



AVERTING CATASTROPHE

AIDS in 21st Century Africa



A report by the Africa All Party Parliamentary Group

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Executive Summary

The Africa All Party Parliamentary Group has received over 50 written evidence submissions from experts and organisations working on HIV/AIDS in Africa and heard from 12 expert witnesses. In its analysis of this evidence, the Group has found that the AIDS epidemic is an exceptional threat to African societies and states as well as to millions of African people. It requires an exceptional response. Sporadic projects are not enough and will not avert the worst predictions. Like a surging flood, the death rates from AIDS will rise. The epidemic has the potential to tear apart social fabric, destroy developmental gains and plunge some regions into decades of stagnation and insecurity. In the worst affected areas AIDS threatens social, economic and political collapse. The window of opportunity to avert complete catastrophe is closing rapidly but the world has been slow to act. The time for action is now. Africa, indeed the world, cannot afford further delay.

The Group makes a number of recommendations, which are given in full at the end of this report. The seven most urgent recommendations are given below.

Key Recommendations to the UK Government:

- 1. Plug the gap in funding needed to avert the worst predictions by:**
 - (a) Setting a timetable for UK overseas development assistance to reach 0.7% of GNI within the next Parliament.**
 - (b) Launching the International Finance Facility in 2005.**
 - (c) Pushing for the urgent use of unspent funds within the European Development Fund.**
 - (d) Increasing UK funding to the Global Fund to Fight AIDS, TB and Malaria to US\$ 216 million¹ for the 2005 funding rounds.**
 - (e) Pushing for better coordination of existing and new funds.**
 - (f) Working with partners including the Breton Woods institutions to ensure that HIV/AIDS funding is treated as exceptional investment and not delayed or reduced because of expenditure frameworks.**
- 2. Make sure policy across all UK Government Departments on HIV/AIDS is coherent and joined up. Under the leadership of DFID, every UK government department should develop policies to support coordinated and intensified efforts to fight the global HIV/AIDS epidemic.**
- 3. Support African governments, NGOs and community organisations to put together a full scale social rescue package. Such a package should be used to address the orphan crisis and the wider threat to the social fabric posed by the AIDS crisis.**
- 4. Support African governments to provide integrated health interventions including prevention and nutrition programmes and basic treatments such as antibiotics for opportunistic infections and antiretroviral therapy (ART). To deliver these swiftly, governments will need to harness the capacity of business, NGOs and community organisations.**

- 5. Support African governments and civil society in affected countries to develop policies and programmes to ensure access to health interventions on the basis of equity, cost effectiveness and transparency, and in particular to ensure that women are prioritised.**
- 6. Support African governments in affected countries to prepare for losses in capacity through capacity building programmes and massively scaled up staff training programmes particularly for key public sector workers such as teachers, health workers and public service managers.**
- 7. Use the UK's 2005 chairmanship of the G8 and presidency of the EU to urge all major donors to increase coordinated spending on HIV/AIDS to meet existing commitments and to prioritise the issues highlighted above.**

Background: The Scale of the Epidemic and the International Response

“HIV/AIDS globally is the worst disaster in recorded human history. It is already worse than the Black Death in Europe in the 14th century and the word ‘already’ is very significant because it is going to get much worse before it gets better even if we did all the right things tomorrow – and we are not.” (Professor Richard Feachem)²

Scale of the epidemic in Sub-Saharan Africa

Sub-Saharan Africa is home to between 25.0 and 28.2 million people infected with HIV/AIDS³. UNAIDS estimate that, in 2003 alone, 2.3 million Africans died of AIDS. Despite high death rates, the number of people infected continues to rise as new infections outstrip the number of deaths. In 2002 seven countries saw infection levels surpass 30% in the age band 15-49 years.

	Sub-Saharan Africa	Global Total
Estimated Number living with HIV/AIDS during 2002	25-28.2 million	40 million
Estimated Number of new HIV infections during 2002	3.0-3.4 million	5 million
Estimated Deaths from HIV/AIDS during 2002	2.2-2.4 million	3 million

Table 0.1

UNAIDS/WHO HIV/AIDS Regional Estimates as of end 2003. Source: UNAIDS 2003

Rates of infection vary enormously across Africa and even within countries. 30% of people living with HIV/AIDS worldwide are in Southern Africa, although the region is home to only 2% of the world's population.

In Swaziland and Botswana in 2002 national HIV prevalence stood at 39%. 10 years earlier the figure for Swaziland was at 4%. This shows how fast the epidemic spreads if unchecked. The figures indicate that a 15 year old Botswanan boy has approximately an 80% chance of contracting HIV at some time in their lives and dying of AIDS⁴.

In many countries the full extent of the epidemic is not yet known. Prevalence rates in Nigeria and the Democratic Republic of Congo have not been accurately measured. Sudan's epidemic has yet to be assessed: an end to Sudan's civil war may provide the best opportunity in a generation for development, but the return of refugees and the demobilisation of soldiers could trigger an HIV epidemic. The same concerns exist for other post conflict countries such as Angola and the Democratic Republic of the Congo, whose citizens may well be returning after taking refuge in countries with high HIV prevalence rates.

In a 2002 publication the US National Intelligence Council talked about 'the next wave' of HIV/AIDS. It predicted that in Africa's most populous country, Nigeria, the number of infected people will reach 15 million by 2010. It also estimated that in Ethiopia in 2010 HIV infections may reach 10 million⁵.

These figures outstrip current numbers in South Africa, where many would agree crisis point has already been reached. It should cause grave concern in those countries and among the international community. Yet it is still possible that successful interventions now could avert the catastrophically high levels of infection that have been predicted and curb the subsequent death rates that would follow.

Key Impact Groups

HIV/AIDS can affect anyone but young people and women, particularly young women are most at risk. They also bear the brunt of the epidemic's impact. Children also suffer many of the impacts, particularly orphans. UNICEF estimates that in 2003 there were more than 34 million orphans in the region, 11 million of them orphaned by AIDS⁶. By 2010 there will be 42 million orphans in Africa, of whom 20 million will have lost one or both parents from AIDS⁷. The burden of care for these orphans often falls on other vulnerable groups, such as the elderly.

Impact Areas

The current HIV infection rates can be described as the first wave of the epidemic. The size of this wave indicates the size of the second wave; HIV/AIDS deaths. That in turn brings the third wave; the 'impact wave'. This report examines aspects of this impact, how it affects communities, economies and key groups such as medical staff, teachers and security forces whose debilitation and death will seriously affect wider societies and states. The predictions are grim, leading the group to conclude that AIDS is a serious security issue and could contribute to the collapse of nation states in Africa. However if significant and effective interventions are made now to reduce the size of the first two waves, then the final wave – the impact wave – can be reduced. The Group feels however that so far interventions have been neither sufficiently effective nor big enough to make that difference.

The International Response

The domestic and international response to the HIV/AIDS epidemic in Africa has been hideously slow. The main obstacles have been lack of political will and the stigma attached the HIV/AIDS. This has allowed the epidemic to reach pandemic proportions in some countries. In the last few years however African governments and the international community have made a renewed effort to tackle HIV/AIDS. Political will and funding have risen significantly.

The UK is now the world's second largest bilateral donor for HIV/AIDS, after a seven fold increase between 1997-98 and 2002-03. In 2003 the UK spent US\$452 million directly on HIV/AIDS⁸. The biggest bilateral donor is the USA. In 2003, USAID's budget for HIV/AIDS programs was US\$795 million. Now the President's Emergency Plan for AIDS Relief (PEPFAR) has committed US\$15 billion over five years, focussed on specific countries.

As political will and funding have increased several new initiatives have been set up in addition to bilateral initiatives. These include The Global Fund to fight AIDS TB and Malaria, The Clinton Foundation and The World Health Organisation's 3 by 5 initiative which aims to get 3 million people in developing countries on anti-retroviral therapy (ART) by 2005. 2 million of these will be in Africa. All of these new initiatives and sources of funding are welcome but they risk failure to reach their full potential because they lack coordination and sometimes take up valuable capacity in African administrations. Each funder chooses to focus on a different area and they usually require different conditionalities and reporting systems. As in the poem of the blind men and the elephant – where each man feels a different part of the elephant and draws different conclusions about the whole - it is only by working together that each party can understand and deal effectively with the bigger picture.

To coordinate these new initiatives UNAIDS has proposed the *Three Ones* initiative which sets out principles to coordinate HIV/AIDS responses:

One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.

One national AIDS authority, with a broad-based multi sectoral mandate.

One agreed country-level monitoring and evaluation system.

The Three Ones approach has received strong support from DFID which also calls for better coordination in the *UK's Call to Action on HIV/AIDS*. The Group believes that full endorsement and practical implementation of the three principles will help to maximise the impact of HIV/AIDS interventions and reduce the strain on the administrative capacity of recipient countries.

Summary

The AIDS epidemic is an exceptional health crisis with potentially catastrophic impacts on physical and economic security and on the basic social fabric. The world has been slow to react to the AIDS crisis, but political will and funding are now increasing, leading to a number of initiatives that require coordination and sustained and enlarged support.

Key Impact Groups

Chapter One Young People and Women

HIV and AIDS can affect anyone, young or old, men or women, heterosexual or homosexual. In Africa today HIV infection is concentrated among young people. More women than men are infected, particularly amongst the younger age groups. Africa's young women are more at risk of HIV infection than any other group. Worldwide up to 60% of all HIV infections in women occur before the age of 20⁹. If current infection rates are sustained upwards of half of today's 15 year olds in the worst affected countries will become HIV positive¹⁰.

This section looks in more detail at how HIV/AIDS affects young people and women. It examines how gender and the balance of power between men and boys and women and girls affect the causes and consequences of the epidemic in Africa.

Young People and HIV/AIDS

"In a world beset by the devastating HIV pandemic, we are leaving our young people, the flower of our church and society, to wither and die through ignorance, the absence of open, honest and compassionate sharing of vital information, our embarrassed silence and resistance to reality. Our young people, who make up the majority of those infected, bear the marks of suffering too. They suffer the devastating impact of stigma the signs that mark our silence, our complicity, our lack of compassion and dishonesty."
(Archbishop Njongonkulu Ndungane)¹¹

Young people are in general the most sexually active so, unsurprisingly, they have high rates of infection. They are key drivers of the HIV epidemic and will also be its main victims. But they are also the most productive members of society, the wealth creators. They also form new families and have children who must be cared for and educated. The deaths of large numbers of young people could devastate African societies and economies.

	Female HIV Prevalence rates in 2001 (15-24 age group) Low - High	Male HIV Prevalence rates in 2001 (15-24 age group) Low - High
Botswana	30% - 45%	13%-19%
Lesotho	25% - 51%	11% - 23%
South Africa	21% - 31%	9%-13%
Kenya	12%-19%	5%-7%

Source: The Tip of the Iceberg: The Global Impact of HIV/AIDS on Youth 2002 The Henry J Kaiser Family Foundation

The US Census Bureau predicts that the number of people in the world aged between 15 and 24 years old living with HIV/AIDS will increase by 70% between 2002 and

2010¹². In countries like Botswana up to 45% of young women and 19% of young men are already estimated to be living with HIV. The impact of a 70% increase is almost unimaginable¹³. Already estimates suggest that in the worst affected countries a 15 year old has upwards of a 50% chance of contracting HIV at current levels of risk, and as high as 80% in Botswana¹⁴. If these predictions are borne out such countries will face catastrophe.

Young People and Prevention

At the UN General Assembly Special Session on HIV/AIDS in 2001, world leaders committed themselves to reducing “by 2005, HIV prevalence among young men and women aged 15-24.”¹⁵ But infection rates among young people are continuing to rise and the target set by the international community will be missed.

Preventing HIV infection among young people and other high risk groups is the first line of defence. Prevention efforts must be well targeted to be effective. If young people in general and young women in particular are at highest risk, they also logically need to be the main focus of prevention efforts to ensure maximum impact. They must also be well resourced over a sustained period of time, and remain a cornerstone of a comprehensive HIV/AIDS strategy even after infection rates drop.

Although the Group does not seek to make programmatic recommendations the following key issues are highlighted:

- Preventing HIV infection is the first line of defence against HIV/AIDS and the most cost effective.
- New infections are growing rapidly. In 2002 between 2 and 3 million more sub-Saharan Africans were infected indicating a need for scaled up and effective prevention interventions in all countries including those where infection rates are already high.
- Young people in general and particularly women and sex workers, are the drivers of the epidemic and prevention interventions will have most impact if they target these groups. Making these interventions friendly to youth and women will be essential to their effectiveness.
- Prevention efforts must be maintained over a long period to make a sustainable difference to infection rates.
- Prevention efforts must be a top priority in the context of a comprehensive HIV/AIDS strategy, combining prevention, treatment, care and support in countries with both high and low rates of infection.
- Stigma remains a serious barrier to improving prevention. Open discussion of sex, HIV/AIDS and other STIs is vital. The association of HIV/AIDS with promiscuity makes HIV positive people often feel ashamed. Characterising sex as dirty is unhelpful in breaking down stigma. Politicians must take the lead by talking about how HIV/AIDS have affected them, their families and friends and helping to end the taboo associated with the disease.
- The spread of HIV/AIDS must be seen within local economic and social contexts. Poverty and the imbalance of power between men and women fuel the epidemic.

Impacts on Young People

The highest levels of infection occur in the teenage and early adult years but death only follows between eight and ten years later. Unless life-extending treatment is offered, deaths are concentrated among the 20 to 34 year-olds¹⁶. At present in sub-Saharan Africa, a large proportion of young people do not know their HIV status and so invest in their future normally by pursuing education, building a career and starting a family. But they may also practice unsafe sex, further fuelling the epidemic.

But what will happen when this young generation, the most productive in society, begins to suffer debilitation and death from AIDS? Young adults, particularly women, are also the primary carers and educators of young children. Large numbers of deaths among these groups are personal tragedies but they will also have a profound effect on society. The roles of parents are fundamental to social reproduction and development. The predicted losses among this group, whether they are subsistence farmers, industrial workers or city professionals, will threaten social cohesion and economic security at the local and national level. These issues are discussed in chapters two and three.

Research is essential into the psychological impact of HIV/AIDS on young people, both HIV positive and negative. This generation will watch their peers, older siblings and friends fall ill and die around them. Will they become fatalistic and decide not to invest in their futures? Will the incentive of deferred gratification, one the chief drivers of economic development, be diminished? Will they simply not bother to enrol for higher education or training?

Most young people also tend to have less resources and savings than older people and those with children will have even fewer. They will not be able to buy HIV/AIDS treatments or even afford a healthy life style and good nutrition, both vital in delaying the onset of AIDS-related illnesses.

The stigma that still surrounds HIV/AIDS in many countries may leave some HIV positive people rejected by their families, including their parents. The possible consequences of such rejection are discussed in chapter four.

The Gender Divide

Women, particularly young women and girls, are disproportionately vulnerable to HIV infection and they also bear a disproportionate burden of the impacts of the epidemic.

The Vulnerability of Women

Biological, cultural and economic factors contribute to the vulnerability of women in the epidemic. The HIV virus, carried in sexual fluids, passes more easily from men to women during intercourse than vice versa, and can be further facilitated by vaginal lesions, caused by other STIs or by violence. Younger girls tend to have thinner mucous membranes and are thus even more susceptible.

The relative lower status of women in Africa restricts their control over sex and money. It is difficult for women to insist men use condoms, or even to refuse sex at all. They may

also suffer violence and rape. Box 1.0 summarises gender issues and the spread of HIV and AIDS.

In parts of Africa it is not unusual for older men to use their wealth to buy sex from girls or young women. But older men are also likely to have had more partners and therefore more likely to have sexually transmitted infections.

Women often cannot obtain the same level of health services as men in Africa. Girls may have less access to education than boys and so less access to prevention information. Where girls can get to school, sex education may be taboo and considered as a corrupting influence. Some girls and young women have only a basic knowledge of sexual reproduction and sexually transmitted diseases¹⁷.

Speaking to journalists in May 2004, Pallo Jordan, the South African Minister for Arts and Culture, said that traditional African culture was a serious barrier to attacking AIDS because the traditional African way of introducing young people to sex “does not give the scientific facts about sexuality”. “How do we break out and have a greater openness about sexuality?” he asked. It is difficult for outsiders, particularly Europeans, to discuss African cultural issues. But strong leadership and grassroots support, is needed to address these issues at local and national level, discouraging traditional practices that are clearly damaging and encouraging cultural practices which protect women.

Box 1.0 Gender Relations and the spread of HIV and AIDS

Sexual violence against women

In periods of instability and increased mobility sexual violence tends to increase. One graphic illustration of this is provided by the use of rape as a weapon of war. Ten years after the Rwandan Genocide, some of those who survived but were raped are now dying of AIDS.

A report by VSO documents evidence of widespread rape and coercion of young women in some stable areas with school age ‘date’ and ‘gang’ rapes now being widely reported in Namibia, for example. In South Africa a survey found that one in four South African young men out of 37,000 surveyed admitted forcing a woman to have sex by the age of 18, two in ten thought that women enjoyed being raped. (*Gendering AIDS: Women, men, empowerment and mobilisation*, 2003, VSO)

The relative lower status of women

In some cultures wives are treated as their husbands’ property. The traditional payment of bride price has become more commercial and strengthens the notion of ownership. Where husbands consider their wives as property and where wives see themselves as such, wives have little or no control over their sex lives and will find negotiating condom use and sex difficult.

Specific cultural practices

In one area of Zambia, girls are led to believe that vaginal fluids are a sign of promiscuity. Some use herbal potions to suppress the production of vaginal fluids in order to achieve the ideal of ‘dry’ sex. Dry sex practices are more likely to cause lesions, which can facilitate the transmission of HIV. (hrw.org/reports/2003/africa1203/6.htm). This practice has also been reported in other regions.

The Kenyan National AIDS Control Council has identified several factors which increase women’s vulnerability in parts of Kenya. These include polygamy, female genital mutilation, bride price payments when perceived as turning women into property, widow inheritance, and the practice among pastoralist groups of allowing the unmarried young warrior age groups to

The impact of HIV/AIDS on women.

In most African communities women are the main carers and homemakers, expected to care for children, for household members and an extended family. AIDS can only make this burden heavier as family members become sick.

“African men in general and Namibian men in particular still believe that there is always a division between men and women. That means men regard light work as for a woman while heavy work is for them. Therefore, since HIV and AIDS work doesn’t involve visible physical work, they think that’s women’s work. In Owambo culture, a man who works with or among women is regarded as a woman with a man’s skin. From that belief or kind of behaviour, men are under pressure from other men as well as from women.” (Namibian AIDS campaigner)¹⁸.

When women in Africa come under pressure in the home there is little or no outside help. The only source of outside support is usually the extended family and local community. Local government and social services do not exist or are incapable of providing support either financial or material. The burden on women will continue to increase, potentially reinforcing gender stereotypes¹⁹.

When a woman requires care, will men take up the role of carer? And will women’s position in society prevent them receiving health care when they fall sick? There is evidence to suggest in some regions that there are far fewer women than men in hospital although HIV infection rates are higher among women²⁰. Lack of economic independence for women and traditional gender roles give men priority for treatment²¹.

Box 1.1: KENWA

The Kenya Network of Women with AIDS is a mutual support network for women living with HIV and AIDS and their families. A number of their members found they were not able to access the same resources for treatment and care as men.

Carol joined KENWA in 2000 after the death of her husband after which she discovered he had died of AIDS and she too was infected. Before the recurrent illnesses and subsequent death of her husband, the family was financially stable and with some investments in the transport sector and in livestock. However, when the husband started ailing, as he controlled the family income, he secretly started visiting expensive doctors and getting expensive treatment. When Carol enquired from her husband what he was ailing from, he told her it was typhoid and TB. Carol’s husband passed on after having drawn a lot of resources from their businesses thereby sending some of them tumbling. Now after his death, Carol’s business was to keep alive besides trying to keep her children in school. Any time she had an opportunistic infection, she would do everything to attend to it. She sold her farm as she was not able to pay a loan the husband had received from the Agricultural Finance Corporation. All the family savings have gone into buying drugs. They had 50 goats and 35 heads of cow; she sold them one by one to buy drugs. Sadly, Carol passed away last year leaving behind three orphans in the hands of their grandparents. Any remaining assets were sold off to meet funeral costs.

(Extract from KENWA written evidence submission)

Women may be blamed for HIV infection and find themselves facing destitution, ejected from their homes by their husbands. In some countries women also have few legal rights

to property and may be unable to inherit their husbands' property after he dies, leaving widows at the mercy of their in-laws.

If, as predicted, infection rates are higher among women than men, and women are less able to obtain care and treatment, death rates among women, especially mothers of young children, will be particularly high. That means there will be more orphans. This is potentially catastrophic for the family, the bedrock of society in Africa. This issue is discussed in detail in chapter two.

Interventions that focus on gender and young people

Gender inequality helps AIDS spread and makes the epidemic's impact worse. But aiming prevention programmes exclusively at women, which many 'gender focused' interventions tend to do, may not work. The empowerment of women is essential to giving them the ability to protect themselves from HIV. Several women's organisations help women achieve economic independence, for example by providing access to credit and income generating schemes²². Such schemes are vital to enable women to cope with the impact of AIDS.

But men are also central to the fight against AIDS and to the protection of women. Men's groups and groups that bring men and women together will be central to addressing ideas of masculinity which rest on sexual conquest, physical prowess and economic power. Gender relations should focus on prevention and ways of supporting those who bear the burden of care and treatment.

The young may be driving the epidemic but they are also the key to stemming and stopping it. Changes in the balance of power between men and women and new ideas of masculinity and femininity only come about slowly. Older people are generally less receptive to change. Younger people, still forming their own attitudes, will not necessarily choose what their parents did if they see logical alternatives.

To prevent the spread of HIV/AIDS the distribution of contraceptive products remains essential. Condoms are the main effective product available and their distribution and education about their use, especially among young people, is vital. But women cannot force men to wear condoms so other products are also needed. Microbicides whose development is supported by DFID, have real potential to empower women to protect themselves. They also mean that women can protect themselves against STIs and HIV and still conceive and have children.

*"We need a product women can use, covertly, if necessary, that does not have to be used for every sex act so when you are talking about sex workers woman can apply such a product before they go out to see their clients where they are not at risk of violence. We know that for a lot of women that sex violence is greatly increased when woman try to negotiate condom use."*²³

Mothers who are HIV positive must be given priority for access to treatment because of their vital roles as carers, educators and providers in families. At present men are more likely to buy medical treatment than women even though women represent more than 50% of those infected. DFID advocates that 50% of all those on ART treatment should be women and girls²⁴ but that figure could be raised even higher. The effect of gender inequality on the availability and use of treatments such as ART, must be studied. Where

medicines are in short supply people tend to share them out within families. Sometimes men commandeer for themselves treatments prescribed for women in their families. This problem emphasises the necessity of monitoring prescriptions and educating recipients on the importance of completing courses. It also underlines the importance of the struggle for gender equality. Individual countries will have to debate priorities for ART but guidelines on issues such as gender may help to create open and transparent debates between governments and civil society about AIDS priorities.

BOX 1.2: Breaking the Boundaries: South African young people talking about sex

South Africa's national *loveLife* programme has become well known. It is the largest effort of its kind and has adopted a deliberately unorthodox approach to get young people and their parents to talk about sex, sexuality, relationships and HIV.

loveLife has adopted a comprehensive approach combining sexual health and HIV/AIDS education with services in public clinics and countrywide support programmes designed to address the key behavioural determinants of South Africa's high HIV infection rates, particularly coercion, sexual abuse and transactional sex. Any attempt to make something 'youth friendly' must be appropriate to local youth cultures.

The life style approach the programme takes has been developed specifically for a South African context, but if it is successful in actually reducing reductions in HIV prevalence among young people then lessons can be drawn about upfront and youth focussed prevention for other contexts and mediums.

Overcoming the stigma of HIV/AIDS is essential to successful prevention and to tackling its impact. No society can fight AIDS if it excludes the carriers of HIV. But prejudice and stigma reduce the willingness of people to seek testing for their HIV status. If they are afraid of friends and neighbours finding out they are HIV positive, they may not seek treatment and care.

*"If you go to a clinic and you line up in the waiting-room, and then as you come out some of you are carrying a tin of powdered milk; that is like wearing one of those T-shirts saying "HIV Positive". You have to have a level of empowerment to be able to wear one of those T-shirts, and those women did not. It was like having it branded on their forehead. They were leaving the tins by the door as they left because you have to walk all the way from the clinic to the bus stop. It is the same with breast-feeding: with women who were not breast-feeding, there would be gossip. That is what has to be overcome, and there needs to be government programmes to do that."*²⁵

To overcome the stigma of HIV/AIDS there must be education programmes that turn the gossip which denigrates a woman who uses powdered milk into support for her. But there are limits to educational programmes and they also take time. Secondly everyone, however poor, deserves professional health services that respect patient confidentiality and dignity.

Other issues that need to be addressed include the legal disenfranchisement of women and some young people, particularly with regard to inheritance rights. Every government should review laws that affect gender relations in the light of the battle against AIDS. At

a national level that may be straightforward but tackling the issues of tradition and culture in a local context will be harder.

Summary

Young people and women are the key drivers of the epidemic but they are also the least powerful groups in African society. They are also the groups that will be most affected by AIDS and this will have wider impacts on their societies and their economies.

The Group makes the following recommendations to the UK Government:

- **Recognise that preventing HIV infection among the largely young populations of most sub-Sahara African countries will reduce overall prevalence and that effective prevention efforts are an essential part of a comprehensive response to the epidemic.**
- **Ensure that a balanced approach to the continuum of HIV/AIDS interventions from prevention to treatment (including ART) and including impact mitigation is central to DFID's HIV/AIDS policy and also integrated into other DFID policies. A balanced comprehensive approach is needed in all affected countries, not only those with the highest rates.**
- **Support African governments to work with civil society and develop policies to ensure access to health interventions based on equity, effectiveness and transparency. In particular, such policies need to ensure that women are prioritised in order to safeguard the social fabric.**
- **Support education programmes to raise awareness and ensure take-up of available prevention, testing and treatment services is not hindered by stigma.**
- **Support interventions to mitigate the impacts of AIDS on women, in particular to give financial and material support for care of the sick and orphans and vulnerable children in their communities.**
- **Support programmes that empower women and support local and national initiatives to examine gender relations.**

Chapter Two Orphans

"If a child is brought up an orphan, they are not getting the parenting which they so desperately need; they are not getting the skills of citizenship which they need. So for me, that is the priority, but it is also the one that we know least about." (Professor Alan Whiteside²⁶)

Analysts are already talking about Africa's 'orphaned generation'²⁷. At current rates of infection this is, unfortunately, no exaggeration. At the end of 2003 UNICEF estimated that 11 million children under the age of 15 in sub-Saharan Africa had lost one or both parents to HIV/AIDS²⁸. By 2010 there will be 42 million orphans in the region, of whom 20 million will have lost one or both parents to AIDS²⁹.

Such a huge number of orphans means more than the sum of individual tragedies. It will have important impacts on wider society. The Group believes that the orphan crisis is potentially the most catastrophic single impact of the AIDS epidemic. It is unfolding on such a scale that traditional 'coping mechanisms' (at the household and community level) are buckling under the strain and traditional interventions (of governments NGOs and donors) will be insufficient.

The impact of orphanhood on children

"Most women are very worried of what will happen to their children. It is not that they are very worried that they will die, but they are more worried what will happen to their children and there is no guarantee that your child is not going to join the street and end up being dead." (Asunta Wagura³⁰)

UNICEF estimates that in most sub-Saharan African countries extended families assume responsibility for over 90% of orphans³¹. For cultural and practical reasons institutions are far less important. In Uganda, for example, only 2,500 orphans out of 1.7 million are cared for in orphanages³². However, given the rapid increase in orphans driven by the AIDS epidemic, traditional coping mechanisms are under unprecedented stress often leaving vulnerable children without care and support.

Orphaned children suffer the emotional stress of watching a parent die perhaps for over a year. This can affect a child for life. And they lose their key provider and protector. That makes them very vulnerable. Orphans often end up among the most marginalised groups in society. In Addis Ababa more than 75% of child domestic workers are orphans³³. In Zambia 65% of child prostitutes in one area and over 50% of children living on the street are orphans³⁴. In 2001 a World Bank study estimated that there were over 1 million street children in sub-Saharan Africa³⁵.

Other studies have shown that orphaned children are more likely to be stunted or wasted because of poor nutrition. Stunting has long term effects. It can compromise the immune system and severe cases can affect mental functioning³⁶. The implications for educational achievement are clear and this may also affect their ability to function socially and economically³⁷.

While parents are ill and after their death many children have to take on the role of supporting the family. For some this will mean farming the family land while others will

have to go and find work. Children are left the grinding every-day tasks such as cleaning the home and collecting water – exhausting work that can take hours. All of these extra tasks, caring for sick parents, domestic chores and earning money will affect the amount of time a child has to go to school or for ‘childhood’ activities.

Non-orphans will also be affected. Most orphans are taken in by their extended family, by aunts, uncles and grandparents. When orphaned children are taken into a household with other children, resources are stretched and both orphans and non-orphans can lose out. In most cases orphans are cared for as one of the family. But some orphaned children are treated as a sub-member of the household, having to work for their keep and doing far more than the children of the head of the household. A 2002 survey in Lusaka found that only 56% of 13 to 18 year-old orphans reported that they were ‘well treated’³⁸

The conditions of poverty, homelessness and exploitation forced on many children orphaned by AIDS violate the International Convention on Human Rights and the Convention on the Rights of the Child (See Box 2.0).

This violation of rights and the poverty and disillusionment of orphans can give them a sense of grievance as they become adolescents and adults. In the long term this could help create a potential threat to security. This issue is discussed in chapter four.

Box 2.0: Children’s rights

The situation of many AIDS orphans in Africa is in breach of their basic human rights and their rights under the International Convention of the Rights of the Child – to which the majority of African states are signatories.

Article 27 Convention on Rights of the Child

1. State parties recognize the right of every child to a standard of living adequate for the child’s physical, mental, spiritual, moral and social development.
2. The parent(s) or others responsible for the child have the primary responsibility to secure, within their abilities and financial capacities, the conditions of living necessary for the child’s development.
3. State Parties, in accordance with national conditions and within their means, shall take appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing.

Orphans and vulnerable children and education

Several factors affect what happens to a child’s education when a parent dies because of AIDS. The gender and age of the child, whether the mother or father dies and how wealthy or poor the household is will all make a significant difference to how death affects the child³⁹. Children who have been in school for some time are less likely to drop out than younger children. Loss of a mother has a greater impact on school attendance than loss of a father⁴⁰. When a mother dies children, particularly girls, are expected to take on more domestic tasks. Among children who drop out of school because of the indirect impact of AIDS, the majority are girls. Some argue that while the father is alive extended family members are reluctant to take on parental

responsibilities⁴¹. In Uganda an AIDS orphan has 50% less chance of going to school than a non-orphan⁴².

Orphans who stay enrolled at school may attend more sporadically because of pressures at home. Their results may also suffer because of time lost and the emotional stress of a death in the household. This is especially true when mothers die.

Children from poor households will already have been up against barriers to school attendance, most relating to the costs. Even in countries where primary schooling is free other costs, such as books and uniforms, are significant barriers for the poor. Perhaps even more than cost, children from poor families are kept back from school because they have to spend time on caring for sick relatives, domestic chores and income generation.

In the schools themselves under-funding, inappropriate curricula and the increasing absence of teachers due to AIDS-related illness all lower education standards and discourage people from sending their children to school. Some cultures attach little importance to academic qualifications and this is compounded by the lack of job opportunities for school graduates. Parents and guardians may feel that education is not a good investment either for their own or for adopted children.

In addition to these problems of education in Africa, orphans and vulnerable children face specific difficulties. If the main earner of a household is sick or dies costs such as education impose a heavy financial burden and children may be expected to find paid work to earn their own school fees. Older children may be expected to care for the sick and for younger siblings, in effect taking on the role of the head of the household at a very young age. A child in an AIDS-affected household will also be under emotional stress or a sense of family shame and this may discourage children from attending school. Other studies have noted depressive behavioural traits and clear signs of fear and anxiety⁴³.

Households and Coping Strategies

An AIDS-affected household experiences a decrease in resources and a simultaneous increase in demands for those resources. When a productive member of the household falls ill the household loses an income. While they are ill they use up resources, both time and money, as the household tries to obtain medicines. The household may be forced to sell assets, such as livestock. This common coping strategy may leave households more vulnerable than ever to further shocks and strains. When a once-productive household member dies there is the – often huge - expense of a funeral, then children and elderly people are left behind with a diminished asset base and little or no income. AIDS often brings many deaths to the same household so traditional coping mechanisms fail.

“Even in the olden days people used to die but orphans were one or two. But today a whole family could be wiped out of adults” (A Zimbabwean care giver)⁴⁴

Many people in power in African countries and in donor countries like the UK still cling to the hope that the extended family and traditional community systems would cope with the growing number of orphans as they have always done. But with a growing number of

orphans, the question has to be asked what exactly does coping mean? Some orphans may be near starvation, out of school, without care and support and facing exclusion and discrimination. In a 2001 assessment of the situation of orphans in Botswana researchers found destitute children foraging in rubbish dumps, severely mistreated, suffering sexual abuse in widespread prostitution. Some orphans had committed suicide. This cannot be described as coping under any circumstances.

A satisfactory level of coping would ensure that AIDS orphans have a roof over their heads, regularly attend school if they are of school age, are well-nourished and cared for emotionally, physically and financially.

The Group believes that the orphan crisis in some regions of sub-Saharan Africa will lead to the collapse of traditional coping mechanisms and that the mechanisms of social reproduction, on which societies and economies are based, are at risk.

The burden on older people

“Older people, demographically and otherwise are often really invisible, you do not see them, so any children that live with them also become invisible. We know often they are not invited to community meetings and consultations. We need to do much more to support older people who are often the primary care givers of orphans and face quite extreme isolation in many countries.”
(Wanjiku Kamau)⁴⁵

Older members of the extended family are frequently the primary carers for children orphaned by AIDS. Even before the parent has died, a grandparent may have to take on the care of their grandchildren while nursing their own child. UNICEF estimates that around 60% of orphans and vulnerable children are living with grandparents⁴⁶.

Even without the impact of the HIV/AIDS epidemic, many older people are already among the poorest groups in African societies. A recent study by Help Age Kenya showed that while the essential minimum monthly household expenditure was estimated at US\$91, the average income of households headed by older people was around US\$32⁴⁷. Yet 32% of grandparents in Uganda, 43% in Tanzania and 38% in Zambia were caring for orphans in a 2001 study⁴⁸. These elderly headed households are under great strain.

Grandparents and other elderly relatives usually want to help care for the orphans within their family but find themselves unable to provide for them. Age diminishes their strength to dig and weed a plot of land or to manage livestock and their ability to earn money is limited⁴⁹.

Many older people in Africa have had to watch their children die slowly from AIDS then have to bury them, then take in their grandchildren. This process is an emotional and financial strain. However in some cases the grandchildren can provide both emotional and financial support to their grandparents. This mutual support is important but it is important that children who are left in the sole care of an elderly relative are not forced to give up their childhood and their education.

In the longer term these grandparents will not exist. The parents of today's orphans have already died so when they grow up and have children of their own, they will not have grandparents to rely on if they themselves are infected with HIV and die.

Prior to the advent of the state pension most societies relied on the 'intergenerational bargain' to ensure that the elderly are cared for⁵⁰. Parents expect their children to provide for them when they can no longer support themselves, yet so many elderly people are losing their children to AIDS that they will be left without support and care they had expected. On the contrary they have been left to care for their offspring's orphaned children. Some argue that the 'intergenerational bargain' is such a fundamental pillar of the social order that if the bargain is undermined, the social order will collapse⁵¹.

Possible Interventions

The Group believes that the orphan crisis is unfolding on such a scale that existing intermittent and patchy interventions will be insufficient to avert the erosion of social support systems and order on which societies and their economies rely. Interventions will have to be rapidly scaled up.

Interventions fall into two categories. First those which seek to reduce the number of AIDS orphans by keeping their parents alive. Despite the costs of medication, this key intervention may be more cost effective than supporting children once they are orphaned. Second are those interventions which support children once they are orphaned or made vulnerable by the epidemic.

Reducing the number of children orphaned by HIV/AIDS

"Our priority is... the future of our children... So if we get social support to end poverty, treatment for opportunistic infections and AIDS illnesses, this will give people longer years to stay with our children and contribute to support them to be also responsible members of society. So our priority is care and support and the protection of our children." (Asunta Wagura)⁵²

The international community, affected governments, the private sector and NGOs will have to work together with other actors to help local communities to reduce the number of orphans over a long period. This means increasing prevention efforts and medical treatment to prolong the life of parents and avoid children becoming orphans.

The task is to keep parents already infected healthy and alive for as long as possible to ensure that their children will have the maximum time being parented. Since the loss of a mother tends to have the greatest impact, mothers should be the focus, though not the exclusive focus, of programmes to prolong life. National parliaments need to work with civil society and debate how much priority mothers of young children should receive in the light of the particular challenges at the local and national level.

Programmes for the prevention of mother to child transmission of HIV (PMTCT) are already being used as starting points for the provision of wider medical treatment. Pregnant HIV Positive women who receive treatments like nevirapine to prevent their child becoming infected with HIV, can then continue with medical attention to ensure

they remain alive to care for their young children during the most critical and formative years. The same systems can also provide welfare support and advice to help HIV positive parents remain healthy for longer.

At the national, district and local level the effectiveness of PMTCT as a starting point for longer-term treatment has to be analysed through programmes that are actually operating and which can be evaluated as they run. If successful they should be rolled out rapidly. Given the rate at which children are becoming orphans, parent focused treatment programmes are urgently needed.

The Group believes that preventing or delaying the death of parents may be more cost effective than taking on the care of orphans. It will also reduce the scale of the humanitarian, economic and social impacts.

Supporting orphans and vulnerable children

“All these orphans...need to be brought up, need to be cared for, need to be cuddled, need to be looked after, and that is a high human resource requirement. We need millions of women in Africa to be mobilized to care for those orphans, and we probably need to pay them because, lets face it, they have not got the resources.” Alan Whiteside⁵³.

Apart from the appalling personal toll on individuals, the AIDS crisis is causing conditions in which the rights of children and basic human rights are being grossly violated. It threatens economic viability of households and impacts on wider communities whose ‘coping mechanisms’ are being overwhelmed. It threatens peace and security in affected countries and their neighbours and in the wider world. The responsibility to care for Africa’s orphaned generation lies with their communities, their local authorities, their national governments and with the international community. Piecemeal efforts to address the problem will no longer suffice, the international community and national governments have to change gear.

The UN General Assembly’s Special Session on HIV/AIDS said that governments would: “By 2003, develop and by 2005 implement national policies and strategies to: build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS.” It is now 2004 and many countries are still a long way from implementing strategies. Several have not yet fully developed them.

The Group is aware that there are many types of intervention to support orphans and vulnerable children, and it does not seek to make programmatic recommendations. However, evidence received by the groups draws attention to the following issues.

Community based support is more feasible and appropriate than institutional care for the majority of orphans and vulnerable children. Care in an orphanage can be up to 15 times more expensive than community based care⁵⁴ - one source quoted a figure of 100 times.⁵⁵ But however cheap, leaving orphans and vulnerable children in their communities raises the question of how to support the carers.

To help organisations working with orphans and vulnerable children, UNICEF and UNAIDS have put together a *‘Framework for the Protection, Care and Support of*

Orphans and Vulnerable Children living in a world with HIV/AIDS. This provides broad strategies for creating short to medium term programmes and is supported by most organisations working in the field. It identifies five broad strategies:

1. Strengthen the capacity of families caring for orphans and vulnerable children
2. Strengthen and support community based responses
3. Ensure access for orphans and vulnerable children to essential services
4. Ensure that governments protect the most vulnerable children
5. Raise awareness to create a supportive environment for orphans and vulnerable children

The details of achieving these goals will depend on local context but there is a clear emphasis on supporting orphans and vulnerable children within families and giving help through community strategies. This framework requires the support of all donors and their partners.

Education specific interventions

Ensuring access to education for orphans and vulnerable children must be a key target of interventions. The implications of HIV/AIDS for the internationally agreed target of primary education for all, one of the millennium development goals, are severe. Box 2.1 summarises some of the interventions already in use and the Group makes the following observations:

- The potential scale of the orphan problem indicates that, like welfare interventions, education specific interventions can no longer be piecemeal projects if they are to have an impact, but must be comprehensive.
- The single biggest barrier to education is school fees. Where primary school fees have been abolished, enrolment has rapidly increased, as in Uganda in 1997 and Kenya in 2003. Through most of the 1980s and 1990s the international community and particularly the International Financial Institutions advocated user fees in education as part of structural adjustment programmes. While fiscal responsibility is central to economic stability we should now accept that an uneducated workforce is a recipe for stagnation or decline and not does produce the sought for stability and growth. The Group believes that DFID and other donors including IFIs should now advocate free primary education in all AIDS-affected countries in Africa and give grants to assist the poorest and most vulnerable to pay for school related costs such as uniforms and books.
- The need for children to spend time on income generation can prohibit or reduce school attendance. This demonstrates the clear link between general welfare and school attendance. An improvement in general welfare is likely to improve school attendance.
- The use of community schooling should be explored to fill temporary gaps in state provision.

Box 2.1: Interventions to improve access to education for orphans and vulnerable children

Orphan and vulnerable children specific

Subsidisation of school-related costs (schools fees, scholarships, education vouchers)
Income generating schemes (to reduce a child's time needed to earn income)
Community and home based responses (supporting children within the household)
Teachers taking on counselling
Support to schools admitting orphans and vulnerable children

General

Abolition of primary school fees
Community Schools
Increase capacity of teacher training colleges to increase number and quality of teachers
Revision of curricula to include vocational and life skills
School feeding programmes

Based on a table from: Ensuring Education Access for orphans and vulnerable children, World Bank and UNICEF

Supporting orphans and vulnerable children in their communities

We ought to be pouring huge amounts of money into social welfare. We ought to be supporting orphans, we ought to be supporting the people who are looking after those orphans. We need to be looking at welfare transfers, pensions for the elderly, child grants.” (Alan Whiteside)⁵⁶

A massive social rescue package is needed to support orphans and vulnerable children, their carers and their communities. This will require more money but also a new understanding of what is needed to avert major economic and social collapse and potential insecurity. As capacity to do this on the scale required is scarce at government level in most African countries, the most effective way would be to support the communities themselves or even individual households. They may have the capacity but lack finance and logistics so government grants to help care for orphans and vulnerable children so the household can be kept afloat and the children kept in school are an obvious option.

In South Africa, the richest country in the region and also the country with the highest number of infections, such government grants are available. Through the Home Affairs Office, the Social Development Office and the Courts, the South African Government provides grants for the elderly, for disabled people, for foster care, for care dependency, and for child support. See Table1.1.

Grant Type	Amount per month	
Old Age	R700	£56
Disability	R700	£56
Foster Care	R500	£40
Care dependency	R700	£56
Child support	R160	£13

Table2.1: Based on a table in Rhetoric to Action, August 2003, New Philanthropy Capital pp11

Clearly this type of grant-making system could support precisely the type of in-community care that will be required to look after the basic needs of Africa's orphans.

But in South Africa, where state structures are relatively strong, less than half of those entitled to the Child Support Grant were receiving it in 2002⁵⁷. Those who did qualify for payments had often waited months for their first payment. Failure of the government of the most economically developed country of sub-Saharan Africa to administer a grant system that reaches those most in need, indicates that African countries that have weak government capacity would find it very difficult, if not possible, to implement such programmes.

Organising interventions is complex and requires integrated planning and a high level of political support and commitment. Direct ministerial responsibility at the highest levels of government is important. Governments need to give a high priority to the development of integrated services across government departments to meet the complex needs of orphaned children. Then they must ensure that there are competent local delivery vehicles. These are difficult tasks, especially given the capacity constraints at both central and local government levels in Africa.

Utilising Community Capacity

While state capacity is weak, many countries have significant untapped capacity at the grassroots. An effective response to the orphan crisis will need to use this capacity.

“...Communities are aware of the challenges on the ground and the resources they have, they have the potential to address the challenges out there.”
(Asunta Wagura)⁵⁸

External supporters and partners should feed this capacity, providing funds and logistics to communities and community based organisations including faith groups.

In most African communities affected by HIV/AIDS people have come together to help each other and particularly to care for children. It is essential that donors, whether governments or NGOs, that are able to fund projects and bring other resources use and build on structures that communities have themselves set up. The programme will then be grounded in authentic community experience. Such structures also help avoid duplication. Community-based responses rely largely on volunteers who know better than anyone what is feasible given their time and resources. If we expect community members to play an active role - and the evidence suggests that their role will be essential if the response is to be effective - it is vital to involve them from the start.

Each organisation working with orphans may take a different approach hence the importance of a strategic framework and a single national HIV/AIDS plan. One example of making the best use of community leadership in partnership with NGOs is the Community Care Coalitions. They identify orphans and vulnerable children, assess who are the most vulnerable and judge how best to assist them or their households. These CCCs provide various types of support either directly or by allocating tasks to other community members. Such tasks include: emergency nutritional support, assistance with basic household tasks, care for chronically ill, palliative care, nutrition, hygiene training, psychosocial support, referrals to health care facilities, and education of pregnant and lactating women regarding prevention of mother to child transmission⁵⁹.

Direct support for community organisations can be very effective. Such organisations include faith-based groups and groups run by people living with HIV. One example of a

community-based group that has successfully grown with external support is given in box 2.2.

Box 2.2: The Kenya Network of Women with AIDS (KENWA)

In 1993 five HIV positive women who had been rejected by their families because of their HIV/AIDS status decided to set up KENWA. Today KENWA's membership includes 3000 women living with HIV/AIDS and over 700 orphans. KENWA functions on a volunteer spirit of and through the commitment of key individuals who have been involved from the early years. (Asunta Wagura KENWA's Executive Director won the 2003 Kenyan Community Abroad Excellence Award). KENWA grew from the bottom up as a mutual support group, it now has NGO status and supports women and children in five slum areas of Nairobi who are affected by HIV/AIDS. It now reaches around 500,000 people. The main ways in which KENWA offers care and support to women living with HIV/AIDS and their children are: food and clothing, education of orphans, home-based care, prevention of mother to child transmission, counselling, medical support, economic empowerment.

The organisation has been supported by funds from The Global Fund and International NGOs. The organisers believe that they could do more with increased funding.

An organisation like KENWA, provides a best practice model that other communities (particularly women in poorer urban communities) can follow. Donors and governments need to support successful community based organisations, scale up their responses where successful, and replicate them in other places.

"Victims are weak and powerless. A victim is passive. A victim is no longer responsible. I am not a victim. I am powerful and a force for change. ...The virus has only weakened my immunity but not my humanity. I will never allow that to happen." (Asunta Wagura in a speech to Kenya Community Abroad).

All community-focused responses will ideally take place in a context of transparently agreed national plans for orphans and vulnerable children and a detailed action plan to implement it and pay for it. The precise details of national plans may require discussion in national parliaments in cooperation with civil society and community groups. Likewise national governments must provide the right legislative and legal framework for the best possible assistance to orphans and vulnerable children.

The focus on the community does not excuse donors or governments from their responsibility to protect the rights of orphans and vulnerable children in Africa. Nor should it be allowed to delay action. On the contrary it is about ensuring those rights are ensured in a community context. Working with communities is being realistic. Many African states simply do not have the capacity to care for this number of orphans or to coordinate schemes to foster them. But at the grassroots in Africa there is capacity, commitment and local knowledge. Donors and governments must find the resources to ensure that these communities and community organisations can be supported. Some statisticians estimate that, globally, £6 billion per year will be needed to match the crisis⁶⁰. This will require new sources of funding which must be well coordinated to maximize impact. A large proportion of those funds must be directed to community organisations. The Group makes a number of recommendations on funding and coordination in the final chapter of this report.

Summary

The Group believes that the potential scale of the orphan crisis is the biggest single impact of the AIDS epidemic and one that could fundamentally undermine the basic process of social reproduction on which societies and economies rely.

Interventions to reduce the impact come in two stages.

1. Reduce the number of children who are orphaned by using treatment to extend the lag between HIV infection and death from AIDS. To do this access to treatment for parents of young children has to be a priority. The group recommends that the UK Government:
 - **Support African governments to work with civil society to develop policies to ensure access to health interventions based on equity, effectiveness and transparency. In particular such policies will need to ensure that women are prioritised, in order to safeguard the social fabric.**
 - **Recognise that ART can extend life for HIV-affected people considerably and is the single most important strategy to mitigate the impact of AIDS. Support roll out of treatments at scale, where possible with state leadership but utilising capacity in other sectors.**
 - **Support African governments to provide integrated health interventions including prevention and nutrition programmes and basic treatments such as antibiotics for opportunistic infections and antiretroviral therapy (ART). To deliver these swiftly, governments will need to harness the capacity of business, NGOs and community organisations.**
2. Support orphans and vulnerable children and their carers. The Group believes that current interventions need to be transformed to match the scale of the orphan crisis both in breadth and depth. The Group recommends that the UK Government:
 - **Support African governments, NGOs and community organisations to put together a social rescue package to match the crisis. Such a package should be used to address the orphan crisis and the wider threat to the social fabric posed by the AIDS crisis.**
 - **Support African governments to ensure policy coherence on HIV/AIDS including on orphans and vulnerable children, across ministries, with leadership at the highest level and direct responsibility for the welfare of children at senior rather than junior ministerial level.**
 - **Take on a role of leadership and coordination in helping countries and other stakeholders to best address the needs of orphans and vulnerable children.**

Impact Areas

Chapter Three: The Economy, Households and Livelihoods

AIDS and Economic Growth

There is growing awareness that the HIV/AIDS epidemic is a major threat to Africa's economic development, and may in fact be the single greatest obstacle to the continent achieving the Millennium Development Goal of reducing extreme poverty by half and eliminate hunger, by 2015.

However, this awareness has been slow to dawn. Early estimates of the impact of HIV/AIDS on national economies predicted a relatively modest reduction in growth, which could be manageable⁶¹. Some even speculated that the loss of population would exceed the reduction in GDP, thus leading to an increase in per capita GDP. Such analyses have been superseded by more realistic and far more pessimistic estimates.

More recently, economists have looked at a wide range of impacts of HIV/AIDS. These begin with the additional costs to firms, government and households of sickness and death, with increased spending on medical care, funerals, insurance, etc., alongside lower efficiency associated with absenteeism, low morale, posts left unfilled, and time off to attend funerals. They include the human capital costs of training replacements for staff who have died. Government and household spending is diverted from investment to health care. More widely, the changing demographic structure of a population impacted by AIDS (notably the increased ratio of workers to dependents) has far-reaching economic consequences. In the longer run, the truncation of life expectancy is likely to change economic rationality, as individuals have less incentive to save and invest for a future that may not exist⁶². Some but not all of these factors have been incorporated into macro-economists' models.

One World Bank study calculated that the HIV epidemic had already cost Africa 0.8% of economic growth per year⁶³. The report estimated that in a country with 20% HIV prevalence the likely loss to annual GDP growth would be in the region of 2.6% per year. This means that over a 20-year period GDP would actually be 67% less than without HIV/AIDS⁶⁴.

This is in an era in which to pull itself out of a rut of economic underdevelopment the African continent is seeking to achieve 7% year on year economic growth, under the New Partnership for Africa's Development (NEPAD). The combination of NEPAD and the internationally agreed Millennium Development Goals have provided clear targets for African Development. Unfortunately both rely on economic growth rates that are far from likely on Africa's current trends. Indeed, a 'downward spiral' rather than high economic growth is being predicted in the areas with highest HIV prevalence⁶⁵.

Slower growth and the loss of productive members of the economy also weaken the state's tax base, thus reducing its ability to spend on key services including those aimed

at human capital accumulation like education. The human resource crisis and decline in economic growth are mutually reinforcing processes.

In short, without major efforts at mitigation, the HIV/AIDS epidemic will make it impossible for Africa to achieve the MDG of reducing poverty by half and eliminating hunger. This point was stressed by Prof. Alan Whiteside in his evidence, who concluded: 'the millennium development goals are now unachievable in some countries and need to be re-examined'⁶⁶.

The Group identifies four main reasons why the impacts are so substantial.

1. The effects of the epidemic are felt first and hardest at the level of the household. This is the foundation of society and the economy, but the essential activities that take place in the domestic sphere--especially those undertaken by women--are not adequately captured in economic statistics.
2. There is a major impact on the private sector. As every scenario for economic growth and development in Africa gives pride of place to private sector investment and expansion, the impact of the epidemic on business demands special attention.
3. The HIV/AIDS epidemic is a long-wave event. Its effects unfold over a generation or more. The impact of orphanhood on the educational prospects of children is severe, and this is reflected in emerging models for the long-term impact of the epidemic.
4. The effects are systemic, with vicious feedback loops. There is a danger of the most heavily impacted countries being locked into chronic poverty. This is what Peter Piot has called the 'exceptionalism' of AIDS.

Impact on the Domestic Economy

The largest part of any African economy is invisible in economic statistics for GDP and other measures of monetary income. This is the domestic sphere, where (according to the proverb) women 'hold up more than half the sky.' This work is essential to social reproduction; nurturing children, passing on knowledge, care and welfare of children, as well as caring for the sick and the elderly. It is essential work that maintains the medium and long term functioning of an economy. When they do consider this 'invisible' work, policy makers tend to work on the assumption that there is an unlimited supply, but this is not the case. Given the impact of HIV/AIDS on women, on households and on social reproduction, economists and policy makers will need to consider this far wider impact.

The Group considers that the impact of HIV/AIDS on Africa's families and their livelihoods constitutes a social crisis of the first order. This is a long-term emergency. It is a humanitarian challenge to development⁶⁷. The loss of livelihoods for large numbers is a threat to economic and physical security for entire countries and regions.

The economic pressure on AIDS-affected households come from two directions: supply and demand. On the supply side AIDS affected households will lose labour and income. Estimates put the average reduction in annual income for households with a chronically ill member at 30-35%⁶⁸. Another study indicated that an adult death resulted in a 45% decline in a household's marketed maize, but where the cause of death was identified as AIDS the loss was over 60%⁶⁹.

In terms of demand, already declining income has to stretch even further because of increasing medical costs while a household member is ill and then funeral costs. A Zimbabwean study put average funeral costs at US\$104.80. Overall the study found that average expenditure on healthcare, funeral and memorial service costs is equivalent to about half of the average per capita income in Zimbabwe⁷⁰. These double pressures on households massively increase their vulnerability.

The HIV/AIDS epidemic contributed to poverty and food insecurity for many households and communities in Africa during the southern African drought of 2002⁷¹. As the pressures imposed by the epidemic continue to mount, an ever-larger number of households will lose their livelihoods and be reduced to food insecurity

Box 3.1: HIV/AIDS' impact on households

Impact on family resources:

A sudden decline in income and other resources will occur with the illness or death of an adult member. This is often coupled with an increase in demand for these resources. Household members may use some of the following 'coping strategies':

- Working long hours in the fields
- reducing the land under cultivation
- substituting labour intensive crops for less intensive crops
- reducing the variety of crops
- delaying of weeding (reducing the harvest)
- Abandonment of the farm in favour of other income generating activities
- Reduction in variety of food grown and consumed
- reduce the number of meals or size of portions, particularly for children
- sell most of what the household produces and other sell assets to pay for medicines

Many of these coping strategies will actually increase household vulnerability. A family may have sold all their assets while the father was ill dying with AIDS. But AIDS clusters around households so in most cases the living partner will also fall ill, but the household's options will be dramatically reduced.

Based on Education & HIV/AIDS: Ensuring Education Access for Orphans and Vulnerable Children, a Training module (World Bank and UNICEF)

The 'New Variant Famine' hypothesis describes a situation in which HIV/AIDS reduces the viability of agrarian livelihoods as well as their ability to withstand or recover from shocks. Where this situation is not uncommon it adds a new dimension to understanding food shortages⁷². This identifies four factors as new additions to the 'usual' food shortage equation:

1. Household-level labour shortages due to adult morbidity and mortality, and the related increase in numbers of dependants.
2. Loss of assets and skills due to adult mortality.
3. The burden of care for sick adults and children orphaned by AIDS
4. The vicious interactions between malnutrition and HIV

This creates a new category of 'AIDS poor' households who are unable to meet their food needs through cultivation and frequently find traditional coping strategies are insufficient to cope with these new pressures. This issue is discussed with reference to the impact of orphans on household coping strategies in chapter two.

The household is a basic building block of African society, as it is in European society. It is a basic mechanism for social reproduction – this mechanism is under threat because of the impact of HIV/AIDS.

Impact on business

Africa's business community has been at the forefront of recognising the dangers posed by AIDS, measuring the impact, and (in some cases) responding.

In 2003 the South African Business Coalition on HIV and AIDS and the Bureau of Economic Research conducted a survey of 1006 South African companies. 34% of the companies surveyed reported that HIV/AIDS had already had a negative impact on their profits⁷³. The survey also found that the sector most badly affected by the epidemic is manufacturing, the least affected being the retail sector.

The authors of the report also argue that the reason that the impact on profits has so far been higher in the manufacturing sector than in the building and construction sector is that the latter can more easily draw on a pool of available workers as more of their workers are unskilled, and *temporary*. Therefore as long as the pool of workers remains, these workers are replaceable.

In the same survey 39% of companies said that HIV/AIDS had reduced labour productivity and increased absenteeism. The companies ranked the following AIDS related costs as the most costly to their profits:

- 1st lower labour productivity and increased absenteeism
- 2nd high employee benefit costs
- 3rd lost experience and skills

Yet this survey and others found that despite these costs very few firms had set up comprehensive HIV/AIDS workplace programmes to protect and retain their workers in good health⁷⁴.

Business is reluctant to invest in human capital in sub-Saharan Africa, for example through training. With high levels of premature deaths amongst their workers the incentive to invest is yet further undermined. This unwillingness to invest in human resource development is adversely affecting the global competitiveness of countries in sub-Saharan Africa and their prospects for economic growth.

The impacts are not focussed only on manufacturing or heavy industries, agriculture provides a key example of a sector which may face this 'human resource crisis' sooner rather than later. The FAO estimate that by 2020 the epidemic will have claimed one fifth or more of all those working in agriculture in many southern African countries⁷⁵.

"HIV/AIDS- related morbidity and mortality disrupt the agriculture sector's operations and systematically erode institutional capacity with regards to agricultural staff, extension service organisations, national agricultural

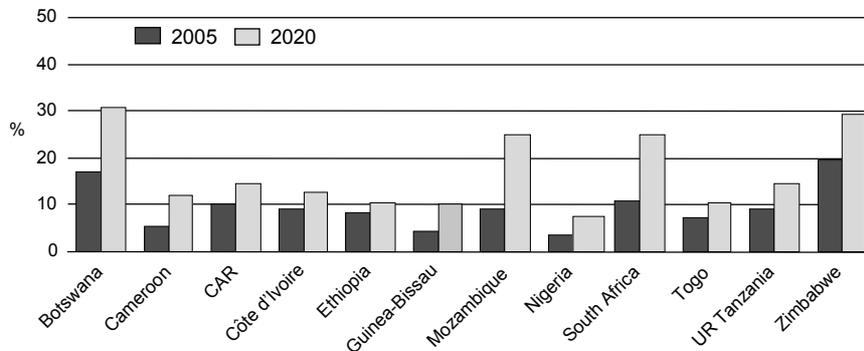
research organisations, higher educational institutions, commercial agricultural enterprises, as well as local informal institutions.”⁷⁶

Agriculture still generates a significant proportion of sub-Saharan Africa’s GDP, indeed many African countries are dependent on agriculture not only for national food security but also for essential foreign exchange as overall agriculture accounted for nearly 20% of sub-Saharan African exports in 2001. The viability of this key sector is seriously under threat because of HIV/AIDS. Governments must ensure that Ministries of Agriculture (MoA) are addressing problems both at the national and local level. A number of mitigation initiatives have been identified by NGOs and the FAO. All have some positive impact, but none have yet been taken to scale. Ministries of Agriculture face the double challenge of implementing new programmes while simultaneously facing attrition amongst their own staff due to HIV/AIDS.

Long-term impact on human capital

In evidence to the Group Peter Piot talked about a ‘human resource crisis’ in Africa because of HIV/AIDS⁷⁷. The loss of both skilled and unskilled workers affects the economic foundations of society as a whole. The impact of AIDS on key public services like health and education, which are fundamental to economic development, is also of great concern and is discussed in chapters six and seven. Moreover, this is not a one-off impact. It will last for years, possibly generations.

Percentage of workforce lost to AIDS
by 2005 and 2020 in selected African countries



Sources: ILO (2000) POPILO population and labour force projection; UN Department of Economic and Social affairs, Population Division (1998) World Population Prospects: the 1998 Revision
01 July 2002 slide number SSA-17

Source: UNAIDS Epidemiology slide set: HIV/AIDS and sub-Saharan Africa

In 2003 a World Bank study tried to model the long-term economic impact of HIV in South Africa. The study built on the insights of participatory research that AIDS weakens the transmission of knowledge and skills from one generation to the next and concluded that the key impacts would not be seen in the next 10 or even 15 years. Rather, there is a threat that because of an *orphaned generation* lacking attention, love, care and education; without effective mitigation interventions the epidemic will lead to “a complete economic collapse will occur within three generations.”⁷⁸

Box 3.2: Bell et al's three stage theory of AIDS induced economic collapse

1. AIDS destroys human capital selectively – focussing on young adults. “It reduces their productivity by making them sick and weak, and then it kills them in their prime, thereby destroying the human capital progressively built up in them through child rearing, formal education, and learning on the job.” pp8
2. AIDS weakens mechanisms that generate human capital formation. The household as a key building block of society is undermined and in too many cases dissolved. Loss of income reduces school attendance. Decreasing life expectancy decreases incentives for education. “poor education of children today translates into low productivity of adults a generation hence.” pp8
3. As adults, AIDS orphans will not be able to pass on knowledge to their own children – leading to an erosion of knowledge with each new generation: “As the transmission of capacities and potential from one generation to the next is progressively weakened and the failure to accumulate human capital becomes more pronounced, the economy will begin to slow down, with the growing threat of collapse to follow.”

The Group concurs that the AIDS epidemic is a long-wave event, whose impact will be felt well into the future. As Prof. Feachem noted in his evidence, “*We have seen nothing like this and the curve is upwards, even with our best efforts, before it goes downwards, peaking at 2020/2030 if we are lucky; 2050/2060 if we are not*”.

Systemic Impacts

The impacts of the HIV/AIDS epidemic amount to more than the sum of the above. The entire nature of societies and economies may be changed. For example, the epidemic may widen the gap between rich and poor with AIDS orphans constituting a whole underclass while those unaffected and those able to afford treatment will live their lives in close proximity yet a world apart. High levels of inequality could have serious repercussions for both the economy and security (see chapter four)

Similarly, certain sectors of the economy will be worst hit, while others are able to insulate themselves. For example, mineral extraction is likely to remain profitable, while investment in manufacturing is less so, reducing the continent's chances of diversifying and developing. If ODA expands while economies stagnate, an increase in external dependency may follow.

Perhaps most serious of all are the implications of an economic slowdown and increasing poverty for the socio-economic risk factors that spread the HIV/AIDS epidemic itself. Peter Piot, in his Presidential Fellows Address to the World Bank in 2003, spoke of the 'exceptionalism' of AIDS, noting that:

'Many diseases and natural disasters create their own brutal equilibrium, a self-regulating mechanism that eventually enables society to cope, if not to overcome. AIDS, thus far, seems different. Virtually all its impacts serve to weaken our defences and accelerate its spread, not to limit it. By selectively killing young adults, AIDS removes the keystone of developing societies. The surviving children are less likely to be in school, well-nourished, or properly

socialized. This makes them more susceptible to the very situations that enable HIV to spread, and so the circle turns.'⁷⁹

The implication of this 'exceptionalism' is that urgent action now can help prevent descent into a vicious cycle, but that such action must be of a scale and nature quite different to what has gone before.

Possible Interventions

Clearly work on prevention must be stepped up because, in the long run, successful prevention is the most cost effective strategy. However, thus far prevention has not been entirely successful in Africa as current infection rates indicate. In Africa impact mitigation will now be necessary to averting catastrophe.

The foundation of impact mitigation is keeping people alive and healthy for as long as possible. Medical interventions to maximise the life of an HIV positive person range from the simple such as good nutrition, through the treatment of opportunistic infections right up to the use of ART when immune systems become seriously weakened by the virus. All of these interventions are needed as part of an integrated response.

Some sectors, especially businesses, are providing treatment including ART for their employees. However, averting the worst impacts those on the basic social fabric is possible only through government-led programmes.

The conclusion drawn from the evidence presented to the Group is that both social and health spending need to be prioritised to avert crisis. Massive social spending, or some sort of social rescue package, is necessary. To ensure that sufficient resources reach households and families, and especially women, to enable them to hold together the basic social fabric. How such spending should be channelled will be an issue for governments to decide when they consider their own capacity and the capacity of community organisations.

Health spending will also need to be dramatically stepped up to avert crisis. Integrated health services which include a continuum of HIV interventions from prevention through to anti-retroviral therapy, must be taken to scale.

While preventing deaths will be central to averting predicted economic collapse, the governments of affected countries must also prepare for substantial losses across sectors. Investment in education will also be necessary to ensure that a human resource shortage cannot become a crisis. Auditing to identify strategically important impact areas can take place both within companies and at the sector wide level.

The Group has identified agriculture as a key sector of concern both because it is a significant part of many African countries earnings, but also because at the household level agricultural livelihoods are being undermined by the epidemic.

The international community, governments of affected countries and the private sector must step up their efforts to prevent this predicted complete economic collapse. Economic collapse can lead to other crises both social and political. This future problem

will not only affect individual countries concerned but as the experience of 'failed states' elsewhere demonstrates, it is a matter of regional and international security.

Summary

The Group argues that HIV/AIDS is an exceptional threat to Africa's economic development and to the economic foundations of society.

The most important economic impacts of the epidemic occur at the level of households and families, and their increasingly desperate struggle for a livelihood. The depth of the misery and impoverishment of families affected by AIDS, and especially the women who bear the greater burden of struggling to cope, is largely invisible in macro-economic statistics. A social disaster is unfolding but has not so far caused a sufficiently serious impact on the major development indicators to cause a sense of urgency among ministers of finance in Africa and their counterparts in developing countries.

The Group is firmly committed to the importance of wider development priorities but has found that in countries with high HIV prevalence rates wider developmental efforts are being seriously undermined by the impact of the AIDS epidemic. As such spending on HIV/AIDS must be a top priority and must also be a fully integrated component of wider development efforts.

The Group makes the following recommendations to the UK Government:

- **Support research and interventions that address the links between HIV/AIDS and food insecurity at the household level.**
- **Support African governments and civil society in affected countries to develop transparent policies and programs to ensure equitable access to health interventions and in particular to ensure that women are prioritised.**
- **Support African governments, NGOs and community organisations to put together a social rescue package at scale. Such a package should be used to address the orphan crisis and the wider threat to the social fabric posed by the AIDS crisis.**
- **Recognise that ART can extend life for HIV affected people considerably and is the single most important strategy to mitigate the impact of AIDS. Support roll out of treatments at scale, where possible with state leadership but utilising capacity in other sectors.**
- **Support African governments to provide integrated health interventions to include prevention and basic treatments such as ensuring good nutrition, and providing antibiotics for opportunistic infections as well as complex antiretroviral therapy at scale. Utilise other groups such as the private sector, NGOs and CBOs for additional capacity and speed but where possible facilitate state leadership**

- **Scale up government capacity building programmes and tailor them to build capacity in both in those areas identified as under most threat from AIDS and in those areas where capacity is needed in order to coordinate the battle against the epidemic.**
- **Establish a unit within the DTI in partnership with experienced companies to advise other companies with operations in Africa on developing fully comprehensive HIV and AIDS programmes for both their workers, their families and the communities in which they work and where migrant labour is used also in the communities from which their workers come and return to.**

Chapter Four Security

The Africa APPG received evidence indicating HIV/AIDS poses a double threat to security in Africa. First armies and security forces suffer high levels of HIV/AIDS infections. High proportions of military personnel will fall sick and die, potentially weakening their capacity in terms of both size and expertise. Secondly the impacts of AIDS on the rest of society and the economy could threaten security.

These two possibilities together constitute a national and pan African threat but could also threaten international security; and require immediate action. The UN Security Council has already agreed in its special session on HIV/AIDS that the epidemic constitutes a human security issue. The Group believes that the international response must now be stepped up further, to reflect this grave threat.

The Impact of HIV/AIDS on the Security Services

Africa's armed forces have rates of HIV infection as high as 60% - some of the highest concentrations anywhere⁸⁰. Military personnel are a high risk group, more likely to contract Sexually Transmitted Infections including HIV than civilians. During conflict the chances of infection increase significantly⁸¹.

Weakened armed forces and internal security forces can undermine a state's monopoly on violence, and, by extension, a country's stability. Loss of military personnel through AIDS can undermine military services in several ways. High illness and death rates reduces numbers of capable soldiers and other personnel. To replace them, new soldiers and staff have to be trained quickly and by speeding up training, quality may decline. But even the best training is no substitute for experience and skills learned in the field.

As with teachers and medical staff, HIV infection is highest among young people but the ten-year lag between HIV infection and death means that those who fall ill and die have years of experience that no training can replace. Studies on the impact of AIDS on the South African National Defence Force indicate that it could lose 25% of its Majors and Lieutenant Colonels⁸². This rate of attrition at middle and high ranks could be catastrophic to security forces.

Governments rely on their security forces to ensure stability, particularly their police forces. The losses, both in numbers and skills, will affect the entire security sector. It may be essential to provide treatment to protect key members of the security forces to ensure that the state fulfils its duty to protect its citizens and enforce law and order.

The Role of Conflict

Understanding how conflict has spread HIV/AIDS in Africa is central to understanding its patterns of infection. Little is known, for example, about HIV prevalence in the Democratic Republic of Congo which has suffered ten years of war. Rape was widely reported by human rights groups but now troops are being demobilised after the peace agreement. Experts can only guess what impact the return of tens of thousands of young demobilised fighters, many of them infected with HIV, will have on their communities

inside and outside Congo. As peace comes to Angola, Sudan and the Mano River region of West Africa, the same question arises. Experts suspect HIV prevalence rates are high amongst young fighters. It is essential and urgent to provide testing, counselling and medical services to ensure that HIV is not spread further by demobilised troops.

Peacekeeping Forces

Peacekeeping forces are also at risk. They face the same risks as national armies and are even more mobile so they have the potential to fuel and spread the epidemic. An estimated 11% of Nigerian peacekeepers returning from Sierra Leone and Liberia were HIV positive, for example⁸³. The UN has around 46,000 peacekeepers globally, most of them are deployed in Africa and are essential to the maintenance of a number of peace agreements⁸⁴. As well as UN troops regional deployments, such as ECOWAS and the EU and bilateral deployments such as the British and French troops are also playing a key role in a number of countries in Africa. A weakened capacity amongst troops who are essential for policing peace agreements and protecting civilians could be catastrophic.

Peacekeeping is also a particular type of military operation requiring particular skills, expertise and experience. A loss of those with experience in this field could have wider repercussions for the effectiveness of remaining forces.

Wider impacts of AIDS on Security

The Economy

Most security experts agree that economic decline helps cause or fuel conflicts. Others argue that economic inequality is a better indicator. Statistics also indicate that human development indicators, such as child mortality, are linked to state failure⁸⁵. According to the International Crisis Group countries with high HIV prevalence rates will, on current trends, decline economically and become increasingly unequal. Slow economic growth also undermines tax revenues so governments have less to spend on strengthening the capacity of the state and providing essential public services such as security.

As indicated in chapter three the economic impacts of AIDS are not simple and include the potential loss of mechanisms of social reproduction on which whole societies and economies rely.

National Security

Destitution and the perceived injustice of vast inequality can increase levels of crime. South Africa has the highest number of people infected but also the highest GDP in Africa and some believe it faces a 'crime time bomb' because of the wider economic and psychological impacts of AIDS. AIDS orphans are identified as the spark of such a 'crime bomb'⁸⁶. Other research has identified street children in particular, as associated with crime.

But personal security is only part of the greater issue of national security which looms over all AIDS-affected countries. Will the orphaned generation (as discussed in chapter two) present a national security threat? Experience in Sierra Leone and Rwanda

suggests the catastrophic consequences when large numbers of unemployed and disillusioned young people are given weapons, a cause and a power-hungry leadership that offers a sense of belonging that they may have long sought.

*"[On] the issue of orphans, of millions of children growing up outside the family context, often on the street, outside school etc, in societies that are, for example, highly politically unstable. These are natural reserves for any warlords who put a Kalashnikov in their hands and off they go."*⁸⁷

Lower life expectancies may also affect social behaviour. Rational economic behaviour prompts people to set money aside for treatment and for care of dependents. But if people believe they will not live much longer and may die a slow and painful death from HIV/AIDS they may behave differently. This could lead to, or heighten, a sense of fatalism, particularly among disillusioned young people⁸⁸. Research in Sierra Leone reveals this phenomenon even before HIV/AIDS had taken hold in the region. Violent young rebels from the Revolutionary United Front explained their violent impatience saying: "because we are all dying of AIDS"⁸⁹.

We do not know how millions of orphans, brought up without parents and often in conditions of extreme hardship, will feel when they reach adulthood or how will they behave. Will they be a destabilizing force or will their childhoods lead them to play a positive role in society, perhaps leading civil society movements? Some predict the incubation of a new or distorted political consciousness leading in a few decades to a new generation of political leaders "whose worldview has been forged by their experience of AIDS"⁹⁰. Unfortunately most experts predict that the overwhelmingly negative experience of being orphaned by AIDS, will lead adult orphans to adopt a negative and disruptive attitude to established society and its systems. This whole area requires substantive research to help governments plan for and avert such crises.

International Security

The Group believes that the impacts of AIDS constitute a national security issue for the worst affected countries. However they will also affect Africa as a region. The conflicts in the Mano River region, Sierra Leone, Liberia and Guinea, and the war in the Democratic Republic of Congo demonstrated that wars in one country spread only too easily to another. If the orphaned generation create instability in one country, neighbouring countries will find it hard to protect themselves.

In 2002 the US National Security strategy identified for the first time the threat posed to US security by weak states, citing it as greater than the threat posed by strong states⁹¹. Insecurity and state failure in the developing world are now considered a security threat to western countries. The impacts of AIDS may help to contribute to state failure and the links to the HIV/AIDS epidemic further complicate the connections between Africa's orphaned generation and the rest of the world:

"Here we have an epidemic disease which creates orphans in very large numbers. In the rich world, this disease can now be controlled effectively by anti retroviral drugs. These drugs are hard to obtain in Africa and will continue to be hard to obtain even under the WHO 3 by 5 initiative. Hence a generation or two of orphans will exist in the perception that the rich world did not do enough to save them from orphaning... We need to give serious thought to the implications of millions of people growing up with this view. It is almost

inevitable that in their desperate circumstances, they will look for ways to express their anger at a perceived withholding of the medications they and their parents will have required.” Professor Tony Barnett⁹²

We have seen the potential for radical reactions from young people in other parts of the world because of perceived injustice, poverty and a sense of exclusion and powerlessness. Consider for example the role of young people in Sierra Leone and the Middle East. A minority have been convinced that they can end this powerlessness through violence. Extremists exploit such circumstances to their own advantage. They may find many willing recruits among the most disillusioned members of Africa’s orphaned generation. Such extreme groups may also find it easy to move to and operate from states whose security structures have been weakened by the epidemic. This would pose a direct threat to international security.

Possible Interventions

Mitigating the potential impact of HIV/AIDS on security services

All security services need to implement effective prevention programmes. Keeping HIV prevalence levels low amongst members of the security services is central to maintaining their capacity and reducing the extent to which security services, particularly mobile armed forces, provide a vector for HIV/AIDS transmission.

Some African countries such as Ethiopia are already doing this (see box 4.1). The high prevalence amongst soldiers in Uganda after years of war and instability brought home the severity of the HIV/AIDS problem in the late eighties. The Ugandan authorities which had come to power through war and retained it through force, quickly realised that these levels of infection meant a lot of their troops would die. They set up HIV/AIDS campaigns both within the armed forces and across Ugandan society.

UNAIDS is ensuring that all UN Peacekeeping forces have an HIV/AIDS programme, the MONUC force in the DRC is one example. Demobilised soldiers undergoing ‘reintegration’ programmes should also be targeted as a matter of urgency. The African Union is currently setting up an African Standby Force for peacekeeping operations and this force must integrate HIV/AIDS into its operations.

The UK Ministry of Defence has stated that UK forces deployed in Sub-Saharan Africa are briefed on HIV/AIDS and other STIs based on the guidelines of the UK Chief Medical Officer’s Expert Advisory Group on AIDS⁹³. Such advice is necessary for all armed forces working in AIDS affected regions.

Secondly, to minimize staff attrition, the security services must set up other effective HIV/AIDS programmes from counselling and testing to treatment and care. Much like other government departments and private companies, military leaders have a responsibility to protect their staff with comprehensive programmes for all security services originating from or acting in AIDS affected regions.

This is easy to recommend, difficult to deliver. For example if HIV positive soldiers are given expensive treatment, they will become dependent on it and may refuse to leave military service as a result. This is a serious potential source of conflict and needs to be addressed in the design of programmes. For example rank may not be the most sustainable way to distribute limited treatment.

The African Comprehensive HIV/AIDS Partnership (ACHAP) which is a public private partnership in Botswana has set up a number of clinics providing HIV/AIDS services, including ART. The Government of Botswana has located two of the sites on military compounds⁹⁴. This is one way in which the impact of AIDS on security services can be mitigated, indeed it may be easier than protecting staff in other sectors because security forces tend to live in a compound, separate from wider society.

Box 4.1: The Ethiopian Defence Force

In 1996 with prevalence rates of 6% among the armed forces, the Ethiopian Military began to take serious and innovative action against HIV/AIDS. Under the command of Lieutenant General Gebre Tsadkan Genretensae, then Chief of Staff, the Ethiopian Defence Force undertook a prevention programme that kept HIV prevalence levels low. Rates amongst civilians continued to increase. Significantly the HIV/AIDS programme was made a command responsibility rather than being relegated to the medical service.

Lack of resources were just one of the challenges the programme faced but EDF also realised that the programmes had to be very long term. The report on the programme states: "Fighting HIV/AIDS is not a short time affair. It demands organisational commitment, continuous attention and persistent drafting of programmes, allocation of resources and manpower, building good practice through rigorous review and evaluation, coordination, and overview of the implementation process."

(HIV/AIDS in the Ethiopian Military: perceptions, strategies and impacts)

Every country faces different circumstances. Many of those emerging from conflicts have a surplus of soldiers and these countries face challenges of demobilisation and reintegration. Other countries need to prevent potentially devastating levels of staff attrition that would undermine their capacity to provide basic security.

However, at both ends of the spectrum, HIV/AIDS programmes are necessary within the security services. Programmes can be designed to suit the context of each nation, its level of threat and its priorities. Some may seek to emphasise the protection of security staff through extensive prevention and treatment programmes, others will concentrate on ensuring that security service staff, particularly demobilised fighters, do not become a major vector for the HIV epidemic.

Mitigating the wider impact of HIV/AIDS on Security

Economic decline, caused by the AIDS crisis, may contribute to insecurity. The potentially devastating impacts of AIDS on economies and livelihoods are discussed in Chapter three.

The 'orphaned generation' has been identified as a key driver behind potential conflict. Key interventions to minimise the impact of the orphaned generation on security will be:

1. Minimise the number of children orphaned, by keeping parents or guardians alive for as long as possible, the death of a mother appears to have the greatest impact on children, so prioritising young mothers will be most effective.
2. Minimise the destitution, homelessness and hopelessness among orphans. This will involve huge increases in social security, massively increased support for

- care of orphans and other vulnerable children within their communities, through foster care or other types of support. Both these types of intervention are discussed in more detail in chapter two.
3. Invest in conflict prediction and prevention and incorporate the impacts of HIV/AIDS into those programmes. Investigate the potential impact of HIV/AIDS related grievances.

Fatalism can be a key reason for resorting to violence. Young people may digress into such fatalism when they lose their parents to AIDS and fear the same fate for themselves. The only antidote is hope. Grievances can be identified and addressed before they are played out through violence. Pro poor economic development that assists the most vulnerable and provides opportunities for the young will be crucial. But more specifically young people, who watched their parents die painfully and slowly, will only have hope if they see they have a better chance of survival than their parents. They need better chances of remaining HIV negative and better chances of accessing treatment and care if they do become HIV positive.

National and international security is threatened by HIV/AIDS. The issue needs urgent coordinated action from both African and Western governments.

Summary

The Group believes that AIDS constitutes a double security threat both through undermining the capacity of the security forces and by actually causing insecurity. On this basis the group makes the following recommendations to the UK Government:

- **Support African governments to address HIV/AIDS amongst their security services, through comprehensive programmes.**
- **Support programmes to address HIV/AIDS in Multilateral and British forces operating in AIDS affected countries.**
- **Support research to identify key impact areas within the security services to help governments plan for and mitigate these impacts, for example through support for the UNAIDS office on AIDS Security and Humanitarian Response.**
- **Support African governments and civil society in affected countries to develop transparent policies and programmes to ensure equitable access to health interventions and in particular to ensure that women are prioritised.**
- **Support African governments, NGOs and community organisations to put together a social rescue package at scale. Such a package should be used to address the orphan crisis and the wider threat to the social fabric posed by the AIDS crisis.**
- **Support further research into the impacts of AIDS on security, in particular the potential impact of AIDS orphans.**

Chapter Five Governance

As yet there has been minimal investigation into the impact HIV/AIDS will have on governance. The establishment of the Commission for HIV/AIDS and Governance, under the ECA is a step forward. However, many governments have yet to investigate and therefore comprehend or prepare for the impact on their ability to function as the AIDS death toll continues to rise. The Group believes that the AIDS epidemic constitutes a threat to the smooth functioning of key institutions and to overall governance capacity.

Like other sectors the civil service will face staff attrition because of the HIV/AIDS epidemic. However losses will not simply be quantitative. Of most concern is the loss of key staff members in key institutions. As in many countries governance is already a problem, the impact of AIDS on governance capacity could be particularly devastating.

Human Resource Losses

Civil servants, like workers in other sectors, are at risk from HIV and AIDS. Extended periods of absence due to AIDS related illnesses, then deaths due to AIDS will significantly reduce human resources and therefore capacity to function effectively. Staff and family funerals are an added cost and surviving colleagues will miss work to attend them.

The sheer number of those lost and the number of productive hours lost due to AIDS related absence will be a major impact on government capacity. Funds will have to be diverted to recruit and train replacements at a far more rapid rate than would be the case without HIV and AIDS. However, losses will not be spread evenly across either ministries or levels, nor indeed will the wider impact of these losses be uniform.

Qualitative losses

The process of economic development and particularly the development of complex institutions is premised on a degree of longevity. Because AIDS infection is concentrated on the young and the lag between infection and death is around 8-10 years people are lost in their prime, critically reducing staff longevity. The layer of older, more experienced members is likely to be decimated by HIV/AIDS in some countries.

These key and experienced people will have to be replaced and trained which will constitute a major cost. However, experience cannot be fully replaced by training extending the negative impacts well beyond the economic. Complex institutions may cease to function properly, having lost key staff, and therefore not only capacity is at risk but also invaluable experience and 'institutional memory'⁹⁵.

It is the more complex organisations which rely most on 'institutional memory' and staff experience, making government bureaucracies particularly vulnerable in the face of high levels of staff attrition and higher staff turnover at the middle and high levels.

For example, the International Development Select Committee visited Malawi in 2002 where they met the Agriculture Minister and his top officials to discuss food insecurity.

The delegation later learnt that a third of those officials were HIV positive. The officials who had gathered experience during the 2002 food shortages may not be there in five or ten years time. Their experience will not be available to tackle similar problems in the future and there is no training that can replace that type of experience.

Financial remuneration from employment in the civil service does not compete with the private sector but some staff appreciate other benefits such as long term employment, the idea of a 'job for life'. With reduced life expectancy staff expectations will be altered, and more of the best will leave for the private sector – further reducing capacity. Increases in workloads due to staff attrition may also encourage staff to move to the private sector, creating a vicious circle of capacity loss.

Reduced longevity and other pressures related to AIDS may also alter other behavioural incentives. For example, reduced life expectancy and the need for immediate medical payments and fear about the economic prospects for dependents after death, may increase incentives for corrupt behaviour⁹⁶.

The links between governance problems and the AIDS epidemic urgently require further research in order to help governments plan to reduce the negative impacts of the epidemic on governance.

Governance Problems

The quantitative and qualitative reduction in capacity across the key institutions of government will compound already low capacity and other governance problems.

Free market economics dominated development policy and wider financial frameworks in the 1980s and 1990s. This was coupled with a distrust of the African state because of past misuse of funds. For the last quarter of a century donors have not trusted the archetypal African state because it failed to use money effectively. In the 1980s donors began to focus instead on NGOs to provide services and development.

“...the capacity of the state to deliver basic services has been undermined over the years, partly because of AIDS but partly also because of medium term expenditure frameworks, because of fiscal discipline imposed on governments.” (Peter Piot)⁹⁷

More recently some donors, including DFID, have been at the vanguard of a developmental paradigm shift, which has rediscovered the importance of state capacity. These donors are now funding 'capacity building' programmes where administrations are weak but where they are also confident that such capacity will not be undermined by other problems such as corruption. Carefully designed capacity building programmes will be fundamental both to African governance itself but also to the state's ability to plan and implement HIV/AIDS programmes to protect itself and the nation.

Today many African states are already weak, constrained by low capacity, diminished by decades of bad government, wars, corruption and underinvestment. Public service provision requires efficient tax collection and the conditions for wealth creation. That requires a strong state and a strong state requires revenues creating a virtuous circle. The Group believes that the impact of the AIDS epidemic will add a further dimension to the cycle of under capacity.

Potential Consequences

A reduction in governance capacity could have a number of consequences depending on existing deficiencies and where the impacts of HIV/AIDS will hit most.

Declining state capacity will also reduce the ability of the state to fight the AIDS epidemic – thus the epidemic could create a vicious circle in which governance is undermined by failure to fight AIDS effectively and the ability to engage in that fight is undermined by the impacts of previous failures.

Already in some countries, states are finding that they don't have the capacity to spend money available to fight HIV/AIDS. Yet if they do not do so they will find themselves further undermined by the crisis. For example in Ethiopia, a World Bank grant for HIV/AIDS has not been spent at the rate at which the country needs it to be spent or indeed at the rate that the World Bank expected it to be spent⁹⁸. Yet Ethiopia is at a cross roads – if prevention programmes are not rolled out quickly the country will head towards a disastrous level of HIV – which will further reduce capacity to implement HIV and other programmes. Public services are likely to be hit hard. The key services of health and education are discussed in chapters six and seven.

Inadequate capacity is not only a problem for public service provision and administration but also for tax collection. With the possibility of AIDS affected economies contracting, tax bases will also be reduced. Governments will be left with less tax to collect and less capacity with which to effectively collect the maximum available. This is at a time when demand for spending in areas such as health will increase putting further pressure on decreasing revenues.

A decrease in state capacity will also threaten the state's resilience and its ability to recover from other shocks whether economic or political.

With historical precedents for pandemics causing panic and helping to bring about resurgences of fundamentalist or millennial religion, democratic developments may also be under threat in worst affected areas. Where the public feel that the government has failed either to protect the nation or to respond to the epidemic it is likely to face a crisis of legitimacy. Those who claim to be able to fulfil that basic duty of protecting citizens are likely to receive public support, irrespective of democratic credentials.

Traditionally gerentocratic organisations may also become more youth dominated:

“Men and women who have decades of political experience, strong networks and respected judgement, are being lost, and younger cadres are being promoted to fill the posts but cannot fill the structural gap. Relatively benign patrimonial systems may become more criminalized and violent; long established political parties may come to resemble their thuggish youth wings.”⁹⁹

However, we cannot be sure whether the HIV/AIDS pandemic will undermine civil society or provide a catalyst for its development. It may in fact trigger community mobilisation in the form of vociferous civil society groups as has been seen with the Treatment Action Campaign (TAC) in South Africa. Unfortunately there are other

examples of civil society organisations being undermined by HIV/AIDS due to the loss of staff and volunteers¹⁰⁰. Whether democratic pressures will be emboldened or undermined by HIV/AIDS will depend on the context, intervening factors, individuals and crucially on the support given to civil society.

In short high death tolls will hit government departments, civil services in general and politicians themselves. Staff attrition will impact on the capacity of governments to function and to respond to the epidemic. The long term viability of complex institutions will also be undermined because of an erosion of institutional memory. African institutions are often already weak under-capacitated and not resilient. The impact of AIDS on governance is under-researched but given these basic observations it is an area that requires immediate research and immediate action.

Possible Interventions

The gap in knowledge about this issue of governance needs to be rectified.

Governments need a clear understanding of the threats to them in order to plan for them and attempt to mitigate them. The exact strategy required will vary in each case but these few basic observations suggest some possible starting points.

Already weak states are likely to become weaker as their limited capacity is further undermined by a loss of experienced staff. Interventions fall into two categories: the first is to prevent or delay as many of these losses as possible, the second is to plan for the unavoidable losses to capacity by building up capacity in advance or by changing the way an institutions works.

Minimising staff attrition

Like companies, governments need to ensure that they can provide an initial outlay to protect their key institutions from unsustainable levels of staff attrition. To allow staff to die prematurely will prove more expensive in the long run, indeed it may prove terminal for some key institutions, and therefore for the state itself. Thus, workplace prevention, treatment and care programmes will be central to protecting an institution's capacity to function.

Provision of treatment in order to extend the healthy and productive years of staff members' lives are likely to be central to retaining institutional memory and capacity. The experience of international corporations, some of which have launched major workplace programmes in order to protect productivity and profitability, indicate possible strategies for public service programmes. Every government and ministry will need to look at how to allocate treatment, where they cannot afford universal prescription from the outset. Every institution will need to openly and transparently discuss their options with their staff in order to put together a programme of staff treatment that is not a cause for conflict but focuses limited resources where they can be most effective.

Any attempt to avoid the controversy is likely to backfire on governments when the public at large realise they have been entirely excluded from the decision-making process. Better to face the difficult decisions head on. Members of Parliament can play a key role in bringing the debate about access to health services for key workers to their constituents and by representing their interests as the debate moves forward.

Capacity building

Capacity building now will be essential to retaining capacity as AIDS death tolls rise. Capacity building programmes need to take into account the very specific threats to capacity from HIV and AIDS. It will be necessary to predict where key losses will be concentrated, find which will have most impact in the short and long term and start putting extra capacity into those areas now.

Capacity building is essential and urgent for governments that face high attrition in the next decade. However it also essential for countries at earlier stages of the epidemic in order to avoid the vicious circle of low government capacity failing to stem the epidemic and the epidemic further reducing government capacity either to govern or to fight the epidemic. Indeed countries where HIV and AIDS have not yet damaged governmental and institutional capacity to implement prevention and mitigation strategies have a window of opportunity that must not be missed.

It is essential that the rising levels of ODA and funding to fight HIV/AIDS are channelled to underpin rather than undermine state capacity. While in many cases governments are inefficient and unable to spend money effectively and sometimes NGOs look a better conduit of funds, it is important to ensure that government capacity is not undermined, or duplicated, but supported. The AIDS crisis in Africa requires immediate action, thus organisations such as NGOs that can deploy resources and services rapidly will be central to the fight against AIDS. But over the longer term and particularly since treatment has become a more realistic option, state structures will be essential to the roll out of HIV/AIDS treatments. Investment in state structures now, rather than duplicate temporary structures, will be central to both state capacity and the longer term strategy of fighting HIV and AIDS. Clearly NGOs still have a central role to play in implementing programmes through such structures.

If governments cannot prevent losses of ability, skills and experience, and find that they cannot build extra capacity in time, they may need to adapt. Could they function through simpler structures with a 'stripped down organisational apparatus'¹⁰¹, a system that is less vulnerable to knowledge loss and high staff turnovers? Technology could also be central to maintaining capacity and institutional memory in complex and indeed simple organisations. This is an area in which the private sector may be able to provide some advice, but research is needed to guide governments to ensure they protect rather than further diminish capacity. All these factors should be taken into account by donors who embark on capacity building programmes.

Barriers to state capacity building

Building state capacity is key, capacity to spend available funds effectively, capacity to implement and monitor programmes and the capacity to protect itself.

The urgency of the AIDS epidemic means that in many countries NGOs will play a major role in responding to the epidemic, directing funding away from the state. To an extent this is unavoidable but the Group believes that NGOs, governments and other parties need to improve coordination to ensure that state capacity is supported, not undermined, by the use on non-state actors.

Some Governments have also faced problems in accessing funding for HIV and AIDS programmes because of expenditure frameworks designed to limit and stabilise spending. It is imperative that AIDS is considered an emergency situation and not hindered by expenditure frameworks. While these frameworks, agreed by countries with the IMF, are central to preventing high inflation, the Group believes that the AIDS crisis, if unchecked, will fundamentally undermine budgetary stability anyway. Thus a balance must be found between economic stability and the spending necessary to prevent catastrophe. In terms of action by the UK this is a matter for DFID and the Treasury. The UK is the second largest shareholder of the IMF and we could have an influence in finding a better balance on this issue.

Summary

The Group believes that low state capacity has weakened the response to HIV/AIDS in some countries, but that the capacity to respond to the crisis has been further weakened by the impact of the epidemic itself.

The Group also believes that the impact of AIDS on governance could well devastate state capacity. The Group has identified three key areas in which interventions to avert the worst impact of governance capacity:

1. Minimising impacts by protecting staff from HIV and AIDS
2. Building state capacity in advance of the worst impacts

The details of the interventions will obviously vary but the design of effective interventions will depend on an urgent increase in research into the links between governance capacity and the impacts of the AIDS epidemic.

- **Support African governments in affected countries to prepare for losses in human capacity through massively increased staff training programme for key public sector workers both at the front line and other key staff such as public service managers and administration managers.**
- **Support African governments and organisations such as UNAIDS to calculate possible staff attrition in key sectors such as health, education and security, and in key roles within these sectors, in order to help governments plan for increased recruitment and training needs.**
- **Scale up government capacity building programmes and tailor them to build capacity in both in those areas identified as under most threat from AIDS and where capacity is needed in order to coordinate the battle against the epidemic.**

Chapter Six The Health Sector

The HIV/AIDS epidemic is putting enormous pressure on health services by creating a new group of ill and chronically ill patients and it is eroding the capacity of health services from within. The health sector in AIDS affected countries is being undermined both in terms of supply and demand.

Increased Demand

In Africa it is estimated that average spending on public sector health provision is 1.5% of GDP. Another 1.8% is spent on private sector health services. These combined represent an average of only 3.3% of GDP, well below the global average of 5.5%. The sums spent on health in Africa are, anyway, tiny compared to spending in the west. Yet with these tiny resources the health sector is trying to make an impact on the biggest disease since the Black Death¹⁰², taking a huge slice from a tiny cake.

A large proportion of hospital beds in affected countries is taken by people suffering from HIV/AIDS and related illnesses¹⁰³. In Zambia it is estimated they occupy more than half of all beds in major hospitals¹⁰⁴. In Malawi the figure is 60-70% of its 1000 beds leaving only half (or less) of an already skeletal health service to care for other illnesses¹⁰⁵. It is estimated that in 2005 Namibia will have more HIV/AIDS inpatients than hospital beds¹⁰⁶.

With minimal human, financial and physical resources many health services in the region are not able to withstand the increased demand created by the HIV/AIDS epidemic. Now these countries need to roll out complex anti-retroviral treatments and other HIV/AIDS programmes that require yet further resources.

HIV negative citizens in AIDS affected countries also suffer:

“The impact is such on the health services that it has deprived people who are HIV-negative as well as positive because the impact has been right through the health service both on staff, the quality of care and the displacement of resources because so much of the emphasis now has to be on AIDS because it is such a complex disease. Therefore, the health services are completely crippled as a result of this epidemic, yet they need to be strong in order to provide the level of service that will help people address the epidemic.” (Dr. Sunanda Ray)¹⁰⁷

African governments face competing demands for spending with relatively small budgets. For example debt and war also demand state finances. Nigeria spent 0.5% of GDP on health in 2000 but 6.2% on servicing debt in 2001. Ethiopia spent 1.8% of GDP in 2000 on health but 6.2% on its army and 2.9% on servicing debt¹⁰⁸. In Mozambique, where AIDS has been on the agenda of the leadership for some time, total per capita expenditure on health was \$10.7 in 2001. The Government plans to raise this to \$15.9 by 2005 and \$21.3 by 2010¹⁰⁹. This doubling of per capita health spending in ten years is an excellent advance, but the final figure is unlikely to keep pace with the new pressures provided by the AIDS epidemic and cover wider health spending.

Although African leaders committed their governments to increase spending on health in 2001, in many of the worst affected countries the increases will barely keep existing health systems afloat. In May 2004 African Health Ministers resolved to mobilise greater domestic resources for health spending and to realise their 2001 target of allocating 15% of national budgets to health¹¹⁰. This target now has to be met. In many countries exponential increases are needed to improve effectiveness and roll out HIV/AIDS treatment and cater for wider health demands.

Decreasing Capacity

Years of underinvestment in African health services have left them in tatters. Spending has too often been concentrated in urban areas, leaving health services in rural areas almost non-existent. Low budgets and a lack of trained personnel render health services skeletal, for example in Ethiopia there are an estimated 3 doctors per 100,000 people, in Tanzania there are estimated 4 per 100,000 people¹¹¹. Yet these trained personnel, the foundation of any health service, are also being lost because of the epidemic.

Health workers are as vulnerable to HIV/AIDS as anyone. Many countries do not know the levels of HIV prevalence amongst their health workers so their governments cannot predict or plan. In Botswana up to a third of health workers are HIV positive, and the figure is expected to rise to 40% by 2005¹¹². In Lusaka, Zambia, 39% of midwives are reckoned to be positive and 44% of nurses¹¹³. The death of such large numbers of trained and experienced staff will devastate health sector capacity.

Those with HIV/AIDS also suffer a long illness, often up to a year. Health services are further damaged by long periods of absenteeism when staff may not actually be replaced. And AIDS does not allow nursing staff to be rewarded with recovering patients. Watching patients die slowly, unable to give them the medication, time and care they need is a disillusioning and depressing experience. Working with AIDS patients in an over-stretched and under-funded system may drive health workers to find jobs elsewhere.

“Shortage of drugs and declining service conditions have affected morale amongst staff throughout the health sector, as they feel less and less able to respond to the health needs of people with AIDS and see the quality of care they provide falling with declining resources.”¹¹⁴

Health sector workers are being lost, for a number of interrelated reasons. A VSO survey of Malawian nurses who left the country found that 40% gave high work load as the reason for leaving, 25% said a lack of protective equipment and 10% said sickness¹¹⁵.

The rate at which staff are being lost is in many cases faster than they can be replaced.

“In Malawi, the attrition rate is about 25 per cent per year and it is roughly one third nurses dying from AIDS, one third emigrating to South Africa and one third internal migration to the private sector from the public sector.” (Peter Piot)¹¹⁶

Replacing staff at this rate would take a massive training programme, far beyond the existing capacity of countries like Malawi. Yet Ministries of Health will need to plan for even higher levels of staff attrition in the coming years.

However the problems of manning African health services are not always clear cut. For example in Kenya about 4,000 nurses cannot be employed by the state because of the cap on state employment¹¹⁷. Yet the country's health system cries out for more nurses and health staff. This must be addressed as a matter of urgency. Now more committed to fighting the HIV/AIDS epidemic than ever before, the international actors must see that their commitment to fighting HIV/AIDS must extend to and affect all areas of policy. Unless this is addressed the international efforts to fight HIV/AIDS could be undermined.

In some countries it is not simply a shortage of frontline staff that is the problem, but a shortage of skilled public service managers to deploy efficiently staff and resources. Already in short supply the loss of more public service managers could prove catastrophic to wider health systems.

Problems rolling out HIV/AIDS services

With the public health sector already overstretched and facing further erosion because of HIV and AIDS, AIDS-affected countries face serious obstacles to providing HIV/AIDS health services. These obstacles relate to costs and capacity.

Even with dramatic decreases in the cost of anti retroviral therapies (ART) in the past few years, the drugs remain relatively very expensive in poor countries.

But even if all HIV/AIDS drugs were free and available, universal ART roll out within the next few years will be impossible in most African countries, because of a lack of health sector capacity. Even limited provision is unlikely under current circumstances in many countries unless extra capacity is put in place now.

*"It is not just a simple theme that there are these anti-retrovirals; make them available to people. There are many other elements that need to be taken into consideration. Does the health system have the capacity to deal with this issue? Unfortunately in many of our countries that is a problem. It is not just as easy as having ARVs and giving them to people. It is not that simple."*¹¹⁸

The lack of capacity relates to physical infrastructure and human resources. The human resources needed to provide HIV/AIDS health services are both a matter of quantity and quality. More frontline staff are needed with the skills to prescribe and monitor treatments. But as well as front line staff there is a managerial issue, the capacity to deploy and deliver. Given that many donors run their own state health services this is clearly an area in which knowledge sharing can be improved.

Treatment of HIV related illnesses and particularly the use of anti-retrovirals is complex. While generic drugs combine ART therapies into a fewer number of pills, all prescribed medication must be monitored both to ensure effectiveness and to guard against resistant strains developing through unregulated or sporadic use. In the ACHAP ARV programme in Botswana effective monitoring has required development of a computer programme which reports when repeat prescriptions are late or early indicating less than 100% adherence. Such a system requires skills, financial and physical resources that are currently absent in many cases.

Less complex and costly than ART are other basic health interventions that could significantly extend the lag between infection and death and increase years of healthy and productive life. Healthy living, including a good diet is vital to staying healthy even though HIV positive. Persuading people to change lifestyle is not easy and before they can be moved they need to know their status. In the meantime government led national-wide campaigns to ensure a basic level of nutrition for all would contribute greatly to improving health generally and averting the onset of opportunistic infections.

Treatment of opportunistic infections also prolongs life and ensures that people do not develop AIDS quickly. Left untreated they can develop into more serious diseases that are harder to cure but a simple course of antibiotics can often kill off the infection at an early stage. That means fewer people will reach the lower CD4 counts that require ART.

However even simple early stage interventions are too much for some African health services and training and infrastructure must be built in these areas as well as in programmes to provide ART. Simple antibiotics need to be made more available in African health services and because they are cheap and easy to prescribe, their distribution should receive as much attention as ART.

Many people suffering from HIV/AIDS only go for treatment when they are chronically sick. At this stage they cannot be given anything other than palliative care, but nursing the chronically ill puts huge pressure on health service resources. Earlier interventions given for free or very cheaply will delay use of and may save health service resources such as beds and expensive ART.

Home based care and palliative care within communities is a possibility if communities are given training and support. Home based care cannot be allowed to become a pseudonym for home based neglect¹⁹. Within a structure and system under overall supervision of the health service, NGOs and community based organisations will support community members in home based care, and monitor their needs. Their coordination at local and district level and an understanding of best practice and basic standards of care are essential.

These components are all necessary to a comprehensive HIV/AIDS programme but they will put existing human, physical and financial resources under more pressure. Ministries of Health will need far greater support to build human and physical capacity and require huge increases in funding and improved coordination with non-state actors.

Using HIV/AIDS to Build Health Sector Capacity

Organisations like the World Health Organisation have eradicated polio, small pox by a programme of immunisation. Temporary structures were set up, separate from or parallel to state structures, and very little infrastructure remained after the event.

Despite the need for urgent action against HIV/AIDS we cannot allow temporary and extra-governmental structures to be parachuted in and allowed to disappear when the initial task is complete. Firstly because the initial task with HIV/AIDS will not be completed at best for decades. Secondly, the temporary structures erected in the past missed the opportunity to build the capacity of state structures. And thirdly it is essential to integrate HIV/AIDS services with other health services because of the way other diseases feed off HIV/AIDS. For example it is estimated that 30% of HIV positive people

in the developing world are also infected with TB. The unification of the health services will also help to overcome stigma by not having special clinics or nurses for HIV/AIDS patients which may discourage people going to them.

“The treatment programmes must definitely be done through some existing structure, like probably the TB services; and that will address the escalation of TB as well; through the antenatal clinics, with reference to child transmission prevention, but in the process improving antenatal care for all women, linking up with home based care.”¹²⁰

Furthermore while in some countries 30% of people may be HIV positive, the 70% majority are still HIV negative. Many African governments point out that malaria still kills one million Africans every year and ask if malaria sufferers should be neglected because of special efforts on AIDS. It is right that both HIV Positive and HIV Negative should in the longer term, benefit from new investments.

DFID has indicated a preference for its HIV/AIDS programmes to be implemented within the broader national health system, precisely in order to avoid building up only temporary capacity. This approach has pros and cons:

“In the short term, this approach may result in less efficient implementation of specific interventions – since it relies on generalists who have multiple competing priorities for their attention. In the long term, however, it is more likely to lead to sustainable increases in capacity for planning, implementation and monitoring of improved health services across the board, from which HIV/AIDS interventions must benefit.”¹²¹

While sustainability of health services will be essential, the Group believes that the HIV/AIDS epidemic is urgent and HIV/AIDS treatment services must be fast-tracked to avoid catastrophic mortality levels.

Non-state capacity can be used to help fast-track HIV/AIDS treatments. Some NGOs and some businesses have the capacity to act quickly and to reach areas that have limited provisions. This comparative advantage must be utilised but must be centrally coordinated to ensure maximum impact.

There are some successful examples of health services being provided through a combination of state and non-state actors. The *loveLife* programme in South Africa, which receives funding from the private sector and government, has tried to add value to existing infrastructure:

“Public health clinics are also very widely disseminated and they are potentially critical hubs for community based HIV prevention, treatment, cure and support. A lot of our work with the public clinics is not only trying to make them friendly to young people but also to create a foundation through management improvement and systems improvement whereby you can begin to introduce treatment over time and make the connection with the social security system.”¹²²

The ACHAP programme in Botswana is also a public private partnership which is already rolling out ART to Botswanans at a number of sites across the country (see Box 6.1). This programme has also tried to build human and physical capacity in the health

sector. Such programmes can only become self-sustaining if improvements to infrastructure are left behind when these non-state actors leave, and the skills, insights and experiences are also retained by the staff. Their success will also depend on commitment from all levels of government.

Box 6.1: African Comprehensive HIV/AIDS Partnerships (ACHAP)

Initiated in Botswana in 2000 ACHAP is a comprehensive HIV/AIDS prevention and treatment programme undertaken in Africa. It operates as a public private partnership between the Bill & Melinda Gates Foundation, Merck & Co. Inc. and the Government of Botswana.

Collaboration between the private sector and the Government enables funding to be targeted at specific projects on the ground. But by building on local capacity, programmes are more likely to result in long-term success and sustainability.

ACHAP projects have focused on strengthening the Botswana healthcare system's skills base through recruitment and training in managerial, leadership, and clinical and technical skills. It has involved procuring and upgrading treatment space and setting up drug procurement, storage and distribution systems.

Additionally, the support of traditional healers, who are very influential in the local community, has been sought and a traditional healer has been seconded to the Government to create a meaningful HIV/AIDS education programme for the healers themselves.

When the private support ends the Botswanan Government will take over the programme, having had significant assistance with the initial financial, logistical, managerial and human resources to set up the programme.

Several different organisations are working together on programmes to roll out HIV/AIDS treatments, particularly ART. Bilateral donors are combining with the Clinton Foundation initiative and the WHO 3 by 5 programme and NGOs. Co-ordination of interventions is essential to maximize capacity and effectiveness while minimising duplication. The 'Three Ones' approach espoused both by UNAIDS and DFID is a useful framework for increasing coordination of funding, particularly in the provision of health services where so many different initiatives are being implemented. All interventions should be obliged to fit in with a detailed national strategy, designed by government in consultation with civil society. In Botswana the ACHAP programme also assisted the Government in developing a detailed national Strategic Framework. This assists the Government to coordinate interventions and utilise them to assist the Ministry of Health to respond to the crisis in the short and long term.

Addressing the Human Resource Crisis in the Health Sector

Improving staff retention

With many staff sick or dying from HIV/AIDS illnesses it is essential for health services to value their staff and provide them with care, support and protection.

Staff attrition rates are so high that providing them with good health services will be central to averting a deepening human resource crisis in the health sector:

“We should treat them to keep them within the system, to create loyalty so that they stay, but also to then make them into a community resource so that they are the people who are doing the counselling, the education in the schools.”
Dr Sunanda Ray¹²³

Ministries of health may use incentives similar to those used by the private sector such as “golden handcuffs’ to encourage newly trained staff to stay in country for a minimum period and to these might be added bonuses for uninterrupted service. This applies not only to front line staff but also to key public service managers who are essential to the functioning of the sector.

Low pay is also a central issue affecting staff retention. The public health sector cannot compete with private sector rates. The Malawian health sector cannot pay wages comparable to South Africa, let alone the British health sector. Countries like Britain which lure large numbers of health sector staff from AIDS affected countries need to consider these practices and their effects. AIDS-affected countries should consider how to keep their health workers for example by enhancing job security, giving personal health benefits and by making their staff feel they really do make a difference.

The UK National Health Service already has a code of conduct prohibiting the recruitment of health workers from most AIDS affected countries in Africa. However private agencies which supply the NHS and the UK private health sector, are able to recruit in countries facing AIDS crises. Tightening this loophole or finding other ways of helping and compensating the losing countries is a high priority. These are not ordinary migrant workers supporting their families and their nation with remittances and foreign exchange. They are essential workers in the battle against AIDS.

Possible strategies could include a limitation on the time migrant health workers from AIDS-affected countries are permitted to stay. They could be given extra training while overseas. Or the receiving country could pay for replacing them or training more medical staff in the source countries. The Group believes that the use of health professionals trained in AIDS affected countries by wealthier countries may be stemmed by reducing incentives to come, and by increasing incentives to stay. But where staff are used by health services in other countries then the ministries of health that provided their training should be directly compensated.

Under present conditions staff losses to illness or other occupations will not be halted, but they could be slowed. Few Ministries of Health know what level of loss they should be planning for. Research is necessary to plan effective strategies for mitigation. It should determine which areas will suffer most losses and how can extra funding be most effectively used to ensure African Health services do not collapse. These strategies will then need funding.

Recruiting and training new staff

In badly affected countries staff will probably be lost faster than they can be replaced. Funds for medical training need to be increased and incentives devised to persuade

students to take up nursing and medicine. For example improved bursaries to induce more students to take up nursing or medical courses may be used.

Issues of low morale and low pay also impede recruitment and can be partially addressed by improving the benefits available to health sector staff, in particular in terms of access to health services including HIV/AIDS treatments. While the Group does not expect the public sector to be able to compete with the private sector in terms of pay, small but significant increases in pay are helpful to staff retention and are straightforward to implement, if funded. It may be possible to link pay increases with extra training on HIV/AIDS treatments.

The Group also notes that it is not only front line staff that are essential to the running of the health service, administrators and particularly skilled public service managers are already in short supply in many affected countries. Training of public service management is one other area that donors can directly support.

The Group believes that donors can play a key role in massively scaling up recruitment and training of health professionals, both front line and other key staff such as skilled public service managers, through financial and logistical support as well as through sharing expertise in training programmes.

Summary

The Group believes that HIV/AIDS is undermining the health sector in many African countries by increasing demand for health services while eroding capacity to provide those services. In particular the health sector faces a human resource crisis and lacks the capacity to comprehensively roll out ART and other HIV/AIDS services. Yet to protect itself and wider society providing these services will be essential. The Group also believes that where well coordinated and sustained, non-state actors can assist governments to build capacity in their health services over the short and medium term.

The Group makes the following recommendations to the UK Government:

On Improving Health Services:

- **Support African governments to provide integrated health interventions including prevention and nutrition programmes and basic treatments such as antibiotics for opportunistic infections and antiretroviral therapy (ART). To deliver these swiftly, governments will need to harness the capacity of business, NGOs and community organisations.**
- **Recognise that ART can extend life for HIV affected people considerably and is the single most important strategy to mitigate the impact of AIDS. Support roll out of treatments at scale, where possible with state leadership but utilising capacity in other sectors.**
- **Support African governments to work with civil society to develop policies to ensure access to health interventions based on equity, effectiveness and transparency. In particular such policies will need to ensure that women are prioritised, in order to safeguard the social fabric.**

- **Scale up government capacity building programmes and tailor them to build capacity in both in those areas identified as under most threat from AIDS and in those areas where capacity is needed in order to coordinate the battle against the epidemic.**
- **Establish a unit within the DTI in partnership with experienced companies to advise other companies with operations in Africa on developing fully comprehensive HIV/AIDS programmes for both their workers, their families and the communities in which they work and where migrant labour is used also in the communities from which their workers come and return to.**
- **Encourage non-state actors with valued capacity skills and resources to take part in national programmes, led by national governments, as well as those for their own workers and their communities.**
- **Support African governments and the World Health Organisation to calculate possible staff attrition in key sectors such as health, and in key roles within these sectors, in order to help governments plan for increased recruitment and training needs.**
- **Support African governments to mitigate the impact of losses in human capacity through massively scaled up staff training programmes particularly for teaching and medical staff. The Group recommends that the Department for Education and Skills and the Department of Health work with DFID to support distance learning courses for key professionals such as teachers and nurses.**
- **Reduce UK use of health professionals trained in AIDS affected countries by reducing incentives to come time allowed to remain or by compensating Ministries of Health who paid for those professionals' training.**
- **Ensure policy across all UK Government Departments on HIV/AIDS is coherent and joined up. Under the leadership of DFID, every UK Government department should develop policies to support coordinated and intensified efforts to fight the global HIV/AIDS epidemic.**

Chapter Seven

The Education Sector

Education is essential for growth, economic and social development and is fundamental to fighting HIV/AIDS. The capacity of Africa's education system is being seriously undermined by the epidemic.

Goal Two of the Millennium Development Goals is to achieve universal primary education by 2015. This was always ambitious for many African countries and the impact of HIV/AIDS will make it unachievable.

If Zambia achieved the 'Education for All' goal, the number of children enrolled in schools would increase from the 2001 figure of 1,886,400 to 3,192,500 by 2010. But net enrolment rates have actually declined indicating how unlikely achievement of the target now is in many countries¹²⁴.

Chapter two discussed in detail the problems faced by children from AIDS affected households in getting into a school, going regularly and staying the course. Here we will look in more detail at the impact of HIV/AIDS on the supply of education rather than the demand for it.

The Impact of AIDS on Education

Funding

As described in chapter three HIV/AIDS is likely to severely impact economic growth and therefore government revenues available to spend on education. It is too early to infer that decreasing government revenue and increasing pressure for spending on health will mean that education spending will be cut or frozen. But given the importance of education in preventing further HIV infection in the long term and in general economic development, governments will need to guard against reducing education budgets to pay for increased health services. Indeed significant increases in education spending will also be necessary.

Human resources

Teachers in Africa are mostly young and upwardly mobile and therefore in the group most at risk from HIV and AIDS. "HIV positive teachers are estimated at more than 30% in parts of Malawi and Uganda, 20% in Zambia and 12% in South Africa"¹²⁵. The World Bank estimates that in the worst affected countries of Africa about 10% of teachers will die over the next five years."¹²⁶

In the case of Mozambique, there are currently 80,000 teachers for a population of 4 million. Estimates suggest infection rates of 17% across the nation's workforce. The government believes that around 10,000 teachers will be lost to AIDS between now and 2010 – an average of 1,200 teachers per year¹²⁷. In many countries teachers are dying faster than they can be trained. In Zambia they are dying twice as fast as they can be trained¹²⁸.

And death from AIDS comes after a long illness. HIV positive teachers may feel sapped of energy, isolated and fearful – affecting their teaching abilities. Estimates suggest that a teacher loses six months off work before developing full-blown AIDS. Then they will lose a further 12 months¹²⁹. Teacher absenteeism due to HIV/AIDS in Zambia is estimated at 20 million lost teacher hours between 1999 and 2010¹³⁰.

During this time teachers still receive their salaries but substitute teachers must also be paid else classes are left untaught. For every sick teacher a whole class of children are affected.

“If you just look at mortality and deaths then the problem does not hit you in the face, but when you add to that those who are ill and do not have access to treatment because their salary is far too low to afford it, then we get to a situation where schools are without teachers, de facto.” Peter Piot¹³¹

Already children may be in classes of up to 80¹³². Teachers cannot be trained at a matching rate so schools will either allow class sizes to expand further or rely on unqualified staff. Moreover, most deaths are amongst staff in their 30s and 40s leaving a smaller number of the most experienced staff to pass on their knowledge and skills to younger recruits.

HIV/AIDS will impact on staff numbers and institutional knowledge across the entire education sector, not just at the front line. Non-teaching staff are also at risk and their loss will also erode the capacity of the education sector.

Economic costs for Ministries of Education

Studies in Zambia and Mozambique indicate that the cost of providing substitutes for sick teachers is likely to be much greater than the cost of training new teachers¹³³. In countries with high rates of AIDS the combined costs of both replacement and extra training could cripple the education sector:

“In Swaziland...the theoretical cost of hiring and training teachers to replace those lost to AIDS is estimated to reach US\$233 million by 2016 – an unsupportable cost that exceeds the total 1998-99 government budget for all goods and services.”¹³⁴

Other outlays, such as providing bursaries for AIDS orphans, will further strain Ministry of Education budgets.

HIV/AIDS will increase the cost of achieving the goal of education for all and the time taken to achieve it. It is estimated that HIV/AIDS will increase the existing funding gap to achieve the goal by one third¹³⁵.

The loss of teachers to HIV/AIDS is catastrophic but other staff within Ministries of Education are dying too. The loss of administrators, officials, inspectors and managers, essential staff, is significantly reducing the capacity of Ministries of Education to respond to impacts on the front line of education. In particular, public service managers, those responsible for deploying limited resources efficiently are already in short supply and small losses among this key skilled and experienced group could have very wide repercussions for the education sector. The Group notes that while there has been

useful research into the potential losses amongst teachers, there is less consideration of wider losses within Ministries of Education and argues that both must be understood and planned for.

Box 7.1: Costs incurred to the education system by HIV/AIDS:

- Training teachers to replace those ill/deceased through AIDS
- Training teachers to replace those who take up higher paid jobs (vacant due to AIDS)
- Teacher absenteeism
- Funeral grants
- Double teaching duties
- Larger class sizes and reduced quality of teaching
- Activities to enrol orphans and vulnerable children

(Based on a table from *Education and HIV/AIDS: Modelling the Impact of HIV/AIDS on Educational Systems*, World Bank)

The Impact on the quality of education

Reduced numbers of healthy staff obviously diminish the quality of education. In one Malawi primary school a study indicated that between seven and 10 teachers were absent each day out of a total of 51. The students of the absent teachers were spread across other classes so class sizes were between 50 and 100¹³⁶.

Not only the loss of teachers but also of key administrative and managerial staff will affect front line education services. Research is needed in this area to help ministries of education predict and plan for the possible effects.

There are other aspects of the impact of AIDS on education:

- The impact of AIDS is likely to hit rural areas more than cities. In Zambia it has become progressively harder to post teachers to rural areas, in part because HIV infected teachers want to be near to hospitals and health services¹³⁷.
- Healthy teachers are likely to have to take on extra teaching to make up for the absenteeism of their colleagues, putting them under greater pressure for no additional reward. This is likely to affect the quality of education and the willingness of healthy teaching staff to remain in the profession.
- Most deaths are amongst staff in their 30s and 40s leaving a smaller number of the most experienced staff to pass on their knowledge and skills to younger recruits.

The impact of AIDS on education is not a short or medium term issue, but will affect future generations. If education quality is reduced today, the teachers and workers of tomorrow may well be lost both in terms of quality and quantity. The longer capacity is eroded now, the less the resilience in the future. Losses of education capacity now will not be recovered for years, perhaps decades.

Possible Interventions

Planning in Ministries of Education to mitigate impacts

Loss of teachers is one area in which research into the potential impacts of HIV/AIDS is relatively advanced. A model known as the Ed-SIDA model, can be applied anywhere to predict the costs of AIDS to the education system¹³⁸. It can also predict changes in supply and demand under different scenarios, allowing Ministries of Education to plan more effectively.

In Zambia the model showed that teachers' deaths from AIDS are expected to rise from 796 in 2000 to about 1,105 in 2010. The cumulative number of AIDS deaths between 1990 and 2010 will be 17,416¹³⁹. Costing teacher training at US\$790 per teacher, combined with in service training means that HIV/AIDS will cost the Zambian Ministry of Education US\$14 million. Absenteeism associated with HIV/AIDS is likely to cost a further US\$7,314,000 up to 2010, according to the model.

The Zambian Ministry of Education has already altered teacher training practices so that teachers are in post after two rather than three years. This has meant that teacher deaths due to AIDS are reduced from half of the planned annual recruitment of new teachers to one third¹⁴⁰.

As in Zambia the model can be used to indicate to governments how many teachers they need to train to keep ahead of HIV/AIDS:

*"The pupil teacher ratio is 52:1 in presence of the epidemic in 2000. This would have been 42:1 in absence of effects of HIV/AIDS. In 2010, the ratio is expected to be 65:1 under projected recruitment practice of 3660 new teachers annually. In the absence of HIV/AIDS this ratio would be 49:1."*¹⁴¹

The model also found that Zambia would have to recruit 6,780 a year to achieve both high levels of enrolment and reasonable class sizes¹⁴².

Unlike Zambia, Burkina Faso has an 'emerging epidemic'. The model, using low and high projections, of HIV infections found a difference of about 5,600 teachers who will become HIV positive. The results indicate the importance of prevention to minimise the impact on the education sector. If Burkina Faso and countries like it reach rates of infection suffered by Southern Africa, they will very soon face the same scale of impact and knock on effects on the education sector. With current pupil teacher ratios currently at around 70 to 1 Burkina Faso cannot afford to miss this window of opportunity. If action is taken now to prevent infection among teachers in Burkina Faso, it could make a significant difference in the future, avoiding the full epidemics as Zambia has experienced.¹⁴³

Results from such models can be used by governments to predict needs and find strategies to fill those needs. However two key problems remain: the capacity and the resources to plan, implement and evaluate interventions to mitigate the impacts, donors can assist in all three areas. Such planning also needs to take place amongst non-teaching staff within Ministries of Education where losses could also be catastrophic for front line education.

The Group believes that donors like the UK can assist governments to speed up recruitment and training and also improve retention of key workers such as teachers. Staff training programmes can be logistically and financially supported, and new media can be used to extend the outreach of training courses. The Department for Education and Skills should work with DFID to fund distance learning courses for key professionals such as teachers and nurses, in cooperation with African education institutes and other partners such as the BBC World Service and the Open University.

Building capacity

To implement complex programmes to mitigate the impact of AIDS on education and to keep the sector running effectively more capacity needs to be developed. Donors have a key role in helping to build that capacity not simply in terms of number but also in training some Ministry of Education staff with specific skills such as public service management.

Some African governments are aware of the need to build capacity in the education sector. VSO for example receives an increasing number of requests for volunteers from education ministries and teacher training colleges¹⁴⁴. While such volunteers may provide valuable input and experience, it is doubtful whether they will be able to plug the gap on the scale and timeframe needed.

The role of community or informal education must also be considered by Ministries of Education and can be utilised where state capacity is lacking but capacity amongst community groups is present but in need of financial and other support¹⁴⁵.

At a high level meeting on education and HIV/AIDS in East Africa in September 2003, World Bank officials asked African Ministry of Education officials why resources available for AIDS and education through the Global Fund and the World Bank were not always made use of. The African officials identified difficulties including a lack of capacity to carry out evaluation. They also explained that, unlike NGOs, they often found it difficult to fast track activities and resource allocations because of cut backs and bureaucracy¹⁴⁶.

Some progress is being made. Kenya's Ministry of Education has begun a pilot study to provide ART to teachers, and Uganda plans to establish a welfare scheme for infected and affected teachers¹⁴⁷. However it is not clear whether any countries have yet managed to implement anything substantial at the school level. Many interventions are still being piloted and as yet governments have no capacity to scale up these programmes.

At the same meeting Ministry of Education officials agreed that donors could assist Ministries improve their capacity to respond to the impacts of HIV/AIDS at scale by helping Ministries share best practice, experience and knowledge across the region. Donors can assist Ministries of Education through support for knowledge sharing forums on formulating appropriate strategies and providing the support to put them into action.

Minimising staff attrition

Keeping teachers alive and well so that they can continue to teach for as long as possible and keeping key administrators and managers alive and productive will require provision of health services to staff. Testing will ensure that in the early stages HIV-positive staff can follow a healthy lifestyle and seek treatment for opportunistic infections.

Ministries of Education will need to provide ART to some staff to prolong productive lives and also to indicate a sense of worth and loyalty to the rest of the staff. If the minimum cost of training a teacher is US\$790 – as it is in Zambia¹⁴⁸ - and if further costs such as funerals and payment of substitute teachers as well as sick pay to permanent teachers are added, then providing ART to teachers with AIDS may save Ministries of Education money. It would also retain those teachers' experience and expertise - something that cannot be learnt at teacher training colleges.

Providing free health services for HIV-positive front line staff also reaps other benefits. Teachers would become better educated about HIV/AIDS, about available health services and medicines and what signs to look for in others. Healthy HIV-positive teachers could also help break down the stigma of AIDS.

Education ministries will need to work with health ministries to coordinate health services for those who constitute the backbone of the education system. Ministries of Education need to be transparent and open with all staff in identifying key staff or in deciding to ensure access to treatment for all staff, on the basis of need. But it is imperative that action is taken quickly to ensure that catastrophic death rates are averted.

Summary

Already the goal of achieving universal primary education by 2015 is likely to be missed in AIDS affected African countries. Efforts must now be redoubled to ensure that education systems do not collapse, but are reinforced and potentially improved. Funding, staff protection, capacity building and assistance in the sharing of best practice will be essential to protect education systems from erosion and in some cases from collapse.

The Group makes the following recommendations to the UK Government:

- **Support African governments to calculate possible staff attrition in key sectors such education, and in key roles within these sectors, in order to help governments plan for increased recruitment and training needs. such as teachers.**
- **Support African governments in affected countries to prepare for losses in human capacity through massively scaled up staff training programmes for teachers and key public service managers. The Group recommends that the Department for Education and Skills works with DFID to also fund distance learning courses for key professionals**
- **Support African governments to work with civil society to develop policies to ensure access to health interventions based on equity, effectiveness and transparency.**
- **Scale up government capacity building programmes and tailor them to build capacity both in those areas identified as under most threat from AIDS and where capacity is needed in order to coordinate the battle against the epidemic.**

Wider Conclusions

The Group has concluded that the AIDS epidemic is an exceptional threat to Africa's stability, security and development. We have found that AIDS poses a severe threat to the social fabric and have identified the key sectors whose debilitation and loss will most severely damage society in general. The International Community, African governments, civil society and the private sector will need to work together to avert the most catastrophic predictions. The Group notes two dimensions to improving the response to the epidemic, in order to avert catastrophe.

1. Funding Issues

Throughout this report the Group makes observations regarding potential impact and the importance of scaling up or adding new responses. The Group appreciates that to address these issues will require increased funding and better coordination of funding.

2. Priority Areas

The Group does not make detailed programmatic recommendations but highlights a number of areas which must be prioritised in order to avert the worst impacts predicted. Many of these are well known and are already central to many existing interventions, others less so.

The Economics of Responding to HIV/AIDS

The Group concludes that the impacts of HIV/AIDS on affected countries will be devastating without effective interventions now. Effective interventions on the scale needed will require huge funding increases. Already opportunities to reduce the projected impact of the worldwide pandemic have been missed because the political will to foot the bill was lacking. Political will in the UK and elsewhere has now begun to build and funding has increased significantly but the Group believes that even more funding will be needed.

The United Nations estimates that the total cost of HIV/AIDS programmes globally is US\$10 billion annually. About two thirds of the global HIV infections are in Africa and numbers are still rising. This implies that the continent needs at least \$7 billion annually for prevention and treatment programmes alone. Comprehensive welfare or other support for children orphaned by AIDS, emergency food security measures and other impact mitigation activities, are additional to this. The amount needed to address these issues adequately needs to be calculated and factored in¹⁴⁹.

Both donors and African governments face challenges as they assess competing priorities for spending. The Group is firmly committed to the importance of wider development priorities but has found that in countries with high HIV prevalence rates, wider developmental efforts are being critically undermined by the impact of the epidemic. Spending on HIV/AIDS must therefore be made a top priority and fully integrated into wider development efforts.

At the donor level, HIV/AIDS is receiving greater priority. The Group welcomes the *UK's Call for Action on HIV/AIDS*, which demonstrates the UK's commitment and illustrates its

efforts, led by DFID, to develop a new policy to combat the epidemic. While DFID has an important leadership role, other departments: particularly the Ministry of Health, the Department for Education and Skills, the Home Office, the Department of Trade and Industry, the Foreign Office, the Ministry of Defence and the Treasury need to update their policies too.

DFID's re-assessment of its HIV/AIDS strategy needs to acknowledge that the nature of the epidemic is so exceptional that the response must be exceptional in both scale and type. And must be designed in consultation with recipient governments and with civil society. The use of direct budget support must be fully reconciled with the high priority rightly given to averting the worst impacts of the HIV/AIDS epidemic.

Funding complications

The Group recognises that there are valid economic concerns about a sudden massive expansion of aid flows but argues that HIV/AIDS is an exceptional threat to Africa's economic development, stability and security. The response should also be exceptional.

Sudden inflows of money can lead to problems of inflation, appreciation of the exchange rate and a fall in exports, lack of capacity to absorb the funds, corruption and dependency. It is important that aid monies should be provided in a way that does not upset carefully worked out macro-economic policies designed to maximise growth and reduce poverty. But, if AIDS is allowed to spread unchecked, it will threaten economic stability itself.

Expenditure ceilings are used to ensure a level of stability and limit inflation. However, the Group argues for two reasons that such ceilings should not in any way delay or reduce the huge increase in HIV/AIDS spending that is necessary. Firstly, unless the devastation of AIDS is abated, no economic development will be possible. Indeed, physical insecurity and state failure threaten some countries. Secondly the Group agrees with the analysis of UNAIDS Executive Director, Peter Piot¹⁵⁰ in arguing that spending money to keep people alive should not be regarded as consumption but as investment in human capital, helping to avert disaster.

AIDS is a profound emergency and requires substantially more funding. Possible economic side effects of HIV/AIDS spending, such as inflation, should be dealt with by intensive economic measures but the onus should no longer be on embattled health workers to try to find ways to staunch the flood with inadequate resources. As Peter Piot says, it should be up to economists to find 'means of accommodating vast new inflows without stirring economic demons.'¹⁵¹

Some African countries have only a limited ability to absorb and use a huge increase in HIV/AIDS funds. Several of the worst affected have limited capacity and this capacity is being further weakened by the epidemic itself. Capacity building programmes, supported by donors, should focus on two areas: first those where the capacity to disperse and utilise funds is lacking, and second where capacity is under threat because of the impacts of AIDS.

It is also imperative that other, non-governmental actors are involved in the battle against HIV/AIDS. Evidence received by the Group indicates that capacity at grassroots level is under-utilised in many African countries. Communities and community

organisations know their area better than anyone and have a commitment that others may lack. They should be supported. How community organisations can best receive funding may vary by country and by donor but other interventions demonstrate that this capacity can be tapped and mobilised with outside funding. One model of coordination in the deployment of funding that could be used is the country coordinating mechanism of the Global Fund. However, any system for deploying funds must be monitored and refined to ensure its effectiveness.

Another complication related to governments' capacity to handle new aid inflows, is the coordination of donors. New funders include bilateral donors and others such as the USA, the WHO 3 by 5 initiative, the Global Fund and the Clinton Foundation. All funders have their own priorities. Without coordination a proliferation of donors could take up valuable administrative capacity in recipient countries and lead to duplication and gaps in coverage. Donors must ensure that they coordinate their activities and allow recipient governments to set their own priorities. *The Three Ones* approach advocated by UNAIDS will be key to improving coordination. It suggests three guiding principles: the use of an agreed HIV/AIDS Action Framework to coordinate the work of all partners, one national AIDS authority with a broad-based multi-sectoral mandate and one agreed country-level monitoring and evaluation system. The Group commends the support given to *The Three Ones* approach by DFID; and notes the opportunity provided by the UK chairmanships of the G8 and EU in 2005 to bring other donors on board and to put the principles of *The Three Ones* into action.

Sources of new funds

The Group acknowledges the significant increases in HIV/AIDS spending in Africa but believes that a great deal more will be needed to avert the impacts predicted. A number of new funding sources can and should be used.

1. Increased Bilateral Assistance

As indicated bilateral assistance has already increased significantly over the last few years. The Group acknowledges that since 1997 UK ODA has almost doubled, and that spending on HIV/AIDS in developing countries as a whole has increased seven fold¹⁵² a considerable achievement for the Treasury and DFID.

Despite recent increases in HIV/AIDS funding, not least by the UK, yet more funds should be found by donors as they strive to reach the UN recommended ODA spending of 0.7% of GDP. In the UK 0.4% should be reached in 2005/6, an increase of over a third on 1997 levels. The Group commends the UK Government for setting a timetable for reaching 0.4% and calls for a further timetable for the UK to reach 0.7% within the next Parliament. However, by the time many countries reach 0.7%, the window of opportunity to avert catastrophe will have been missed forever. More immediate sources of funding are also needed.

2. International Finance Facility

An International Finance Facility (IFF) was proposed by HM Treasury and DFID in January 2003. The IFF could leverage an additional US\$50 billion a year for development assistance between now and 2015 from international capital markets by

issuing bonds, based on legally binding long term donor commitments. The proposal has the potential to double current ODA levels. Some of this money could be used to avert the worst impacts of the AIDS crisis in Africa and indeed elsewhere. The immediacy of the AIDS crisis demands an immediate and proportionate response; thus the IFF cannot be delayed any further. The Group calls on the UK Government to use its chairmanship of the G8 in 2005 to launch the IFF and ensure that it is functioning and disbursing funds by the end of that year and to ensure that funds are well directed for key priorities including the AIDS crisis.

3. European Development Fund

The Group believes that the European Development Fund can and should be used to provide urgent funding. An estimated €10 billion is unspent in the EDF. This money could be disbursed much faster and focussed on the HIV/AIDS crisis in Africa. The crisis is so urgent that further delay in the disbursement of this money would be a failure to fulfil our moral responsibility. The Group calls on the UK Government to use its position within the European Union, especially its presidency of the EU in 2005, to push for these funds to be dispersed rapidly. If the EU's development institutions do not have the capacity to ensure that this money is spent effectively, the Group recommends that the money be channelled through another organisation such as the Global Fund to fight AIDS, TB and Malaria.

The role of the private sector

The Group notes that the private sector collectively commands far greater funds than governments. The Group also notes the excellent progress being made by some companies operating in Africa in addressing HIV/AIDS amongst their workforces and the establishment of the Global Business Coalition on HIV/AIDS. The Group calls on the UK Government to establish a unit within the DTI in partnership with experienced companies to advise other companies with operations in Africa on implementing fully comprehensive HIV/AIDS programmes for their workers, their families, the communities in which they work and, where migrant labour is used, in the communities from which their workers are recruited and later return to. Where possible private sector initiatives should link with and therefore support state structures rather than duplicate them.

Companies who want to do more as part of the wider fight against AIDS can work with governments to set up nationwide programmes, as has occurred in Botswana. They can also contribute funds to other organisations such as the Global Fund to fight AIDS TB and Malaria.

Priorities for Intervention

Evidence received by the Group has highlighted the importance of the following issues.

The AIDS epidemic is at different stages of intensity in different regions of sub-Saharan Africa. In east and southern Africa the epidemic is already generalized, in countries like Nigeria and Ethiopia prevalence rates are rapidly escalating. All affected countries must develop a comprehensive national HIV/AIDS containment and management strategy which balances prevention, care and support, treatment and impact mitigation. These responses should be seen as a continuum.

Prevention is the first line of defence and also the most cost effective. Even in countries where prevalence rates are already high, prevention efforts must still remain a priority and should be scaled up and more effectively targeted among high risk groups such as sex workers, women and young people. During 2002 there were three million new infections in Sub-Saharan Africa. Continuation of that level of new infections would be disastrous.

Education is central to prevention and successful prevention programmes will be key to endeavours to achieve primary education for all.

Good nutrition is vital to retaining health while living with HIV and the Group calls on the UK Government to ensure that national nutrition and food security are considered part of an effective HIV/AIDS strategy. Early treatment of secondary and opportunistic infections resulting from HIV is a cost effective means of maximising the healthy life span of HIV positive patients. Treatment of opportunistic infections is possible using easy to prescribe and relatively cheap antibiotics. Very many African health services however have not been able to provide even these basic services.

Anti-retroviral therapy (ART) will also be a fundamental part of impact mitigation by extending healthy and productive lives. The Group believes that ART should be rolled out at a much faster pace in Africa; but should not be allowed to divert resources from other important and cost effective interventions such as prevention and treatment of opportunistic infections. ART is nevertheless the most effective way of extending healthy life span in the later stages of the virus. Despite the relatively high cost of ART and the costs involved in ensuring appropriate management systems and monitoring procedures, the Group believes that ART has a key role to play in averting massive human resource depletion and protecting the social fabric in the worst affected countries. Donors and policy makers need to work on this longer time horizon when they consider the feasibility of scaling up ART. It also builds hope amongst HIV positive people and encourages people to get tested.

All of these health interventions depend on the public health infrastructure and human and other resources to deliver them. In many African countries this is simply lacking. Investment in strengthening the overburdened public health systems capacity in the worst affected countries must be a top priority of a comprehensive donor response to the epidemic. The Group wishes to highlight the potential to use HIV/AIDS treatments, including ART, to build capacity in the state health sector. However, we also acknowledge the urgency of the situation and the need to be pragmatic about speeding up roll out by using what capacity is available to ensure maximum coverage and to avoid duplication. In particular the Group has noted the importance of state leadership and coordination but the potential partnership with non-state actors to speed up delivery.

Poor take up of treatment has been highlighted as a particular and complex problem. It is frequently related to the stigma surrounding HIV/AIDS. Removing the stigma attached the AIDS victims through education and other interventions, is central to both effective prevention and to the take up of AIDS treatment.

The Group's investigation has also highlighted the importance of addressing the issue of equity and of ensuring that key groups have treatment where treatment resources are limited. While aiming to bring treatment up to full coverage, the Group acknowledges this

will not be possible in many countries in the short or even medium term. Limited resources will need to be directed to where they will have the most impact. Thus the Group identifies three principles on which policies on access to health services should be based:

1. Equity
2. Cost Effectiveness
3. Transparency

The Group has highlighted the threat to the social fabric and to social reproduction in areas with high death tolls and suggests that averting such a crisis should be the first priority. Women and young mothers in particular can be identified as central to this and the Group therefore suggests that if treatment has to be prioritised, young mothers should be at the top of the list.

DFID advocates that 50% of ART recipients should be women. However, since more than half of those infected are women, particularly young women, and because women are pivotal to averting collapse of the social fabric, the Group believes that 50% may not in fact be an equitable or ideal figure, but an absolute minimum. The Group believes that, because of their centrality to the maintenance of the social fabric, positive discrimination in favour of women, not just equity of access, will be crucial, if controversial. It is up to governments in affected countries to make these difficult decisions and they must do so through public and transparent discussion.

The prevention of mother to child transmission must also be a priority and is already being effectively used as a starting point for ARV roll out among young mothers. This is an intervention area that could be quickly scaled up to reach all HIV positive mothers.

Other groups may also be identified as key targets for health interventions, such as key workers like health professionals. Affected countries need to consider this issue and conduct open discussion to ensure that priorities are agreed transparently and within the context of the challenges and resources of that country. Parliamentarians can play a key role in bringing the voice of their constituents into this debate and ensure that the development and implementation of health policy in this area is both transparent and accountable.

The setting of explicit priorities for treatment, following public discussion, can occur only in Africa, in the countries affected by the HIV/AIDS epidemic, but few developing countries have experience of health priority setting and will need technical assistance to do this effectively. We recommend that DFID works with UNAIDS and the World Health Organisation to develop a 'toolkit' for health priority setting in AIDS affected countries in Africa and promotes its use by ministries of health in AIDS affected countries in Africa and by other agencies.

The Group believes that the window to avert total catastrophe has not yet closed. However it draws the grim conclusion that it is too late to avert serious impacts in some countries. Planning to withstand key impacts will be fundamental to an effective response. The impacts of AIDS on the health and education sectors, on Governance, security and the economy are examined in respective chapters.

Particular concerns relate to staff attrition in key institutions and in key public services like health, education and security. Staff attrition is both quantitative and qualitative as those lost are frequently the most experienced.

Also unavoidable and already at crisis levels in some countries is the increase in the number of orphans and other children made vulnerable by AIDS. The Group considers this problem to be the biggest single impact of the AIDS epidemic and one that could fundamentally undermine the basic processes of social reproduction on which societies and their economies rely. This issue is discussed in the *Orphans* chapter but also on the chapters on *Economies and Livelihoods* and *Security* as in both contexts massive growth in orphan populations constitutes a major threat.

The Group argues that a comprehensive social rescue package is needed to support orphans and vulnerable children, their carers and their communities. This will require not only more money but also a new understanding of what is needed to avert major economic and social collapse and widespread insecurity. As capacity to do this is scarce at government level in most countries, the communities themselves which may have the capacity but not the financial and logistical means, need to be directly supported. This issue is discussed in chapter two.

Summary

The Group concludes that the AIDS epidemic is an exceptional crisis and as such requires an exceptional response. All of these issues need to be addressed, from prevention through testing and treatment to impact mitigation if the worst impacts are to be averted. To do this more and better coordinated funding is needed and that funding needs to get to the front line as quickly as possible, before the last window of opportunity to avert catastrophe closes. If we miss this window AIDS will go down in history as the biggest humanitarian, economic and political crisis of the modern era.

Full list of Recommendations

Key Recommendations to the UK Government:

1. Plug the gap in funding needed to avert the worst predictions by:
 - (a) Setting a timetable for UK overseas development assistance to reach 0.7% of GNI within the next Parliament.
 - (b) Launching the International Finance Facility in 2005.
 - (c) Pushing for the urgent use of unspent funds within the European Development Fund.
 - (d) Increasing UK funding to the Global Fund to Fight AIDS, TB and Malaria to US\$ 216 million¹ for the 2005 funding rounds.
 - (e) Pushing for better coordination of existing and new funds.
 - (f) Working with partners including the Breton Woods institutions to ensure that HIV/AIDS funding is treated as exceptional investment and not delayed or reduced because of expenditure frameworks.
2. Make sure policy across all UK Government Departments on HIV/AIDS is coherent and joined up. Under the leadership of DFID, every UK government department should develop policies to support coordinated and intensified efforts to fight the global HIV/AIDS epidemic.
3. Support African governments, NGOs and community organisations to put together a full scale social rescue package. Such a package should be used to address the orphan crisis and the wider threat to the social fabric posed by the AIDS crisis.
4. Support African governments to provide integrated health interventions including prevention and nutrition programmes and basic treatments such as antibiotics for opportunistic infections and antiretroviral therapy (ART). To deliver these swiftly, governments will need to harness the capacity of business, NGOs and community organisations.
5. Support African governments and civil society in affected countries to develop policies and programs to ensure access to health interventions on the basis of equity, cost effectiveness and transparency, and in particular to ensure that women are prioritised.
6. Support African governments in affected countries to prepare for losses in capacity through capacity building programmes and massively scaled up staff training programmes particularly for key public sector workers such as teachers, health workers and public service managers.

¹ The figure of US\$216 million is based on a 6% share of the total US\$3.6 billion required by the Global Fund in 2005, on the basis that UK GDP is 6% of total GDP of donor (richest 37) countries.

7. Use the UK's 2005 chairmanship of the G8 and presidency of the EU to urge all major donors to increase coordinated spending on HIV/AIDS to meet existing commitments and to prioritise the issues highlighted above.

Further Recommendations to the UK Government:

8. Increase support for UNAIDS' *Three Ones* initiative to ensure that funding is more coordinated and therefore more effective.
9. Ensure that the initiatives that the UK Government has signed up to, such as the WHO 3 by 5, are met.
10. The exceptional scale of the AIDS crisis poses a challenge to existing development mechanisms, an exceptional response will be required. DFID's use of direct budget support needs to be fully reconciled with the high priority rightly given to averting the worst impacts of the AIDS epidemic while also facilitating pro-poor development.
11. Ensure that a balanced approach to the continuum of HIV/AIDS interventions from prevention through treatment and including impact mitigation is central to DFID's HIV/AIDS policy and also integrated into other DFID policies. A balanced comprehensive approach is needed in all affected countries not only those with the highest rates.
12. Recognise that preventing HIV infection among the largely young populations of most sub-Sahara African countries will reduce overall prevalence and that effective prevention efforts are the first line of defence against the epidemic.
13. Learn from the failure to stem infection in those countries which now have very high prevalence rates to ensure the window of opportunity is used to avoid such high rates in other regions.
14. Recognise that ART can extend life for HIV affected people considerably and is an essential part of an overall strategy to mitigate the impact of AIDS. Support roll out of treatments at scale, where possible with state leadership but utilising capacity in other sectors.
15. Ensure that national nutrition and food security are considered part of an effective HIV/AIDS strategy.
16. Work with UNAIDS and the World Health Organisation to develop a 'toolkit' for health priority setting in AIDS affected countries in Africa and promotes its use by ministries of health in AIDS affected countries in Africa and by other agencies.
17. Encourage governments of AIDS affected countries to meet their commitments to increased health spending quickly.

- 18. Recognise that affected countries will also need to prepare for impacts on a larger scale and prioritise this within UK policy.**
- 19. Support education programmes to raise awareness and tackle stigma to ensure take up of available prevention, testing and treatment services is not hindered by stigma.**
- 20. Support African governments and organisations such as the World Health Organisation to calculate possible staff attrition in key sectors such as health, education and security, and in key roles within these sectors, in order to help governments plan for increased recruitment and training needs.**
- 21. Scale up government capacity building programmes and tailor them to build capacity in both in those areas identified as under most threat from AIDS and where capacity is needed in order to coordinate the battle against the epidemic.**
- 22. Support African governments to mitigate the impact of losses in human capacity through massively scaled up staff training programmes particularly for teaching and medical staff but also for key public service managers. The Department for Education and Skills should work with DFID to also fund distance learning courses for key professionals such as teachers and nurses.**
- 23. Reduce UK use of health professionals trained in AIDS affected countries by reducing incentives to come time allowed to remain and by compensating Ministries of Health who paid for those professionals' training.**
- 24. Establish a unit within the DTI in partnership with experienced companies (and coalitions of companies) to advise other companies with operations in Africa on developing fully comprehensive HIV/AIDS programmes for both their workers, their families and the communities in which they work and where migrant labour is used also in the communities from which there workers come and return to.**
- 25. Continue to support programmes that empower women and support local and national initiatives to look at gender relations.**
- 26. Support interventions to mitigate the impacts of AIDS on women, in particular to financially and otherwise support care of the sick and of orphans and vulnerable children, in their communities.**
- 27. Support African governments to ensure policy coherence on HIV/AIDS including on orphans and vulnerable children, across ministries, with leadership at the highest level and direct responsibility for the welfare of children at senior rather than junior ministerial level.**

- 28. Take on a role of leadership and coordination in helping countries and other stakeholders to best address the needs of orphans and vulnerable children.**
- 29. Support research and interventions that address the links between HIV/AIDS and food insecurity at the household level.**
- 30. Scale up government capacity building programmes and tailor them to build capacity in both in those areas identified as under most threat from AIDS and in those areas where capacity is needed in order to coordinate the battle against the epidemic.**
- 31. Encourage non-state actors with valued capacity skills and resources to take part in national programmes, led by national governments, as well as those for their own workers and their communities.**
- 32. Support African governments to address HIV/AIDS amongst their security services.**
- 33. Support programmes to address HIV/AIDS in Multilateral and British forces operating in AIDS affected countries.**
- 34. Support research to identify key impact areas within the security services to help governments plan for and mitigate these impacts, for example through support to the UNAIDS office on AIDS Security and Humanitarian Response.**
- 35. Support further research into the impacts of AIDS on security, in particular the potential impact of large numbers of AIDS orphans.**

Annex 1

The Africa All Party Parliamentary Group

The Africa APPG was established in January 2003.

The current officers of the All Party Group are as follows:

President: Lord Hughes of Woodside

Vice-Presidents: Lord Avebury and Baroness Chalker

Chair: Hugh Bayley MP.

Vice-Chairs: Lord Lea, David Chidgey MP & Laurence Robertson MP.

Secretary: Oona King MP.

Treasurer: Lord Freeman

The Africa APPG also has an Executive Committee of a further 13 members. In total the Group has over 170 Members.

The administration costs for the Africa APPG are covered by the Royal African Society and a number of donations as detailed on the Register of All Party Groups.

Annex 2

The Inquiry into the Impact of AIDS on Sub-Saharan Africa

The Africa APPG decided to embark on this inquiry following a presentation made by Professor Alan Whiteside and Dr Alex de Waal to the Africa APPG and the AIDS APPG in May 2003.

The Following Members took part in this inquiry:

Hugh Bayley (Chairman)	Lord Holme of Cheltenham
Mr David Chidgey	Helen Jackson
Mr Tony Colman	Lord Lea of Crondall
Mr Ian Davidson	Ms Ann McKechin
Mr Nigel Evans	Baroness Northover
Lord Freeman	Earl of Sandwich
Mr Neil Gerrard	Baroness Warwick
Baroness Greengross	Baroness Whitaker
Ms Sally Keeble	

A **Steering Committee** was established to help guide the Africa APPG throughout the process. The Group is grateful to the external members of the Steering Committee:

Richard Dowden (Director of the Royal Africa Society), Alex De Waal (Director of Justice Africa), Edwige Fortier (Co-ordinator of the HIV/AIDS APPG), Professor Tony Barnett (LSE)

Written evidence was requested on the 1st of December 2003 with a deadline of the 9th of February 2004. Over 50 written evidence submissions were received. A full list of written evidence submissions is available on request.

Four Oral evidence sessions took place in Spring 2004:

Session : 1	Thursday 26 th February 2004	Witnesses: Dr Peter Piot, Director of UNAIDS Dr David Harrison, Chief Executive Officer of loveLife Dr Alex de Waal, Director of Justice Africa
Session 2:	Tuesday 2 nd March 2004	Witnesses: Rt Hon Hilary Benn MP, Secretary of State for International Development Wanjiku Kamau, Stop AIDS Alliance
Session 3:	Thursday 4 th March 2004	Witnesses: Professor Alan Whiteside, Director of the Health Economics research Division, the University of Natal Professor Richard Feachem, Director of the Global Fund to fight AIDS TB and Malaria Asunta Wagura, Director of the Kenya Network of Women with AIDS
Session 4:	Thursday 11 th March 2004	Witnesses: Dr Sunanda Ray, former Director of the Southern Africa HIV/AIDS Information Service Hon Daniel Khamasi MP (Kenya) Hon Mxolisi A Dukwana MPL (South Africa) Hon Bernard Mulengani MP (Uganda)

Endnotes

- ¹ The figure of US\$216 million is based on a 6% share of the total US\$3.6 billion required by the Global Fund in 2005, on the basis that UK GDP is 6% of total GDP of donor (richest 37) countries.
- ² Richard Feachem in oral evidence to the AAPPG 04.03.04
- ³ UNAIDS *Epidemic Update*, December 2003
- ⁴ www.unaids.org/EN/resources/epidemiology/EPI_search.asp
- ⁵ US National Intelligence Council 2002
- ⁶ *Africa's Orphaned Generations*, November 2003, UNICEF
- ⁷ *Children on the Brink*. 2002, USAID
- ⁸ Answer to written parliamentary question, Gareth Thomas 03.03.04.
- ⁹ *HIV and AIDS Young People: Hope for Tomorrow*, pp16, August 2003, UNAIDS
- ¹⁰ www.unaids.org/EN/resources/epidemiology/EPI_search.asp
- ¹¹ Quoted in *Dying to Learn: Young people HIV and the Churches*, Christian Aid/Stop AIDS Campaign 2003
- ¹² Quoted in *The Tip of the Iceberg: the Global Impact of HIV AND AIDS on Youth*, July 2002, The Henry J Kaiser Family Foundation
- ¹³ *ibid*
- ¹⁴ www.unaids.org/EN/resources/epidemiology/EPI_search.asp
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- ¹⁶ *The Tip of the Iceberg: the Global Impact of HIV AND AIDS on Youth*, July 2002, The Henry J Kaiser Family Foundation pp4
- ¹⁷ *Gendering AIDS: Women, men, empowerment and mobilisation*, 2003, VSO
- ¹⁸ *quoted in Gendering AIDS: Women, men, empowerment and mobilisation*, 2003, VSO pp20
- ¹⁹ *ibid*
- ²⁰ *ibid* pp 21
- ²¹ *ibid*
- ²² KENWA written evidence to the AAPPG
- ²³ Wanjiku Kamau in oral evidence to the AAPPG 02.03.04 pp22
- ²⁴ DFID written evidence to the AAPPG
- ²⁵ Sunanda Ray in oral evidence to the AAPPG 11.03.04
- ²⁶ Alan Whiteside in oral Evidence to the AAPPG 04.03.04
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- ²⁸ *ibid*
- ²⁹ *Children on the Brink: A Joint Report on Orphan estimates and Program Strategies*, 2002, UNICEF/UNAIDS
- ³⁰ Asunta Wagura in oral evidence to AAPPG 04.03.04
- ³¹ UNICEF written evidence to AAPPG pp5
- ³² World Vision written evidence to AAPPG pp5
- ³³ UNICEF written evidence to AAPPG
- ³⁴ *ibid*
- ³⁵ *Social protection of Africa's orphans and other vulnerable children: Issues and Good Practice Program Options*, Subbarao et al, 2001, World Bank.
- ³⁶ *AIDS in the Twenty-First Century: Disease and Globalisation*, Barnett and Whiteside, 2002, Palgrave Macmillan
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- ³⁸ Quoted in *Education and HIV/AIDS: Ensuring education access for Orphans and Vulnerable children*, pp22, World Bank & UNICEF, 2002
- ³⁹ *ibid*
- ⁴⁰ *ibid*
- ⁴¹ *Contrasting Primary School Outcomes of Paternal and Maternal Orphans in Manicaland, Zimbabwe: HIV/AIDS and Weaknesses in the Extended Family System*, Nyamukapa and Gregson 2003
- ⁴² *Education and HIV/AIDS: Ensuring Education Access for Orphans and Vulnerable Children*
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- ⁴⁴ Quoted in *Contrasting Primary School Outcomes of Paternal and Maternal Orphans in Manicaland, Zimbabwe: HIV/AIDS and Weaknesses in the Extended Family System*, Nyamukapa and Gregson 2003
- ⁴⁵ Wanjiku Kamau, in oral evidence to AAPPG 02.03.04 pp23
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- ⁴⁷ Help Age International Submission

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- ⁵⁵ World Vision written evidence to AAPPG pp5
- ⁵⁶ Alan Whiteside in oral evidence to the AAPPG 04.03.04 pp17
- ⁵⁷ *Rhetoric to action - HIV/AIDS in South Africa: A guide for donors and grant-makers*, 2003, New Philanthropy Capital, pp11
- ⁵⁸ Asunta Wagura in oral evidence to the AAPPG 04.03.04
- ⁵⁹ World Vision UK written evidence to AAPPG pp9
- ⁶⁰ *ibid* pp2
- ⁶¹ Christian Aid written evidence to AAPPG pp2
- ⁶² *How will HIV/AIDS transform governance?* de Waal, Africa Affairs: Vol 102, Number 406, January 2003
- ⁶³ Christian Aid written evidence to AAPPG pp2
- ⁶⁴ *HIV/AIDS and Economic Growth: A Global Perspective*, Bonnel R., 2000. The South African Journal of Economics 68.5 820-55, cited in Christian Aid written submission pp2.
- ⁶⁵ Justice Africa second written submission pp2
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- ⁷⁵ FAO written evidence to AAPPG pp1
- ⁷⁶ *FAO written evidence to AAPPG pp2*
- ⁷⁷ Peter Piot in oral evidence to the AAPPG, 26.02.04
- ⁷⁸ Bell et Al, 2003, *The Long-Run Economic Costs of AIDS: Theory and Application to South Africa*, http://www1.worldbank.org/hiv_aids/docs/BeDeGe_BP_total2.pdf pp2
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- ¹⁰¹ *ibid* pp12
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- ¹⁰³ Daniel Khamasi in oral evidence to the AAPPG, 11.03.04, pp5
- ¹⁰⁴ Zambia HC written evidence to the AAPPG pp 4
- ¹⁰⁵ The Superintendent of Lilongwe General Hospital told the International Development Select Committee delegation who visited the hospital in 2002
- ¹⁰⁶ Avert written evidence to AAPPG, pp2
- ¹⁰⁷ Dr Sunanda Ray 11th March pp3
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- ¹¹⁷ Peter Piot in oral evidence to the AAPPG 26.02.04, pp11
- ¹¹⁸ Mxolisi A Dukwana MPL, Provincial Legislature, South Africa, *in oral evidence to the AAPPG, 11.03.04, pp12*
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- ¹²³ Dr. Sunanda Ray in oral evidence to AAPPG, Pp20
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- ¹²⁸ Richard Feachem in oral evidence to AAPPG, 04.03.04, pp27
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¹⁴⁵ *ibid* pp 5

¹⁴⁶ *Report of high level meeting on education and HIV/AIDS* in East Africa 29th September 2003 pp3

¹⁴⁷ *ibid*

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¹⁴⁹ Some estimates suggest a further US\$6 billion will be required.

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