World Vision

False Economies

Why AIDS-Affected Countries Are a Special Case for Action

Edited by Kelly Currah and Alan Whaites

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Executive Summary

There are more than three million children living with HIV/AIDS and are more than 14 million children under 15 who have lost one or both parents to HIV/AIDS—12 million of them live in Africa. By 2010, 42 million people will live with HIV/AIDS, with over 20 million children orphaned by AIDS under the age of 15.

Despite welcome announcements of substantial increases in commitments from the U.S., the investment of the rich world in the fight against AIDS will remain inadequate unless further funds are forthcoming from states of the Organisation for Economic Co-Operation and Development (OECD). This report shows that for the equivalent of only a few days' military spending, the world's richest states could drastically change the future for AIDS-affected countries. Resources are not enough, however. A new category of AIDS-Affected Countries should be created, granting substantial relaxations in international conditionality requirements.

This report points to an insidious aspect of the crisis; donor rhetoric is to date unmatched by donor commitment. World Vision research has shown that this lack of commitment is sentencing AIDS-affected countries to a stalling of development that will linger long after rates of infection have peaked.

Chapter One assesses the inclusion of effective strategies to combat HIV/AIDS within the World Bank/International Monetary Fund (IMF) conditionality instrument of Poverty Reduction Strategy Papers (PRSPs). The paper shows that countries such as Mozambique, Rwanda and Zambia are struggling to combine the pressure to be ambitious in the drafting of PRSPs with the restraints imposed by inadequate funding support.

Chapter Two uses a country case study of Malawi to examine the effect on government policy options of the HIV/AIDS crisis. The chapter looks particularly at the ways in which conditionality hinders the task of implementing effective HIV/AIDS policies. Conditionality on the spending of AIDS funds from external donors ensures that Malawi is limited in its ability to invest in the treatment of people living with AIDS or to assist those left behind by the disease. Donors prefer that their money go to prevention. Chapter Two also points to the negative role played by the imposition of cash budgets by the IMF.

Chapter Three focuses on the long-term development crisis that has been created by the inaction to date. The chapter concentrates on the situation of the millions of children categorised as "orphans and other vulnerable children" (OVCs). By focusing on education and, to a lesser degree, health and nutrition, the chapter offers a hopeful perspective on what can be done—with the most basic interventions being possible for as little as US$200 per annum.

The World Bank and IMF have recognised in the past that some countries merit a more relaxed approach to conditionality, particularly those countries emerging from conflict. This report suggests that AIDS-affected countries are a special case, deserving a more relaxed conditionality framework in order to enable national governments to focus more effectively on the fight against AIDS.

The international community urgently needs to

- Create a category of AIDS-Affected Countries that entails a more flexible approach to development funding and conditionality.
- Substantially increase resources dedicated to the fight against AIDS, including US$3.5 billion allocated for the task of prevention and at least a £2.6 billion annual commitment to the needs of OVC, which is directly targeted to key areas such as health and education.

- Ensure that all PRSPs from AIDS-affected countries adequately address the issue of HIV/AIDS, including as a cross-cutting theme, and that assistance is provided for national capacity to implement the strategy paper. As part of a comprehensive approach to HIV/AIDS, PRSPs should include attention to the following areas:
  - Strengthening care for orphans and vulnerable children
  - Reducing the vulnerability of girls and women to HIV
  - Increasing access to treatment and care
- Designate all significantly AIDS-affected countries as a special category meriting a relaxed conditionality framework and a more focused policy-reform environment, including more flexible approaches to fiscal discipline.

Introduction

Aids-Affected Countries: A Special Case for Action

There are currently over three million children living with HIV/AIDS and more than 14 million children under 15 who have lost one or both parents to AIDS and AIDS-related illnesses. Twelve million of these orphans live in Africa. It is now estimated that 42 million people live with HIV/AIDS and that by 2010 over 20 million children under the age of 15 will be orphaned by AIDS.

This deadly pandemic is taking its toll, not just on families and communities, but also on whole nations and regions. Ninety per cent of those with HIV/AIDS live in less-developed and transitional countries, with little access to the drugs they need at prices they can afford.

This report argues that the world must act urgently to address the needs of countries severely affected by AIDS. The impact of AIDS on future generations, particularly orphans and vulnerable children (OVC), represents a major development challenge. Without action, AIDS will be a development disaster long after infection rates have peaked.

The evidence in the three papers presented below suggests that AIDS-affected countries are seriously hampered in tackling the long-term consequences of AIDS by existing international conditionality and development finance frameworks. Greater progress is dependent on those countries being able to operate in a more supportive policy environment. The governments involved must also firmly grasp the policy challenges brought by AIDS, not only by prioritising investment in health and social care, but also by ensuring that funds are well spent. This report suggests that progress in these areas can be achieved by the creation of a new category of AIDS-Affected Countries with concomitant flexibility in conditionality and increased levels of development finance.

AIDS: A Development Disaster

In Zambia, one in five adults is infected with HIV/AIDS; the average life span has fallen to 33 years. In Malawi, HIV/AIDS has hit the country's most productive citizens, crippling the economy and depriving schools of teachers, hospitals of doctors and nurses, and business of workers. Everyone suffers as a result of AIDS.

OECD (Organisation for Economic Co-Operation and Development) nations and the wider international community have frequently pronounced their horror at the human and developmental disaster being wrought by AIDS. More than a decade after the disease first began to have a serious impact, donor countries agreed to the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria, although since its creation they have failed to fund it adequately.

Despite welcome announcements of substantial increases in commitments from the U.S., the investment of the rich world in the fight against AIDS will remain inadequate unless further funds are forthcoming from OECD states. World Vision estimates from available OECD donor accounts that, depending on the expenditure conditionalities of the new U.S. funding, the total amount of bilateral support for the fight against AIDS will range from US$3–4 billion per year in the five years from 2004 onwards. To put this into perspective, this equals two days' spending on the military by the world's 20 biggest arms buyers, and only three days' combined military spending for the U.S., Japan, the U.K. and Germany.[1] Sadly, priorities for human security seem skewed away from the very real threat posed by HIV/AIDS.

Even if this US$3–4 billion were devoted just to those with AIDS, this would amount to less than US$100 per infected person. Yet, in reality, priority areas such as prevention, care of those affected but not infected and investment in new health infrastructure must

also be funded. For example, the UN agency UNAIDS estimates that global expenditure on prevention will fall US$3.5 billion short of the amount actually needed by 2005.[2] Yet, with adequate expenditure, the same report estimates that two thirds of the projected 45 million new infections this decade could be prevented.

The Cost of Failure

Clearly, failures of investment mean that the available funding from donor countries will not in itself allow AIDS-affected countries to tackle the urgent problems they face. This report, however, points to a more insidious side of the crisis. World Vision research has shown that the lack of commitment of official donors is sentencing AID-affected countries to a stalling of development that will linger long after rates of infection have peaked.

Such failure to invest now in the generation most impacted by AIDS means that the productive human resources essential to economic and social progress are being badly eroded. Illiteracy and poor nutrition are on the rise; morbidity, mortality and other human development indicators are falling fast. The potential for the OVC of the AIDS crisis to become a lost generation for development is high.

World Vision has seen this phenomenon close-up on the ground. World Vision works with thousands of children orphaned by AIDS or affected by its impact on their communities and families. This combined group of OVC globally numbers into the many millions. The long-term economic problems created by AIDS are made real in the lives of these AIDS-affected families and OVC. This report therefore focuses on some of the economic issues that have become contributory factors in the AIDS crisis.

First and foremost among these problems has been unwillingness on the part of the international community to address AIDS as a development crisis. The enormous number of development plans for Africa—from the G8's Action Plan for Africa to the New Plan for African Development—all underline the role of economic growth in delivering development, yet they fail to account for and address the economic consequences of HIV/AIDS.

A recent paper produced jointly by International Monetary Fund (IMF) staff and the London School of Economics argues that the impact of HIV/AIDS on a country is not accurately captured in the traditional statistics: "Our results show that HIV/AIDS does have a catastrophic welfare impact that dwarfs the economic assessments based on per capita income'.[3] In other words, gross domestic product (GDP) alone cannot accurately account for the impact of the disease on a country.[4]

While donor countries remain oblivious to the links between the prevalence of HIV/AIDS and economic performance, some parts of industry has taken on the problem. Increasingly, a few responsible large corporations are supplying their employees with needed HIV/AIDS drugs to ensure production and retention of skills. The international community needs also to recognise this direct link.

For AIDS-affected countries, the long-term dangers faced as a result of the HIV/AIDS disaster are compounded by an international "conditionality" framework. "Conditionality"—the conditions attached to assistance from rich countries and institutions (whether that be aid, loans or debt relief)—is still based largely on a pre-AIDS worldview.

As the papers included in this report show, there is an urgent need for reform of conditionality to bring it into line with the new realities facing AIDS-affected countries. This report also proposes that such reform should be based on existing models, particularly those currently in use for least developed and post-conflict countries.

This reform and the availability of extra funding are, however, not enough. Governments in AIDS Affected Countries must also invest more in health and related areas of social care, such as the education of OVC. Allocating additional funds to this work can also only be effective if Public Expenditure Management (PEM) systems are adequate to ensure that money reaches the front-line services combating AIDS.

In this report three chapters highlight the need for such change by reviewing the current international environment in which countries must try to battle

against AIDS and by examining the long-term development cost of failure.

Chapter One assesses the inclusion of effective strategies to combat HIV/AIDS within Poverty Reduction Strategy Papers (PRSPs). These strategy papers represent a new form of conditionality introduced by the World Bank and IMF in 1999. PRSPs are intended to provide comprehensive and nationally-owned strategies to address poverty at the national level. Although each PRSP is, in theory, drafted by the national government concerned, its final approval rests with the Bank and Fund in Washington, and their guidance has heavily influenced the content of the strategies.

PRSPs are now required of all countries accessing concessional lending from the World Bank and to date, over 20 have been approved. PRSPs have also become a co-ordinating framework for other development actors, particularly bilateral donors. The pivotal role of these new strategies within the framework of international assistance therefore gives great importance to the degree to which they adequately address issues relating to HIV/AIDS.

Chapter One uses country case studies to review HIV/AIDS inclusion in PRSPs, and discusses the strategies being proposed. The paper shows that countries such as Mozambique, Rwanda and Zambia are struggling to combine the pressure to be ambitious in the drafting of PRSPs with the restraints imposed by inadequate funding support. Equally concerning in most PRSPs, HIV/AIDS is not sufficiently addressed as a cross-cutting theme that needs to be dealt with in all areas of policy (for example, rural development) but instead as a health/social welfare problem.

The underlying constraint on governments in adequately bringing PRSPs to bear as a weapon in the fight against AIDS is *capacity*. Lack of staff and resources have prevented governments from establishing the infrastructure they need to adequately implement a national plan. Even critically important tasks, such as the decentralisation of AIDS strategies, are hindered by the failure of resources.

Chapter Two uses a country case study of Malawi to examine the impact on government policy options imposed by the HIV/AIDS crisis. To date, no systematic and comprehensive attempt has been made to establish a clear link between HIV/AIDS and economic performance. Sadly, this includes a failure to adequately integrate the impact of AIDS within the annual country assessments undertaken by the IMF. These assessments are crucial tools used by those who set international conditionality as the basis for evaluating economic performance.

The paper looks particularly at the ways in which conditionality hinders the task of implementing effective HIV/AIDS policies. This includes the problem of implementing conditionality on the restoration of fiscal discipline in the context of one of the highest HIV/AIDS infection rates in the region. Malawi typifies many of the challenges facing countries most affected by HIV/AIDS. With over 60% of the population living below the poverty line, income per head has actually fallen over the last decade. In the same decade, HIV/AIDS has driven life expectancy back to the levels of the 1950s (only 39 years).

In Malawi, HIV/AIDS has become the leading cause of death in the 20–49 year age group—the most productive part of the population. This has created both an economic crisis of productivity as well as a growing challenge of dependency, as the numbers of children orphaned by AIDS increases. For any government, this would represent an enormous problem of long-term strategy and economic management. In Malawi, health expenditures have doubled as a proportion of the national budget, yet the country faces significant constraints as it seeks to redress the crisis of AIDS.

Conditionality on the spending of AIDS funds from external donors ensures that Malawi is limited in its ability to invest in the treatment of people living with AIDS. Donors prefer that their money go to prevention. As Chapter Three shows, lack of treatment for parents greatly exacerbates the emerging problem of the lost generation of orphans and other affected children. Lack of treatment also ensures that people living with AIDS can be economically active for shorter periods, accelerating the speed with which their families are thrust into poverty.

Using interviews and information available from international financial institutions, Chapter Two points to the negative role played by the imposition of cash budgets by the IMF: "The enforcement of a cash budget could unduly penalise complying ministries and produce undesirable results. In its original form, this fiscal instrument is blunt and uneven because it is not targeted to specific expenditure pressure points." The paper concludes that if an effective strategy against AIDS is to be pursued in Malawi, current conditionality will need to be significantly relaxed.

Chapter Three focuses on the growing long-term development crisis that has inevitably been created by the lack of international action. The chapter concentrates on the situation of the estimated 14 million children categorised by the narrowest definitions as OVC. These children represent an integral part of the future capacity for development of their countries. Their education, health and social development will be important determinants of future economic growth.

At present, however, the chapter finds that OVC remain inadequately treated by the global response to AIDS. Predominantly cared for within extended families, many are pushed into poverty by the deaths or illness of parents and guardians. Consequent failure to attend school has become a very visible sign of the OVC problem, as have growing numbers of street children in AIDS-affected countries.

The chapter looks at existing interventions undertaken to assist OVC, particularly by civil society organisations. It finds that effective programmes can be undertaken to help ensure that OVC reach their potential. By focusing on education and, to a lesser degree, health and nutrition, the chapter offers a hopeful perspective on what can be done.

By aggregating available figures from civil society organisations and through a survey of World Vision partners, the chapter is also able to estimate the costs of providing education and nutrition for OVC. The results suggest that these essential investments in the future human capital of AIDS-affected countries can be provided at relatively low cost—with the most basic interventions being possible for as little as US$200 per annum.

Using a crude aggregation of figures it is possible therefore to suggest that current numbers of OVC could be substantially helped for the equivalent of one day's military expenditure by the world's top 20 spenders. It is difficult not to conclude that an investment in the health and education of OVC will make a considerably greater contribution both to their own countries and to the international community, than alternative forms of expenditure.

A Special Case for Action

Committing of Resources

This report underlines the fact that resources remain a vital problem in the fight against AIDS. Until the international community is willing to invest seriously in the addressing of AIDS-related problems, the disease will continue to represent a developmental and human disaster for the countries affected. A substantial increase in expenditure must include resources both for the treatment of those infected and also for the development of national capacity.

This report also shows, however, that resources alone are not enough. The international community must also recognise that AIDS-affected countries represent a special case in relation to economic conditionality. As Chapter Two highlights, the challenges and problems imposed by AIDS mean that the conditionalities that have become routine over the last two decades now simply combine to hinder governments in implementing effective policies.

A New Category: AIDS-Affected Countries

The World Bank and IMF have recognised in the past that some countries merit a more relaxed approach to conditionality, particularly those emerging from conflict. In 2002, the World Bank also proposed categorising some countries as Low Income Countries Under Stress (LICUS) based on chronically poor performance in implementing reform (often conflict-related). The UN has established a similar category for the Least Developed Countries (LDC). A new classification for AIDS should replicate the Heavily Indebted Poor Country (HIPC) classification of countries, wherein as soon as a country matches the cri-

teria of the status, a range of policies automatically take effect.

A new AIDS category could provide the countries involved with breathing space in adhering to the rigid and extensive conditionality constraints that many developing countries find imposed on their domestic management. LICUS countries, for example, are encouraged to focus on only one major area of economic reform, substantially reducing the capacity burden imposed on under-resourced governments.

The LDC category is an institutionalised category; the criteria for eligibility are based on a simple evaluation of the country's development. Assessment as "low-income" rests not simply on a three-year average estimate of GDP, but also a human resources weakness criterion (based on nutrition, health, education and literacy) and an economic vulnerability criterion (based on instability in agriculture and exports). Entry into the Aids-Affected Country (AAC) category should be based on equally simple criteria: the prevalence of HIV/AIDS in a country, the current and future impact on society (including the existing and forecast impact on life expectancy) and the economy, and the vulnerability of the populace to economic hardship.

This report suggests that like LICUS countries, AACs need a more relaxed conditionality framework in order to enable national governments to focus more effectively on the fight against AIDS. In such countries, economic development will be recognised as depending on an improvement of the social condition of the populace through a reduction in HIV/AIDS occurrence.

As in the LICUS category, the AAC category will include a range of eligible countries, from Malawi to South Africa—where despite reasonable wealth and good governance, the high incidence of HIV/AIDS threatens the future wealth and welfare of the country should the epidemic not be addressed as soon as possible.

As soon as a country is classified as an AIDS Affected Country, five policy changes should immediately apply.

- *Cash budget flexibility:* Countries in this category should be allowed to expand their budget deficits beyond the current 1.5% of GDP preferred by international financial institutions, at least over the medium-term. Budget deficits should be allowed to go to up to 3% of GDP, as long as the increased expenditure is directed towards health and social spending associated with combating HIV/AIDS.
- *Economic Reforms:* Countries mobilising their resources to combat HIV/AIDS must be allowed to focus on a limited number of conditionalities. LICUS countries are allowed a highly focused reform agenda that "would consist of two or three reforms that are important in economic terms and likely to result in a rapid and substantial payoff, but that are also feasible in socio-political terms, tending to unite a broad coalition for reform."[5] These countries cannot take on the fight against the disease while coping with a wide array of conditionalities. Instead, for AACs, conditionalities should be limited to government capacity-building and improved efficiency in health and social policies.
- *Trade Access:* Like LDCs, AACs should have the "everything but arms" tariff-free entry of their goods into European Union markets and similar concessions should be made by other developed states. Continuing market restrictions on countries battling against HIV/AIDS hampers government effectiveness in battling the disease and adds to the burden of small producers.
- *Trade-Related Aspects of Intellectual Property Rights:* Working in conjunction with the World Trade Organisation, AACs should be allowed access to drugs for HIV/AIDS and related diseases as a matter of urgency. Whether or not the AAC has a generic pharmaceutical industry, it should be allowed to import the cheapest and most effective drugs available.
- *Funding:* Finally, AACs should be prioritised for increased overseas development assistance. If increased government expenditures in AIDS-affected countries are to be sustainable, without

continuing budget deficits that will become unmanageable in the medium/long-term, substantial growth in international AIDS funding must occur. Aid should be co-ordinated by donor countries, and it should be focused on the areas most important to combating the disease and the consequences of the disease.

Without a concentrated effort by all sectors of government (not just health ministries) to secure the future of the human capital of their countries, issues such as trade liberalisation risk becoming moot. The creation of a new AAC category should also not detract from the continuing priority that must be given to AIDS prevention in those countries that currently do not have a high prevalence rate for infections.

The World Bank, in consultation with international organisations, the donor community, affected governments and NGOs, must immediately undertake the necessary research to determine the criteria for AAC designation and the possible range of policies to give such countries the freedom to fight HIV/AIDS. A task force on AACs should be established within the next year and the category be created as soon as possible.

Conclusion

As a Christian organisation, World Vision believes that action to safeguard human lives is always warranted, and no greater threat to human security currently exists than the danger posed by HIV/AIDS. Certainly the billions spent per day by richer nations on their militaries seem to be the product of skewed priorities in the face of the AIDS threat facing millions of children.

Can the world afford to have some 20 million orphans and vulnerable children reach adulthood without hope, education, adequate nutrition and, in many cases, without the care of adults?

The international community must engage in the fight against AIDS fully committed to the challenges that it brings. Such commitment will entail both expense and a willingness to be more flexible than in the past. Most urgently, the international community needs to

- Create a category of AIDS-Affected Countries that entails a more flexible approach to development funding and conditionality.
- Substantially increase resources dedicated to the fight against AIDS, including US$3.5 billion allocated for the task of prevention and at least a £2.6 billion annual commitment to the needs of OVC, which is directly targeted to key areas such as health and education.
- Ensure that all PRSPs from AIDS-affected countries adequately address the issue of HIV/AIDS, including as a cross-cutting theme, and that assistance is provided for national capacity to implement the strategy paper. As part of a comprehensive approach to HIV/AIDS PRSPs should include attention to the following areas:
    - Strengthening care for orphans and vulnerable children
    - Reducing the vulnerability of girls and women to HIV
    - Increasing access to treatment and care
- Designate all significantly AIDS-affected countries as a special category meriting a relaxed conditionality framework and a more focused policy-reform environment, including more flexible approaches to fiscal discipline.

HIV/AIDs Inclusion in the Poverty Reduction Strategy Paper Process

Joe W. Muwonge

Introduction

The World Bank and International Monetary Fund (IMF) have indicated that the use of Poverty Reduction Strategy Papers (PRSPs) signals a new approach to tackling the challenges of poverty alleviation and economic development among low-income countries. Launched in 1999, the PRSP replaced the old tripartite Policy Framework Paper (PFP) drawn up between the IMF, World Bank and a country's government for concessional loans. Both the IMF and World Bank are expected to align their respective lending programmes to a country's PRSP. This means that the country's Assistance Strategy and all loans and grants must be based on the PRSP. Major international donors appear to have acquiesced to the Bank-Fund model of development that is encapsulated in the PRSP.

The PRSP framework was originally conceived as a condition of the Heavily Indebted Poor Country (HIPC) Initiative. Countries seeking debt relief through the HIPC programme were required to prepare a PRSP to show how money freed from debt servicing would be used to alleviate poverty. Since then, however, PRSPs have enlarged in scope and have become the centre-piece for policy dialogue and negotiations in all countries that receive financing from the World Bank's International Development Association. The World Bank and IMF initially identified over 70 countries that require PRSPs. To date, 45 Interim PRSPs and 22 PRSPs have been completed and submitted to the World Bank Fund boards.

In theory, the PRSP is a document prepared by a country's government under supervision of Bank-Fund teams. The PRSP is expected to

- identify the incidence and causes of poverty
- explain who the poor are
- offer strategies for overcoming poverty, including policy and expenditure targets
- be locally generated and owned, developed through wide participatory dialogue, and focused both at the macro and micro policy-making levels
- encourage the accountability of governments to their own people and domestic constituencies rather than to external funders, so that the poor become active participants—not just passive recipients

Because of the important roles that the World Bank and Fund have in global policy-making and governance, PRSPs have a leveraging role beyond debt relief and concessional credits. They have become the key policy instruments through which the world's major donors relate with low-income countries. Without a Bank-Fund approved PRSP, a low-income country can be virtually cut off from international aid, trade and finance. The U.S., European Union and Organisation for Economic Co-Operation and Development (OECD) members have fully endorsed the PRSP framework and agreed to base their respective official aid to low-income countries on the guidelines provided within the respective country's PRSP.

The purpose of this paper is to examine the extent to which HIV/AIDS and related issues are being addressed in existing PRSPs; the challenges that exist; and recommendations for reflecting these issues firmly in the PRSP framework. This examination is based on monitoring of the PRSP process in four African countries: Mozambique, Rwanda, and Zambia.

Mozambique

Key Elements of the National Strategy for STD/HIV/AIDS

In 2000,

- Approximately 12.2% of the adult population was infected with HIV.
- The total caseload was 1.14 million infected, of whom 148,930 had full-blown AIDS.
- Approximately 160,000 deaths had occurred due to AIDS. There were 175,600 known orphans of AIDS and it was anticipated their number would exceed 926,000 by 2010. On average, 430 new cases of HIV were being registered each day.

The principal determinants of the epidemic in Mozambique were stated as

- macro-economic: poverty, unemployment, migration, illiteracy
- cultural: sexual taboos, traditions, low status of women causing powerlessness to negotiate sexual relationships
- behavioural: unsafe sex, and having multiple sexual partners

The following priority vulnerable groups were identified:

- students and young people not in school
- long distance truck drivers
- uneducated women
- miners and their wives
- sex workers and their clients
- police
- soldiers
- people infected with sexually transmitted diseases (STDs)
- street children
- orphans and people living with HIV/AIDS (PLHA)

Little was known about the full impact of the epidemic on the country in 2000. But educated guesses suggested HIV/AIDS was having a devastating effect on the following sectors: health, education, agriculture and transport. Geographically, the most devastated areas were and still are the economic corridor zones in the centre, south and north of the country. This includes the provinces of Tete, Manica and Sofala, where, in all three, the HIV prevalence rate exceeds 19%, and the southern province of Gaza, with a prevalence of 16%. All affected areas constitute the transport corridors linking Zambia, Zimbabwe, Malawi, and Swaziland to the sea, and then the rural areas from which most of the mine workers to South Africa are drawn. It should be pointed out that all countries neighbouring the zones of greatest infection in Mozambique have significantly higher HIV/AIDS prevalence rates than Mozambique's.

Given the situation portrayed above, Mozambique has responded to the pandemic by developing a national strategy. The strategy calls for a multi-sectoral approach to the fight against HIV/AIDS, guided by an Inter-Ministerial AIDS Commission and directed and co-ordinated by a National Programme for Combating STDs/AIDS (NPC STD/AIDS). The National Programme has a decentralised structure involving a main base in Maputo, and then three regional coordination bases in three large regions of the country: the southern, central and northern regions. The general objective of the NPC STD/AIDS is to prevent HIV infection and provide health care to PLHA and their households. The main goal over the period (2000–2002) was to provide good quality prevention activities for 3.31 million people who have casual sexual relationships; provide medical, psychological and social support to 1.3 million PLHA and 120,000 orphans; and extend coverage to the most vulnerable groups, initially in the corridor areas.

The NPC STD/AIDS is an arm of the Ministry of Health and oversees implementation of the medium-term plan in the fight against AIDS. Other ministries are also expected to play a role.

Development of the national strategy for the period 2000–2002 was based on the following principles:

- giving priority to combating AIDS and reducing absolute poverty
- prioritising concern for the human being
- ensuring the relevance of the national response by involving PLHA
- giving priority to the economic corridor zones in the centre, south and north of the country
- increasing coverage to vulnerable groups
- resolving the main problems that hinder implementation of the national response
- promoting concrete multi-sectoral implementation
- making ministries responsible for areas of activity falling within their ministries
- implementing new measures of management and co-ordination, and implementing concrete measures to finance the fight against AIDS and to ensure its sustainability

Strategic goals have been defined for every priority area. Each ministry takes responsibility for a vulnerable group falling within that specific ministry. Thus, major programme components for the Ministry of Health are the following: prevention of sexual transmission through diagnosing and treating STDs and promoting the use of condoms; prevention of transmission via blood; health care and social support for PLHA; and monitoring and surveillance. Major programme components of other ministries are as follows:

- Ministry for the Co-ordination of Environmental Action (MICOA): preventive programmes for 200 MICOA employees nation-wide, 200 dependent families in Costa do Sol and 250 families in Greater Maputo
- Ministry of Education: family life education to 15,000 teachers
- Ministry of the Interior: prevention programmes for 18,000 police, special police and border guards nation-wide
- Ministry of Defence: prevention programmes for 18,000 soldiers and 15,000 civilian dependents
- Ministry of Culture, Youth and Sport: Education for Reproductive Health programmes to 417,000 young people aged 10–24 in Maputo and Quelimane cities, and to 100,000 young people not in school
- Ministry for the Co-ordination of Social Action: community-based support programmes to reach 4000 AIDS orphans and 5000 street children, with a focus in Maputo, Cabo Delgado, Zambezia and Manica
- Ministry of Agriculture and Fisheries: prevention and awareness programmes for 106,000 rural women in selected districts nation-wide
- Ministry of Labour: addressing AIDS in the work place
- Ministry of Justice: addressing AIDS in the criminal justice system for 6,000 prisoners

Prevention efforts for the highly mobile populations would fall under a number of these ministries as well as the Ministry of Transport and Communications. Running parallel to government response would be community response spearheaded by non-governmental organisations (NGOs).

The co-ordinating bodies at the central level are the Inter-Ministerial Commission and the NPC STD/AIDS. The President of the NPC STD/AIDS is appointed by the President of the Republic and is also answerable to him.

The NPC STD/AIDS budget was estimated at US$40.5 million in 2002. This translates into an increase of US$8 million a year to US$13.5 million, with 64% of the budget going into essential activities as opposed to the current 20%. With this shift of emphasis, it was anticipated that the cost of reaching a person each year would be reduced from US$16 down to US$8.3 by 2002. Of the US$40.5 million, approximately US$19.69 million would go towards prevention, US$5.42 million to impact reduction (of which US$1.2 million is allotted to support for orphans), US$1.32 million to Advocacy, Information and Communication, US$2.04 million to

Research and Innovation, US$1.77 million to Training and Refreshment, and US$10.35 million to Management and Monitoring. Financing of the ministries' plans (particularly of those already involved in the integrated programs, such as the Ministry of Education and the Ministry for the Co-ordination of Social Action) would be obtained by including their HIV/AIDS inputs in the budgets of the respective programmes. In addition, there would be a common fund at the disposal of the National Committee for Combating AIDS, to be used as an alternative whenever donations are delayed.

Community response, which is on the increase, is co-ordinated through the activities of NGOs (as of 2000, out of the 58 HIV/AIDS programmes and projects, 29 were operated by national NGOs and associations, and nine by international NGOs.). The target groups are social groups such as young people, PLHA, teachers, and health workers.

Key Elements of the Mozambican PRSP

The PRSP in Mozambique is based on six priorities aimed at promoting human development and creating a favourable environment for rapid, inclusive, and broad-based growth. The fundamental areas of action are: (i) education, (ii) health, (iii) agriculture and rural development, (iv) basic infrastructure, (v) good governance, and (vi) macro-economic and financial management. These areas for actions are considered fundamental for reducing poverty and for stimulating growth. Their selection was based on the diagnosis of poverty determinants in Mozambique, and consultations with some civil society and the private sector.

The vision within the strategy emphasises the reduction of absolute poverty defined in terms of material need and lack of capacity and opportunities. A basic premise of the present strategy is that rapid, sustained, and broad-based growth is essential for the reduction of poverty. Therefore, the strategy incorporates policies and reforms to stimulate growth, as well as direct measures aimed at providing better opportunities for the poor. The target of 8% average annual growth will create conditions for the incidence of absolute poverty to be reduced from around 70% to less than 50% by 2010. The national poverty line was calculated at 2150 kilo cal per person per day, and real annual consumption was estimated at MT (*metical*)160,780 per year—the equivalent of US$170. Hence the country is among the poorest in the world.

According to one government survey, 69.4% of the 10.9 million Mozambicans live below the poverty line, and could be considered as living in absolute poverty. Poverty is significantly higher in rural areas, and regional differences in poverty are large. The central provinces are the poorest; Maputo stands out as the richest. Differences between the poor and non-poor are, however, quite small. Health and education are two related variables, and differences in these, especially regarding gender, are the most significant variables. Education efforts directed to women seem to be the most important avenue for reducing the poverty level. Economic infrastructure also has a large impact, as improvements in health and education are related to an increase in income levels.

On the basis of these conclusions, the poverty assessment pointed out the following six areas that should be the focus of the PRSP:

- increased investment in education
- sustained economic growth
- a sectoral pattern of growth favouring faster growth in the industrial services sector
- measures to raise agricultural productivity
- improved rural infrastructure
- reduction of fertility and dependency-load within households

Accordingly, the Mozambique government has stated the medium-term and long-term objectives to be poverty reduction. To achieve this, the government prepared a Plan of Action for the Reduction of Absolute Poverty. Several ministries under the leadership of the Ministry of Planning undertook the preparation. The goal was to reduce absolute poverty to 60% by 2004.

HIV/AIDS Coverage within the PRSP

Within the Mozambique PRSP, HIV/AIDS and related issues are provided for under Health, Education and Social Action. Although the country committed itself to a multi-sectoral approach in the HIV/AIDS National Strategic Plan, no mention of HIV/AIDS and related issues is made within the remaining ministries.

The main objectives for health include expanded and improved coverage of primary health care through special programmes for target groups such as women and children; a campaign to reverse the current growth of the HIV/AIDS epidemic; and greater effort in the fight against endemic diseases such as malaria, diarrhoea, TB and leprosy. The health sector is also recognised as playing a fundamental role in directly improving the well-being of the poor, while at the same time contributing to rapid economic growth by improving the quality of human capital. The principal measures to be undertaken to address the HIV/AIDS crisis include:

- Carry out essential and high-quality preventive measures, targeting the 2,310,000 people estimated to have sexual relations with irregular partners. These measure include treatment of STDs, counselling and voluntary testing, controlling blood transfusions and testing for syphilis.
- Set up and operate confidential counselling and voluntary testing centres in Maputo, Chimoio, Beira, Nampula, Tete and Quelimane. Establish and operate day care units in Maputo, Chimoio, Beira, Nampula, Tete and Quelimane.
- Carry out education and information campaigns on STD/HIV/AIDS, to include theatre shows for 3,900,000 people.
- Distribute condoms to 4,500,000 HIV-positive persons.
- Provide partner education to 1,250,000 vulnerable people.
- Ensure essential health care services—30,000 clinical treatments and home care —for 9,500 people living with HIV/AIDS, as well as their families.
- Ensure provision of psychological, medical and social care in all health centres in district headquarters along the corridors in the south, centre and north of the country.
- Ensure the availability of voluntary and confidential testing for 32,000 people with HIV/AIDS.

The main objective in education is stated as achieving universal primary education, while rapidly expanding secondary education and technical-vocational training. The programme also includes a commitment to combat HIV/AIDS through schools by

- including material on education and prevention of HIV/AIDS in the school curricula
- producing and disseminating informational material on HIV/AIDS for students and teachers
- undertaking an assessment of the impact of HIV/AIDS on the education sector and incorporating the results into educational planning

The main objective for the Ministry of Social Action is to ensure the protection of the most needy, defined later on as orphans, single mothers, the elderly, drug addicts and people with no source of income.

The budget disparities between sectors and provinces and between urban and rural are quite sharp in Mozambique. Coupled with the shortage of resources, some of the sectors are ending up with a situation where both the quality and quantity of programmes is much too curtailed. For example, looking at the budget distribution by sector (2000), the allocation was: Education: 15.4% of the national budget, Health: 14.4%, and Social Action: 0.71%. These figures were a significant improvement on the 1998 figures (Education: 7.9%, Health: 14.3%, Social Action: 0.33%).

With an HIV/AIDS prevalence rate of around 15%, the Health budget allocated only 11% to HIV/AIDS. Orphans and Vulnerable Children (OVC) are clearly not receiving the appropriate attention. The projected goals for the Ministry of Social Action would reach only 1.5% of registered OVC and 0.38% of the handicapped. HIV/AIDS is covered under Health

and Education, and within these sectors, focus is on prevention, with very little budget devoted to addressing the impact. Of the amount budgeted to combating HIV/AIDS (MT2,318.3 billion) in health and education, 80.7% (MT1,872.7 billion) is devoted to prevention, while addressing the impact is allocated only 19.2% (MT 446.1 billion).

In framing the PRSP, the government used the strategic plans of individual ministries and the guidelines it had developed for its own fight against poverty prior to the launch of the PRSP process. The PRSP that emerged was not the result of a coordinated discussion by all stakeholders. Rather, it is a compendium of various sector plans compiled together by the Ministry of Finance and Planning, aided by the World Bank and IMF, and within which poverty alleviation became the overriding issue.

None of the projects are currently developing activities that target soldiers, prisoners, and highly mobile populations such as long distance truck drivers, miners and migrant workers. Most community response is urban-based, especially in and around Maputo.

The participation of those that work directly with the vulnerable groups, including persons directly affected by HIV/AIDS, was minimal at best. Very few agencies were invited to provide input, and discussion was itself very limited, even among governmental agencies. There is no strong culture of consultation between government and civil society in Mozambique, and some NGOs lack a country-wide umbrella through which they can make their voice heard. Furthermore, there was a rush to get approval of the PRSP to trigger the flow of funds into the treasury. The country is 60% dependent on foreign budget support. At the time when the PRSP was being developed, a major flood emergency had just taken place, and there was urgency to secure funds for the recovery effort.

Although the PRSP contains a discussion on HIV/AIDS, the goals of the UN General Assembly Special Session, which call for a multi-sectoral approach to HIV/AIDS, are not clearly reflected in this strategy. Priority areas within the PRSP are education, health, governance, infrastructure, agriculture and macro-economic stability. Although the PRSP was published in April 2001, in reality work had started much earlier. The National Strategic Plan, which set the framework for ministries to develop their strategic plans, was designed in 1996 and then approved by government in 1999. It is acknowledged that this strategy is now dated. The Mozambique PRSP is expected to be up for review within 2003.

Rwanda

Key Elements of the National Strategic Plan for HIV/AIDS

According to UNAIDS, the total number of adults and children infected with HIV/AIDS in Rwanda in 2001 was 500,000, out of a national population of 7.4 million. Of these, 430,000 were considered adults (15–49 years old) and 65,000 were children (aged 0–14). The total number of adults and children who had already died of AIDS was 49,000. Clearly, HIV/AIDS had emerged as a public health crisis, to which the government of Rwanda was committing 10% of the entire Health expenditure.

The prevalence of HIV has increased dramatically in all parts of the country as a consequence of large-scale population movements and the use of rape as a weapon during the genocide. The prevalence is 11.2% nationally—10.8% within the rural areas, where upwards of 80% of the population lives. In 1986, the prevalence rate was a mere 1.3% in rural areas.

As a result of these factors, human resources have been drastically reduced. In 1995, core civil servants who had not completed secondary education accounted for 79% of the total civil service force. It is estimated that 400,000 adults are currently infected with HIV and that 5–10% develop AIDS every year. HIV/AIDS is further aggravating the impact of each of the above factors on children. Estimates suggest that 25% of children aged 0–18 years are OVC—270,000 as a result of HIV/AIDS. Some 65,000 households are child-headed. The task of caring for OVC is becoming more difficult, as traditional family structures were destroyed during the genocide and no clear policy exists. There is a lot of child vulnerabil-

ity in Rwanda due to a multiplicity of causes including war, genocide, ongoing civil strife within the Great Lakes Region and poverty.

As a response to this crisis, the government has established a National AIDS Commission to help articulate a multi-sectoral approach. Branches of this Commission are being established at provincial and district levels and personnel are being put in place. In addition, the country has appointed a Minister of State in charge of AIDS, who will help articulate the issues of HIV/AIDS at Cabinet level. The First Lady has hired a technical adviser on OVC issues in her office and has committed to using her office to advocate for OVC. Clearly, the appropriate structures are being put in place. The critical challenge is to have these funded.

Recently, Rwanda received US$15 million from the Global Fund for expansion of Voluntary Counselling and Testing (VCT), prevention of mother-to-child transmission and access to treatment. An application of US$58 million for expanded care has been submitted to the Global Fund and is awaiting decision. The World Bank is supplying a grant of US$25 million into the AIDS effort; the date of effectiveness is early this year. Clearly, there is significant local commitment and this could be enhanced by HIPC intervention.

Rwanda's government has developed a proposal for a national strategy for multi-sectoral interventions against HIV/AIDS. The programme has been costed at US$68 million over five years. The areas of intervention are

- prevention of HIV transmission by reinforcing information, education and communication
- provision of VCT
- promotion of the use of protection
- reinforcement of the treatment of STDs
- safety of the blood supply
- prevention of mother-child transmission
- medical and psycho-social care of people with AIDS
- support to affected individuals and families

Key Elements of Rwanda's PRSP

According to the poverty diagnostic exercise undertaken in 1999/2002, Rwanda's poverty is the outcome of both economic and historical factors. The economic structure reflects chronic failures to achieve productivity increases in a context of a large and growing population. This failure became increasingly evident in the 1980s and early 1990s, leading to severe structural problems. Second, the war and genocide of 1994 left a horrific legacy, further impoverishing the country and leaving a number of specific problems and challenges. As a result, the country faces the following micro-economic structural problems:

- Low agricultural productivity. This was aggravated by the failure of past agricultural policies, in particular the failure to make the transition in the early 1980s from low-value agriculture to high-value farming. As a result, farmers do not have the resources to risk investment in technological and methodological change.
- Low human resource development, especially in literacy and skills development.
- Limited employment opportunities, with an over-supply of unskilled workers in comparison to their low demand.
- High population density and growth.
- High transport costs, on account of Rwanda's land-locked position, which have been aggravated by the imposition of axle-weight limits in neighbouring countries. Internal transportion costs also pose a major constraint, partly because of the de-capitalisation of the rural sector.
- Environmental degradation, with deforestation, poor water management, and a chronic decline in soil fertility.

Other problems and challenges that Rwanda faces include

- *The legacy of genocide:* Between April and July 1994, there was a systematic campaign of genocide aimed at completely eliminating a substantial sec-

tion of the population, and killing many others who opposed the ideology. The country continues to live with the consequences of the genocide, which profoundly affected the lives of all Rwandans. Up to one million people were killed and three million fled into exile in neighbouring countries. Shelter and capital stock were reduced both in the household and small business sectors. Even today, poor households have not been able to replenish their livestock holdings. Parts of the country are now facing a serious lack of infrastructure as a result of destruction during the war and the movement of people into areas that were previously sparsely populated. Networks of social links in rural and urban areas have been damaged, impeding internal commerce. About 107,000 people are in prison awaiting trial for genocide-related crimes, imposing a large economic burden both on the state and also on the women and children responsible for feeding the prisoners. The experience of violence, including the systematic use of rape, has traumatised a high proportion of the population, whose physical and mental health continue to be severely affected

- Child-headed households: The war and genocide left 85,000 child-headed households. Some of the children have since grown up or been absorbed into other households, but most of them still face a higher burden of responsibility and work than their peers. A high proportion of households are headed by women (34% in 1996) and by female widows (21% in 1996). Men form the minority of the adult population. While prisoner and widow-headed households are often among the poorer households, the high proportion of female household heads has also presented a challenge to the traditional gender roles in Rwanda.
- Threats to security: Continued external security threats, including the insurgencies of 1996/7 and 2001, remain a serious obstacle to recovery. There is an acute need for political development to aim at reconciliation and to forge a new sense of national identity and social cohesion.

Priority Areas

Through extensive national consultations, six broad areas have been identified for priority action to address the problems listed above. Ranked by importance, these are

- rural development and agricultural transformation
- human development
- economic infrastructure
- governance
- private sector development
- institutional capacity-building

HIV/AIDS, technology, gender, environment, *imidugudu* (people displaced and feared due to supposed links to the genocide), employment, capacity-building and inequality are considered cross-cutting issues that every ministry should mainstream. The PRSP calls on every sector strategy to take into consideration each of these cross-cutting issues in all policy and programme formulation

HIV/AIDS Coverage within the PRSP

The issue of HIV/AIDS is addressed both within the human development focus of the PRSP, and also as a cross-cutting developmental issue. As a human development issue, HIV/AIDS constitutes a core programme within the Ministry of Health and within the Ministry of Education. Rwanda has committed to implementing a multi-sectoral approach to HIV/AIDS and a strategy to that effect was designed to take effect in 2002.

The main objectives of the health sector are

- the prevention of disease, particularly malaria and HIV/AIDS
- increased access to basic health care, particularly through the reduction of costs to the poor and the provision of health information at the community level
- improvements in the quality of health services
- support of the mainstreaming of a multi-sector approach

Prevention would involve dissemination of information using some very basic curative techniques. These would deal with most of the major diseases affecting the people of Rwanda, which include malaria, HIV/AIDS, and child diarrhoea. Emphasis is to be placed on community health by training community health workers, traditional birth attendants and traditional health practitioners.

The education sector has mainstreamed teaching about the HIV/AIDS epidemic. It has two main objectives: first, to prevent the spread of HIV/AIDS among learners and educators; and second, to provide social support and care for learners and educators infected and affected by HIV/AIDS. In order to develop capacity within the ministry to deal with the challenges of HIV/AIDS in the education sector, the PRSP provides for the creation of an HIV/AIDS co-ordinating unit within the Ministry of Health, with its focal people being placed at the provincial level.

The PRSP is seen as an instrument that was pushed by the World Bank as a conditionality to trigger debt relief. The process lacked enough time. Only one and a half years were devoted to the entire process. Approximately four months of this was devoted to training, one month to the training of trainers, and then four months for stakeholder participation. Although NGOs were invited to participate, this was done after preparation of the Interim PRSP. Even after this, NGOs were slow to get their discussions going because some were not organised and there were no funds allocated for the process. Action Aid, which took the lead role, did so by using its own resources. The entire exercise took place in surroundings where appreciation by government as to the potential role that NGOs could play was not yet established.

Within the existing PRSP, there is a feeling that HIV/AIDS and OVC issues could have been articulated more. To incorporate these issues properly is a challenge that NGOs need to focus on when the PRSP comes up for revision

On a positive note, it is not felt that the absence of strong statements on HIV/AIDS within the PRSP will inhibit the allocation of money to areas related to HIV/AIDS. The level of political commitment is quite high, and HIV/AIDS-related activities are co-ordinated by a Cabinet-level officer. In addition, the six priority sectors in the PRSP are issues that could impact HIV/AIDS if they are properly addressed. These include agriculture and food security, human development (including settlement of the displaced, justice and reconciliation), health and education. Furthermore, significant developments are taking place that could address the plight of the vulnerable. For instance, the country did ratify the Convention on the Rights of the Child. Policy is being prepared and could be ratified by Parliament early next year. The Ministry of Social Affairs is the lead agency. UNICEF has helped to set up an umbrella agency on children. Structures are being created in-country to address the HIV/AIDS issue in a more effective manner.

Of particular note is the commitment to decentralisation of programming management from province to district level. This has the potential to bring about better targeting, easier access to critical services and, in general, better accountability. In keeping with this change, even the AIDS Commission is establishing branches at district levels. It is felt that this process would facilitate clear targeting and response, but the main difficulty remains the inability to train staff that would make decentralisation of fiscal management real.

Zambia

Key Elements of Zambia's HIV/AIDS Crisis

The prevalence and incidence of HIV/AIDS have reached alarming levels in Zambia. There is no aspect of life that has not directly or indirectly been negatively influenced by the AIDS epidemic. AIDS has become the major cause of illness and death among the young and middle-aged. AIDS is depriving households and society of a critical human resource base and thereby reversing the social and economic gains made since independence.

The inter-relationship between HIV/AIDS and poverty is complex. The manifestations of HIV/AIDS lead to poverty, and the state of poverty directly or indi-

rectly creates vulnerability to HIV/AIDS. HIV/AIDS leads to poverty by eliminating the productive sector of society—the 15–45 year age group. It is estimated that with an HIV prevalence of 20% (the current rate in Zambia), mortality in the 30–35 year age group goes up by approximately 40 deaths per 1,000 people. Economic growth and prosperity hinge on a healthy human resource base. Investment in strategies that fight the HIV/AIDS epidemic will, therefore, have a major impact on poverty reduction.

Since the first diagnosed case in Zambia in 1984, HIV/AIDS has become increasingly widespread, with an estimated adult HIV prevalence of 14% in rural areas and 28% in urban areas in the 15–49 year age group. Although the epidemic is showing signs of stabilisation in urban areas, the rates continue to rise in some rural areas. Currently, about 20% of the adult population aged 15 to 49 are living with HIV. The studies in Ndola revealed a prevalence rate of 32% among females and 25% among males. About 8% of boys and 17% of girls aged 15 to 24 are living with HIV and the prevalence rate is up to 40% among teachers. In June 2000, there were 830,000 people over the age of 15 living with AIDS. Of these, 450,000 were women while 380,000 were men. The peak ages for HIV infection among females is 20 to 29 years while that for males is 30 to 39 years. Young women aged 15 to 19 are five times more likely to be infected, compared to males in the same age group.

AIDS disproportionately affects women. It is estimated that 1.2 times as many women are afflicted with AIDS as are men. Women are thought to be two to four times as susceptible to HIV infection during unprotected intercourse, and more vulnerable to other STDs. Furthermore, women are culturally less able to protect themselves against a spouse suspected to be infected. It is estimated that 25% of pregnant women are HIV-positive. Approximately 39.5% of babies born to HIV-positive mothers are infected with the virus. 5% of rural and 7% of urban populations have taken an HIV test. Life expectancy at birth has dropped by nearly 14 years, to 37 years.

Since the advent of the HIV/AIDS epidemic, the tuberculosis (TB) case rate increased nearly five-fold to over 500 cases per 100,000 people in 1996. There are now in excess of 40,000 new TB cases reported every year. This figure is expected to rise by 10% annually in the next few years. Tuberculosis co-infection has also resulted in an increased mortality rate of TB patients on treatment by over 15%.

The HIV epidemic has left an estimated 600,000 orphans (2000), projected to reach 974,000 in 2014. Most of these children have no hope of obtaining formal education. This, in turn, will affect the quality of the labour force. Of these orphans, 6% become street children, with fewer than 1% living in orphanages.

The impact of HIV/AIDS on the health care system itself has been profound. It is projected that AIDS patients will occupy 45% of all hospital beds by 2014, crowding out other patients. The cost of hospitalising an AIDS patient is estimated at US$200 per patient per day. This is against the current per capita expenditure on health by the government of approximately US$3 per year. With AIDS expenditures rising, HIV/AIDS will inexorably consume more resources at the expense of other diseases. There are, however, some hopeful indications. The prevalence of HIV-positive tests in 15- to 19-year-olds dropped over most of the country between 1994 and 1998. In Lusaka, for example, while the rate was 28% in 1993, it had dropped to 15% in 1998. At the same time, the overall prevalence of positive tests in the whole population appears to be stable and is not increasing. This has been attributed to behaviour changes. The recent Sexual Behaviour Survey has documented further evidence of behaviour changes. Although the current burden of infection will continue to affect Zambia for many years, it is hoped that the tide may be turning.

The framework mandates the formation of a national joint planning team, established in 2002, to be comprised of representatives from government, NGOs, faith-based organisations and the private sector.

From the time that the first AIDS case was diagnosed in Zambia, the Zambian government has developed four national plans in response to the epidemic. The Ministry of Health implemented the first

and second plans, while the third one involved all ministries, since a multi-sectoral response is perceived to be more effective. The current framework is being co-ordinated by the National HIV/AIDS Council, which follows a multi-sectoral approach in the fight against the epidemic.

Key Elements of Zambia's PRSP

Until two decades ago, Zambia was one of the most prosperous countries in sub-Saharan Africa; it now ranks as one of the Least Developed Countries. The majority of the people suffer from weak purchasing power, homelessness, and insufficient access to basic necessities such as education, health, food and clean water. Poverty can be defined in the Zambian context as a lack of access to income, employment opportunities and normal internal entitlements for the citizens (to such things as freely determined consumption of goods and services, shelter and other basic needs of life). Currently, about 73% of Zambians are classified as poor. Poverty is more prevalent in rural areas than in urban areas.

According to the Central Statistical Office's 1998 Living Conditions Survey, 83% of the people in rural areas were poor compared to 56% in urban areas. Additionally, the incidence of poverty was gender-specific. The bulk of the extremely poor households, which were more likely to experience shortages of food, were those in which females were the heads.

The worsening poverty trend in Zambia is primarily the product of

- Lack of economic growth while the population has more than tripled since independence.
- Inadequate or inappropriate targeting of the poor and vulnerable people. This is evidenced by inappropriate budgetary locative patterns that have generally biased resources against pro-poor interventions.
- Weak integration of the poor—particularly small-scale farmers—into the market.
- Absence of well-conceived livelihood approaches that address rural and urban poverty.
- Poor people's weak access to real assets due to unfavourable land ownership laws and unsupportive land tenure systems that have worsened labour and land productivity.
- Weaknesses in governance in both its economic and political dimensions.

In the 1990s, HIV/AIDS and other diseases worsened the poverty situation. At a time when resources were already low, HIV/AIDS increased the disease burden, thereby impacting the family, community, the working environment, human capital and many other areas.

Little can be achieved to reduce poverty unless measures are taken to revive Zambia's economy. Accordingly, Zambia's PRSP focuses on measures to achieve strong sustained economic growth. A growing economy that creates jobs and tax revenues for the state is a sustainable growth tool for reducing poverty. The key elements of this strategy are

- enhanced agricultural development
- tourism
- transport
- energy and infrastructure
- education
- health
- HIV/AIDS

Overall emphasis is on growth-enhancing orientation as opposed to poverty reduction. At a time when mining is uncertain, emphasis is placed on agriculture and tourism. In order to enable agriculture to take off, improvements in infrastructure, marketing and administration are also issues of focus.

This is balanced by a focus on social issues, within which education, health and the cross-cutting issue of HIV/AIDS are made priority components.

HIV/AIDS in the PRSP

HIV/AIDS-related interventions in the PRSP fall into two main categories. First level interventions include the reduction of new HIV/AIDS infections. Specific programme activities aim at promoting safe sexual

practices among high-risk groups such as youth, men, sex workers, and prisoners. This is to be achieved through several interventions, including implementation of multi-sectoral behaviour change using communication campaigns. Behavioural research in Zambia shows that awareness and knowledge levels about HIV/AIDS are quite high among most target groups. Key challenges related to behaviour change in Zambia remain. These include: the adoption of safer behaviours; low levels of knowledge and awareness of existing low levels of personal risk perception for HIV (especially among youth); low levels of belief in the efficacy of condoms to prevent HIV transmission; low levels of knowledge about the links between STIs and HIV transmission; and gender equity issues that prevent girls and women from negotiating safer sex or refusing sex.

The PRSP provides for the addressing of these issues using proven communication techniques implemented by NGOs and CBOs working in Zambia. Mass media, peer education, drama, outdoor media and work with community leaders will be some of the strategies used to change these key attitudes and beliefs that remain barriers to safer behaviours. Although the programmes are expected to reach all sectors of Zambian society, the priority target groups for these interventions will include youth in the 15–24 year age group, and high-risk groups including sex workers, military and uniformed personnel, anglers and fish traders, truckers, prisoners and refugees.

The government has also stated that there will be efforts to improve free condom distribution. Although there is an extensive condom social marketing programme nation-wide, the Ministry of Health further contributes to condom supply by distributing approximately 18,000,000 free condoms annually in government health clinics and to partner NGOs and CBOs. Questions have been raised regarding distribution and monitoring systems particularly in relation to rural areas. Funds will be used to develop an improved monitoring information system and to improve regular condom distribution mechanisms throughout the country.

The second thrust for addressing HIV/AIDS is to reduce its socio-economic impact. The main focus here will be on individuals and families in the work place, in homes, and in the whole of Zambian society. The government will promote positive and healthy living among asymptomatic HIV-positive people. This will be achieved through the following:

- *Expansion of access to quality Voluntary Counselling and Testing (VCT) services:* VCT will be enhanced, as this has proven to be effective both as a prevention measure and as a link to care and support services. Funding will be used to expand access to, and improve the quality of, VCT services through both public and private sectors and in urban and rural areas nation-wide. The funding will be used to improve access and/or referral to post-test services and to train VCT counsellors. It will also help cover personnel costs, training of laboratory technicians, improved or expanded facilities, and integration of TB prophylaxis and/or treatment into VCT services. At present, both the government and civil society are involved in institutional and community-based VCT services in 52 major centres. The intention is to promote the service and increase VCT uptake in all 72 districts of Zambia. The programme will be implemented under the co-ordination of Zambia VCT Services and will include the government, NGOs, and private sector partners.
- *Community home-based care:* This will inevitably improve the quality of life of people living with AIDS. The funding for this activity will be used to expand sustainable home-based care for PLHA, support caregivers and children, and strengthen links between home-based caregivers and private and public health facilities. 80% of urban patients and 70% of rural patients need to be reached by 2005. Currently, it is estimated that 60% of urban patients and 30% of rural patients have access to community-based home care. Thus, a 20% increase in capacity will be needed in urban areas and a 40% increase in rural areas. Implementers will be NGOs, CBOs, FBOs, and civil society.
- *Anti-retroviral (ARV) treatment:* Since the 1990s, HIV/AIDS treatment has included anti-retrovirals (ARVs) mainly in the private sector, with the public

sector providing laboratory support. Funds for this activity are meant to introduce a pilot-guided scheme on the use of ARVs in the public sector, beginning with three districts and later expanding to all provincial centres. The scheme is going to be subsidised and a revolving fund will be established for this. The roles of the various non-governmental organisation networks in the delivery mechanism will be defined. Monitoring of patients on drugs will also be carried out.

- *Improving the quality of life of OVC:* The focus will be on the expansion of existing programmes, targeting the high-risk groups with peer education, drama, condom promotion/distribution, and other interpersonal outreach activities. There is a need to scale up existing programmes that work with high-risk groups, including military and uniformed personnel, prisoners, sex workers, truckers, refugees, and fishermen and fish traders. Support to these projects will be through modest grants of financial assistance to CBOs, FBOs, and other community groups, and assistance that strengthens the capacity of these groups to care for the most vulnerable community members. These groups will be linked with one another through networks, exchange visits, and other approaches that facilitate collaboration and mutual learning. The National Aids Council and relevant ministries will work with civil society organisations to develop the criteria for the catalytic projects and monitor them.

Second Level Priority Programmes

The second level priority programmes will aim to reduce new HIV/STD infections. These focus mainly on children, youth, women and situations providing risk for HIV transmission. The programmes will concentrate on the following:

- *Improving STD management and treatment in Zambia to reduce STDs:* Management of STDs is a proven intervention to reduce the risk of HIV transmission. Funding will be provided to strengthen the STD management capacity of both public and private organisations. Funds will be used to procure STD drugs and commodities; train health workers on syndromic management of STDs; develop and implement a system for monitoring drug resistance; and create a management and information system for monitoring the distribution and procurement of STD drugs. Traditional healers will also be trained in early identification/management and referrals as well as partner notification.
- *Expansion of access to quality prevention of mother-to-child transmission:* There are currently 10 health centres in three out of 72 districts that are implementing the full package of prevention of mother-to-child transmission programmes (AZT or Nevarapine drugs). These sites, now reaching 10,000 women, will be scaled up so that 100,000 women are reached in the second year, 250,000 in the third year, 350,000 in the fourth, and 450,000 in the fifth year. The Ministry of Health and Central Board of Health will implement this initiative through health centre staff, in collaboration with NGOs and other private health institutions.
- *Prophylaxis against TB:* The programme will promote positive and healthy living among asymptomatic HIV-positive people. This is especially important because, since the advent of the HIV/AIDS epidemic, the TB case rate has increased nearly five-fold. Prophylaxis against TB will be useful.
- *Drugs for opportunistic infections:* Drugs for TB and HIV-related diarrhoeas are part of the basic health care package as indicated in the Health chapter. However, drugs for other conditions not covered under basic health care will be needed separately. The supply of these drugs will improve the quality of life of people living with AIDS.

A number of clinical, epidemiological, behavioural, and impact studies related to HIV/AIDS will be carried out. A sentinel surveillance system for HIV and population-based studies will continue to be used to monitor the trend of the HIV epidemic. A system of collecting information from health facilities that is already in place to capture cases of AIDS, TB, and STDs will be used. Lastly, data from various pro-

grammes and ministries will have to be collated and analysed at the national level.

Gender

Issues of gender play a very important role in developing a sustainable strategy for poverty reduction. The National Gender Policy defines gender as an analytical concept, which focuses on women's roles and responsibilities in relation to those of men. In economic development, these roles and responsibilities explain existing income disparities between women and men. This is also related to the differential impact on women and men. Female participation in affairs that directly affect women is still limited. As a result, women remain more susceptible to the effects of poverty than men. In addition to economic factors, the socially and culturally ascribed gender roles have contributed to high poverty levels among women. Women are usually not part of decisions made about resource allocation at household and other levels.

Following the points raised in the previous section, Zambia estimates that US$1,200 million is available for spending on PRSP programmes over the period 2002–2004. This is deliberately projected below the US$1,600 million estimate for capital expenditure, to take account of the difficulties that will be faced in trying to re-align capital expenditures towards PRSP priorities. Against this, costed programmes, which were initially submitted for the PRSP, were in excess of US$4 billion. These submissions underwent strict evaluation with stakeholders in terms of their contribution to economic growth and enhancement of welfare, especially for the very poor. On this basis, only the core priorities that could fit within the general budget ceiling of US$1.2 billion were retained. The rest of the submissions, many of which are important, have been costed at zero as a way of indicating that there are insufficient resources to include them.

This PRSP puts emphasis on agriculture, tourism, transport, and energy infrastructure for the productive sectors, and education, health and HIV/AIDS with regard to the social sector. Currently, there is substantial uncertainty in the economy due to an imminent pull-out of the crucial mining sector by one large investor because of low copper prices. This potentially threatens to bring about economic decline, as the bulk of urban centres (representing 50% of the population) are mining centres. It is in line with the major objective of arresting and reversing the fallen per capita GDP, while building human capital and focusing on the poor, that the priority sectors as outlined above have been chosen.

HIV/AIDS and Health

In the past decade, HIV/AIDS has contributed enormously to the rise in poverty through a heavy disease burden and many deaths of breadwinners, parents and many other categories. Among the severe consequences of this is the large number of orphans and street children. To combat this threat, preventive measures will continue to be undertaken. Substantial resources have also been earmarked for those already afflicted, through enhanced funding of home-based care as well as a revolving fund to introduce treatment of patients with ARV drugs.

Health has also been provided for with substantial resources. The bulk of this provision is on basic health care, primarily at the district level, followed by the second and third level health packages. Basic health care involves basic drugs and prevention of common ailments like malaria, diarrhoea, and others, which tend to afflict the poor more.

Overall Allocation of Resources

In accordance with the priorities identified above, the overall allocation of PRSP expenditures within the total resource envelope of US$1,200 million is presented in Table 1 below.

Observations

Based on this examination of the extent to which HIV/AIDS and related issues are being addressed in PRSPs, the following conclusions can be drawn:

- The PRSPs examined fall into two categories. In one category (Mozambique and Zambia), HIV/AIDS is not addressed as a cross-cutting issue for rural development. It is mostly addressed as a health and education issue. In the other cat-

Table 1: Sectoral Share of PRSP Budget, 2002–2004

Sector	Cost (US$)	Share of Total Budget
Roads	229,000,000	19.1
Health	200,150,000	16.7
Agriculture	173,000,000	14.4
Education	147,500,000	12.3
Energy	114,000,000	9.5
HIV/AIDS	94,600,000	7.9
Tourism	58,700,000	4.9
Water and Sanitation	42,400,000	3.5
Macro-economic Reforms/Institutions	38,200,000	3.2
Governance	27,000,000	2.3
Mining	26,600,000	2.2
Transport	22,000,000	1.8
Industry	12,500,000	1.0
Social Safety Net	9,000,000	0.8
Environment	3,000,000	0.25
Monitoring and Evaluation/Statistics	1,500,000	0.12
Gender	976,500	0.1
Total	**1,200,126,500**	**100.0**

egory (Rwanda), HIV/AIDS is approached as a cross-cutting issue. There is effort to intensify the multi-sectoral response at the district level and within other ministries.

- Participation of civil society has mostly been partial, limited only to participation of a few NGOs. Members of Parliament and other representative bodies as well as business leaders have not been involved.
- Although it is recognised that country ownership is vital to ensure success, for the most part country ownership has been restricted to technocrats. The process has also been hampered by the link between the PRSP process and urgency to trigger the HIPC process and release of urgently needed funds. This was the case in Mozambique, where the PRSP exercise came at a time when the country was experiencing devastating floods. With this, securing funds for the recovery effort became the overriding issue.
- The information available from the analysis of poverty does not always represent the basis of the formulation of the strategic plan. Most of the strategies contained in the PRSP in Mozambique are simply the sum sectoral strategies, and few countries have adopted clear and transparent criteria for prioritisation of the activities.
- The overwhelming number of PRSPs have just entered implementation. Hence there is little basis for evaluating them on performance.

The ideal approach with which to assess the level of HIV/AIDS inclusion within the PRSP is to examine (i) the extent to which HIV/AIDS appears in the strategic objectives of the PRSP, (ii) whether these objectives are reflected in the log frame with clear budget allocation, and (iii) whether the necessary support services are provided for in the log frame, again with clear budgets.

Although countries recognise HIV/AIDS as a cross-cutting issue that needs to be addressed in order for any poverty initiatives to have impact, and have decided to mainstream it within each of the strategic pillars of their PRSPs, not all strategic pillars contain clear actionable objectives on HIV/AIDS that are reflected in both the log frame and budget. In the Zambia PRSP for instance, actionable statements on HIV/AIDS appear under

- Education: commitment to use schools as a centre for disseminating information
- Health: commitment to increase the percentage of the population practising safe sex
- HIV/AIDS sector: objectives to mobilise for a

multi-sectoral approach; promote behaviour change; increase/improve STD management; destigmatise HIV/AIDS; improve VCT; reduce mother-to-child transmission; and improve home-based care, community-based support for orphans, drug supply and hospital care

There are no actionable objectives appearing under tourism, industry, agriculture, mining, energy or transportation, even though it is acknowledged that these sectors have considerable access to the population at risk.

Capacity is seen as the issue. AIDS commissions are still operating at the national level. They have not yet effectively decentralised to the district level, where they could provide technical support to those sectors that are interfacing directly with communities. Equally significant, some of the sectors have not yet positioned informed programme persons who would strengthen the links with the AIDS commissions.

There is awareness about these shortcomings in all countries, and it is hoped that they will get addressed in the PRSP revision process. Uganda's PRSP revision is currently underway, and the information gathered through the revision process will be used to design a multi-country assessment of existing PRSPs.

The AIDS Epidemic in Malawi: Experience with Intervention Programmes

James Munthali

Introduction

The global HIV/AIDS pandemic is becoming the single, major challenge for public health authorities and for economic managers in their attempts to foster sustainable economic growth and development in many poor countries, especially in sub-Saharan Africa. The impact of this devastating pandemic on the economies of southern Africa has been widely publicised. Some have drawn a historical parallel with the outbreak of the bubonic plague in the fourteenth century and the major wars and political purges of the twentieth century. Yet none of these earlier calamities fully reflect the situation that is still unfolding in sub-Saharan Africa, particularly in southern Africa, where the humanitarian and economic catastrophe is unprecedented (MacFarlan, Maitland and Sgherri 2001). In Malawi, as in most of southern Africa, HIV/AIDS has become a "Silent Crisis" that is quietly killing thousands of adults each year in the prime of their lives, decimating the work force, and destroying the rural poor communities.

HIV/AIDS poses the greatest threat to any economic development gains made since Malawi attained its political independence in 1964. The epidemic has undoubtedly overshadowed the efforts of this small, land-locked country to pursue prudent management of its resources, including the development of its human capital. It has become a major contributor to the weak growth performance of recent years and threatens to undermine or even reverse the gains in the country's nascent democracy, which was only beginning to take root following the advent of multi-party polity in 1994. The scourge of this epidemic is weakening public institutions, especially the public service that plays a central role in governance, planning and management of economic and social development.

Malawi's health indicators are weak and still deteriorating; recent estimates are sobering. The HIV/AIDS infection rate in Malawi is one of the highest in the region and is still growing, particularly among the most productive groups. With the sharp rise in adult mortality rates, life expectancy has declined sharply in recent years. HIV/AIDS is now estimated to be the leading cause of death among the most productive age group. Yet the epidemic may not have peaked, and the country faces a monumental task in putting together credible mitigation measures to reduce the incidence of the disease on a sustainable basis. In the meantime, health services are already overwhelmed as HIV/AIDS-related conditions account for a substantial proportion of all in-patient admissions at government hospitals. This situation is expected to worsen.

Like many of its neighbours in southern Africa, Malawi faces an enormous challenge in implementing a robust national response for HIV/AIDS prevention, care and support. Unfortunately, despite the weakening health indicators, the international financial community has been slow to respond with more imaginative adjustments to their lending policies and practices in order to help Malawi and similarly-affected countries to adapt to this deepening crisis. Moreover, attempts to establish a link between the HIV/AIDS pandemic and economic performance have been lacking, sparse or oftentimes entirely overlooked in annual surveillance reviews conducted by the International Monetary Fund (IMF). This paper will discuss the impact that the HIV/AIDS epidemic has had on Malawi's economy and reflect on the restoration of fiscal discipline in the context of IMF-supported programmes. The paper recommends that the IMF should review its own policies for HIV/AIDS-stricken countries and, as in the case of post-conflict countries, relax conditionality in order to allow maximum flexibility in the design of economic adjustment programmes to permit these countries to

fight their greatest challenge.

The paper examines domestic and external constraints that undermine progress towards effective HIV/AIDS prevention, treatment and control. Thus far, the bulk of intervention programmes have been implemented with financial assistance from external donors and the involvement of non-governmental organisations (NGOs). The following pages highlight the economic backdrop and population trends in Malawi, and continue with a description of the magnitude and nature of the HIV/AIDS problem. This leads into a brief consideration of the framework for current intervention programmes that is being facilitated by the National Aids Commission, a government organisation established to monitor and co-ordinate HIV/AIDS programmes in the country. The paper proceeds to focus on factors that hinder the implementation of effective interventions, highlighting both external and domestic constraints. The concluding section highlights some pertinent lessons of experience and proposes some possible recommendations.

Background

The study has principally utilized published information and data on the Malawi experience to date in the fight against HIV/AIDS. In addition, interviews with key individuals that are on the front lines of this "war" were undertaken in the first half of December 2002. Thanks to the sponsorship of World Vision International, these personal interviews revealed a number of critical issues, most importantly that external donors remain essential in the implementation of ongoing mitigation measures. Thus, donor funding has driven almost all intervention programmes in Malawi, despite the government's recent efforts to increase budgetary allocations to fight this deadly disease.

Some economic indicators are important in demonstrating the depth and breadth of poverty in Malawi as a significant driving force behind the rapid escalation of the HIV/AIDS epidemic These indicators also highlight the urgent need to implement more effective intervention measures and to reinforce poverty reduction policies. Malawi is one of the poorest countries in the world. An estimated 65.3% of the population (or about 6.3 million people in 1998) lives below the poverty line, and an estimated 28.2% of the population lives in dire poverty (Malawi 2002, PRSP). Malawi's gross domestic product (GDP) was estimated at a meagre US$170 per capita in 2000 (World Bank 2002), which compares with a peak of US$230 recorded in 1991 and an average of US$309 for sub-Saharan Africa, excluding South Africa and Nigeria. Real GDP growth is estimated to have slowed to only 1.7% and, according to recent projections, GDP in 2001 contracted by as much as 1.5% (IMF 2002, Staff Report), highlighting the recent decline in per capita income and the continued deterioration in living standards for most Malawians.

Malawi's economy depends heavily on rain-fed agriculture, which accounts for an estimated 35% of the country's GDP and about 93% of export earnings, and which employs about 85% of total population. With 80% of the nation's food coming from subsistence agriculture, Malawi remains highly vulnerable to weather-related shocks. In 2001 and 2002, a combination of inopportune heavy rains interspersed with extended periods of drought contributed to the worst famine in recent times. And significantly contributing to the famine, according to the UN Population Fund, was the high incidence of HIV/AIDS (UN Population Fund 2002) that affected farm labour availability.

Malawi's total population, which had been growing rapidly since the beginning of the twentieth century, is estimated at 11.04 million (2000) (UN Population Fund 2002). The annual rate of growth slowed to an average of 2.7% between 1990 and 2000, down from an average of 3.2% between 1975 and 1984 and 3.4% between 1985 and 1989 (World Bank 2002). As already indicated, an increase in mortality rate during the past decade, resulting from the high prevalence of HIV/AIDS, has reduced life expectancy to an estimated 39 years (1999). By some estimates, it had fallen to 37 years by 2001 (Central Intelligence Agency 2002) and further decline is anticipated. Thus, within a decade, the impact of HIV/AIDS has driven life expectancy back to where it

was in the 1950s, when it was estimated at only 37 years. Indeed, a World Bank assessment study concluded that AIDS-related deaths will be the single largest determinant of life expectancy in Malawi. Besides, the population dependency ratio, which is used to analyse the economic implications of changes in age distribution, continues to rise due to the high incidence of HIV/AIDS. A higher dependency ratio indicates a heavier burden on the economically active population aged 15–64. The number of orphans is growing at an alarming rate. Recent data show that the dependency ratio has increased from 0.97 in 1977 to 1.01 in 1987 and 1.06 in 1992 (Malawi Government 2002). It has been suggested by the Malawi government that this may have contributed to many children dropping out of primary school and seeking work before the age of 15.

The Magnitude and Impact of the HIV/AIDS Epidemic

In a 1998 World Bank study, it was confirmed that the HIV/AIDS epidemic had already reached crisis proportions only a decade after the first AIDS case had been identified in Malawi. More recent cross-country data also reveal that the disease in Malawi is one of the most severe in the region and in the world. Thus, the World Bank study concluded that the increasing numbers of AIDS-related deaths is decimating the base of productive adults in the public and private sectors, threatening to deplete the country's human capital and undermining development efforts.

Since the first AIDS case was identified in Malawi in May 1985, HIV began to spread quietly at first. But then the epidemic exploded sharply in the subsequent decade, as seen among pregnant women attending antenatal clinics in Blantyre, the single most populated commercial centre in the country. HIV sero-prevalence in Malawi rose from 3% in 1986 to 35% in 1996 (World Bank 1998). Although the government does not conduct regular national surveys, a UNAIDS survey updated in 2002 indicated that the HIV prevalence rate in 1999 had reached 16.0% among Malawians aged 15–49, in comparison to a rate of 35.8% in Botswana the highest in southern Africa where the average was estimated at 19%. Malawi's 16% prevalence rate is significantly higher than the 8.6% average for sub-Saharan Africa, underlining the severity of the epidemic in Malawi. The government has recently established an AIDS Cases Surveillance System that is based on monthly returns from a number of screening sites. Although these figures indicate that new cases peaked at 5,370 in 1996, and could be declining somewhat, the government is quick to admit that serious problems occur in diagnosing AIDS cases in Malawi. Indeed, the National AIDS Commission, the body responsible for monitoring and reporting on the AIDS epidemic, indicates that monthly submissions totals are likely under-reported.

When the prevalence data are disaggregated, they reveal that the age-specific data of women attending antenatal clinic show a very high prevalence rate among those aged 25–29 years, peaking at 28% in 1998 (UNAIDS 2002). This implies that a large number of women in their prime reproductive age are being infected and, coupled with high fertility rates, the potential for mother-to-child transmission has also increased.

It is generally accepted that HIV/AIDS is the leading cause of death in Malawi among the most productive age group (20–49 years). HIV/AIDS is believed to be responsible for about 50,000 to 70,000 adult and child deaths annually (Global Fund 2002). UNAIDS estimates that as many as 80,000 deaths in Malawi in 2001 were due to AIDS. Meanwhile, the number of children who have lost their one or both parents to AIDS and who are alive and under the age of 15 had risen to a cumulative 470,000. In the light of current trends in AIDS-related deaths, it is projected that more than 60,000 orphans will be added each year.

To better understand the effect of HIV/AIDS on the economy, specific studies are needed to provide an estimate of its impact. The World Bank and IMF have the resources to help Malawi and other poor countries make a more pointed assessment of the drag HIV/AIDS has on economic growth in order to highlight this silent crisis. Similar studies were undertaken in the 1990s and there is a need to take a fresh look at the effects of HIV/AIDS on economic

growth and per capita income, even in the context of annual economic reviews and surveillance by the IMF. In 1992, Forsythe reported that an HIV-infected Malawian loses as much as 15.6 productive years and works for only 9.7 years out of a potential 25.3 years. Cuddington and Hancock (1995) predicted that annual per capita GDP could fall only moderately by 0.2 percentage points per year and that the level of GDP per capita would decline by about 1% by 2010. Since the average annual per capita growth was as low as 0.2% between 1986 and 1996, its projected further decline assumes even greater significance. Thus, it is estimated that HIV/AIDS-related illness and death lead to significant reduction in household income and, consequently, to the deepening of poverty.

In addition to examining the ever-increasing burden of orphans, studies have evaluated the impact of AIDS by looking at certain key social indicators like education and health. The government has determined that the quality of education will likely suffer from the erosion in the supply of teachers who become affected by HIV/AIDS and from the decline in supervision through losses of school inspectors. On the demand side, children could drop out of school if their families are unable to pay school fees or need additional income, requiring them to enter the work force prematurely. Moreover, children could be required to care for their sick parents or siblings. As well, orphaned children are reportedly more likely to drop out of school (Malawi Government 2002).

In a cross-country study, Haacker (2002) confirms that Malawi, like its southern African neighbours, will not be able to maintain the quality of education because of increased mortality of teachers, which will worsen the teacher-pupil ratio. In order to maintain the teacher-pupil ratio reported in 1996, Malawi would have to train 14% of the total number of teachers as of 2000 simply to replace those who succumbed to HIV/AIDS. This number rises sharply to as much as 46% by 2010 (Haacker 2002)—a rather difficult objective to achieve, given the limited training capacity in the country. Haacker concludes that Malawi will also need to substantially increase the number of newly trained teachers in order to avoid further deterioration in the teacher-pupil ratio. The government concedes that the combination of pressures arising from a reduced supply of teachers and fewer children could cause the education system to collapse, ultimately undermining prospects for economic and social development of the country.

The impact on the health sector stands out much more sharply because it is immediate; HIV/AIDS directly increases the demand for health services, while also affecting some of the health staff. Malawi's health services are already overwhelmed by the high number of HIV/AIDS patients, and the situation is expected to worsen in the coming years. Reportedly, some 70% of bed occupancy in public hospitals is considered to be HIV/AIDS-related (Malawi Government 2002). Haacker has attempted to examine the quality of health services in relation to total health expenditure per capita, which in Malawi was estimated at US$9 in 2000. In relation to GDP, health expenditures amounted to 5.8% in 1997 (Haacker 2002). These indicators compare very unfavourably with those prevailing in industrial countries. It is hardly surprising that health services have come under serious strain and would deteriorate further with increasing demand in the coming years. Meanwhile, employees in the health sector are also being affected by the disease and much will need to be done to keep the number of doctors and nurses constant. For example, the training of doctors would have to be expanded substantially, by over 25% in the period between 2000 and 2010, to maintain the present per capita ratio—an almost impossible task given the limited capacity to absorb and turn out more doctors.

Overall, the government has concluded that because of the rapid expansion of HIV infection and the delay before the onset of ill health, the impact on the health sector over the coming decade will be greater than in the past two decades combined. With the prospective development of new therapies and vaccines for HIV/AIDS, health sector costs for infrastructure, drugs, training and personnel expenditure are expected to rise substantially (Malawi Government 2002). As with the education sector, it is feared that the quality of health care will be seriously undermined at a time when it is most needed.

Malawi's Response to HIV/AIDS

When the first case of AIDS was identified in 1985, Malawi's attempts to deal with the epidemic focused largely on increasing awareness in order to prevent the spread of HIV infection. These efforts were co-ordinated through the National AIDS Control Programme, which was set up under the Ministry of Health and Population. The task was principally to help implement effective preventive measures, while monitoring and reporting on the progress of the epidemic in Malawi. The Programme was reconstituted in July 2001 as the National AIDS Commission and more recently was moved to operate under the Office of the President and Cabinet in order to raise its political profile.

Malawi's efforts to broaden its efforts against the HIV/AIDS epidemic to include care and support have been limited mainly by the paucity of financial and institutional resources. This slow and fragmented governmental response prompted a review in 1999 and 2000 of the whole HIV/AIDS control programmes, following extensive consultations with stakeholders, including the donor community. The result was the formulation of a plan—the National HIV/ AIDS Strategic Framework for HIV/AIDS Prevention, Care and Support—covering the period of 2000 to 2004. The Framework seeks to broaden the scope of Malawi's response, using a multi-sectoral approach to HIV/AIDS intervention, including the provision of Voluntary Counselling and Testing services, the prevention of mother-to-child transmission, the treatment of opportunistic diseases and the use of anti-retroviral therapy. Meanwhile, the government has also recognised that the implementation of HIV/ AIDS activities thus far has been guided by various disparate documents. Thus, the intent of the national policy on HIV/AIDS was to bring all these elements into a single comprehensive document which was completed in first draft in November 2002.

In the meantime, when the Malawi Government published its Poverty Reduction Strategy Paper (PRSP), a key document under the IMF-sponsored enhanced Heavily Indebted Poor Countries Initiative, HIV/AIDS was identified only as one of a number of cross-cutting issues. However, the PRSP has emphasised the clear link between HIV/AIDS and poverty, with the latter being a key underlying factor driving the epidemic. Accordingly, all the key elements of the HIV/AIDS Strategic Framework were included in Malawi's PRSP, focusing on the reduction in the incidence of HIV/AIDS, the improvement of the quality of life of those infected, and the mitigation against the economic and social effects. Based on the three-year fiscal projections of the PRSP, the government, for the first time, allocated an amount equivalent to 2% of total expenditure to specific HIV/AIDS activities in the 2002/03 budget.

The government acknowledges the formidable challenge of implementing a multi-sectoral response to the HIV/AIDS epidemic. Existing resources to mount effective intervention programmes are very limited; consequently, efforts to mobilise, strengthen and supplement those resources are underway. To this end, Malawi's development partners continue to play a crucial role in supporting the implementation of the National HIV/AIDS Strategic Framework over the next five years.

In 1996, the total expenditure on AIDS prevention, sexually transmitted infections (STIs) and community-based AIDS care amounted to approximately US$10.5 million (World Bank 1998). Of this amount, external donors provided over 95% of the resources spent on various categories of AIDS control. This level of expenditure and participation by donors is consistent with the pattern of spending in most of Malawi's neighbouring countries in southern Africa. At this high level of donor participation, however, the government's commitment to spearheading the fight against this deadly disease has been questioned. The government stresses its political commitment by the establishment of a Cabinet Committee on Health and HIV/AIDS, chaired by the Vice President, which meets regularly to co-ordinate the multi-sectoral response. The Cabinet Committee guided the development of Malawi's project proposal to the Global Fund. Besides this recent institutional change, Malawian authorities have stressed that concrete steps are being taken to substantiate this political commitment by increasing annual budgetary allocations.

Overall, annual expenditures on health care have been raised from an average of around 6–9% of total government recurrent outlays in the 1990s to 15% in 2001, consistent with commitments under the PRSP and those made in Abuja in 2001 (Global Fund 2002). In the context of the Global Fund proposal, the government's contribution over the five-year implementation period will amount to US$14.8 million, or 16.8% of commitments, totalling about US$110 million. Malawi's development partners' contribution, however, will remain substantial, especially when the Global Fund resources are taken into account.

At this level of financial support from a diverse number of donors, the government is likely to face a substantial amount of conditionality from donors, not only in terms of financial accountability but also other performance tests to ensure that their financial assistance meets donor requirements and oversight. The proposition in this paper is that such conditionality could impair the authorities in their provision of sufficient resources to effectively combat HIV/AIDS.

Factors Affecting HIV/AIDS Interventions

What are the domestic and external factors that may hamper the implementation of effective intervention programmes in Malawi? An effective HIV/AIDS intervention programme, as defined in the strategic framework formulated by the National AIDS Commission, emphasises three aspects: HIV/AIDS prevention, treatment and community support. Key governmental interventions are Behavior Change and Communication, Voluntary Counselling and Testing, Control and Management of STIs, Blood Safety and Prevention of Mother-To-Child Transmission.

The bulk of the financial support so far has been largely directed towards control and prevention programmes as key to arresting the spread of HIV/AIDS. However, there is growing recognition that providing treatment and social support for people living with HIV/AIDS is equally important, so as to improve the quality of their lives and prevent transmission within the wider community. Perhaps more significantly, care and treatment improves prospects for voluntary testing, and reduces the despair and hopelessness usually associated with an HIV-positive result. Hence, the integrated approach to treatment and care now adopted in the Strategic Framework can help to reduce the stigma and promote more openness about the status of infection. Moreover, the enhanced ability to diagnose and treat infectious diseases such as tuberculosis, STIs and other opportunistic diseases would help in reducing their transmission and improve overall public health prospects.

Domestic Constraints

To implement such credible and comprehensive intervention programmes, the Malawian authorities will need to address the serious domestic constraints that hamper progress in the fight against HIV/AIDS. Recognition of these constraints as well as measures to redress them will be important in reinforcing donor confidence in the Strategic Framework. Most of these constraints have reportedly been identified and extensively discussed with development partners in the context of prospective donor assistance, including the Global Fund and the World Bank. The factors discussed in this section are by no means exhaustive, but stress important perspectives on the challenges that the government faces in implementing effective intervention programmes.

The most obvious constraint is the apparent inadequacy in financial and institutional capacity, which affects a wide range of areas, including key economic development sectors. As noted, total expenditure for HIV/AIDS prevention, STIs and community-based AIDS care by the government and NGOs was approximately US$10.5 million in 1996. Yet, the government's contribution was only 3%, with over 95% of the total met by donor assistance. This implies that the government can give only little direction in the placement of donor's contributions. The World Bank AIDS Assessment Study (1998) found an inordinate amount—44% of allocated funds—went towards travel and training, leaving much smaller amounts for prevention and care. For example, only 24% of the total expenditure was spent on prevention, which is the key to slowing the spread of the

epidemic. Only 11% was spent on education and activities targeted at sex workers (2%) and youth (9%), 18% on STI and AIDS treatment; and 10% on reducing the personal and social impact of HIV infection, mainly through community-based care programmes. The National Aids Secretariat received only 5% of the outlays (World Bank 1998). This underscores not only the very limited financial capacity of the government to meet the formidable challenge posed by the HIV/AIDS epidemic, but also the inability to influence the allocation of such resources. Thus, it is generally agreed that the government funding of the National Aids Commission would enhance Malawi's ability to direct the placement of donor assistance toward the areas where the funds would do the most good.

The weaknesses in human and institutional capacity cannot be resolved at least in the short-term. For example, the government now recognises the urgent need to adopt a multi-sectoral approach to HIV/AIDS intervention and that action should be taken to mobilise available human capital at the community level to fight the epidemic. Meanwhile, the leadership apparently has neither internalised the reality that AIDS is a serious threat to the country's development nor adjusted institutional systems to address this epidemic. Nonetheless, the recent change in bringing the National Aids Commission under the Office of the President and Cabinet, in conjunction with the adoption of the Strategic Framework, suggests that governmental responsibility to plan and direct an AIDS response is now better placed for developing effective action.

This recent change has paradoxically left the Ministry of Health and Population without a core basis for the co-ordination of its own HIV/AIDS activities. Without funding, the ministry would have to request extra-budgetary spending or seek a re-deployment of its staff resources.

It is recognised that only through changes in individual sexual behavior and social norms can further increases in prevalence rates be arrested. To change these norms would necessarily involve institutions outside the health sector, especially in homes, schools and communities. The government has recently adopted a strategy that focuses on this and other relevant issues in the context of its multi-sectoral approach by taking steps to decentralise activities at the regional, district and community levels. These levels of government operations, however, constitute the weakest link in the institutional chain to fight this deadly disease. With several local and international NGOs, including World Vision Malawi, implementing interventions throughout the country, the government has only recently increased its involvement to guide where and what models of interventions should be applied and how these should be evaluated. This is an important first step to strengthen interventions at local and community levels. The prospective provision of grants under the Strategic Framework should improve co-ordination between government donors and NGOs. Overall, much remains to be done to strengthen domestic capacity in the fight against the HIV/AIDS epidemic.

External Constraints

For the purposes of this paper, external constraints include those factors that could impede or lead to the withholding of assistance for the implementation of intervention programmes. This necessarily involves conditions that needed to satisfy donor requirements for assistance to specific HIV/AIDS and other health sector projects as well as other more general economic adjustment and structural reform programmes. Since most documents shedding light on such conditionality have not been available, the points made in the paper derive in part from interviews with various officials in Malawi. Useful insights are also offered by The Global Fund proposal and the Letter of Intent and Memorandum of Economic Policies and Technical Memorandum of Understanding (dated July 19, 2002), which set out policies to be followed in the context of Malawi's request for financial assistance from the IMF. As the leading of the two Bretton Woods lending institutions on HIV/AIDS issues, it would have been more instructive to consider conditions attached to the World Bank's credit/grant that was being concluded when this paper was being finalised.

Although problems in fiscal accountability and other related difficulties have led to delays in the disburse-

ment of donor balance of payments or budgetary support, no such delays were reported on direct project assistance, including funding for HIV/AIDS programmes. Notwithstanding, donors have emphasised their concern about financial accountability and have called for greater transparency in spending priorities. In some instances, as in the case of USAID, the motivation to use NGOs is to augment domestic capacity and to minimise leakages in their assistance by going directly to those in need. However, the exclusive engagement of U.S.-based NGOs as lead organisations in project implementation may place undue restrictions in the optimal use of these resources.

In Malawi, donor assistance for HIV/AIDS interventions has included funding for the operations of the National AIDS Commission, and it is conceivable that conditionality could be quite significant, given donor requirements and close scrutiny. This is to be expected when donor agencies need to satisfy their respective legislative oversight. However, it appears that the uniqueness and severity of the HIV/AIDS situation in Malawi may have increased donor empathy and sensitivity. Both Commission officials and some of the donor agencies reported that conditionality has been held to a bare minimum. For example, Norway is funding Commission activities with little conditionality, except for the submission of periodic financial reports. Reportedly, the Canadian International Development Agency, which normally requires very strict conditions, is following the Norwegian example.

The potential that donor concerns may cause friction in programme implementation has been noted in connection with the deliberations of the Board of Trustees of the National AIDS Commission. Although occasions could arise where the Board might prefer to pursue certain policies inconsistent with donor requirements, in such situations the Executive Director would normally seek to strike a compromise to develop consensus around the Strategic Framework. The Executive Director emphasised that such instances have been rare in the past and have been safeguarded by the fact that any donor to the Trust can attend and participate in the Trustees' meetings. This has ensured that friction and mistrust is held to a minimum. More significantly, in the last two years the National AIDS Commission has developed a commonly acceptable financial reporting mechanism that would satisfy all donors; this exercise was being undertaken with full participation of donor agencies. Although the document has taken a relatively long period of time to complete, some of the participants indicated that the time invested was worth the effort to facilitate future disbursements under the Strategic Framework.

Notwithstanding, Malawi's heavy dependence on donor assistance means there is a risk that HIV/AIDS intervention programmes might not fully reflect the country's urgent needs and unique circumstances. Since the disease has strong cultural ramifications, Malawian input and leadership is essential if rural, traditional communities are to be effectively integrated in the intervention programmes.

Of particular interest is the indirect impact of the more general conditionality associated with World Bank and IMF programmes. While pertinent questions have been raised regarding the design of economic adjustment programmes and the application of IMF conditionality, the focus here is on fiscal adjustment and the implied tight stance of the budget that is considered key in restoring discipline and establishing early macro-economic stability. In Malawi, where the government operations constitute a significant proportion of value added, the pursuit of prudent fiscal policies is also critical in promoting a more efficient allocation of the country's scarce resources. The Malawi government is currently implementing an economic adjustment programme under the Poverty Reduction and Growth Facility, initially approved in 2000. This programme is being implemented in the context of the enhanced Heavily Indebted Poor Countries Initiative, the mechanism under which Malawi and other poor countries will receive debt relief from the IMF and the World Bank. In that regard, the IMF now emphasises the quality of government spending to ensure that budgetary resources are channeled to pro-poor activities, including HIV/AIDS intervention programmes.

Malawi's on-and-off relationship with the IMF

stretches back to the mid-1970s and culminated in successive programmes during the 1990s, starting with a standby arrangement in 1994 when a new democratically elected government assumed office (IMF 2002, Staff Report). In the current and previous programmes, fiscal adjustment has been central to economic adjustment. Under the present programme, it is expected that the budget deficit will be reduced by about 2.5% of GDP between 2001/02 and 2002/03, to be achieved mainly through "substantial cuts in non-priority spending" (IMF 2002, Public Information Notice). While questions could be raised regarding the speed of this adjustment, given the overwhelming magnitude of the country's needs, it is significant that the government is expected to increase pro-poor spending in key areas of agriculture and social services like health and education.

However, economic adjustment effort continues to place emphasis on the restoration of fiscal discipline to ensure that government spending is contained within programmed limits and kept consistent with the country's inflation and balance-of-payments objectives. To this effect, the government introduced in the mid-1990s a cash budget or cash management system to better monitor and control spending by ministries/departments, taking into account revenues collected and anticipated donor support. Although instituted to be a short-term measure for the early re-establishment of fiscal discipline, the persistence of overspending has led to adjustments on expenditure control through the introduction of a Credit Ceiling Authority and Commitment Ceiling System. While it is not clear how the modified and reinforced cash management system is working, the control over spending has remained elusive as slippages in the implementation of the programmes have persisted—attributed to, among other things, an "increase in non-priority public spending, such as travel and representation" (IMF 2002, Public Information Notice).

In an environment of persistent fiscal indiscipline, the enforcement of a cash budget could unduly penalise complying ministries and produce undesirable results. In its original form, this fiscal instrument is blunt and uneven because it is not targeted to specific expenditure pressure points. These pressure points often reflect political choices that are outside the control of ministries/departments that deliver key social services. The curtailment in the delivery of services often occurs when no clear spending priorities are specified. For example, media reports indicate that ministries are often unable to deliver services as a result of reduced funding, either when revenues were running behind the programmed expenditure or donor assistance was delayed or withheld. Also, certain government operations have on occasion had to be suspended temporarily to ensure that overall spending is held within the prescribed limits. Reportedly, the University of Malawi has had to open late or close early, ambulances have had to be grounded for long periods of time and teachers' wages have been delayed.

There are no reports that HIV/AIDS programmes have been affected by the implementation of a cash management system, primarily because most of the intervention activities are off-budget. Nevertheless, a thorough study of possible "collateral" damage that may result from the enforcement of such measures on the delivery of services and the execution of pro-poor activities, including HIV/AIDS, would be helpful in understanding possible linkages between funding and programme implementation.

In the particular case of Malawi, the IMF brought HIV/AIDS considerations into its discussion in the context of the MPRSP and in the Staff Report of July 2002. The latter limited its discussion to a bullet point and included a box that reflected the findings of an IMF Working Paper by Haacker. Since it has not yet been determined that HIV/AIDS directly affects economic performance in Malawi, the focus of the IMF has been on measures to restore financial and macroeconomic stability in line with its core mandate as defined by its Articles of Agreement. Yet the magnitude and urgency of HIV/AIDS in Malawi demands an in-depth treatment to mainstream and comprehensively integrate intervention measures into overall economic policies. The IMF and the World Bank could play a leading role in studying the link between economic performance and this silent crisis, whose

macro-economic effects are less observable than the typical shocks. Even when resources were allocated in the 2002/03 fiscal year, there are reports that most of the ministries were spending below expectation, in part because of capacity problems and, perhaps more significantly, because ministries had not yet developed specific HIV/AIDS programmes. An examination of the actual expenditure outturn at the end of year in relation to budgetary and the PRSP expectations will be highly important.

Conclusion and Recommendations

The HIV/AIDS epidemic in Malawi has without doubt reached catastrophic proportions, and is wreaking havoc on a population that is one of the poorest in the world. The disease has already reversed the gains made in economic and social development that had been achieved since the country gained political independence in 1964. With social indicators already weak, the high prevalence of HIV/AIDS infection rates is placing a very heavy burden on Malawi's meagre resources, with the unpleasant prospect that poverty is likely to deepen as the death toll increases.

The government's efforts to control and arrest the spread of the disease have been slow and fragmented. However, steps have been taken to respond more comprehensively through the Strategic Framework, which rightly emphasises a multi-sectoral approach.

- In order to fully implement this national response, Malawi will need the full commitment and support of its development partners. The severity and urgency of the HIV/AIDS problem requires that donors remain flexible, with minimal requirements for conditionality, especially at the level of intervention programmes.
- The government should consider assuming the full responsibility of its National Aids Commission, to better direct intervention efforts and release donor funds to further reinforce mitigation activities.
- At the macro-economic level, the IMF in particular needs to raise the profile of the HIV/AIDS problem and undertake an in-depth analysis of its impact on the economy. At the same time, the IMF needs to allow greater flexibility in the application of its conditionality, including the reinforcement of the recent increases in HIV/AIDS and pro-poor expenditures. Malawi should be assisted in developing robust economic growth models that fully integrate the impact of HIV/AIDS.
- In the case where intervention programmes are included in annual budget allocations, attempts should be made to assess the outcome periodically, as called for under the PRSP process.
- As indicated in Malawi's PRSP, there is an urgent need to mainstream and fully integrate HIV/AIDS intervention programmes in the poverty reduction efforts and overall macro-economic adjustment.
- More generally, the IMF should consider treating HIV/AIDS-stricken countries like Malawi along the lines accorded to post-conflict countries, by substantially relaxing conditionality to allow a more aggressive response to HIV/AIDS.

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Meeting Basic Needs of OVC: A Global Imperative with Emphasis on Education and Health Care in Africa

Don Brandt

Introduction

Of the world's 14 million children orphaned by AIDS under the age of 15, about 12 million live in sub-Saharan Africa (SSA). Most reside in the "AIDS Belt" that extends from South Africa north through Ethiopia. Yet not all orphans "lost" one or both parents to HIV/AIDS. Although HIV/AIDS is now Africa's leading killer, most parents have died from other diseases or causes, such as war or accident. While AIDS accounts for 32–38% of orphans in SSA today,[6] the future looks very different. By 2010–2015, nearly half of orphans in most eastern and southern African countries will have lost one or both parents because of HIV/AIDS.

Orphans, however, are just one of the many groups that make up the population of orphans and vulnerable children (OVC).[7] For a number of reasons, including ostracism, care providers soon discovered that orphans shouldn't be distinguished from other children in need. Yet, by expanding the definition of "vulnerable" to all very poor children, the number of youngsters living without most of their basic needs met probably includes about 50 million and may rise to over 100 million by 2010.[8] Providing OVC with the basic needs of primary education, food, health care, housing, clothing and security, plus psycho-social help, will be a formidable undertaking.

Programmes that tried to meet the needs of only those children orphaned by AIDS failed for various reasons. Programmes that gave resources to orphans or households with orphans were deeply resented by other destitute families in the community. In other cases, households adopted orphans in order to receive resources. Some parents in Botswana even registered their own children as orphans in order to receive government assistance. For these reasons World Vision believes that all interventions to address the needs of OVC must be rooted in action to assist their wider communities. In contrast, HIV/AIDS is viewed as a stigma in many SSA societies. So, too, is registering a child as an AIDS orphan.

The difficulty of providing more basic needs for orphans and other vulnerable children in areas with high HIV prevalence rates led Mark Lorey, Director of the World Vision Hope Initiative's Models of Learning Programme, to promote a two-stage programming model. First, regional or national situational analyses should be done to reveal the highest levels of OVC in the nation or province. Second, within these designated areas, community people should be charged with defining and identifying (i.e., targeting) the most vulnerable children.[9]

To ignore the burgeoning OVC population is to invite serious social, economic and political costs. The HIV/AIDS pandemic has already cut economic growth in a number of SSA nations as measured in terms of gross domestic product (GDP). In some countries there are indications that literacy rates will decline, partly because more poor children—many of whom are OVC—aren't attending school. Literacy, though, is not only positively associated with per capita GDP but with health and nutrition issues that directly affect such developmental concerns as maternal and child mortality. The neglect of basic care of OVC has already led to security problems, most easily seen in the rapid rise in the number of street children in many SSA cities, and with them, the associated increase in property crime and drug use. Security issues are likely to increase in several SSA countries with high HIV infections among military personnel. At the same time, OVC and other poor children will be prime candidates to join rebel militia groups.[10]

Purpose

If countries are to avoid the very worst economic and developmental scenarios that AIDS might bring, then investment in the future of OVC will be essential. Without attention to the educational and nutritional needs of these children, the economies of AIDS-affected countries will, in some cases, be impacted by a lost generation without the literacy or health care needed to make a strong positive contribution to economic growth. This chapter argues that if the international community is serious about long-term human development in Africa, then the needs of OVC present an urgent crisis that must be addressed. Currently, the future human and social capital of a continent is being sacrificed by the lack of political will on the part of governmental donors and international financial institutions.

Yet, interventions to drastically transform the situation of OVC are possible. Research from World Vision programmes and data from other non-governmental organisations (NGOs) show that these ventures are also low-cost, in an environment in which resources for the fight against AIDS remain scarce. Focusing primarily on education, this paper illustrates that OVC can be provided with the educational help they need for an average of US$200 per annum. Health and nutritional needs constitute what World Vision believes to be a second essential area for action. Both education and health care are areas in which World Vision has extensive experience, and both may also be considered as human rights, according to the Convention on the Rights of the Child and other international treaties.

- *On education:* States Parties recognise the right of the child to education and with a view of achieving this right progressively and on the basis of equal opportunity, they shall, in particular: (a) Make primary education compulsory and available free to all. (Article 28, 1, a)
- *On health/nutrition:* States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. State Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services. (Article 24, 1)
- *On health/nutrition and education:* States Parties recognise that every child has the inherent right to life. States Parties shall ensure to the maximum extent possible the survival and development of the child. (Article 6, 1 & 2)

  States Parties recognise the right of every child to a standard of living adequate for the child's physical, mental, moral and social development. (Article 27, 1)

These are strong words. To put them into practice for 50 million or more children in SSA will be an enormous feat. Cost estimates to do so are crude approximations, chiefly due to a dearth of reliably derived figures. Benefits, or returns on this investment, are even more difficult to estimate with any sense of precision.

Orphans and Vulnerable Children

Orphans of AIDS are generally identified as children younger than 15 years old whose mother ("maternal orphan"), father ("paternal orphan") or both parents ("double orphan") are deceased.[11] The age of other OVC are similarly defined. World Vision normally characterises childhood as ending at the age of 18, the age established by the Convention on the Rights of the Child. While recognising that basic needs of many OVC aged 15–18 are not being met, for the purposes of this chapter, OVC will normally refer to children under 15—an acknowledgement that most orphan and OVC information is based on the 0–14 year age group.

Although approximate, data on orphans is much more readily available than figures for all OVC, Asia, due to its huge size, has the largest number of orphans, estimated at 65.5 million in 2001. Of that total, 1.8 million or 2.75% are children orphaned by AIDS. Latin America's 162,289 orphans are fewer than Asia's, but at 7.1 the percentage of orphans of AIDS is higher. The orphan percentage leaps to about 12% of children under 15 in SSA. Of these orphans, more than 32% live without one or both parents due to AIDS-related deaths. Within each of the fol-

lowing 19 SSA countries, the number of AIDS orphans represents even more than 32% of the total number of all orphans: Burundi, Burkina Faso, Botswana, Central African Republic, Republic of Congo, Cote d'Ivoire, Democratic Republic of Congo, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Uganda, Tanzania, Zambia and Zimbabwe.[12]

Growing numbers. The situation of children orphaned by AIDS will worsen in SSA during the next few years. The U.S. Census Bureau predicts that by 2010 the number of children under the age of 15 will increase to 349 million, as will the total number of orphans (to about 42 million). A significant difference between 2001 and 2010 is that the percentage of children orphaned by AIDS will have grown to 48% of all orphans—that's 20 million children compared to 12 million today.[13] Nations with especially high percentages of AIDS orphans in 2010 will include Botswana, Burundi, Cameroon, Central African Republic, Republic of Congo, Cote d'Ivoire, Kenya, Lesotho, Liberia, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe. Of these 18, 12 are countries with World Vision national offices. In addition, three of SSA's largest nations will experience sizeable increases in the number of children orphaned by AIDS as a percentage of all orphans from 2001 to 2010: Nigeria, 18% to 40%; Ethiopia, 26% to 43%; and Democratic Republic of Congo, 34% to 42%.[14]

Unless there is a drastic drop in HIV infections, the number of children orphaned by AIDS in most SSA countries will continue to increase until about 2015 and then slowly drop. The primary reason for this is the time lag between the expected declines in the rate of adult deaths due to AIDS and when children are no longer considered dependent orphans (age 15 or 18). This may be seen in Uganda with an official HIV adult prevalence rate of about 5%, yet with orphans of AIDS accounting for 51% of all orphans—the 7th highest percentage in SSA. By 2010, that percentage should shrink to 39, or a rank of 22 in 41 SSA nations. In contrast, the percentage of children orphaned by AIDS in six countries will exceed 75% of total orphans (Botswana, Lesotho, Namibia, Swaziland, Zambia and Zimbabwe).[15]

Much has been written about the limitations of the extended family system in SSA in providing care for the predicted near-doubling of children orphaned by AIDS between 2001 and 2010. A key concern is that most families that absorb orphaned relatives are already poor. In 2000, for example, 22% of registered orphan caregivers in Botswana were unemployed, and about 40% of caregivers were grandparents or other elderly relatives.[16] In a high-impact HIV area in Tanzania, 39% of caregivers were unemployed, 55% were self-employed (75% of which were subsistence farmers) and only 2.4% worked in jobs with paid employment.[17]

Further evidence of household vulnerability is described by Deininger, Garcia and Subbarao from data based on the Zambian national orphan report and surveys from high HIV prevalence areas in Uganda and Tanzania. Results indicated that grandparents served as caregivers for 32%, 38% and 43% of orphans in Uganda, Zambia and Tanzania, respectively. The report also mentioned that in Zambia, an older orphan was the primary caregiver for 11% of orphans; in Tanzania it was 10%.[18]

Growing vulnerability. When destitute orphans go to live with poor families, these households generally become even more vulnerable as they try to support the children. Not surprisingly, in the area of Tanzania surveyed by Whitehouse, households could not meet "some" or "most" of the basic needs of 66% of orphans. The percentage of orphaned children affected by inadequate provisions of specific basic needs included education (materials, uniforms), 40.9; health care, 23.3; clothes, 20.7, food, 10.9 and other, 4.2.[19] Yet, it's not only children orphaned by AIDS and other causes who are poor. OVC include millions of additional children in SSA.

For example, 80% of Zambia's rural population lives below the country's poverty level[20] and at least 75% of orphaned children are poor.[21] A child living with HIV-positive parents is therefore almost certainly already poor or soon will be. Once the child's parents die, he/she will probably be taken care of by a relative. If that family is poor, the children in that

household may well become more vulnerable to hunger and disease with the addition of one or two AIDS orphans. Quite simply the `extended family' solution to the problem of OVC does not exist, the wider poverty of communities and impact of AIDS dictates that broad social interventions and services must be provided.

Other desperately poor children are the abandoned. Especially in peri-urban slums, children are discarded by young, unmarried teenage girls. Increasing numbers of street children, whether orphans, abandoned or runaway children, illustrate the challenges facing OVC. Additional examples include children who work, beg or are prostituted instead of attending school, as well as severely abused children and children raised under conditions of poor parenting.

Other "vulnerable children," like orphans, generally face a number of interrelated pathologies including the following:

- some or most basic needs not met
- often not able to attend primary school
- habitually absent due to work or illness, and frequently held back
- usually not able to afford secondary school
- poor health care and inadequate diet, and, in the case of children orphaned by AIDS, psychological trauma of seeing parents die; missing parents, love and compassion

The Cost of Inaction

Clearly, much more assistance is needed in the provision of services to OVC, if only measured by the tremendous economic, political and social costs for *not* taking action. The prospect of an economically dis-empowered and marginalised generation emerging in many SSA countries is daunting, particularly if that generation could be providing a foundation for renewed economic growth following the peaking of rates for AIDS mortality. Instead, even after the AIDS death rate begins to fall, countries will face long-term economic costs in terms of the neglected education and health of OVC. The economic benefits of education are discussed below, but it is worth remembering that real investment will be needed if OVC and their generation are to assume the developmental challenge, given the wider impact of HIV/AIDS on human capital in affected countries. Markus Haacker of the International Monetary Fund (IMF) has reviewed some likely consequences of AIDS on productivity and growth in southern Africa:

> In the "medium term," the negative impact of the decline in productivity and in experience on the rate of return to capital are offset by reduced investments rates (reflecting capital outflows or a decline in foreign direct investment). The resulting decline in capital-labour ratio (falling by between 4 and 10 percent, accounting for a decline in output of 1.2 to 3.1 percent) then reinforces the decline in productivity and experience, and output per capita falls by 4.0 to 10.2 percent.[22]

Haacker has estimated that by some definitions, it will take affected countries 45 years after AIDS has peaked before per capita output growth recovers.[23]

Social consequences of failing to invest in the OVC generation will be equally serious. It is well documented that due to cultural, social, economic and physiological reasons, girls in SSA are at higher risk of contracting HIV/AIDS than are boys. Poor girls, attracted to older men for food, clothing and other gifts, or living as prostituted children, are particularly susceptible to the disease. Whether girls or boys, children orphaned by AIDS are often psychologically traumatised, living lives with high levels of aggression, anxiety and depression. Without adequate care, this may translate into a "substantial rise in juvenile crime."[24] In fact, rising levels of petty crime accompanied by illicit drug use are already seen in urban areas, partially due to the increased number of street children. Lack of jobs will criminalise more OVC as they struggle to survive. The more that basic needs and nurture of orphans and other vulnerable children are ignored, the more property crime is expected to grow.[25]

Facing the Problem

The international community, particularly donor governments and multilateral agencies, must face up

to the urgent need for investment in the future of OVC. Several approaches should be adopted, among these the adequate treatment of parents and family members.

Caring for the rising number of OVC in SSA requires commitments of resources and pro-poor-children policies by government and international agencies. Ultimately, this implies reducing adult deaths due to complications from HIV/AIDS. Two parallel paths are required. The first is prevention. The "A, B, C" behavioural programme promoted by World Vision and other faith-based organisations emphasises abstinence outside of marriage (A), faithfulness to one's spouse within marriage (B) or condom use if a person cannot or doesn't choose to abstain or be faithful (C).

However commendable and effective, prevention programmes are not enough. Corollary treatment programmes are needed extend the lives of people with HIV/AIDS, if the rising population of children orphaned by AIDS is to be seriously reduced. This means that very inexpensive, if not free, anti-retroviral drugs must be available to all people who are HIV-positive in SSA. Agreements with international pharmaceutical companies have driven down the price of brand name medicines, but the cost of these drugs is still much too high for most Africans.[26] Governments must not only encourage sales of much cheaper generic drugs, but also lobby international donors to subsidise costs. A study in South Africa concluded that if anti-retroviral drugs were added to HIV prevention measures, then the predicted number of two million maternal AIDS orphans (under age 15) in 2010 would be cut in half. That's one million more children living with their mothers![27]

Healthier parents not only live longer but also are more economically productive. In contrast, studies show that in households of HIV/AIDS-weakened adults, food production sharply declines. Hunger and malnutrition further weaken both farmers and their children, creating a rise in the number of OVC. Thus, food security becomes a major issue in HIV/AIDS households. Programmes that call for combinations of food subsidies and appropriate food technologies may also be needed. For example, World Vision has shown that wooded and herbaceous plant species grown in combination or rotated with traditional crops virtually eliminate the need for expensive commercial fertiliser. Some of these soil-enriching crops, such as pigeon pea (*Cajanus cajan*) and Lablab (*Lablab purpureus*) also produce edible products.[28] Additionally, agricultural research stations, government agencies and NGOs are promoting the distribution of higher yielding and more nutritious non-genetically modified varieties of basic crops, such as maize (*Zea maize*), cassava (*Manihut esculenta*), groundnut (*Arachis hypogea*), sorghum (*Sorghum bicolour*), cowpea *(Vigna unguiculata*) and sweet potato (*Ipomoea batatas*).

Education

Primary education for every child is a global Millennium Goal. It is also a human right, as articulated in the Convention on the Rights of the Child (Article 28) and the International Covenant on Economic, Social and Cultural Rights (Article 13). The UN Millennium Summit set a target date of 2015 for when basic education should be available to all the Earth's children (Goal 2, Target 3). "All children" is an extravagantly inclusive term as it embraces the very poor, especially children orphaned by AIDS and other OVC.

Achieving the goal of quality universal free primary education in most SSA countries will be very difficult for a couple of reasons. The first is a lack of resources. Almost all SSA nations are poor. As a consequence, most school districts charge fees (tuition) that parents or other caregivers must pay in addition to school materials and uniforms. In states with free primary education, such as Uganda, Tanzania and Malawi, reports indicate that while more children are attending school, schools are overcrowded and the quality of education has suffered.[29]

To help remedy the lack of school funding, NGOs have a long history of subsidising education, either at the individual child or community levels. The problem remains that the education of most poor SSA children is not paid for by benevolent donors. Yet the benefits of universal basic education far exceed the costs, according to governments, NGOs and in-

ternational agencies. The World Bank has stated that "the education of children and youth merits the highest priority in a world afflicted by HIV/AIDS."[30]

The Bank argues that education is also "pivotal" in achieving the Millennium Development Goals of reducing child mortality and lowering birth rates. Especially relevant to this report, the Bank sees education as an important tool in curbing HIV/AIDS.[31] While free primary education has social and private costs,[32] it is clear to the Bank that benefits greatly outnumber costs.

Costs and benefits. Private and social benefits of education are so intertwined that it's difficult to separate the two. Benefits include the following:

- Increased literacy
- Economic growth and better job opportunities
- Reduced child mortality with increased female literacy[33]
- Reduced vulnerability to HIV/AIDS (schools serve as an excellent avenue for delivering HIV prevention messages)[34]
- Behavioural change. Especially after the initial or early stage of HIV infection, education serves as an "AIDS vaccine." According to Hepburn, "the more educated segments are generally better able to protect themselves and change their behaviour."[35]
- Reduced opportunistic infections and expensive medical care
- Greater gender equality
- Reduced number of street children and urban crime
- Reduced property crime and increase security

Resources for education should greatly benefit from a drop in HIV/AIDS infections. In 33 SSA countries, the pandemic adds US$450–550 million per year to the cost of achieving universal, free primary education (Education for All Initiative).[36]

Periodically, researchers have attempted to calculate the cost effectiveness or cost benefits of education. The World Bank sponsored a study that calculated private and social rates of return of public primary and secondary schooling in Malawi. Cost and benefit figures were calculated from 1990/1991 data. They do not reflect the tremendous economic costs of HIV/AIDS that could be substantially reduced through compulsory free primary education, especially if HIV prevention programmes are included in the education curricula. Nor do the figures reflect that primary education is free in Malawi today.

The study indicated that the private rates of return to investment in primary education were outstanding: between 21.95% and 22.76%. The private rates of return on investment in secondary education were lower, but still quite high: 8.65% to 15.3%. Data for social rates of return were 19.9% to 20% and 7.7% to 14.1% for primary and secondary education, respectively. This means that for each *kwacha* or dollar invested, the combined private and social rate of return for primary education over a person's lifetime was between 41.85% and 42.76%.[37]

Another World Bank report examined direct monetary benefits of education through cost/benefit analysis via the internal rate of return technique. As in the Malawi study, both private and social costs and benefits were calculated. Results were comparable. The private rate of return to investment on primary education was 28%; the social rate of return was 19%, giving a total of a 47% return over the working lifetime of a person.

Just as informative, a Ghanaian study disaggregated education by gender and economic class. Girls who received a primary education benefited twice as much as did boys. The combined social and private rate of return on investment for girls was a huge 63.9%. For boys it was a very respectable 28.9%. Results by economic class revealed that both the poor and non-poor benefited almost equally (42.9% versus 46%, respectively).[38]

A report by van der Gaag used the benefit/cost framework to examine wage differentials under two contrasting situations. Both situations looked at hypothetical well-nourished, healthy girls of normal or above intelligence. Girl A stayed at home until age

12, then worked until she retired at 55. Girl B attended primary school from age six to 12, at which time she entered the labour force, retiring at 55. Under these circumstances, based on data drawn from several countries, every extra year of primary education yielded a productivity (or hourly wage) increase of 10–30%. Girl B will have earned 60% to 180% more per hour for every hour worked for 43 years, than Girl A.[39]

Specific cost examples. The World Bank reports used benefit and costs data from the early 1990s. Current figures can be difficult to assess, as they often are based on crude estimates, and frequently include other expenses besides education. For instance, Deininger *et al.* collected information on the annual cost to support an orphan in Uganda. Their study surveyed organisations and agencies that provided care for 1.7 million or 4.8% of all orphans in Uganda. Annual costs ranged from US$81.75 to US$222.50 (Table 1). All programmes were community-based. In looking at these data, two factors should be kept in mind. First, quality of care wasn't assessed. Second, comprehensiveness of care (how much) wasn't examined. All programmes did include a primary education component.

Table 1: Per Capita Orphan Programme Costs in Uganda[40]

Provider	**Annual cost (US$)**
International NGOs	222.50
National NGOs	209.60
CBOs*	81.75
Religious groups	120.89
Local government agencies	129.96
Private sector	192.36
Average (of a total of 83,100 orphans)	209.33

*community-based organisations

Early in 2003, World Vision surveyed 12 southern partners located in countries with high HIV prevalence rates. Offices were asked to estimate costs of providing community care for a number of OVC interventions. Replies varied considerably, given the national context in which the office operated. A rough average figure for providing "essential care," including primary education, was about US$200 annually per orphaned or vulnerable child.[41]

Since education is often combined with other orphan and/or OVC interventions, Table 2 shows costs for primary education and other interventions by source/provider and country/countries.

Barriers. If the World Bank, UNICEF, UN Development Programme and the entire UN system as well as NGOs and most governments are in favour of compulsory, free primary education, why then are 130 million children not attending school? Part of the answer lies in cultural traditions that are sceptical about the utility of a formal education. Part of the problem in areas with high HIV/AIDS infection rates is a shortage of teachers and severe overcrowding of classrooms. So little learning is accomplished that some parents stop sending their children to school.[43] Children orphaned by AIDS or children living with HIV-positive parents may avoid school because of psychological trauma caused by stigmatisation from other pupils and teachers. And part of the problem is related to safety, especially for girls, both at school and in travel to school and back.

Most of the barriers are financial, to some degree at least. Primary education is not free in most of SSA, and even in countries without tuition fees, families are still required to buy uniforms and school supplies. All the cost/benefit analyses that document wonderful rates of return on education investments don't help the family that can't pay tuition fees or buy uniforms and school supplies. Other poor families see high opportunity costs of children attending school and not working, especially in situations where the value of education is already questioned. School fees may need to be diverted to pay the medical bills of a parent sick with HIV/AIDS. At the same time, boys and girls may need to do more home or garden chores as the health of their parents deteriorates.[44]

Table 2: Primary Education and Combined Education and Other Interventions

Provider/Source	Country/ countries	Cost US$/year	Education only	Education + other
World Vision	10 in SSA, Haiti, Cambodia	65	Yes	
Maua Methodist Hospital	Kenya	80	No	Food for guardians
Evangelical Lutheran Church	Zimbabwe	100	Yes	
Deininger *et al.*	Uganda, Burundi	105	No (no school fees in Uganda)	Vaccinations
FDC	Mozambique	20	Yes	
FDC	Mozambique	100	No	Food, transportation
World Medical Fund	Malawi	96	No (no school fees)	Clothes, uniforms, food inputs
AIDS Orphans Education Trust	Uganda	300	No (no school fees)	Clothes, food, school supplies
Nazarene Compassionate Ministries	five in SSA	222	No (no school fees in three)	Food; others unclear
UNAIDS	Zambia	100	Yes	
Maryknoll	Cambodia	960	No	Foster care: food, housing, medicine
Christian Unity Fellowship	Rwanda	120	Yes	
World Bank	(general)	50	Yes	
Serving in Mission	(general)	300	No	General support
All As One	Zimbabwe	480	No	Foster care

For references see footnote.[42]

As a group, these nations are too poor to provide quality, free, universal, primary instruction. A comment about Zambia applies to most SSA: "perhaps in the area of education . . . government, donors and the development community have failed the Zambian child the most."[45] Industrial countries as a group have turned to multilateral assistance while reducing bilateral aid. This makes the World Bank's "investment" of US$9.7 billion in 78 countries for education purposes (as part of the Education for All campaign) appear to be impressive.[46] Unfortunately, total socio-economic giving of wealthier nations, as a percentage of GDP, has declined.

OVC in last place. It should come as no surprise that orphans and other vulnerable children—after refugees, the poorest of the poor—are the least educated. For example, in Mozambique only 24% of double orphans attend primary school versus 68% of children whose parents are both alive. In Niger, 28% of orphans are absent from school compared to 10% of non-orphans. Among children aged 7–9 in Burundi, 40% are in school if both parents are alive. With the death of the father, enrolment drops to 33%; if the mother dies, only 21% of these children are in school. Double orphans in Malawi are almost twice as likely to drop out of school than children whose parents are alive (17.1% versus 9.5%). The double orphan/non-orphan enrolment differences are reported in most countries. For example, the gap is 8% versus 30% in Niger; 52% versus 72% in Tanzania; and 18% versus 50% in Benin. Some countries, though, are closing the gap, such as Malawi, Mali and Zimbabwe. Dropout rates among orphans tend to remain high, even in countries trying to close the enrolment disparity. In one region of Kenya, 56% of orphaned girls and 47% of orphaned boys dropped out of school. In urban Zambia, 32% of OVC are not in school versus 25% for non-OVC. Rates for rural areas are 68% and 48%, respectively.[47]

How to get more children, especially OVC, into primary school is a key concern of parents, other caregivers, government and international agencies, NGOs, CBOs and OVC themselves. Whitehouse asked OVC to state their greatest perceived needs. Education and the opportunity to go to school headed their lists, followed by a desire for love and compassion and understanding teachers who don't beat or berate them.[48]

Most of the leadership in innovative programmes to lower school costs have come from SSA country or community initiatives. A fairly typical example appears in an Alliance report on education.[49] Many Zambian villages support "open community schools." They are "open" because all primary school age children are welcome in these free schools (no fees are charged nor are uniforms required). Teachers are not paid and space for classes is donated. An objective of community schools is to compress six years of primary education into three. The main difficulty reported with these schools is quality. Volunteer instructors may not be competent, and certified teachers tend to leave when jobs open in public schools.[50]

Other innovative schemes include Uganda's foster care programme. Poor families receive subsidies for OVC care. This initiative raised some concerns about the difficulty in assuring that OVC obtain the designated benefits. Modifications of the programme call for community committees to pick the neediest OVC. Vouchers are provided to subsidise health care and school expenses (tuition is free). The foster care results for primary education are encouraging. A 1999 study showed that school attendance of foster children was 84%—the same rate as non-foster children.[51] About 20% of Uganda's orphans are incorporated in the foster family programme at an annual cost of US$300 million.[52] Educational subsidies are being adopted or explored by other state agencies, NGOs and other organisations.[53]

Primary Health Care and Nutrition

Health and nutrition are so closely tied as to be nearly inseparable. Most childhood diseases are exacerbated because of malnutrition and other nutrition problems. To a large extent, health and nutrition are associated with income. It comes as no surprise that poor children are frequently both hungry and ill. Nor is it surprising that SSA and South Asia, the world's poorest regions, have the highest incidence of sick and malnourished children. In Zambia,

for example, 50% of children are chronically malnourished and 42% (usually the same children) are stunted. A survey of children under age five in Malawi reported that 48% are stunted.[54] Health and nutrition problems of OVC are more severe. Deininger *et al* makes clear that maternal and double orphans have higher levels of stunting and malnutrition than non-orphans.[55]

Few would disagree with Loening-Voysey and Wilson, who maintain that OVC should receive a minimum of three well-balanced and nutritious meals each day, plus full immunisation and access to basic medical treatment.[56] Yet that goal is not met among most of the world's children. The ability to attend school and learn is clearly associated with wellness. OVC and other poor children often go to school on an empty belly, or children miss school because of hunger and diseases related to malnutrition.

Many NGOs and CBOs have provided meals for children before or after school. An example is Noah's Ark, a CBO in South Africa. After school, children accepted into the programme perform chores, such as helping in the vegetable garden, for which they receive an evening meal.[57] In Lusaka, Zambia, OVC in 21,000 families receive a school lunch of high-energy biscuits.[58] Janke promotes free in-school or take-home meals for OVC and other poor children to offset parents' opportunity costs for sending their children to school. Caution is needed in designing school feeding programmes. Caregivers must not consider a free school meal as a substitute for breakfast or dinner at home. Management of meals may best be done by parents' committees.[59]

Specific cost examples. As with primary education, estimated costs of subsidised feeding for OVC vary widely. Most charities don't specify the type and amount of food served per child. An article from the Evangelical Lutheran Church in Zimbabwe says that US$365 a year will feed an orphan. In Kilgali, Rwanda, a year's food supplement will cost donors US$40 for each orphan. Cereal with milk is priced at US$24 annually per orphan in Uganda. Results of the World Vision survey indicate that yearly community-based food aid will cost about US$300 per orphaned or vulnerable child, and that the price of agricultural assistance annually for each of these children is about US $200.[60] The World Bank reports that reduction of iron deficiency anaemia costs a scant US$1per per year.[61]

Compounding the problem of cost and coverage is programme fragmentation. No one agency or organisation can provide all the education, health care, nutrition and other needs of OVC and other poor children. Programmes are patchy, however, and partnerships are few because government agencies, NGOs and CBOs are notoriously independent.[62]

Partly due to the fragmented, disjointed manner of providing health care and nutrition, the World Bank, UNICEF and the World Health Organization inaugurated a programme called Focusing Resources on Effective School Health or FRESH. The programme works in partnership with communities and is promoted as "one of the most cost-effective ways to reach school age children" with health care, hygiene and sanitation.[63] Benefits include increased school enrolment, reduced school dropouts rates, increased clean water and adequate sanitation, diminished risk behaviours that lead to HIV infections and discrimination of people living with AIDS, reduced worm infections and micro-nutrient deficiencies, and tobacco-use prevention.[64]

Conclusion

African nations and highly affected HIV/AIDS countries elsewhere in the world are facing a catastrophe with devastating effects at both individual and national levels. The personal consequences of AIDS now for millions of families are appalling, and yet the costs of AIDS will not be limited to the terrible statistics of death and infection. AIDS will impoverish countries for many years after infection rates have peaked. The wider debilitating effects on the development process will cost lives in countless other ways and will sentence further generations of children to poverty.

Action can be taken, however, to try to limit the long-term disaster brought about by AIDS. In particular, donors and multilateral agencies as well as local governments can act to ensure that OVC do not become a lost generation, economically and so-

cially marginalised. It could be claimed that the world has awakened to the realisation that the number of children orphaned by AIDS in SSA will grow exponentially during the next few years. While many organisations do have orphan programmes, most caregivers will remain family members. Private donors in the North do not clearly understand that millions of other children are growing up just as poor as orphans. Like orphans, these other "vulnerable children" are living without many of their basic needs, including health care, nutrition and education, being met.

NGOs, CBOs, religious groups and government and international agencies should address the life needs of all OVC. To do so will require enormous efforts to alter policies, encourage innovation and press for co-operation among agencies, organisations and other groups. Doing so will also require much larger inflows of resources from donors. Yet there are programmes that demonstrate how educational and health interventions can transform the futures of OVC. These interventions are inexpensive, yet could represent a substantial investment in the long-term development of the countries concerned.

Action is now urgently needed to ensure that all OVC have access to the educational, health and social assistance that they need if the worst-case development scenario for AIDS is to be avoided.

Conclusion

Those who live with HIV/AIDS in the developing world face heartbreaking dilemmas as a daily event. Whereas their counterparts in richer societies might look forward to years free of full-blown AIDS and a substantially longer life expectancy (thanks to effective health care and medication), few people in poor countries have such a prognosis. Each person in poverty living with AIDS must rapidly consider who will care for children, and may die knowing that those children will be left to fend for themselves.

The world has failed those with AIDS in developing countries. Rich countries have not been willing to focus on the threat to human life posed by this problem as rigorously as they must. The failure to reach out to those suffering from AIDS is a contradiction to the basic Christian message that many in the rich world would claim as their own heritage of belief.

Jesus Christ stood in stark contrast to the conventions and beliefs of his day when he showed compassion for those afflicted by leprosy, at that time considered a hopeless disease. Jesus' gift to the sufferer went beyond healing to the restoration of dignity and hope—a new realisation of self-worth.

As an organisation that seeks to follow Jesus in serving the poor, World Vision is deeply conscious of the need to return to AIDS-affected countries the ability to effectively address the problems they face. Rather than placing restrictions and constraints on the fight against AIDS, developed countries and international financial institutions should empower states to pursue effective AIDS policies.

Those same developed countries and institutions must also question the priorities that lead them to continue to under-fund the fight against AIDS. For the same cost as a few days' military spending, substantial progress could be made.

Notes

[1] Center for Defense Information (Center for Defense Information website).

[2] Global HIV Prevention Working Group, "Access to HIV Prevention: Closing the Gap," (UNAIDS, May 2003), 1–3.

[3] Nicolas Crafts and Markus Haacker, "Welfare Implications of HIV/AIDS" (May 2003), 5.

[4] Ibid., 4.

[5] *World Bank Group in Low-Income Countries under Stress: A Taskforce Report*. (World Bank, September 2002), v.

[6] Figures vary, as even the best are estimates.

[7] OVC include all orphans under age 15 and not only those orphaned by AIDS. "Vulnerable children" is an imprecise term, but it tends to be identified with children under 15 who are not orphans, yet are directly affected by HIV/AIDS. Examples are children in families caring for orphans and children whose father or mother is HIV-positive.

[8] The World Vision AIDS initiative team (Hope) have estimated 49 million OVC in 2002, increasing to 92 million by 2010 using orphaning and HIV infection estimates. Ken Casey, Special Representative to the World Vision International President, HIV/AIDS Hope Initiative, memo to the author, 19 May 2003. The Francois-Xavier Bagnoud Association estimates that there will be at least 100 million OVC in the world by 2010.

[9] Mark Lorey, "Strategic Approach to Targeting Programs," in Anthony Levine, ed., *Orphans and Other Vulnerable Children: What Role for Social Protection?* (Social Protection Unit, Human Development Network, World Bank, Oct. 2001), 24.

[10] Readers may wish to see comments by Lincoln Ndogoni, World Vision Psycho-Social Programme Researcher, quoted in "Fighting Adult Battles" and "International Guilt," two themes in the forthcoming *Children of Promise Bible Studies* (Mission Advanced Research and Communications Center Publications, Oct. 2003).

[11] See, for example USAID's *Children on the Brink 2002* (USAID website, 2002).

[12] Ibid., 22–2

[13] Family Health International, "Care for Orphans, Children Affected by HIV/AIDS and Other Vulnerable Children," (Family Health International, funded by USAID, The Synergy Project website). This document estimates the total number of orphans under 15 at 44 million in SSA by 2010. Of this, children orphaned by AIDS will number 29 million or 66%.

[14] USAID, *Children on the Brink 2002, loc. cit.*, 7, 28

[15] Ibid., 22, 28

[16] UNAIDS, "Focus: AIDS and Orphans," in *Report on the Global HIV/AIDS Epidemic 2000* (UNAIDS website, 2002), 137.

[17] Anna Whitehouse, "A Situation Analysis of Orphans and Other Vulnerable Children in Mwanza Region, Tanzania," (The Synergy Project, funded by USAID, The Synergy Project website), 39. Of the remaining caregivers, 0.5% were enrolled at school or college and 3.4% of replies were not recorded.

[18] Klaus Deininger, Marito Garcia and K. Subbarao, "AIDS-Induced Orphanhood as a Systemic Shock: Magnitude, Impact and Program Interventions in Africa," (World Bank, World Bank website, Nov 2001), Table 1.

[19] Whitehouse, *loc. cit.*, 42–43.

[20] UNAIDS, "Children Orphaned by AIDS: Front-line Responses from Eastern and Southern Africa" (UNAIDS website, 1999), 1.

[21] Michael Fleshman, "AIDS Orphans: Facing Africa's 'Silent Crisis'," *Africa Recovery*, October 2001.

[22] Markus Haacker, "The Economic Consequences of HIV/AIDS in Southern Africa," IMF Working Paper WP02/03 (IMF, 2002), 34.

[23] Ibid., 36

[24] Leigh Johnson and Rob Dorrington, "The Impact of AIDS on Orphanhood in South Africa: A Quantitative Analysis" (Centre for Actuarial Research, University of Cape Town, Oct. 2001), 27.

[25] Martin Schonteich, "A Generation at Risk: AIDS Orphans, Vulnerable Children and Human Security in Africa," Paper presented at the conference on Orphans and Vulnerable Children in Africa, Uppsala, Sweden, Sept. 2001 (www.nai.uu.se/sem/conf/orphans/schonteich.pdf), 3–4.

[26] Even with an agreement with major drug companies, the monthly price of a basic anti-retroviral drug "cocktail" in South Africa is R (Rands) 1,700, about US$202 or US$2,424/year. The Treatment Action Campaign would like to drive the price down to R275 a month or about US$405 annually. From "South Africa: The Price of Three Million Lives," *Daily Mail & Guardian (Johannesburg)*, 7 March 2003, 2. Even at this discounted price, the drug treatment is unaffordable for most people. In Cape townships, for example, 76% of households live below the poverty line of R352 (about US$504/year). "Blacks Getting Poorer, Says Cape University Study," *IRINNews.org*, 14 May 2003, 1.

[27] Kerry Cullinan, "HIV Plan Saves Lives and Cash," *Sunday Times* (South Africa), 30 June 2002, 2

[28] Joe Muwonge and Don Brandt, "From Hunger to Harvest: Food Security and Environmental Renewal through Agroforestry in Zambia," World Vision Special Report (World Vision International, Dec. 2002).

[29] Amy E. Hepburn, "Primary Education in Eastern and Southern Africa: Increasing Access for Orphans and Vulnerable Children in AIDS-affected Areas," (Duke University, funded by USAID, June 2001), 18.

[30] Don Bundy and Manorama Gotur, eds. *Education and HIV/AIDS: A Window of Hope* (Washington: World Bank, 2002), ix, xv.

[31] Ibid., xvi, xvii.

[32] Social costs, such as tuition, may be totally or partially paid by the public. Private costs include such things as uniforms, school supplies and the significant opportunity costs for many poor families of children attending school and not working.

[33] A 10% gain in female literacy yields a 10% reduction in child mortality. Hepburn, *loc. cit.*, 6.

[34] In Zambia during the 1990s, the HIV rate of women with a secondary education fell by 50%, while the HIV rate for women without a formal education only marginally declined. Bundy and Gotur, *loc. cit.*, 7.

[35] Hepburn, *loc. cit.*, 9.

[36] Bundy and Gotur, *loc. cit.*, xviii.

[37] "Rates of Return to Investments in Education in Malawi," in "Annex 3a of *"Malawi: Primary Education Project*, 1995 (World Bank website), 4.

[38] "Cost-Benefit Analysis: Returns to Education," in Annex 3-3 of "Ghana: Basic Education Sector Improvement Program," 1996 (World Bank website), 2–3.

[39] This section of van der Gaag's study examined private costs and benefits. Perhaps it would be more realistic if opportunity costs were calculated for Girl B, as the chances would be good that Girl A would be working at least part time from age six to 12. However, the study didn't include the social benefits that accrue with a primary education—benefits that the Malawi and Ghana reports show are almost equal to private benefits, even without calculating education's social benefits of reducing HIV infections. Jacques van der Gaag, "Early Child Development: An Economic Perspective," World Bank Report, n.d., (World Bank

website, 1996), 2–8.

[40] Deininger *et al.*, *loc. cit.*, Table 12.

[41] "Essential care" includes education and "all the activities considered necessary for providing quality OVC programmes." Don Brandt, compiler, "Results of the Orphans and Other Vulnerable Children (OVC) Survey for National Offices," unpublished World Vision report, April 2003, 6–7.

[42] Brandt, *loc. cit.,* 5; "AIDS Orphan's Project–Maua Methodist Hospital," (2001), (www.cox-internet.com/1stumc/Orphans.htm); "AIDS in Africa," (2002), (http://www.elca.org/dcs/aidsin.html), 3; Klaus Deininger, Marito Garcia and K. Subbarao, "AIDS-Induced Orphanhood as a Systemic Shock: Magnitude, Impacts and Program In Africa," PowerPoint version, (World Bank website, Nov 2001), 15; Fundacao para o Desenvolvimento da Comunidade, "Reencontro: Assistance to AIDS Orphans, A Community Based Initiative," (2002) (www.synergos.org/gpcparlor/southernafrica/02/fdcreencontro.pdf), 2, 4; "AIDS Orphans," (World Medical Fund, World Medical Fund website, 2001), 1; "You Can Help," (AIDS Orphans Education Trust, www.orphanseducation.org/you_can_help.htm), 1; "AIDS Caregiver Program," (Nazarene Compassionate Ministries, Nazarene Compassionate Ministries website, 2003), 2; "Orphans," (UNAIDS, UNAIDS website, Jan. 2002), 1; "The Education of AIDS Orphans in Cambodia," (Mary Knoll website, 2001), 1, "Child Development Centre," (Christian Unity Fellowship website, 2001), 1. Serving in Mission mail enclosure (May 2002); Bundy and Gotur, *loc. cit.*, 25.

[43] 1999 teacher deaths affected 860,000 children in SSA, mostly in southern and eastern Africa. Absenteeism increases as the disease progresses—an average of six months in the early stages of HIV to 12 months with full-blown AIDS. Substitutes are often not provided due to budgetary constraints. Bundy and Gotur, *loc. cit.*, 11–13.

[44] Such as cleaning, food preparation, cooking, caring for younger siblings and various farm-related tasks from field preparation to weeding to care of farm animals.

[45] Fleshman, *loc. cit.*, 5.

[46] Bundy and Gotur, *loc. cit.*, xxi.

[47] Hepburn, *loc. cit.*, 10; Deininger *et al.*, *loc. cit.*, 2, 4; Bundy and Gotur, *loc. cit.*, 19; Deininger *et al.*, PowerPoint version, *loc. cit.*, 10; UNAIDS, "Focus: AIDS and Orphans," *loc. cit.*, 135; and UNAIDS, "Children Orphaned by AIDS," *loc. cit.*, 2.

[48] Whitehouse, *loc. cit.*, 34.

[49] See the "Strategies" section of the International HIV Alliance, "Building Blocks: Africa-Wide Briefing Notes, Education," (International HIV/AIDS Alliance, funded by USAID, The Communications Initiative website, Jan. 2003), 10–15.

[50] Fleshman, *loc. cit.*, 5–6; Hepburn, *loc. cit.*, 22–23; and Fleshman, *loc. cit.*, 5.

[51] Deininger *et al.*, *loc. cit.*, Table 10 and Deininger *et al.*, PowerPoint version, *loc. cit.*, 7.

[52] Deininger *et al.*, *loc. cit.*, 1.

[53] See especially Hepburn, *loc. cit.*

[54] "Children Orphaned by AIDS, *loc. cit.*, 2 and "Malawi: Focus on Impact of Poverty, AIDS on Schooling," *IRINNes.org*, 6 May 2003, 2.

[55] Deininger *et al.*, *loc. cit.*, 1–2.

[56] Heidi Loening-Voysey and Theresa Wilson, "Approaches to Caring for Children Orphaned by AIDS and Other Vulnerable Children," (Institute of Primary Health Care—South Africa, funded by UNICEF, The Synergy Project website, Feb. 2001), 18–19.

[57] Thabislie Gumede, "Orphans of AIDS Learn the Skills of Survival," *Sunday Times* (South Africa), Nov 2002, 1.

[58] "School Feeding Scheme for HIV/AIDS Orphans," *IRINNews.org*, 27 Aug. 2002, 1.

[59] Cornelia Janke, "Food and Education: Background Considerations for Policy and Programming," (Catholic Relief Services, July 2001), 26, 29. For a general description of health and nutrition needs and means, see the "Health and Nutrition section

of the International HIV Alliance, "Building Blocks: Africa-Wide Briefing Notes," *loc.cit.*

[60] In order, "Aids in Africa," *loc. cit.*, 2; "Child Development Centre," *loc. cit.*, 1; *Ibid*; and Brandt, *loc. cit*.

[61] World Bank, "Why a FRESH Approach to School Health," (World Bank website, 2002), 2.

[62] See Family Health International, *loc. cit.*, *Care for Orphans, Children Affected by HIV/AIDS and Other Vulnerable Children,* 2–3.

[63] "World Bank, "Why a FRESH Approach?" *loc. cit.*, 1.

[64] *Ibid*, 2. Page 2 reported that due to clean water and improved sanitation in Bangladeshi schools, enrolment of girls increased 15%.

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World Vision is a Christian relief and development partnership which serves more than 85 million people in some 80 countries. World Vision seeks to follow Christ's example by working with the poor and oppressed in the pursuit of justice and human transformation.

Children are often most vulnerable to the effects of poverty. World Vision works with each partner community to ensure that children are able to enjoy improved nutrition, health and education. Where children live in especially difficult circumstances, surviving on the streets, suffering in exploitative labour, or exposed to the abuse and trauma of conflict, World Vision works to restore hope and to bring justice.

World Vision recognises that poverty is not inevitable. Our Mission Statement calls us to challenge those unjust structures, which constrain the poor in a world of false priorities, gross inequalities and distorted values. World Vision desires that all people are able to reach their God-given potential, and thus works for a world which no longer tolerates poverty.

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