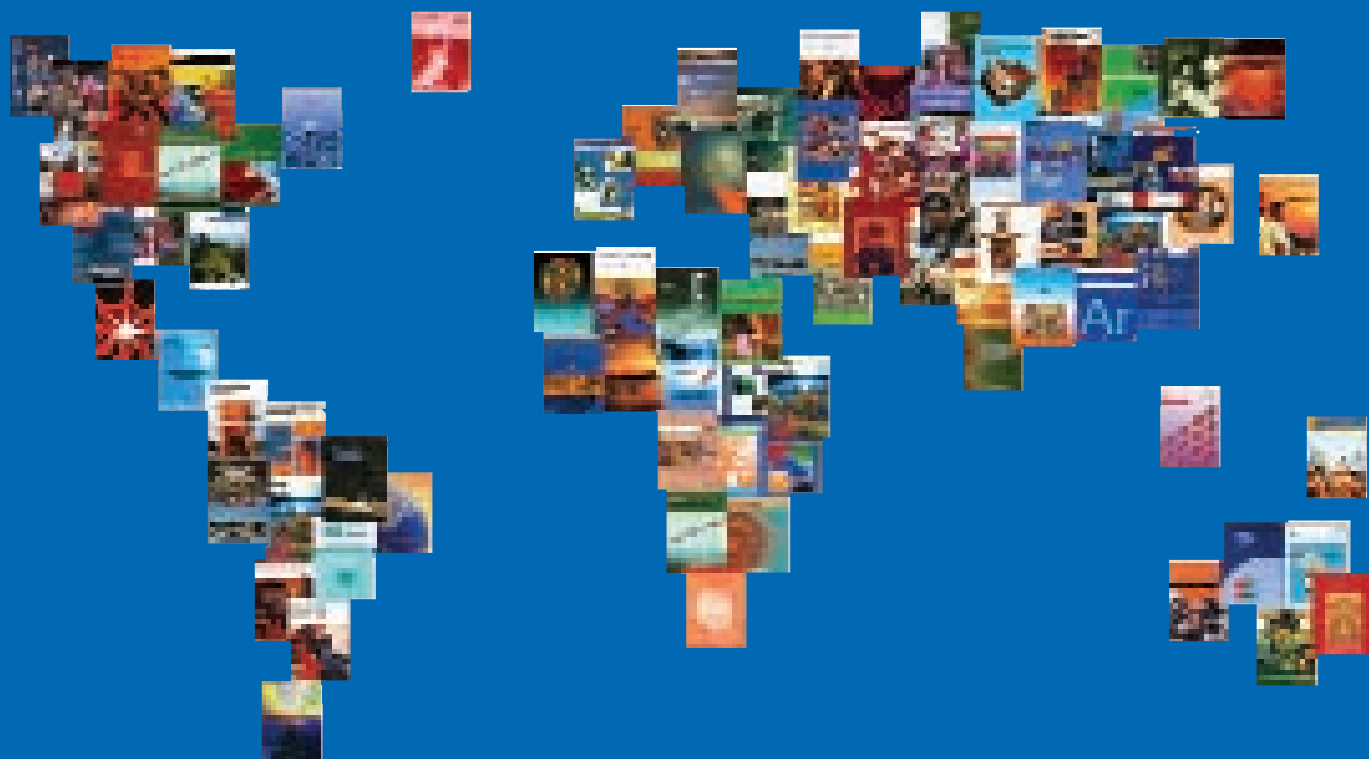


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NHDR Occasional Paper 4

HIV/AIDS and Human Development Thematic Guidance Note



4

By Dace Dzenovska, Nadia Rasheed
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Foreword

It is with great pleasure that the HIV/AIDS Group in the Bureau for Development Policy (BDP) and the National Human Development Report (NHDR) Unit of the Human Development Report Office present the NHDR Thematic Guidance Note on HIV/AIDS and Human Development.

This guidance note is part of a series that came about in response to the suggestion of national human development report teams from around the world who were seeking to apply a human development vision to policy making in various sectors or themes, but found a paucity of concrete written guidance to support them in this task.

Each of these guidance notes has been jointly commissioned by the NHDR Unit and the relevant policy bureau of the United Nations Development Programme (UNDP). The purpose of the series is to provide theoretical background and practical support for development practitioners to address certain themes within a human development conceptual framework. The note does not offer a 'blueprint' or prescriptive recipe, as the work of making the human development approach operational in a local context must be rooted in the development challenges faced there. The papers draw upon a thorough review of a number of NHDRs addressing the theme in question as well as cutting-edge literature in the field. They also include analysis from global Human Development Reports and other relevant international agreements and materials.

Producing these papers has presented a rare opportunity to discuss these themes and their links to human development, and to exchange experiences and good practices in producing NHDRs. Along the way, a draft version of each publication was shared online with the Human Development Report Network and the relevant UNDP Practice Network, and through discussions held at UNDP headquarters. Comments and suggestions emanating from this process have been incorporated into the final version, with the aim of building upon all available research and experience.

It is our hope that this guidance note will support the development of NHDRs that advocate for immediate action to challenge HIV/AIDS and advance effective strategies to halt the spread of the epidemic.



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Introduction

“The global HIV/AIDS epidemic, through its devastating scale and impact, constitutes a global emergency and one of the most formidable challenges to human life and dignity, as well as to the effective enjoyment of human rights, which undermines social and economic development throughout the world and affects all levels of society—national, community, family and individual.”

—UNGASS Declaration of Commitment

The purpose of this document is to provide guidance for the preparation of NHDRs focusing on HIV/AIDS. NHDRs are an effective tool for providing concrete and actionable policy messages and recommendations aimed at government decision-makers, civil society leaders, the private sector, the media, donors, international organizations and the general public.

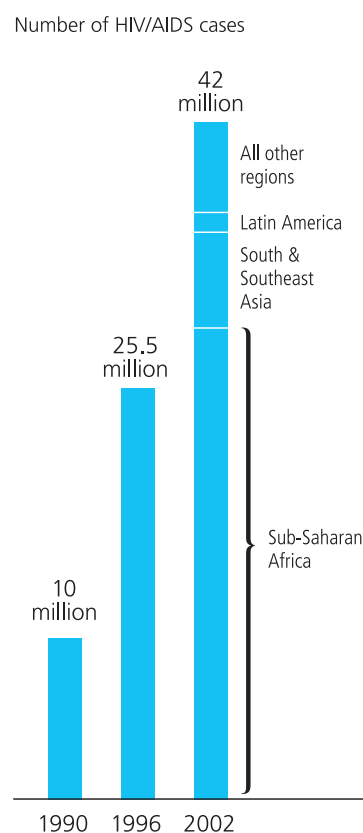
These guidelines are intended to help in preparing NHDRs that promote a better understanding of the social and economic factors fuelling the spread of HIV/AIDS, as well as its devastating impact on human development. In addition, the guidelines are intended to assist in the integration of HIV/AIDS in NHDRs focusing on a wide range of development concerns. Most importantly, the aim of the guidelines is to support preparation of NHDRs that promote implementation of effective strategies to reverse the spread of the epidemic—strategies that address individual, societal and institutional factors that impact the growth of HIV/AIDS.

The guidelines build on the concepts and principles of human development outlined in the global Human Development Reports, as well as the UNDP Corporate Strategy on HIV/AIDS and the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) Declaration of Commitment. The guidelines also draw on reviews of existing national and regional human development reports that focus on HIV/AIDS, including Botswana (2000), Burkina Faso (2001), Cambodia (2001), Namibia (1998), South Africa (1998), Uganda (2002), Zimbabwe (2003), Eastern Europe and the CIS (2004), and South Asia (2003).

NHDRs will be prepared for countries with very different HIV/AIDS epidemics. The following overarching guidelines are aimed at reports that either primarily or partially focus on HIV/AIDS, and should be adapted to individual settings. Integrating HIV/AIDS into a human develop-

ment framework is just as important in high-prevalence as in low-prevalence contexts. In high-prevalence countries or settings, this integrated framework can support work to mitigate the impact of the epidemic, as well as prevent its further spread. In many presently low-prevalence countries, the potential for the epidemic to expand is a very real threat. It is therefore important that NHDRs focusing on other themes take account of HIV/AIDS. Acting early may prevent the devastating impact witnessed in high-prevalence countries. In any setting, HIV/AIDS hinders human development, and the dynamics of the epidemic need to be explored in terms of human development, regardless of the present magnitude of the epidemic.

Figure 1: HIV/AIDS cases have skyrocketed



Source: Human Development Report 2003

SECTION 1

HUMAN DEVELOPMENT AND HIV/AIDS

“The objective of development is to create an enabling environment for people to enjoy long, healthy and creative lives.”

*—Mahbub ul Haq, architect of
the Human Development Report*

The process of coming to terms with the concept that people’s welfare is an end in itself—rather than an input for economic growth and productivity—has been lengthy and thought provoking. Global, regional and national human development reports have contributed to the recognition that human development differs from previous approaches to development because it places people at the centre of the development process. Human development is about expanding choices and opportunities to lead a long, healthy and knowledgeable life. It is about choices and opportunities to participate in social, cultural, political and economic processes taking place in society, and to lead a life of dignity, respect and well-being.

THE HIV/AIDS EPIDEMIC

“The impact of HIV/AIDS is unique because it kills adults in the most productive period of their lives, depriving families, communities, and nations of their most productive people. Adding to an already heavy disease burden in poor countries, the HIV/AIDS epidemic is deepening poverty, reversing human development, worsening gender inequalities, eroding the capacity of governments to provide essential services, reducing labour productivity, and hampering pro-poor growth.”¹

Since the diagnosis of the first HIV/AIDS cases in the early 1980s, understanding of the epidemic has passed through several stages. While at the outset HIV/AIDS was mainly considered a public health issue, it is now seen as a development concern of the highest priority, requiring a multisectoral approach and response that focus not only on how the virus is transmitted, but also on the factors that render people and communities vulnerable.

HIV transmission is often associated with stigmatized aspects of human behaviour, such as sexual activity, drug use and commercial sex. At the start of the epidemic, and still in some contexts, these associations have obscured

understanding of the mechanisms rendering people and communities vulnerable. The UNGASS Declaration of Commitment recognizes factors that place individuals at risk of HIV infection, including underdevelopment, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information, and sexual exploitation of women, girls and boys. The Declaration calls for strong leadership at all levels of society, based on personal commitment and concrete actions, for an effective response to the epidemic.

HIV/AIDS strikes at the heart of development. The epidemic is a reflection of societal dysfunctions at the levels of the individual, families, communities, systems and structures. In order to effectively address the epidemic, it is necessary to understand all these dynamics and to work to address individual attitudes and behaviours that fuel its spread; societal values, norms and cultural patterns that result in denial and discrimination; and systems and structures that organize society in ways that result in inade-

BOX 1: A definition of human development

“Human development is about much more than the rise or fall of national incomes. It is about creating an environment in which people can develop their full potential and lead productive, creative lives in accord with their needs and interests. People are the real wealth of nations. Development is thus about expanding the choices people have to lead lives that they value. And it is thus about much more than economic growth, which is only a means—if a very important one—of enlarging people’s choices.

“Fundamental to enlarging these choices is building human capabilities—the range of things that people can do or be in life. The most basic capabilities for human development are to lead long and healthy lives, to be knowledgeable, to have access to the resources needed for a decent standard of living and to be able to participate in the life of the community. Without these, many choices are simply not available, and many opportunities in life remain inaccessible.”

—Human Development Report 2001

quate policy, legislative or resource environments for an effective response.

IMPACT ON HUMAN DEVELOPMENT

HIV/AIDS reverses gains in building basic human capabilities, and denies people opportunities for living long, healthy, creative and productive lives. The epidemic impoverishes families, places burdens on families and communities to care for the sick and dying, results in social exclusion and affects people's psychological well-being. Women and girls are particularly vulnerable to the epidemic and its impacts, and bear the burden of caring for families affected by HIV/AIDS.

The long-term human development impact is felt in all sectors of public and private life. The epidemic strains national and local budgets, deprives sectors such as education and health of skilled workers as a result of illness and death, and inhibits the capacity of various sectors to sustain previous levels of productivity and services. While the long-term consequences may not yet be visible in some countries, the dynamics of the spread of the epidemic can be indicative of the potential magnitude of its impact.

Applying the human development approach to HIV/AIDS helps to focus the analysis and policy recommendations on people rather than on the virus—a prerequisite for mobilizing effective action to reverse the epidemic. The value added of analysing HIV/AIDS through a human development lens is that it lends itself to a more inclusive and people-centred approach to addressing the impact of the epidemic and promoting effective action. For this reason, NHDRs can provide:

BOX 2: Fallout in Botswana

"HIV and AIDS strikes at the very core of human development. It shortens human life, erodes people's sense of dignity and self-esteem, causes social exclusion, and traumatizes and impoverishes individuals, families and whole communities. More of the national resources will have to be committed to the health sector at the cost of investment in human development. Productivity and economic activity decline with the spread of the epidemic. Overcoming human poverty has become a bigger challenge than it could ever have been without HIV and AIDS."

—Botswana NHDR 2000

- ▼ A more comprehensive analysis of the far-reaching socio-economic impacts of HIV/AIDS at individual, household, community, sectoral and national levels;
- ▼ A policy-relevant analysis of the deeper social, cultural, economic and political factors that are driving the spread of the epidemic, looking beyond the primary causes of infection;
- ▼ A useful vehicle for assessing a country's response to HIV/AIDS thus far, looking squarely at achievements, constraints and levels of political commitment;
- ▼ An analytical framework placing individual behaviour in a structural context, addressing the linkages between individual attitudes and behaviours, social values and norms, and societal systems and structures;

BOX 3: Addressing the relationship between human development and HIV/AIDS

The reports reviewed for these guidelines thoroughly explain the concept of human development, trace its history and monitor its achievements. The approach differs slightly from report to report. While the **Botswana**, **Burkina Faso** and **Namibia** NHDRs include brief yet informative sections on the global concept of human development in the main text, the **Cambodia**, **South Africa** and **Zimbabwe** reports apply human development to its specific context from the very beginning. The **Eastern Europe and CIS** and **South Asia** regional reports also consistently implement a human development approach throughout the reports.

At the conceptual level, all HIV/AIDS-specific

reports recognize HIV/AIDS as a development challenge rather than merely a public health concern. Overall, the reports are successful in exploring the relationship between human development and HIV/AIDS in terms of the current and potential impact on different dimensions of human development, such as longevity, knowledge and living standards. The **Uganda** NHDR identifies HIV/AIDS as a serious threat to health, security and development, and as a serious challenge to leadership at all levels. The **Zimbabwe** report links poverty, gender inequality and vulnerability to the epidemic. Many reports identify HIV/AIDS as the single most devastating factor undermining human development.

▼ A deeper analysis of what needs to be done to reverse the epidemic, offering concrete policy recommendations that promote a comprehensive approach and generate multisectoral action, through full mobilization of actors and institutions well beyond the health sector.

IMPACT ON HUMAN DEVELOPMENT INDICATORS

The global Human Development Reports have developed a number of composite indices to measure progress in human development. The five main composite indices are the human development index (HDI), the gender-related development index (GDI), the gender empowerment measure (GEM) and the human poverty indices (HPI-1 and HPI-2). (See Table 1.)

Since 1990, the HDI has measured average achievements in basic human development. The GDI and GEM were introduced in 1995 to measure gender dimensions of human development and inequalities. The HPI has been used as a measure of human poverty, or deprivations in human development, since 1997. The HDI, GDI and HPI are composed of indicators measuring longevity, knowledge and standard of living, as shown below. GEM measures gender inequality on the basis of economic and political opportunities.

The impact of HIV/AIDS on human development

indices is felt most directly through longevity indicators such as life expectancy at birth (HDI and GDI), and the percentage of population not expected to survive beyond the age of 40 (HPI-1). The impact of the epidemic could also be felt in indicators of educational attainment such as female school enrolment ratios.

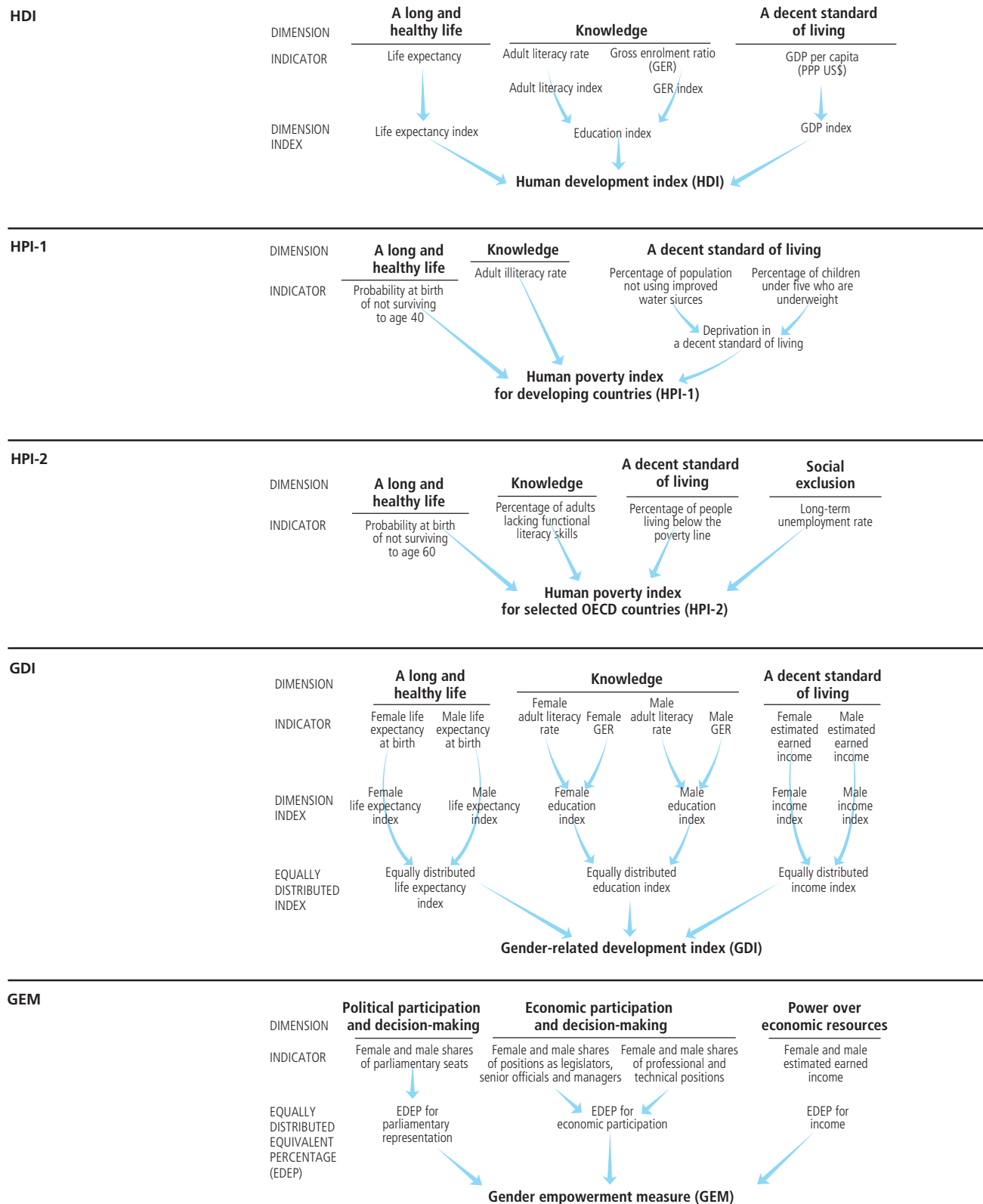
Although the human development indices are useful measures for comparing progress between countries and provide comparisons for different groups or regions within countries, they cannot sufficiently reflect the impact of HIV/AIDS on individuals, families, communities and nations, or capture all dimensions of human development. NHDRs should therefore use a range of indicators, in addition to human development indices, to illustrate the impact of the epidemic, and to measure and evaluate progress in the response. Internationally agreed development goals, which are discussed later in this guidance note, also provide a number of useful guides and measures. In addition, it is helpful to employ qualitative information to reflect many of the aspects of the epidemic (such as stigma and discrimination) that are not readily measurable through quantitative approaches.

NOTES

¹ UNDP (2002a).

TABLE 1: Calculating the human development indices

The diagrams here offer a clear overview of how the five human development indices used in the Human Development Report are constructed, highlighting both their similarities and their differences.



Source: Human Development Report 2003

Guidance Note for NHDRs on HIV/AIDS

The HIV/AIDS epidemic is one of the greatest challenges facing developing countries. By the end of 2004, some 40 million people were living with the virus across the globe.¹ Despite two decades of efforts to curtail the spread of HIV/AIDS, the number of new infections continues to grow. While sub-Saharan Africa has been the region most impacted by the epidemic, HIV/AIDS continues to expand around the world, with an alarming escalation in Eastern Europe and Asia. The epidemic is increasingly affecting women, particularly young women, and nearly half of all people living with HIV/AIDS by the end of 2004 were women. Addressing the devastating impacts of the epidemic—including distressing loss of life, orphaning of children, illness, loss of productivity, and stigma and discrimination—is a development challenge of the utmost priority.

A successful response to the HIV/AIDS epidemic requires a multisectoral approach that involves a wide range of actors and sectors—including government, civil society, the private sector and communities—with the full participation of women and people living with HIV/AIDS. NHDRs focusing on HIV/AIDS should adopt a comprehensive multisectoral framework for analysis, addressing social and economic impacts. Reports should take account of, and recommend, strategies that tackle prevention, care and treatment, vulnerability reduction and mitigation of socio-economic impacts.

In countries that are presently considered to have a low HIV prevalence or others where it could be difficult to devote an entire NHDR to HIV/AIDS, it may nevertheless be possible to include a special section on HIV/AIDS (or to issue a special edition NHDR on HIV/AIDS) as a means of raising awareness, addressing the cost of inaction and encouraging national responses.² Moreover, HIV/AIDS should be integrated into NHDRs focusing on other themes to ensure that the critical nature of this challenge is not overlooked. In low prevalence settings where the socio-economic consequences of the epidemic are less visible, it is sometimes more difficult to convince policy makers of the threat that HIV/AIDS poses. Reports should therefore make a clear and convincing case for why early action is necessary, and argue that the HIV/AIDS epidemic must be tackled with urgency, advocating for an immediate and scaled-up response to limit future impacts on society and the economy.

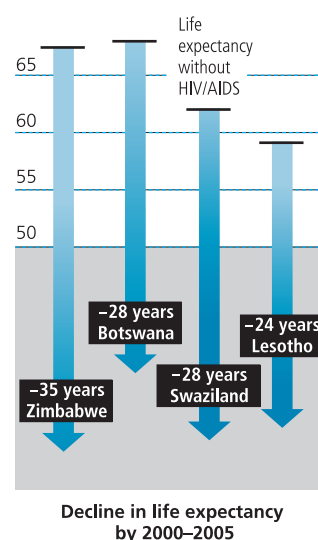
SOCIO-ECONOMIC IMPACT OF HIV/AIDS

The HIV/AIDS epidemic impacts human development in a number of ways, and through numerous mechanisms. HIV/AIDS affects multiple sectors and levels of government and civil society. Listed below are several examples of such mechanisms, with a short description of factors to investigate and focus on when exploring how HIV/AIDS impacts human development and vulnerability to the epidemic. The degree to which these mechanisms are relevant will vary depending on the context, country or region. For each NHDR, therefore, authors need to consider which of the following indicators are relevant, and explore additional factors and indicators.

Demographic impacts

In addition to prevalence rates, depending on the magnitude of the epidemic in a country, HIV/AIDS can make itself felt in demographic indicators such as life expectancy, mortality

Figure 2: Loss of life expectancy due to HIV/AIDS



Source: Human Development Report 2003

ty rates, and distribution of the population across age and gender groups. In severely affected countries, the projected population structure may be better described as a population chimney than the traditional population pyramid. For example, assuming that patterns of new infection do not change greatly, Botswana will in 20 years have more adults in their 60s and 70s than adults in their 40s and 50s. This situation would impact greatly on individual, family and community well-being, productivity and welfare. A description of demographic impact can therefore illustrate the devastating effects of the epidemic.

NHDR authors need to carefully evaluate which quantitative and/or demographic indicators would be most useful in describing the epidemic in the relevant context. NHDRs should examine prevalence rates and incidence of mortality disaggregated for age, gender and geography wherever possible, as well as incidence for vulnerable or marginalized populations such as commercial sex workers or intravenous drug users. While the impact of HIV/AIDS may not always be apparent in aggregate demographic trends, the epidemic still poses a severe human development challenge. Authors of each NHDR should therefore consider how information about demographic impact adds to the description and analysis of the epidemic in a particular context.

BOX 4: Population declines

In **Zimbabwe**, where one in four adults is estimated to be living with HIV/AIDS, the NHDR states that a 23 per cent reduction in population growth is projected for 1992–2010. The **Eastern Europe and CIS** report indicates that HIV/AIDS is accelerating Russia's 'natural' population decline.

Sectoral impacts

Depending on the magnitude of the epidemic in a country, sectors such as health, education and agriculture can be greatly impacted by HIV/AIDS. In countries with high prevalence rates, the economic impacts of the epidemic can be devastating across all sectors. HIV/AIDS kills off skilled workers and reduces productivity as a result of illness and death, as well as activities such as caring for those who are ill and attending funerals. The epidemic can severely impact development by lowering productivity across sectors and, as a consequence, economic growth. NHDRs should address the impact and potential effects of the epidemic on all relevant sectors of the economy, including the public and private sectors, and recommend strategies for effectively mainstreaming HIV/AIDS into sectoral plans and policies.

BOX 5: A multisectoral approach

The **Zimbabwe** NHDR emphasizes the importance of a multisectoral approach and analysis to enable a broad response. It includes the findings of a comprehensive survey of the impacts of the epidemic on a variety of sectors, including agriculture, the military, national security and business.

In addition to discussions on sectoral and household implications, the **Eastern Europe and CIS** report presents an example of analysis of the macroeconomic impact of HIV/AIDS on growth and development for one country in the region. The report also highlights that critical extractive industries, such as oil and gas, face the greatest risk as these sectors rely heavily on migrant labour.

THE EDUCATION SECTOR

HIV/AIDS has an enormous impact on the education sector. In highly affected areas, AIDS-related illnesses or deaths result in a shortage of teachers, negatively impacting the quality of education. HIV/AIDS challenges the education sector to respond with appropriate messages and programmes, to enable students and teachers to protect themselves and others from infection, and to combat stigma and discrimination against people living with or affected by HIV/AIDS. Too often, school girls face sexual violence and harassment by both teachers and male students, putting them at greater risk of HIV infection. In most countries it is young people and young women who are most vulnerable, including university students.

In households impacted by AIDS, loss of income or diversion of earnings towards health care can reduce resources for school fees and supplies—and children, par-

BOX 6: Fewer teachers

Zambia reports that AIDS now kills more teachers every year than there are new teachers graduating from the teacher training colleges. Every year, therefore, Zambia has progressively fewer and fewer teachers. This pattern can also be seen in other countries. When teachers are ill, the quality of teaching worsens, placing extra burdens on teachers who are healthy, and preparing the ground for burnout and even fewer available teachers.

BOX 7: Reports on education impacts

The **Botswana** NHDR includes an in-depth discussion on the education sector, and identifies ‘three windows of impact’—learning conditions, teaching and output. Impact on learning conditions includes decreased ability to perform as a result of: trauma resulting from illness of relatives and teachers, and death of guardians; students dying of AIDS; and children dropping out of school to take care of relatives or due to financial burdens placed on the family as a result of AIDS. Impact on teaching manifests through the loss of teachers to AIDS and poor quality of instruction due to poor health of teachers. Impact on output is defined as a continued possibility of infection while in school.

Zimbabwe notes that AIDS-related deaths among teachers rose by 40 per cent in 2000–2001, and that an increasing number of students, mostly girls, are dropping out in order to take care of the sick at home.

HIV/AIDS has had serious consequences on education in **Uganda**, as it has inflicted a heavy toll on students, parents and teachers, “thus affecting one of the great pillars of development.” While no sector-specific data exists in **South Africa**, the report estimates that a large proportion of learners are at risk. The report notes that primary school enrolment is already decreasing, which can only be partially explained by declining fertility rates. An increasing number of orphans may contribute to the financial pressure on the state for provisioning of school fees and supplies, and the report also recognizes the potential reduction in the number of teachers due to illness. The NHDR makes an excellent effort to outline potential devastating impacts, and urges comprehensive assessment and action. The **Namibia** report references anecdotal evidence of loss of human resources within the education system.

BOX 8: Reports on health impacts

The **South Africa** NHDR notes that the public health care system is experiencing increases in the demand for health care, public health expenditures, HIV/AIDS hospital admissions, related illnesses, and the spread of HIV/AIDS among health workers leading to staff shortages. The **Burkina Faso** report notes that the country’s health sector has been “overwhelmed” by the epidemic. Although the **Namibia** NHDR does not extensively consider the impact on the health sector, it notes the estimated direct medical costs in a table on financial implications. The report also mentions existence of anecdotal evidence on the loss of skilled workers, including health workers, but does not provide an in-depth analysis due to lack of concrete evidence. The **Zimbabwe** NHDR points out that despite the fact that the health sector coordinated the national response to HIV/AIDS, health workers are no less affected by HIV/AIDS than the general population.

The **Cambodia** report makes an interesting observation when finding, through qualitative data gathered for the report, that the HIV epidemic does not seem to affect the demand for health care services. The HIV

prevalence rate is estimated at three per cent, enough to expect the epidemic to be reflected in the demand for health care. The authors of the report attribute this to very low consumption of health services in general. This is in turn a result of low expectations of the public health service due to the limited availability of health staff, the poor state of infrastructure (health care facilities are difficult to reach for sick people), and the low availability of medication and other help once the health facility is reached. The HIV epidemic appearing not to impact the health sector therefore does not imply that there is no need for services, rather that people in need do not turn to health services. This illustrates the need for knowledge of the dynamics behind the statistics in order to interpret data, as well as show how deep, structural changes in both the health care sector and people’s perception of this sector may be necessary in order to address the epidemic. The **South Asia** report addresses the health insurance sector, noting that there are few analyses of the effects on the private health insurance sector, mainly due to the exclusion of people living with HIV/AIDS from the pool of insurable individuals.

ticularly girls, may be pulled out of school. Loss of household income can also result in children having to spend their time earning money, rather than at school. This is particularly acute for orphans who are left to fend for themselves.

Illiteracy and lack of information increase vulnerability to HIV infection by hindering access to prevention messages and limiting knowledge of modes of transmission and prevention methods. Girls are particularly at risk of not being enrolled in school, or being withdrawn early in families affected by HIV/AIDS, exacerbating female vulnerability to the virus. The education sector may also be challenged to find innovative teaching methods to cope with the absence of teachers, develop life skills programmes and reach children not attending school.

THE HEALTH SECTOR

The HIV/AIDS epidemic can impact the health sector in several ways. Firstly, more patients need medical care, placing a larger demand on the health system, including for counselling and testing, treatment and care, prevention and care for sexually transmitted infections, and prevention of mother-to-child transmission. Secondly, by creating a need for expensive care and treatment, health care resources could be diverted from other parts of often already under-financed systems.

HIV/AIDS also affects health workers, creating shortages of staff and resulting in staff burnout, and thereby reducing the capacity of the health sector to handle the epidemic or forcing the sector to spend more on training new health workers. In addition, health care providers are often called on to support home-based care. Stigma and discrim-

BOX 9: Antiretroviral therapies

Antiretroviral (ARV) treatments that slow the onset of AIDS have been available since 1996. In 2000, the cost of ARVs was as high as US \$12,000 for one person per year, but generic competition and differential pricing by pharmaceutical companies have led to dramatically lower prices in developing countries, as low as US \$140 under a deal negotiated by the Clinton Foundation in 2003. Brazil, India and other countries with a generic drug industry have used provisions in patent regimes to produce affordable generic drugs, and countries that planned to set up facilities to produce drugs in 2004 and 2005 include Ethiopia, Kenya, Mozambique, Nigeria, South Africa, Tanzania, Uganda and Zambia. Several countries now offer universal or extensive coverage for ARVs, including Argentina, Barbados, Botswana, Brazil, Chile, Cuba, Mexico, Senegal, Thailand and Uruguay.³

Although the falling cost of AIDS drugs has made treatment far more affordable than in the past, it is still too expensive for the majority of people living with AIDS in developing countries. In July 2004, less than eight per cent of people in need of treatment received it. As progressively more countries are bound by the Trade Related Aspects of Intellectual Property agreement under the World Trade Organization, ensuring that trade agreements and patent laws do not undermine sustainable access to low-cost treatment (through generic production or parallel importing of cheaper drugs from

other countries) has become a priority. This will require an intensified response that develops national capacities for generating enabling public health and trade policies; incorporating best practice patent and compulsory licensing laws; and speeding access to technology transfers for production through South-South exchange.

Some experts have argued that providing ARVs to people in developing countries is a serious challenge as drugs require strict adherence that is difficult to maintain for people living in poverty, and since health care sectors may not have adequate capacity. However, studies conducted demonstrate that adherence in poor countries is no worse than in rich countries, and experience shows that if organized properly, drugs can be made available in most countries. In addition to ARVs, people living with HIV/AIDS need drugs to treat opportunistic infections that result from weakened immune systems. These drugs may be easier to administer, and also easier for health systems to procure if they are off patent.

Realizing the right to health requires facilitating access to medication. Drugs that prolong lives mean that families keep their breadwinners, children keep their parents, and communities keep their members. Drugs administered to HIV-positive pregnant women lower the risk of a baby becoming infected. NHDRs therefore need to investigate the opportunities for making drugs universally available.

ination in the health sector is a significant concern that can discourage individuals from seeking information, counselling and testing, and treatment. It is vital that health workers do not discriminate against people living with or affected by HIV/AIDS, and provide confidential and supportive environments that are conducive to openly and effectively challenging the epidemic.

NHDRs should address issues relating to the capacity and reach of the health sector, including concerns such as availability of trained health workers, hospital beds and medication. The health sector also plays an important role in tracking the reach of the epidemic and the number of people accessing treatment. However, HIV/AIDS should not be addressed simply as a health sector challenge—the impact on the health sector must be placed in a context of the impact on other sectors of the economy.

ARV treatments for HIV/AIDS are today far more affordable than in the past, and health care systems in developing countries are increasingly dispensing ARVs. Treatment provides the best opportunity for people living with HIV/AIDS to enjoy happier, healthier and more productive lives. Treatment therefore also presents the best opportunity for countries to mitigate the severe economic and social impacts of HIV/AIDS, including stemming the loss of capacity across sectors of the economy.

In July 2004, less than eight per cent of the six million people with HIV/AIDS who needed immediate treatment in developing countries were receiving it. The World Health Organization's three-by-five initiative, which aims to provide treatment to three million people living with AIDS in developing countries by the end of 2005, is a key campaign for increasing access to ARVs with targets for 50 developing countries. A number of donors, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, have played an important role in helping to finance treatment across the developing world.⁴

The UNGASS Declaration of Commitment urged countries to have a strategy for access to treatment and care in place for an effective response to the epidemic. NHDRs need to investigate opportunities for making drugs universally available in a particular country, and for administering these drugs. Issues that should be addressed include trade agreements, intellectual property rights dimensions, and sustainable access to low-cost treatment through generic production or parallel importing. In addition to procuring ARVs, challenges that remain in many countries include training sufficient numbers of health workers and health administrators for successful treatment delivery, availability of paediatric ARVs for children, and ensuring equitable access to treatment and care for women.

THE PUBLIC SECTOR

HIV/AIDS can hinder the functioning of government sectors and ministries, and affect the delivery of essential serv-

ices such as health care, education and justice. The epidemic can impede government activities due to loss of workers and skills, a reduction of public revenues, and the diversion of budgets towards coping with the impact. Consequently, survival of civil society institutions can be threatened, with a corresponding impact on governance. NHDRs also need to consider the capacity of public systems and structures to manage the impact of the epidemic, and to plan and implement effective responses. In addition, HIV/AIDS workplace programmes should be implemented for public sector employees.

THE PRIVATE SECTOR

HIV/AIDS impacts the private sector through loss of skilled personnel, and reduction of productivity when workers are living with HIV/AIDS or spending time on activities such as caring for the sick and attending funerals. The private sector may face increased expenses such as those for training new workers, covering health care costs, and implementing workplace prevention and treatment pro-

BOX 10: An economic toll

The **Botswana** NHDR, on the basis of a UNDP/government macroeconomic study, concludes that the GDP growth rate is expected to fall by 1.5 per cent by 2021, skilled labour shortages will worsen, the financial pressure on the private sector will increase due to personnel costs (training of new staff and benefits), government expenditure will rise and revenues shrink, and investor confidence will fall. The **Namibia** NHDR notes that economic implications will result for the same reasons HIV/AIDS causes demographic shifts—the high prevalence among the young, skilled and productive.

The **South Africa** NHDR concludes that impact is not visible as of yet, and even a questionnaire sent to a small sample of private companies indicated that HIV/AIDS was not on their agenda. The report proceeds to draw on experiences from other countries to outline potential threats and their magnitude. **Burkina Faso** considers economic growth targets in the country's Poverty Reduction Strategy Paper (PRSP), which estimates that the economic growth rate will fall by 0.8 per cent per year as a result of HIV/AIDS. The mechanisms that translate into loss of skilled labour are similar for the public sectors, as the South Africa and the Namibia reports demonstrate. The **Uganda** report notes that the high incidence of AIDS-related deaths has greatly reduced cultivated land, agricultural production and GDP growth.

grammes. NHDRs should not overlook the short- and long-term economic impacts of the epidemic, which in turn affect human development.

HIV/AIDS IN THE WORKPLACE

HIV/AIDS strikes hardest at the population of working age. In both the public and private sectors, it is important to address workplace impacts such as absenteeism, high turnover, reduced morale and loss of skills. Workplaces are central settings for reaching the most impacted population with prevention messages, and for addressing stigma, discrimination, care, support and treatment. Respecting the rights of workers is a fundamental part of the response to the epidemic, and prevention programmes and provision of treatment can offset much higher future costs due to illness or loss of skilled workers. The International Labour Organization's (ILO) Code of Practice on HIV/AIDS and the World of Work contains fundamental principles for developing workplace responses, including prevention of HIV/AIDS; management and mitigation of the impact of HIV/AIDS; care and support of workers infected and affected by HIV/AIDS; and elimination of stigma and discrimination on the basis of real or perceived HIV status.⁵ NHDRs should consider the workplace impacts of the epidemic, as well as the status of workplace activities to address it.

Poverty and inequality

The human development perspective on the HIV/AIDS epidemic helps to understand the social mechanisms that stimulate or curb it. Poverty and inequality are important facilitators of HIV infection, and an NHDR on HIV/AIDS needs to analyse how these mechanisms work in the context in question. Poverty and inequality can be linked to a range of factors—such as lack of access to information, marginalization, inequitable wealth distribution and lack of access to health care—that increase vulnerability to infection.

Gender inequality, or inequality in terms of income, resources and opportunities, all render individuals and communities vulnerable to infection through a number of mechanisms. Lack of access to information and health care can place individuals and households at a greater risk of becoming infected. HIV/AIDS also has a greater impact on poor households, which find it more difficult to cope with the additional burdens. Members of a poor household are more likely to drop out of school, and therefore have fewer opportunities to access information and protect themselves. They will have greater difficulty accessing health care services and receiving treatment. As income dwindles, nutrition worsens, and with malnutrition comes increased vulnerability to disease in general, as well as reduced ability to work or to participate in family and community life.

BOX 11: The costs of inequality

The **South Africa** NHDR identifies low social cohesion embedded in the apartheid legacy and high income inequality as the most prominent structural reasons for the spread of HIV/AIDS, which in turn give rise to labour migration, lack of access to health services, prevalence of illnesses, increase in commercial sex work and the practice of keeping lovers or 'urban wives'.

The **Botswana** NHDR makes similar conclusions, namely, poverty increases reliance on survival strategies such as migration for men, rendering both parties vulnerable to infection. Inequality, especially overlap of gender and income inequality, functions as a decisive co-factor.

In **Eastern Europe and the CIS**, poor women are more likely to become sex workers to sustain themselves or their families and due to the fact that poverty reduces the choices they have.

In **South Asia**, the rich enjoy access to better, private health services while the poor continue to be restricted to public hospitals. HIV/AIDS worsens this inequality and the poor remain unable to cover high health costs.

Mobility, migration and trafficking

Mobility and migration are key elements in the spread of the HIV/AIDS epidemic. They can be linked to a number of factors that increase vulnerability to HIV, including separation from regular partners, economic hardships and marginalization. The 1998 South Africa NHDR, for example, details how male work migration leads to separation of spouses for long periods of time. Migration often results in sexual networking patterns involving commercial sex, as well as relationships both in the home base and with new partners away from home. Work-related migration, a result of industrial and economic development patterns concentrating employment away from people's homes, paves the way for sexual behaviour that renders both those who migrate and their partners vulnerable to infection.

The trafficking of women, men and children for forced labour or sex work is a deeply distressing and far too common practice that increases vulnerability to HIV/AIDS. Women and girls in many regions of the world face exploitation and sexual violence as a result of trafficking. This issue has received particular attention in Eastern

Europe and Asia. UNDP's Regional HIV/AIDS and Development Programme for South and North East Asia has detailed the links between gender, HIV/AIDS and trafficking, arguing that "an integral connection is evident between HIV/AIDS, gender and trafficking through the nexus of vulnerability and sexual violence. Trafficked women and girls represent the most vulnerable category as far as sexual violence is concerned."⁶ The Regional Programme describes several links between HIV/AIDS, trafficking and gender, including in the following ways:

- ▼ Factors that relate to trafficking of women and girls—including social disadvantage, sexual violence, gender-related social and economic disempowerment, sexual behaviour, and lack of access to health care and education—also increase vulnerability to HIV.
- ▼ Trafficking dislocates women from their communities and systems of social support and protection, intensifying vulnerability to the virus.
- ▼ Trafficking and violence deny women control over their working and living conditions, as well as control over their bodies and sexual relations.
- ▼ Stigma, discrimination and marginalization are common features in societal attitudes towards women affected by trafficking, resulting in violations of sexual and reproductive rights, rights to mobility and residence, and rights to essential services, confidentiality and free association.

NHDRs on HIV/AIDS need to explore issues related to migration, mobility and trafficking, examine how they are linked with the epidemic's dynamics in a particular country, and recommend implementation of strategies that promote safe mobility and empower migrants (including through national, intra- or cross-regional collaboration).

Conflict and emergency settings

Situations of conflict or natural emergencies can heighten risks of exposure to HIV. Civilians living in conflict settings, or who have been displaced from their homes, are at greater vulnerability to infection due to factors such as the break up of families, sexual violence, lack of information, and lack of access to health services and means of protection. Uniformed forces, who tend to be young, highly mobile and away from families for long periods of time, also face increased vulnerability to HIV. In some cases, however, conflicts may limit mobility and in so doing contain the spread of the virus. It is also important therefore to focus attention on HIV/AIDS in post-conflict settings, where the opening up of societies coupled with unstable social and economic conditions could increase vulnerability. The Inter-Agency Standing Committee Task Force on

HIV/AIDS in Emergency Settings has developed useful guidelines for interventions in emergency settings, including a matrix highlighting key actions.⁷ In 2000, the UN Security Council passed a resolution deeming HIV/AIDS a security issue. NHDRs prepared for countries with conflict or emergency settings should consider the impact of HIV/AIDS on human development and human security.

WOMEN, GIRLS AND HIV/AIDS

Disempowerment of women and girls is one of the key drivers feeding the growth of the HIV/AIDS epidemic. In many countries, lack of social, economic and legal rights increases women's vulnerability to the virus, and HIV/AIDS in turn creates a new cycle of vulnerability as women and girls bear the brunt of its impact on families and communities. While women are biologically more susceptible to HIV infection, legal, social and economic inequities limit women's livelihood opportunities and access to resources, and impact their ability to access information, negotiate safe sex and protect themselves from the virus. In AIDS-affected households, women and girls carry the burden of caring for those who are ill and other family members, curtailing their educational and economic opportunities. Women living with HIV/AIDS are more likely than men to face stigma, marginalization, and loss of property and inheritance, in addition to reduced access to care, treatment and support.

Women and girls represent a rapidly increasing proportion of people living with HIV/AIDS. Globally, women now make up almost half of those living with the virus, increasing from just 35 per cent in 1985.⁸ While the growing feminization of the epidemic is most apparent in sub-Saharan Africa, this trend is rising globally, with the number of women living with HIV continuing to increase in every region. In sub-Saharan Africa women make up 57 per cent of people living with HIV/AIDS, and young women are three times as likely to be infected as men of the same age. In the Caribbean, and North Africa and the Middle East, women now account for nearly 50 per cent of people living with HIV/AIDS.⁹

Existing NHDRs on HIV/AIDS provide insight into the manifestations of female vulnerability and power relations between men and women. These include lack of

BOX 12: The most vulnerable

Paragraph 4 of the UNGASS Declaration of Commitment states that "women, young adults and children, particularly girls, are the most vulnerable," and underscores that "empowering women is essential for reducing vulnerability."

BOX 13: Gender and HIV/AIDS in reports

NHDRs on HIV/AIDS provide insight into the manifestations of female vulnerability, including lack of capacity and status to insist on safe sex, fear of violence from partners, lack of education, low social status, and engaging in sex for money and security. The **Botswana** report includes an in-depth discussion on the linkages between HIV/AIDS, and exploitative intergenerational sexual relations, rape and violence, low social status of women, and inequality in education outcomes. The **South Africa** NHDR concludes that gender inequality is not only fuelling the epidemic, but gender roles are also affected by the epidemic. This becomes evident when considering the distribution of impact of HIV/AIDS at the household level. Women are likely to take on the greater burden with regard to caring for the sick and dying, and lose opportunities for income generation, which may influence their status within the household and the community. Girls are more likely to be withdrawn from school. Overall, efforts to promote equal access to choices and opportunities are greatly undermined.

The **Cambodia** NHDR describes the extreme gender inequality in the country as providing a fertile ground for the epidemic, through mechanisms such as lower school enrolment and higher drop-out rates for girls. Gender segregated lives and high mean age at marriage, coupled with a tolerance of consumption of commercial sex, mean that men, married as well as unmarried, make use of these

services. The report states that continuing the country's downward trend in HIV incidence requires that structural issues, including gender inequalities, be addressed. The **Burkina Faso** report emphasizes traditional practices that expose women to the risk of HIV infection. These include forced and early marriage of young girls to older and sexually experienced partners, genital mutilation, scarification and tattooing, and the practice of widow inheritance. The last is practiced in several contexts, and while the main objective is to ensure social protection for a widow by allowing or expecting her to marry her deceased husband's male relative, this may increase vulnerability to HIV/AIDS.

The **Zimbabwe** report states that women are bearing the brunt of caring for the sick and a growing number of orphaned children, with very little help from others in the community. Certain cultural beliefs regarding gender roles ('women as the natural caregivers in the home') exert more pressure on women to succumb to male sexual demands that are often unsafe, and to take care of the sick. In **Uganda**, HIV incidence among girls aged 15–19 is three times that of boys in the same age group. Young girls are exploited by older men and are sometimes powerless to negotiate safe sex. Similarly, the prevalence of HIV/AIDS in women aged 15–35 is much higher than in men, therefore women are dying at a higher rate than men.

capacity and status to negotiate safe sex, fear of violence from partners, lower educational attainment, and unequal social, economic and legal status. Deep-rooted gender inequality fuels the spread of HIV/AIDS through lower school enrolment for girls, for example, or a high consumption of commercial sex services by both married and unmarried men, as described in the Cambodia NHDR. Sexualized violence and rape are also disturbing practices that should not be overlooked.

In severely affected countries, inequitable gender roles may not only prepare the ground for the epidemic, but gender roles are themselves affected by the epidemic. At the household level, women take on a greater burden in terms of caring for the sick, and income generation or the loss of it. Girls are more likely to be withdrawn from school when family resources dwindle. The HIV/AIDS epidemic can therefore also undermine girls' and women's educational and economic opportunities, and general access to choices, and as a consequence women's

human development.

NHDRs should address the underlying norms, values and practices that render women more vulnerable to HIV infection. They should also consider issues such as inequitable property and inheritance rights that disempower women. In the case of women living with HIV/AIDS and their children, denial of these rights can leave families destitute and without access to treatment, and may drive women and children to engage in risky survival strategies. Effective responses to HIV/AIDS must tackle the gender dimensions of the epidemic, and involve women in shaping national and community responses.

When considering how gender dynamics are related to the spread of HIV/AIDS in a particular country or context, it is important not to limit the discussion to women. Policies and programmes aimed at strengthening the position of women may fail if they do not involve men and consider how the role of men, gender and power relations, and societal dynamics influence the spread of HIV/AIDS.

FROM RISK TO VULNERABILITY

The UNGASS Declaration of Commitment, under the heading ‘Reducing vulnerability’, states that “the vulnerable must be given priority in the response,” and adds that empowering women is essential for reducing vulnerability. It sets 2003 as a deadline for all countries to have in place “strategies, policies and programmes that identify and begin to address those factors that make individuals particularly vulnerable to HIV infection, including underdevelopment, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or commodities for self-protection, and all types of sexual exploitation of women, girls and boys, including for commercial reasons.”¹⁰

HIV transmission is often associated with stigmatized aspects of human behaviour, such as intravenous drug use, commercial sex, and sexual activity between men or between men and women. At the start of the epidemic, and still in some contexts, these associations have obscured understanding of the mechanisms that render people and communities vulnerable to the epidemic. Sex and drug use are usually thought of as belonging to the private domain, as individual behaviour resulting from each individual’s own

BOX 14: Knowledge and behaviour change

Although knowledge and awareness are necessary in order to stop the spread of HIV/AIDS, these are not enough to bring about behavioural change. Curbing the spread of the epidemic therefore requires acknowledgement that behaviour is a result of a complex interplay between a number of factors, where knowledge and awareness do not necessarily play the determining role. On the individual level, power, self-esteem and capacity to negotiate within a sexual relationship may be crucial to whether safer sex or sexual abstinence is practised. In order to bring about actual behavioural change that would stop the spread of HIV/AIDS, there is a need for recognition of the deep and complex patterns that result in certain behaviours. In addition, prevention activities have often hinged on lowering risk, which varies according to setting. It is therefore important that programmes are tailored to the individual context, recognizing that awareness raising can only be one component of the response if behavioural change is the desired result, and that risk reduction has to make sense in that particular context in order to tailor effective policies and messages.

BOX 15: Stigma and social invisibility

The **Eastern Europe and CIS** report notes that the stigmatization and criminalization of sex workers and intravenous drug users has prevented the equal, non-discriminatory implementation of harm reduction programmes. The **South Asia** report states that the epidemic has been ‘socially invisible’ due to stigma and taboos surrounding HIV in most South Asian societies. Ignorance about the causes of HIV and preventative protection has damaging consequences, as it fosters a society that considers itself to be ‘behaviourally immune’ to HIV/AIDS, since it is perceived to only affect stigmatized ‘others’.

choice. This conceptualization paved the way for the notion of ‘risk behaviour’, and the approach was to identify sub-populations with ‘risk behaviour’ and develop interventions in order to curb this behaviour. As the Cambodia NHDR notes, “this approach, useful as it may be, turned out to be highly insufficient for reducing the spread of HIV. Two main factors may help account for its shortcomings: the social determinants of human behaviour and the necessity of understanding ‘risk’ within a particular context.”¹¹ Individual attitudes and behaviours are linked to and conditioned by social values and norms, and societal systems and structures. The notion of ‘risk’ behaviour can indeed hinder the response to HIV/AIDS if particular groups in society are stigmatized, and driven underground and away from participation in communities and access to information, care and support.

NHDRs should take account of vulnerable groups including young people, and particularly young women. In addition, factors or settings that place groups at increased vulnerability should be explored—including injecting drug use, commercial sex work, mobility, trafficking, sexually transmitted infections, prisons and sexual violence. The factors that increase vulnerability will vary according to the national context or setting, and strategies such as harm reduction programmes for intravenous drug users should be explored.

Social exclusion

Socially excluded groups and individuals are more vulnerable to HIV/AIDS through a range of factors. These include lower access to knowledge and prevention messages, inability to negotiate safe sex, lack of access to health care, higher risk of sexual abuse and involvement in commercial sex. Socially excluded groups will vary according to the context, but include intravenous drug users, commercial sex work-

ers, prisoners and sexual minorities.

HIV/AIDS poses a threat to the fabric of society and is increasingly recognized as a risk factor for social instability. NHDRs need to explore the social contracts that guide relations between men and women and within families, between people living with HIV/AIDS and those who are HIV-negative, between generations, and between rich and poor. Societal values, norms and culture can affect the spread of the epidemic as well as implementation of the response.

Sexual minorities

HIV/AIDS has disproportionately affected sexual minorities. Men who have sex with men, for example, have been and are still particularly affected. In many societies, sexual minorities are largely invisible or ignored, and often have little opportunity to publicly raise their concerns. The vulnerability of sexual minorities is intensified by social marginalization of groups and behaviours, which drives them underground. As a result, HIV/AIDS prevention, care and support activities are often not available for sexual minorities.

Addressing sexuality and the concerns of sexual minorities is often a sensitive issue. Social exclusion and criminalization of sexual minorities and non-heterosexual behaviour fuel the spread of the epidemic. NHDRs can constitute an important vehicle for opening dialogue and debate on the subject. Reports should consider how legal frame-

works and social dynamics impact sexual minorities and the response to HIV/AIDS.

BOX 16: Personal experiences

The **South Africa** NHDR consistently illustrates personal experiences of people living with HIV/AIDS and of affected families, through excerpts from qualitative interviews. For example, the report describes feelings of lack of hope that inhibit action; destructive behaviour resulting from fear, anger and depression; and numerous discriminatory practices occurring in workplaces and within the public domain. The **Namibia** NHDR also briefly notes the fear, great emotional distress and isolation experienced by individuals affected by HIV/AIDS.

People living with and affected by HIV/AIDS

Individuals living with HIV/AIDS and their families often face the trauma of stigma and marginalization in their daily lives, along with the realities of reduced income and lack of access to adequate health care. Families affected by AIDS face increased expenses and reduced savings, as well as adverse impacts on children's schooling and well-

BOX 17: Affected households

All reviewed reports describe the impact of HIV/AIDS at the household level. The **Cambodia** report emphasizes how HIV/AIDS and poverty reinforce one another and render households extremely vulnerable to both, mainly as a result of household spending on health services. The **Zimbabwe** report describes a disintegration of households and families, with family value systems breaking down and traditional roles, duties and responsibilities becoming blurred. This is also an emerging trend described in the **Eastern Europe and CIS** report. In **South Asia**, one of the most visible and immediate impacts of HIV/AIDS is on the earnings and incomes of affected households, especially since HIV tends to affect individuals in their most productive years.

Information on household impact comes from various sources. For example, the **Botswana** report relies on a macroeconomic impact study, whereas the **Namibia** NHDR benefits from qualitative studies. The **South Africa** report outlines the potential impacts on

households and notes that "the nature of impact and the consequences for poor households and gender equality are yet to be researched." Qualitative data can often provide more insight with regard to the different manifestations of impact. The **Namibia** NHDR describes isolation, great emotional distress and fear experienced by families affected by AIDS. Similarly, the **South Africa** report provides powerful insights through interviews that address perceptions, practices and beliefs.

The **Botswana** report describes the problems experienced by home care facilities, including lack of support from the government. There is a close connection between pressure on women to take care of the sick either at the household or community level, and lack of capacity in the health care system. Whereas women's involvement in caring for the sick lifts some pressure off the health care system, this can prevent women from participating in income-generating activities and increase their vulnerability.

being. As a result, orphans and other vulnerable children can fall into a cycle of vulnerability to HIV/AIDS. NHDRs should address these vulnerabilities, in addition to the individual attitudes, lack of understanding and intolerance that feed silence and denial, and fuel the spread of the epidemic.

HUMAN RIGHTS, HUMAN DEVELOPMENT AND HIV/AIDS

In addition to the work done at the level of UNGASS and the Millennium Declaration, the UN system has also focused on HIV/AIDS from a human rights perspective. The Office of the High Commissioner for Human Rights (OHCHR) has carried out important work on the relationship between HIV/AIDS and human rights. This serves as a useful practical guide on the consequences of human rights

obligations in response to the epidemic.¹²

The human development approach has much in common with a human rights approach. Human rights and human development are both centred on securing basic freedoms. Human rights principles express the noble idea that that all people have claims to social arrangements that protect them from the worst abuses and deprivations, and that secure freedom for a life of dignity. Human development, in turn, is a process of enhancing human capabilities, to expand choices and opportunities so that each person can lead a life of respect and value. When human development and human rights advance together, they reinforce one another, expanding people's capabilities, and protecting their rights and fundamental freedoms.¹³

The framework of human rights provides concrete legal instruments for a response to HIV/AIDS. International human rights norms not only offer a coherent, normative framework for analysis of the epidemic, they also provide a

BOX 18: A rights-based approach

A rights-based approach is relevant to HIV/AIDS both in terms of individual rights of people living with HIV/AIDS, and rights related to the more structural determinants of the epidemic, such as social and economic rights. The **Botswana, Cambodia and South Africa** NHDRs emphasize the importance of looking at HIV/AIDS through a human rights lens, and outline the relationship between human development and human rights. The human rights framework is used to advocate non-discriminatory legislation and regulations that would protect people living with HIV/AIDS from further exclusion. Several aspects of human development also apply to human rights, and a rights-based approach to human development is presented in the Cambodia NHDR. Aspects of poverty that exacerbate the HIV/AIDS epidemic simultaneously affect human rights, such as the right to health and housing, the right to effective means of expression, and fundamentally the right to life. The Botswana report also provides useful examples of how human rights are linked to the lives of people living with HIV/AIDS, and addresses the right to health and medical services, and the right to a decent standard of living.

The framework provided by social, economic and cultural rights is, however, not generally used in the reports reviewed when discussing the role of factors such as poverty, unemployment or poor nutrition in facilitating the spread of HIV. While recognizing the importance of a rights-based approach, some reports provide

few concrete suggestions on how to address human rights violations such as discrimination against people living with the virus.

The **Eastern Europe and CIS** and **South Asia** reports, however, both provide extensive recommendations for a human rights-based approach to HIV/AIDS. The Eastern Europe report argues that meeting the challenge of HIV/AIDS is fundamentally a "matter of governance," as it cites the UNGASS Declaration and international human rights law covenants. The report also notes that the human rights response in Eastern Europe and CIS is complicated by the disempowering legacy of communism, including pervasive social controls, cynicism and apathy that have generated polarized societies. The report is a clear indication of the relevance of country-specific contexts that affect the way in which the epidemic is approached. The South Asia report highlights numerous international human rights instruments, and emphasizes the need to engage in law reform and to identify legal obstacles to an effective HIV/AIDS strategy.

Employment-related rights are important in addressing discrimination against people living with HIV/AIDS, as many experience unemployment as a result of HIV status. The reports generally do not discuss the epidemic in the context of the world of work. However, the South Asia report addresses HIV outreach workers as among the vulnerable and marginalized groups.

legally binding foundation with procedural, institutional and other accountability mechanisms to address the societal basis for vulnerability and implement change.¹⁴ Discrimination and stigma hinder access to services and drive people away from support, be it through public or private networks. As the Eastern Europe and CIS report describes, stigmatization of intravenous drug users has hampered the implementation of harm reduction activities that help to prevent the spread of the epidemic. Driving people to silence, or driving them away from communities and networks, hinders HIV/AIDS response efforts.

Inequitable property and inheritance rights increase vulnerability and exacerbate impacts of HIV/AIDS. Lack of enforcement or denial of women's property and inheritance rights can leave women and their children disempowered and vulnerable to exploitation. When women living with HIV/AIDS and orphans and children affected by AIDS are denied these rights, they are likely to lose access to shelter, care and treatment, and economic and educational opportunities. This situation can create new cycles of vulnerability by pushing women and children into risky survival strategies.

The *UNAIDS Handbook for Legislators on HIV/AIDS, Law and Human Rights* describes three ways in which lack of protection for human rights fuels the epidemic:¹⁵

1. Discrimination increases the impact of the epidemic on people living with HIV/AIDS and those presumed to be living with HIV/AIDS, as well as their families and associates. For example, a person who loses her or his job because of their HIV status is faced with problems relating to the loss of income, exacerbated by increased expenses for health care and other HIV/AIDS-related expenses. If the person is a breadwinner, the entire household suffers.
2. People are more vulnerable to infection when their economic, social or cultural rights are not respected. For example, a refugee may be separated from former sources of support (such as family), or may lack food or other essential resources, and therefore be more likely to engage in activities that place his or her health at risk (such as unsafe sex) in exchange for money or food.
3. Where civil and political rights are not respected, and freedom of speech and association is curtailed, it is difficult or impossible for civil society to respond effectively to the epidemic. In some countries, laws that refuse official registration to groups with certain memberships (for example, sex workers) hamper peer education. In these cases, a meeting of a non-governmental organization (NGO) or community-based organization (CBO) with such a membership would be viewed as an illegal activity.

The publication *HIV/AIDS and Human Rights: International Guidelines*, issued by the Joint UN Programme on HIV/AIDS (UNAIDS) and OHCHR, is an important guide for a rights-based approach to HIV/AIDS.

DEVELOPMENT GOALS

The UNGASS Declaration

The UNGASS Declaration has played a pivotal role in focusing international attention on the epidemic and highlighting the importance of committed leadership. The Declaration of Commitment was adopted by consensus and sets targets that are valid for and in all countries. Countries have committed to addressing the HIV/AIDS crisis by taking action on a range of issues, including: leadership; prevention; care, support and treatment; human rights; reducing vulnerability; orphaned and vulnerable children; social and economic impact; research and development; conflict and disaster-affected regions; and resources. (See Table 2.)

The UNGASS framework also sets core indicators at national and global levels for the implementation of commitments. National level core indicators are particularly useful for countries wishing to produce NHDRs focusing on HIV/AIDS. (See Table 3.) The core indicators spell out the time-bound response that each country should have in place, and provide measurable targets. The national composite policy index assesses progress in the development of national HIV strategies. (See Table 4.) Policy messages should be targeted at fulfilling these commitments. NHDRs can therefore provide useful tools for governments as well as actors in other sectors to address UNGASS commitments and the epidemic itself—placing UNGASS commitments in a human development context.

The Millennium Development Goals

Following the Millennium Summit in September 2000, the UN General Assembly agreed on eight development goals to sustain development and eliminate poverty. The Millennium Development Goals (MDGs), to be achieved by 2015, provide a framework for measuring development progress. Goal six is aimed at combating HIV/AIDS, malaria and other diseases, with the target of halting and beginning to reverse the spread of HIV/AIDS by 2015. Reaching this target is critical for the achievement of the remaining MDGs. (See Table 5.)

TABLE 2: Areas of action in the UNGASS Declaration of Commitment¹⁶

Leadership	<p>Strong leadership at all levels of society is essential for an effective response to the epidemic</p> <p>Leadership by governments in combating HIV/AIDS is essential, and their efforts should be complemented by the full and active participation of civil society, the business community and the private sector</p> <p>Leadership involves personal commitment and concrete action</p>
Prevention	Prevention must be the mainstay of our response
Care, support and treatment	Care, support and treatment are fundamental elements of an effective response
HIV/AIDS and human rights	<p>Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS</p> <p>Respect for the rights of people living with HIV/AIDS drives an effective response</p>
Reducing vulnerability	<p>The vulnerable must be given priority in the response</p> <p>Empowering women is essential for reducing vulnerability</p>
Children orphaned and made vulnerable by HIV/AIDS	Children orphaned and affected by HIV/AIDS need special assistance
Alleviating social and economic impact	To address HIV/AIDS is to invest in sustainable development
Research and development	With no cure for HIV/AIDS yet found, further research and development is crucial
HIV/AIDS in conflict and disaster-affected regions	Conflicts and disasters contribute to the spread of HIV/AIDS
Resources	The HIV/AIDS challenge cannot be met without new, additional and sustained resources
Follow-up	Maintaining the momentum and monitoring progress are essential

TABLE 3: Core indicators for implementation of the Declaration of Commitment

Indicator	Reporting schedule	Method of data collection
<i>National commitment and action</i>		
Amount of national funds spent by government on HIV/AIDS	Biennial	Survey of financial resource flows
National composite policy index	Biennial	Country assessment questionnaire
<i>National programme and behaviour</i>		
Per cent of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year	Biennial	School-based survey and educational programme review
Per cent of large enterprises/companies that have HIV/AIDS workplace policies and programmes	Biennial	Workplace survey
Per cent of patients with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled	Biennial	Health facility survey
Per cent of HIV-infected pregnant women receiving a complete course of ARV combination therapy	Biennial	Programme monitoring and estimate
Per cent of people with advanced HIV infection receiving ARV combination therapy	Biennial	Programme monitoring and estimate
Per cent of intravenous drug users who have adopted behaviours that reduce transmission of HIV	Biennial	Special survey
Per cent of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Every 4–5 years	Population-based survey
Per cent of young people aged 15–24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner	Every 4–5 years	Population-based survey
Ratio of current school attendance among orphans to that among non-orphans, aged 10–14	Every 4–5 years	Population-based survey
<i>Impact</i>		
Per cent of young people aged 15–24 who are HIV infected	Biennial	HIV sentinel surveillance
Per cent of HIV-infected infants born to HIV-infected mothers	Biennial	Estimate based on programme coverage

TABLE 4: National composite policy index**Strategic plan**

Country has developed multisectoral strategies to combat HIV/AIDS.

Country has integrated HIV/AIDS into its general development plans.

Country has a functional national multisectoral HIV/AIDS management/coordination body.

Country has a functional national HIV/AIDS body that promotes interaction among government, the private sector and civil society.

Country has a functional HIV/AIDS body that assists in the coordination of civil society organizations.

Country has evaluated the impact of HIV/AIDS on its socio-economic status for planning purposes.

Country has a strategy that addresses HIV/AIDS issues among its national uniformed services (including armed forces and civil defence forces).

Prevention

Country has a general policy or strategy to promote information, education and communication (IEC) on HIV/AIDS.

Country has a policy or strategy promoting reproductive and sexual health education for young people.

Country has a policy or strategy that promotes IEC and other health interventions for groups with high or increasing rates of HIV infection.

Country has a policy or strategy that promotes IEC and other health interventions for cross-border migrants.

Country has a policy or strategy to expand access, including among vulnerable groups, to essential preventative commodities.

Country has a policy or strategy to reduce mother-to-child HIV transmission.

Human rights

Country has laws and regulations that protect against discrimination against people living with HIV/AIDS.

Country has laws and regulations that protect against discrimination against groups of people identified as being especially vulnerable to HIV/AIDS.

Country has a policy to ensure equal access for men and women to prevention and care, with emphasis on vulnerable populations.

Country has a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by an ethics committee.

Care and support

Country has a policy or strategy to promote comprehensive HIV/AIDS care and support, with an emphasis on vulnerable groups.

Country has a policy or strategy to ensure or improve access to HIV/AIDS-related medicines, with an emphasis on vulnerable groups.

Country has a policy or strategy to address the additional needs of orphans and other vulnerable children.

TABLE 5: The impact of HIV/AIDS on selected Millennium Development Goals

MDG	Effect of HIV/AIDS	Impact on progress towards goal
1. Eradicate extreme poverty and hunger	The loss of productive capacity among families affected by HIV/AIDS has a major impact on economic growth, food production and nutritional well-being (in the hardest-hit countries, economic growth has fallen by 4%, and labour productivity has been cut by up to 50%).	In Burkina Faso, the proportion of people living in poverty is projected to increase from 45% to nearly 60% by 2010 as a result of HIV/AIDS. Studies have shown that in Thailand, food consumption in affected households fell by 15–30%.
2. Achieve universal primary education	Reduced number of teachers due to illness and absenteeism with reduced quality of education services. More school children are caring for their sick parents and such responsibilities force them to drop out of school. AIDS-related illness eats into family budgets, making it more difficult to pay school fees.	In the worst affected countries, education quality and enrolment, especially among the most vulnerable groups, have already been reduced. In the Central African Republic and Swaziland, school enrolment is reported to have fallen by 20% to 36% due to AIDS and orphanhood.
3. Promote gender equality and empower women	Girls are more likely to be kept out of school to provide care, or when resources are limited. Women take on greater burdens of caring and face greater economic insecurity when wage earners fall ill. While gender equity (social and economic) is a critical factor in reducing risk, AIDS exacerbates burdens on women and gender inequalities.	In some of the worst affected countries, nearly 50% of children who lose their parents to HIV/AIDS drop out of school, the majority of them girls.
4. Reduce child mortality	Infant and child mortality will continue to increase for the next decade, and possibly longer, due to parent-to-child HIV infection.	In some countries, there will be deterioration. Under-five mortality in South Africa will increase to 160 per 1,000 live births by 2010, instead of falling to 44 per 1,000 (as per the MDG) by 2015.
5. Improve maternal health	HIV/AIDS is both a direct and indirect cause of maternal deaths.	In many parts of Africa, young women and teenage girls are five to six times more likely to be infected. New infections are disproportionately concentrated among poor and illiterate adolescent women in childbearing years.
7. Ensure environmental sustainability	Illness, increased labour demands for caring and lost labour reduce time for collecting water, especially for women. Human resource losses and costs in water supply services affect delivery and increase the cost of services to households.	Loss of household resources and labour time make easy access to safe water critical. The epidemic will slow or reverse progress towards this goal.
8. Develop a global partnership for development	HIV/AIDS continues to place additional resource burdens on developing countries, including for provision of ARVs.	The epidemic could hinder progress towards achieving this goal in terms of dealing comprehensively with developing countries' debt problems and providing access to essential medicines.

Source: Adapted from UNDP 2002a

KEY ELEMENTS FOR AN EFFECTIVE RESPONSE

The magnitude and impact of the HIV/AIDS epidemic demand a groundbreaking vision for development actions. There are a number of key elements that have proven to be essential for a successful response. NHDRs need to critically review national responses. Key success factors such as political will and leadership, enabling legal frameworks, and multisectoral responses have already been mentioned and need to be considered in the national context. UNAIDS lists nine common features for effective national responses to HIV/AIDS. These can serve as useful guides, checkpoints and indicators when reviewing the national response to the epidemic.¹⁷

Political will and leadership

The key requirement for an effective response to HIV/AIDS is committed leadership at all levels of society—including leadership to address the socio-economic factors fuelling the epidemic, to implement an effective response and to commit resources to addressing HIV/AIDS. The response to HIV/AIDS must involve political, civil society and community leaders, including women and people living with HIV/AIDS. Leaders should provide hope, challenge harmful norms, and promote the values and principles of human rights and gender equality. This includes a willingness to break the silence surrounding HIV/AIDS, and tackle stigmatized and taboo issues dealing, for example, with sexuality, gender or harmful practices. Leaders must involve all sectors of society, and undertake strategic actions on available knowledge and experience. Effective responses are characterized by political commitment to address HIV/AIDS, from the community to the national level. Political commitment involves a willingness to create an enabling policy, legal and resource framework for HIV/AIDS actions, including addressing human rights violations.

BOX 19: Levels of leadership

The first thematic section of the UNGASS Declaration of Commitment states that “strong leadership at all levels of society is essential for an effective response to the epidemic. Leadership by governments in combating HIV/AIDS is critical and their efforts should be complemented by the full and active participation of civil society and the private sector. Leadership involves personal commitment and concrete actions.”

Societal openness and determination to fight stigma

HIV/AIDS-related stigma and discrimination make prevention difficult by forcing the epidemic out of sight and underground. To be effective, the response needs to make HIV/AIDS visible, and foster a willingness to discuss both individual and structural factors that contribute to its spread. It is essential that discrimination against people living with or affected by HIV/AIDS is addressed head on, as marginalization only leads to further spread of the epidemic. People living with HIV/AIDS must also be actively

BOX 20: Participation of people living with HIV/AIDS

Participation of people living with HIV/AIDS at all levels of policy making and implementation has proved to be important for programme and policy relevance and quality, and is a stated aim in the UNGASS Declaration. The reviewed reports show that this has only occurred to a limited degree. The reasons for this include marginalization and discrimination against HIV-positive individuals, and lack of community and civil society participation in central policy making and implementation.

The reports describe activities undertaken by community organizations to address HIV/AIDS in the areas of training, education and care taking. However, participation should go beyond that. Voices of people living with HIV should be heard throughout research, development and implementation phases of response strategies. The **Burkina Faso** NHDR describes how the greater involvement of people living with or affected by HIV/AIDS is an overriding principle in the country's national strategic framework for responses to the epidemic for 2001–2005. The report also shows how the country is working on involving civil society, the research community and people living with HIV/AIDS in its response. The **Uganda** report notes that participation of people living with HIV/AIDS in prevention activities at various levels has proved to be an important and growing ‘best practice’. The **South Africa** NHDR provides explicit accounts of people living with HIV/AIDS, and thus paints a more realistic picture of HIV/AIDS experiences, which are important for identifying complex causal relationships and strengthening the response. The **South Asia** report mentions the importance of making legal remedies available to HIV-positive individuals by inserting relevant provisions in the respective constitutions, and civil and criminal codes.

involved in implementing the response to the epidemic at all levels. The World AIDS Campaign 2002–2003 focused on countering stigma, and UNAIDS has developed several useful tools and resource materials on the importance of fighting stigma, as well as practical advice for taking action.¹⁸

A strategic response

A well thought out and strategic national response, involving a wide range of actors and stakeholders, drawn from public, private and voluntary sectors, forms the basis for an effective response. A variety of actors must be involved, including people living with HIV/AIDS, women's groups, NGOs, civil society organizations (CSOs), CBOs and faith-based groups. A country strategy should map the causes and responses to the epidemic, drawing on best practices and evidence-based methods to develop an implementation plan for prevention, care and impact mitigation. HIV/AIDS must be integrated into national and sub-national development plans and planning instruments, including poverty reduction strategies, and mainstreamed into sectoral policies and plans. It is important that the national strategy builds on available data and fills knowledge gaps, both quantitative and qualitative. NHDRs should advocate for balancing prevention with reduction of vulnerability, mitigation of social

and economic impact, and care and treatment.

A strategic response must be coordinated so that elements reinforce rather than counter or duplicate one another, and provide synergy for scale-up. In 2004, UNAIDS endorsed the Three Ones principles for the coordination of national AIDS responses. These guiding principles promote one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority, with a broad-based multisectoral mandate; and one agreed country-level monitoring and evaluation system.

Multisectoral and multilevel action

Addressing the complex dynamics of the epidemic requires involvement of all sectors—public, private and voluntary—and at different levels—local, regional and national. HIV/AIDS must be integrated into sectoral plans and policies at all levels, and implementation of the response needs to be concerted, in order to be effective. People living with HIV/AIDS must play a prominent role and bring experiences and perspectives into policies, and programme development and implementation.

Different ministries can work within their domains to respond to HIV/AIDS. Ministries of education can work

BOX 21: Mainstreaming HIV/AIDS into development planning

Mainstreaming HIV/AIDS into development planning and poverty reduction strategies is necessary in order to effectively respond to the epidemic and address its impacts, as well as to further synergy between HIV/AIDS responses and work to eradicate poverty. Countries have committed to paragraph 38 of the UNGASS Declaration of Commitment, which states: “By 2003, [at the national level] integrate HIV/AIDS prevention, care, treatment and support and impact-mitigation priorities into the mainstream of development planning, including in poverty eradication strategies, national budget allocations and sectoral development plans.” PRSPs are important tools for development planning and poverty reduction in developing countries. NHDRs should provide examples and recommendations for mainstreaming HIV/AIDS into development planning, highlighting issues that are particularly important in that context. NHDRs should provide guidance on how to integrate HIV/AIDS into the PRSP, highlighting issues and areas to focus on. For PRSP countries, those that fall under the heavily indebted poor

countries initiative (HIPC), and other countries where this is relevant, NHDRs should provide guidance on how money freed up through debt relief could be channelled to HIV/AIDS responses.

The **Burkina Faso** NHDR includes information about the PRSP, which has been developed under the HIPC initiative, and argues that implementation of this strategy will strengthen human development and in turn impact determinants of the HIV epidemic. Heavy debt burdens limit government capacity to shift financial resources to prevent further spread of HIV/AIDS and mitigate its impact on human development. The Burkina Faso report also notes that the country has, as a result of debt alleviation through the HIPC initiative and application of the 20/20 principle, opened “new channels of support.” NHDR discussion of possibilities for debt alleviation in return for earmarking freed-up resources for HIV responses would provide useful insights, and also benefit governmental and non-governmental agencies working on debt and debt relief.

BOX 22: UNGASS on strategies to address impacts

The UNGASS Declaration of Commitment paragraph 68 states that all countries, “by 2003, shall evaluate the economic and social impact of the HIV/AIDS epidemic and develop multisectoral strategies to address the impact at the individual, family, community and national levels; develop and accelerate the implementation of national poverty eradication strategies to address the impact of HIV/AIDS on household income, livelihoods and access to basic social services ...; (and) review the social and economic impact on HIV/AIDS at all levels of society, especially on women and the elderly, particularly in their role as caregivers.”

with school curricula and teachers. Ministries of labour can work with the private and public sector to implement workplace programmes. Ministries of defence can work with the armed forces, who are themselves vulnerable to infection. Ministries of trade and commerce can implement policies that facilitate access to medication. Ministries of health can provide treatment and counselling through the health care sector, as well as monitor the epidemic and provide information. The private sector can work with the non-governmental sector and health sector to make sure that means of protection against infection, such as clean syringes and condoms, are available and affordable. The media can disseminate prevention messages, and messages promoting gender equality and countering stigma and discrimination, to transform negative images of people living with HIV/AIDS and women. The non-governmental sector plays an important role in advocacy, developing policy, implementing programmes and reaching out to vulnerable groups.

Community-based responses

The devastating effects of HIV/AIDS are felt most deeply in communities. Since the beginning of the epidemic, many communities have mobilized themselves to deal with the impact of AIDS. Inadequate social services have resulted in community members—particularly women and girls—providing the bulk of care and support for families affected by AIDS, including caring for people who are ill and children orphaned by AIDS. To be effective, national and sub-national HIV/AIDS responses must be decentralized to involve and reach communities, support their efforts and provide resources. District level authorities must be encouraged to work directly with communities and community groups. Getting resources to communities should be a priority—to finance treatment and care, support prevention efforts, reduce vulnerability and mitigate impacts.

Reducing vulnerability

Reducing vulnerability to infection is part of the process of multilevel and multisectoral action outlined above, but is so important that it merits consideration on its own. As the Cambodia NHDR demonstrates, vulnerability to infection is a result of deep-rooted mechanisms such as discrimination against women. Societal forces that determine vulnerability to HIV/AIDS therefore need to be addressed directly, including through political commitment and social policies.

Longer-term and sustained response

Responding to the epidemic is a long-term and continuous struggle. Experience from Western countries, where HIV/AIDS is now growing in certain groups as new generations enter sexually active ages, teaches that a long-term approach must be taken. Sustainable programmes and strategies therefore need to be established and funded. HIV/AIDS needs to be mainstreamed into development planning and kept high on the agenda.

BOX 24: Legal frameworks

The right legal framework is fundamentally important in addressing the epidemic, both in ensuring effective responses, and adequate fiscal and other resources to support them. Providing the right legal framework can include amending legislation to prohibit discrimination against people living with HIV/AIDS or marginalized groups who are vulnerable to infection. It could include legislation to ensure the rights of school children and youth to be educated on how to protect themselves, or public health legislation facilitating confidentiality and reproductive health services for all.

Several countries have amended their legislation with the intent of curbing the HIV/AIDS epidemic. Some amendments and changes, however, contribute to further stigmatization and discrimination, and have the opposite effect by driving people away from seeking information and services. It is therefore essential that legal frameworks at a minimum do not turn people away from education and services, or drive people out of their networks and communities, as this will only further the spread of the epidemic. Law reform should focus on anti-discrimination, public health protection, privacy, criminal law, and improving the status of women, children and marginalized groups. Laws should be placed firmly within a human rights framework.

BOX 23: Evaluating responses to HIV/AIDS and offering recommendations

All reports reviewed recognize the establishment of national structures and development of multisectoral response strategies as positive achievements. The vast majority of 'lessons learned' concern governance and capacity issues.

The following shortcomings are noted throughout the reports:

Increasing, yet still insufficient political commitment and leadership

Uneven political commitment across regions

Lack of capacity within civil service

Insufficient intersectoral cooperation

Insufficient communication within government, and between government and other actors

Insufficient, yet increasing, participation of people living with HIV in the response

Lack of participation by the population, especially women

Reluctance to participate on the part of the private sector

Ineffectiveness of tentative and under-resourced responses

Limited financial resources

Insufficient funding for the NGO sector, especially for community-based care

Lack of sufficient monitoring and evaluation mechanisms

Insufficient openness and discussion about HIV/AIDS

In evaluating the national response, the **Namibia** NHDR delineates the national plan for a multisectoral, decentralized programme, which has been accompanied by major institutional restructuring efforts to promote response strategies within government structures. Similar plans have been developed in **Burkina Faso** and **Cambodia**. The Namibia NHDR also outlines sector-based responses, including involvement of the media, NGOs and the private sector. The **South Africa**

NHDR describes the process leading to the National Plan launched as a result of a national conference with broad participation from government, NGOs and the private sector. The **Botswana** NHDR tracks historical development of response strategies across three stages: blood screening; IEC programmes; and expansion to a more comprehensive response addressing structural determinants.

Recommendations are key features of NHDRs that also help to strengthen the clarity of policy messages. The Botswana NHDR calls for action on three levels: prevention, treatment and care, and development. Concise policy recommendations are developed for each level of intervention covering both behavioural and structural determinants of the epidemic. It is especially notable that the recommendations successfully urged provision of new drug therapies.

The **Eastern Europe and CIS** report calls for a rebalancing of social priorities to allow for implementation of human rights principles, and emphasizes that injecting drug use and sex work must be viewed through a public health lens to better respond to HIV/AIDS. The report also strongly urges multisectoral action, rather than a solely health sector focus.

The **South Asia** report calls for anti-discrimination legislation, including in the areas of employment and access to private health care. The South Africa NHDR advocates improved coordination and communication between government and social movements; reaffirmation of participatory approaches; greater efforts to halt discrimination; social, economic, and political empowerment of women; attacking poverty; filling research gaps; and involvement of every South African in response efforts.

The Burkina Faso report touches on issues such as alleviating poverty and gender discrimination, and strengthening legal frameworks and multisectoral cooperation. The following issues and aspects, however, deserve more attention in NHDRs: participation; evaluation of poverty reduction measures; enabling access to ARV treatment; clarity of policy messages; and achieving UNGASS and MDG targets.

Learning from experience

More than 20 years have passed since the first HIV diagnosis, and a wealth of experience has been accumulated on how to effectively challenge the epidemic. Responses therefore need not start from scratch, but can draw on past successes and failures, both from the same context, and from other countries and communities. In addition to implementing innovative strategies, national responses can also benefit from and scale up successful local responses and programmes.

Adequate resources

National HIV/AIDS strategies and programmes need to be accompanied by the necessary financial and human resources. Although financial resources are critical, programmes can also draw on knowledge and other resources across a range of sectors. An example is the inclusion of HIV/AIDS in school curricula, which can be very effective at marginal cost.

While the HIV/AIDS response remains under-financed, countries are increasingly receiving funds through donors such as the Global Fund. It is important that national responses make effective use of new funds and address issues of human capacity needs for successful implementation, management and monitoring of programmes. At the same time, many developing countries face restrictive macroeconomic frameworks and other processes that can result in public sector cut backs. Shortages of personnel in the health and education sectors, compounded by losses due to HIV/AIDS, are a serious challenge to the national response. It is crucial that countries address human resource capacity and financial needs in relation to macroeconomic frameworks and public sector reforms.

THE WAY FORWARD: CONCRETE, POLICY-ORIENTED ADVOCACY MESSAGES

Rather than merely describing the situation in a country, an NHDR must develop analysis and concrete advocacy and policy messages relevant to the particular context that help to generate action. Below are some suggestions for the types of messages the NHDR should develop. For each, background has been provided earlier in these guidelines. The messages should be adapted to the individual context.

HIV/AIDS must be placed at the centre of national development agendas¹⁹

- ▼ HIV/AIDS cannot be addressed simply as a public health concern.

▼ HIV/AIDS needs to be integrated into national and sub-national development planning, PRSPs, sector plans, national budgets, and other national strategies and plans.

▼ Implementing the UNGASS Declaration of Commitment on HIV/AIDS must form an integrated part of the country's response to the epidemic.

▼ Resources should be channelled to responding to the epidemic, and where relevant, HIV/AIDS should be reflected in debt relief processes.

▼ Responding to HIV/AIDS should form the centre-piece of the capacity development dialogue.

▼ In implementing the MDGs and the Millennium Development Campaign, HIV/AIDS must be a key part of the agenda.

Committed leadership is needed at all levels of society

▼ Committed leadership is needed at all levels and in all sectors of society: leadership to generate effective action.

▼ Leadership requires political will and commitment at the highest levels that translates into action, open dialogue, resources, priorities and involvement of all sectors of society.

▼ Leadership needs to break the silence, mobilize entire nations, and promote open dialogue about sex, gender, inequality, norms and rights.

▼ Leadership must challenge harmful norms, and empower and respect the rights of people living with HIV/AIDS and women.

▼ Leadership should provide hope to generate action by individuals, communities and institutions.

▼ People living with HIV/AIDS and women must be active leaders at all levels of the response to HIV/AIDS.

▼ Community leadership and decision making is essential for addressing HIV/AIDS.

Multisectoral mobilization and action is key for an effective response

▼ Mobilization of all sectors of government (health, education, justice, labour, etc.) and all levels of government (central, provincial, district) is necessary, with every sector accountable for contributing to the response.

▼ Mobilization of civil society organizations, trade unions, the private sector, women's movements, youth groups, human rights activists, the media, farming

cooperatives, etc., in concerted action with the public sector, is important.

- ▼ National responses need to go beyond narrow health sector interventions.
- ▼ Prevention, treatment, care and support, vulnerability reduction and impact mitigation need to be carried out in synergy, not in competition.
- ▼ Successful prevention efforts require much more than the traditional focus on IEC programmes; condom distribution; treatment for sexually transmitted infections and safe blood programmes (the usual health sector-based interventions). Prevention can only be effective through social mobilization, facilitation of open dialogue, and addressing of factors that render people vulnerable to infection—requiring involvement of a wide range of actors, sectors and institutions.
- ▼ Multisectoral action requires comprehensive national strategic HIV/AIDS plans that reflect UNGASS commitments.
- ▼ Workplace HIV/AIDS programmes are an important element of the HIV/AIDS response.

A decentralized approach is necessary

- ▼ Recognizing that communities lead the way, strategies need to grow out of and respond to community needs.
- ▼ District level authorities must be empowered to work hand in hand with community groups.
- ▼ Resources, both fiscal and other types, need to reach the community level.
- ▼ Community voices must be brought into the national response.

More and better allocated resources

- ▼ More resources need to be mobilized from all sources to sustain the response to the epidemic. Sources include national budgets, official development assistance, debt relief, private foundations, corporations, international organizations, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and other donors.
- ▼ Available resources need to be better allocated in accordance with a multisector response for prevention, care, support and treatment. Resources are also needed in non-health sectors, and, even more importantly, for community-based mobilization and action.

Gender equality is key for challenging the spread and impact of the epidemic

- ▼ The response must be sensitive to the underlying gender dimension, as gender inequality has proven to be a key factor in fuelling the epidemic.
- ▼ The response must empower women and girls, and address their particular vulnerability and the disproportionate burden they carry for care and support.
- ▼ Unequal economic, legal and social rights, and inequitable access to treatment, care and support for women must be challenged.
- ▼ Men should be encouraged to share the responsibilities of providing care and support for people living with HIV/AIDS and affected families.
- ▼ Addressing gender dynamics and power relations requires focusing on men as well as women.
- ▼ Women must play a leading role in the response.

Human rights forms the basis for an effective response

- ▼ Human rights form the normative framework for the entire response to the epidemic.
- ▼ Human rights are both a legal and ‘social’ issue. Legal frameworks need to be amended to promote human rights, and human rights are instrumental in individuals’ daily lives.
- ▼ Realizing human rights is both imperative in itself and instrumental in reversing the epidemic.
- ▼ Respecting human rights leads to an enabling environment for an open dialogue—facilitating contributions of people living with HIV/AIDS to the response; helping to challenge stigma and discrimination that fuel the epidemic; and protecting women, people living with HIV and vulnerable groups.

National capacity drives the national response

- ▼ Sustained results will depend on national capacity and ownership across all sectors and levels.
- ▼ Sustained results emerge from country-led strategic planning through consultation and multisectoral action, as opposed to fragmented donor-driven projects.
- ▼ National processes must also bring in community voices.

GETTING THE MESSAGE ACROSS: SOME PRACTICAL HINTS FOR WRITING AN NHDR

The process of preparing an NHDR should involve consultation with and participation of a broad range of national partners across sectors, including government, NGOs and CSOs, people living with HIV/AIDS, women's groups, academics and UN agencies. Broad participation helps to ensure that relevant issues are addressed, and that there is greater national buy-in of the report's analysis, findings and recommendations. It also helps in enlarging the number of advocates for the report who can carry key messages and recommendations to policy makers, the media and the public. Most importantly, broad consultation and participation will help to translate the recommendations into action and support implementation of the response.

NHDRs have several audiences, including policy makers, civil society actors, multilateral agencies and the media. Some are already familiar with much of the information contained in the reports, while others are only beginning to grapple with these issues. A report needs to speak to both of these target groups. The report should be analytical, rather than just descriptive, and the language needs to be clear and concise, and avoid unnecessary repetition. The structure must be easy to navigate.

BOX 25: Preparing Ukraine's report²⁰

(1) Expert drafts expanded outline; (2) Outline discussed with national partners and within the UN Theme Group on HIV/AIDS; (3) Experts and institutions contracted to collect information and data, and prepare first draft; (4) Substantive editor reviewed the document and proposed second draft; (5) Report findings and suggested policy options discussed through informal consultations with national partners and presented to the UN Theme Group, with special emphasis on policy messages that were agreed with key partners; (6) Report launched with national partners—government and civil society—and media coverage.

NHDRs can play an important role in strengthening or generating national responses and highlighting success stories. Reports can use boxes or in other ways highlight experiences, for example from NGOs, the public sector, the private sector, development actors, communities and people living with HIV/AIDS. Reports can also look to other countries to show examples of successful responses. A good quote can get the message across powerfully, as well as provide the reader with insight into key concerns. Issue boxes, which many NHDRs already use, can be useful for drawing attention to certain topics, in addition to charts, graphs and tables. Finally, the lay-out and design of the report needs to engage the reader's interest. Form and presentation, not just content, are an important part of how the message of the report will be received.

NOTES

¹ UNAIDS (2004b).

² Guatemala has devoted sections of two NHDRs to HIV/AIDS, and Ukraine produced a concise special edition NHDR on HIV/AIDS in addition to the 2003 Ukraine NHDR.

³ UNAIDS (2004a).

⁴ By the end of 2004, the Global Fund had approved US \$3.1 billion in grants over two years to 127 countries; 56 per cent of grants funded HIV/AIDS programmes.

⁵ ILO (2001).

⁶ UNDP (2005).

⁷ Inter-Agency Standing Committee (2004).

⁸ UNAIDS, UNIFEM and UNFPA (2004).

⁹ UNAIDS (2004b).

¹⁰ UN (2001).

¹¹ Cambodia Ministry of Planning and UNDP (2001).

¹² OHCHR and UNAIDS (1998).

¹³ UNDP (2000a).

¹⁴ UNAIDS/IPU (1999).

¹⁵ Ibid.

¹⁶ Approved by UNAIDS in May 2002.

¹⁷ UNAIDS (2000).

¹⁸ UNAIDS (2002).

¹⁹ This can be a key overarching message for the NHDR.

²⁰ Contribution from Natalya Gordienko, Bratislava Regional Centre, to discussion on HIV/AIDS and NHDR Knowledge Networks.

UNDP's Response to HIV/AIDS

UNDP, as a cosponsor of UNAIDS, has a specific and well-defined contribution to the overall response of the United Nations system and in helping countries implement the UNGASS Declaration of Commitment. Distinct from the roles of other UNAIDS cosponsors, UNDP focuses on actions aimed at creating an enabling policy, legislative and resource environment essential for effective development planning, and for a truly multisectoral response to the epidemic. UNDP's Strategy on HIV/AIDS focuses on three types of services or service lines that are complementary and intertwined:

1. Promoting leadership at all levels, and developing the capacity of governments, civil society, development

partners, communities and individuals to effectively respond to the epidemic;

2. Strengthening development planning and systems to comprehensively address HIV/AIDS at national, district and community levels;

3. Generating a society-wide response that is gender-sensitive and respectful of the rights of people living with HIV/AIDS through advocacy and communication.

The table below illustrates sample outcomes and outputs for each of UNDP's service lines.

TABLE 6: UNDP's service lines on HIV/AIDS

Service lines	Sample outcomes and outputs
<p>Leadership and capacity development to address HIV/AIDS: UNDP provides support for national HIV/AIDS strategies that mobilize social and political leadership and action across all sectors. These strategies involve the promotion of a deep transformation of norms, values and practices, guided by the principles of participation, gender equality and human rights. UNDP also assists governments, community organizations, civil society and the private sector to develop capacity to address the underlying causes of the epidemic, and strengthens the capacity of communities for action, social mobilization and change.</p> <p><i>Core results</i></p> <p>Multi-stakeholder leadership capacity developed at individual, institutional and societal levels that generates breakthrough responses for reversing the course of the epidemic.</p> <p>Individual and community responses to the epidemic developed addressing attitudes and practices that influence the spread of the epidemic.</p>	<p>Multi-stakeholder leadership capacity developed</p> <p>Leadership capacities of networks and organizations (including for people living with HIV/AIDS and CSOs) developed</p> <p>Leadership coalitions for transformative development established and supported</p> <p>CBOs and CSOs supporting community responses</p> <p>Community reflection and actions to address HIV/AIDS</p> <p>Community support for care and treatment</p> <p>Deeper understanding of factors influencing HIV/AIDS</p> <p>Underlying causes fuelling the epidemic addressed</p> <p>HIV/AIDS workplace programmes for UNDP staff developed and implemented</p>

Service lines

Development planning, implementation and HIV/AIDS responses:

UNDP promotes national development planning processes as multisectoral and multi-level engagements by governments, the United Nations and other partners. This involves the mainstreaming of HIV/AIDS into national development planning instruments, including national development plans and budgets, the PRSP process, HIPC and other debt processes, UN Development Assistance Frameworks (UNDAFs), country programmes and sectoral studies.

Core results

Broad-based, multisectoral and multilevel response generated, integrating HIV/AIDS into national development plans, and mainstreaming HIV/AIDS into key sectors and ministries.

Individual, institutional and societal capacities developed to effectively respond to the epidemic in crisis countries, high-prevalence countries, small island states and countries with other special circumstances.

Advocacy and communication to address

HIV/AIDS: UNDP uses advocacy and communication to promote a deeper understanding of the epidemic, reduce its impact and reverse its spread. Areas of support include: communication strategies to address stigma, discrimination and gender relations that render women and girls vulnerable to infection; advocacy for legal reforms; policy dialogue on prevention and impact mitigation; and formulation of anti-discrimination legislation for people living with HIV/AIDS.

Core results

Enabling environment developed to achieve UNGASS goals and MDGs, addressing human rights, gender equality, and issues of vulnerability and silence that fuel the epidemic.

Advocacy and communications strategies created that develop a deeper understanding of the epidemic and its underlying causes, and address issues of vulnerability, stigma and discrimination.

Rights of people living with HIV/AIDS and vulnerable groups protected and promoted.

Sample outcomes and outputs

HIV/AIDS mainstreamed into development planning instruments (national development plans and budgets, poverty reduction strategies/PRSPs, expenditure frameworks, and HIPC and other debt processes), Common Country Assessments (CCA)/UNDAFs and country programmes

HIV/AIDS mainstreamed into line ministries and sectoral policy studies

National AIDS councils strengthened

Multisectoral HIV/AIDS responses planned and implemented at national, sub-national and district levels

HIV/AIDS aspects of the Convention on the Elimination of All Forms of Discrimination Against Women implemented

HIV/AIDS strategy developed in emergency settings and response generated

Strategies addressing the loss of work force due to HIV/AIDS formulated

Funds mobilized and allocated

ARV therapies made widely available

The Resident Coordinator system supported to implement CCA/UNDAF and UN Implementation Support Plans

National and regional human development reports with an HIV/AIDS focus prepared

Multi-stakeholder national policy dialogues to achieve UNGASS goals and create an enabling environment promoted to address prevention, treatment and care, socio-economic impact mitigation, mobile and migrant populations, and reducing vulnerability and vulnerable groups

Round tables on resource mobilization and high-level seminars on HIV/AIDS undertaken

Legal reforms and formulation of anti-discrimination legislation for people living with HIV/AIDS and gender equality

Communication strategies formulated to promote gender equality, and address gender dimensions of HIV/AIDS, and stigma and discrimination against people living with HIV/AIDS

Media and artists energized to change HIV/AIDS discourse

Acronyms

ARV	Antiretroviral
AIDS	Acquired immune deficiency syndrome
BDP	Bureau for Development Policy
CBO	Community-based organization
CCA	Common Country Assessment
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CSO	Civil society organization
GDI	Gender-related development index
GEM	Gender empowerment measure
HDI	Human development index
HIPC	Debt Initiative for Highly Indebted Poor Countries
HIV	Human immunodeficiency virus
HPI	Human poverty index
IEC	Information, education and communication
ILO	International Labour Organization
MDG	Millennium Development Goal
NGO	Non-governmental organization
NHDR	National human development report
OHCHR	Office of the High Commissioner for Human Rights
PRSP	Poverty Reduction Strategy Paper
SADC	Southern African Development Community
UNAIDS	UN Joint Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	UN Development Programme
UNGASS	UN General Assembly Special Session on HIV/AIDS

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This guidance note draws upon experiences and practices for addressing HIV/AIDS and human development issues based on a review of over 20 National Human Development Reports (NHDRs). The paper explores the linkages between HIV/AIDS and human development, and offers a theoretical background and practical guidance to assist NHDR Teams and UNDP Country Offices in the challenge of addressing HIV/AIDS within the framework of the human development conceptual approach.