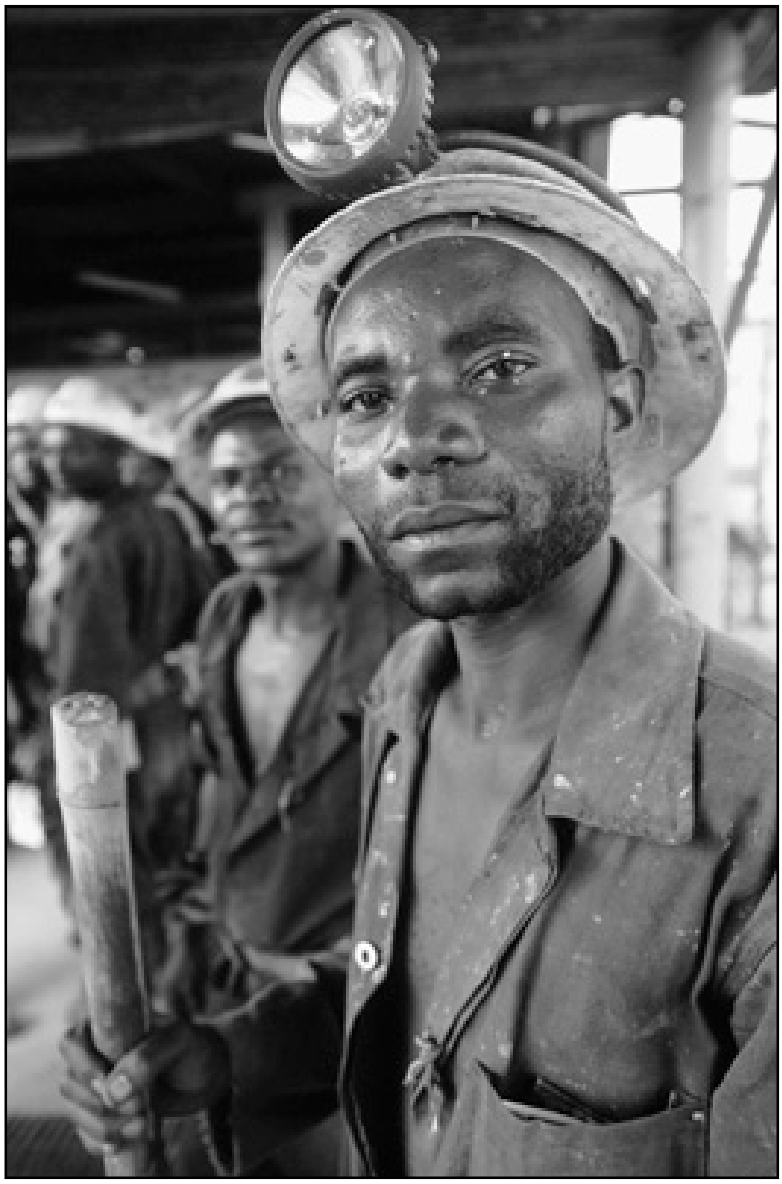
Downward Spiral

The absence of HIV from economic policy-making



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Christian Aid
We believe in life before death

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Contents

Acronyms and abbreviations 2

Foreword 3

Executive summary 5

Introduction 8

1. The effect of HIV on growth and poverty 11

2. The effect of poverty, inequality and economic change on HIV 15

3. Sweet or sour? The sugar belt of western Kenya 23

4. Other downward spiral case studies 33

5. Recommendations to policy-makers 37

Notes 41

References 43

Acronyms and abbreviations

ACK	Christian Aid partner, Anglican Church of Kenya
AIDS	acquired immune deficiency syndrome
CCFMC	Christian Aid partner, Catholic Correspondence Course Franciscan Missionary Charism
CHEP	Christian Aid Partner, Copperbelt Health Education Project
COMESA	Common Market for Eastern and Central Africa
DFID	Department for International Development
GDP	gross domestic product
HIV	human immunodeficiency virus
IMF	International Monetary Fund
KSh	Kenyan shillings (144.61 KSh = £1)
LEB	life expectancy at birth
LSE	London School of Economics
MDG	millennium development goals
PRSP	poverty reduction strategy paper
PSIA	poverty and social impact analysis
SAPs	structural adjustment policies
STIs	sexually transmitted infections
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
WTO	World Trade Organisation
ZCCM	Zambia Consolidated Copper Mines (a government-run mining company)

Foreword

In this paper we are told that in Zambia '…given the downturn in mining prospects, PRSP (poverty reduction strategy paper) proposals for new investment in this sector may be over-optimistic. Mining sector policies should rather emphasise cost-cutting and efficiency measures…'. So 'cost-cutting' is central to the solution.

Here is a paradox: economic and fiscal policy management is at best concerned with the medium term. Businesses are doing well if they can plan five years ahead and so, by and large, are governments. But 'cost-cutting and efficiency measures' may have awful long-term costs and consequences as they throw people out of work, cut wages and force the poor onto the margins of survival, where sexual relations may become an important part of staying alive – in the short term. How are we to reconcile the short-term gains and the long-term pains of 'cost-cutting', particularly when the gains and the pains are so unequally distributed?

We are now in the fourth decade of the HIV/AIDS epidemic – or that, at least, is as long as we have been aware of its presence and effects. It has taken this long for our politicians and policy makers to understand just how big and bad this event is. There are still those who fail to understand its implications for development prospects in some of the world's poorest societies. When we consider the full extent of the epidemic, from initial infections to the later waves of impact evidenced by huge numbers of orphans, destruction of social and economic fabric, and weakening of already fragile governmental structures and administrative capacity, it can seem overwhelming. We must be clear that the development community, governments and business all have to take account of HIV/AIDS for the long term. The full wave of the epidemic and its impact will exceed a century. Current decisions about macro-economic management of poor countries will have very long-term effects on the progress of and response to HIV/AIDS. Terms of trade and tariff regimes may seem far removed from the intimacies of sexual relations, but they will influence who has sex with whom and on what terms, as they affect migration, producer prices and other livelihood options.

Long wave events such as HIV/AIDS pose important challenges. They are difficult to understand because their origins are complex, involving social, economic and viral processes going back decades if not centuries. The ability of the viruses to mutate and recombine, the fact that people have to migrate for work, that they live in areas of war and civil disorder – all these have deep roots and it is impossible to identify causes in a way that meets the canons of scientific evidence. Whether or not structural adjustment programmes (SAPs) 'caused' an increase in the HIV/AIDS epidemic is an irresolvable conundrum of the same type. This paper does not attempt to answer that question conclusively: no answer is possible. We have to distinguish clearly between that realisation and the recognition that, via many complex pathways, SAPs probably increased poverty and did little good. While it is possible to see correlations between SAPs and the growth of HIV/AIDS epidemics, it is not possible to draw a clear causal link.

It is, however, safe to say that because in the past most SAPs were designed without HIV/AIDS in mind, some have undoubtedly been damaging as far as the interaction between economic policy and HIV/AIDS is concerned. Routine use of perspective HIV/AIDS impact analyses could reduce the risk of sub-optimal policy recommendations in the future and that is the lesson of this paper. The resolutions of the United Nations General Assembly special session on HIV/AIDS in 2001 (UNGASS) and the growing calls for expansion of anti-retroviral provision under the WHO's '3 by 5' initiative, all point to the growing need to recognise the centrality of HIV/AIDS in any economic policymaking in relation to the world's poorest countries.

Whether or not SAPs actually contributed to the growth of the epidemic is by now an historical question and is impossible to answer. However, the new generation of poverty reduction strategy

papers (PRSPs), which have largely replaced SAPs, must take full account of the relation between macro-economic and fiscal policies and the epidemic, if we are not to be debating the same issues five or ten years from now. It is doubtful that many of this new generation of macro-economic policy papers do take note of HIV/AIDS as anything other than an after-thought. One response to this paper would be if PRSPs all took account of HIV/AIDS issues.

Nowhere is recognition of the links between macro-economic policy and HIV/AIDS more necessary than in the implementation of the UK Department for International Development's (DFID) recently published strategy paper[1] and in the US government's already widely contentious PEPFAR[2] programme. Neither of these can be successfully implemented without placing them firmly in their macro-economic contexts.

This important paper from Christian Aid shows us how macro-economic policy can affect poor communities. Although the links are not clear, increased poverty, inequality and social breakdown lead to general ill-health, and, in an environment where HIV is widespread, to a long wave HIV/AIDS event that will be with us all, throughout our lives whether we live in rich or poor countries.

Tony Barnett, ESCR Professorial Research Fellow, Development Studies Institute,
London School of Economics and Political Science

Executive summary

'HIV is one of the greatest threats to eradicating poverty'.[3] This was not said by an African group of HIV-positive activists or Christian Aid, but by the UK government.

Getting economic policy right is one of the most important factors in reducing poverty. But reality does not always match rhetoric, because economic policy-makers fail to take account of HIV.

Although the world is waking up to the scale and impact of the HIV epidemic, the response is still being left largely to HIV specialists. This is despite the fact that HIV affects every area of development. As economic policy-makers continually fail to place HIV centre-stage in their work, more lives will be lost, economic growth will continue to be curtailed and poverty eradication will become an even more distant dream. At times, the decisions they take may actually contribute to hastening the spread of HIV.

This report shows how HIV, poverty and economic change are linked and recommends how policies should deal with this. It is aimed at economic policy-makers at the World Bank, International Monetary Fund (IMF) and the World Trade Organisation (WTO), donor governments and developing country governments.

Sweet or sour?

The inter-relationship between economic policy and HIV is illustrated in this report by a case study from an area of western Kenya, that is economically dependent on sugar cane. Here, the high poverty rate is exacerbated by the high prevalence of HIV, which contributes to a fall in income and an increase in household poverty. Agricultural productivity is falling, health services are overstretched and school drop-out rates are increasing.

In 2000, key restrictions on sugar imports were removed, as part of Kenya's commitments under the Common Market for Eastern and Central Africa (COMESA) trade agreement, bringing gains to some Kenyans. For sugar producers, however, many of whom were smallholders already on low incomes, the outcome was different. Processors were unable to compete with imports from more competitive African producers. Payments became unreliable, and when prices paid to cane growers fell by up to 37 per cent, it had knock-on effects on the whole local economy. Christian Aid, with partners Catholic Correspondence Course Franciscan Missionary Charism (CCFMC) and Anglican Church of Kenya (ACK), asked a wide range of people in affected communities how this drop in income had influenced their vulnerability to HIV. The general consensus was that it had had a detrimental influence. Some of the main reasons they gave are listed below:

- The inequality of income has increased, encouraging people to become involved in sexual transactions and to take on more sexual partners.
- More women are involved in sex work, many on a part-time and informal basis, including young women, married women and widows.
- Economic pressures have encouraged some traditional practices, such as wife inheritance, whereby a widow is 'inherited' by her brother-in-law. While this practice can act as an economic safety-net, it also leads to increased HIV transmission.
- More women are boosting their income by making and selling illegal brew. The availability of this cheap alcohol can lead to high-risk sexual activity.
- Falling incomes lead to higher drop-out rates from secondary school, as parents can no longer afford school fees, leaving teenagers with few economic opportunities, which further encourages sexual transactions.

If, as seems likely, these changes lead to higher HIV prevalence, this in turn will further harm the economy and lead to an increase in poverty. This prospect could have been avoided if the impact of trade policies on these key vulnerable groups had been taken into account and if the trade liberalisation process had been undertaken in a more nuanced and gradual way. Indeed, the Kenyan government has, somewhat belatedly, recognised the problems caused by liberalisation, and introduced some protection for the sugar sector for a limited time.

The downward spiral of HIV and poverty

HIV and poverty are intimately linked in a mutually reinforcing and detrimental way. On the one hand, poverty provides the context in which HIV is more likely to spread. On the other hand, HIV contributes to increased poverty. HIV increases poverty, which in turn increases HIV, creating a downward spiral.

- HIV increases poverty and reduces growth: one World Bank study[4] suggests that, in a typical African country over a 20-year period, gross domestic product (GDP) could be 67 per cent lower because of HIV. HIV has a high social and economic impact because it strikes adults in their prime, leaving children without parents, schools without teachers and companies and governments without skilled workers.
- 95 per cent of HIV-positive people live in developing countries. Although HIV is not solely a disease of poverty, poverty increases people's vulnerability to HIV, in part because the need to earn money changes behaviour. By increasing opportunities to trade sex and by reducing social cohesion, inequality is also related to HIV vulnerability; seven out of the world's ten most unequal countries are also in the top ten countries for HIV prevalence.

HIV makes short-term poverty a permanent condition

Sudden economic change in a society often leads to higher inequality and poverty for some groups which, in turn, can make people more vulnerable to HIV. Even if economic change does not increase poverty or inequality, the accompanying social disruption and mobility may still increase vulnerability to HIV.

Economic change is clearly often necessary and desirable. However, policies which are intended to bring about overall improvement often make little difference to some poor people and in some cases can leave people worse off. The policy architects may argue that this impoverishment will be short-term, but while someone may become temporarily poorer, if they also contract HIV, their HIV status will be permanent. Once they are HIV-positive, their poverty is likely to deepen and high levels of HIV will dramatically affect a country's long-term growth prospects.

So there is a clear need to integrate HIV into all economic policy-making. HIV prevention, treatment, care and support programmes, though essential, are insufficient if they are implemented in isolation from the economic context.

In practice, this will mean different things in different circumstances: it could result in new and different economic policy approaches, it could mean implementing a policy more slowly, or it could mean making HIV prevention and care more widely available. To break the downward spiral, policy-makers need to allow for the impact and cost of HIV during economic planning and they must reassess policy options for economic change, in the light of their likely effects on the spread of HIV.

Four reasons for integrating HIV into economic policy-making

- **Economic reasons:** economic development and poverty reduction objectives will be compromised in many countries if HIV is not addressed.

- **Financial reasons:** lower levels of economic growth, to which HIV contributes, leave poor countries less able to access commercial funds from the international financial system, more vulnerable to future economic shocks and in need of more aid funds. This will cause problems for both borrowers and lenders.

- **Political reasons:** many governments and international institutions have rightly staked much political capital on the attainment of the Millennium Development Goals, which are jeopardised by the HIV epidemic.

- **Humanitarian reasons:** tackling HIV alongside economic policy-making in a comprehensive fashion will immeasurably improve the quality of life – and in some cases, save the lives – of millions of women, men and children in many of the world's poorest countries.

Recommendations

International institutions and donors should:

- review policies and conditions to ensure that countries are not advised or forced to adopt economic policies which are likely to have adverse impacts on their HIV epidemics, as part of a general move to increase countries' autonomy in economic decision-making
- ensure that their advice and any conditions adopted, actively support national plans to respond to HIV, paying particular attention to any proposed social spending cuts, expenditure ceilings or limits on budget deficits
- integrate HIV into all poverty and social impact analyses (PSIAs) to inform all economic policy recommendations
- include HIV prevention and care components in all relevant development projects: for example, ensuring priority for HIV awareness, treatment of sexually transmitted infections and girls' schooling
- ensure that the UNAIDS estimate of at least US$20 billion per year is available for HIV prevention, care, treatment and support by 2007.

National governments should:

- design economic policies in ways which they believe will best benefit both their short- and long-term social, economic and HIV problems
- integrate HIV into poverty and social impact analyses to inform all economic policy choices
- realistically project the impact of HIV on all areas of spending when planning their budgets
- ensure HIV responses are integral to poverty reduction strategies
- scale up HIV prevention, care, treatment and support, especially during processes of rapid economic change, paying particular attention to supporting orphans and other vulnerable children.

Introduction

The world is waking up to the scale and impact of the HIV epidemic and the appropriate rhetoric is emerging from governments and the international institutions. Action, however, is still being left largely to HIV specialists. Peter Piot, director of UNAIDS, has said: 'Finance people and trade people set the agenda. I've always been shocked by their questions. It's not bad-will, but they are naïve. I have to make the case again and again that AIDS is not just about health, it's affecting economies.'[5]

Getting economic policy right is one of the most important factors in reducing poverty. As a result, economic policy-makers have a powerful influence on all areas of policy. Although the UK government has acknowledged that 'HIV is one of the greatest threats to eradicating poverty',[6] economic policy-makers are still not taking account of HIV.

HIV affects every area of development, and must no longer be treated as a stand-alone problem. Unless all policy-makers and particularly economic policy-makers, incorporate HIV more centrally into their work, lives will continue to be lost, economic growth will be curtailed and poverty eradication will become an even more distant dream. Decisions made by economic policy-makers may even at times contribute to hastening the spread of HIV.

This report explains how and why this happens. It is aimed at everyone who shapes economic policy in and for poor countries, including developing country governments, the international institutions (World Bank, IMF and WTO) and developed country government departments (for development, finance and trade).

Box 1

How severe is the HIV/AIDS crisis?[7]

- more than 13,000 people became HIV-positive every day in 2003
- nearly 8,000 people died from HIV-related illness every day in 2003
- 38 million people are HIV-positive worldwide
- 95 per cent of people living with HIV are in the developing world
- in the hardest-hit countries of southern Africa, one in three adults is HIV-positive
- around 12 million children in Africa have lost one or both parents to HIV.

The downward spiral

HIV and poverty interact in two ways, which exacerbate each other, creating a downward spiral:

The HIV epidemic increases poverty and reduces economic growth, without which it is difficult to fight poverty. HIV is different from other epidemics and will have a greater economic impact. Most illnesses strike the very young and the very old, with horrendous human consequences, but HIV is also killing millions of adults in their prime. This is leaving children without parents and families without breadwinners. It is leaving hospitals without nurses and schools without teachers. It is leaving companies and poor country governments without the vital skills they need, affecting fragile economies.

Poverty is one factor that makes people more vulnerable to HIV. Sudden economic change – particularly sudden impoverishment – also makes some groups more vulnerable to HIV. This is very important because, although people may become poor temporarily as a consequence of economic change, if they become HIV-positive, their HIV status is permanent.

To break this spiral, policy-makers need to allow for the impact and cost of HIV during economic planning and they need to reassess the policy options for economic change, in the light of their likely effects on the spread of HIV.

Integrating HIV into economic policy

In 2004, the world is responding to the HIV epidemic with funding and programmes for prevention and treatment. The UK government in particular is stepping up its commitment, with a new strategy for tackling HIV in the developing world and has massively increased funding to £500 million per year – its fair share by GDP of the annual US$20 billion that UNAIDS says is needed by 2007. Christian Aid applauds the UK government for this. There is still much to be done – globally, HIV funding and programmes are still falling far short of what is needed – but progress is being made.

The same cannot be said about integrating HIV with economic policy-making. Policy-makers may know what to say, but they do not appear to have put their words into practice: rhetoric is often far ahead of reality. Some examples are given in Box 2.

This report lays out the evidence that HIV and economic policy-making need to be integrated, looking first at how HIV is increasing poverty and depressing growth. It then considers the evidence that poverty and sudden economic change may contribute to HIV vulnerability, recounting a detailed case study from western Kenya and two other case studies from Zambia and Mali. Finally, it makes recommendations for policy-makers.

Box 2

Rhetoric v reality

IMF/World Bank
Rhetoric: 'The AIDS crisis has for some countries represented a catastrophic setback to their hopes of economic progress, a setback from which it will take years, even decades to recover.' Anne Krueger, first deputy managing director, IMF[8]

'AIDS is turning back the clock on development. In too many countries the gains in life expectancy won are being wiped out. In too many countries, more teachers are dying each week than can be trained. We will mainstream AIDS in all World Bank work.'
James Wolfensohn, president of the World Bank[9]

Reality: The World Bank is leading the development of poverty and social impact analysis (PSIA),[10] and the IMF is following their example. Most PSIAs do not mention HIV and the World Bank's *Users' Guide to PSIA*, the key current reference publication for practitioners, fails to mention HIV. Over a third of poverty reduction strategies[11] in 14 key countries make no reference to resourcing any HIV response; two-thirds contain no indicators against which to measure progress on HIV.[12]

The World Bank has an HIV section as part of its assessment for all development loans and grants. This is positive, but some staff see HIV analysis as a tick-box exercise rather than a serious consideration, according to bank insiders.[13]

UK government
Rhetoric: 'Unless urgent action is taken, the epidemic will turn the clock back decades in the fight against poverty.' UK government *Platform for Action on HIV/AIDS*, 2003[14]

Reality: In a recent study of DFID's country assistance plans in key countries, the UK National Audit Office found that it was difficult to identify the prioritisation given to HIV within DFID's wider development programme in many countries, and that some plans failed to reflect the impact of HIV on poverty reduction.[15]

World Trade Organisation
Rhetoric: 'The main objective of the new round is to assist developing countries' integration into the world trade system in a way that will help them combat poverty.' European Commission statement on the Doha development agenda round of trade talks.[16]

Reality: Some developing countries are permitted flexibility in their implementation of trade liberalisation agreements through special and differential treatment clauses. They may also benefit from special developing country deals, such as the EU's Everything but Arms initiative. However, HIV plays no part in a country's eligibility to such initiatives. At the time of writing, only least developed countries are eligible for these flexibilities and any offers of eligibility beyond these countries have no legal basis.

1. The effect of HIV on growth and poverty

> '*HIV causes far greater long-term damage to economies than previously assumed, for by killing mostly young adults, the disease is robbing the children of AIDS victims of one or both parents to love, raise and educate them, and so undermines the basis of economic growth over the long haul.*'
> World Bank press release, 23 July 2003[17]

HIV has a dramatic impact on people's livelihoods. According to the United Nations Development Programme (UNDP), 'achieving the Millennium Development Goals (MDGs)[18] …will not be possible without an effective response to the AIDS crisis.'[19] Much political capital has been staked on reaching the MDGs and jeopardising them will rightly worry all politicians and economic policy-makers concerned with development.

The overarching MDG is to halve the number of people living in poverty by 2015. The HIV epidemic may reduce the likelihood of attaining this goal because:

- the direct impact of HIV is to increase poverty in affected households and communities
- poverty reduction is much more feasible in the context of growth – in highly affected countries, HIV is lowering the rate of economic growth.

How HIV can increase poverty

The effects of HIV, compared with other epidemics, are especially pronounced because it disproportionately affects adult wage-earners. The impact of HIV is particularly strong on poor households.

Immediate impact

- People who cannot afford nutritious food, clean water and sanitation, healthcare, antiretroviral therapy and support, get sick more quickly and die earlier.
- People cannot work when they are sick and therefore lose earnings, or grow less food.
- Poor people with HIV may sometimes feel it is pointless investing in the future.
- The impact of HIV adds to other problems, as illustrated by Africa specialist Alex de Waal: 'If AIDS is the only disaster that threatens, it is likely that individuals and communities will take action against it. But when AIDS is only one disaster among many, it is not the highest priority.'[20]

Medium-term impact

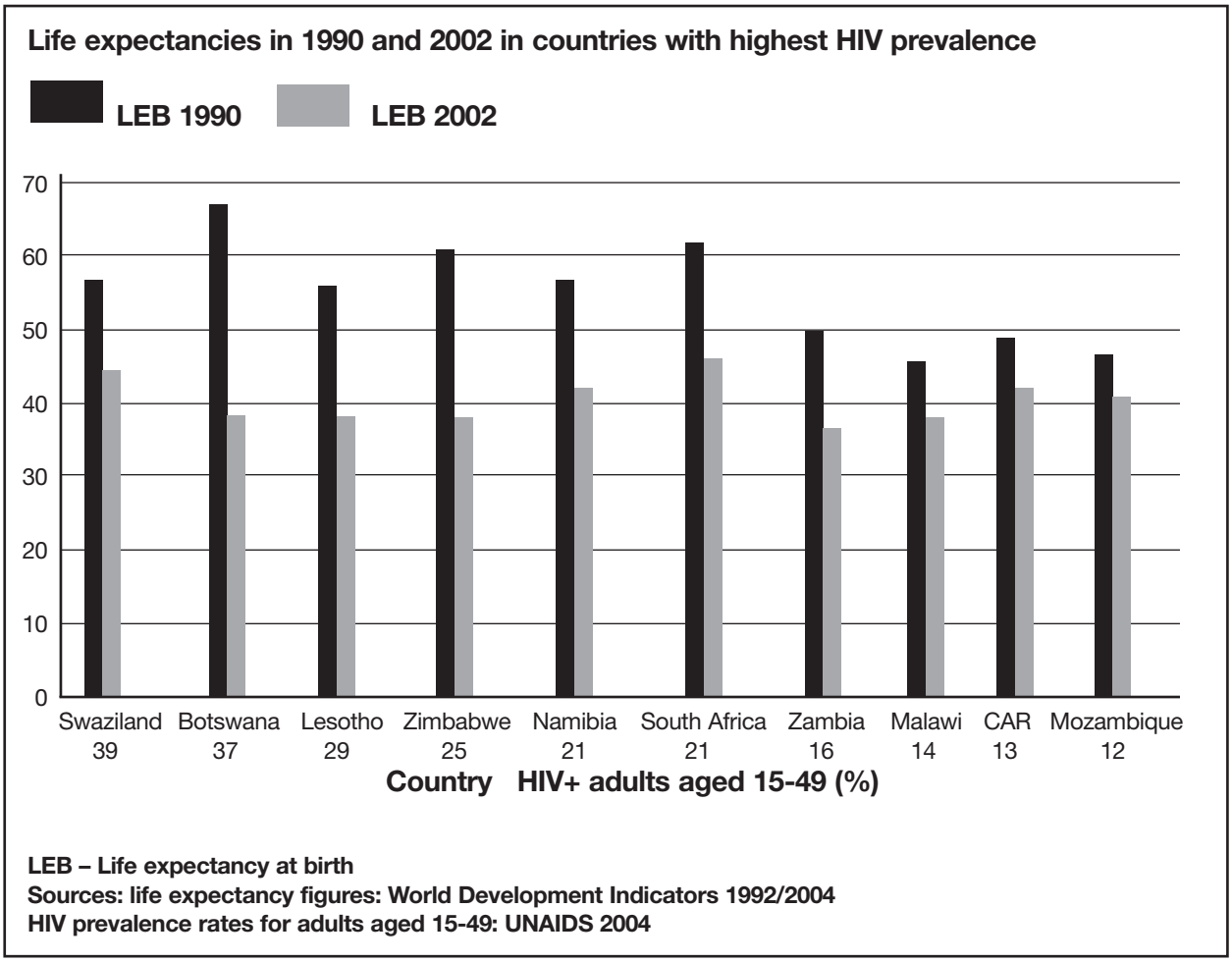
- People may sell assets (for example, animals or a vehicle) to try to pay for healthcare or funerals, or to replace lost income when they can no longer work.
- Children drop out of school, either because the fall in income means that the family can no longer meet the costs, or because the children need to work or care for sick parents or siblings.
- Surviving relatives care for the rising number of orphans, resulting in fewer productive adults supporting more dependents.

- Other impacts on health, such as an increase in TB within communities with high HIV prevalence, may affect both HIV-negative and HIV-positive people.[21]

These kinds of impacts are well documented. AIDS-affected households appear more likely to suffer from severe poverty than other households, with older parents who lose adult children to HIV particularly likely to become destitute. In South Africa and Zambia, studies of AIDS-affected households, most of which were already poor, found that monthly incomes fell by 66-80 per cent due to coping with HIV-related illness.[22]

The Human Development Index is used to measure progress in reducing poverty. Between 1995 and 2001, this index fell in nine out of ten of the countries most affected by HIV.[23] Life expectancy has fallen dramatically in all these countries. (see Graph 1)

Graph 1



LEB – Life expectancy at birth
Sources: life expectancy figures: World Development Indicators 1992/2004
HIV prevalence rates for adults aged 15-49: UNAIDS 2004

The impact of HIV on growth[24]

The economic impact of HIV is only felt at a national level once it has reached a high prevalence level, and after people become ill in significant numbers. There are many ways HIV can impact on growth in high-prevalence countries. For example:

- Direct costs to businesses: employees needing time off sick or to attend funerals, or increased recruitment and training costs. For example, at Gold Fields, South Africa's second-largest gold mining company, around 30 per cent of its workforce is HIV-positive. The company has calculated the costs to its business of HIV and implemented a comprehensive HIV programme for employees, which includes antiretroviral therapy. It estimated that by 2009, its HIV programme would cost US$5 per ounce of gold produced. Without the programme, the cost of HIV would be US$10 per ounce.[25]

- Households with a sick person are likely to save less and spend what they have, to try to deal with the illness. This fall in savings and erosion of assets cumulatively affects the rest of the economy.

- In the longer term, the knowledge and skill level of the population will go down, reducing 'human capital'. The resulting population structure, skewed by a fall in the income-earning adult population, will increase the proportion of people dependent on others for their livelihood.

- Widespread HIV and the death of so many young adults will put added strain on communities, value systems and institutions, reducing 'social capital'.

However, some arguments suggest that the adverse affects of HIV on growth will not be very significant. For example, it has been argued that because most high-prevalence countries have surplus labour, employees who die could easily be replaced. Another argument is that GDP per head is likely to rise as the death rate increases. This is known as the 'Black Death effect', following what is said to have happened in Europe during that epidemic in the 14th century.

Changing assessments of the impact of HIV on growth

Because so many different factors influence growth, and because the impact of HIV takes a long time to be fully felt, it has been difficult to ascertain the overall effects of HIV on growth. These are likely to become clearer, however, through the use of comprehensive economic modelling approaches, many of which have been developed over the last decade. As these approaches become more sophisticated and more tightly linked to real world conditions, their conclusions are likely to be more accurate.

Studies in the early 1990s concluded that the impact of HIV on economies would be negative but small. For example, one World Bank cross-country study[26] concluded that growth rates would be reduced by around one per cent per year, varying a little depending on the country.[27] A widely cited rule of thumb was that an HIV prevalence rate of ten per cent would lead to a reduction in economic growth of 0.4 per cent.[28]

Several more recent studies have taken a less optimistic view. One key World Bank study[29] estimates that the HIV epidemic had already reduced Africa's economic growth by 0.8 per cent per year during the 1990s and that growth per head had also fallen. It continues by suggesting that '…in the case of a typical sub-Saharan African country with an HIV prevalence rate of 20 per cent, the rate of growth of GDP would be some 2.6 percentage points less each year. At the end of a 20-year period, GDP would be 67 per cent less than otherwise.'[30]

Another study,[31] focusing on South Africa, which represents over a third of Africa's economic output, concludes that GDP would be 17 per cent lower and that GDP per head would be eight per cent lower, by 2010 than it might have been without HIV.[32] This study looks at the slow and gradual nature of the impact of HIV, pointing to how the reduced rates of learning and saving money accumulate over time.

A qualitatively different study[33] argues that, rather than being thought of as a shock or add-on factor, HIV should now be considered as an integrated factor in the economy. 'The impact of the disease cannot be treated as an exogenous influence that can be tacked on to models derived on the presumption that the workforce is HIV-free. HIV/AIDS has become an endogenous influence in most African countries, adversely affecting their potential for growth and development.'[34] This model is based on endogenous growth theory, which envisages a beneficial spiral of increasing returns following the generation and dissemination of knowledge. The study's author believes that, in the context of HIV, the endogenous growth model may effectively run in reverse, implying dramatic economic contraction.

Another important study derived from endogenous growth theory was published in 2003. This World Bank study[35] argues that the accumulation of human capital is a key factor in the generation of economic growth over the long term. HIV weakens the mechanisms through which knowledge and abilities are transmitted from one generation to the next and the full effects are only felt after a long time. It concludes that in the absence of HIV, there would have been modest growth in South Africa, with universal education obtained over three generations. If nothing further is done to combat the epidemic, 'a complete economic collapse will occur within three generations.'[36] However, with optimal spending on HIV, including on antiretroviral therapy, growth could be maintained, albeit at a slower rate than would have happened in the absence of HIV.

Conclusion

It has never been in doubt that HIV impoverishes households. One study in Zambia,[37] for example, has found that most households which lost their breadwinner to HIV experienced an 80 per cent drop in income.

It is now becoming increasingly clear that HIV will reduce economic growth in the highly affected countries at a national level, as well as on the household level. A World Bank study,[38] for example, estimated that after 20 years, GDP would be 67 per cent less in some countries than it would have been without HIV.

While studies in the 1990s found that the impact of HIV on growth would be slight, recent studies predict dramatic long-term impacts on national economies. These later studies employ more sophisticated methodology, which takes account of the way HIV weakens the mechanisms through which knowledge is transmitted from one generation to the next, reducing human capital. A 2003 World Bank study on South Africa[39] concludes that if nothing further is done to combat the epidemic there, 'complete economic collapse will occur within three generations.'[40]

This depressing effect on growth will make poverty reduction more difficult and the MDGs even harder to reach.

2. The effect of poverty, inequality and economic change on HIV

> '*Poverty, ignorance, unemployment and inequality are the handmaidens of the epidemic. They help spread HIV.*'
> Peter Piot, director of UNAIDS, lecture to World Bank, November 2003[41]

While the impact of HIV on poverty is well documented, little attention has been paid to the role that economic factors play in determining people's vulnerability to becoming HIV positive. The HIV virus causes AIDS and sexual intercourse is the dominant way in which the HIV virus is transmitted. But the overall economic environment can be an important influence on sexual behaviour. Although the relationship between poverty and HIV is neither simple nor causal, poverty is one factor which may increase a person's vulnerability to HIV. Income inequality is also related to the prevalence of HIV, and sudden impoverishment particularly increases vulnerability.

Economic policy-makers need to take notice of these relationships. If economic policies fail to reduce poverty and inequality, they may also fail to tackle HIV. Economic policies that increase inequality, or lead to the sudden impoverishment of certain groups, may actually increase some people's vulnerability to HIV. While this effect may be inadvertent and the economic policy may lead to greater long-term gain, policy-makers clearly need to consider the implications for HIV incidence nonetheless.

Poverty and HIV

Poorer countries have higher HIV prevalence
Ninety-five per cent of HIV-positive people live in developing countries. In general, the prevalence of HIV is higher in countries with lower national income, higher levels of poverty and lower levels of human development.[42] According to the World Bank, there is a relationship between income levels and HIV prevalence: in the average developing country, a US$2000 increase in per capita income is associated with a four per cent reduction in the HIV infection rate of urban adults.[43] Although a correlation between the two does not mean that one causes the other, it does suggest that further examination of the relationship is warranted. But the relationship does not hold true for all countries or regions: Botswana and South Africa, for instance, have high HIV levels, but are relatively wealthy countries within Africa.

Poor people are often more vulnerable…
There is national-level evidence that poor people are more likely to be at risk of contracting HIV, for example:

- a 2001 survey of over 15,000 women in Cambodia (which has one of the highest HIV prevalence rates in Asia) showed that the wealthiest women were twice as likely to know how to prevent HIV transmission, twice as likely to practise safe sex and almost four times as likely to know where they could be tested for HIV, as the poorest women[44]
- a household study in Thailand found that people from the poorest and least educated households are most likely to have HIV-positive members[45]
- studies in Africa show that men and women living in areas with higher life expectancy and literacy are significantly more likely to use condoms[46]
- evidence from some countries at advanced stages of the HIV epidemic, shows that new HIV infections disproportionately affect poor people, unskilled workers and those lacking literacy skills – especially young women in each of these categories.[47]

…but rich people can be vulnerable too

The link between HIV and poverty is not a clear-cut one: high levels of HIV prevalence also occur in relatively wealthy communities and there are some very poor communities with little incidence of HIV. The latter could be explained by a community's isolation, or because it is subject to relatively strict social rules which tend to discourage the spread of HIV. Male circumcision is a factor which is significant in protecting against HIV,[48] and may explain in part why rates have remained lower in west Africa, where the practice is widespread.

In the early days of the epidemic, HIV was thought to be mainly a condition of the wealthy, because better-off people often travel more and have more opportunity to buy sexual services and drugs. But once information and knowledge about the disease becomes available, the wealthy learn to protect themselves against HIV and they are not forced into sexual transactions in order to survive, as poorer people can be. Even in countries which have a high overall prevalence of HIV, the level of infection amongst the better educated started to decline during the 1990s.[49] In the early 1980s in Brazil, three-quarters of newly diagnosed HIV-positive people had a secondary education; by the early 1990s this share had fallen to a third.[50]

How are poor people vulnerable to HIV?

According to a review of the literature undertaken by Tony Barnett and Michael Blackwell,[51] it is widely accepted that five significant economic factors influence the spread of HIV: poverty, income inequality, population mobility, rapidly changing insecure livelihood patterns and falling health and education budgets. Here we look at some of the ways that poor people are likely to be more vulnerable to contracting HIV.

Need for income

The need for money among those who cannot meet their basic needs can be a powerful factor in driving people into sex work and informal sexual transactions.[52] Poverty can also lead to an increase in migration, as people leave their homes to search for work. Labour migrants appear to have higher HIV rates than non-migrants, regardless of the HIV rate at the site of departure or destination.[53]

Life priorities

For some people, especially if they are very poor, the risk of becoming HIV-positive is a low priority compared with immediate needs such as getting enough food. Anthropologist Martha Ward of the University of New Orleans sums this up: 'Poor women ask "How am I going to take care of my family? I have to put food on the table now. You think AIDS is a problem? Let me tell you – I've got real problems."'[54] The hopelessness of poverty can also lead to alcohol or drug use, making risky behaviour more likely and therefore increasing vulnerability to HIV.[55]

Women have less power

In many cultures, women's economic dependence and social norms make it impossible for them to negotiate condom use and also reinforce traditions such as wife inheritance, whereby a widow is 'inherited' by her brother-in-law – a practice which prevents women from being left destitute, but also increases their vulnerability to HIV. 'Poverty and gender are inextricably entwined. Seventy per cent of the world's poor are women. It is poor women who are most susceptible to HIV infection.'[56]

Knowledge factors

Poor people are less likely to be literate or go to school, reducing their chances of learning how to protect themselves.

Access to healthcare and condoms

Poor people are less likely to have other sexually transmitted infections treated, which increases their risk of becoming HIV-positive because HIV can penetrate damaged tissues more easily.

They are also less likely to have access to HIV prevention services, voluntary counselling and testing services, or to prioritise spending their limited money on condoms.

Physical factors

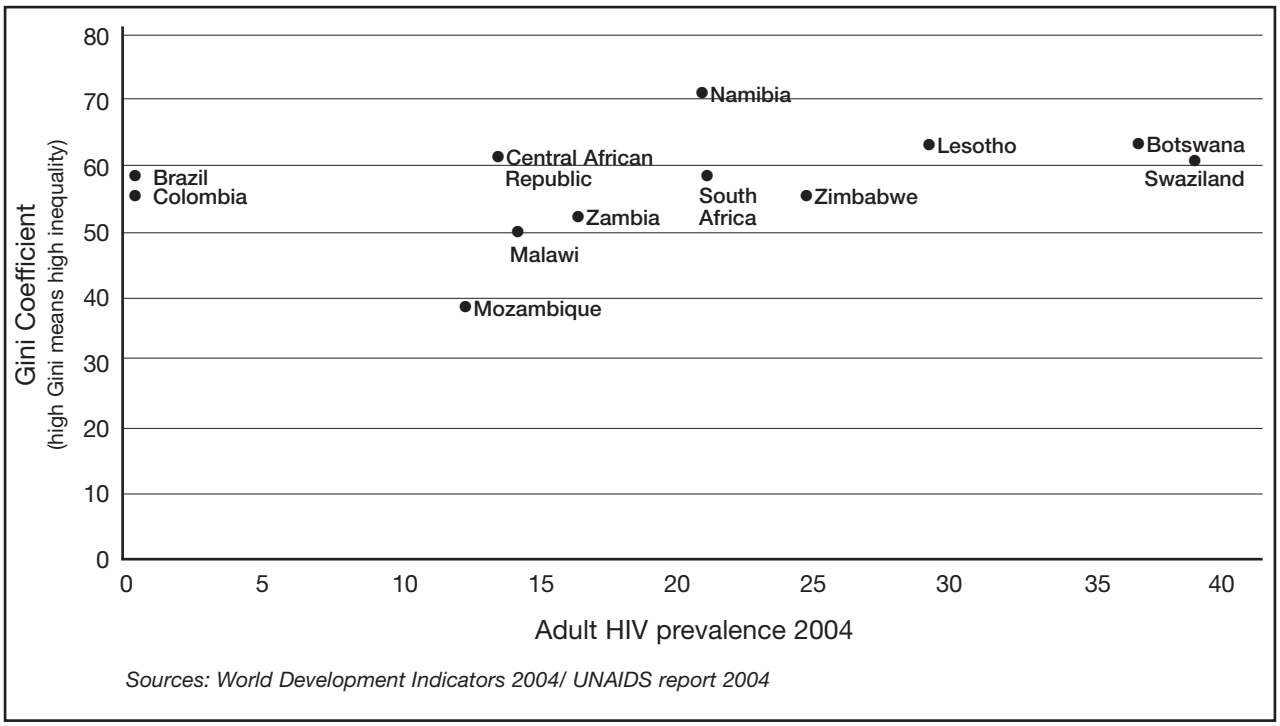
There is emerging evidence that poor nutrition not only increases the chances of HIV-positive people developing AIDS sooner, but also makes them more likely to become HIV-positive after being exposed to HIV.[57] There is also some evidence that people taking antiretrovirals (who are usually better-off) are less likely to pass on HIV than those who are not.[58]

Inequality and HIV

There is a relationship between income inequality and HIV. The ten most unequal countries in the world – Namibia, Lesotho, Botswana, Sierra Leone, Central African Republic, Swaziland, South Africa, Brazil, Colombia and Zimbabwe – include seven of the ten countries with the highest HIV prevalence rates. Namibia, for example, has an HIV prevalence of 21.3 per cent and the greatest disparity between rich and poor in the world. A mere ten per cent of the population hold 65 per cent of the wealth, while the poorest ten per cent earn just 0.5 per cent of national income.[59]

Globally there is an overall correlation between income inequality and HIV. Graph 2 shows the relationship in the ten countries with most inequality and most HIV. There are several explanations for this, which are discussed below.

Graph 2: Income inequality and HIV prevalence



Sources: World Development Indicators 2004/ UNAIDS report 2004

Opportunities to trade sex
More people are likely to be involved in sexual transactions in communities with large wealth disparities than in those with a more even distribution of wealth. This is because poorer people have the opportunity to make money by trading sex with those who are better off. If poverty is more uniform, such opportunities are clearly fewer. This dynamic applies to a range of relationships, including sugar daddies, or relationships between younger women and older men. Peer group pressure on girls to gain status through the money and gifts they gain from a sugar daddy is an important factor in this dynamic, as girls have fewer opportunities than boys to earn cash from casual work.[60]

Migration and urbanisation
Migration is associated with high HIV prevalence. Where there is poverty in one region and economic opportunity (real or perceived) elsewhere, people will go in search of the latter. This dynamic particularly drives urbanisation. In urban settings people have more sexual partners, there is more commercial sex and rates of sexually transmitted infections are higher, than in rural settings.[61]

Social cohesion
In unequal societies, social cohesion – the system of bonds, conventions, expectations and obligations between people – is often weaker than in more egalitarian societies. According to Barnett and Whiteside,[62] a combination of the overall level of wealth in a society and the level of social cohesion, can predict the occurrence of a severe HIV epidemic. Social cohesion is often particularly low in post-conflict situations and where there are many migrants or internally displaced people. In these situations, people are more likely to find sexual partners outside their 'usual' groups.[63]

Links between economic change and HIV

So far we have discussed the static links between poverty, inequality and HIV. We will now consider what happens when there is sudden economic change.

If a community is suddenly impoverished, some of the HIV vulnerability factors are likely to become more intense. The need to replace lost essential income becomes more urgent, raising the likelihood of transactional sex and migration. The sudden loss of earnings in a context of low income and high unemployment is particularly likely to lead to a rise in hopelessness, frustration, boredom and alcohol or drug use in many societies and lead to an increase in HIV vulnerability The exception is when impoverishment reduces the ability to move in and out of a community, which could reduce some opportunities for HIV to spread.

Ironically, economic development may also increase HIV vulnerability. While new projects can reduce poverty for some (by providing jobs locally), they may also increase poverty for others (for example, those displaced to make way for the development). A large building project for example, is likely to attract large numbers of migrant workers, which in turn will tend to attract a growing number of sex workers. There is a further example in Box 3.

There is an even more complex relationship between changes in inequality, poverty and HIV. Economic growth, while sometimes contributing to poverty reduction, can often increase inequality. The effects of such growth on the spread of HIV will vary, depending on the balance between these and other factors in a given society. Barnett and Blackwell sum up this complexity as follows:

> As poverty increases, so usually do income and class inequality. Mobility increases as people seek to escape poverty and work away from their homes. Increased poverty, inequality and

mobility weaken or break up the social framework in which people live – a framework that may have disciplined sexual relations in ways that reduce disease transmission. This framework may be thought of, in part, as 'social capital.' Finally, rapid change and insecurity often increase the incidence of transactional sex as a part of women's livelihoods. When, against this background a government cuts back spending on health and education, it creates an environment conducive to HIV transmission.[64]

Box 3

Economic development and HIV – the Volta River Dam, Ghana

'Frequently cited in the scant research to date on development projects and the creation of a context for the spread of HIV, is the case of the Volta River Dam, built to generate the huge amount of electric power used to process bauxite into aluminium for export. Construction of the dam in the 1960s, necessitated some 8,500 sq km to be cleared for the dam's reservoir. This displaced thousands of farmers, many of them women. Some men took up fishing; some migrated downriver to jobs on the construction site. But many women farmers ended up as service workers in the bars and hotels built to cater to the construction workers. "From there it was only a small step into prostitution", writes Decosas, the case study author. A generation later, the fatherless daughters of the migrant construction workers who built the huge dam had little choice but to follow their mothers into the business of selling sex. In the mid-1990s, HIV prevalence in the area surrounding the dam was found to be 5-10 times higher than in the rest of Ghana.'[65]

The debate on structural adjustment and HIV

Structural adjustment provides a recent example of sudden economic change in many of the countries with high HIV rates, provoking debate on whether there is a link between such policies and HIV.

Structural adjustment is a shorthand term for a cluster of reform policies that many developing countries followed in the 1980s and 1990s, often as conditions for accessing finance from the World Bank, IMF and bilateral donors. These policies usually comprised three elements or phases: austerity, market liberalisation and privatisation, otherwise known as the Washington consensus policies.[66] Many poor countries did not have the luxury of choosing whether to embark on reforms, as their economies were stagnating and they were increasingly forced to borrow in order to maintain internal viability. Reform and structural change were frequently needed, but at what pace and on what terms? Although the term structural adjustment is no longer used, similar types of economic reforms are ongoing.

Some commentators have suggested that the package of policies propounded by the Washington-based institutions may at times have favoured the spread of HIV.[67] In the best-known example, a group of researchers from the University of California published a paper[68] in the mid-1990s, arguing that structural adjustment policies (SAPs) led to:

- increased poverty, and a decline in the importance of the rural economy
- increased urbanisation
- development of transport infrastructure
- reduced spending on health and social services.

It was agreed that these all favoured the spread of HIV.[69] Further examples are in Table 1. Rebuttals to this kind of argument fall into three categories. Firstly, some commentators have suggested that these effects are inevitable aspects of economic reform and development. Richard Feachem, now director of the Global Fund to fight AIDS, TB and malaria, remarked that part of the paper cited above could be paraphrased as follows: 'Economic development is bad because it facilitates the spread of communicable disease by bringing people into closer contact with each other.'[70] But this implies that there is a single path to economic development. In fact there are many, some of which increase HIV vulnerability less than others. For example, if care is taken to minimise an increase in inequality, people will be less vulnerable to contracting HIV.

The second argument is that it is impossible to establish a clear general correlation between structural adjustment policies and the spread of HIV because so many interweaving factors influence HIV transmission rates and economic conditions, and because the delay between HIV infection and HIV-related disease makes it difficult to isolate the variables needed to draw firm policy conclusions. For instance, Barnett and Blackwell, in their study for Christian Aid, concluded that:

> While it is possible to see correlations between SAPs and the growth of HIV epidemics, it is not possible to draw a clear causal link. Some causal social and economic phenomena… often exist independently of SAPs. It is safe to say, however, that because in the past most SAPs were designed without HIV in mind, some have undoubtedly been sub-optimal as far as the interaction between economic policy and HIV is concerned.[71]

Finally, some authors have claimed that structural adjustment did not in fact increase poverty, and that any alternative economic policy might have had worse results.[72]

Christian Aid's view is that structural adjustment policies of the type promoted by the international financial institutions were misguided and because they were not always implemented as part of a longer-term strategy aimed at reducing poverty, they often failed to do so. They were usually insensitive to local circumstances and were frequently pushed through quickly, with weak country-based evidence and without sufficient consultation or local ownership. They usually failed to assist those whose lives and livelihoods were adversely affected by the adjustment process and failed to learn the lessons of intervention and support upon which many of the success stories of development were critically based. As a result, while such policies created opportunities for some people, they also deepened the poverty of many others and increased inequality in some cases.[73] They therefore need to be seen as contributing to HIV prevalence.

Table 1

Structural adjustment policies and the main variables argued to be associated with HIV/AIDS transmission[74]

This table provides a list of key variables likely to influence the spread of HIV and links these to different elements of a typical structural adjustment package. In most cases, a causal linkage is not implied.

Main variables associated with increased HIV/AIDS transmission	Manifestations of these variables	Elements of a SAP that could give rise to or strengthen these variables
Increased poverty	Malnutrition weakens resistance to disease.	Trade liberalisation can shift emphasis to export crops and reduce the number of subsistence farmers. It can also involve the lifting of import tariffs and consequently lead to an increase in food prices. Without subsistence farms to fall back on, people might not be able to afford as much food as before. Currency devaluation can lead to increased prices for imported foodstuffs and essentials.
	Small businesses (often run by women) cannot afford credit to survive.	Increasing interest rates can lead to economic recession.
	Women who cannot find other ways to make money, undertake sex work or transactional sex.	Increasing interest rates can lead to economic recession and unemployment.
	Local traders lose custom as traditional customers get poorer.	Increasing interest rates can lead to difficulties in financing essential inputs for farm production. Deregulation of the economy generally requires the lifting of price controls; food and other consumer subsidies cease.
	Increased unemployment.	Privatisation of public enterprises and services leads to price rises, pay cuts and job cuts. Fiscal prudence requires the downsizing of government and public service payrolls.
	Loss of social benefits.	Labour flexibility is encouraged and employment-related benefits are cut.
	Loss of assets leaves less cash available to purchase medical treatment.	User fees for health and education services are introduced.
	Other	Shift to export crops makes people vulnerable to drops in world commodity prices. Floor prices for agricultural stabilisation are abandoned, or para-statal marketing boards are replaced by free market models. There is an acceptance that short-term pain is necessary for long-term gain.
Increased income inequality	Shift from traditional to market economics increases socio-economic differentiation.	Deregulation and liberalisation require abandonment of traditional economic relationships. The shift from subsistence farming to paid labour increases standing of men vis-à-vis women.
Increased mobility	The number of sexual contacts increases, as men who are away from their family may have more sexual partners.	Shift away from traditional crops and subsistence farming mean that some farm labourers will need to move to larger farms or into towns seeking work.
	With partners away from the home, women become more likely to sell sexual services (often to obtain money for survival of children). They can also be infected by their partners returning from their travels.	Trade liberalisation can shift the emphasis to export crops and encourage the development of roads and transport infrastructure to facilitate the rapid transport of goods to ports or airports. This also requires more lorry drivers. The encouragement of foreign investment can lead to the development of logging, mining and other industries that typically require groups of men to live without their families away from home. The encouragement of industrial production attracts workers to towns and can lead to a higher number of sexual contacts. The encouragement of a tourist industry can lead to the development of a commercial sex industry.

Table 1 continued

Changed traditional livelihood patterns, leading to reduced social cohesion	Societal restraints on young unmarried women having sexual relations are weakened.	Trade liberalisation can shift the emphasis away from families working on small plots of land to individuals working as wage labourers on large plantations.
	Societal restraints on sexual relations outside marriage are weakened.	Deregulation and liberalisation can encourage industrialisation and a shift from country to towns, and a breakdown of household regimes' behavioural norms.
Decreased national budgetary resources	Reduced spending on health services leads to a loss of testing facilities (particularly for blood screening) and a fall in the treatment of STIs, which increase vulnerability to HIV. Reduced spending on health services may lead to lower use of syringes, etc.	Fiscal prudence can require cuts in health services.
	Reduced spending on education leads to reduced provision of public HIV education. Reduced spending on education leads to fewer places available for girls in secondary education.	Fiscal prudence can require cuts in education services.
	Reduced spending on agriculture depresses harvest levels.	Fiscal prudence in agriculture can lead to delays in the supply of seeds and fertilisers, and to cutbacks in agricultural and veterinary advice.

Conclusion

Poverty, inequality and HIV are intimately linked. Ninety-five per cent of people living with HIV are in developing countries and once the HIV epidemic has taken hold in a country, poor people (especially women) are often more vulnerable than better-off people. They are also less likely to be able to cope with the impact of HIV. Poor women are vulnerable for various reasons including:

- the need for income may force them into sexual transactions
- the urgent need to put food on the table may override the longer-term risk of HIV
- economic dependence on their husbands makes it hard to negotiate condom use
- they may not have access to knowledge.

A high level of inequality is also linked to increased HIV vulnerability. The world's ten most unequal countries include seven of the countries with the highest HIV prevalence. This is because an unequal community creates opportunities for sexual transactions and inequality often leads to poor social cohesion.

If economic change increases inequality in a society and poverty for some groups, it can also lead to a higher vulnerability to HIV. In Christian Aid's view, this may have occurred in many countries following the process of structural adjustment. But even in cases where economic change does not increase poverty or inequality, the accompanying social disruption and increased mobility can lead to a higher HIV risk. What happens in practice will depend on the particular circumstances, and the interplay of economic and other influences.

Policies aiming to promote economic development may contribute to poverty reduction in the long term and therefore an eventual reduction in vulnerability to HIV. However, the short-term impact of economic policy decisions may also increase HIV vulnerability for some people. Because HIV cannot be a short-term outcome for those who contract the virus, economic policy-makers must always consider the likely impact of their decisions on HIV.

3. Sweet or sour? The sugar belt of western Kenya[75]

'*There is much, much more HIV than five years ago because many parents are dead and since they were the breadwinners, the families left behind are in absolute poverty. So this makes the youth get involved in sexual practices in a bid to support their siblings.*'
Benta, sugar cane labourer, Nyando district, Kenya

HIV increases poverty. Poverty, inequality and economic change increase vulnerability to HIV. In this case study we consider how these links manifest themselves in the lives of ordinary poor people in the Kenyan sugar belt, where poverty and HIV have been prevalent for many years. As this case study shows, the economic events of recent years illustrate how the downward spiral discussed in this report can operate in practice, and how different economic decisions might have arrested it.

Christian Aid partner organisations the Catholic Correspondence Course Franciscan Missionary Charism (CCFMC) and the Anglican Church of Kenya (ACK) both work in the area of western Kenya known as the sugar belt, because sugar production is dominant. In January 2004, the two organisations facilitated research to investigate the relationship between HIV and economic change in two local districts – Nyando (HIV prevalence around 29 per cent) and Butere-Mumias (HIV prevalence officially estimated around 14 per cent, but thought in practice to be far higher). The researchers interviewed more than 60 people to find out whether they believed there were links between the spread of HIV and the economic situation and what those links might be. Accurate figures for localised trends in HIV prevalence did not appear to exist; the research instead concentrated on whether there were changes in behaviour, making people more vulnerable to HIV. The general consensus was that recent widespread losses of income had indeed led to behaviour changes that would increase HIV vulnerability.

Benta's story: HIV increases poverty

Benta is a sugar cane labourer in Nyando district. Like most people in the area, she relies on sugar cane as her main source of income. She has five children, between the ages of five and 17. Her husband died a few years ago. She believes that he died of AIDS and that she and her five-year-old daughter are HIV-positive. She says: 'I'm not sure I'm positive, but I know what I'm feeling. I know I'm not healthy. And my daughter has never been healthy like my other children.'

Benta and her family live in her husband's family's homestead. Her husband had four brothers, but two of them and their wives, have died – Benta suspects of AIDS. Her father-in-law is a small-scale farmer but his farm is not doing well enough to support Benta, so she labours on other people's farms. Her household income amounts to about 300 KSh (just over £2) per week. This buys milk, maize, soap, sugar, cooking fat and matchsticks. If there is not enough money she prioritises the maize and soap. 'Sugar is a luxury,' she says. She also grows vegetables to eat.

HIV has created money problems for Benta. 'People rely on the main breadwinner and when this person is gone, poverty sets in,' says a care volunteer from the Ekama Home Based Care Programme, Butere-Mumias District. Benta finds it more difficult to cope without her husband's income. And she is finding it impossible to work as she did previously 'Before, I could weed two rows of sugar cane in a day. But now I can only do one row in a day and mostly I can't finish it. I get very tired nowadays. I think I get tired because of the disease I suspect I have, but mainly because I'm poor. I don't have much to eat to get the energy for weeding.' It is hard to support the family: 'I'm really straining to make ends meet,' she says.

Moreover, she has had to sell some assets. 'I sold all my livestock – two cows, and all my sheep and goats – to pay for healthcare for my husband when he was sick. I've spent so much money on treatment for my daughter. I cannot afford to buy antiretrovirals for her or for me.' The cost of antiretrovirals has gone down, from 70,000 KSh (£48) per month to 1,000 KSh (£6.90), but this is still too much for someone on Benta's income. Some families are in an even harder situation, unable to afford soap, bedding or basic painkillers. The lack of clean water makes hygienic home-based care very difficult. 'Before, they could come to the hospital when they were sick. Now we have to look for them in the village. They buy a bit of paracetamol,' says a community health worker.

The cost of funerals compounds the situation, although in Benta's case her husband's funeral was not a major issue. 'The church bought the coffin and they just dressed him up in his old suit, then his father had to slaughter a ram to be taken to the funeral. The cost wasn't high because I'm poor… We tried to bury him as fast as possible.' CCFMC workers say that for many, '…funerals are very expensive. People have to eat before and after the burials. It takes up to three months, during which the family has to feed visitors. The family has to slaughter a cow, whether they are rich or poor. You have to give your in-laws preferential treatment. Villagers come and stay for up to two weeks and some bring their whole family.'

Her financial situation has affected Benta's decision on HIV testing. 'I would have wished to confirm my status, but when I think of the poverty I'm in and what I could do with the money, I chose to ignore the test. I also don't want the extra worry that someone has confirmed my status to be positive.' Testing is free, but she would have to travel to the health centre and lose a day's income.

Benta believes that her situation is affecting her chances of living longer. 'I have to labour hard and can't eat properly so I don't think I will live as long as I would have wished.' If she is right, her children will become orphans. Benta did not talk about what would happen to them. For some, the extended family support system is breaking down, and there are increasing numbers of street children and child-headed households. 'A long time ago the immediate family took responsibility for these children [orphans]. There was enough income and food and not so many orphans. These days their numbers have risen and the economic situation is worse. You have your own problems to worry about. These children are left to fend for themselves,' said home-based care volunteers from Ekama.

All Benta's children of school age are still in school. In many other families, children, particularly girls, are taken out of school to save money. Although primary schooling is now free, the cost of uniforms and books still needs to be met, and some children have to care for their sick parents and to work. Dropping out of school does save money in the short term, but it also compromises a child's long-term earning potential.

The impact of HIV on the region and the country

The Nyando district development plan[76] records a number of ways in which HIV affects the district, including:

- health services that are overstretched with growing numbers of AIDS patients and have to spend large sums on drugs for HIV-related diseases
- education services that are losing four teachers every month
- secondary school drop-out rates that are increasing
- lower agricultural production (mainly of sugar cane), resulting in lower income levels for families
- a sugar industry that is struggling with high medical bills for workers and absenteeism (this was confirmed by a detailed 1997 study of HIV in the sugar estates).[77]

The Butere-Mumias development plan[78] is also concerned about the wider impact of HIV. 'Overall, the most hit area is the sugar industry, which has seen many energetic members succumbing to this scourge. Officers in whom the company has invested a lot in the form of training end up dying at an early age. The agricultural sector in general has suffered a great setback as many progressive farmers have succumbed.'[79]

Sugar cane is only a small part of Kenya's overall economy, but the situation is similar in other sectors. One 2001 study forecast that the overall growth of Kenya's GDP would be 14 per cent lower by 2005 than it would have been without HIV/AIDS.[80]

Falling earnings from sugar

Apart from HIV, people in the sugar belt face another problem: falling incomes. Around half of the adult population works in agriculture and the majority of the population relies on sugar cane for a large part of their income, working as smallholder cane farmers, casual labourers or sugar company employees (a relatively small number). The sugar industry is so dominant that many others – shopkeepers, taxi cyclists, bar owners – are also indirectly dependent on its fortunes.

More than half the population in the sugar belt lived below the food poverty line in 1997 (the latest figure available).[81] From 2000 to 2002, farmers were generally paid very late for their sugar cane. One farmer says: 'We rely on previous payment to pay for the weeding of the land for the next crop. So this [late payment] has affected us because we cannot weed for the next crop.' More recently, the prices the sugar companies paid smallholder farmers for their crops dropped by between eight and 37 per cent (for reasons explained later in this chapter). This reduction in earnings for farmers has been passed on to casual labourers: Benta used to get 50 KSh for weeding a row of sugar cane; she now gets 30 KSh. There have also been many job losses among sugar factory workers.

People have tried to compensate for the drop in income in various ways: by leasing their land, increasing casual labour or growing more food or cash crops (a difficult option, because food crops get stolen). The women try activities such as market trading, savings cooperatives or selling illegal brew. The men may look for work elsewhere – on taxis or buses – or turn to livestock trading. But the majority of people interviewed agreed that farmers have not been able to replace their lost income through these means. A health worker says: 'The boys have joined the Boda Boda [bicycle taxi] group. Now there are too many Boda Boda and at the end of the day you have earned nothing. This also increases crime'.

As income falls, HIV incidence goes up

The interviewees all agreed that the impact of HIV had increased over the last ten years. This is confirmed by hospital admission figures for AIDS-related conditions, given in Table 2. The overall reduction in hospital admissions in 2000, according to one key health worker, is due to a drop in incomes and people's inability to pay hospital charges.

Table 2

Hospital admissions for AIDS-related conditions, 1993-2001, St Mary's Hospital, Butere-Mumias

Year	Total admissions	AIDS	Malnutrition	Gastro enteritis	Pneumonia	TB
2001	8,157	639	858	916	2,733	312
2000	8,900	249	1,111	2,040	2,316	302
1999	10,226	236	702	842	810	227
1998	10,597	175	506	70	702	249
1997	13,336	275	206	332	602	207
1996	13,863	230	604			227
1995	14,571	223				
1994	16,959	133				
1993		209				

Data from St Mary's Hospital and primary health care programme.[82] In many cases, HIV will not have been tested for. But it can be assumed that a high proportion of these conditions are HIV-related and therefore that an upward trend in the conditions probably reflects an upward trend in HIV infection.

The figures above reflect HIV-related illness, not HIV prevalence (illness only appears around eight-nine years after a person is infected). Adult HIV prevalence in Nyando district rose from 19 per cent in 1990 to 29 per cent in 1999.[83] More recent figures were not available, so definitive evidence of recent local HIV trends cannot be presented here.

Christian Aid asked people whether changes in behaviour following the need to replace lost income from sugar cane might have made people more vulnerable to HIV. The majority of people interviewed – including farmers, health workers, factory managers, youth leaders, NGO staff and people living with HIV – believe that the loss of income had led to increased spread of HIV through several different mechanisms, not all of which are obvious. We explore these mechanisms in some detail here.

Increased inequality of income

The drop in sugar price has, according to key informants, increased the disparity between rich and poor. Many of the better-off are employed in the sugar factories, and while job losses from the factories have increased poverty, those who are still employed earn between £70 and £175 a month, leaving them with a reliable disposable income – unlike cane farmer families. This inequality is fuelling the spread of HIV because, as one home-based care volunteer from Ekama explains: 'You have a few people with lots of money, the factory workers. Then you have lots of people with no money. The local women understand that the factory workers have lots of money and their husbands don't, so this spreads HIV.' This disparity has always encouraged sexual transactions, but many more women are now becoming involved, spreading HIV into new sections of the community. Eric Ochanji of CCFMC says: 'During the sugar boom, only a few people were vulnerable [to HIV] – those who had the money. Now it is everyone.'

Formal and informal sex work

The majority of interviewees agree that there has been a visible increase in sex work since the drop in sugar income. Clients, according to interviewees, are primarily sugar company employees, but also include sugar cane farmers after harvest time, and truck drivers. Sex work is proving a viable income-earning alternative, and is sometimes the only option for many girls and women. A sex worker earns 20-200 KSh per encounter. In comparison, Benta earns 30 KSh

for a day's weeding. 'Before, when people used to work and get good money from the factories, prostitution was not much. But when people were laid off and the price of cane went down, it became quite common. When you confront young people about this, they tell you that you are old and should stay at home', says Dina, a sugar cane farmer.

Sex work is often not a full-time occupation as Lawrence Okundo, the provincial AIDS committee manager in Nyanza, explains: 'During payment for the cane there is lots of sexual activity, whether it is commercial sex work or not. People know when the farmers get money. Ladies flock to the centres when payments are made. When there's no money, they leave.'

Girls and women who engage in sex work come from all sections of the community. One health worker gave this example of a married woman:

> I know of a couple who have separated because the woman kept on telling her brothers-in-law that, unless she has sex with a man to give her money for food, then she cannot survive… One day she pronounced: 'I'm tired of looking for men to give me money.' Her husband knew, but he didn't care as long as there was food on the table. The husband has his sugar cane but the money is little and it's not coming. This is only one woman. How many women are living in the same situation?

Young unmarried girls and women are also engaging in sex work: 'It [sex work] has gone high because those children who are parking [seeking partners in local bars] are the very children whose parents cannot afford to send them to school. But now the parents can't tell them to stop because the children will say "but you can't take me to school",' says a home-based care worker. In some cases mothers are actively encouraging their daughters.

Widows also engage in sex work. 'When they have lost their husbands, they live in poverty. In a bid to look after their families, they look for other men,' says Margaret, a sugar cane farmer. And finally, other sex workers are migrants into the sugar belt.

The sex work clients include better-off sugar company employees, sugar cane farmers, casual labourers (particularly when they have just been paid) and visitors to the area (although these have diminished, as the sugar belt is now known to be an HIV danger zone). The majority of clients are older men, as younger men generally do not have the money to pay. Sex is also sometimes exchanged for a service, such as a taxi ride.

As well as formal sex work in bars and so on, much informal sex work takes place around festivals and funerals, which can last for weeks. An HIV worker says, 'At night the place is fully packed and people are drunk and lots of activities go on. This has to do with traditional practices but also with poverty, because people who don't have money will go to the funeral, have sex and earn a living. I've seen people going from one funeral to another.'

Sugar daddies, multiple partners and sex for gifts

Interviewees report various other ways in which rising poverty is driving an increase in numbers and types of sexual partners, and therefore HIV vulnerability. These kinds of relationship form a continuum with informal sex work.

A girl is said to be looking for a sugar daddy when she seeks an older, better-off man who can offer gifts or financial support to enable her to continue her education. 'If you can't buy a book for your child, the child will go somewhere else. The only source is a man,' says a home-based care worker. This situation compromises the girl's power to negotiate sexual matters such as condom use. Young people report that girls will often have a sugar daddy at the same time as boyfriends of their own age. Sugar mummies are also becoming more commonplace.

More people, from different backgrounds – married and unmarried, young and old – are said to have many sexual partners. More partners can mean more money, food and gifts. Benta says: 'I believe it is the drop in the [sugar cane] price and the closure of the industry that has made people very poor and desperate. And that has led them to engage in indiscriminate sexual practices.'

Alcohol

Following the reduction in sugar cane income, many more women are boosting their incomes by making and selling illegal brew, which is widely available and very cheap. Interviewees report that this availability has led to an increase in drinking amongst the men, many of whom are frustrated and feeling hopeless about their futures. 'Men take local brew to forget their problems. If the children are sick at home he will forget that night. And then it is easy to lure a drunk person into risky activities,' says an Ekama volunteer.

Lack of access to secondary education

Fees for primary education were abolished in Kenya in 2003, rapidly reducing drop-out rates. But secondary schooling, for which fees and money for books and uniforms for example, still have to be found, remains a distant dream for most. Only around 20 per cent of sugar belt children (slightly more boys than girls) of secondary school age are enrolled. In the context of the lack of secondary education and vocational training, high unemployment and few opportunities, young people are vulnerable to risky behaviour.

More girls are seeking work as housemaids, which is also risky. 'The men of the household can take advantage of them, and if such men are HIV-positive, there is a high risk that they themselves will became positive as a result,' says a home-based care volunteer from Ekama.

Reduced uptake of health services

People have to pay for healthcare, which has has become more difficult since incomes fell. While this clearly affects people's ability to cope with the impact of HIV, it is also important for HIV prevention. Because other sexually transmitted infections are likely to go untreated, the risk of HIV transmission increases. 'Our people are not able to afford treatment for even the most common infections. A poor woman is walking around with open wounds,' says an HIV worker.

Migration

Although migration is not new in the sugar belt, the pattern has changed. During the sugar industry's heyday, there was inward migration to the area, with people seeking work opportunities. Short-term outward migration was also common, as cane farmers, especially men, used their income to travel to towns for recreation. This migration probably contributed to the early spread of HIV, and provides an example of how positive, as well as negative, economic change can increase HIV vulnerability.

Interviewees report that migration now follows a different pattern, as people, particularly young people move away in search of income. They may go to the Ugandan border to trade. 'When people are moving they may sleep out for many days, they don't come home and may engage in sexual activities.' They may go to the 'beaches', or the shores of Lake Victoria, where men look for fishing opportunities and women work as petty traders. 'The fishermen cannot be categorised as poor people: they get a lot of income from fish and spend this on leisure, which is driving HIV in that industry,' says Lawrence Okudo, AIDS committee manager in Nyanza. Many young men are also turning to truck driving and *matutu* (touting), so they are on the road for long periods. Some of the skilled workforce in the sugar industry have also been made redundant, and '…have found jobs in town and go back to their families during the weekends. They either marry other women or have multiple partners in town,' says Anne-Marie Ochieng of CCFMC.

The vulnerability of orphans to HIV
Extended family members are no longer able to care for orphans as they did in the past, because their resources are now more stretched. There are increasing numbers of child-headed households and street children, who are both exceptionally vulnerable. 'These children lack proper care and parental guidance, so they make their own choices. They end up in the wrong company and with the wrong people. People take advantage of them. Because they are poor, they will do anything for food – they are at risk,' say members of a home-based care programme.

Early marriage
Early marriage was reported as a cause of higher HIV prevalence in Butere-Mumias district. Increased poverty has reduced girls' educational and employment opportunities, and marriage is one solution. Girls often prefer to marry more prosperous (and therefore often older) men, and in a polygamous society this can increase vulnerability to HIV, because the exposure of one family member puts all at risk.

Wife inheritance
Wife inheritance is a traditional practice in the region. If a man dies, his brother or cousin inherits the widow and looks after her and her children (although increasingly an unrelated man may 'inherit'). Community groups in Butere-Mumias reported that, in the context of reduced incomes, this practice has increased because widows are desperate for financial security. With the high HIV prevalence in the area, wife inheritance spreads HIV because there is a high chance that the woman's husband died of HIV, and that she is unknowingly HIV-positive.

In Luo culture (the dominant culture in Nyando district) 'widow cleansing' is also a common practice, whereby a widow must have sex with her inheritor, traditionally a relative of her deceased husband, to be cleansed of certain taboos. However, some men are rejecting the role of inheritor because of fear of HIV. In the context of poverty, young men have become paid 'professional inheritors'. 'Wife inheritance is [male] commercial sex work,' says Eric Ochanji of CCFMC.

Sexual violence
A group of people living with HIV in Nyando District report that sexual violence has increased, because young men without incomes cannot attract girlfriends. They report that in some areas, a woman alone in the cane fields is in danger of being raped.

Factors that influence the prevalence of HIV

Of course, not everything about HIV is related to poverty or the loss of sugar income. Interviewees reported other factors which they believe have helped to increase the spread of HIV in the sugar belt, including:

- low condom use for social and religious reasons; because women cannot negotiate their use; and because of poor availability
- men budget poorly and women do not generally control income, so women need to generate extra income, sometimes through sex work
- some traditional practices, such as female genital mutilation (in the Butere-Mumias district)
- having multiple sexual partners, unrelated to a need for money
- a lack of awareness of HIV, or denial (HIV awareness appears to be high in the area, due to high prevalence)
- some HIV-positive people are said to be deliberately infecting others
- the major highway running through the area (transport routes are often arteries of HIV spread, because sex workers frequently gather at truck stops)

- the high prevalence of HIV on sugar company estates
- the flood-prone nature of the area (which leaves people regularly impoverished).

Christian Aid asked 21 of the women and 17 of the men interviewed to rank the different factors that lead to increased HIV prevalence in order of importance. Some of these are contradictory, reflecting the complexity of the situation. The results are set out in table 3.

Table 3

Factors that influence HIV prevalence in order of importance	
1	Loss of income from sugar/poverty
2	Sex work
3	Traditional practices (specifically wife inheritance, polygamy and funerals)
4	Dropping out of school
5	Migration
6	Alcohol
7	Early marriage
8	Behaviour and multiple sex partners
9	Lack of awareness, ignorance and denial
10	Sugar daddy and mummy
11	Lack of condom use
12	Deliberate infection
13	Having too much money
14	Female genital mutilation
15	Rape

Clearly the increase in poverty in the sugar belt over the last few years is not the only factor influencing sexual mixing. But it is an important factor in an environment where sex, any sex, is a risky undertaking because HIV prevalence rates are so high. Although a few interviewees argued that high-risk behaviour was more common when there was more money around, most were confident that sexual mixing has increased with rising poverty. This, they believe, is mainly because inequality has risen too – as more people lack options to earn a living, more become involved in sexual transactions.

Why did sugar prices fall?

Kenya produces about 400,000 tonnes of sugar a year for marketing, mostly in the sugar belt region, and consumes about 600,000 tonnes.

Sugar is Kenya's third largest agricultural commodity by value, after tea and coffee.[84] The sugar industry is a major income source for 100,000 small-scale farmers[85] and supports the livelihoods of more than six million people.[86]

In the early 1970s sugar growing was a Kenyan success story. The government worked with international companies to encourage sugar farming and build processing factories throughout the area. By the 1980s, Kenya was self-sufficient in sugar, and had started to export, but problems began to surface in the 1990s. Although these were partly related to the removal of price controls on inputs, which resulted in the doubling of fertiliser prices, they were also related to the nature of the sugar industry.

The Kenyan sugar industry is not competitive: in 2002, Kenyan sugar cost US$350-380 per tonne to produce, compared to less than US$200 per tonne in Sudan or Malawi.[87] This is partly because of internal problems in the industry, including poor management, a lack of investment and corruption.[88] It is also down to the 'outgrower' system, whereby most sugar cane is grown on smallholdings, distributing income much more widely than would occur on plantations, but failing to capture economies of scale. Some sugar processors ran up debts during the 1990s, and two mills closed in 2000.

Its precarious situation meant that the liberalisation of imports hit the Kenyan sugar industry hard. As a member of the new Common Market for Eastern and Central Africa (COMESA), Kenya scrapped tariffs for sugar imports from other COMESA members in 2000. Kenya has benefited from COMESA in many ways – tea exports, for example, have grown enormously – but the Kenyan market was flooded with sugar from competitor countries such as Malawi, Zimbabwe and Sudan, and there were rumours in the press of illegal sugar imports.[89] Wholesalers preferred to buy from these cheaper sources, although, according to Christian Aid interviewees, they did not pass on these savings to consumers. The Kenyan factories found themselves unable to sell their stocks, and withheld their payments to cane farmers for several months. The farmers, in turn, could not repay loans for inputs and transport fees, and the system collapsed.

To alleviate these problems, in February 2002 the Kenyan government announced that the zero-tariff regime under COMESA would only apply to 200,000 tonnes of imports from COMESA countries – the shortfall between Kenya's marketed production and market requirements. They were able to do this by using a COMESA safeguard,[90] similar to mechanisms used by the EU – the UK, for example, has recently applied to restrict imports of farmed salmon from non-EU countries.[91] The COMESA safeguard has now been extended until 2007 and in the meantime, sector reforms have been planned, which will hopefully ease the transition to a liberalised market. The safeguard appears to be having an impact – in the first half of 2004, sugar production increased significantly.[92]

In 2003, the government also set the prices paid to farmers at a lower rate (US$29/US$26, or 2,015/1,750 Ksh per tonne). Initially farmers protested, but by early 2004 many felt that knowing they would be paid, albeit at a lower rate, was better than not knowing when or if payment was going to come at all.

The IMF, in its 2003 Article IV consultation with Kenya,[93] appears willing to tolerate the situation, as long as it is short term:

> Kenya continues the pursuit of a discriminatory policy on wheat and sugar imports from COMESA trading partners, which is designed to protect local producers from what are described as 'unfair trading practices'. These are viewed as temporary measures, pending the resolution of these trade frictions through consultations or the COMESA dispute settlement mechanism… The mission urged the [Kenyan] authorities to review the recent protective measures [on sugar and others] in the context of their efforts to develop a medium-term trade strategy conducive to promoting strong economic growth.[94]

By including this issue in the Article IV consultation, the IMF is putting pressure on Kenya to end its use of the COMESA safeguards. No similar discussion appears, for example, in the UK's Article IV consultation.

Conclusion

As with all HIV epidemics, a multitude of factors have contributed to the spread of HIV in the Kenyan sugar belt, leading to the high prevalence rates. By 2000, following liberalisation, sugar imports flooded the Kenyan market, and a vulnerable industry was pushed over the edge. The sugar industry was unable to cope, and sugar farmers' income, already low, fell further. Many local people believe this led to an increase in the number of people putting themselves at risk of HIV. The combined problems of dealing with HIV and with loss of income, have made life very difficult for many households.

The Kenyan government – under terms permitted in the COMESA trade agreement – has temporarily reversed liberalisation and reintroduced tariffs, allowing the sugar sector to adjust and reduce the adverse impacts of liberalisation. The IMF is encouraging Kenya to end this protection. Christian Aid believes trade agreements should allow governments to intervene in markets for development aims. Further, when liberalising sectors they should be allowed to do so in a way and at a pace that prevents extreme hardship, for example by supporting sectors to become competitive before they have to compete internationally, or by developing alternative sources of livelihood. In some cases, protection may need to continue for the foreseeable future if the livelihoods of millions of small farmers and the people dependent on them, are not to be eroded.

If this does not happen, the consequences in the context of HIV are evident: while people may be made temporarily poorer by sudden economic change, the negative impact of contracting HIV is permanent.

4. Other downward spiral case studies

This chapter contains two shorter case studies, further illustrating the links between HIV, poverty and economic change, and indicates how policy-makers should take them into account when formulating policies. The first focuses on how the privatisation of the Zambian copper mines led to increased unemployment in an area of high HIV prevalence. The second examines how a recent increase in migration from Mali to Côte d'Ivoire, a result of falling incomes in Mali, has left more Malians vulnerable to HIV.

Case study one: The end of the mine? The Zambian copper belt[95]

> '*It's a spiral. Poorer people get HIV and become poorer.*'
> Christopher Chagu Kangale, programme manager at Christian Aid partner Copperbelt Health Education Project (CHEP)

Over the last decade, poverty has increased in the towns of the Zambian copper belt,[96] where HIV prevalence is around 25 per cent.[97] CHEP works with the communities in the copper belt on HIV prevention, care and support. In 2003, CHEP carried out research to increase its understanding of how changes in the wider economy have influenced the spread of the epidemic. They facilitated focus group discussions with community representatives from six copper belt towns, including women and men, some living with HIV, from a variety of occupations.

The end of the mine
Padson is 56 years old. He worked for 18 years at Roan Antelope mine in Zambia's copper belt, until he was laid off in 1999. Roan Antelope had been run for decades by the Zambian government, but as part of the general mine privatisation programme, was taken over by an Indian-based company, Binani, in 1998. After only two years, the venture went bust, leaving massive debts and thousands of people jobless. Only now, in 2004, has a new investor been found and the mine is due to reopen with a scaled-down staff.[98]

According to Padson, when the mine closed, 4,000 workers were laid off in his town, Luanshya, alone. Ten times this number lost their livelihoods, as each mine worker supported around ten people. When Padson was laid off, life became much harder. 'I was given only a small amount of money. It did not last long – I have a wife and nine children to support. When it ran out we were left with nothing… We find it difficult to have enough food for all of us.' Padson copes by growing some food himself, and by taking on work on other people's land, or mending fences. He is sometimes paid in maize meal.

This sudden loss of income has affected the life of Padson's family in many ways. He says, 'My children who were school age when I was working did go to school. But since I have been retrenched [laid off] none of my children have started school.' In any case, the value of school for his children is less clear to him, as 'now there are no jobs anyway… If the mines had continued our children would have had jobs in them… now they have no futures.' This means that the young men of the town, who expected jobs but are unemployed, 'sit around all day drinking beer'.

Two townships, Luanshya and Roan, are inhabited by former Roan Antelope mine workers. The government-run mining company, Zambia Consolidated Copper Mines (ZCCM) effectively ran a social welfare system for the town's inhabitants, including basic services. Padson says, 'We had free electricity. When a bulb died, the mines would replace it. Now we have no electricity at all, we

can't afford it. And we have no water – the whole area has been disconnected.' His family draw water from a neighbour's well. ZCCM also provided schools, health clinics and social facilities such as tennis courts, a football stadium and football league, which occupied young people and contributed to Zambia's reputation as a great footballing nation. Even support for baby clothes was available.

Now, all this has stopped. Many clinics and schools have closed and there is no free healthcare. Support for football has diminished, and Zambia is less successful at international level. According to one visitor, Luanshya and Roan are like ghost towns, shells of their former selves. Bottle stores and coffin makers are probably the most profitable businesses.

The link with HIV

CHEP asked the focus groups they interviewed what they believed had driven the spread of HIV in their communities. The groups named a wide variety of factors, often listing traditional practices such as wife inheritance; an attitude to life that 'it can't happen to me'; high alcohol consumption; social factors such as a lack of information about HIV; and economic factors such as poverty, mobility in search of income, and unemployment.

When the groups were asked about the relative importance of all the factors, poverty was deemed the most important, making people more likely to pursue high-risk sexual behaviour to try to raise some money. Second was the lack of information on HIV and third, as a major forerunner of poverty, was unemployment. Many of the issues mentioned by Padson and echoed by other interviewees play a role in linking increased poverty to higher HIV vulnerability. These include:

- the fact that children are taken out of school
- the loss of free healthcare
- the difficulty of getting adequate food for the family
- the fact that young adults feel no hope for their future and spend the day drinking beer.

The groups were also asked to divide the factors they thought led to the spread of HIV into those that the community could influence, and those it could not. Communities were thought to have least control over poverty, unemployment and mobility (a consequence of unemployment).

The privatisation process and its impacts

The Zambian copper mining industry has been a backbone of the economy since independence in 1964. Today, mining accounts for 70 per cent of the country's foreign exchange earnings. [99] It has also been a source of national pride. As Padson says: 'We felt proud to work for the mines. It was a Zambian mine and we were working for the nation.' However, the country's dependence on copper has become increasingly problematic. International copper prices have fallen and output from the Zambian mines has also gone down, due to a mix of declining ores, a lack of investment and poor management.[100]

Mine privatisation is thus one of the core policies of Zambia's economic restructuring programme, and was a condition of several IMF and World Bank programmes during the 1990s.[101] While it is generally agreed in Zambia that some form of privatisation offers the best hope for the copper industry, the form it should take has been the subject of much debate. Privatisation started in the mid-1990s, and is still not complete. It has been beset with delays and pull-outs. The situation at Roan Antelope mine is a case in point: the mine closed two years after privatisation and several years on, has not reopened. There is a similar story at Zambia's biggest mine, which was bought by Anglo-American, who subsequently pulled out.[102]

Privatisation has had some positive effects. In the early years of the current decade, mine output increased and employment appeared to be recovering to some extent. (This recent brightening in mining prospects has been helped by an upturn in international copper prices.) On the other hand, redundancies have been high: employment fell during the long, slow decline of the mines in the late 1980s and early 1990s; it dropped further during the pre-privatisation restructuring of the mid-1990s; and it fell catastrophically in some areas after privatisation. In total, mining and quarrying employed almost 65,000 people in 1991: by 1998 this figure had fallen to 40,000.[103] Poverty rose dramatically in the copper belt region during this period, partly due to the loss of employment, and partly because of other factors such as the recession that followed the economic stabilisation programme. The HIV epidemic itself will have had an impact too. Inequality in the copper belt region also rose sharply.[104]

Conclusions

During the 1990s, HIV in urban areas of Zambia increased dramatically, as did poverty in the copper belt. People living in the copper belt believe that the increase in poverty, much of it driven by unemployment, is an important driver of the epidemic.

It is too early to judge the long-term effects of privatising Zambia's copper mines: it may eventually lead to a viable but smaller copper industry, or it may be the beginning of the end, as Zambia loses out to more competitive mines overseas. This case study is not attempting to judge whether privatisation of the copper mines is the right or wrong policy. However, if HIV had been explicitly considered in the planning of the privatisation process, greater care might have been taken to mitigate some of the impacts of privatisation. The process could have been modified to reduce the number of sudden job losses and the loss of social provision and to be more aggressive and pro-active in encouraging new investment to absorb those unable to find work in the restructured industry.

The implementation of privatisation in general has recently been a controversial political issue in Zambia, where the president, Levy Mwanawasa, recently said: 'Privatisation has contributed to high levels of poverty, loss of employment and asset stripping. We are not saying that we do not want to privatise, all we are saying is that we want to slow down the process. Our experience has been that of job losses, so we want to examine other ways this can be done.'[105]

In encouraging the privatisation of the industry, the IMF and World Bank do not appear to have considered the implications for HIV prevalence. The 2002 joint staff assessment[106] of the Zambia poverty reduction strategy paper (PRSP), acknowledges the adverse impact of HIV on the economy and the need to integrate HIV across sectors. The 2004 progress report underlines these references.[107] But the assessment also observes that, 'given the downturn in mining prospects, PRSP proposals for new investment in this sector may be over-optimistic. Mining sector policies should rather emphasise cost-cutting and efficiency measures.'[108] This seems to imply prioritisation of measures that will lead to further job losses in the sector, and there is no apparent consideration of the impact on HIV. This could lead to more instances of the situation graphically described by Padson, where 'the mine just sits there like a skeleton, and we sit in its shadow with no food.'

Case study two: Migration from Mali to Côte d'Ivoire and back again[109]

> *People are going away in order to find a living, but instead they are finding HIV, and bringing it back*.
> Yacouba Kone, the head of Christian Aid's office in Mali

This case study is mainly derived from the experience of Yacouba Kone, head of Christian Aid's office in Mali, and that of Christian Aid partners working in Mali.

Although there was steady economic growth in Mali during the 1990s, over 60 per cent of the population live in poverty.[110] Despite this, adult HIV prevalence has up to now remained – for Africa – relatively low at 1.9 per cent.[111] This is the case in many west African countries – HIV has not taken as much of a hold there as in other parts of the continent. It is not understood why. HIV prevalence in Mali is highest in the southern regions, which border two higher-prevalence countries – Côte d'Ivoire and Burkina Faso.[112] More women than men are becoming HIV-positive.

Four-fifths of Mali's population works in agriculture. In 1990, the government adopted a structural adjustment programme for the agricultural sector. One of the objectives of the programme, supported by the World Bank, was to liberalise markets in cereals and cotton. Cotton is the country's major cash crop, while cereals are grown for mainly for food.

According to Yacouba Kone, during the 1990s production of cereals and cotton increased, but profit margins fell, following the withdrawal of government subsides for inputs such as fertilisers. In the case of cotton, the global price also fell dramatically, although it is now increasing again. The structural adjustment programme allowed some access to credit for producers, but the interest rate was very high and many producers had to sell off possessions to repay debts.

The population of southern Mali does not traditionally migrate, except at times of drought, and the last major drought was in the mid-1980s. Since agricultural incomes fell, however, migration has increased and occurs even when there is no drought. Thousands of people, especially the young, are migrating to neighbouring Côte d'Ivoire, sometimes with their families, in search of a better livelihood.

Côte d'Ivoire has a much higher prevalence of HIV than Mali, at seven per cent of the adult population. The people living in Mali's border zone have now realised that people are returning from Côte d'Ivoire sick, they think with HIV-related illness. There are very few prevention services or local facilities to support people living with HIV. The situation has become worse since the outbreak of rebellion in Côte d'Ivoire. 'Significant seasonal migration of agricultural workers to Senegal, Côte d'Ivoire and France during Mali's non-agricultural season, could have a serious effect on the spread of HIV in Mali in coming years. Migration to and from Côte d'Ivoire poses particular risks.'[113]

Many returnees are in a desperate situation. Those who are unwell are unable to do farming work. Young women may be obliged to undertake sex work in Sikasso, the biggest town near the border, which could lead to HIV spreading further. Many young people have not heard of condoms. Only 14 per cent of young Malian women who had sex in the last year with someone other than a regular partner reported using a condom.[114] 'When you explain to them what it is about, they just laugh, because they don't know the danger of unsafe sex. This is the right time to act if we want to prevent a human tragedy in a near future as a result of AIDS spread in the region,' says Yacouba Kone.

5. Recommendations to policy-makers

Most of what is good for development is also good for HIV and vice versa. Twenty years on, if we have helped the developing world to achieve those Millennium Development Goals, I can assure you AIDS will be in retreat... Twenty years from now, let it be said that we not only saved the second generation from the catastrophe, but that we planted the seeds for a world where nothing like AIDS could ever run rampant again.
Peter Piot, director of UNAIDS, lecture to World Bank, November 2003

This report has shown that HIV and economic policy are closely inter-related: the HIV epidemic increases poverty and reduces growth while, in turn, poverty makes people vulnerable to HIV. What is more, sudden economic change may make some groups of people more vulnerable to HIV, particularly if it increases inequality or impoverishes some groups. These two sets of relationships are themselves usually inter-linked, reinforcing each other and leading to a downward spiral.

Economic change is clearly often necessary and desirable. However, policies which are intended to bring about overall improvement can often lead to changes which make little difference to some poor people, and can even leave them worse off. The policy architects may argue that this impoverishment will be short term. However, if an HIV/AIDS perspective is factored in, then further questions are raised. While it is possible for someone to become poorer on a temporary basis, if they become HIV-positive, this will be permanent. Once they are HIV-positive, their poverty is likely to deepen, and high levels of HIV will dramatically affect a country's long-term growth prospects.

The implication is clear: it is no longer acceptable for economic policy-making to take place without incorporating the many dimensions of the impact and effects of HIV on the population. At one level, more programmes are needed to deal with the impact of HIV through support and treatment, and to prevent HIV by encouraging condom use, faithfulness and/or abstinence. But the long-term effectiveness of such programmes is likely to be eroded unless complemented by parallel policies to address the economic aspects of HIV.

Four reasons for integrating HIV into economic policy-making

There are several compelling arguments for economic policy-makers in international institutions, donor and national governments, to consider HIV. These are set out below.

Economic reasons
Where the epidemic is advanced, it will undermine economic goals by increasing poverty and depressing economic growth. The downward spiral will ensure that poverty caused by HIV leads to a further spread of the virus.

Financial reasons
Lower levels of economic growth, to which HIV contributes, will leave poor countries less able to access commercial funds from the international financial system, more vulnerable to future economic shocks and in need of more aid funds. This will cause problems for both borrowers and lenders.

Political reasons
The UK government and many of the international institutions have rightly staked much political capital on the attainment of the Millennium Development Goals, which are jeopardised by the HIV epidemic. In developing countries, policies which reduce poverty are usually important to a majority of the population, and governments that fail to reduce poverty are politically unpopular. Governments face real political difficulties when they prioritise HIV, because of the stigma attached to it. They can overcome these difficulties by highlighting the way the epidemic increases poverty.

Humanitarian reasons
Tackling HIV alongside economic policy-making in a comprehensive fashion will immeasurably improve the quality of life – and in some case, save the lives – of millions of women, men and children in many of the world's poorest countries.

Policy implications

The implications of HIV in economic policy decisions fall into three broad categories, as discussed below.

1. The impact of HIV
In high prevalence countries, the HIV epidemic is going to have a far-reaching impact on many aspects of the economy over the next few crucial decades. Policy-makers need to incorporate HIV into all their plans and decisions, including macroeconomic ones, and those related to social and development spending. Poverty reduction strategies are a key area where an HIV perspective is important throughout.

When allocating budgets, policy-makers need to analyse the likely impact of HIV on all financial and economic sectors and population groups, and the likely needs generated by HIV. Revenue flows may go down, and spending priorities are likely to need to shift. For instance, the epidemic will generate major demographic changes and the loss of human capital, which will need to be addressed. There is no point in assuming that most highly skilled jobs in the economy will be met by local training institutions, if there are insufficient teachers and if students die before or soon after graduating. Antiretroviral therapy may improve the situation, but the costs need to be factored in.

Key areas for consideration include:
- the cost of responding to the epidemic through prevention, care and treatment
- the cost of mitigating the impact of the epidemic through expanded social support, particularly for orphans and other vulnerable children
- likely reductions in tax revenue and savings
- increased demand for health services (including replacing large numbers of staff)
- pro-actively responding to (or better, preventing) institutional weakness due to loss of staff in areas such as education and the central civil service
- the demographic effects of HIV, and the likely loss of human capital, in economy-wide human resource planning. This might include, for example, planning for economic development in areas with a lower skill base.

In many countries the budget for HIV responses is controlled by the health ministry. Although a health service response is important, money clearly needs to be available in other areas too. Therefore some Christian Aid partners have suggested that HIV budgets should be located centrally, so that all ministries can draw on them.

2. The spread of HIV
Economic policy decisions which are not shaped by an explicit HIV perspective may increase the vulnerability of some groups to the virus. Thus all policies need to be informed by the analysis of their likely impact on HIV, while policy options should be chosen in the light of this analysis. This should be done as part of wider PSIA – see Box 4.

Such an analysis will at times mean changing priorities. For example, a poor country's government may prefer to place more emphasis on protecting livelihoods, and consequently alter the rate of liberalisation, if it appears likely that the economic disruption caused by rapid liberalisation may increase HIV spread. International rules and conditionalities should not merely accommodate, but actively encourage poor country governments to incorporate an HIV dimension into their economic policy choices.

There will be other times when policy is adopted that is likely to worsen the spread and/or impact of HIV, because it is believed this will create greater overall long-term benefits. In these circumstances, additional measures to address the adverse impact of HIV should be a pre-requisite to implementing such a policy.

Policy-makers must also take into account the issue of widening inequalities. Economic growth is important for sustainable poverty reduction. But if it leads to greater inequalities, HIV could spread at a faster rate than it would do if a more equitable growth path were pursued. As the World Bank has rightly observed, 'rapid and fairly distributed economic growth will do much to slow the HIV epidemic.'[115]

Finally, successful poverty reduction will in itself reduce HIV vulnerability. As Collins and Rau put it, 'If, on a worldwide basis, poverty constitutes the primary risk environment for HIV infection, should we not be asking what causes poverty?'[116]

Box 4

Poverty and social impact analysis
The impact of economic policy change on poverty should be considered before policy is decided. The World Bank and IMF still drive forward policy reforms in developing countries without sufficient public discussion and without paying sufficient attention to the likely impact of those reforms on poverty. The World Bank has made repeated commitments to ensure that poverty and social impact analyses (PSIAs) are made an integral component of all major economic reforms; recently the IMF has also supported the PSIA approach. Effective PSIAs would contribute to ensuring that policy decisions were not made purely on the basis of aggregate economic efficiency arguments.

To be more effective and to incorporate a wider framework, PSIA needs to:
- consider a range of possible policy alternatives, not just one
- be carried out independently of the policy-makers
- include non-monetary aspects of poverty
- be published and publicly debated before the policy decision is made
- influence the decision on policy alternatives.

3. Intensifying the response to HIV
The immediate responses to HIV – prevention, care, treatment and care of orphans and other vulnerable children – need be scaled up and fully funded. In particular, it is important to prioritise support for orphans and vulnerable children: if they grow up educated and emotionally secure, the

future economic impact of the epidemic will be less severe. Scaling up both HIV prevention programmes, and care and treatment programmes, will in turn reduce orphan numbers, because fewer parents will become HIV-positive. Those who do, will stay healthy longer.

In July 2004, the UK government made a firm commitment to deal with the issues raised in this report. In *Taking Action – the UK's strategy for tackling HIV in the developing world* – it said:

> If a government decides to privatise a previously state-owned asset, there may be implications for employment in nearby communities, leading to poverty and vulnerability to HIV. When a major highway is built, it may increase the access of poor people to markets and services, but may also make them more vulnerable to HIV. The impact on AIDS of each proposed reform must form a part of analysing the poverty, social and environmental aspects of the programmes.[117]

Christian Aid hopes to see the far-reaching action necessary to put this commitment into practice.

Recommendations

International institutions and donors should:

- review policies and conditions to ensure that countries are not advised or forced to adopt economic policies which are likely to have adverse impacts on their HIV epidemics – this should be part of a general move to increase countries' autonomy in their economic decision-making
- ensure that their advice and any conditions adopted actively support national plans to respond to HIV, paying particular attention to any proposed social spending cuts, expenditure ceilings or limits on budget deficits
- integrate HIV into all poverty and social impact analyses to inform all economic policy recommendations
- include HIV prevention and care components in all relevant development projects: for example, ensuring priority for HIV awareness, treatment of sexually transmitted infections and girls' schooling
- ensure that the UNAIDS estimate of at least US$20 billion per year is available for HIV prevention, care, treatment and support by 2007.

National governments should:

- design economic policies in ways which they believe will best benefit both their short- and long-term social, economic and HIV problems
- integrate HIV into poverty and social impact analyses to inform all economic policy choices
- realistically consider the projected impact of HIV during the planning of budgets in all areas of spending
- ensure HIV responses are integral to poverty reduction strategies, and include consultation with HIV-positive people in strategy processes
- scale up HIV prevention, care, treatment and support, especially during processes of rapid economic change, paying particular attention to supporting orphans and other vulnerable children.

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Christian Aid works in some of the world's poorest communities in more than 50 countries. We act where the need is greatest, regardless of religion, helping people to tackle the problems they face and build the life they deserve. At home and overseas, we campaign to change the structures that keep people poor, challenging inequality and injustice.

Christian Aid is a member of the Stop AIDS Campaign, an initiative of the UK Consortium on AIDS and International Development, a coalition of more than 60 groups campaigning to urgently increase international action on HIV.

Front cover picture: Mine workers at NFC Africa Mining shaft at Chimbishi, Zambia. Since the government sold the mine in 1997, the mine shafts have been left to flood and the infrastructure of the plant left to rot. A Chinese company has since invested in the mines providing jobs for local miners

Photo: Christian Aid/David Rose

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