Conceptual Shifts for Sound Planning:
Towards an Integrated Approach to HIV/AIDS and Poverty

concept paper
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Acknowledgements

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List of Acronyms

AIDS: Acquired Immune Deficiency Syndrome
HIV: Human Immune-Deficiency Virus
SADC: Southern African Development Community
PRSP: Poverty Reduction Strategy Paper

Preface

"Mainstreaming AIDS" like its twin sister "multi-sector response to HIV/AIDS" are programming concepts that mean different things to different people. This has not helped in policy debate and programming national responses to HIV/AIDS. To facilitate a shared understanding of what these critical concepts mean the Regional Project has since 2000 organized a series of workshops for policy makers in the sub-region. These workshops have become platforms for policy dialogue, but more importantly as places where the Regional Project introduces potential methods and tools to mainstream AIDS into the development agenda. In developing these methods and tools the Regional Project has been working from the premise that the relationship between AIDS and development is not linear but cyclical. Firstly, AIDS related mortality and morbidity undermines the capacity of individuals, households, communities and sectors to carry out development efforts. Secondly, development may accelerate or inhibit the spread of HIV in a given community. Thirdly, there is always a time delay associated with the appearance of AIDS-related impacts and development policy changes. With this time delay in mind one sees a case of a vicious cycle that must be transformed into a virtuous cycle.

Recent global, regional and national conferences have put HIV and poverty at the centre of the development agenda, and this has been clearly reflected in the recent millennium goals for development. This concept paper is an attempt on the part of the Regional Project to contribute to the important programming and policy debate on how to mainstream AIDS into poverty—focusing on what and why. The "how to" question will be answered in the second set of concept papers which are going to focus on the use systems and strategic thinking in mainstreaming AIDS into development efforts.

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Introduction

In a report presented at the XIV International Conference on AIDS in Barcelona, 2002, UNAIDS emphasised the reality that more than 28 million people in sub-Saharan Africa are currently living with HIV/AIDS. This means that just over 70% of the total global population living with HIV/AIDS is concentrated in the region. The report also reveals that 81% of the total number of women living with HIV/AIDS live in sub-Saharan Africa, as do 87% of all children living with HIV/AIDS. At the same time, the region hosts 11 million children who are orphaned due to the epidemic, which means that eight out of ten AIDS orphans worldwide live in sub-Saharan Africa. In contrast to earlier assumptions about how epidemics develop and plateau, the report notes that, based on global trends, HIV/AIDS is at the early stage of development and that its long-term evolution is still unclear.

There is, however, no doubt that HIV/AIDS poses one of the most critical development challenges in sub-Saharan Africa. The reason why sub-Saharan Africa is disproportionately vulnerable to HIV/AIDS stems, to a large extent, from the high levels of poverty in the region.[1] Thus, the key policy imperative is to develop frameworks and interventions that reduce poverty whilst simultaneously preventing the spread of HIV/AIDS. Such an integrated response to poverty and HIV/AIDS also needs to take into account that millions of people are currently living with HIV/AIDS and that there is an increasing need for treatment, care and impact mitigation interventions to prevent more people from falling into poverty.

Despite a multitude of efforts at community, national and global level to curb the spread of HIV and cope with the effects of the epidemic (some of which have made impressive strides and serve as beacons of hope), there is increasing awareness that existing models for intervention are inadequate for the task. Dominant approaches to HIV/AIDS have tended to focus on epidemiological and/or behavioural aspects of HIV/AIDS, without due regard for the broader socio-economic and political environment. As a result, there is "little conceptual or programmatic guidance for moving beyond the simple acknowledgement of poverty as a contributing factor in HIV/AIDS risk" (Collins and Rau 2000: 1). Planning an effective response to the challenges is vital, but given the complex nature of poverty, HIV/AIDS, the external environment and institutions, and with so many factors unknown, planning needs to be informed by a sound conceptual basis. It also needs to be sufficiently flexible to allow for ongoing learning and revision. The aim of this paper is to contribute to this lacuna by exploring the conceptual linkage between HIV/AIDS and poverty.

This concept paper is based on a workshop titled "Mainstreaming of HIV/AIDS into Poverty Reduction Strategies", which was convened by the UNDP Regional Project on HIV and Development in sub-Saharan Africa and took place in Zambia in June 2002. The workshop brought together representatives of UNDP country offices, governments and civil society organisations from Angola, Lesotho, Malawi, the United Republic of Tanzania, Zambia and Zimbabwe. The paper draws on the conceptual frameworks and models presented by Dr Roland Msiska, the Project Director, and further elaborates on these paradigms. The tenor of the workshop was in line with a recent shift in thinking about HIV/AIDS which holds that it is crucial to address the economic, political, social and cultural factors that render individuals and communities vulnerable to HIV/AIDS (see UNAIDS 2002). Thus, this concept paper starts from the premise that poverty and inequality, in particular gender inequality, are core factors mediating vulnerability to HIV infection and to the impacts of HIV/AIDS-related illness and death. There is ample empirical evidence that confirms this. In addition, HIV/AIDS has the potential to aggravate poverty and inequality. The interconnectedness between poverty, inequality and HIV/AIDS warrants an integrated response to these development challenges.

[1] It is important to note that the relationship between poverty and HIV/AIDS is not simplistic (see Collins and Rau 2000). Some countries in East and West Africa have a low HIV prevalence rate, despite high levels of poverty. Also, not only poor people are infected or affected by HIV. This indicates that poverty is not the only factor that enhances vulnerability to HIV/AIDS and its impacts.

Because the main objective of the workshop and of this paper is to provide a conceptual framework that links HIV/AIDS to poverty in sub-Saharan Africa, other significant factors of vulnerability to HIV/AIDS are potentially unexplored or under-explored. It is hoped that future work will address these issues.

Structure of the paper

Because HIV/AIDS in sub-Saharan Africa is predominantly spread through sex between men and women, the way men and women behave in sexual encounters is critical to reversing the epidemic. As a starting point, this paper reviews the various reasons why people engage in sexual activity and links these reasons to the dominant HIV prevention technologies. The central argument is that sexual behaviour does not occur in a void, but is influenced by external factors in the social, political, economic and technological environment.

The following section aims to provide conceptual clarity on poverty, since the way in which poverty is conceptualised determines what type of poverty reduction strategies are formulated. This is followed by an outline of the gender relations framework, which can significantly enrich the understanding of poverty and can help to reveal some underlying assumptions of poverty reduction strategies.

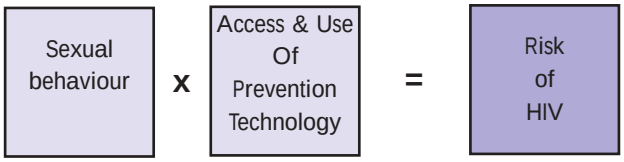
The next section explores in some detail the relationship between poverty and HIV/AIDS. It first discusses how poverty at individual, household and community level impacts on the various stages of HIV/AIDS, after which it looks at how HIV/AIDS impacts on poverty.

The final section proposes some models for an integrated response to poverty and HIV/AIDS. Firstly, it looks at how HIV/AIDS can be mainstreamed into poverty reduction strategies from a prevention perspective. Secondly, it looks at how HIV/AIDS can be mainstreamed into poverty reduction strategies from an impact perspective. Finally, the conclusion sums up the key issues that are revealed in the paper.

Understanding sexual behaviour

In a context like sub-Saharan Africa, where HIV/AIDS is predominantly sexually transmitted (and more specifically, through heterosexual sex), sexual behaviour is the obvious starting point for preventing the further spread of the epidemic. The key challenge in reducing the risk of HIV infection is to modify sexual behaviour and link it with appropriate prevention technologies (see Figure 1).

Figure 1. Sexual behaviour and access to prevention as risk factors of HIV infection



However, the 'ABC' of prevention efforts (Abstain, Be faithful, Condomise) that many countries have adopted has not always been very effective. There are at least two reasons for this.

Firstly, this approach does not take adequate consideration of the variety of reasons why people engage in sexual behaviour. Table 1 summarises the key reasons why people have sex and relates each of these reasons to the dominant prevention technologies. It is clear that abstinence and mutual faithfulness are inappropriate in most instances of sexual activity, whereas condom use is possible only in a few instances. For example, the original model of HIV prevention through condom use made sense in the context of men having sex with men, but is inappropriate for couples wanting to have children. The fact that sub-Saharan Africa has the highest fertility rate is indicative of the high level of unprotected sex. In contrast, Information, Education & Communication (IEC) and Voluntary Counselling and Testing (VCT) are more appropriate, because they reflect more comprehensive approaches to HIV prevention.

Secondly, and linked to the previous point, prevention efforts (especially the ABC of prevention) tend to be

based on an assumption that sexual behaviour is a matter of individual choice and is fundamentally about exerting individual responsibility. Rape is the most obvious refutation of this assumption, but in many other instances we find that freedom of choice regarding sexual behaviour is circumscribed by external factors, such as social norms and values and one's socio-economic position in society. In other words, people's views on sexual matters and their sexual behaviour and experiences are profoundly influenced by factors in the external environment. For example, assumptions about mutual faithfulness do not hold in contexts where it is culturally condoned, and possibly encouraged, that men have numerous sexual liaisons, often simultaneously, regardless of their marital status. Similarly, assumptions about mutual consent and equal power in sexual relations are not only untenable in the case of rape, but also in contexts where sexual activity is a survival strategy in exchange for money, goods or protection.

Thus, the extent to which individuals can protect themselves from becoming infected with HIV depends on factors such as knowledge about risk and how to prevent infection, skills and means to act on that knowledge, the level of confidence and assertiveness, the amount of power a person has to negotiate sexual behaviour, and the extent to which prevailing norms and values support protective and preventive behaviour. It also depends on how accessible and affordable the means of prevention are in society.

In summary, preventing the further spread of HIV requires an understanding of why people engage in sexual activity and of the social, political, economic and technological context in which they live, as these factors influence the extent to which individuals can consciously choose to engage in sexual behaviour that minimises their risk of HIV infection and can access appropriate prevention technologies. The simple formula presented in Figure 1 needs to be interpreted with this complexity in mind. The next sections will look at two characteristics of the external environment, namely poverty and gender inequality, which are significant factors in enhancing vulnerability to HIV infection and to the impacts of HIV/AIDS.

Defining poverty

Poverty is arguably the most salient issue in current international and national development debates. Yet, despite much debate about poverty and numerous conscious attempts to address poverty, it is quite clear from the literature that there are different ways of conceptualising poverty. This points to different perceptions of the meaning of poverty and of how the level and depth of poverty can be measured (MacPherson and Silburn 1998). These perceptions also change over time, as our knowledge and assumptions get tested in real life situations. The UNDP (2001) publication *Choices for the Poor* summarises the current thinking about poverty. In Chapter 2, Julian May concludes that despite optimistic assertions of a shared international perspective on

Table 1. The effectiveness of HIV prevention technologies

	Prevention Technologies				
Reason for sexual activity	**Abstinence**	**Mutual Faithfulness**	**Condom**	**IEC**	**VCT**
Reproduction	No	Possible	No	Yes	Yes
Pleasure (mutual consent)	No	No	Yes	Yes	Not significant
Power/entitlement (rape)	No	No	No	No	No
Experimentation	No	No	??	Yes	No
Acceptance (peer pressure)	No	No	??	Yes	Yes
Ritual purposes and/or inheritance	No	No	No	Yes	Not significant
Sex as a commodity for exchange	No	No	Yes	Yes	No

Adapted from: UNDP Regional Project on HIV and Development in sub-Saharan Africa (2002)

poverty, there is as yet no clear consensus on how poverty should be conceptualised or measured. Yet, some patterns seem to be emerging, which are helpful for the issues under consideration in this paper.

Whereas previously poverty was seen as a lack of income, which could be measured by the number of people living below the absolute or relative poverty line, nowadays we recognise that poverty is *multi-dimensional*. This notion refers to the various inter-related aspects of well-being that influence a person's quality of life and standard of living, which can be material (e.g. food, income, housing, etc.) and non-material (e.g. participation in decision-making and social support networks). The World Summit for Social Development in Copenhagen, 1995, defined poverty as:

> a lack of income and productive resources sufficient to ensure sustainable livelihoods; hunger and malnutrition; ill health; limited or lack of access to education and other basic services; increased morbidity and mortality from illness; homelessness and inadequate housing; unsafe environments; and social discrimination and exclusion. It is also characterised by a lack of participation in decision-making and in civil, social and cultural life (Article 19).

Although most policy documents and research reports readily recognise that poverty is multi-dimensional, in reality there is still a tendency to reduce poverty to a lack of income and use income-based indicators to measure the scale of poverty. One of the challenges related to a multi-dimensional interpretation of poverty relates to the choice for, and weighting of, indicators of poverty.

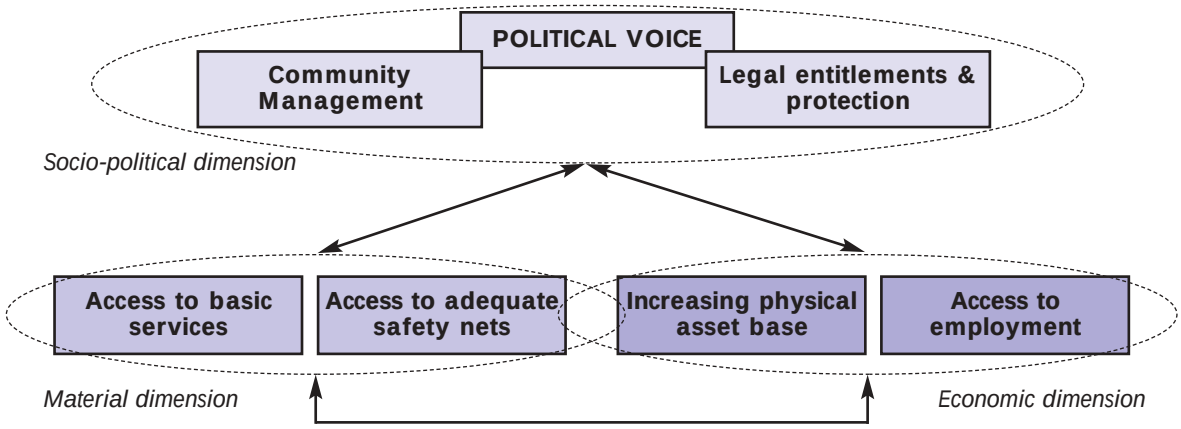
Furthermore, there is greater appreciation that poverty is a *relational* concept. This can be interpreted in two ways. Firstly, deprivation is usually measured in relation to the standard of living of other social groups (for example, the share of national income of the wealthiest and poorest 20% of the population). This is referred to as relative poverty. Secondly, people's experiences of poverty often encompass processes of social exclusion from mainstream institutions, such as the economy, political structures and social networks. Invariably, this is experienced as powerlessness.

It is also increasingly recognised that poverty is not a static condition, but has a *temporal* dimension. Whereas for some people or households poverty is a chronic condition, many others continuously move into and out of poverty. Sometimes this is related to seasonal trends, for example in the case of cyclical processes related to climatic conditions or when employment opportunities are linked to seasonal activities (e.g. harvest time). At other times, poverty stems from a lack of safety nets and the inability of individuals and households to cope with shocks and stresses, such as retrenchment, ill health, death or natural disasters.

The way in which poverty is conceptualised and measured is significant, because it influences what type of poverty reduction strategies are formulated. Figure 2 captures the various inter-related dimensions of poverty that poverty reduction strategies need to consider. Whereas the recognition of the multi-dimensional, relational and temporal nature of poverty adds value to our understanding of how poverty manifests itself and how people experience impoverishment, it also makes the measurement of poverty and the formulation of poverty reduction strategies much more complicated. In other words, it is impossible to have an absolute definition of poverty, which is universally applicable, and a single indicator (such as level of income) to measure poverty. Instead, poverty must be conceptualised as a dynamic concept, and needs to be 'related to the specific life situations of a country's population' (May 2001: 23). A useful working definition describes poverty as 'the inability of individuals, households or entire communities to command sufficient resources to satisfy a socially acceptable minimum standard of living'.[2]

[2] This definition of poverty is taken from the recently published report of the Committee of Inquiry into a Comprehensive System of Social Security for South Africa (2002), titled *Transforming the Present – Protecting the Future*.

Figure 2. Dimensions of a poverty eradication framework



The distinction between poverty at individual, household and community level in the working definition is useful and can help in the formulation of appropriate, multi-level poverty reduction strategies. *Individual poverty* is characterised by a lack of or insecure income, a lack of basic necessities (e.g. food, clothing, etc.) and a lack of power. *Household poverty* has similar features as individual poverty. In addition, it is characterised by an inability to provide for the household, a lack of assets and a lack of support networks. Since poor households tend to be concentrated in particular localities, communities are often also referred to as being poor. *Community poverty* refers to a lack of services and infrastructure and a lack of social cohesion (May 2001).

Whereas it is useful to distinguish between individual, household and community poverty, there are also some difficulties associated with it. For one, it is not always possible to make a neat distinction, especially between individual and household poverty where similar types of deprivation may be identified (e.g. lack of food security). Secondly, and more importantly for the purpose of this paper, policy interventions aimed at households and communities are often based on an (explicit or implicit) assumption that households and communities are homogeneous and harmonious entities, where resources and power are distributed equitably. As a result, the social relations and power dynamics within households and communities are made invisible (Kabeer 1994).

Gender theory offers a useful framework to analyse the internal structure and relational dimensions of households and communities. The application of gender analysis can help to uncover some of the assumptions underpinning poverty reduction strategies, which result in their limited effectiveness to address poverty and to reduce vulnerability to HIV/AIDS. How poverty enhances vulnerability to HIV infection and AIDS and, vice versa, how HIV/AIDS aggravates poverty, will be the theme of the section after the discussion on gender and power.

Gender and power

Women's empowerment and gender equality have been on the international development agenda since the 1970s. Since then, there has been a conceptual shift from focusing on women in development, which emphasised the importance of recognising their contribution to development processes and the need to ensure that women benefited equally from these processes, to a focus on gender relations, which looks at structural inequalities between the sexes and the institutionalisation of male power.

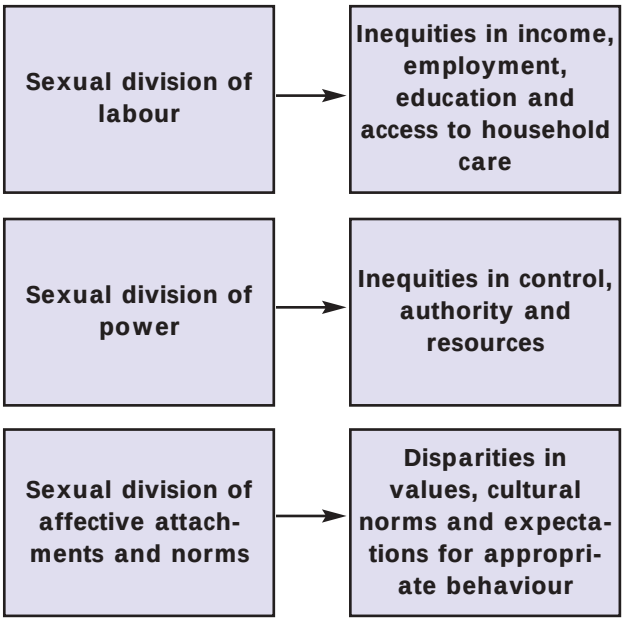
Gender analysis, or the analysis of gender relations, tries to explain how simple facts of biology (i.e. being of the male or female sex) have become socially constructed as gender difference and gender identity (Kabeer 1994). In other words, what is considered 'natural' for women and men in terms of attributes, behaviour, aspirations, work and so on, is part of intricate social processes and interactions that influence us from birth.

The essence of gender analysis is a focus on the complex web of social relations through which women are positioned as a subordinate social group in the division of resources, labour, opportunities and power. This perspective on gender as a category of social relations has a number of important implications:

1) Gender is one aspect of a complex web of social relations; it is interwoven with other aspects, such as class, race/ethnicity, physical ability, and so on. This means that women (and men) are not a single, unified category.
2) Any intervention aimed at uplifting or empowering women needs to recognise that gender is a relational concept: women are disadvantaged *in relation to* men, with some women being more disadvantaged *in relation to* other women.
3) Social relations are not value-free: they are relations of power. Gender relations reflect power imbalances between men and women.
4) These power imbalances are embedded in various institutional domains, such as the household, the community, religious institutions, the workplace, the political sphere, the legal system and the economic domain.
5) Gender is not a static concept: the nature of gender relations varies between cultures and changes over time.

The nature of gender relations finds expression in a sexual division of labour, of power and of affective attachments and social norms. Each of these components is linked to a specific set of outcomes, which serve as constraints on individual choice and agency (see Figure 3).

Figure 3. Gender relations framework



The *sexual division of labour* refers to the roles women and men traditionally play in the household, in the community and in the workplace. Women tend to be disproportionately responsible for household tasks, rearing children and caring for the family. As caregivers, women themselves usually have less access to care in the household. In the community, women play similar roles as community organisers and providers of services and support, often on an informal basis, whereas men are more visible in leadership roles and in formal, paid positions. The division of labour also finds expression in occupations that are traditionally associated with men (such as police officer or economist) and women (such as nurse or teacher). Women tend to be employed in lower paid positions, but even if they hold similar positions to men they tend to earn less. In general, education and employment opportunities tend to favour boys/men over girls/women. Thus, the sexual division of labour results in inequities in income, employment, education and access to household care between men and women.

The *sexual division of power* refers to the level of control and authority attributed to men and women in various institutional domains, such as the home, the community, the workplace, political structures, the legal system and the economic system. In all these spheres, men are traditionally imparted with more, if not exclusive, power and authority and dominate in formal positions of power (e.g. in management, political office and community leadership positions). The prevailing notion of the man as the head of the household also attests to this. The sexual division of power results in inequities in access to, and control over, resources between men and women, restricts women's control over their bodies, and curtails the extent to which they can exercise social, economic and political power.

The *division of affective attachments and norms* refers to the different attributes associated with, and behaviour expected from, women and men. For example, where women are expected to be nurturing, men are expected to be strong and protective.

This division results in differential value attached to each sex (what women do or how they behave is not awarded with the same value as what men do) and in different cultural norms and expectations for appropriate behaviour of men and women. This includes social norms and values related to sexual behaviour of men and women respectively. For example, women are usually expected to be ignorant and submissive in sexual matters, whereas men are expected to be experienced and initiate sexual contact.

In summary, gender analysis lays bare social relations of inequality, which find expression in a sexual division of labour, power, attributes and associated value. These sexual divisions are sanctioned and perpetuated by social norms and values and have become institutionalised in political, social and economic domains. As such, gender analysis contributes to our understanding of how individual choice and behaviour (including sexual behaviour) is influenced and constrained by external factors.

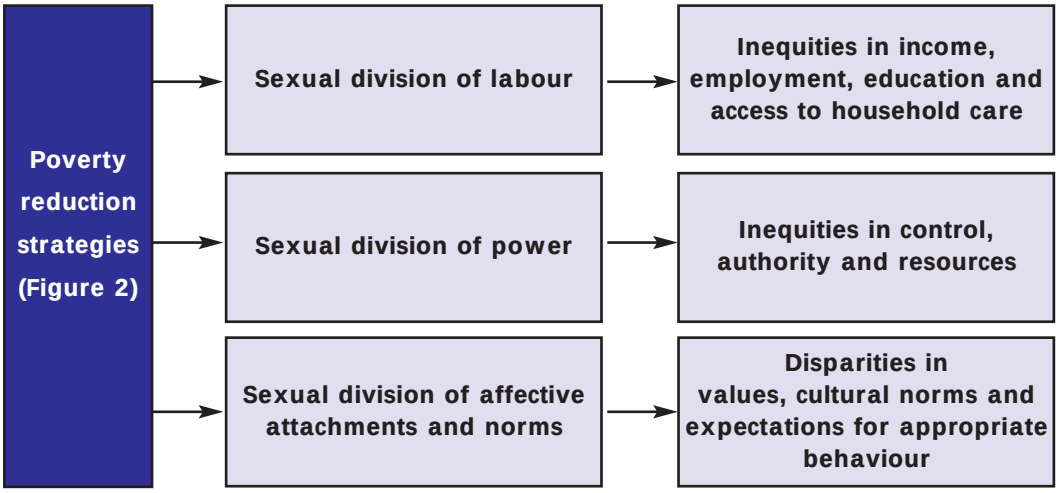
Linking gender and poverty

The gender relations framework enriches the conceptual understanding of poverty in a number of ways.

Firstly, a focus on gender confirms the multi-dimensional nature of poverty. In addition to material dimensions of poverty, a focus on gender relations draws attention to qualitative dimensions, such as lack of self-esteem and autonomy and participation of women (see Kabeer 1994). Secondly, it challenges assumptions that every individual experiences poverty in the same way and that households and communities are homogeneous and inherently harmonious entities. As such, gender analysis also helps to reveal how poverty reduction strategies may serve to perpetuate intra-household and intra-community inequities if they are designed and implemented in a 'gender-blind' manner, without due recognition of the sexual division of labour and power imbalances.

This seems to be the case with most Poverty Reduction Strategy Papers (PRSPs), which identify unemployment as a core factor in poverty. As a result, anti-poverty strategies are formulated that tend to focus on income generation and employment creation on the assumption that the benefits gained will benefit all members of the household equally. Yet instead they are likely to perpetuate the constraints produced, such as inequities in income, employment, resources and control. The challenge is to formulate poverty reduction strategies that translate into equitable outcomes in the household and in the community. Thus, poverty reduction strategies need to be assessed through the gender relations framework (see Figure 4).

Figure 4. Analysis of poverty reduction strategies through the gender relations framework



Adapted from: UNDP Regional Project on HIV and Development in sub-Saharan Africa (2002)

Poverty and gender inequality are key factors influencing sexual behaviour, i.e. why people engage in sexual activity and how much power they have in determining the nature and frequency of sexual activity. They also determine the extent to which people can access and control HIV prevention technologies and opportunities for treatment and care, and their capacity to cope with HIV/AIDS-related illness and death. The next section will explore the relationship between poverty and HIV/AIDS in more detail. In doing this, it is important to bear in mind that poverty reduction strategies that do not take account of the gender distributional nature of interventions are likely to reinforce the disempowerment of women, with the potential of fuelling the HIV/AIDS epidemic.

The relationship between poverty and HIV/AIDS

Although HIV/AIDS does not only affect poor people, the poor now constitute the absolute majority of those living with HIV/AIDS (World Bank 1997). It is increasingly clear that poverty is a factor in the spread of HIV and reduces the capacity of individuals, households and communities to cope with the impacts of HIV/AIDS. At the same time, there is evidence that HIV/AIDS intensifies poverty and pushes more households into poverty (Collins and Rau, 2000). Below, we will explore this bi-directional relationship in more detail. We will first look at how poverty impacts on HIV and AIDS, after which we will explore the impact of HIV and AIDS on poverty.

This paper distinguishes between four stages related to HIV/AIDS:

1. not yet infected, which is the stage when a person is potentially vulnerable to HIV infection;
2. infected with HIV, but a-symptomatic (i.e. not affected by HIV/AIDS-related illnesses);
3. infected with HIV and symptomatic (i.e. affected by HIV/AIDS-related illnesses);
4. AIDS-related death.

Each of these stages will be related to three levels of poverty: individual, household and community poverty. This distinction is helpful in identifying the specific nature of the relationship between poverty and HIV/AIDS at different levels. It also allows us to see the interconnectedness between the three levels of poverty. However, because poverty at individual and household level has similar features, it is not always possible to neatly distinguish between individual poverty and household poverty in the context of HIV/AIDS. As we will see, individual and household poverty impact in similar ways on the various stages of HIV/AIDS, although there are more obvious distinctions when we look at the impact of HIV/AIDS on individual and household poverty respectively.

1. How does poverty impact on HIV and AIDS?

Table 2 captures the key impacts of poverty at individual, household and community level on the various stages of HIV/AIDS.

Stage 1: not yet infected

Individual poverty enhances vulnerability to HIV infection through a lack of knowledge/information about the risk of infection and how to prevent it, a lack of resources to act on this knowledge (for example, lack of money to buy condoms), and a lack of skills and power to negotiate safe sex. Also, for many people poverty is about a daily struggle for survival. In this context, the long-term and invisible threat of disease and death may be of less concern.

Two survival strategies usually adopted by poor people significantly increase the risk of HIV infection: the use of sex as a commodity in exchange for money, food, goods or protection, and labour migration to areas where the prospects of work appear better (Collins and Rau 2000). With respect to sex as a commodity, this clearly characterises a situation of unequal power relations, if not powerlessness, where it is highly unlikely that safe sex can be demanded. Also, the reward for unprotected

sex is usually higher, which serves as a disincentive to condom use. Labour migration enhances risk of HIV infection in the sense that the conditions during and after the journey put migrants at risk of infection. These conditions are characterised by emotional distress, social dislocation and vulnerability to attacks (including rape). Areas where new migrants settle often lack the services and infrastructure to deal with the influx and may not bring the employment opportunities that migrants were hoping to find, which points to important features of community poverty.

Household poverty increases vulnerability to HIV infection in similar ways as individual poverty, but brings into focus relational dimensions. For example, it shows how poverty can facilitate the spread of HIV within the household, between spouses (e.g. migrants and their wives) and between parents and children (through mother-to-child transmission). Household poverty can constrain women to purchase formula milk to prevent transmission of HIV to their children. Also, where sexual activity is adopted as a strategy to overcome household poverty, it is usually women and girls that are at risk of becoming infected.

Clearly, individual and household poverty are interlinked with a lack of services, resources and facilities at community level. The lack of education and information services on HIV/AIDS restricts people's access to information and knowledge about how to prevent HIV infection. The lack of health services for sexually transmitted infections (STIs) increases the risk of HIV infection, as does the lack of condoms. Similarly, the lack of surgery facilities to provide elective caesarean sections and the lack of preventive antiretrovirals in public hospitals significantly increase the risk of babies contracting HIV during birth. In addition, the lack of water and sanitation impedes the use of breast-milk substitutes to prevent mother-to-child transmission. Community poverty, in particular the lack of employment or income-generating opportunities, pushes people (often young, able-bodied adults) into migration, whereas the lack of infrastructure and services in the receiving areas (often informal settlements or overcrowded compounds) also create a context of vulnerability to HIV infection. This vulnerability is exacerbated by the fact that receiving areas often do not offer security of tenure and residents have little, if any, legal and police protection against violence and harassment.

Stage 2: infected, yet a-symptomatic

One potential consequence of individual and household poverty is that people are unaware of their HIV status, because of a lack of knowledge about HIV/AIDS and/or a lack of resources to go for testing. At community level, testing facilities may not be available or adequate (for example, if there is not enough trained personnel to administer the service required). Even if someone's HIV status is known, poverty at all three levels will prevent individuals concerned from accessing life-prolonging treatment (i.e. antiretroviral drugs), because individuals or households cannot afford to purchase such treatment where it is unavailable in the public health sector. Individual/household poverty further results in inadequate food intake, which weakens the immune system and accelerates ill health, thereby allowing the virus to progress more rapidly.

Stage 3: infected and symptomatic

Poverty at individual and household level means that people are unable to afford medicines to treat opportunistic diseases or to pay for transport to access health services. Again, food and nutritional deficiency will prolong illness and, at this stage of HIV/AIDS, accelerate death. There are once again obvious linkages with community poverty. Inadequate health services to treat opportunistic diseases, including insufficient clinics, personnel, medicines and other resources, possibly combined with a lack of affordable and adequate transport to health facilities, deprives people living in poor communities from accessing appropriate health care for HIV/AIDS-related illnesses. Similarly, lack of social services and community-based care means that opportunities for support and care for people living with HIV/AIDS and their families are absent.

Stage 4: AIDS-related death

Although at this stage the individual has passed away, individual poverty still impacts on this stage by preventing the person from purchasing a burial plot and a coffin in advance. Similarly, household poverty impacts on the ability of relatives to afford funeral costs, which do not only include a coffin or transport to the graveyard, but also expenditures associated with customary practices (e.g. food). Poverty at community level can impact in two ways: there may be a lack of adequate burial facilities to cope with the increasing number of deaths, and social networks may crumble under the pressure of regular funerals and the time and money associated with them.

Table 2. The impact of poverty on HIV/AIDS

Level of poverty Stages of HIV/AIDS	Individual	Household	Community
Not yet infected ➨***vulnerability and risk***	• lack of knowledge/information about the risk of HIV infection • lack of resources to purchase protection (e.g. condoms) • sex as a commodity in exchange for money, food, goods or protection • lack of power (economic, social, political) to negotiate safe sex • immediate survival needs more pressing than long-term, invisible threat (possibly social disillusionment, which may lead people to engage in high-risk behaviour) • labour migration as a strategy to overcome poverty, which puts migrants at risk of infection	• lack of knowledge/information about the risk of HIV infection • lack of resources to purchase protection (e.g. condoms) or to prevent further transmission from mother to child (e.g. cost of replacement feeding) • sex as a commodity in exchange for money, food, goods or protection (when women and children are prostituted) • labour migration as a strategy to overcome poverty, which puts migrants and their spouses at risk of infection	• lack of education/information services • lack of adequate health services (e.g. STI treatment, surgery facilities to provide elective caesarean sections and preventive antiretrovirals) • lack of provision of condoms • lack of water & sanitary conditions (for breast-milk substitutes) • lack of employment/income-generating opportunities forces young adults to migrate to areas where prospects seem better • inadequate and insecure living conditions in settlements where migrants settle: informal housing, overcrowding, social dislocation, etc. • lack of legal and police protection against violence and insecurity of tenure
Infected, but a-symptomatic	• unaware of/inability to afford testing facilities • inability to purchase life prolonging treatment which is not available in the public health sector • inadequate food intake/nutrition, which diminishes resistance and accelerates ill health	• unaware of/inability to afford testing facilities • inability to purchase life prolonging treatment which is not available in the public health sector • inadequate food intake/nutrition, which diminishes resistance and accelerates ill health of infected person(s)	• lack of accessible testing facilities in proximity • lack of antiretroviral medicines in public health care services
Infected and symptomatic (AIDS-related illnesses)	• inability to afford appropriate health care for opportunistic diseases or to pay for transport to access services • inadequate food intake/nutrition, which prolongs illness and accelerates death	• inability to afford appropriate health care for opportunistic diseases or to pay for transport to access services • inadequate food intake/nutrition, which prolongs illness and accelerates death of infected person(s)	• inadequate health services to treat opportunistic diseases (i.e. lack of resources, medicines, personnel, clinics and distance to services) • inadequate public transport to clinics (unaffordable/insufficient) • lack of resources to provide care and support to people living with HIV/AIDS and their relatives
AIDS-related death	• inability to afford funeral costs (e.g. purchase burial plot and coffin)	• inability to afford funeral costs (coffin, transport, food, customary practices)	• inability to afford costs associated with regular funeral attendance (time, money) • possible lack of adequate burial facilities to cope with increased demand

Thus, it is clear that poverty impacts on HIV/AIDS in various ways, depending on the stage of HIV/AIDS and the level of poverty. This is not to suggest that only poor people are at risk of contracting HIV. Rather, poverty creates a particular risk factor and diminishes one's capacity to prevent HIV infection. It also reduces the ability of individuals, households and communities to cope with HIV/AIDS-related illness and death. Furthermore, it is also obvious that individual, household and community poverty are interlinked, which suggests that poverty reduction strategies aimed at simultaneously reducing the challenges associated with HIV/AIDS need to focus on all three levels. Before looking more closely at the implications for poverty reduction strategies, we will explore the relationship between poverty and HIV/AIDS from the other direction, namely how HIV/AIDS impacts on poverty.

2. What is the impact of HIV and AIDS on poverty?

Table 3 captures the key impacts of the different stages of HIV/AIDS on poverty at individual, household and community level.

Stage 1: not yet infected

Prior to infection, individuals and households may experience stigma, discrimination and social exclusion if they are perceived to be a risk group and are (at this stage wrongly) associated with HIV/AIDS. For example, orphans, widows, migrant workers and members of particular ethnic groups may be held responsible for the spread of the epidemic. At community level, fear and stigma associated with HIV/AIDS has the potential to further undermine social cohesion, resulting in impoverishment of social support networks. Thus, this stage of HIV/AIDS is mainly related to a social dimension of poverty. Yet, it can have economic implications for affected individuals or households if, for example, people refuse to buy someone's products or if employment opportunities are thwarted because of stigma, fear and discrimination.

Stage 2: infected, yet a-symptomatic

As with the previous stage, the stigma, fear and discrimination associated with HIV/AIDS is likely to aggravate social isolation of individuals and households and undermine social cohesion at community level. Also, attempts to hide HIV status by individuals and/or households for fear of stigma and social exclusion are likely to intensify social isolation at both levels.

Stage 3: infected and symptomatic

At this stage of HIV/AIDS, the impacts on poverty become more severe and manifold. The reduced ability to work because of increasing bouts of illness results in a loss of income at individual and household levels. Where food security is directly linked to small-scale agricultural production, illness will reduce the capacity to produce food for domestic consumption (and possibly for the market). In both cases, hunger and malnutrition are likely. Whilst income is reduced, costs for treatment and care increase. For example, urban households affected by HIV/AIDS in Côte d'Ivoire have seen their health care expenditure rise by 400% whilst their incomes have dropped by 52-67%. To cope, these households have had to cut their food consumption by up to 41% (UNAIDS 2001). As a consequence, individual/household income is diverted from other needs of individuals and of other members of the household respectively to treatment and care, especially if the affected person is a caregiver/provider. Evidence from Côte d'Ivoire suggests that more money tends to be spent on health care for men living with HIV/AIDS than for women with HIV/AIDS (UNAIDS 2002). In addition, the loss of income and assets is likely to push households into further debt.

Depending on which member/members of the households is/are infected with HIV, the roles of other members are likely to change, especially if it concerns a provider and/or caregiver. There will be pressure on women, children and the elderly in particular to look after the sick, which is likely to have implications in terms of their ability to work or their schooling prospects, and/or to substitute for lost income.

At community level, increased demands for health and welfare services may lead to the possible collapse of these services, if these are unable to cope, or could result in escalating costs, which means fewer people will be able to access these facilities. Bearing in mind that the human resource capacity of these services themselves are affected by HIV/AIDS, there will also be an eroding process from the inside. The overall effect is twofold: there will be increasing competition for ever scarcer resources, resulting in greater possibility for conflict, and increased pressure on community networks to step in and attend to the services vacuum.

Stigma, discrimination, fear and prejudice remain central to this phase as well, with the associated experiences of social exclusion and impoverishment.

Phase 4: AIDS-related death

An AIDS-related death may push individuals, especially widows and orphans, into poverty through the loss of entitlements or other forms of protection against impoverishment. These individuals may or may not be infected with HIV and are likely to experience stigma and social isolation.

At household level, one of the most immediate impacts of an AIDS-related death – especially if it concerns an adult death – is likely to be the loss of household income or livelihood. There is an increasing body of evidence that confirms this. For example, research from Zambia shows that in two-thirds of families where the father has died of AIDS-related illness, monthly household income fell by over 80% (UNAIDS 2002). Similarly, a study from Zimbabwe suggests that households with an AIDS-related death saw the production of maize decline by almost two-thirds and of vegetables by almost half (Kwaramba 1997). As a result, food consumption declines, as is evidenced in Tanzania, where food consumption in the poorest households dropped by 15% after the death of an adult (UNAIDS 2002).

At the same time, it is likely that household income and/or assets are directed towards funeral costs at the expense of other needs of household members such as food, clothing, transport, education etc. Funeral costs can exceed medical expenditure by far. For example, Tanzania households with an AIDS-related death spent up to 50% more on funerals than on medical care (UNAIDS 2002). To cope with the immediate costs of a funeral or the longer-term costs of loss of income, households may be forced to sell off assets and/or take out loans, thereby sinking into deeper impoverishment. Within the household there is likely to be a shift in tasks to substitute for lost income. Where this negatively affects the ability of children to attend school, their future prospects to escape poverty are under threat. An AIDS-related death, especially an adult death, results in a breakdown of household structures and associated forms of security, especially for women, children and the elderly. This puts pressure on other households to accommodate those affected by an AIDS-related death. For example, in Botswana the poorest quarter of households is expected to take on four more dependents as a result of HIV/AIDS (UNAIDS 2002). Where relatives seek to conceal the cause of death for fear of stigma and exclusion, they are likely to experience social isolation.

AIDS-related deaths will also aggravate community poverty. The collapse of families due to a disproportionate number of deaths of young adults leads to increasing pressure on community networks to provide social safety nets, particularly for widows/widowers, orphans and the elderly. At the same time, the community experiences a loss of productive members in services such as health, education and uniformed services, which erodes the capacity of these services to respond adequately to the various impacts of HIV/AIDS, and of those fulfilling leadership roles in the community. Thus, the social and economic fabric of the community will be eroded.

It is clear from the discussion presented here that HIV/AIDS has the potential to intensify individual, household and community poverty and to push more individuals, households and communities into poverty.

However, the cumulative impact of HIV/AIDS transcends the micro level and makes itself felt at sector level and at macro level, which reduces government's ability to respond to the challenges of poverty and HIV/AIDS in a comprehensive manner. For example, in many countries in southern Africa, sectors such as health and education are experiencing a dramatic increase in morbidity and mortality of personnel. Malawi and Zambia are experiencing five- to six-fold increases in illness and death rates amongst health workers. In Zimbabwe, one out of five male teachers and close to one out of three female teachers are infected with HIV (UNAIDS 2002). This has significant implications for the capacity of these sectors to deliver on their mandates. The impact of HIV/AIDS at sector level and at macro economic level will be further elaborated upon below.

Table 3. The impact of HIV and AIDS on poverty

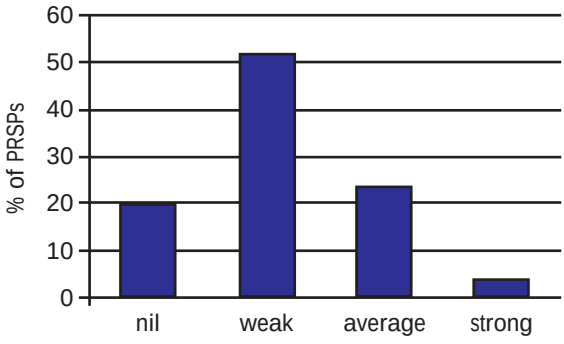
Level of poverty Stages of HIV/AIDS	Individual	Household	Community
Not yet infected	• possible stigma, discrimination, exclusion if perceived as a risk group (possibly with economic implications)	• possible stigma, discrimination and exclusion if perceived as risk group (possibly with economic implications)	• fear and prejudice may further undermine social cohesion
Infected, but a-symptomatic	• possible stigma, discrimination and exclusion if HIV status is known (possibly with economic implications) • social isolation as a result of attempting to hide HIV status because of associated stigma	• possible stigma, discrimination and exclusion if HIV status is known (possibly with economic implications) • social isolation as a result of attempting to hide HIV status because of associated stigma	• fear, prejudice and exclusion may further undermine social cohesion
Infected and symptomatic (AIDS-related illnesses)	• loss of income and/or ability to produce food due to increased illness • diversion of income from other needs (e.g. food, clothing, transport) to medical costs • possible stigma, discrimination and exclusion if HIV status is known • social isolation as a result of attempting to hide HIV status because of associated stigma	• loss of household income and/or food security due to increased illness • diversion of household income and/or assets from needs of other household members (food, clothing, education, transport, etc.) • loss of assets and possibility of increased debt through loans • increased demands on women, children and elderly in particular to look after the sick and/or substitute for lost household income (i.e. diversion of tasks to care and/or income substitution) • possible stigma, discrimination and exclusion if HIV status is known • social isolation as a result of attempting to hide HIV status because of associated stigma	• increased pressure on health and welfare services, leading to possible collapse of services or escalating costs • increased absenteeism of public sector employees in health, education, etc., which further erodes the institutional capacity to provide services • increasing competition for scarce resources, possibly leading to conflict • increased pressure on community networks to cope with increasing demands in light of inadequacies of public sector services
AIDS-related death	• may result in poverty for other individuals (e.g. orphans, widows who lose assets), who may or may not be infected with HIV • possible stigma, discrimination and exclusion of relatives of the person who died of AIDS-related illnesses	• diversion of household income/assets from needs of other household members (food, clothing, education, transport, etc.) to funeral costs • loss of assets and possibility of increased debt through loans (for funerals, or to deal with loss of income and/or assets) • loss of household income/livelihood • shift of tasks to substitute for lost income (away from education, which entrenches capability poverty) • breakdown of household structures and associated forms of security • pressure on other households to accommodate those affected by AIDS-related death • possible stigma, discrimination and exclusion or further social isolation if attempting to conceal the nature of death	• collapse of family structures due to disproportionate deaths of parents, leading to increased number of orphans, with pressure on community safety nets to absorb them • loss of productive members of the community, including erosion of human resource capacity in sectors like health, education, etc. • loss of those fulfilling leadership roles • erosion of social and economic fabric

In concluding this section, the preceding discussion has demonstrated that the relationship between poverty and HIV/AIDS is bi-directional: whilst poverty enhances vulnerability to HIV infection and undermines the capacity of individuals, households and communities to cope with the multiple impacts of HIV/AIDS, HIV/AIDS in turn aggravates poverty in its various dimensions and at different levels. This means that Tables 2 and 3 cannot be read in isolation of each other. Appendix 1 merges both tables to illustrate the complex, mutually enforcing relationship between poverty and HIV/AIDS. The next section will seek to tease out the implications for poverty reduction strategies to be inclusive of HIV/AIDS considerations.

Towards an integrated approach to poverty and HIV/AIDS

A recent UNAIDS (2002) report refers to a review conducted by the UNAIDS Secretariat of 25 full and interim PRSPs prepared by countries in sub-Saharan Africa to assess how well these strategy documents are dealing with HIV/AIDS (see Figure 5). The review found that five PRSPs (20%) had no analysis of the relationship between HIV/AIDS and poverty, whereas in just over half (13, or 52%) the analysis was weak. Only one PRSP (4%) was considered to have a strong analysis, with the remaining six (24%) reflecting an average understanding. This indicates that there is significant scope for improvement.

Figure 5. Analysis of the relationship between AIDS and poverty in PRSPs in sub-Saharan Africa



Source: UNAIDS (2002: 169)

The central concern of this section is to contribute to this policy flaw and suggest an integrated approach to poverty and HIV/AIDS. First we will look at a conceptual model for mainstreaming HIV/AIDS into poverty reduction strategies from a prevention perspective, after which we will explore how to mainstream HIV/AIDS into poverty reduction strategies from an impact perspective.

Mainstreaming HIV/AIDS into poverty reduction strategies from a prevention perspective

The first imperative is to ensure that poverty reduction strategies simultaneously reduce the spread of HIV. This requires, firstly, an understanding of poverty as a contributing factor of vulnerability to HIV infection. It also requires a critical analysis of proposed poverty reduction strategies to assess whether these help to reduce vulnerability to HIV infection or, unwittingly, enforce such vulnerability. The discussion so far has presented a number of building blocks that form the basis for a more comprehensive model (see Figure 6).

The following steps can be used to review and, if necessary, revise poverty reduction strategies to ensure that attempts to address poverty simultaneously address vulnerability to HIV infection:

1. Identify the elements of poverty reduction strategies and assess which dimension(s) of poverty each element or proposed action seeks to address (see Figure 2);
2. Using the gender relations framework, assess what sexual division (of labour, power and affective attachments and norms) each proposed anti-poverty action will influence and how;
3. Following on from this, assess whether the proposed action is likely to entrench or reduce inequities stemming from the sexual division of labour, power and affective attachments and norms;
4. Review how these outcomes are likely to influence sexual behaviour and the reasons why people engage in sexual activity;

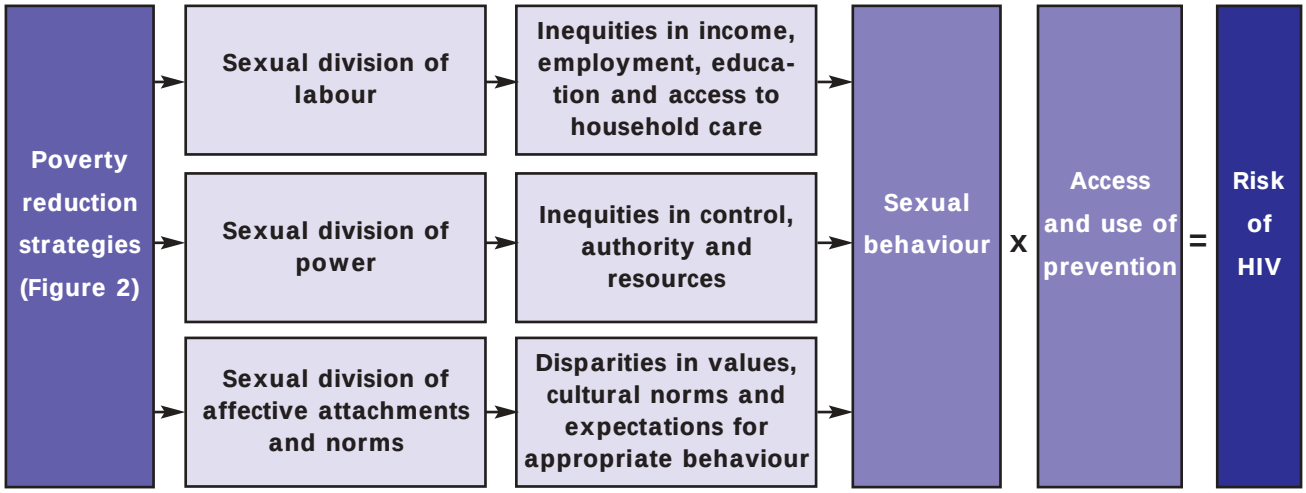
5. Review how these outcomes are likely to influence the extent to which people can access prevention technologies and whether these prevention technologies are appropriate in relation to the various reasons why people engage in sexual activity.

The next example serves to illustrate how the model could be applied. As mentioned earlier, PRSPs tend to emphasise employment creation and income-generation as central to poverty reduction. Thus, they focus on the economic dimension of poverty (see Figure 2). Using the gender relations framework, it is obvious that this intervention relates directly to the sexual division of labour. The question is whether the intervention is likely to perpetuate or transform the sexual division of labour: is it based on assumptions about the man being the head of the household and the provider of the family, thereby ignoring the productive role of women? Does it approach employment in gender- stereotypical ways, by allocating specific types of jobs to men and women respectively? What are the policy assumptions about the roles men and women perform at home, in the community and in the workplace? In looking at the outcomes produced, the question is to what extent employment creation schemes perpetuate inequities in employment and income between men and women. If the intervention leads to widening income inequalities between men and women, it could result in a situation where women need to resort to sexual networking to get some money while men have more money to pay for sex. As such, the intervention may in fact contribute to the spread of HIV.

On the other hand, the analysis could inform a revision of the proposed intervention to ensure that it results in equitable opportunities for employment and income between women and men. Therefore, by contributing to financial security of both women and men, one of the reasons why people engage in sexual behaviour (and, more specifically, unsafe sex) could be addressed.

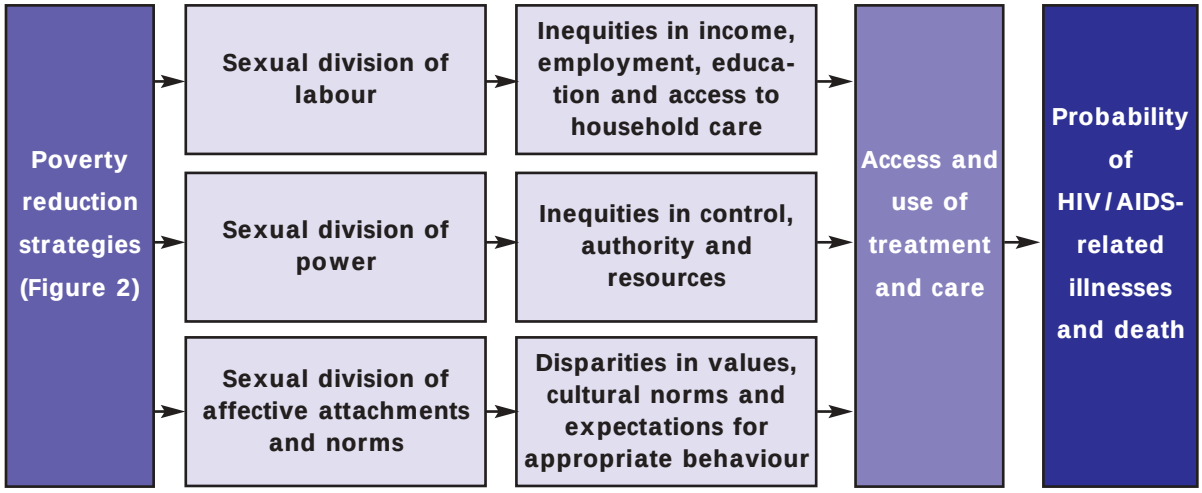
However, lack of financial security is not the only factor that influences sexual behaviour or access to prevention technologies. Issues of power and control and social norms and values are equally important in determining sexual behaviour and access to prevention technologies. It is therefore also important to look at how the intervention is likely to impact on the sexual division of power and of affective attachments and norms and the associated outcomes. For example, what are the policy assumptions about the distribution of resources and power in the household? Is it correct to assume that the income generated will benefit all household members equally? And to what extent will the intervention perpetuate or challenge dominant perceptions about what is considered appropriate work for men and women and the differential value attached to work done by women or men?

Figure 6. Model for preventing the spread of HIV through appropriate poverty reduction strategies



Adapted from: UNDP Regional Project on HIV and Development in sub-Saharan Africa (2002)

Figure 7. Model for ensuring equitable access to treatment and care through appropriate poverty reduction strategies



Adapted from: UNDP Regional Project on HIV and Development in sub-Saharan Africa (2002)

This example serves to explain that poverty reduction strategies aimed at income generation may, at best, have limited impact on reducing vulnerability to HIV infection. Clearly, what is needed is a comprehensive poverty reduction plan, with multiple interventions that are interrelated. The purpose of the exercise was to illustrate that specific anti-poverty interventions can, unintentionally, enhance vulnerability to HIV infection if these actions result in a perpetuation of disparities in income, power and social values.

So far, the discussion has focused on how poverty reduction strategies can help to reduce the spread of the HIV/AIDS epidemic. Thus, it has focused on the first stage of HIV/AIDS, prior to infection. Figure 6 can be adapted to allow us to assess how poverty reduction strategies can be linked to the second and third stage of HIV/AIDS and can contribute to equitable access to treatment and care (see Figure 7).

Mainstreaming HIV/AIDS into poverty reduction strategies from an impact perspective

This section will discuss critical issues for mainstreaming HIV/AIDS into poverty reduction strategies based on an understanding of the impacts of HIV/AIDS at micro (i.e. individual and household), sector and macro level. Such an understanding will allow for an assessment and, where necessary, a revision of poverty reduction strategies. From an impact perspective, the following three issues require further investigation:

1. The impact of HIV/AIDS at micro level: how will HIV/AIDS affect the levels and depth of poverty, in particular at individual and household level?
2. The impact of HIV/AIDS at sector level: how will HIV/AIDS affect the capacity of sectors and institutions that are critical for achieving the outcomes and targets in poverty reduction strategies?
3. The impact of HIV/AIDS at macro level: how will HIV/AIDS affect macro economic trends, in particular the prospect of economic growth?

The remainder of this section will discuss these questions in some detail.

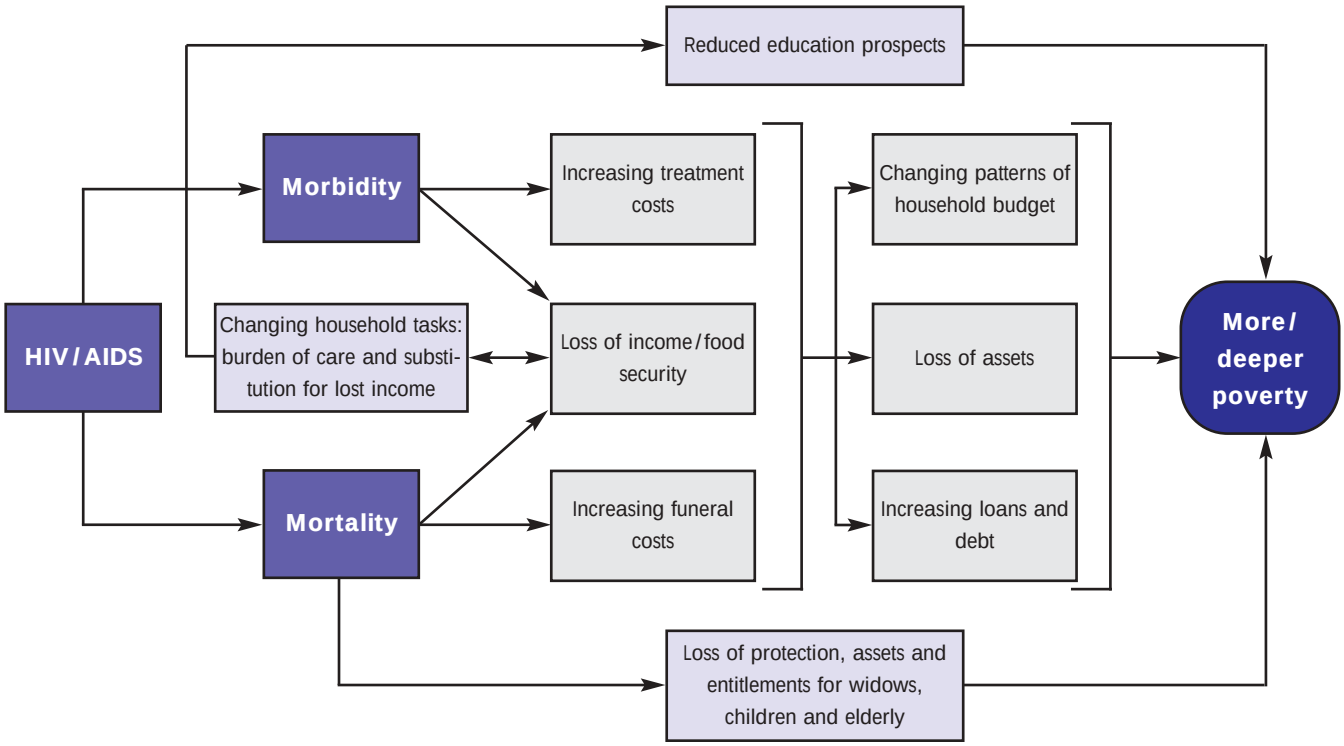
1. The impact of HIV/AIDS at micro level

The impact of HIV/AIDS on poverty has already been discussed and requires little additional discussion here. Figure 8 captures this dimension of the relationship between poverty and HIV/AIDS in graphic form.

2. The impact of HIV/AIDS at sector level

The second area of impact is at sector level, on institutions that are expected to contribute to poverty reduction. These sectors include health, education, agriculture, etc. As suggested earlier, the capacity of these sectors will be eroded due to increasing morbidity

Figure 8. The impact of HIV/AIDS at micro level



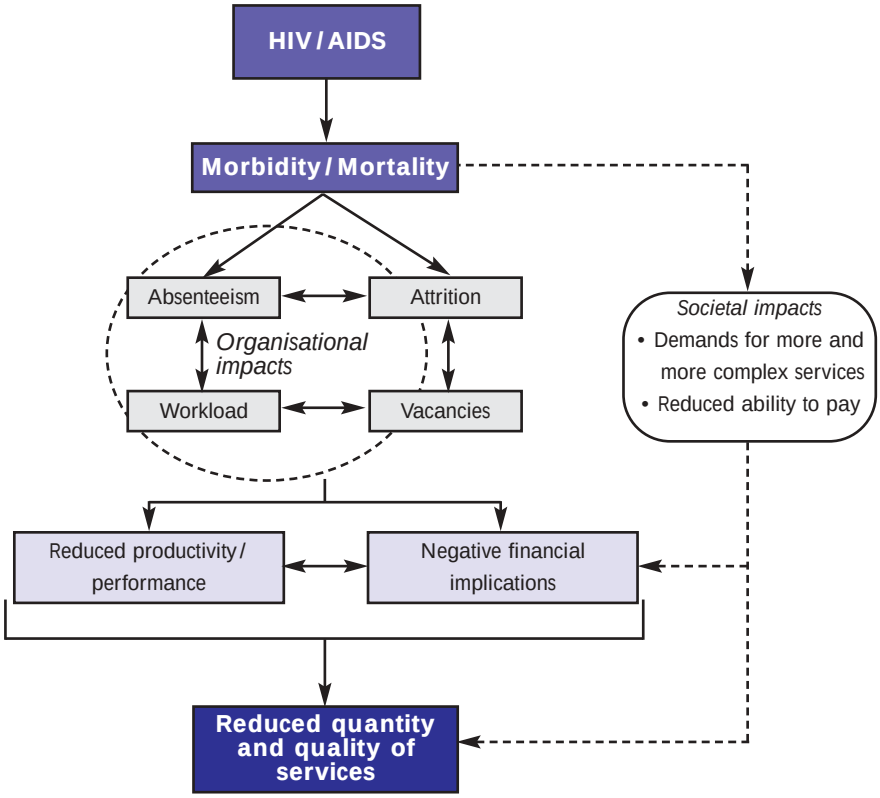
Adapted from: UNDP Regional Project on HIV and Development in sub-Saharan Africa (2002)

and mortality among employees. As Figure 9 shows, the debilitating impact of HIV/AIDS on sectors follows the two main pathways of morbidity and mortality. Increased levels of illness and death amongst employees leads to absenteeism and attrition, which in turn reinforce each other. Attrition results in vacancies. A high number of vacancies combined with a high absenteeism rate increases the workload of other staff members. This, in turn, may result in even higher levels of vacancies and absenteeism. Collectively, these human resource impacts negatively affect productivity and performance, not only of individual employees, but also of the organisation as a whole. Furthermore, the organisation will be faced with significant costs for recruitment, training and benefits, amongst others. At the same time, the loss of productivity is also likely to result in a loss of income or revenue. Ultimately, the quantity and quality of services will be under threat.

If we add the societal impacts of HIV/AIDS to the picture we find that there is increasing pressure on sectors to help individuals, households and communities cope with the HIV/AIDS epidemic. Yet, their ability to pay for more, and possibly more complex, services is likely to be significantly reduced.

Unless poverty reduction strategies are informed by an understanding of how HIV/AIDS is expected to affect the capacity of each sector, they are likely to be unfeasible and will, at best, be only partially realised. Again, examples from education and health can illustrate this point. The loss of teaching staff to HIV/AIDS will erode the capacity of the education sector to provide adequate coverage of services and good quality education. At the same time, there is a decline in school enrolment rates, with girls most affected. For example, in Swaziland and the Central African Republic school enrolment has declined by 20-36% due to HIV/AIDS (UNAIDS 2002). These trends will jeopardise poverty reduction strategy targets for education to increase school enrolment rates. Similarly, significant increases in health worker morbidity and mortality combined with the demand for more and more specialised health services to deal with HIV/AIDS will erode the capacity of the health sector to deliver on its mandate and achieve poverty reduction strategy targets for health.

Figure 9. Sector Impact of HIV/AIDS



Adapted from: Malawi Institute of Management (2002)

3. The impact of HIV/AIDS at macro level

It is clear that, through the impact on households, communities, the labour force and sectors, the HIV/AIDS epidemic thwarts the prospect of economic growth. It has been estimated that for countries with national HIV/AIDS prevalence rates of 20%, annual GDP growth is likely to drop by an average of 2.6%. This is confirmed by recent calculations, which suggest that the rate of economic growth in sub-Saharan Africa has decreased by 2-4% due to AIDS (UNAIDS 2002).

Without recognition of the macroeconomic impact of HIV/AIDS, economic growth targets are likely to be unrealistically high. Amongst others, this will have implications for the amount of resources available to address the developmental challenges of poverty and HIV/AIDS. It is therefore essential for poverty reduction strategies to be informed by a realistic assessment of the macroeconomic impact of the epidemic.

It is, however, not easy to assess the macroeconomic impact of HIV/AIDS, partly because the epidemic is still evolving and partly because it is difficult to attribute a decline in economic growth to one single factor, i.e. HIV/AIDS. There is a need for better data collection and analysis that can lead to more accurate modelling of the macroeconomic impact. One of the challenges is to ensure that informal sector activities are also reflected in the analysis.

In conclusion, mainstreaming HIV/AIDS into poverty reduction strategies from an impact perspective requires that poverty reduction strategies are reviewed on the basis of how HIV/AIDS is expected to impact on the micro, sector and macro level. These findings need to inform the development of alternative strategies. As part of this, it means that targets need to be re-examined and, where necessary, adjusted to take into account how HIV/AIDS is likely to thwart the realisation of those targets. It will also be imperative to develop an appropriate monitoring and evaluation framework for an integrated response to poverty and HIV/AIDS. The models presented in this paper can be used as tools to evaluate current poverty reduction strategies and to guide strategic intervention in relation to poverty and HIV/AIDS.

Conclusion

Poverty, inequality and HIV/AIDS constitute the most significant development challenges in sub-Saharan Africa. Independently, these are complex issues; collectively, their interrelated nature adds to the complexity of the challenge. This concept paper is written from the perspective that HIV/AIDS is a crosscutting issue, rather than a standalone, additional concern for poverty reduction strategies. This calls for an integrated response, which locates poverty, inequality and HIV/AIDS in the broader social, political, economic and technological context. Such an understanding of the external context is crucial in recognising how individual behaviour, attitudes and perceptions in general, and in relation to sexual activity in particular, are influenced and constrained by factors in the external environment. The fundamental challenge is to reduce poverty whilst stemming the spread of HIV and to cope with the multiple impacts of the HIV/AIDS epidemic in such a way that it contributes to poverty reduction. The task ahead is enormous, but not impossible. It is hoped that this concept paper will contribute to an effective, integrated response to poverty, inequality and HIV/AIDS.

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Appendix: Bi-directional relationship between poverty and HIV/AIDS

A vicious cycle: impact of poverty on HIV/AIDS and impact of HIV/AIDS on poverty

Level of poverty Stages of HIV/AIDS	Individual	Household	Community
Not yet infected *vulnerability and risk*	• lack of knowledge/information about the risk of HIV infection • lack of resources to purchase protection (e.g. condoms) • sex as a commodity in exchange for money, food, goods or protection • lack of power (economic, social, political) to negotiate safe sex • immediate survival needs more pressing than long-term, invisible threat (possibly social disillusionment, which may lead people to engage in high-risk behaviour) • labour migration as a strategy to overcome poverty, which puts migrants at risk of infection • possible stigma, discrimination, exclusion if perceived as a risk group (which may have economic implications)	• lack of knowledge/information about the risk of HIV infection • lack of resources to purchase protection (e.g. condoms) or to prevent further transmission from mother to child (e.g. cost of replacement feeding) • sex as a commodity in exchange for money, food, goods or protection (when women and children are prostituted) • labour migration as a strategy to overcome poverty, which puts migrants and their spouses at risk of infection • possible stigma, discrimination and exclusion if perceived as a risk group (which may have economic implications)	• lack of education/information services • lack of adequate health services (e.g. STI treatment, surgery facilities to provide elective caesarean sections and preventive antiretrovirals) • lack of provision of condoms • lack of water and sanitary conditions (for breast-milk substitutes) • lack of employment/income-generating opportunities forces young adults to migrate to areas where prospects seem better • inadequate and insecure living conditions in settlements where migrants settle: informal housing, overcrowding, social dislocation, etc. • lack of legal and police protection against violence & insecurity of tenure • fear and prejudice may further undermine social cohesion
Infected, but a-symptomatic	• unaware of/inability to afford testing facilities • inability to purchase life prolonging treatment which is not available in the public health sector • inadequate food intake/nutrition, which diminishes resistance and accelerates ill health • possible stigma, discrimination and exclusion if HIV status is known • social isolation as a result of attempting to hide HIV status because of associated stigma	• unaware of/inability to afford testing facilities • inability to purchase life prolonging treatment which is not available in the public health sector • inadequate food intake/nutrition, which diminishes resistance and accelerates ill health of infected person(s) • possible stigma, discrimination and exclusion if HIV status is known • social isolation as a result of attempting to hide HIV status because of associated stigma	• lack of accessible testing facilities in proximity • lack of antiretroviral medicines in public health care services • fear, prejudice and exclusion may further undermine social cohesion
Infected and symptomatic (AIDS-related illnesses)	• inability to afford appropriate health care for opportunistic diseases or to pay for transport to access services • inadequate food intake/nutrition, which prolongs illness and accelerates death • loss of income and/or ability to produce food due to increased illness • diversion of income from other needs (e.g. food, clothing, transport) to medical costs • possible stigma, discrimination and exclusion if HIV status is known • social isolation as a result of attempting to hide HIV status because of associated stigma	• inability to afford appropriate health care for opportunistic diseases or to pay for transport to access services • inadequate food intake/nutrition, which prolongs illness and accelerates death of infected person(s) • loss of household income and/or food security due to increased illness • diversion of household income and/or assets from needs of other household members (food, clothing, education, transport, etc.) to funeral costs • loss of assets and possibility of increased debt through loans • increased demands on women, children and elderly in particular to look after the sick and/or substitute lost household income (i.e. diversion of tasks to care and/or income substitution) • possible stigma, discrimination and exclusion if HIV status is known • social isolation as a result of attempting to hide HIV status because of associated stigma	• inadequate health services to treat opportunistic diseases (i.e. lack of resources, medicines, personnel, clinics and distance to services) • inadequate public transport to clinics (unaffordable/insufficient) • lack of resources to provide care and support to people living with HIV/AIDS and their relatives • increased pressure on health and welfare services, leading to possible collapse of services or escalating costs • increased absenteeism of public sector employees in health, education, etc., which further erodes the institutional capacity to provide services • increasing competition for scarce resources, possibly leading to conflict • increased pressure on community networks to cope with increasing demands in light of inadequacies of public sector services
AIDS-related death	• inability to afford funeral costs (e.g. purchase burial plot and coffin) • may result in poverty for other individuals (e.g. orphans, widows who lose assets), who may or may not be infected with HIV • possible stigma, discrimination and exclusion of relatives of the person who died of AIDS-related illnesses	• inability to afford funeral costs (coffin, transport, food, customary practices) • diversion of household income/assets from needs of other household members (food, clothing, education, transport, etc.) to funeral costs • loss of assets and possibility of increased debt through loans (for funerals, or to deal with loss of income and/or assets) • loss of household income/livelihood • shift of tasks to substitute lost income (e.g. jeopardising education) • breakdown of household structures and associated forms of security • pressure on other households to accommodate those affected by AIDS death • possible stigma, discrimination and exclusion or further social isolation if attempting to conceal the nature of death	• inability to afford costs associated with regular funeral attendance (time, money) • possible lack of adequate burial facilities to cope with increased demand • collapse of family structures due to disproportionate deaths of parents, leading to increased number of orphans, with pressure on community safety nets to absorb them • loss of productive members of the community, including erosion of human resource capacity in sectors like health, education, etc. • loss of those fulfilling leadership roles • erosion of social and economic fabric

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