick multiply. As men fall ill, women often step into their roles outside the homes; in parts of Zimbabwe, women are moving into the traditionally male-dominated carpentry industry, for example. Despite the dependency on women at the household level, two studies in Côte d'Ivoire and Thailand (in the late 1990s) show that more money tends to be spent on health care for men who become ill with HIV/AIDS than on women.

Going hungry: the impact on food security

HIV/AIDS poses a potentially major threat to food security and nutrition, mainly by diminishing the availability of food (due to falling production, and loss of family labour, land, livestock and other assets) and reducing access to food as households have less money. Research in the United Republic of Tanzania has shown that individuals' food consumption dropped by 15% in the poorest house-

holds after the death of an adult. The prospect of widespread food shortages and hunger is real. Some 20% of rural families in Burkina Faso are estimated to have reduced their agricultural work or even abandoned their farms because of AIDS. In Ethiopia, AIDS-affected households were found to spend between 11.6 and 16.4 hours per week performing agricultural work, compared with a mean of 33.6 hours for non-AIDS-affected households.

With fewer people available to work in the fields, households often farm smaller plots of land or switch to less labour-intensive subsistence crops, which often have lower nutritional and/or market value. Although yields drop and incomes shrink, farming households may still cope, especially in areas where different crops can be planted throughout the year. Where one or two key crops must be planted and harvested at specific times of the year, however, losing even a few workers at the crucial planting and harvesting stages can scuttle production.

These kinds of difficulties are being experienced also in countries with lower national HIV prevalence rates and, in early 2002, they prompted the United Nations World Food Programme to coordinate a food donation scheme for families affected by HIV/AIDS in four Asian countries (Cambodia, China, Laos

Women are crucial to food security

Women contribute to over 50% of food production in sub-Saharan Africa and Asia, and typically carry out the most labour-intensive farming activities. In many regions, they are the linchpins of subsistence farming, which tends to be most vulnerable to the effects of HIV/AIDS. And they are also usually responsible for preparing food. Research carried out in Uganda in the 1990s showed that food insecurity and malnutrition ranked foremost among the immediate problems faced by many female-headed AIDS-affected households. These factors contribute to reduced consumption and less nutritious diets.

and Myanmar). A similar plan was being proposed for southern Africa. The World Food Programme has also run food security projects for women widowed as a result of AIDS (in Zambia).

Since nutrition requires an integrated approach to household food security, health and care, it forms a logical entry point for helping affected communities to cope with the epidemic. Securing the right of women and children to retain the land and assets of a

deceased husband/father, for example, helps households cope. Other remedies include promoting less labour-intensive crops that still serve as nutritious food sources, and setting up or expanding school-based feeding programmes. For example, UNICEF is extending the role of schools as community resource centres—an initiative that complements the World Food Programme's proposal that school-based feeding programmes include 'take-home rations'.

Early responses bring high rates of return

The most potent way to avert the devastating impact of HIV/AIDS is to act before the epidemic spins out of control. Calculations of the rates of return on Thailand's investments in HIV/AIDS prevention suggest that, in 1990–2020, the avoided medical expenditures alone would have meant rates of return in the order of 12–33% for that period. If averted income losses are added (as additional benefits that stem from the reduced numbers of AIDS deaths), the rate of return rises to 37–55%. Brazil's widely praised efforts to provide universal treatment and care, in addition to its well-planned prevention programmes, are estimated to have avoided 234 000 hospitalizations in 1996–2000.

The impact on the health sector

In all affected countries, the HIV/AIDS epidemic is bringing additional pressure to bear on the health sector. In countries where per capita health expenditure is low, extending prevention and care for sexually transmitted infections, counselling and testing, prevention of mother-to-child transmission services, and HIV treatment and care strains health budgets and systems. As the epidemic matures, the demand for care of those living with HIV/AIDS rises, as does the toll taken among health workers. In sub-Saharan Africa, the annual direct medical costs of AIDS (excluding antiretroviral ther-

apy) have been estimated at about US\$30 per capita, at a time when overall public health spending is less than US\$10 for most African countries. Even in high-income countries that appear to be holding the epidemic at bay, the pressure on health budgets and health insurance schemes is significant. At the turn of the century, the direct medical costs of treating HIV/AIDS patients in the European Union ranged from about US\$3400 per person annually, in the early stages of symptomatic HIV infection, to more than US\$50 000 in the latter stages of AIDS.

Health-care services face different levels of strain, depending on the number of people who seek services, the nature of the demands for health care, and the capacity to deliver that care. In the early stages, HIV-infected persons (often experiencing common bacterial infections) tend to use primary-health-care and outpatient services.

As HIV infection progresses to AIDS, there is an increase in total hospitalizations related to HIV/AIDS. The 2001 Swaziland Human Development Report estimated that people living with HIV/AIDS occupied half the beds in some health-care centres in that country. HIV prevalence among hospitalized patients was almost 33% in one Tanzanian hospital, making HIV infection the major cause of illness leading to hospitalization. In Zimbabwe, 50% of all inpatients in wards studied were infected with HIV. Without major interventions, the problem will worsen. The World Bank estimates that the number of hospital beds needed for AIDS patients could exceed the total number of beds available in Swaziland by 2004 and in Namibia by 2005.

Hospital occupancy rates, though, can underestimate the impact on health services, since hospitals in some areas might already be operating above capacity. Several studies have suggested that the epidemic is having a negative impact on the overall quality of care provided. A shortage of beds, for example, means that people tend to be admitted only at the later stages of illness, reducing their chances of recovery, as some Kenyan hospitals have discovered. Lengthy hospital stays are being reported in Botswana's hospitals, meanwhile, along with staff shortages and staff burnout. Up to 30% more time is being spent diagnosing and investigating cases that have grown more complex as the

epidemic intensifies. Demands for counseling have increased, while hospital expenses on drugs, linen, blood, and HIV and other tests have risen by up to 40%. Beyond the increased burden on hospitals and health-care facilities, there will be a significant increase in costs for basic health care as the epidemic expands. At the same time, the demand for health services is expanding and more health-care personnel are being affected by HIV/AIDS. Malawi and Zambia, for example, are experiencing 5–6-fold increases in health-worker illness and death rates. To compensate, the training of doctors and nurses would have to increase by an estimated 25–40% in 2001–2010 in southern Africa, for example. Increased workloads and stress might also spur emigration by health professionals. Recognizing the need to buttress the health sector, African leaders attending the Organization of Africa Unity's special summit on AIDS in April 2001 pledged to allocate 15% of their total annual budgets to health care.

The emergence of community-rooted home-care initiatives, often organized by people living with HIV/AIDS, have become one of the outstanding features of the epidemic and a key coping mechanism for mitigating impact. Although initiated by communities and often operating from a religious or non-governmental organization base, the effectiveness of home-based care depends on support from formal health, welfare and other social sectors. A recent exercise calculating the likely cost of providing home-based care and support countrywide in South Africa concluded that, while not cheap, it is an affordable option (see 'Treatment, care and support' chapter).

The impact on the education sector

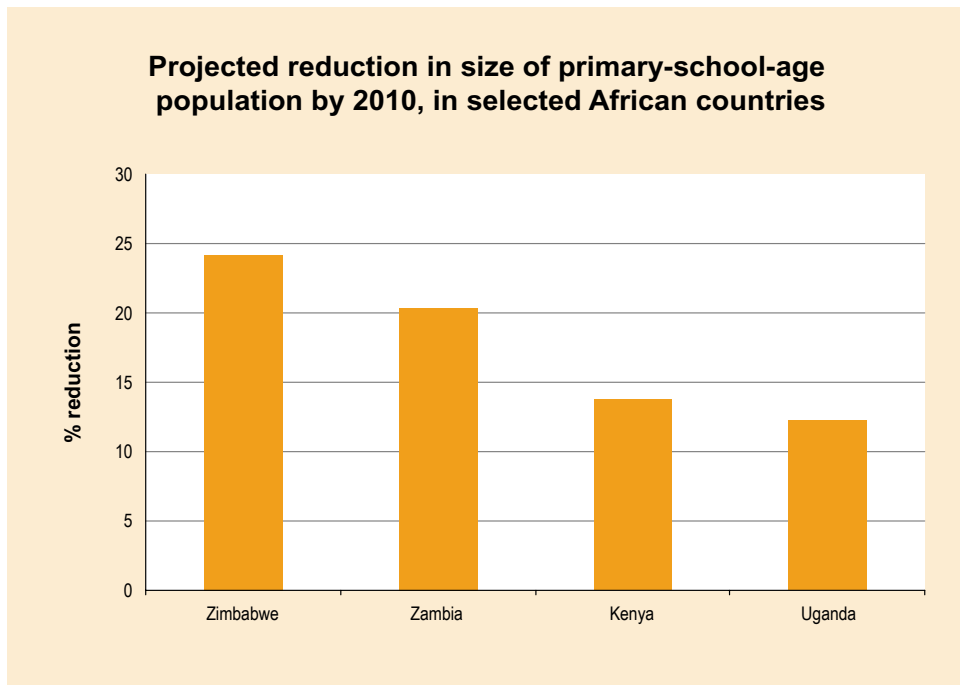
The extent to which schools and other education institutions are able to continue functioning (as part of the essential infrastructure of societies and communities) will influence how well societies eventually recover from the epidemic.

A decline in school enrolment is one of the most visible effects of the epidemic. The contributing factors include: the removal of children from school to care for parents and family members; an inability to afford school fees and other expenses; AIDS-related infertility and a decline in birth rate, leading to fewer children; and the fact that more children are themselves infected and do not survive through the years of schooling (see Figure 11).

According to research by the Health Economics and AIDS Research Division of the University of Natal in South Africa, for example, the number of pupils enrolling in the first year of primary school in 2001 in parts of KwaZulu-Natal Province was 20% lower than in 1998. Economic hardship was a major factor in this reversal, but the study also suggests that some children were not living long enough to enter school. In the Central African Republic and Swaziland, school enrolment is reported to have fallen by 20–36% due to AIDS and orphanhood, with girls most affected.

AIDS is also hampering the ability of education systems to perform their basic social mandates, as more teachers succumb to the disease. A recent study in Manicaland, Zimbabwe,

Figure 11



Source: World Bank, 2000

found that 19% of male teachers and almost 29% of female teachers were infected with HIV—almost exactly the same proportion as among working men and women in the general population. According to the South African Democratic Teachers Union, nationwide AIDS-related deaths among teachers rose by over 40% in 2000–2001, as calculated from claims to the union’s funeral plan between June 2000 and May 2001. Illness or death of teachers is especially devastating in rural areas, where schools often depend heavily on one or two teachers. Moreover, skilled teachers are not easily replaced. Swaziland has estimated that it will have to train 13 000 teachers over the next 17 years just to keep services at their 1997 levels—7000 more than it would have to train if there were no AIDS deaths.

While the loss of teachers and administrators directly affects the quality of education, there is also the danger that demands on the health and welfare services might divert resources

from education to other sectors. The costs associated with training new teachers and hiring substitute teachers will also strain budgets, crowding out investments in infrastructure, materials and human resources. Such improvements are especially necessary for countries aiming to compete in an increasingly knowledge-based world economy.

Among the efforts to avert such outcomes is the World Bank’s Ed-SIDA Initiative. Along with creating tools for proactive planning and management, the scheme trains education planners to model changes in the supply of, and demand for, education. Examples include making projections of teacher illness and mortality, calculating whether there will be sufficient teachers to meet education goals, and analysing the changing realities and needs of students. To date, planners from 10 African countries have participated in Ed-SIDA training, and the Initiative is being extended into other countries in sub-Saharan Africa.

Going beyond the obvious: adapting education

AIDS makes it necessary to devise new ways of turning education against the epidemic. School planners and policy-makers envision alternative forms of schooling, such as schooling structured around modules and semesters rather than around age-linked grades.

With a project in 11 African countries, the US Agency for International Development (USAID) helps schools emphasize classroom-based prevention, life-skill messages, as well as programmes for children who have dropped out of school to care for ailing parents or because they must work to support the household. Among the interventions is an interactive radio education programme that was piloted in Zambia in order to provide an education for orphans and vulnerable children. The AIDS Support Organisation (TASO)—a Ugandan group that has traditionally provided support for people living with HIV/AIDS—found that the major concern of parents caring for orphaned and vulnerable children was the costs associated with attending school. TASO now supports 232 primary, secondary and vocational education students by providing school fees and teaching materials. The programme also trains teachers in basic counselling skills and offers child/guardian workshops so that guardians and children have a forum for discussing, and finding solutions to, their problems. Calling on retired teachers offers another means of coping with education systems strained as a result of AIDS.

Impact on enterprises and workplaces

HIV/AIDS dramatically affects labour, setting back economic activity and social progress. The vast majority of people living with HIV/AIDS worldwide are between the ages of 15 and 49—in the prime of their working lives.

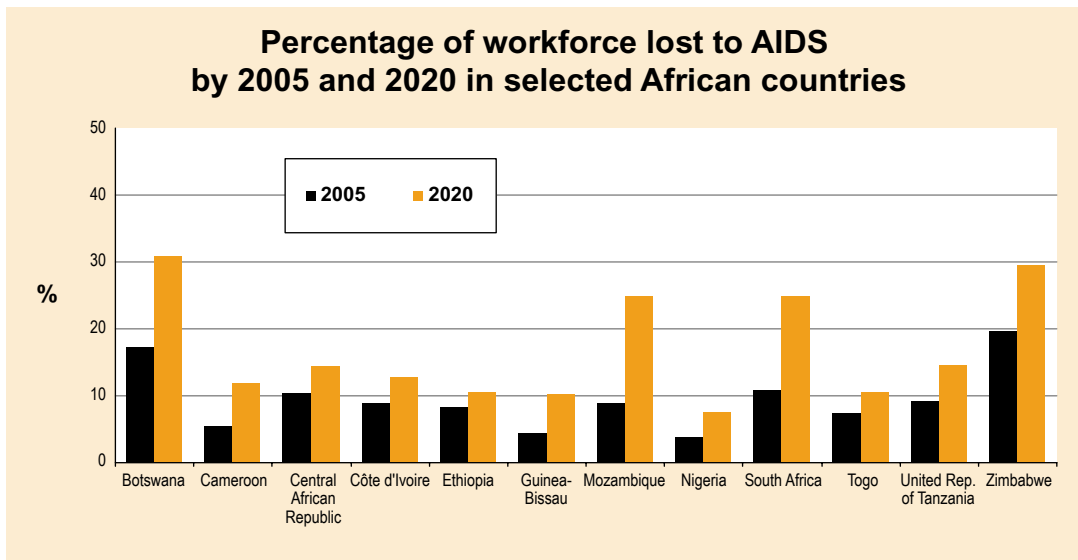
Productivity and profitability are core concerns for enterprises, large and small. AIDS weakens economic activity by squeezing productivity, adding costs, diverting productive resources, and depleting skills. In addition, as the impact on households grows more severe, market demand for products and services can shrink. The epidemic hits productivity mainly through increased absenteeism, organizational disruption, and the loss of skills and ‘organizational memory’. Rising absenteeism tends to push visible costs up while forcing productivity down, putting profits at risk. Production cycles can be dis-

rupted, equipment stands idle and temporary staff may need to be recruited and trained. Comparative studies of East African businesses have shown that absenteeism can account for as much as 25–54% of company costs. Quality control of products and services often suffers, which can erode the customer base.

A study in several southern African countries has estimated that the combined impact of AIDS-related absenteeism, productivity declines, health-care expenditures, and recruitment and training expenses could cut profits by at least 6–8%. NamWater, Namibia’s largest water purification company, has reported that HIV/AIDS was hindering its operation as absenteeism rose and productivity rates dropped.

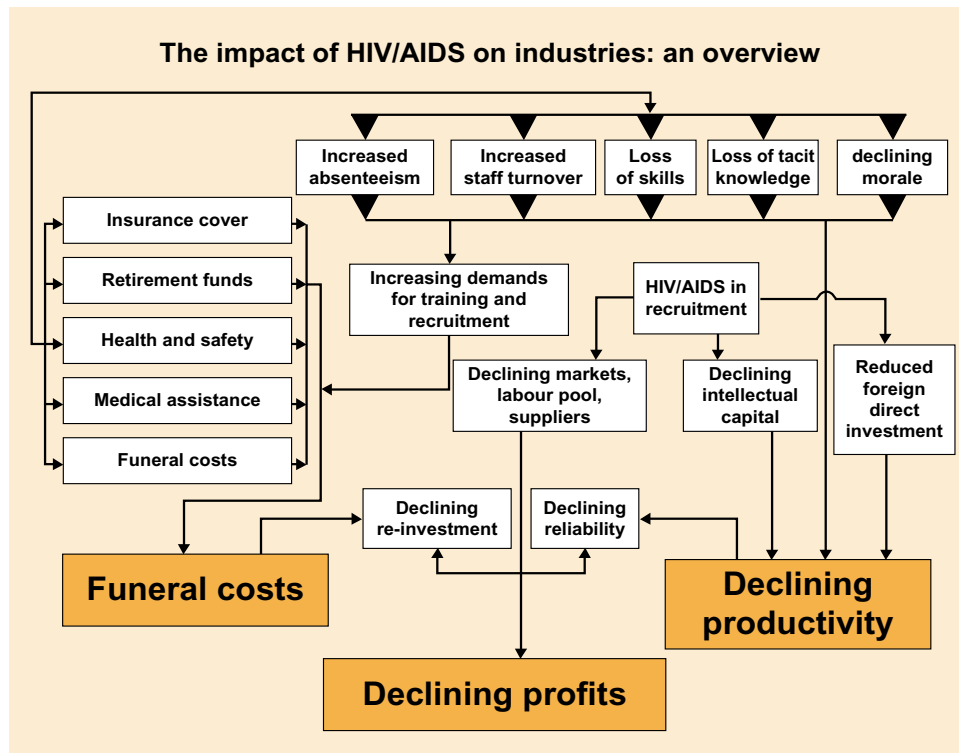
The impact on informal enterprises can be especially harsh. When the lead entrepreneur

Figure 12



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

Figure 13



Source: UNAIDS (2000) Adapted from *The Business Response to HIV/AIDS: impact and lessons learned*

is no longer able to work, there is a high risk that the entire enterprise will collapse.

High rates of absenteeism, morbidity and mortality trigger increasing disorganization in workforces, as a result of rising staff turnover, loss of skills, and weakened morale. A study of a bus company in Zimbabwe showed that AIDS-related absenteeism accounted for 54% of all AIDS-related costs, followed by HIV-related symptomatic illness at 35%. Loss of know-how tends to be the most often-cited cost factor on the shop floor. Thus, even in high unemployment areas (with an apparently 'bottomless' pool of unskilled or semi-skilled labour), the drain on visible and invisible skills and knowledge ends up being considerable. The ensemble of effects is illustrated in Figure 13. To respond to these problems, companies must invest in increased training and recruitment.

Company costs for health-care, funeral benefits and pension fund commitments are likely to rise unexpectedly as early retirements and deaths mount. A study of a commercial agricultural estate in Kenya showed that AIDS-related medical expenditure surpassed projected expenses by 400%. Funeral costs are also provided by a number of employers, especially in Africa, and these are rising sharply. However, these effects are not confined to countries of the South. In the United States of America, the Centers for Disease Control and Prevention has reported that firms with around 1000 employees found that the five-year cost to their business ranged from US\$17 000 to US\$32 000 for each worker with HIV. Supporting prevention programmes therefore makes good economic sense. Health-care provision is also a good investment since it limits or prevents sickness and absenteeism.

What can be done

In 1999/2000, Botswana's diamond mining company, Debswana, carried out an institutional audit to gain a more detailed picture of the epidemic's impact on the company and its operations. It discovered that retirements due to ill health and AIDS-related deaths had risen markedly. In 1996, 40% of retirements and 37.5% of deaths among workers were due to HIV/AIDS; by 1999, the proportion had risen to 75% and 59% respectively. Company hospitals were also recording more admissions of workers with HIV/AIDS-related conditions. A concerted response was called for.

The audit examined skill levels, ease of training and replacement of relevant skills, as well as the related costs. It analysed risk-reduction strategies for critical posts, estimating liabilities and costs associated with benefits, developing systems of productivity monitoring, and considering potential treatment options and costs. The result was a landmark policy to cover 90% of the cost of antiretroviral treatment for workers and their spouses, and to require suppliers of goods and services to the company to have AIDS programmes in place. In addition, prevention measures were given top priority.

Ignoring the potential impact?

Many enterprises still do not regard the epidemic as a major threat. Rapid assessments carried out by ILO in enterprises of various sizes and sectors surveyed managers' perceptions of the epidemic. In South Africa, while more than 60% saw the epidemic as a very serious threat at national level, only about 20% thought it seriously threatened

their enterprises. Of those employers alert to the problem (especially in the transport, mining and manufacturing sectors), most said it already affected productivity and the effects were visibly increasing costs. Although enterprises in trade and finance reported little visible impact on their health bills, most said they were affected by increased absenteeism (see 'Focus: AIDS and the world of work').

Macroeconomic impact: real but elusive

Through its impact on the labour force, households and enterprises, HIV/AIDS can act as a significant brake on economic growth and development. Reliable knowledge of the impact of HIV/AIDS on the national economy and its various sectors and participants is valuable for effective national strategic planning and necessary for strong advocacy.

A range of studies agrees that the net effect of the epidemic on per capita gross domestic

product (GDP) growth is negative and possibly substantial. For those countries with national HIV/AIDS prevalence rates of 20%, annual GDP growth has been estimated to drop by an average of 2.6 percentage points. More recent calculations have suggested that the rate of economic growth has fallen by 2–4% in sub-Saharan Africa as a result of AIDS. Meanwhile, nationally-focused studies have forecast that, by 2015, the economies

of Botswana and Swaziland would grow by 2.5 and 1.1 percentage points less, respectively, than they would have in the absence of the epidemic. Long-term scenarios developed for Mozambique indicate that AIDS would reduce gross domestic product and could discourage foreign and domestic investors.

By the beginning of the next decade, South Africa, which represents about 40% of sub-Saharan Africa's economic output, faces a real gross domestic product 17% lower than it would have been without AIDS. One study has forecast that South Africa's economy would grow 0.3–0.4% less annually in 2000–2015, than it would have in the absence of the AIDS epidemic. Research has also shown that, despite the fact that AIDS would have the most impact on relatively unskilled sections of the labour market, unemployment levels would remain largely unchanged. According to an annual investor survey by BusinessMap SA, the AIDS epidemic has increased the risk profile for investment in southern Africa. Investors now seek premium rates of return of 15–20% in South Africa and an even higher 25% or more in the rest of the region.

The economic impact is forecast to hit home on other continents, too. Research at the University of the West Indies has estimated that AIDS could cause an average 5% loss of GDP by 2005 in Jamaica and Trinidad and Tobago. One study has projected that gross domestic product in 2005 would be around 4.2% lower in the Caribbean than it would have been in the absence of the epidemic.

More research is required to achieve greater precision in the modeling of macroeconomic impact. It is particularly important to distinguish the impact of AIDS on weakening economies from other negative factors such as declining terms of trade, heavy debt burdens and the effects of structural adjustment, weak governance systems, political instability and conflict. Per capita calculations can also disguise and underestimate the human impact of AIDS. The epidemic kills people, as well as eroding economic productivity. In settings where informal economic activities (including subsistence agriculture) feature strongly, measured economic output only scratches the surface of the total impact of HIV/AIDS on livelihoods, food security, community welfare and the destinies of societies.

Security at risk

AIDS generates more demand for resources and services at all levels of society, while simultaneously weakening the underpinnings of the economy and the State. On the economic and development fronts, several of the worst-affected countries were already struggling with daunting development challenges, excessive debt burdens and declining terms of trade before the epidemic hit. This is most obvious in many sub-Saharan African coun-

tries, but is increasingly becoming the case in some countries of the former Soviet Union where socioeconomic setbacks have accompanied economic restructuring. HIV/AIDS is exacerbating these frailties in numerous ways. If effective responses are not introduced and the epidemic is allowed to grow unchecked, its multiple effects could cascade across society, heightening the risk of insecurity, as policy-makers are now beginning to discover.

Recognizing the security implications of HIV/AIDS, the UN Security Council made history in January 2000, when, for the first time, it debated a health issue. By subsequently adopting Resolution 1308 (2000), it highlighted the potential threat the epidemic poses for international security, particularly in conflict and peacekeeping settings.

Chain reaction

In any country, stability and progress depend on social cohesion. Citizens need to trust the rule of law, they need to believe that the State protects their most basic interests, and they need to know that they and their children can look forward to improved standards of living. The AIDS epidemic weakens many of these pillars of social cohesion. This is because HIV/AIDS, along with other factors (such as conflict and economic stagnation), can have a destructive effect on human security (i.e., on people's right to safety from the threats of hunger, disease and repression). This is especially important in light of the fact that many countries in both the region with the fastest growing epidemic (Eastern Europe) and the region with the highest national HIV prevalence rates (sub-Saharan Africa) are fledgling democracies, where restructured State bureaucracies are trying to foster the trust of citizens.

In many of the countries worst affected by HIV/AIDS, States' capacities to support households have suffered in the past two decades. By adding further pressure to national budgets and by weakening State institutions, the epidemic makes it even more difficult for the State to perform one of its primary duties: protecting citizens from human suffering, including hunger, disease and destitution. The epidemic does not spare the educated

and skilled personnel who administrate and manage State and other large institutions. In Zambia, nearly two-thirds of deaths among managers have been found to be attributable to AIDS, while an ING Barings study has forecast that 23% of South Africa's skilled workforce will be HIV-positive by 2005. As the provision of essential services falters (most obviously in health, education, welfare and justice) the poor and most vulnerable households endure the worst of the consequences. Even where traditional or new, locally-based social safety nets manage to hold, the failure of the State to adequately support these community-driven coping systems can dent its legitimacy.

The epidemic's potential impact on the rule of law is especially important. Although statistics are hard to come by, attrition rates among staff serving in law and order institutions in high-prevalence countries appear to be on par with those in other sectors (such as education and health). In Kenya, for example, it is estimated that AIDS accounts for up to three-quarters of all deaths in the police force (see 'Prevention' chapter). The sector also includes judges, prosecutors, court clerks and lawyers—all players in maintaining the rule of law and sociopolitical stability.

A State less able to provide social services (be they education, health or justice) may unwittingly foster political alienation and weaken its own political legitimacy. Through its impact on both State and community capacity, AIDS can thus contribute to social disruption and perhaps even civil unrest. Such disruption invariably hurts the most vulnerable sections of society. Children orphaned as a result of AIDS, for example, are left especially vulnerable in such circumstances and, in some settings, can be lured into military/paramilitary

activities with the prospect of 'family' bonds and the promise of food and consumer commodities.

But not all is gloom. In many countries, the epidemic is provoking new forms of mobilization as social networks and organizations emerge to confront AIDS and this, in turn, is invigorating civil society, as this report shows. Community-based support networks are mobilizing themselves around the epi-

demic, and social rights groups are advocating treatment access, protection of human rights and improved socioeconomic conditions. The initiatives mounted by community and other popular forces (and supported by the State and private sector) have proved crucial in those countries battling the epidemic. In all these cases, people have chosen to act not on the basis of fear and denial, but of compassion and solidarity.

Breaking the cycle

Given the uniquely devastating impact of HIV/AIDS on households, communities and entire societies, national policies and poverty-reduction strategies need to be adjusted and expanded accordingly. Unless this happens, AIDS will continue to erode human development achievements, deepen poverty, and further hinder access to education, health and viable livelihoods.

Building human capacity to respond to HIV/AIDS

However carefully compiled and tallied, data can only hint at the epidemic's human impact, whether at the global, societal, familial or individual level. Mobilizing and building the

human capacity to cope with, and overcome, the effects of HIV/AIDS is therefore an essential part of an effective response.

Often, circumstances have led policy-makers and social leaders to enlist community members as leaders of initiatives, rather than positioning them at the receiving end as mere 'beneficiaries' or 'clients'. In Zambia, for example, a National Facilitation Team has been formed to ensure that local responses are nurtured and expanded. Participating members of the Team are drawn from national and local networks and organizations that are keen to develop human capacity as part of their response to HIV/AIDS. The Team is developing innovative ways of transferring knowledge,

Declaration of Commitment

By 2003, integrate HIV/AIDS prevention, care, treatment and support and impact-mitigation priorities into the mainstream of development planning, including in poverty eradication strategies, national budget allocations and sectoral development plans (paragraph 38).

United Nations General Assembly Special Session on HIV/AIDS, June 2001, New York

enabling networks and organizations to learn from local experiences. Facilitating the Team's work are the Community Health Association of Zambia and the Salvation Army, with support from UNAIDS.

Within the education sector, HIV/AIDS has taken its toll on both teachers and pupils. The United Nations (UNICEF, UNESCO, WHO and the World Bank) began the FRESH (Focus Resources on Effective School Health) Partnership, which collaborates with education trade unions affiliated with Education International, ministries of education and teachers' associations, to help strengthen the capacity of teachers to both reduce their own HIV risks and provide HIV/AIDS-related prevention services to their students. Only by directly confronting the issues of teacher shortages and student risks will the two-sided crisis within the education sector be addressed.

In the Caribbean—the second-most affected region in the world—moves are under way to boost the human capacity to cope with the care-related needs generated by the epidemic. Formed to help meet these needs is the Caribbean HIV/AIDS Regional Training network. It aims to involve communities and individuals directly affected by HIV/AIDS in the training of service providers. Countries that have demonstrated strengths in certain areas of service will serve as hubs for training initiatives among neighbouring States. The goal is to further strengthen local capacity, rather than relying on temporary human resources imported from elsewhere.

Defending public services and democratic governance

Special efforts are needed to ensure the maintenance of essential public services. Equitable

access to essential public services is vital, which makes the abolition of user fees for basic services for poor people all the more urgent. The impact of HIV/AIDS on public services must be taken into account in terms of both the increased demand and the reduced capacity to deliver. Replacing skilled professionals is a priority, especially in low-income countries where governments depend heavily on a small number of policy-makers and managers for public management and core social services.

In Malawi, for example, the government has launched a major review of the impact of HIV/AIDS on human resources in the public sector and is preparing to introduce measures to maintain productivity and ensure support to employees affected by the epidemic. The government is considering setting up a system to better track morbidity, mortality and absenteeism in public services, as well as establishing a fund to help staff meet funeral costs and ensure fast-track training and recruitment of replacement staff. It is also adjusting human resource management policies to ensure that essential services are not disrupted, and is stepping up workplace prevention and care activities.

Intensified poverty reduction

Social and economic development strategies that are adapted to the unique challenge of HIV/AIDS are most likely to reduce poverty. For countries affected by AIDS, sustainable poverty reduction is not easily achieved unless macroeconomic policies, too, are geared towards:

- reducing inequalities;
- enhancing access to productive resources for wider segments of the population;

- increasing the discretionary budget (by, for example, reducing debt burdens);
- improving public expenditure on essential services, such as health education and provision of safe water;
- boosting employment opportunities; and
- strengthening social systems and infrastructures.


These are not new issues: AIDS simply makes them more urgent.

Initiatives such as the poverty-reduction strategies required for debt-relief schemes are more likely to yield lasting benefits if they feature commitments and targets specifically related to HIV prevention and care, as well as impact mitigation. These targets could include enhanced access to essential services for AIDS survivors (especially orphaned children), as well as greater food security. In Burkina Faso, for example, the Poverty Reduction Strategy Paper required for receiving debt relief includes HIV/AIDS as an important priority. Consequently, the government has decided to allocate part of its debt-relief savings towards HIV/AIDS prevention and support, providing additional resources and ensuring that the response to HIV/AIDS becomes a central part of the country's development agenda. Uganda's national Poverty Eradication Action Plan focuses especially on alleviating the impact of HIV/AIDS on households and communities. Resources from the country's Poverty Action Fund are channelled

down to district and village level; there, they support surviving members of households affected by the epidemic through income-generating activities, microcredit programmes, training and improved access to schooling for orphans.

A more equitable global system

Many of the world's more marginalized countries also need long-term international solidarity, cooperation and financial support. More equitable investment and trade flows can help ensure that global economic progress also profits the world's poor. So, too, could higher levels of Official Development Assistance in support of poverty-reduction strategies and improvement of social services. Since 1990, official development assistance provided to the 28 countries with the highest adult HIV prevalence rates (more than 4%) have fallen by a third (see 'Meeting the need' chapter).

Admirable and potentially decisive steps have been taken in the past two years towards bringing HIV/AIDS under control. Evident for the first time is widespread political recognition of the crisis, along with the commitment to confront it. Dozens of AIDS strategies have been introduced or are being finalized. New partnerships are being forged, with local community organizations, as always, playing pioneering roles. Still, against the backdrop of havoc created by this epidemic, it is equally clear that much more needs to be done, without further delay. 

Focus:

AIDS and human rights

3 In a world of AIDS, the lack of human rights protection can become a matter of life and death. Conversely, safeguarding those rights can enable people to avoid infection or, if already infected, to cope more successfully with the effects of HIV/AIDS.

HIV/AIDS has burrowed deeper into the social and economic fault lines of communities and societies, and it is widening those fissures further. Around the world, those most affected by HIV/AIDS are people and communities who have unequal access to fundamental social and economic rights. The denial of basic rights limits people's options to defend their autonomy, develop viable livelihoods and protect themselves, leaving them more vulnerable to both HIV infection and the impact of the epidemic on their lives.

It is therefore necessary to assess the epidemic in the context of human rights. Viewing the epidemic in this way also brings into sharper relief some of the prerequisites for an effective response: integrating principles, norms and standards as established in existing inter-

national human rights instruments, and using national and international rights institutions to realize these rights. Ghana's HIV/AIDS National Strategic Framework, for example, now has a chapter on creating an enabling environment, which identifies strategies for addressing human rights, as well as legal and ethical issues. Principles of non-discrimination are integrated into the strategy, which also prohibits mandatory testing.

Human rights that relate critically to reducing vulnerability to HIV/AIDS and mitigating the impact of the epidemic are found in existing human rights instruments, such as the Universal Declaration on Human Rights, the Covenant on Economic, Social and Cultural Rights, the Covenant on Civil and Political Rights, the Convention on the Elimination of all Forms of Discrimination against Women, and the Convention on the Rights of the Child.

Principles of non-discrimination, equality and participation are central to an effective HIV/AIDS strategy that integrates human

Declaration of Commitment

By 2003, enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by, people living with HIV/AIDS and members of vulnerable groups (paragraph 58).

United Nations General Assembly Special Session on HIV/AIDS, June 2001, New York

Table 2

Some key human rights principles	HIV/AIDS-related action	Relevant human rights instruments
The right to the highest attainable standard of physical and mental health	Ensure that HIV-prevention tools and services (such as treatment for sexually transmitted infections, provision of male and female condoms, and voluntary counselling and testing) are available, together with drugs for opportunistic infections, pain and suffering, and antiretrovirals. Ensure provision of the necessary health infrastructure and personnel.	<ul style="list-style-type: none"> • Article 25 of the Universal Declaration on Human Rights • Article 12 of the International Covenant on Economic, Social and Cultural Rights • Article 12 of the Convention on Elimination of all Forms of Discrimination against Women • Articles 24 and 25 of the Convention on the Rights of the Child
The right to information and education	Provide information and education relating to sexual health and HIV prevention.	<ul style="list-style-type: none"> • Article 19 of the Universal Declaration on Human Rights • Article 17 of the International Covenant on Civil and Political Rights • Article 37 of the Convention on the Rights of the Child
The right to privacy	Ensure that counselling and testing are voluntary, and that HIV test results are confidential; guarantee the right of non-disclosure to third parties.	<ul style="list-style-type: none"> • Article 12 of the Universal Declaration on Human Rights • Article 17 of the International Covenant on Civil and Political Rights • Article 37 of the Convention on the Rights of the Child
The right to share in scientific advances and their benefits	Ensure wider access to basic pain prophylaxis and antibiotics for the treatment of sexually transmitted infections and HIV-related conditions, as well as to HIV/AIDS-related treatment and therapies.	<ul style="list-style-type: none"> • Article 27 of the Universal Declaration of Human Rights • Article 15 of the International Covenant on Economic, Social and Cultural Rights

rights. More specifically, the most relevant human rights principles for protecting the dignity of people infected and affected by HIV/AIDS, as well as preventing the spread of infection, include: non-discrimination; the right to health; the right to equality between men and women; the rights of children; the right to privacy; the right to education and information; the right to work; the right to marry and found a family; the right to social security, assistance and welfare; the right to liberty; and the right to freedom of movement.

In the context of HIV/AIDS, governments have the obligation to respect, protect and fulfil human rights. A framework of accountability exists through the series of international instruments established over the past 50 years. Indeed, the past two years have seen wider recognition of HIV/AIDS-related interpretations of human rights frameworks:

- *General comment 14 on the right to Health* (May 2000), adopted by the Committee on Economic, Social and Cultural Rights, situates several key features of the right to health within the context of HIV/AIDS. These include the

availability and acceptability of, and access to, functioning public health-care facilities, goods and services, and programmes.

- *The UN Commission on Human Rights Resolution 2001/33 on 'Access to medication in the context of pandemics such as HIV/AIDS'* recognizes that access to medication in the context of epidemics such as HIV/AIDS is fundamental to achieving the full realization of the right to the highest attainable standard of physical and mental health. The resolution calls upon States to pursue policies that promote the availability of HIV/AIDS-related medications in sufficient quantities and in ways that make them accessible to all.

Furthermore, the integral link between HIV/AIDS and human rights was recognized at the United Nations General Assembly Special Session on HIV/AIDS in 2001.

The international human rights framework provides a solid basis for individuals and organizations to drive home their demands for change and action, to claim and exercise their rights, to resist exclusion and marginalization, and to struggle for social justice.

Realizing rights

Unequal access to life-saving HIV treatments is a glaring human rights issue. It also affects the degree of stigma that persists, since HIV-related stigma and discrimination are largely due to the fact that HIV/AIDS is seen as incurable. Increasing access to medications therefore not only helps to realize the right to health and overcome inequities due to poverty it also changes attitudes.

Deploying rights principles, norms and standards, activists have won ground-breaking victories on this front.

In Costa Rica, local nongovernmental organizations helped a HIV-positive college student file a petition with the Supreme Court demanding combination therapy, which he could not afford. The court ruled in his favour,

triggering a dozen similar petitions. Within weeks, the national social security system was ordered to develop a plan for the provision of antiretroviral treatment to all citizens living with HIV/AIDS.

In Venezuela, Acción Ciudadana Contra el SIDA, together with health professionals, lawyers and AIDS activists, filed a suit in 1997 on behalf of a group of people living with HIV/AIDS who were covered by the Social Security

System. The lawsuit alleged that the claimants were not receiving proper medical attention, as guaranteed by the National Constitution, the American Convention on Human Rights, and other conventions signed and ratified by Venezuela. The court upheld the lawsuit and ordered the Social Security System to provide free treatment to the plaintiffs. Countries in other regions are beginning to follow these examples as they move to realize the rights of people living with HIV/AIDS.

Protecting people at risk and those who are vulnerable

Groups affected by societal discrimination include women and children and, in many places, racial and ethnic groups, migrants and refugees. Other groups suffer discrimination because the activities they engage in are subject to criminal sanctions or social disapproval. Such people include those with different sexual orientations, as well as sex workers, drug users and prisoners (see 'Focus: AIDS and mobile populations' and the 'Prevention' chapter). For example, globally, a significant share of HIV infection occurs in male-to-male sex. Yet, dozens of countries still maintain laws that explicitly prohibit or regulate same-sex sexual relations. The effect is often that of stripping men who have sex with men of vital rights (including the right to access information and services that can protect them from the virus), leaving them highly vulnerable.

Around the world, women's enhanced physiological risk of HIV infection is compounded by economic deprivation, lack of employment opportunities, poor access to education, training and information, and sociocultural norms and practices. In sub-Saharan Africa,

for example, prevalence among teenage girls in some countries is five times higher than that for teenage boys. Most of these infections occur as a result of unprotected heterosexual intercourse. Women's low economic and social status limits their power to negotiate the use of a condom, discuss fidelity with their partners, or leave risky relationships. Such disempowerment increases their vulnerability to HIV; the socioeconomic and sexual discrimination thus experienced by women can ultimately become life-threatening.

Research underscores these realities. In a study in Viet Nam, only 35% of women felt able to refuse their husbands sex, while a UNIFEM study on the impact of HIV/AIDS on communities in Zimbabwe revealed that, even if women were educated about HIV/AIDS, their economic dependence on men left them feeling 'helpless' to negotiate safe sex.

Sexual coercion and violence in all its forms, inside and outside marriage, in peacetime and in conflict, increase the threat of HIV infection for women and girls. In population-based

studies worldwide, 10–50% of women report physical assault by an intimate partner, and between one-third and one-half of physically abused women also report sexual coercion.

Indigenous women, refugees and displaced women, women of certain religious groups, women in migration and trafficked women are also among those most vulnerable, with the attendant HIV/AIDS risks. The impact of war on women and young girls can be particularly severe, with the relatively recent

experiences of Bosnia, Croatia and Rwanda revealing again how rape and other forms of sexual abuse are frequently used as weapons of war.

Policies that reduce people's vulnerability and make it easier for them to choose safer behaviour are vital for an effective AIDS response. Income-generation schemes, improving women's employment opportunities and microfinance schemes are among the potential options for boosting women's economic

Fighting AIDS discrimination

The protection of human rights is critical to reducing the impact of the epidemic on people living with HIV/AIDS. Historically, AIDS discrimination was first witnessed in the victimization of seropositive individuals and in the intolerance and social ostracism inflicted on them. While these abuses regrettably still occur in all countries, responses based both on humanitarian and pragmatic considerations have been developed, and the list of successful HIV/AIDS-related human rights activism efforts has grown impressively.

In Mumbai, India, for example, the Lawyers Collective has successfully defended workers who lost their jobs on account of their HIV status. The Collective also raises public awareness about HIV/AIDS through public rallies, and mobilizes public opinion against stigma and discrimination. One of its significant achievements has been the upholding of a clause that allows people with HIV/AIDS to file their cases under a pseudonym. In New Delhi, meanwhile, the Population Council is helping set up HIV-Patient-Friendly Hospitals. The goal is to make hospitals more attuned to the needs of people with HIV/AIDS.

And in South Africa, the Centre for the Study of AIDS at the University of Pretoria is working to foster a climate for a sustained and effective response to HIV/AIDS on the campus and in society in general. By placing the epidemic in a human rights context, and by challenging stigma, discrimination, racism and prejudices, the University hopes to enable staff and students to freely disclose their HIV status, should they wish to do so. Students receive training in all aspects of HIV/AIDS and are actively supported in their efforts to counter HIV/AIDS-related stigma and discrimination in their communities.

National human rights institutions in Ghana, India and South Africa have launched activities that promote and protect HIV/AIDS-related human rights in their countries. Legislators are also advancing HIV/AIDS-related human rights. The United Kingdom Westminster All-Party Parliamentary Group on HIV/AIDS, for example, held public hearings in 2001 to identify legal and policy reforms to be introduced in the next five years. At a regional level, the Southern African Development Community (SADC) Parliamentary Forum has set up a Standing Committee on HIV/AIDS, which is developing strategic work plans to address HIV/AIDS-related issues.

independence. Among many such initiatives are those of ILO, which is strengthening microfinance and entrepreneurial skills among women in Malawi, Mozambique, the United Republic of Tanzania and Zimbabwe (and integrating AIDS education into the programme).

Evidence in relation to condom negotiation, voluntary counselling and testing, and the uptake of interventions to prevent HIV transmission from mother to child points in the same direc-

tion: women's empowerment and safety depend also on changes in the attitudes and deeds of men and boys. The 2000–2001 World AIDS Campaign was aimed at involving men (particularly young men) more fully in the fight against AIDS. The Campaign, with its slogans, 'Men Make a Difference' and 'I Care... Do You?' highlighted how harmful gender roles make men and women more vulnerable to HIV, and how men could make positive contributions to the fight against the epidemic.

Beyond stigma and discrimination

Widespread HIV/AIDS-related stigma and discrimination persist (see Figure 14), despite the fact that they increase people's vulnerability and, by isolating people and depriving them of care and support, worsen the impact of infection. Indeed, they impede every step in an effective response, from prevention, to treatment, care and support, and even extend into the next generation, placing an emotional burden on children who may also be trying to cope with the death of their parents, due to AIDS.

But stigma and discrimination do not arise in a vacuum. They emerge from, and reinforce, other stereotypes, prejudices and social inequalities, including those relating to gender, nation-

ality, ethnicity and sexuality, as well as activities that are criminalized (such as sex work, drug use or male-male sex). Stigma, discrimination and human rights violations form a vicious circle, legitimizing and spurring each other.

With its focus on stigma and discrimination, the 2002–2003 World AIDS Campaign aims to spur action against stigma and discrimination, as part of worldwide efforts that include:

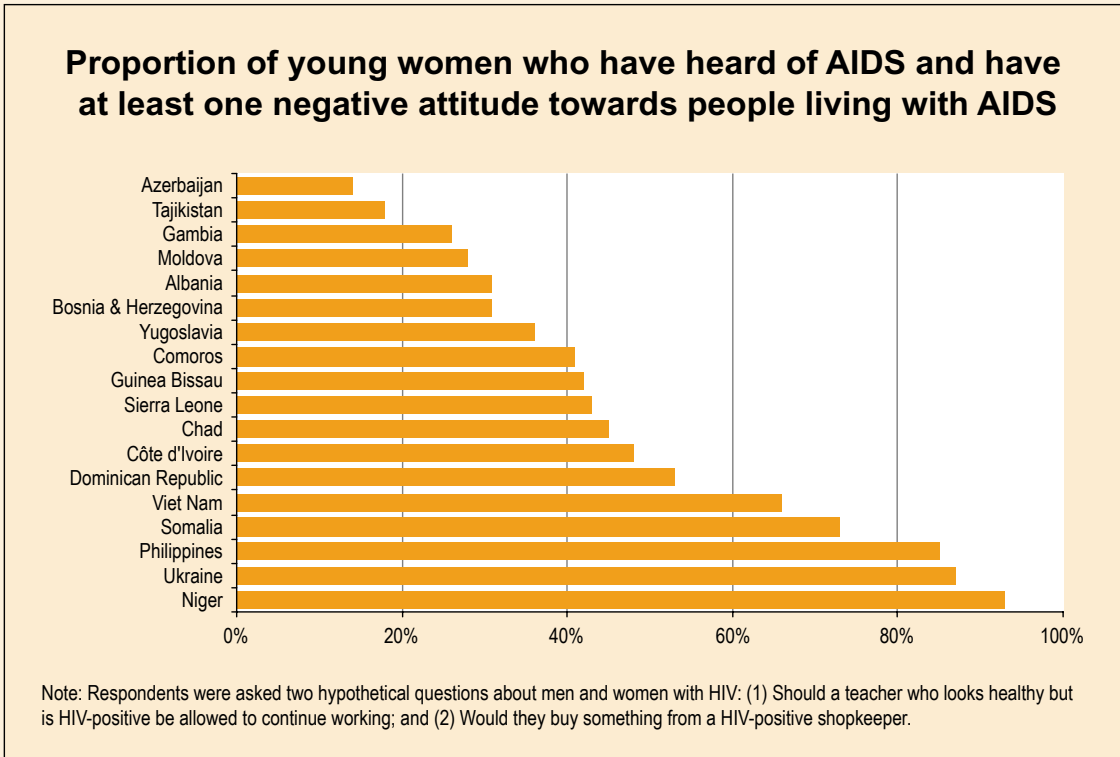
- encouraging leaders at all levels, and in all walks of life, to visibly challenge HIV-related discrimination, spearhead public action and act against the many other forms of discrimination that people face in relation to HIV/AIDS;

Declaration of Commitment

By 2005, ensure development and accelerated implementation of national strategies for women's empowerment, promotion and protection of women's full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls (paragraph 61).

United Nations General Assembly Special Session on HIV/AIDS, June 2001, New York

Figure 14



Source: UNICEF (1999-2001) Multi-Indicator Cluster Surveys

- actively involving people living with HIV/AIDS in the response to the epidemic;
- monitoring violations of human rights, and ensuring that people are able to challenge discrimination and receive redress through national administrative, judicial and human rights institutions designed to safeguard rights;
- creating an enabling legal environment for fighting discrimination; and
- ensuring that prevention and treatment, care and support services are accessible to all.

An effective, long-term response to the epidemic hinges on the recognition and protection of people's rights. Individuals and communities who are able to realize their

rights to information, education, health and health care, and who are protected against discrimination and violence, are less vulnerable to the epidemic.

In 2000–2001, UNAIDS, in collaboration with the International Council of AIDS Service Organizations and its regional structures, concentrated on strengthening civil society capacity to realize and protect HIV/AIDS-related human rights. Working with the Asia Pacific Council of AIDS Service Organizations, UNAIDS developed a training module on human rights and HIV/AIDS for that region, and conducted training in Cambodia. The Latin American Council of AIDS Service Organizations, meanwhile, held a regional workshop to identify the human rights implications of National AIDS strategic plans in the region, and devised strategies to integrate human rights activities into those plans.

Crossing the line

Alongside the growing recognition of the importance to act against HIV/AIDS-related stigma and discrimination is mounting evidence that such challenges do yield success.

In South Africa, the AIDS Law Project at the University of Witwatersrand has steered HIV discrimination cases through the courts, winning precedent-setting judgements on unfair dismissal of HIV-positive persons, and on discrimination against HIV-positive persons in prisons. Members of Uganda's national network of traditional healers have been trained to become community AIDS educators. After years of concerted mobilization and consistent effort in Uganda, people with HIV are becoming more accepted as a normal part of society, and stigma and discrimination appear to be ebbing. In addition, more religious organizations are stepping into the breach, especially in Asia and Africa (see 'National responses' chapter).


And the African Council of AIDS Service Organizations is supporting community-based activities aimed at integrating human rights into prevention and care efforts in Burkina Faso and the United Republic of Tanzania.

Some of the most successful responses to the epidemic have occurred when people, ranging from gay communities in high-income countries, starting in the 1980s, to urban and rural communities in Uganda, and sex workers in Bangladesh and India, have seized the right to speak out, mobilize resources and organize.

In Bangladesh, sex workers have joined in a collective called Durjoy, which combats the trafficking of girls and young women in the sex industry. Along with nongovernmental organizations, Durjoy in 2001 won a court judgement that legally recognized the rights of sex workers to practise their trade and support their families. In Kolkata, India, meanwhile, sex workers have gone a step further

and now build skills among local police to combat violence against them. In addition, they have created a board that brings together sex workers, local sex industry operators and government labour and health authorities to tackle violence in the industry.

The activism of civil society around rights issues remains one of the sterling features of effective responses everywhere, especially when it involves people living with and affected by HIV/AIDS, and young people.

In a range of African and Asian countries, the UNAIDS Secretariat (along with its Cosponsors, the Office of the High Commissioner for Human Rights, and other partners) is supporting training for national partners on HIV/AIDS-related human rights for community AIDS organizations, human rights nongovernmental organizations, political leaders, National AIDS Programme managers, people living with HIV/AIDS, and legislators. 

Focus:

AIDS and young people

Declaration of Commitment

By 2003, establish time-bound national targets to achieve the internationally agreed global prevention goal to reduce by 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25% and by 25% globally by 2010 [...] (paragraph 47).

United Nations General Assembly Special Session on HIV/AIDS, June 2001, New York

Young people are particularly vulnerable to HIV infection, and frequently carry the burden of caring for family members living with HIV/AIDS. Many are vulnerable to HIV because of risky sexual behaviour or substance use, because they lack access to HIV information and prevention services, or for a host of social and economic reasons. Stigma can be

particularly damaging to youngsters at a time when they are trying to consolidate their identity and establish their place in the world.

Yet, it is also young people who offer the greatest hope for changing the course of the HIV/AIDS epidemic, if they are given the tools and support to do so.

Young and vulnerable

An estimated 11.8 million young people aged 15–24 are living with HIV/AIDS. Moreover, about half of all new adult infections—around 6000 daily—are occurring among young people.

While it is difficult for many adults to admit it, large numbers of young people begin sexual activity at a relatively early age, are sexually active before marriage, are not monogamous, and do not use condoms regularly enough to ensure protection. In many coun-

tries, a significant proportion of young people start sexual activity before the age of 15, and many of them are already married (see Figure 15). In addition, experimentation with drug use, including injecting, is often a feature of youth. This underscores the capital importance of implementing prevention programmes long before sexual or drug-injecting activity might commence, because too many young people are unaware of the threat posed by HIV.

Marginalized young people (including street children, refugees and migrants) are at particular risk if they are excluded from health services, exposed to unprotected sex (sometimes in exchange for food, protection or money, or as a result of violence) or use illicit drugs. The estimated 1 million children who are forced into the sex trade every year are especially susceptible to contracting, and then spreading, HIV/AIDS.

In most societies, dominant ideologies promote sexual ignorance (disguised as ‘innocence’) among young women. At the same time, many girls and young women actually

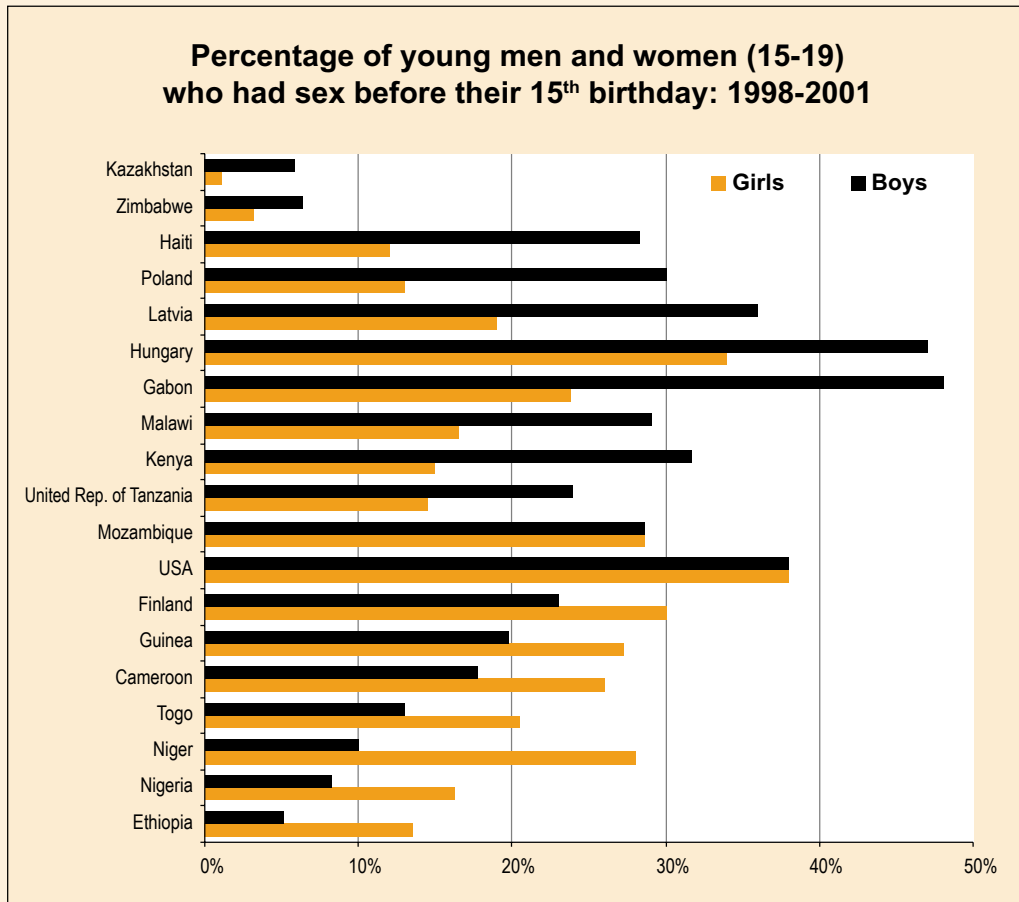
have little control over how, when and where sex takes place, as Figure 16, drawn from a South African national youth survey, shows.

What young people know... and don't know

Young people's vulnerability is compounded by their scant knowledge of how HIV is spread and how infection can be avoided. Many millions still have not heard of HIV or AIDS; many more harbour misconceptions about the disease. In addition, young women in many countries are far less knowledgeable about HIV than are young men. Half of



Figure 15



Sources: Measure Evaluation (1998-2001); UNICEF

Declaration of Commitment

By 2005, ensure that at least 90%, and by 2010 at least 95% of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection [...] (paragraph 53).

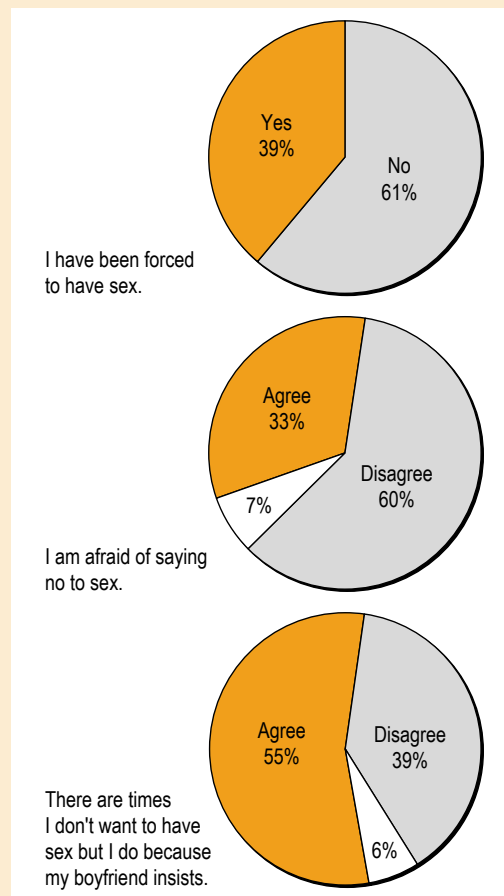
United Nations General Assembly Special Session on HIV/AIDS, June 2001, New York

the teenage girls in sub-Saharan Africa, for example, do not realize that a healthy-looking person can be HIV-positive.

But even where knowledge has been substantially increased, ‘knowing’ is not necessarily ‘doing’. Many young people do not connect knowledge and risk perception with behaviour. The vulnerable circumstances many young people experience might offer a partial explanation. Just as important is the need to understand what helps young people practise safe behaviour—the ‘protective factors’ that help adolescents form coping strategies, develop positive self-esteem and create a social support system that reduces high-risk behaviours. One study in rural Zimbabwe, for example, demonstrated that being a member of a well-run community youth group can reduce a young woman’s chance of becoming infected with HIV. A 2001 study among South African students suggested that condom use is significantly greater among adolescents who feel they can discuss sex with their parents, or adolescents who live in communities with good infrastructure. In contrast, young people living in households that recently experienced disruptive household events (illness, job loss or divorce) were less likely to use condoms. Research also confirms that higher education levels are associated with higher rates of condom use, as Figure 17 illustrates.

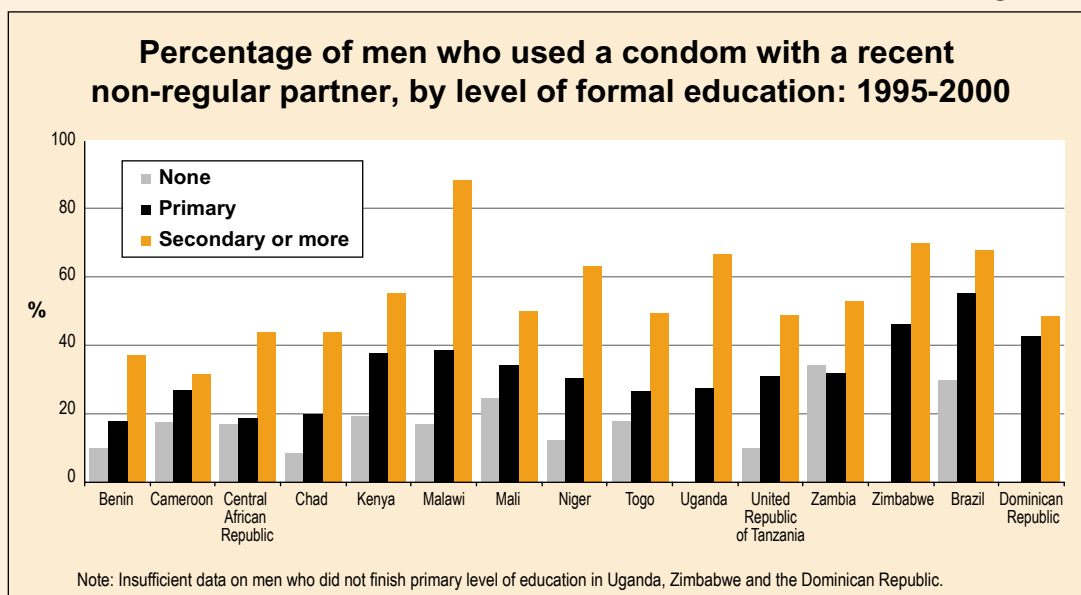
Figure 16

Percentage of sexually experienced girls in South Africa who say...



Source: Kaiser Family Foundation/KLA (2000) South African National Youth Survey

Figure 17



Source: Macro International (1995-2000) Demographic and Health Surveys; UNICEF

Protecting young people from HIV

The future course of the epidemic depends on the efforts mounted today to prevent HIV infection among young people. Taking as an overall principle the conviction that young people are themselves a force for change, several basic strategies are essential to helping young people protect themselves. These include:

- protecting and promoting the rights of the child, including the rights to information, education, health and health care, freedom from rape and sexual coercion and cruel and inhuman treatment, and the right of girls to equality in education, employment, inheritance, marital law, and sexual and reproductive decision-making;
- providing HIV/STI prevention, sexual and reproductive health and life-skills education and information to young people, whether they are in school or not;
- providing reproductive health services, including low-cost or free condoms, voluntary counselling and testing, and diagnosis and treatment of sexually transmitted infections;
- targeting programming to particularly vulnerable groups such as young injecting drug users and young men who have sex with men; and
- combating sexual exploitation of young people.

These strategies are most effective when they take into account the role of gender inequalities in the epidemic, and when they help empower girls and young women against a wide variety of cultural and social inequities that make them more vulnerable than males.

Comprehensive curricula, properly taught

Despite the obvious threat to young people's health and lives, HIV/AIDS is still too frequently regarded as an 'unsuitable' issue for them. But prevention programmes for young people in school are an essential component of any national HIV prevention effort. Several important lessons have been learned about how to do this effectively. Programming should be sustained, starting before puberty and continuing throughout a young person's school years. Many authorities resist the idea that such education should begin before young people become sexually active. But the timing of people's sexual debuts varies widely, and the importance of good health habits, including those regarding sexual health and HIV/AIDS and other sexually transmitted infections, must be driven home at an early age. Preventive health education should be comprehensive, providing an age-appropriate balance of life-skills development, reproductive and sexual health information, and discussion of attitudes and values.

The more information provided, the better, according to a recent study that compared teenage sexual and reproductive behaviour in high-income countries. Relatively low rates of teenage pregnancy and sexually transmitted infections in countries such as Canada, France and Sweden seemed to reflect the success of comprehensive curricula, applied on a national scale, covering a wide range of topics and presenting options for safe sexual behaviour. Less successful outcomes were reported in school systems where abstinence was presented as the only appropriate option for teenagers outside of marriage, and where con-

trapection was incorrectly presented as ineffective in preventing pregnancy, HIV and other sexually transmitted infections.

Other common features characterize successful programmes. Among them is the *consistency of messages*: successful curricula provide and reinforce clear messages about the risks of teenage sexual activity, and how to either avoid intercourse or guard against pregnancy and sexually transmitted infections. Adequately trained teachers who support the programmes increase the potency of such programmes. These programmes also need to take account of traditional beliefs and value systems, as well as the popular mythologies that circulate among young people and their wider communities.

Nigeria recently embraced a comprehensive approach to school-based prevention. It has announced the implementation of a National Sexuality Education Curriculum, which will begin in upper primary grades and carry on through secondary school. Work began on the curriculum in 1998, when widely reported research revealed unexpectedly high levels of HIV and AIDS among the 15–24-year-old age group, which constitutes a large part of the country's population. A great deal of consultation was conducted so as to take into account both international best practices and the particular cultural and religious conditions in the country.

The curriculum is organized around six themes: human development, personal skills, sexual health, relationships, sexual behaviour, and society and culture. Among its various features, the curriculum has a strong life-skills component, emphasizing such skills as decision-making, negotiation and assertiveness. By the senior years of secondary school, all students will have received clear and consis-

tent information about practical issues, such as contraception, family planning, and sexually transmitted infections. And they will also have learned about the responsibilities of family members and the rights of the child.

Access to youth-friendly services

The value of promoting safer sex through education and communication campaigns risks being lost if young people do not have access to further information, advice and reproductive health services, and to treatment for sexually transmitted infections. In many high-prevalence countries, such services are scarce and, even if they exist, young people do not

include young people's perception of low risk, their concerns about lack of confidentiality, and unresolved issues about parental consent.

Current best practice in youth-friendly health services shows they should be affordable, cater to minors or unmarried adults, and offer low-cost or free condoms in an atmosphere that guarantees confidentiality. And, in many settings, flexible opening hours for young people who work or study will make a big difference to the number of people who use such services.

Russia's 'Juventa' medical centre in St Petersburg is a good example of youth-friendly programming. It provides a range of services including

Beyond curriculum: creating 'healthy schools'

The FRESH Partnership (Focusing Resources on Effective School Health) was created to change the way the global community and national governments deal with health and its effects on education. Developed by UNAIDS Cosponsors (UNICEF, UNESCO, WHO and the World Bank) and launched at the Dakar World Education Forum in 2000, FRESH aims to help school systems in low- and middle-income countries overcome health problems that interfere with teaching and learning.

The FRESH approach revolves around core activities that include skills-based education, proposals for school policies that protect students and staff from HIV/AIDS-related discrimination, and the linking of students to health services such as testing and treatment for HIV and other sexually transmitted infections, and access to condoms. These activities are supported by strong school/community partnerships.

FRESH programmes (or ones that incorporate its approach) are being developed in more than 30 countries in Africa, Asia, the Caribbean and Central Asia. In Eritrea, for example, the national Department of Education has selected 20 primary and secondary schools for enhanced school health activities, notably for the prevention of HIV/AIDS and related discrimination. A total of 200 teachers will also receive comprehensive school-health training.

know about them. In a recent study of voluntary counselling and testing services in Kenya, for example, only 11% of untested youth in Nairobi could name a service provider within their communities, though more knew that testing (though not necessarily counselling) was available at a large hospital. Other barriers

HIV counselling and testing, contraception and abortion, treatment of sexually transmitted infections, sexual abuse counselling, and legal assistance. Consultation and other services are free to people under 18, who make up 90% of those visiting the centre. Regular surveys are made of young people's satisfaction with

the services, and changes are made accordingly. Similar approaches, but in a very different setting, are carried out at the Youth Health Centre in the Seychelles. Established with the help of the United Nations Population Fund, the Centre has been able to involve young people in most areas of programming, including an extensive peer educator programme.

Reaching out through peers

Peer education has been adopted by many prevention programmes, both for young people and for other groups, and is regarded as a key strategy for reaching young people who are not in school, as well as those who are.

Properly designed and implemented peer education projects can change behaviour. For example, the *Entre Nous Jeunes* project in Nkongsamba, Cameroon, runs a peer-educator programme to promote preventive behaviours regarding sexually transmitted infections and HIV, particularly among young people who are sexually experienced and in need of reproductive health information. A recent study of the project found that contact with a peer-educator was significantly associated with stronger knowledge about contraception and the symptoms of sexually transmitted infections, and greater use of contraceptives, including condoms. Without the peer-education programme, the level of contraceptive use in the community would have been significantly lower.

Peer education programmes for young people must pay close attention to how they present gender issues. A recent study of one school-based peer education project in South Africa noted that, instead of making young people aware of how traditional gender roles put young people at risk of HIV infection, peer

group meetings actually reproduced those same gender roles. Young men often dominated the meetings, while young women were reluctant to assert themselves. The research underlined the importance of properly training peer educators and also of creating settings in which young people of both sexes can talk openly about sexuality and relationships.

Special needs and special programming

More targeted HIV prevention programmes are needed for specific groups of young people. For example, young men who have sex with men, or who are unsure about their sexuality, may be reluctant to access services geared towards the heterosexual majority (this is particularly true when a young man has been raped or is the victim of incest). Switzerland's Project MSM, implemented by the country's nongovernmental AIDS Federation, reaches out to young men in a number of ways, from youth clubs to the Internet. Its underlying principle is that helping young men accept their sexual preference is a precondition to making them fully aware of the risks of HIV.

In many countries, the majority of sex workers and injecting drug users are young people. And in all countries, the majority of sex workers and injecting drug users start these activities when they are young. With more and more young people turning to injecting drug use in many countries, there is a growing need for preventive programmes specifically adapted for young injecting drug users. These include substance use and drug rehabilitation services, as well as needle-exchange programmes and education on HIV prevention. The same is true for young sex workers. Given the hazards they face, they need more information, regular health check-ups, and easier access

South Africa's 'loveLife': young people's HIV prevention on a national scale

South Africa's 'loveLife' programme began in 1999 with an impressive array of activities, including a national television, radio and print media campaign, youth centres, free clinical health services, and a network of support services. The programme combines well-known public health practice with innovative marketing techniques to promote sexual responsibility and healthy living among young people. LoveLife has had noticeable impact, and currently reaches an estimated 4 million young people each year. Research indicates that, of the 62% of young South Africans who report having heard of the programme, 76% say they are aware of the risks of unprotected sex, and 78% report that they now use condoms during sex. Some 67% say they have had open conversations with friends about sexuality and relationships, while 69% report having limited or reduced their number of sexual partners. The programme was initiated by the Kaiser Family Foundation in partnership with South African nongovernmental organizations, with funding from the South African Government, the Bill and Melinda Gates Foundation, UNICEF and other organizations.

to condoms. Just as importantly, they need support and protection to use these services. Specially-designed programmes can be useful in reaching young people who are already in the workforce (see 'Focus: AIDS and the world of work').

Young people who have had trouble with the law and are living in detention centres or jails are especially vulnerable. Recently, UNFPA worked with Thai health authorities and nongovernmental organizations to bring HIV/AIDS education to juvenile delinquents living in a detention centre in Rayong Province. The project took the innovative approach of involving family relations of the detained young people, and study tours outside the centres.

Combating the sexual exploitation of young people and children

One of the most pressing challenges is to halt the widespread sexual exploitation of young people and children, especially young girls.

This priority received powerful support in December 2001 at the 2nd World Congress against Commercial Sexual Exploitation of Children in Yokohama, Japan. The Congress presented a wealth of evidence of the dangers to which children are subjected, and underlined the connection to HIV/AIDS. The meeting's final declaration—the Yokohama Global Commitment—provided a broad framework for fighting this exploitation.

Children trapped in prostitution are at higher risk of infection, being both less able to resist sexual dominance and more vulnerable to the injuries of aggression. Children's subservient role in commercial sex means that they are often obliged to take multiple clients each day.

Solutions must necessarily be multisectoral, with law-makers and law-enforcement organizations playing a large part. Efforts to change cultural attitudes through mass media campaigns also have an undoubted role. But other parts of society can make important contributions too.

Universal education is a powerful tool against sexual exploitation of young people and children, especially girls. In 1992, Thailand launched a national effort to eradicate child prostitution and to help those at risk of entering the sex industry. (Many girls are sold or coerced into

sex work, often by their families, for economic reasons.) A key strategy was to ensure that all children (both sexes equally) should receive nine years of basic education, and to provide impoverished children with access to education and vocational training. 