



COMMISSIONED DESK-BASED RESEARCH

LITERATURE REVIEW ON HIV/AIDS AND GOVERNANCE

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Literature Review on HIV/AIDS and Governance

Executive Summary

1 Impact of HIV on universal and equitable service delivery

- AIDS attrition and loss of public sector skills, institutional knowledge, and continuity.
- Projections of loss public sector workers
- Effects of sickness, low morale and absenteeism on service delivery
- HIV and the ‘brain drain’
- HIV-driven changes in demand for public services
- Long term effects of absenteeism from education.

2 Implications for effective pro-poor policies and revenue collection

- Projections of the impact of HIV on government revenue and expenditure
- Labour force issues
- Success stories; Uganda, Thailand, Brazil and Senegal

3 Effects of HIV on macroeconomic stability

4 HIV, Voice and Marginalisation

5 SSAJ and HIV

- AIDS widows, orphans and inheritance rights.
- Sexual violence against women and HIV
- HIV in prison systems
- HIV in police forces
- HIV in judiciaries
- Laws/policies that increase vulnerability to HIV

6 HIV and conflict

- Conflict and sexual violence
- Conflict and health services
- Information dissemination during conflict.
- Refugees
- HIV in militaries
- HIV and the nature and duration of conflict
- Demobilisation and HIV

7 Corruption and HIV treatment

8 Summary

Note: ‘HIV’ is used in place of ‘HIV/AIDS’ throughout.

Executive Summary

Structured according to the brief provided by DFID GD, this literature review examines a number of specific concerns relating to the governance aspects of HIV in Sub-Saharan Africa, South Asia, China and Russia. The review covers the impact of HIV on certain aspects of the key capabilities of the Governance Target Strategy Paper, including the impact of attrition on service delivery, HIV and corruption, HIV in conflict situations, and ‘voice’ and marginalisation in the context of HIV.

The main lessons drawn from the review are:

- The absence of information on public sector institutions other than the education sector.
- The complexity of the issues and the difficulties of comparing data between countries.

There is a notable absence of information both on specific issues, and in specific regional contexts. In particular, there is a lack of information on public services other than education, and there is a general lack of data for regions whose HIV histories are relatively short, such as Russia, China and South Asia. However, even in regions where considerable research has been carried out, data are contradictory and reliability is variable. This review exposes the complex nature of the issues associated with HIV and governance, and in particular the difficulties of designing governance interventions when projections of future impact of HIV are challenging, due in part to a lack of current data, and to the enormous complexity of accurately modelling cause and effect in socio-economic systems. An example here is the difficulty of modelling macroeconomic impact, with different models based on different assumptions giving very different outcomes.

Main findings from the review are:

- There are as yet no general assessments of the impact of HIV on the public services as a whole.
- HIV has an effect on government revenue and expenditure, but there are very few firm projections of the scale, magnitude and impact of these anticipated changes, and the few which do exist tend to focus on Southern Africa.
- ‘Success stories’ tend to report critical factors in tackling HIV; political commitment, multisectoral response and community involvement. However, the initial trigger for high-level political commitment been yet to be explicitly identified.
- Projections of the impact of HIV on macroeconomic stability are varied, based on different assumptions, use different models, and are very difficult to contrast. As yet, there is little agreement over the likely scale of impact, but most projections point to small scale change.
- HIV/AIDS exacerbates, and is in turn exacerbated by political and social exclusion. Marginalised people are relatively vulnerable to HIV infection for a number of reasons, and people affected by HIV are in turn subject to further stigmatisation. Once infected, already-marginalised people are poorly placed to protect their rights.
- HIV is a factor in the exercise of rights, and access to justice, particularly for widows and orphans. HIV in prisons is of particular concern in the post-communist region, and within the uniformed services, and a number of laws and policies which serve to increase the vulnerability of certain groups to infection have been identified.
- HIV and conflict are a ‘double emergency’. In conflicts and related emergencies, high-risk sexual behaviour, including sexual bartering and sexual violence, contribute to the spread of HIV.
- There are suggestions that HIV-related corruption is taking place at a number of levels, individual, organisational and national. Many examples cover China’s blood and plasma donation system.

1 IMPACT OF HIV ON UNIVERSAL AND EQUITABLE SERVICE DELIVERY

AIDS attrition and loss of public sector skills, institutional knowledge, and continuity.

- 1.1 The ILO (Cohen 2002) reports that although there have been several studies of the impact of HIV on specific sectors, such as education and health, there is as yet no general assessment of the impact on public services as a whole. The nearest there is to a comprehensive assessment is a study of the impact of HIV on Human Resources in Malawi. This study is important as an attempt to measure attrition of human capital across the public sector in a country experiencing a mature epidemic of HIV. Data showed that over the period 1990-2000 total annual attrition from all sources rose almost six times from 347 to over 2000. The average rate of attrition was 2.3%¹. The causes are complex, although one stands out in all of the organisations: death is the highest cause of attrition, varying between 40 and 58%. For the public service as a whole, mortality over the period has increased by a factor of 10, a situation due primarily to HIV. The high levels of mortality observed would not be present except under these conditions. The Malawi report also concluded that all occupational categories experienced excess mortality, but that there were higher mortality rates among professional staff than among junior technical staff (MIM/UNDP 2002).
- 1.2 The conclusion of the Malawi report hints at implications for institutional knowledge and continuity: The loss of experienced staff impacts negatively both on the coverage of service provision, through a reduction in the total number of staff, and on the quality of services, caused by the loss of skills and experience. Whereas the first (shortfall in the number of people) may be relatively easy to deal with, the second (loss of experience) amounts to a substantial organisational loss. Depending on which staff categories are most affected, certain organisational functions and capacities will be eroded, which will inevitably impact negatively on the core business of the organisation.

Projections of loss of public sector workers

- 1.3 Education and health are identified by the ILO (Cohen 2002) as two key sectors affected by HIV. Cohen points out that the effects on the sectors are complex, and that the interactions between sectors are only now beginning to be identified. Improvements in education and health are both seen as critical inputs for achieving sustainable development, but HIV is making it more difficult for countries to achieve their objectives in these sectors. Most households affected by HIV face deepening poverty, and part of their adjustment to this situation relates to decisions about school attendance, making it more difficult to achieve educational objectives in general, but especially in the case of the education of girls. Importantly, improvements in education have been seen as essential for reducing HIV transmission, as the risk factors faced by young people are in part the outcome of low levels of literacy impeding access to information. Similarly, HIV and AIDS have direct and indirect effects on the healthiness of populations. Functioning health care systems are essential to the diagnosis and treatment of infection, but the HIV epidemic not only raises the demands on health systems, but simultaneously erodes their capacity to provide services.
- 1.4 Projections of percentage losses of education and health workers are fraught with difficulty. There are demographic and aggregation problems in making projections, and the results are uncertain. The World Bank, while acknowledging these drawbacks, makes gloomy projections for SSA: it projects falls in the primary school age population by 2010 of 24% (Zimbabwe), 20% (Zambia), 14% (Kenya), 12% (Uganda). The losses of teachers due to HIV between 2000 and 2010 for the same countries are estimated annually at 2.1%, 1.7%, 1.4% and 0.5%, which are cumulatively very substantial losses (World

¹ The Health sector was excluded from the Malawi study, and no reason was given for this exclusion.

Bank 2000). UNECA (2000) presents reports from Kenya (teacher deaths rising from 450 in 1995 to 1,500 in 1999), Cote d'Ivoire (reported to be losing teachers at the rate of five per teaching day, 900-1,000 per year, but unclear if this attrition is due to mortality or other factors), Zambia ('severe losses' among trainee teachers), Congo (schools closing due to death of teachers from AIDS).

- 1.5 Cohen (2002) states that there have so far been studies of the effects of the HIV epidemic on primary and secondary education in three countries; Malawi, Uganda and Botswana, a consolidated report of the three, The Bennell Report, comprising the most detailed analysis of impact yet produced. Its overall conclusion is that 200,000 teachers, 9.4% of the total employed in 1999, could die of AIDS-related illnesses by 2009. The projection is based on three key assumptions (teachers have the same age- and HIV-profiles as the rest of the population, the 1999 adult HIV prevalence rates in each country will not increase, and teachers are unable to access lifelong antiretroviral drugs). In the view of the ILO (Cohen 2002:15) some of the assumptions are overly optimistic, and the real outcomes therefore likely to be considerably more adverse.
- 1.6 Cohen (2002:16) points out that there are major gaps in knowledge about the education sector in the context of HIV; lack of firm data on absenteeism, organizational capacity loss through mortality of senior teachers, teacher trainers and administrators, and school drop-out rates and their relationship to household poverty. In terms of the health sector, he notes that there are very few comprehensive analyses of the effect of the epidemic. One of the few is a study of Botswana, which concludes that 17-32% of its health workers were infected in 1999, and 28-41% could potentially be infected by 2005. Evidence from elsewhere in Sub-Saharan Africa (SSA) suggests that likely magnitude of the effect of HIV on human resources in the health sector will be immense. A study by WHO in Zambia in the early-mid 1990s concluded that 40% of health sector staff were infected with HIV. Cohen contends that there is no evidence that any country has begun to comprehensively address the human resource planning issues raised by the HIV epidemic, and no evidence that there is capacity either domestically or externally to meet the needs for critical skills and training.
- 1.7 Comparative figures for other regions are not available. For example, as is widely known, the Chinese government officially denied its HIV problem for years, and discouraged accurate monitoring and independent surveillance. The government has also considered the number of infected people in China to be a politically charged topic, with a great deal of national reputation riding on statistics. For these reasons, reliable statistics on the current state of the HIV epidemic in China are difficult to obtain, and therefore future projections extremely difficult to make (Bates, 2002). Similarly, in Russia and India, statistics for the seroprevalence of HIV are rather unreliable; in Russia, medical authorities have registered 200,000 HIV-positive patients, but US intelligence suggests the figure stands at one to two million. In India, UNAIDS suggests that there are four million people infected, but the Health Minister warns that the figure may be higher (Eberstadt, 2002); this figure is currently a source of dispute. The HIV epidemics in Russia, China and India are far newer than those in SSA, and for reasons of the relative youth of the epidemic, and the problems of estimating prevalence, systematic analyses of projections of long-term effects on services, revenues and so on have not yet been developed.

Effects of sickness, low morale and absenteeism on service delivery

- 1.8 Cohen (2002) argues that the costs of the HIV epidemic are not confined to estimates of lost output due to early mortality, although these are clearly very important. There are other costs that are also significant: those due to absenteeism both directly due to illness, and indirectly caused by funeral attendance, caring for sick relatives, disruption of the flow of work and so on. These are estimated in the Malawi report (MIM/UNDP 2002), and found to be 'very significant'. The report notes that policies with respect to sick leave and more general absenteeism are not being observed in Malawi, and that urgent reform is required if the public service is to continue to function. This is a symptom of the

slowness of reaction by Malawi Ministries to this attrition, ongoing for over a decade. Many posts have remained vacant for long periods, and overall vacancy rates are at extremely high levels (58% in Education, and 52% in Water Development, Cohen 2002:10) In all ministries, it was found that the vacancy rate is higher in rural than in urban areas, implying that service delivery may be worse in the former. Costs attached to these issues are directly experienced in the budgets of the various ministries; funeral costs, recruitment and training costs for new staff, and so on. Although low morale is mentioned widely as a result of HIV attrition, there are very few studies which address this issue and which are able to attribute effects to perceived 'low morale'.

HIV and the 'brain drain'

- 1.9 The 'brain drain' is particularly acute in SSA, and while there is little empirical evidence pointing to HIV as a cause of emigration (although many anecdotal references), there is work which identifies the brain drain as a factor compounding the problem of HIV in country. In particular, trained medical staff are among those commonly leaving SSA countries with high seroprevalence rates, for work in other African countries, or further afield. This is a particular problem in South Africa and Zambia. According to DENOSA, 300 trained nurses leave South Africa each month. A vicious cycle has developed in that the nurses remaining in the public service are required to deal with a heavier workload. The flight of specialised skills could have a devastating effect on the quality of care for the terminally ill, especially HIV patients. One of the worst examples of the regional brain drain cited by the IDR is Zambia, where the number of doctors has fallen dramatically, attributed to the brain drain. Zambian doctors have migrated to Europe, the United States and neighbouring Botswana, lured by higher salaries. (GlobalEyes 9/3/02). Part of the brain drain may also be relatively well-qualified people emigrating to obtain ARV treatment for themselves or family members. However, there is very little information available to substantiate this – although there are many websites offering advice to prospective immigrants to the UK and elsewhere about how HIV-positive status might affect their applications (an example is Stonewall, <http://www.stonewall-immigration.org.uk/HIV.htm>).

HIV-driven changes in demand for public services

- 1.10 Just as projections of mortality and prevalence of HIV are difficult to make, extending these to suggest the effect on public services is also extremely difficult. It is particularly difficult to identify changes in demand for public services which are the result of changes in household structure or demography, rather than of high prevalence. It is generally accepted that demand for health services will increase, but there are complex issues here about the precise nature of care required, which bear some relation to changing household structures. Conversely, the provision of ARV treatment actually reduces the demand on health services, as people are not as sick. A report on the impact of HIV in Botswana (BIDPA, 2000) states that the degree to which AIDS patients' treatment is split between hospital-based and home-based care is one of the factors which will determine health spending. Home-based care would require a household structure with a care-giver in the home, and therefore it might be argued that demand for hospital-based care will increase as households become more fragmented (single-parent, grandparents as guardians and so on). The Bennell Report on education, reviewing trends of mortality and student enrolment, concludes that the net impact in Malawi, Kenya, Uganda, Botswana, Zambia and Zimbabwe will be that reduced demand for teachers will outweigh the increase in AIDS-related mortality over the next decade. Somewhat perversely, therefore, the HIV epidemic will make it easier to reduce student-teacher ratios and meet Education for All targets. However, this conclusion is in opposition to that of Kelly (2000, for UNESCO) who concluded that high rates of AIDS-related mortality may raise demand for new college educated graduates above the supply, this prolonging the dependence of schools on unqualified teachers.

Long-term effects of absenteeism from education.

- 1.11 There does not seem to be research yet available which seeks to project levels of literacy given children's absenteeism from school due to the effects of HIV, or how this anticipated change in literacy levels will affect skills in the longer term.
- 1.12 While it is naturally assumed that attending school has a positive effect on the education of children, research has shown that the school environment can place children at risk of infection. Badcock-Walters argues that the assumption that interactive, high-risk sexual activity between learners does not take place in primary education may be badly misplaced. This is because the age-profile of learners in this sector does not necessarily coincide with what might be expected. Over-age learners are a common feature of the school system from the first year. Therefore, the 'age of innocence' may be circumscribed by the pressure, example and action of over-aged learners in the classroom, and their appropriately-aged peers. School data for South Africa show this trend. UNECA echoes this concern, adding that many school children are in danger of sexual harassment from teachers, and that schools commonly do little to help pupils develop behaviour patterns for the responsible management of their sexuality (UNECA 2000).

2 IMPLICATIONS FOR EFFECTIVE PRO-POOR POLICIES AND REVENUE COLLECTION

Projections of the impact of HIV on government revenue and expenditure

- 2.1 It is important to state at the outset that the impact of HIV on revenue and macroeconomics will be very different for highly populated countries (China, India, Indonesia, Russia) when compared to the smaller countries of SSA, and to understand that there are therefore difficulties in comparing statistics.
- 2.2 It is widely acknowledged that HIV will have an effect on government revenue and expenditure, both in terms of increasing expenditure on services due to higher costs of recruitment, training, sick pay, etc., and reducing revenue, due to economic impact. However, there are very few firm projections of the scale, magnitude and impact of these anticipated changes, and the few which do exist tend to focus on Southern Africa.
- 2.3 Greener (undated) argues that HIV will have direct effects on some key areas of government spending, most obviously the health budget. There will also be a range of indirect effects arising from aggregate economic impacts, and increase in poverty. These can be expected to reduce the ability of governments to raise tax revenues (since these depend on the size of the economy), while increasing demands on government expenditure, including poverty alleviation measures. Although there may be some savings, Greener continues, arising from reduced population growth, he expects HIV to exacerbate the pressure for deficit spending by government. It will also distort development spending on other areas, since it will be necessary to use valuable resources in a 'defensive' or socially unproductive way. In addition, he expects the distortions that HIV causes in the labour market to put more pressure on government in its regulatory role (for example the issuing of licences and work permits).
- 2.4 A country study of Botswana (BIDPA, 2000) gives more projections of projected government expenditure. It is anticipated that in Botswana employment costs will increase as a result of the projected increase in skilled labour costs, since government is a major employer of skilled labour. This effect is estimated at 2.3% of the total recurrent budget after 10 years. The pension liability of government is projected to fall, as a result of earlier mortality of the workforce, but the saving will be small, predicted at 0.6% of the total recurrent budget. Training and recruitment costs will increase, but this will also be a small expense, amounting to 0.3% of the total recurrent budget after 10 years. Health spending is expected to increase dramatically, but unpredictably, anticipated to increase total recurrent spending by anywhere between 3% and 12% over 10 years. Population projections of lower numbers of school-age children suggest a saving in education costs translating to 1.5% of the total recurrent budget. Increased poverty due to HIV is projected to lead to increased poverty alleviation expenditure, increasing total recurrent spending by 3-4% after 10 years. Added together, these various changes in expenditure amount to a 7-18% increase in 10 years time. However, the study projected that government revenue would fall. Mineral revenue was seen as unlikely to be affected by HIV (although mining revenue is expected to fall elsewhere because of labour problems, especially in South Africa), but other sources are expected to decline. Botswana's GDP is projected to be 20% smaller than the 'no-AIDS' situation after 10 years, which means that revenues from income and sales taxes will be lower, and resulting deficit pressure will mean that interest from the Bank of Botswana will be lower. This amounts to a projected fall of 10% in government revenues after 10 years. Botswana's overall projection is that expenditure will be in deficit for other reasons in 10 years time, and that additional pressure caused by HIV will make the overall deficit unsustainable.

Labour force issues

- 2.5 The impact of HIV on public sector labour is closely related to its effect on the labour market as a whole. The ILO Programme on HIV and the World of Work reported in June 2002 that HIV has become a major threat to employment objectives and labour market efficiency in all sectors (public, private and informal). The loss of workers and workdays due to AIDS-related illnesses or the demands of caring can result in significant decline in productivity, loss of earning, and attrition in skills and experience. HIV is also changing the age and gender distribution of the work force, and increasing the number of women, children and the elderly facing economic uncertainty. The vulnerability of women to infection, as compared with men, increases gender inequalities.
- 2.6 The most obvious effect of HIV on the labour force from which the public sector draws its employees is that of the impact of HIV on the numbers of people of working age. This effect has been greatest in SSA. Within this region, the highest rate of infection is in Southern Africa (UNAIDS estimates of adult infection rate in this region in 2000 were: Botswana 36%; Zimbabwe and Swaziland 25%, South Africa and Zambia 20%, cf. 8.4% in SSA in general, and a world figure of 1.2%). Most significant for the labour force is what the HIV epidemic does to the structure of populations. The majority of those who die from AIDS are adults in their productive, sexual and reproductive prime. (In 1999, 80% of newly infected people in Rwanda, Tanzania, Uganda and Zambia were aged 20-49) Therefore, the effect of HIV on the labour force is more severe than that on the population as a whole. The loss of people of working age, particularly those over the age of thirty-five, with proportions of men and women varying according to age group, drastically increases the dependency ratio and has profound implications for all employment sectors.
- 2.7 ILO expects that in 29 SSA countries², the number of male and female labour force participants will be 12 and 10% smaller respectively by 2020 than in the absence of HIV; in the eight SSA countries with the highest prevalence rates (Botswana, Kenya, Malawi, Mozambique, Namibia, Rwanda, South Africa and Zimbabwe) the projected cuts are higher still – 19% for men, and 18% for women (Lisk, 2002:5)
- 2.8 Lisk (2002, for the ILO) reports that the early loss of qualified employees in the public sector will result in a decline in the quality of public services, and countries will find it hard to replace highly-trained public servants such as doctors and teachers. In addition, because of greater employment security in the public sector, the costs of absenteeism will be higher than in the private sector. Current ILO estimates suggest that some SSA countries will lose between one quarter and one third of their skilled and educated population. This will result in a decline in productivity and the effectiveness of public administration (Lisk 2002:6).
- 2.9 ILO research suggests that amongst the workers at special risk in SSA (including groups such as sex workers, and migrant workers) is the unexpected group of males with higher levels of education, such as teachers and middle/senior civil servants. ILO suggests that their apparently higher than average risk of contracting HIV may be partly related to mobility, but also reflects their higher disposable income and, perhaps, resulting increased propensity for casual sex (Lisk 2002:9).

Success stories; Uganda, Thailand, Brazil and Senegal

- 2.10 ICAD (2000) discuss the problems of analysing success stories. They write that three examples are commonly quoted as successes; Uganda, Senegal, Thailand and Brazil. In 1986, Ugandan President Museveni publicly acknowledged the country's AIDS problem and established the Uganda AIDS

² Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, DRC, Eritrea, Ethiopia, Gabon, Guinea Bissau, Cote d'Ivoire, Kenya, Lesotho, Liberia, Malawi, Mozambique, Namibia, Nigeria, Rwanda, Sierra Leone, South Africa, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

Commission. In Senegal, the government responded early to promote extensive NGO activity, and in Thailand, lobbying led to the 1991 nationwide programme. More recently, Brazil now leads the developing world in the provision of anti-retroviral drugs (ARVs), with a government policy of universal access.

In each country, strong political commitment is cited as a factor in its response.

The key factors for success seem to be

- political commitment
- multisectoral response
- community involvement

2.11 However, to remain effective in the long term, political commitment must be consistent, and its determinants are complex and difficult to identify. The model of the ‘AIDS champion’, a leader whose charisma and determination pushes through policies against a hostile bureaucracy, has its pitfalls, most obviously the scarcity of champions, the danger of loss of momentum should they leave office, or the risk that they will champion ineffective policies. Even if the initial ‘push’ comes from above, research has shown that policies are adopted more quickly if a broad consultative process is undertaken. In Ethiopia, it took over a decade for a national AIDS policy to be put in place, following repeated internal government review with no community involvement. In South Africa, in a climate of flourishing civil society, a national policy was being debated and adopted within two years, although it remains contentious. ICAD argue that political commitment is more likely if leaders face the consequences of non-action. The less respect for civil and political rights, the less likely it is that government leaders will speak out on HIV, or that communities can challenge ineffective policies. A free and active media is also seen as essential.

2.12 Political commitment is difficult to measure. ICAD suggest the following indicators:

- Budget allocations to prevention and care
- Measures of AIDS programme activity (based on a questionnaire to key informants)
- Indicators of compliance with the International Guidelines on HIV and Human Rights.

Difficulties in measuring commitment mean that it is very difficult to know whether efforts to increase political commitment have any impact on the AIDS epidemic.

2.13 ICAD conclude that although there appears to be widespread agreement that political commitment is an important factor in the successful response to HIV, it remains an elusive concept. It is unclear whether a focus on greater political commitment alone will have a significant impact on the course of the pandemic. It also ignores that reasons why government leaders act, or fail to act, on HIV.

2.14 A paper co-authored by Dr Coll Seck of Senegal (Piot & Coll Seck 2001) argues for the primacy of political commitment; firstly, political leadership is required at all levels to marshal the necessary commitment and resources for the social mobilization on which response to HIV must be built, secondly, responses to the epidemic need to be conceptualised as multisectoral tasks, and not confined to the health sector. Thirdly, national coordination is required, and fourth, responses are successful when people living with HIV (PLWA) are centrally involved in the effort. Lastly, successful responses to the epidemic have their roots in communities. Piot and Coll Seck argue that the common experience of ‘success story’ countries is that risks cannot be reduced in isolation. Where responses have been successful, they contend, they have built wide community support, given ‘target’ groups the driving role in designing and delivering change, and participating in changing the social environment. This ‘expanded response’, they concede, has been criticized as insufficiently prioritised, not focused on outcomes, and lacking in emphasis on sustained behaviour change. However, they argue that evidence from those national and local responses to HIV in which sustained drops in HIV incidence have been observed, or

where low incidence has been maintained despite surrounding trends, shows that success has been achieved where the response is based on a broad social mobilization, accompanied by clear deliverables.

‘Success Stories’

1 Uganda

WHO ‘Health a Key to Prosperity’ states that Uganda's success in reducing high HIV infection rates is the result of high-level political commitment to HIV prevention and care, involving a wide range of partners and all sectors of society. Same-day results for HIV tests and social marketing of condoms and self-treatment kits for sexually transmitted infections, backed up by sex education programmes, have helped reduce very high HIV infection rates. It says that success in reducing the prevalence of HIV in Uganda is the result of a broad-based national effort backed up by firm political commitment, including the personal involvement of the head of state, President Yoweri Museveni. From the outset, the government involved religious and traditional leaders, community groups, NGOs, and all sectors of society, forging a consensus around the need to contain the escalating spread of HIV and provide care and support for those affected.

Green (2001) argues for increased recognition of the contribution of faith-based organisations (FBOs) in Uganda's response to HIV. In 1987 the major FBOs became involved in AIDS prevention, with WHO and later USAID funding. They promoted fidelity and abstinence, and Green argues that some impact studies such as UNAIDS ‘Best Practices’ show that AIDS prevention activities carried out by FBOs in Uganda had significant direct impact on particular populations targeted. Green contends that FBOs that have advocated abstinence and fidelity in Uganda have had significant impact on overall infection rate decline. On the basis of this, Green argues for more equity between resource allocation to the promotion of condom use and to abstinence and fidelity promotion, and for the greater involvement of FBOs in tackling HIV.

Okware et al (2001) argue that Uganda's experience suggests that a multipronged prevention and control strategy can significantly influence behaviour and dent prevalence as well as incidence rates. Early recognition of the problem is necessary, and it must be followed by the construction of comprehensive frameworks for intervention.

However, despite being widely regarded by the international community as having very successfully lowered the rates of HIV, an article in *The Lancet* in July 2002 questioned the basis for the Ugandan claim of success, saying that it has rarely been investigated, and that rates of seroprevalence, rather than rates of infection each year, were often quoted, distorting the picture.

2 Thailand

Janjaroen and Khamman (2002) describe Thailand's response to HIV as one of the most successful. The country's pro-active, multi-sectoral prevention and care efforts have led to risk reduction and reduced incidences of HIV. The Thai experience, they contend, demonstrates that institutional and traditional approaches can be employed together with efforts to empower individuals, families and communities to protect and care for themselves to develop an effective national response. In analysing Thailand's success, Janjaroen and Khamman suggest that a number of lessons can be learned from it: the principal lesson being that the commitment of national leaders at the highest levels is required for effective action. Other lessons are that social capital and civil society need to play a significant role; effective programmes, often based on pilot schemes, lead to effective outcomes; a people-centred approach to programme development should be adopted; prevention works best when targeted at vulnerable groups, and HIV response must be linked to development programmes and to national and provincial level planning. One much vaunted policy in Thailand was 100% condom use in brothels.

3 Brazil

A paper in the *Pan-American Journal of Public Health* (2000) states that Brazil's policy of providing patients with free antiretroviral drugs (ARVs) has played a significant role in the country's achievements. A key to the broad public access to ARVs has been the local manufacture of cheaper generic equivalents of the medicines developed and patented in wealthier countries. By 1999 this approach had cut treatment costs in Brazil by 70% and made it possible for the country to treat many more people than would otherwise have been possible. An important

aspect of this drug policy, which has reduced transmission and morbidity, is the free distribution of ARVs which prevent mother-child transmission. 10 out of the 12 ARVs needed are not patented in Brazil and can therefore be produced as generics. Brazil's ability to produce or import low-costs generic stems from the fact that it did not introduce pharmaceutical patenting until 1996.

However, Brazil's drug policy is not the only reason behind its success in tackling HIV. Another factor has been an intense effort in education and prevention, much of it carried out by voluntary groups, activists and NGOs. Research has indicated that Brazil's young people are amongst the best informed in the world about HIV.

4 Senegal

Senegal is one of the countries cited as an example in the struggle against AIDS in Africa. Since its first confirmed case in 1986, prevalence rates of HIV amongst adults have been kept at between 1.77 and 1.74%. 80,000 adults are infected, out of a population of 9 million. The reasons for this relative success are: Senegal's early response to the disease, vigorous preventative action, care of AIDS patients and the mobilization of people at all levels, including teachers, soldiers, women, religious leaders and NGOs. Democracy and press freedom facilitated open discussion and information dissemination. More than a decade ahead of the discovery of the first AIDS case, the Senegal government had initiated a screening system for blood donations, and there was a programme against sexually transmitted disease, which targeted sex workers. There was trust between medical experts and government officials, and budgetary resources were allocated to tackle the problem of HIV. In 1988, health officials targeted women and young people, particularly students, raising awareness of these groups, which in turn helped raise awareness among vulnerable groups such as migrant and sex workers. Senegal was also among the first African countries to take advantage of access to anti-retroviral drugs. Key aspects of Senegal's approach to tackling HIV were;

- A National Committee to fight AIDS was launched by medical experts and government officials in October 1986
- Peer education; knowledgeable young people talking to others at community level (sports clubs, cultural associations etc.)
- Religious leaders; both Muslim and Christian authorities have been active, organising multi-faith events to disseminate information aimed at changing behaviour.
- Acknowledging cultural practices; many cultural practices prevalent in Senegal enabled religious and cultural leaders to give advice about how best to protect oneself against infection. For example, in the context of *levirate*, where a man marries the widow of his brother and *sororat*, where a woman marries the widower of her sister, religious leaders advise that no one should be obliged to marry if this 'runs the risk of losing your life'
- Awareness among the military; Army soldiers are Senegal's biggest consumers of condoms, and army generals receive training about AIDS from military doctors. While on missions, soldiers are educated about the disease and receive condoms. They also undergo examinations and screening.
- The Health Minister; Senegal's health minister is Dr Awa Marie Coll Seck, a specialist in HIV, who has been on the country's national committee against AIDS since 1986. (Africa Recovery, UN 2001)

2.15 In none of the 'success stories' detailed above has the initial trigger for high-level political commitment been explicitly identified. ICAD (2000) writes that although political commitment has been identified as crucial in achieving progress, few ways have been identified to directly achieve it. In other words, although we can observe the effect of political commitment, the reason why the commitment was there at all is seldom obvious. In one example of political commitment in Zambia, President Kaunda opened international conferences on AIDS – his commitment is seen to stem from his having lost a son to HIV. However, in other accounts of less successful governments, such as China, an unwillingness to admit that HIV was a problem, or even that it was a condition present at all in the country, stalled official moves towards tackling the problem. In China, this reluctance stemmed from Chinese officialdom's initial dismissal of HIV as a 'Western' problem (Bates 2002). In a toolkit produced by the Policy Project, Goliber (2000) states that political commitment 'is often underscored by an accurate understanding of the crisis dimensions of HIV...'. Availability of information, or willingness to believe that information and act upon it, might therefore be an important factor.

3 EFFECTS OF HIV ON MACROECONOMIC STABILITY

- 3.1 ICG (2001) reports the US National Intelligence Council assertion that in Africa's worst-hit countries, HIV has already reduced GDP by 1%. In South Africa, the World Bank estimates that GDP will be 17% lower by 2010 than it would have been without the HIV epidemic. Countries below the 20% seroprevalence level are also thought to face macroeconomic problems. ICG reports various projections that Botswana's economy may shrink by 30% by 2010 as a result of HIV, that Kenya's GDP may be 14.5% smaller in 2005 than it otherwise would have been, and that the combined effects of TB and HIV in Russia could cost 1% of its GDP by 2005.
- 3.2 HIV's effects on labour force have been documented previously, but the impact of these changes on private industry is critical to macroeconomic impact. Key sectors in SSA economies are affected by HIV, notably agriculture, mining and transport. In South Africa in particular, mining is of central importance for revenue, and here and elsewhere, mining is a key source of foreign exchange. HIV affects business investment; as revenues and savings shrink due to reduced workforce productivity and rising costs, the ability to invest is diminished. HIV in Russia threatens to exacerbate the current economic crisis through its impact on the working age population. In China, it is feared that were the HIV epidemic to worsen, the economy could face an intensifying slowdown, along with a reversal of the gains made in reducing poverty over the past several decades. However, a study carried out by NCAIDS (Beijing) concluded that in a worst-case scenario, the AIDS impact on GDP growth would cause a decline of 0.03%.
- 3.3 Eberstadt (2002) projects effects on macroeconomic stability in Russia, India and China. He uses a model based on the World Bank's data for national life expectancy and output per member of the potential workforce, amending these figures with simulations of life expectancy and work force size based on US Census data, according to three different levels of anticipated HIV epidemic, and amends these projections according to three different levels of severity of HIV epidemic. Using his 'health-based productivity' model, he predicts that Russia's output will be radically reduced under even nascent epidemic conditions, and that in a concentrated epidemic, output could be lower in 2025 than it was in 2000. For India, he projects that a nascent epidemic could depress output by 40%, and an concentrated one could mean that output per worker could be no higher in 2025 than it is today. He projects that for China, an epidemic with a peak prevalence rate of 1.5% could cut half a percentage point off the long term economic growth rate.
- 3.4 Greener (undated) presents a contrasting picture. He summarises the various econometric models which have been used since 1992 to try to assess the macroeconomic impact of HIV. He concludes that overall, the models find that while the macroeconomic impact of HIV is likely to be negative, it is also quite small. Furthermore, the reductions in GDP and GDP per capita growth caused by HIV are probably less than the variations in growth rates that result from changes in the broader economic policy environment. It is tempting to conclude, he asserts, that the negative macroeconomic impacts of HIV can be offset by other economic reforms – in fact, he argues, the prospect of HIV-related growth problems should act as an incentive to proceed with reform programmes that are needed for other reasons.
- 3.5 In a recent paper, Haacker (2002) for the IMF questions two main arguments. Firstly, most of the economies worst affected by HIV are characterised by high rates of unemployment or a high share of the working population in the informal sector. He reports that various authors have argued that 'per capita output might actually rise as workers involved in low productivity activities fill the vacancies created by AIDS in the more productive formal sector'. However, he writes, this does not necessarily follow, as higher costs or a decline in the supply of skilled workers would also result in a decline in the demand for unskilled workers in the formal sector.

- 3.6 Secondly, he states that in most studies on the impact of HIV on economic growth or per capita income, the negative impact of declines in productivity or the supply of human capital is at least partially offset by an increase in the (physical) labour-capital ratio. Aggregate changes in savings rates appear to be relatively small, and the steady state capital-labour ratio rises as the growth rate of the working population declines. However, he argues, a significant increase in the rate of return to capital, and the assumption that this would not affect investment behaviour is questionable.
- 3.7 Haacker (2002) examines two methods of modelling the macroeconomic impact of HIV; a dual economy model and a one-sector neoclassical growth model. He finds that it is not possible to confirm the hypothesis that HIV results in a decline in unemployment rates, and therefore on per-capita output. HIV affects both the supply and demand for workers in the formal sector, and the net effect, he says, is ambiguous. He concludes that the lower the level of foreign assets held by a country, or the higher the external debt, the larger will be the adverse effect of HIV. In the context of SSA, this is particularly relevant for highly-indebted low-income countries, and Haacker therefore concludes that any macroeconomic assessment of the impact of HIV should include an analysis of the implications for the sustainability of external debt.

4 HIV, VOICE AND MARGINALISATION

- 4.1 HIV/AIDS exacerbates, and is in turn exacerbated by political and social exclusion. Politically and socially marginalised people including women, migrant workers, sex workers, injecting drug users (IDUs) are relatively vulnerable to HIV infection for a number of reasons, including having relatively restricted access to user-friendly health services, public health information and access to justice (e.g. protection against economic or sexual exploitation). People affected by HIV are in turn subject to further stigmatisation. Once infected, already-marginalised people are poorly placed to protect their rights.
- 4.2 Suggestions from lessons learned from ‘success stories’ of tackling HIV include the importance of an inclusive strategy, based on broad social mobilization. There is a growing literature covering the concept of responding to HIV by involving those most affected. International HIV Alliance (2002) argues that global experience has shown that involving those most affected strengthens the effectiveness of responses to HIV. In relation to HIV programming, this includes involvement in analysing their own vulnerability and risk, in designing projects and in making decisions about interventions. An approach based on felt and expressed needs ensures that resources are used more effectively and sustainably and ownership of projects is thereby strengthened.
- 4.3 In terms of marginalisation, evidence from China suggests that the problems faced by HIV-infected individuals, their families and other supporters goes beyond social stigma. According to Bates (2002) Western journalists’ and Chinese activists’ reports, their basic rights are not properly protected, including their rights to employment, health care, education, privacy, marriage and freedom of movement (though others argue that it is freedom of movement that creates a vulnerable class).
- 4.4 Law enforcement in China often treats the infected as criminals, assuming they contracted the virus through drug use, prostitution or homosexual intercourse. State regulations require that HIV patients be ‘isolated for treatment’, and that men and women in the HIV ‘infective period’ delay their marriage ‘for the time being’. A further problem in China is that central authorities are increasingly ineffective in ensuring adherence to central government directives in the provinces. As a result, provinces have enacted restrictive laws against people living with HIV. For instance, in 2001 Chengdu City prevented the HIV positive from marrying, and mandated AIDS tests for returning Chinese women who had been abroad for more than a year, suggesting that pregnant women with HIV be persuaded to abort their foetuses if medicine to prevent mother-child transmission could not be obtained.
- 4.5 Richter (2002) of the AIDS Law Project in Johannesburg (ALP) writes that South Africa has an AIDS discrimination problem of tremendous magnitude. Although a number of key laws and policies have been enacted, AIDS discrimination continues to have an insidious impact on the private and public lives of people living with HIV, and on South African society as a whole. ALP has identified instances of marginalisation such as employer discrimination, including practices that involved employees (or potential employees) being sent for HIV tests in order to ascertain their HIV status. Their applications for a specific job or for permanent status in the companies would subsequently be rejected and those already employed would be demoted or dismissed from their jobs. Richter argues that certain groups of people can be identified as more likely to experience AIDS discrimination in more aggravated and all-consuming forms.
- 4.6 These people constitute already vulnerable groupings in society and are identified by markers such as race, gender, sexual orientation, class, level of education and economic activity. This pre-existing vulnerability, due to factors other than HIV infection, such as racism, sexism, homophobia, elitism and other forms of xenophobia, compounds and exaggerates the discrimination felt on the grounds of HIV infection and can also be seen as initiating it. She writes that in South Africa, this type of discrimination

originates in specific institutions within societies. Certain groups of people are given preference over others. PLWAs are typically excluded from certain forms of employment, certain positions within workplaces, not seen as subjects worthy of investment such as the building of their skills, capacity or knowledge, excluded from insurance benefits and certain medical aid provisions, as well the protection of the law.

5 SSAJ AND HIV

AIDS widows, orphans and inheritance rights.

- 5.1 This section covers both the issues surrounding the inheritance by widows of material property, and the inheritance of the widows themselves.
- 5.2 Inheritance law in SSA is a complex issue which has led to considerable confusion over the rights of widows and orphans to inherit property. A further discussion of this, with examples from Uganda and Tanzania, can be found in Annex 1.
- 5.3 In a paper reporting a study in Kenya, Ayieko (1997) argues that fear of talking about death has led many parents dying of AIDS to neglect to instruct their surviving dependents about the family properties and how they were to be inherited. Many parents thus die intestate, and financial resources are lost not only to trustees but also to unethical family friends, work colleagues and relatives who take advantage of the unsuspecting orphaned children. Where grandparents are still alive, they often do not have the capacity to follow up their grandchildren's rights due to advanced age, ignorance, fear of being intimidated while pursuing the estate, and feelings of helplessness having lost what they had anticipated as being a financial support. Lengthy procedures and red-tape can also deter many honest individuals from assisting orphans who have lost their inheritances.
- 5.4 In terms of the inheritance of the widows themselves, this practice is increasingly coming under scrutiny due to the effect of HIV. Sleaf (2001) writes that there are fears that such practices may be costing lives, with widows either at risk of becoming infected, or of themselves transmitting the virus to their inheritors (typically their dead husband's brother). In the context of the spread of HIV through heterosexual intercourse, there is evidence of a cultural backlash, a call to impose restrictions on women in order to strengthen traditional culture, this rejecting so-called western sexual mores and gender roles, and in doing so, curtail the spread of HIV.
- 5.5 According to Sleaf, widow inheritance is a practice some think should be revived. In parts of Kenya, elders have expressed a wish to impose widow inheritance on infected widows, taking away the symbolic, traditional, 'sexual cleansing' element of the practice, and renaming it 'symbolic inheritance'. One aim here is to maintain the extended family as a means of caring for AIDS orphans. They fear that the loss of these customs may penalise widows who wish (to avoid destitution) to be inherited. In Zimbabwe, widow inheritance is said to be flourishing, but in Zambia some men are said to have refused to inherit a widow if there was any doubt over the cause of her husband's death. Therefore, Sleaf observes, while on the one hand there is a call for these practices to be abandoned, there is also a belief that the best approach is not to abolish them, but to make them safe, by removing the sexual element.
- 5.6 The 'Children on the Brink 2002' report, from UNAIDS, UNICEF & USAID, states that of the 40 million people estimated to be living with AIDS (LWA) today, around 3 million are children under 15. In addition, the HIV epidemic has orphaned millions of children; more than 13 million children under 15 have lost one or both parents to HIV, and most of these are in SSA. By 2010, this number is expected to have risen to more than 25 million. The report argues that AIDS orphans must be considered alongside orphans due to all causes, children living with sick or dying parents, and households that have taken in AIDS orphans. The growing number of orphans is placing particular stress on household coping mechanisms, as extended families attempt to support orphans of relatives.
- 5.7 The term 'street children' has many definitions, but is generally taken to mean children aged under 18 who see the street as their home, having largely broken ties with their families (either as 'runaways' or

‘throwaways’). AIDS orphans may form one of the sub-groups of street children. Whatever the cause of children being on the street, evidence suggests that some of their behaviours on the street put them at risk of HIV infection (Anarfi, 1997)

- 5.8 The ‘Children on the Brink’ report states that children orphaned by HIV are at serious risk of exploitation, including sexual and physical abuse. Isolated from emotional connections with the family, some turn to risky sexual behaviour, and those forced to live on the streets may turn to prostitution and crime as a means to survive. While many of these children were born free of HIV infection, they then become highly vulnerable.
- 5.9 Anarfi (1997) draws on findings from research carried out in Accra, Ghana, which suggested that street children’s understanding of the issues surrounding HIV (modes of transmission, methods of prevention) were deficient, due in part to the fact that street children are out of the education system, and reported relying on (often equally poorly-informed) friends for information. In terms of street children’s risk behaviour, Anarfi suggests that due to the vulnerability of their situation, many of the coping strategies employed by children are harmful to their health. The majority of street children in the Accra study said they were sexually active. The mean age for first sexual intercourse for both sexes was 14.5. Condom use among sexually active children was at a low level (unsurprising since only half knew this could protect them from HIV infection). Anarfi concludes that street children are vulnerable to HIV infection because they are sexually active, commonly have unprotected sex, and although they are generally aware of HIV, the information they have is insufficient.

Sexual violence against women and HIV

- 5.10 This section covers sexual violence against women in the domestic setting, as compared to the conflict/post-conflict setting, which is included in section 6
- 5.11 Evidence from a small study (n=245) in Dar es Salaam, Tanzania, suggests that HIV-positive women report more lifetime partner violence (sexual or otherwise) (Maman et al, 2002). The authors write that increasingly, violence and threats of violence are emerging as important factors fuelling the rapidly increasing HIV infection amongst women.
- 5.12 There are different ways in which HIV and violence overlap in women’s lives. Violence may increase a woman’s risk of infection through forced or coercive sexual intercourse, and by limiting her ability to negotiate HIV-preventative sexual practices. Physical and sexual abuse during childhood has also been associated with high-risk sexual behaviour in adulthood. In the Dar es Salaam research, the authors found that 16.8% of women interviewed thought that fear of HIV infection was not adequate reason for refusing sexual intercourse. The research concluded that there was a strong association between prior history of violence and women’s HIV status.
- 5.13 Women infected with HIV were significantly more likely to have had a physically violent partner, and to have experienced physical violence, sexual violence, or both, with their current partner. Drawbacks of the study (small sample size, non-representativeness of sample, problems of recall, and of women’s minimalization of experiences of violence) are acknowledged.
- 5.14 A major implication from the study is that in Tanzania, where HIV is increasing, and violence against women is common, large scale and sustained, coordinated and evaluated interventions are needed.
- 5.15 Elsewhere in SSA, Caesar (2001) reports that the belief that sexual intercourse with a virgin, usually a young girl, can ‘cure’ HIV is widely held in Southern Africa, particularly South Africa, implying that this

belief can lead to sexual violence. She also reports anecdotal evidence that disclosure of HIV-positive status can provoke a violent (if not necessarily sexually violent) reaction.

- 5.16 Evidence from China (UNAIDS 2002a) suggests that violence against women, including sexual abuse, reduces Chinese women's control over their exposure to HIV. In particular, the status of new brides in China is particularly low. Young women, taken away from their social networks to live with their husbands' families, are expected to be submissive to their husbands, and to become pregnant as soon as possible. In these circumstances it is extremely difficult for Chinese women to negotiate safe sex.

HIV in prison systems

- 5.17 Penal facilities around the world report grossly disproportionate rates of HIV infection and of confirmed AIDS cases. While overcrowding and a lack of appropriate services facilitates the spread of many infectious diseases in prisons, HIV results particularly from the failure of prison authorities both to protect prisoners from sexual violence and to offer even simple and cheap access to condoms. Access to ARVs has contributed to lower death rates from HIV in Western Europe and North America, but they have been unavailable elsewhere, particularly in Eastern Europe (Canadian HIV-AIDS Legal Network & Canadian Strategy on HIV 2001)
- 5.18 MAP (1998) states that HIV in prisons is a major problem in the post-communist world. The number of infected prisoners in Russia has increased dramatically, and by May 1998 about 25% of all Russian *registered* as HIV-positive were in prisons, the largest proportion of these being in the Kaliningrad, Krasnodar, Rostov and Tver regions.
- 5.19 There is not sufficient empirical evidence to prove that HIV transmission takes place in Russian prisons, but anecdotal evidence would suggest that it does. Sex between men, including rape, takes place, although little is known about its frequency. Risk behaviours such as sexual relations are considered a severe violation of regulations in Russia, and information is suppressed by the institutions concerned.
- 5.20 Drug distribution and consumption also takes place in Russian prisons, and needle sharing is common (MAP 1998). In addition, the traditional Soviet/Russian practice of prison tattooing, with different tattoo designs denoting crimes committed and time served, also presumes the sharing of needles and tattooing equipment. The traditional approach to the control of HIV in prisons has been mandatory testing of all those arrested and under criminal investigation, repeated testing once incarcerated, and isolation of infected prisoners. However, in Russia, despite these policies, no funds have been allocated for the construction of separate accommodation for the infected.
- 5.21 In terms of HIV morbidity in Russian and Chinese prisons, overcrowding and lack of healthcare facilities, and the prevalence of TB amongst prisoners, are contributing factors. A large percentage of Russian prisoners become infected with TB, which itself has reached epidemic levels in the former Soviet Union. TB is now the most common killer of HIV-infected people in the region, and in prisons alone more than 30% of those with TB have a multi-drug-resistant strain of the disease (Malinowska-Sempruch, 2002). According to UNAIDS (2002a) in China the prison population contains a large but quite unattended group of people who need healthcare, HIV prevention and information to adopt safe practices. No figures for HIV infection rates in Chinese prisons are available.

HIV in police forces

- 5.22 It has long been suspected that police officers are a high-risk group for HIV infection, and research is beginning to provide evidence of this. For example, the work of Akinnawo (1995) shows that male Nigerian police officers are at high risk of infection due in part to the nature of their employment.

Nigerian officers are frequently required to move job location, and cannot always take their families with them. This is seen to encourage extramarital affairs and multiple sexual partners. The strain of police work is also said to contribute to pressure on marriages, and therefore to the prevalence of extramarital affairs.

HIV in judiciaries

- 5.23 There seems to be very little information about the prevalence of HIV in judiciaries, other than that which can be inferred from information about the impact of HIV on the public sector in general. Schneider and Moodie (2002) comment on ‘serious impact’ on police and the judiciary in South Africa as part of the high prevalence rate in the senior civil service. There is at present no information pertaining to the impact of reduced judiciaries on access to justice issues, although these can be inferred.

Laws/policies that increase vulnerability to HIV

- 5.24 Evidence here is difficult to identify, and it is not always the case that a law/policy, which makes a certain group more vulnerable to infection, has no positive outcomes. It also seems to be the case that there are examples of policy lacks, or deficiencies, causing increased risk, rather than policies actively acting against certain groups. For example, China has only just introduced sex education into a minority of its schools. It could be argued that the lack of this education is a policy deficiency which has put young people at increased risk of infection.
- 5.25 Another policy example comes from China, where it could be argued that the government’s initial non-acceptance of HIV as a problem for China put the whole country at risk. A particular example is that of the recent relaxing of the *hukou* system of household registration, which bound people either to the rural village or urban area where they lived. This relaxation has resulted in far more freedom of movement, but has done nothing to ensure better access to services.
- 5.26 The most dramatic expression of this freedom, according to Bates, Chang and Palmer (2002) is the ‘floating population’ (*liudong renkou*), an estimated 100 million roaming workers living unregistered and undocumented, without housing subsidies, healthcare or education. These workers are expected to become one of the most significant sources of HIV infections in China. Composed of young to middle-aged men and women, in their most sexually active years, many in this group are poorly educated, use drugs, and over half are estimated to work in the ‘entertainment industry’ which can include commercial sex. Their situation on the fringe of society means that HIV awareness education, monitoring and treatment are extremely difficult to provide.
- 5.27 One of the most important legal/policy issues surrounds treatment of marginalised groups including sex workers and IDUs. Punitive policies can undermine public health interventions. In China, for example, despite regulations to the contrary,³ police often use possession of condoms as proof that women are sex workers, making it almost impossible to increase condom use among sex workers and their clients (*pers.comm.*, Laurence 2003; UNAIDS 2002a:34) .
- 5.28 Another example is that of Vietnam, where AIDS workers argue that the government’s policy of arresting sex workers and drug users under the guise of social rehabilitation only makes the problem worse. The government contends that the source of Vietnam’s HIV problem is heterosexual intercourse involving prostitutes; there are state facilities specifically designed for the rehabilitation of sex workers and IDUs. However, the rehabilitation is ineffective, and this policy stands alone, rather than being integrated into a broader approach including education, awareness raising, condom

³ 1998 Regulation on ‘Principles for HIV/AIDS Education and Communication’

distribution, needle exchange and so on. In fact, UNAIDS in Vietnam consider that the government's policy is driving prostitutes and IDUs underground, where they will be harder still to reach and assist (Schnayerson, 2002).

- 5.29 In Russia the government insists that legal authorities should have access to HIV test results, and people who test positive and are thought to have contracted the infection through illegal drug use are subject to prosecution. This creates a powerful incentive among citizens to conceal and misrepresent their HIV status, and therefore increases the risk of infection (Eberstadt, 2002).
- 5.29 At the SAfAIDS monthly discussion forum (July 2002), Dr Val Ingham-Thorpe, Director of Veritas Trust discussed selected legislation and the legislative process in Zimbabwe and how it impacts on the spread of HIV and AIDS, as well as the efforts by civil society to ensure that legislation does not increase the risk of infection. Some current and recently enacted laws in Zimbabwe have had mixed impacts on the spread of HIV and AIDS in the country. While in some ways the laws have helped in protecting the vulnerable from infection, in other ways they have put them at risk.
- 5.30 Examples of legislation putting groups at risk include the Children's Act (formerly The Children's Protection and Adoption Bill). The Act provides for the protection, welfare and supervision of children and juveniles. However mechanisms for adoption and guardianship provided for in the Act are not coping with the millions of children orphaned as a result of the AIDS pandemic. The Act also provides for stiff penalties for not sending children to school, but does not take into account the economic burden placed on most families by HIV.
- 5.31 Another example is the Deceased Estates Act (DEA). This Act provides for maintenance out of the estate of a deceased person for certain members of his/her family. Amendments to the Deceased Estates Succession Act and the Deceased Persons Family Maintenance Act saw the inclusion of provisions that benefit wives and children more than before. However, the relevance of DEA in the context of HIV and AIDS is limited. For example it does not consider de facto guardians and grandparents who may be the only surviving guardians of children. Furthermore, the justice delivery system has not been able to thoroughly enforce the law.
- 5.32 Specific to the context of Zimbabwe, the enactment of the Land Acquisition Act (LAA) and the subsequent implementation of its provisions has resulted in large movements and displacement of people. The resettlement of large numbers of people was accompanied by regrouping of family units and new, often unsafe sexual relations, which exposed children and women to risk of HIV infection (kubatana.net)
- 5.33 In South Africa, the lack of a comprehensive programme of drug provision for the prevention of mother-to-child transmission of HIV at birth was seen as a policy that has disadvantaged mothers and children alike. In September 2001, the NGO 'Treatment Action Campaign' took the South African government to court, arguing that this lack of provision denied women with HIV and their children access to health care services including reproductive health, discriminated against poor women, and black and coloured women who most often used the public health system, and, crucially, allowed unnecessary and avoidable infections to continue. The NGO was successful in the court case (Achmat, 2001).

6 HIV AND CONFLICT

- 6.1 Save the Children (2002) states HIV and conflict are a ‘double emergency’. In conflicts and related emergencies, high-risk sexual behaviour, including sexual bartering and sexual violence, contribute to the spread of HIV. In such settings, awareness of HIV is low, denial and stigma are widespread, health services are overwhelmed and under-resourced, and do not offer adequate care or protection against infection and disease. HIV rates are suspected to be high in conflict and post-conflict settings, but it is impossible to know, due to lack of surveillance, what the rates are, and whether HIV spreads more quickly. HIV prevalence is estimated to be high and rising in conflict countries like Angola, Sierra Leone, DRC and Liberia, where lack of reliable data makes assessment of epidemiological trends impossible.
- 6.2 Various authors, including Hsu (2001), Dupont (2001) ICG (2001) and Schneider and Moodie (2002) have discussed HIV’ impact on national and international security. Broadly, they argue that as HIV impacts on the critical infrastructures that sustain the security, stability and viability of modern nation-states, it undermines the stability of already weakened states, and adds to their vulnerability to extremists and terrorists. As economies and infrastructures falter, family and social networks fragment, mortality rises, and social and political unrest or conflict become more likely. At the same time, however, the effect of HIV on militaries, especially in SSA, means that at the same time as rising security challenges are faced, militaries’ abilities and capacities to cope are diminishing.

Links between HIV and conflict can be summarised as follows:

Conflict and sexual violence

- 6.3 Conflict can lead to higher rates of HIV infection, through sexual violence and bartering, especially when women and girls become vulnerable. Sexual violence is defined by Gordon and Crehan (undated) as the deliberate use of sex as a weapon to demonstrate power over, and to inflict pain and humiliation upon, another human being. Thus, sexual violence does not have to include direct physical contact between perpetrator and victim; threats, humiliation and intimidation may all be considered as sexually violent when they are used with the above purposes (Gordon & Crehan, 2).
- 6.4 In situations of conflict, the risk of sexual violence increases dramatically with breakdown in law and order, and large numbers of mobile, vulnerable and unaccompanied women and children. For men and boys, socialisation into military culture may involve sexual violence. Conflict situations make women and girls especially vulnerable to sexual violence; ‘forced marriages’, coerced sex and involuntary remarriage are all common in conflict situations where men and women have lost partners. Rape may be used as an instrument of terror or a symbol of victory.
- 6.5 Loss of homes, incomes and security in conflict settings may force women and girls into transactional sex, and in transit, sexually active (by choice or otherwise) refugees will be exposed to different populations with differing levels of HIV infection. In terms of HIV, the authors suggest that infection may be facilitated by sexual violence (ie be more likely than through consensual intercourse) through physical damage to the genital area. Figures supporting the thesis that sexual violence in conflict settings increases the spread of HIV may never be known, but there are proxy indicators. For example, in pre-genocide Rwanda, HIV infection rates were estimated at 25%, and over 35% among the military. The conflict itself created large numbers of refugees, exposing women and girls to risk. While it is certain that some women were infected through rape, the exact proportion or numbers will never be known. Gordon and Crehan report the belief that every female surviving the genocide was raped, and the fear that conditions in refugee camps may expose vulnerable groups to continued sexual violence.

- 6.6 Bazergan (2002) reports that peacekeepers in post-conflict situations are universally identified as the main clients of commercial sex workers. Peacekeepers tend to have disposable income, and missions can act as magnets for the sex market.

Conflict and health services

- 6.7 Conflict can lead to the breakdown of health services, and a resultant lack of protection and healthcare for the population
- 6.8 Save the Children (2002) report that lack of access to education and health services in conflict and post-conflict situations increases vulnerability to infection. In conflict, social services are starved of funds, which go instead to the military, and conflict can also weaken or even destroy health, education and communication systems. HIV care in conflict is limited to basic and inconsistent prevention work, usually confined to medical settings.
- 6.9 War-affected populations often lack access to antenatal services and screening for HIV. Prevention of mother-to-child transmission is therefore hindered. In addition, blood donation services become disorganised, and screening of donated blood is inadequate. In conflict-affected countries, there is an increased need for blood transfusions, and the blood given is less likely to be screened, increasing the risk of HIV infection.
- 6.10 Where district hospitals function, breakdowns in supply mean that they often lack needles and gloves, and have poor hygiene standards. In Angola, for example, donated blood is not screened for HIV outside large urban centres, and even in Luanda, not all blood is screened. Distribution of condoms may also be inhibited by conflict, especially in rural areas. Care for PLWA in countries undergoing conflict is especially limited. In Sierra Leone, 62% of peripheral health units do not function, and there is massive shortage of ARVs.

Information dissemination during conflict.

- 6.11 There is acute lack of knowledge about HIV in conflict situations. Low awareness of HIV in conflict is partly due to the fact that conflict undermines awareness raising and prevention efforts, and partly because, even where awareness is high, the daily realities of life under conflict can diminish the perceived risk of HIV infection. In Liberia and Sierra Leone, for example, Save the Children (2002) reports that awareness levels are very low. Even where awareness raising work is underway, it can be directly disrupted by conflict, such as that carried out by Save the Children in Nepal's Achham district.

Refugees

- 6.12 Conflict can involve movement of refugees, who face risk of infection whilst mobile and vulnerable, and when staying in refugee camps. UNICEF (2002) states that conflict creates and exacerbates the conditions in which HIV flourishes. Crowded, unsafe displacement and refugee camps expose women and children to the risk of sexual violence. Lacking structures to equip people with information about prevention, and with little recreation, reproductive health services or learning opportunities, life in refugee camps is conducive to the spread of HIV.

HIV in militaries

- 6.13 de Waal (2001) notes that soldiers are one of the occupational categories most afflicted by HIV. HIV infection rates amongst soldiers are typically three times higher than in the general population, and are

higher among the higher ranks. Seropositivity rates of 50-90% are, he contends, common in armies in eastern and southern Africa. Military readiness is therefore reduced, as soldiers are commonly ill.

- 6.14 Shortages of experienced and trained personnel, especially in skill-intensive positions in the air force, mechanised divisions and intelligence, will become acute as the epidemic progresses. Civilian-military relations are adversely affected, as the general population often fears that the army is spreading HIV. Spending on healthcare for soldiers and their families, and on pensions, will consume an increasing proportion of defence budgets.
- 6.15 HIV prevalence is high amongst many African nations' peacekeeping forces. For example, Nigeria: 11% of peacekeepers returning from Sierra Leone and Liberia, vs 5% in adult population⁴; South Africa: 60-70% in military vs 20-25% in adult population⁵; close to one third of Namibia's 15,000-strong National Defence Force is infected⁶; a study by PANOS Institute indicates that 25-50% of officials employed in Malawi's army are HIV-positive and may die within four years.
- 6.16 PANOS (undated) argues that while peacekeepers are generally welcomed as guarantors of normality, they are sometimes accused of sexually exploiting local women and children, and of spreading HIV. In 2001, the Eritrean government expressed concern over an allegation of sexual abuse by a UN peacekeeper of an underage girl, and there have been similar accusations in Mozambique and Sierra Leone. The extent to which peacekeepers do spread HIV is uncertain, but whether or not they transmit the virus to the civilian population, peacekeepers are themselves at risk. Nigerian troops on peacekeeping duty must test HIV-negative before deployment and are also tested on return. The reality, say PANOS, is that during peacekeeping missions there is a much higher probability of contracting HIV than of being killed in action.
- 6.17 However, UNAIDS (2002) asserts that while militaries certainly do play a role in the spread of HIV, their role should not be viewed as entirely negative. They state that uniformed services can be important advocates in the fight against HIV, both at the local and the national level. Changing the perception and behaviour of a soldier can go a long way in reaching and having a major impact on the population at large. This is especially true, they argue, in countries where uniformed services represent the only source of security for people in a context of insecurity and unrest.
- 6.18 Testing policies for militaries, including peacekeepers, are critical to the relationship between conflict and HIV. Bazergan (2002) records UN Department of Peace Keeping Operations (DPKO) policy on testing, which states that immune compromise, including HIV, is one of the conditions that should preclude peacekeeping service, but assessments of severity should be made on an individual basis. It states that in UN peacekeeping operations, HIV-positive individuals who do not show clinical manifestations of AIDS are not precluded from peacekeeping service, but that these individuals should not be selected, owing to the risk that treatment for them during service will be inadequate. Their HIV status should also be made known to the Force Medical Officer. It also acknowledges the risk that infected individuals will pass on the infection.
- 6.19 The UN recommends that any individual developing clinical AIDS should be repatriated for treatment. However, in practice DPKO has been less restrictive in the application of these guidelines. Information regarding HIV-positive individuals deployed has never been requested or volunteered in any mission.
- 6.20 Bazergan further states that some nations are reticent about supplying information about their military HIV policies, and that these policies are not always systematically or coherently implemented. Her

⁴ Nigeria AIDS bulletin No15, May 20, 2000

⁵ The Mail and Guardian, Pretoria, March 31, 2000

⁶ UNAIDS/WHO 1999 estimate.

research into peacekeeping missions in Sierra Leone found that all contingents reported a policy of testing prospective peacekeepers before deployment, but that this policy was not always implemented. All contingents operating in the country stated that HIV-positive troops were prohibited from serving, with the exception of Zambia, which prohibited the asymptomatic. Apart from Ghana and Zambia, all also tested troops on return home. Most armies tested on recruitment, but some tested only before peacekeeping deployment. Crucially, tests take place immediately before deployment, and test for antibodies, for which there can be a 'window' period resulting in false negatives. Data management has also been called into question.

- 6.21 Post-test counselling is not always offered, and although serving soldiers would be told of their positive status if thereby precluded from peacekeeping duties, not all prospective recruits would be informed if thereby rejected from employment in the army. For peacekeepers found to be HIV-positive whilst on mission, military policy varied. Bangladesh, Jordan and Pakistan stated that troops would immediately be repatriated; Kenya and Zambia said asymptomatic individuals would remain. Russia and Ukraine were unclear on policy, and many countries claimed to have had no test cases thus far.

HIV and the nature and duration of conflict.

- 6.22 de Waal (2001) notes an incidence of HIV having an impact on conflict: in DRC, the need for the ARV drug AZT by officers in foreign armies stationed in Congo, and the possibilities for earning the money needed for this treatment by smuggling minerals (whereas being retained at home on basic pay would preclude buying life-sustaining drugs) may have contributed to the intractability of the conflict.

Demobilisation and HIV

- 6.22 Demobilisation is the stage at which former combatants are reintegrated into civilian life following conflict. There appears to be little research into this precise issue, but work by Bazergan (2002) on the peacekeeping mission in Sierra Leone has touched upon it. She found that in general, the Republic's armed forces are a high-risk group, with low awareness of HIV. In terms of demobilisation, a reproductive health component of the country's HIV policy, initially provided as part of the demobilisation process, was dropped, reportedly because of financial and time constraints. In the initial stage of pre-discharge orientation, ex-combatants received a reproductive health component, with an emphasis on HIV and other sexually transmitted infections. But the National Committee for Disarmament, Demobilisation and Reintegration dropped this element after six months, reportedly because of financial constraints and complaints by former combatants about the overall time (six weeks) spent in the demobilisation centres.
- 6.23 Carballo, Mansfield and Prokop (2001) argue that given the infection risks associated with demobilized soldiers, it is rather surprising that very little HIV awareness raising has been undertaken during demobilisation programmes, and assert that the opportunity to inform "captive" high-risk audiences of the dangers of AIDS should be seized. They note that the goals of demobilisation programmes relate primarily to the need to guarantee security in post conflict situations.
- 6.24 To date, health, specifically HIV prevention, has not been addressed as a "security" issue, but that is changing rapidly. The UN Security Council has now recognized HIV as an issue of both human and national security. Its omnipresence in SSA is a key reason for the economic and social problems that the region is facing, and it is one of the most important determinants of falling human development indicators throughout the region. As such, they argue, it is surely contributing significantly to political instability and the incapacity felt by many people to plan for the future. Military personnel are at serious risk as a group, and when they are re-inserted into civil society they may also constitute a potential human vector threat.

7 CORRUPTION AND HIV TREATMENT

- 7.1 There are suggestions that HIV-related corruption is taking place at a number of levels.
- 7.2 de Waal (2001) argues that it is ‘certain that HIV is contributing to incidents of corruption’ He contends that on an individual level, those who know they are HIV-positive will try to seek illegal sources of income, both to pay for treatment, and to ensure that their families are catered for when they are incapacitated and after they have died. These people are not only minor bureaucrats, or middle-rank managers, but also government ministers, generals and the owners of businesses. They may also be ready to tolerate extreme abuses of power, or to engage in high-level corruption, to serve their own and their families’ interests.
- 7.3 At an organisational level, in Zimbabwe, allegations of corruption and misappropriation of funds have been levelled against the Zimbabwe National Network for People Living with Aids (ZNNP+), funded in part by a 3% ‘AIDS levy’ on personal and corporate income in the country. It is alleged that the director of the Network misappropriated funds for his own personal use (IRIN News).
- 7.4 At a national level, the corruption present in some governments has an effect on issues associated with HIV. Madavo, World Bank deputy president for the Africa region admitted that only 12 out of every 100 US dollars intended for use to purchase drugs is actually used in this way. Madavo added that 60% of World Bank loans to African governments were directed towards the purchase of drugs to treat HIV-related infections (Agence France-Presse 1999).
- 7.5 UNAIDS (2002a) reports that in China, corruption in blood and plasma donation is increasing the risk of infection of HIV. Blood donation in China is adversely affected by a cultural taboo, and the country suffers from chronically low supplies. This predisposition against donation means that much of China’s blood supply comes illegally from paid sellers, through a lucrative and poorly regulated enterprise.
- 7.6 In a number of provinces, mainly in central China, the poor sell blood and plasma to commercial blood processing companies, which target such areas to avoid interference from the authorities. The blood collecting companies mostly operate illegally and profit from selling blood products domestically and internationally. In plasma donation, blood collected from many donors is mixed, pooled plasma is separated from red blood cells, and then the red blood cells are reinjected back into donors, so as to reduce anaemia, enabling them to sell plasma more frequently (sometimes several times each day).
- 7.7 This method of plasmapheresis can infect a large number of donors on a single occasion, even if only one donor carries the HIV virus. China’s 1998 Blood Donation Law made the sale of blood illegal, but continued demand meant that commercial collection moved underground, where Bates, Chang and Palmer (2002) report incidents of state-run factory workers, who, when given mandatory blood donation quotas to meet, pay dealers (‘bloodheads’) to find migrant workers to donate in their stead.
- 7.8 In many cases, this reluctance to donate stems in part from cultural preference, and also from well-founded fear of contamination from reused needles and unhygienic conditions in many of China’s hospitals. Blood given by different groups of the population is at different levels of risk of passing on infection. For example, according to a report in the People’s Daily (7/7/1998) the prevalence of Hepatitis B virus in voluntarily donated blood was 1%, in blood donated as a civic obligation, 2%, in paid donations, 8-13%, and in blood sold by migrant workers, 40-50%. Blood collectors rarely screen sellers for HIV, nor do they test the blood before selling it to hospitals. Indeed, because of increasing healthcare costs in China, many people needing blood transfusions are advised to go directly to

collection stations to purchase inexpensive blood, bypassing hospital screening altogether (Bates, Chang & Palmer, 2002).

8 SUMMARY

- 8.1 This review has looked at specific issues regarding HIV and governance, and has drawn together findings from research from donors, NGOs and academics from a wide variety of studies at different scales.
- 8.2 One of the main conclusions to be drawn is that data does not exist to answer all of the questions posed. In some cases this is because causality is extremely difficult to establish, and so impact is difficult to assess; in others because data are simply unavailable. However, this lack of data is an opportunity for further research.
- 8.3 In terms of donor approaches and interventions, this review has identified some interesting findings. There is a lack of studies which consider the public service as a whole, rather than concentrating on individual services such as education and health, and therefore there is a lack of understanding and research into how the problems of one sector affect the others – some recent work has been done on the relationships between health and education, but there are as yet very few systematic studies looking at the impact of HIV on the public sector as a whole.
- 8.4 In terms of projections of future impacts, this review has described the difficulty of accurately modelling impact, and in particular has identified problems of identifying cause and effect. For example, it is difficult to identify the impact on long-term literacy of children absent from school to care for sick relatives. Estimates of carer absenteeism exist, as do projections of long-term educational attainment, but identifying the extent to which one will directly affect the other is ambitious. Modelling does, however, have unmet potential for exploring the dynamics between HIV and development. Historically, projections have tended to focus on HIV's demographic and macro-economic impact. The growing recognition that HIV impacts on broader development goals has stimulated an interest in exploring the dynamic relationship between HIV, governance and development. The UNDP in Beijing, for example, has recently commissioned a study on how the legal and policy environment will affect the impact of HIV in China.
- 8.5 The nature of the information presented, in some cases contradictory, based on different assumptions, and leading to different conclusions about the impact of HIV on governance issues, demonstrates some of the problems faced by donor agencies in designing interventions in this area. It is, however, clear that HIV is having a growing impact upon governance and that governance issues in turn impact upon vulnerability to HIV.

Annex 1

Inheritance law in Sub-Saharan Africa

Inheritance law in SSA is a thorny issue. As an example, WidowsRights discusses the multiplicity of inheritance laws in Tanzania. In matters of inheritance in Tanzania, three systems operate hand in hand; Statutory Law, religious laws and customary law. 'Native' Tanzanian affairs are presumed to be regulated by customary law, except where there is an express indication that any other law ought to apply. Statutory law designates a two-thirds share of the deceased's estate to sons and daughters, and a one-third share to the widow/widower. However, to enforce statutory law, it must be accepted by the court that the deceased had abandoned the customary way of life in favour of a non-traditional way. Islamic law creates fixed and unfixed shares of inheritance, which are gender-based. Widows are entitled to one-eighth of an estate if the deceased has children. Islamic law is only applicable if a member of a native tribe shows that at the time of his death, the deceased intended that Islamic law should apply. Customary law completely bars women from inheriting land from their deceased husbands, even when the land is marital property, and subjects the widow to being inherited by her husband's family (WidowsRights, undated).

Confusion over inheritance law is also a factor in Uganda. Two studies are drawn upon here, one of which assumes that widows have the right to inherit their dead husband's property, the other stating that this is rarely the case. Gilborn et al 2001 found that amongst widows, (n=204) 29% said that property was taken from them when their husband died, making them four times as likely as widowers to experience 'property grabbing', a phenomenon whereby inherited property is taken from surviving family members and heirs to whom it rightfully belongs. In addition, 21% of orphans aged 13-18 (n=105) reported experiencing property grabbing. Ntozi, (1997:127), describes traditional Ugandan inheritance systems, asserting that 'in all Ugandan societies most of the deceased man's property is inherited by the heir who cannot be his widow'. 'Property-grabbing' undermines the livelihood of households that are already weakened by the death of adult breadwinners. Despite valid concerns about property grabbing, only 10% of the parents in the Gilborn study had prepared written wills. Almost half the adult respondents in the study reported that property grabbing was a problem in their communities. They believed that property grabbing after the death of a spouse is a greater problem for women than for men. Paternal relatives are thought to be most likely to steal inherited property, but there are also fears that other community members and maternal relatives will also steal. More than 20% of parents fear that their property will not be distributed as they intend, and most are concerned about theft by paternal relatives. The study found the knowledge of Ugandan property and inheritance laws amongst respondents was limited. Gilborn et al claim that Ugandan law upholds the right of women and children to inherit property, with or without a written will. Only 76.5% of respondents in the study knew that children had the right to inherit in the absence of a will, and fewer still (63%) that women had the same right. These studies of inheritance assume a very property centred notion of entitlement and obligation: paying no heed to entitlement of widows to support from kin or affines and concomitant obligation on relatives of diseased to extend support to widows (marrying them being only one of many forms of support). Such obligations are equally subject to neglect of course. The studies also neglect analysis of the institutional strains that must occur where mortality amongst women exceeds that of men.

Annex 2

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