InFocus Programme
on Crisis Response and Reconstruction

Working Paper 6

HIV EPIDEMIC AND OTHER CRISIS RESPONSE IN SUB-SAHARAN AFRICA

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PREFACE

The overall goal of the current ILO InFocus Programme on Crisis Response and Reconstruction is to develop the ILO's coherent and rapid response to the different crises – natural disasters, armed conflicts, financial and economic downturns and difficult political and social transitions – focusing on areas of ILO's comparative advantage. Knowledge development constitutes one of the Programme's four main pillars. The other three are timely needs assessment and programme formulation and implementation in the crisis-affected countries; advocacy at the international, regional and national levels on the employment and other socio-economic dimensions of crisis and the need to address them as an integral component of crisis prevention, resolution and post-crisis reintegration, reconstruction, and development processes; and capacity building of the ILO and its constituents to enhance their effective and active role in crisis response. The Programme's implementation is currently quite advanced in all four areas.

The present paper on *HIV and other crisis response in sub-Saharan Africa* is one of the outputs of the Programme's research work, undertaken with an external network of researchers from various universities and other research institutions around the world.

Desmond Cohen has provided a valuable analysis of the HIV/AIDS epidemic, showing how armed conflicts and other crises in the region are contributing to an escalation of the epidemic. Above all, he has indicated how the ILO's crisis response work can integrate understanding of this interconnection.

The InFocus Programme on Crisis Response acknowledges the contribution of Janine Rodgers and Mike Shone to the commencement of the study, as well as that of Erik Lyby who reviewed the first draft with me. I am also grateful to the ILO's Jobs for Africa Programme, especially Mpenga Kabundi, for providing funding for the exercise. The ILO Crisis Response Programme as well as the ILO/AIDS and Jobs for Africa Programme will do their best to ensure follow-up to the recommendations. We are also sure that others working on the different crises as well as on HIV/AIDS will find the analysis and recommendations useful for their work. We welcome feedback from readers and users of this working paper.

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

The most recent estimate from UNAIDS (December 2001) is that there are presently 40 million people living with HIV globally. During 2001 new HIV infections were 5 million, of whom 1.8 million were women. Since the start of the epidemic in the 1980s, cumulatively some 20 million Africans have died from AIDS, and there are an estimated 28 million people in Africa living with the virus. Other countries in Southern Africa have now joined Botswana with HIV prevalence amongst adults in excess of 30 per cent. In the worst-affected countries, steep declines in life expectancy are occurring, and at the present time four countries in the region have life expectancies at birth of less than 40 years. Across sub-Saharan Africa, life expectancy is estimated now at only 47 years, compared with a non-AIDS projection of 66 years.

An epidemic on this scale has an effect on all aspects of life in the region and is increasingly seen as structurally changing the parameters of development in ways that are only now receiving the attention of the international community. It is increasingly clear that the HIV epidemic has its origins in conditions of poverty, gender inequality and patterns of development that intensify the mechanisms through which HIV transmission takes place. Simultaneously, the HIV epidemic, through its impact on development, exacerbates poverty and gender inequality and undermines the organizational capacity and human and social capital essential for development.

Amongst the factors that are driving the HIV epidemic in Africa are crises such as armed conflict, environmental degradation, and those caused by economic and social policy failures. Similarly, these crises tend to generate the conditions in which the epidemic thrives through the displacement of populations, intensification of poverty and destruction of productive capacity. There are clear bidirectional factors operating which together undermine development in Africa as well as in other regions.

The aims of this paper are threefold. Firstly, it attempts to identify the key concepts essential for understanding the HIV epidemic as a development issue, so that the epidemic is seen as a structural phenomenon which affects all aspects of development in Africa. Secondly, the paper reviews what is known about the interconnections between crises and the HIV epidemic, in order to better understand both the role of crises in respect of the HIV epidemic and the causal role of the epidemic on the conditions in which crises arise. Finally, in section 3 of the paper there is a review of the activities of the ILO Infocus Programme on Crisis Response and Reconstruction, with the aim of identifying the processes whereby the HIV epidemic, seen primarily as a development problem, affects the work of the Programme. The discussion of the Programme=s approach to crisis, and of empirical data, leads to the conclusion that HIV/AIDS needs to be fully integrated into the work of the Programme (and more generally within the ILO). Current approaches require review and modification if they are to be effective in addressing crisis conditions which are made even more intractable under the impact of HIV/AIDS. Suggestions are made as to how best to move forward, both generally with the integration of HIV/AIDS within the work of the Programme and in respect of changes to traditional ILO approaches to crisis, if they are to fully take into account the developmental and other effects of HIV/AIDS.

INTRODUCTION

It is now recognized, rather belatedly, that the HIV epidemic poses major threats not only to social development but more generally to national and international security. This is reflected in the Resolution of the UN Security Council in June 2000 and the clear statement on this issue that emanated from the UN Special Session on AIDS held in June 2001.[1] Thus, the Declaration of Commitment on HIV/AIDS from the UN General Assembly Special Session on AIDS (UNGASS) affirmed the following:

> Noting with grave concern that Africa, in particular sub-Saharan Africa, is currently the worst-affected region, where HIV/AIDS is considered a state of emergency which threatens development, social cohesion, political stability, food security and life expectancy and imposes a devastating economic burden... recognizing that poverty, underdevelopment and illiteracy are amongst the principal contributing factors to the spread of HIV/AIDS, and noting with grave concern that HIV/AIDS is compounding poverty and is now reversing or impeding development in many countries and should therefore be addressed in an integrated manner. ...Noting that armed conflicts and natural disasters also exacerbate the spread of the epidemic. (articles 8, 11 and 12)

The UNGASS went further than just describing the reality of the situation in sub-Saharan Africa and urged Aall UN agencies, regional and international organizations, as well as NGOs involved with the provision and delivery of international assistance to countries and regions affected by conflicts, humanitarian crises or natural disasters, to incorporate as a matter of urgency HIV/AIDS prevention, care and awareness elements into their plans and programmes and provide HIV/AIDS awareness and training to their personnel@ (article 76). The meeting also established specific targets in respect of the various provisions of the Declaration to be met by 2003 (articles 75, 77 and 78 at the Annex of this paper).

It is also worth noting at this point the UNGASS article that is of special relevance to the ILO (article 49) which reads as follows:

> By 2005, strengthen the response to HIV/AIDS in the world of work by establishing and implementing prevention and care programmes in public, private and informal work sectors and take measures to provide a supportive workplace environment for people living with HIV/AIDS.

[1] Declaration of Commitment on HIV/AIDS, UNGASS, 25-27 June 2001.

These global statements of concern about the implications of the HIV epidemic are to be welcomed in that they affirm a commitment to address the complex problems of AIDS. It is, however, going to prove much more difficult to achieve global objectives than it is to set out projected targets, for there continues to be clear evidence that the epidemic is generally not understood as a threat to international security and to social and economic development and that, even where high priority is given to issues of HIV/AIDS, there are great programmatic weaknesses in going forward with effective responses.

In section 1 of this paper, there is a review of the epidemiological situation in sub-Saharan Africa setting out some of the key features of the epidemic. This is followed by a brief analysis of various aspects of the epidemic that are intended to form a basis for understanding some of the key issues that need to be considered in designing and implementing policy and programme responses: issues of the systemic effects of HIV and AIDS; the impact on human capital; and the effects of AIDS on poverty. This is followed in section 2 by a review of the interaction of the HIV epidemic with crises, so as to establish in broad terms the most important relationships between structural variables. Finally, in section 3 the conclusions and insights into epidemic processes and effects are used in reviewing the generic ILO Programme on Crisis Response and Reconstruction with the intention of achieving integration of HIV and AIDS.

At the present time, HIV/AIDS as such has had little part in the design and implementation of the Programme's activities. This in part reflects the scale of the task already facing the Programme in responding to the different structural crises in Africa and in part arises from the decision of the ILO to establish a special unit to address HIV/AIDS in the world of work. This paper is itself a recognition by the Programme that HIV/AIDS affects significantly the crisis-related activities of the ILO, thus making it essential that response processes be reviewed so as to ensure relevance and effectiveness. It is readily agreed by all that HIV/AIDS often has its origins in conditions of crisis and is in turn exacerbated by the social, economic and political effects of crisis.

1. UNDERSTANDING AND RESPONDING TO STRUCTURAL CONDITIONS

1.1 The epidemiological situation

According to UNAIDS (December 2001) there are presently 40 million people living with HIV globally. During 2001 new HIV infections globally were 5 million, of whom 1.8 million were women. As UNAIDS noted in its Report, AAIDS has become the most devastating disease humankind has ever faced.@[2]

AIDS is estimated to have killed 2.3 million Africans in 2001, and since the start of the epidemic in the 1980s cumulatively some 20 million people have died. There were an estimated 3.4 million new infections in 2001, which means that there are presently 28.1 million Africans living with the virus. Several other countries in Southern Africa have now joined Botswana with HIV prevalence rates in excess of 30 per cent. Indeed, within countries there are cities with even higher rates of HIV prevalence amongst adults, some in excess of 50 per cent.

In most countries, there are continuing urban/rural differentials in rates of HIV in the population, but even with lower rates of HIV, most of those infected are in the rural population. The other striking feature of the epidemic which has persisted over time is that more women are infected than men and that women typically become infected at much earlier ages than men (with consequent greater losses of healthy years of life). In the worst-affected countries, there is a steep loss in life expectancy, and four countries now have life expectancies at birth of less than 40 years. Across sub-Saharan Africa, life expectancy is estimated now at only 47 years, compared with a non-AIDS projection of 66 years. There are presently an estimated 12 million children who have lost their mother or both parents to the epidemic, and this appalling number of orphaned children is projected to more than double over the next ten years.

A simple calculation will demonstrate how pervasive the epidemic is within sub-Saharan Africa. As we have seen, an estimated 20 million people have died since the start of the epidemic. A further 28 million are presently living with the virus, and most of them will die within the next ten years. This means that some 50 million people will die from HIV-related illnesses, including AIDS, before the end of the present decade. If it is assumed that about five people within the immediate family are affected for every African who dies, then some 250 million are closely affected. To this number needs to be added those less directly affected such as extended families, colleagues at work, close friends in faith and other communities B perhaps doubling the number of those directly affected to give a total of some 500 million.

[2] *AIDS epidemic update*, WHO/UNAIDS, December 2001.

Such simple calculations demonstrate the scale of the impact of the epidemic in sub-Saharan Africa, suggesting that most of the population is affected. The epidemic has effects on social, political and economic life not witnessed previously, so that all developmental activities, including those relating to security at national, regional and international levels, have to explicitly address the implications of what is evolving as a huge humanitarian disaster. The epidemic undermines development and thus further deepens the conditions in which HIV transmission thrives. Simultaneously, the capacity of families, communities and nations to cope with the complex social, political and economic consequences is reduced. The HIV epidemic is flourishing in a region that has witnessed continuous crises over the past 50 years from a multitude of causes ranging from conflict to natural disaster, and countries are becoming increasingly impoverished. These conditions are exacerbated in many countries by policy responses that often worsen the underlying conditions in which people live.

1.2 Responding systemically

What is often missing from the discussion of the HIV epidemic is an understanding of a country=s complex economic, social and political system, with the result that policy and programmes are based too often on a partial analysis that misses the interdependence. The key fact to understand is that the parts are interconnected within a system, and it therefore requires complex analysis and needs to take account of the ways that the parts interact and interconnect. Therefore the analysis needs to be dynamic rather than static, so that policies have to consider not only the impact effect of HIV on development but also the longer-term effects on the interdependent parts of the system.

Revisualizing the development effects of HIV as being systemic is the first step towards more realistic analysis and thus the basis for more effective policies and programmes. What this entails has been explored elsewhere by the author, but several examples will indicate what is required in thinking systemically about the epidemic.[3]

$ In reviewing the prospects for commercial agriculture in Zimbabwe, where the effects of HIV and AIDS are severe, it is evident that the real problems are not the replacement of unskilled labour. In a country where unemployment is high, there is in general little difficulty in finding replacement labour, although there will inevitably be a loss of specific knowledge due to labour losses. The major problem has its origins in human and organizational capacity losses in those supplying services to commercial farms, where skilled and managerial labour is scarce and expensive to replace. It is thus the discontinuity and higher costs with respect to the supply of inputs from other sectors that are the primary cause of the problems facing commercial agriculture. This is not to argue that internal effects on enterprises will be unimportant, but they are likely to be secondary. Paradoxically, therefore, the more an enterprise is integrated with the market system with respect to inputs, then the more vulnerable it becomes to the effects of HIV on human capital.

[3] Desmond Cohen: *Responding to the socio-economic impact of the HIV epidemic in sub-Saharan Africa: Why a systems approach is needed*, Working Paper, UNDP, 1999.

- One of the most important sectors in all countries is that of transport which plays a critical role in respect of market integration. Now the transport sector also plays an important role in the transmission of HIV, given the fact that labour migration and labour mobility have been important in the spread of infection in populations. This can be seen most evidently in Botswana which has the highest recorded global prevalence of HIV and where there is relatively little difference in rates of HIV between rural and urban/peri-urban populations. The incidence of HIV infection, and its general distribution in Botswana, seem to a significant degree to have been assisted by the existence of a functioning transport network that positively encourages the mobility of labour. Workers in the transport sector in many countries also exhibit high rates of HIV infection - this seems to be especially the case in respect of drivers, road maintenance staff at all skill levels, and those involved in servicing transport equipment. This is a key sector that is crucial for the smooth functioning of the economic system, but which again paradoxically the more efficient it is the more it plays a role in the transmission of HIV. It is also one which is very vulnerable to disruption because of losses in human capital and organizational dysfunctionality due to the impact of HIV and thus will have generalized consequences for the country as a whole.

- Most countries and many development agencies have, as objectives, the eradication of poverty and the achievement of sustainable livelihoods. Now it is evident that the HIV epidemic threatens the achievement of these policy aims through its effects on the level and distribution of poverty. There is increasing empirical data that confirm the hypothesis that those affected by HIV and AIDS will experience greater poverty and that countries will display increasing levels of income and wealth inequality. Poverty is, of course, multidimensional and will manifest itself in different forms of deprivation, including higher levels of food insecurity, rising unemployment, a worsening of housing conditions and reduced consumption of key products and services. This is often associated with stigmatization and discrimination of those infected and affected, including the children of families that have experienced HIV and AIDS. In several African countries one aspect that has been documented is reduced school enrolment of children in families affected by AIDS, thereby having long-term consequences for development which are impossible to predict. There is thus a series of effects caused by HIV/AIDS that require complex and integrated policies and programmes if they are to be effective. These also have to address the inter-generational impacts of HIV, since the children of those affected are likely also to experience poverty and deprivation generally and so become the next cohort of those who fail to practice behaviours that protect them from HIV infection.

What is required is a radical shift in the conceptualization of the HIV epidemic that focuses on the interdependence of social and economic relationships at all levels **B** country, community and family. It means developing much more complex analytical models that are based on a deeper understanding of the relationships. The simplistic models of how to achieve behaviour changes that concentrate on changing the individual instead need to focus on the role which community and group values and norms play in the determination of sexual and drug using behaviours. More generally, what are needed are policies and programmes that address the epidemic and yet reflect a comprehensive understanding of the issues. These must reflect an understanding of the systemic factors that determine both the causes and the

consequences of the epidemic. Unless responses address the underlying structural conditions that determine the processes of HIV transmission, such as poverty, gender and patterns of social and economic development, they will achieve little in the long term. In the same way, if responses to the impact of the epidemic on a society and economy must also reflect the complex interactions that are operating if they are to be effective.

1.3 Human capital

The main channels through which the HIV epidemic affects social and economic development are through its impact on the labour force and its related effects on the level and allocation of savings. It follows that social and economic development will be most adversely affected in those countries with high levels of HIV where morbidity and mortality lead to severe losses of labour **B** with the effects being compounded in those countries where infection rates rise with social and occupational status.

While evidence on the social class gradient of infection is very limited, and often absent for most countries in sub-Saharan Africa, there are some data that support the argument that HIV infection in the early stages of the epidemic was positively correlated with income, educational level and occupational status. There is also considerable information from many sources and countries that suggests that the epidemic is systematically eroding the stock of human capital across all sectors in the worst-affected countries, with losses proportionately highest for skilled, professional and managerial labour.[4] Thus, recent studies of education and health in a number of countries in sub-Saharan Africa point to exceptional and large losses of human resources **B** with further losses predicted during the coming decade.[5]

Modelling the effects of the epidemic confirms what is fairly obvious: the impact on the growth of GDP of the HIV epidemic is greatest where the losses of labour are concentrated amongst those with skills and higher professional and managerial training. In part, this reflects the inadequacy of the stock of human capital with these capacities in developing countries, so that the losses due to HIV and AIDS will therefore have a major impact on the processes of development. It has long been accepted by development professionals that increasing the stock of human capital is essential for development and that losses of human capacity due to epidemic diseases will impede what countries can achieve in terms of poverty reduction and other development objectives. Indeed, the most-affected countries in sub-Saharan Africa are already showing sharp reductions in life expectancy, and further sharp declines are predicted over the coming decade.

[4] *HIV/AIDS as a security issue*, Report of the International Crisis Group, Brussels/Washington, June 2001.

[5] See Malawi Institute of Management/UNDP: *The impact of HIV/AIDS on human resources in the public sector in Malawi*, January 2001; Paul Bennell, Karin Hyde, Nicola Swainson: *The impact of the HIV/AIDS epidemic on the education sector in sub-Saharan Africa: A synthesis of findings and recommendations of three country studies (Malawi, Botswana and Uganda)*, University of Sussex, February 2002.

Improving the stock of human capital has been a major objective of developing countries, and of international donors, precisely because of its causal significance in the processes of development. Achieving this objective has absorbed large quantities of both public and private resources **B** both national and international in origin. It follows that the erosion of human capital due to HIV and AIDS has not only personal costs for those affected, but also significant social costs in terms of lost output due to morbidity and the premature mortality of those who have been educated and trained at great private and social expense.

The HIV epidemic not only reduces the stock of those with higher-level professional and managerial training and experience, but it also reduces the capacity to maintain the flow of those with needed skills and training. There are at least three main reasons for this reduction in capacity:

- The most important direct effect comes from the loss of those with appropriate training, experience and education who have the task of maintaining the flow of newly trained labour. This follows from the fact that institutions with training and educational functions are themselves losing staff due to HIV and AIDS, so that their capacity to meet demands is reduced (including the need to replace their own staff who become sick and die from HIV-related illnesses).

- Significant improvements in the quality of the labour force occurs through on-the-job training and experience, and for various reasons it is likely that this process of enhancement of skills is diminished due to HIV and AIDS **B** most obviously because of pressure on labour costs of all enterprises due to AIDS and less obviously because the capacity for-on-the job training will be reduced by labour losses within the enterprise.

- As personal and other savings are eroded through pressure on both incomes/sales/tax revenues and increases in expenditures such as health and welfare support, there will be a reduced flow of savings to finance the maintenance of the stock of human capital. There will also be a diminished incentive to do so by the personal, private and public sectors, given that the epidemic will reduce both private and social rates of return on investment in education and training **B** both within formal educational and training institutions as well as in on-the-job training.

The need in sub-Saharan Africa is for information on what is happening to the stock of human capital and subsequent action that will enable countries to maintain productive capacity in the face of the HIV epidemic. This is even more essential in situations where crisis response and reconstruction activities will need to build on available stocks of human capital at regional, country and district levels.[6]

These being the over-riding objectives, then what is needed as a first step is to establish the following so that there are base-line data on which to build programme activities that integrate HIV/AIDS:

[6] For an excellent review of the issues relating to education, see Michael J. Kelly: APlanning for education in the context of HIV/AIDS@, in *Fundamentals of Educational Planning No. 66*, UNESCO/IIEP, Paris 2000.

- Using techniques of rapid assessment, establish for sub-Saharan Africa the losses of human capital, with a concentration on losses of those with higher-level professional and managerial skills in both the private and public sectors. Assess the implications of these trends for the functioning of the economic, social and political system — both in terms of the direct impact on particular productive sectors and the systemic effects through the interdependence of the different parts (e.g. how losses of labour in transport affect other sectors). The assessment would also describe and evaluate in broad terms how sectors are responding to the effects of labour losses and with what success. Such an assessment needs also to review policies for renewal of the stock of human capital and for its productive use.

- Undertake a rapid assessment regionally, and in selected countries with mature epidemics, of the effects of HIV and AIDS on the capacity of key tertiary educational and training institutions. Evaluate the impact of the epidemic on the capacity of such institutions to undertake their main educational and training activities, given both their current and predicted losses of human resources due to HIV and AIDS. Assess the institutional policies and programmes and review their effectiveness. Make recommendations as to the policies and programmes that are needed to ensure that these institutions can maintain their capacity and also serve the changing needs of the country. In part, needs will be changing as a consequence of the epidemic which will affect supply and demand conditions facing such organizations.

The conclusions to draw from the preceding discussion are fairly obvious. The HIV epidemic is systematically eroding the capacity of countries through the losses of human capital, such that the base from which to undertake programme activities to address the challenges of crisis and reconstruction will fail unless founded on a realistic assessment of the conditions. Not only will the crises themselves lead to losses of human and organizational capacity, but these losses will be additional to those already being experienced in many countries due to AIDS. It is essential that programmes have the information on capacity across the different sectors if they are to achieve their objectives, particularly in areas of reconstruction, but also in respect of activities addressing more immediate emergency needs in areas such as transport, water supply and food.

1.4 Poverty and AIDS

The relationship between poverty and HIV/AIDS is by no means simple, and indeed many of the non-poor in developing countries are also infected with HIV.[7] As noted above, in the early stages of the epidemic in Africa there was an observed positive correlation between infection and socio-economic status (and education). The reasons for this are unclear, although it is often asserted that income and mobility were factors in establishing risk behaviours that exposed the better-off to HIV infection. It is worth recalling that in the early stages of the epidemic knowledge of HIV and AIDS was generally unavailable, and as yet few people had died from HIV-related illnesses. It is unsurprising, therefore, that those with better incomes and opportunities should have persisted with sexual behaviours that put

[7] Desmond Cohen: *Poverty and HIV/AIDS in sub-Saharan Africa*, UNDP Issues Paper 27, New York, 1998.

themselves and their families at risk of HIV infection. One result of this delay in behaviour change has been erosion of human capital amongst the better educated and experienced which has continued to affect the performance of countries in Africa. This is measurable at this time in losses of qualified personnel across a swathe of industries and service sectors in Africa, especially in areas such as education and health, but is by no means confined to these sectors.

Nevertheless, it is often asserted that what we are observing now in terms of losses of highly trained personnel is mainly a reflection of earlier rates of HIV infection, and that in the light of education and experience those with higher occupational status, higher incomes and greater wealth have now modified their risk behaviours. However, this has yet to be empirically established for Africa, and for the moment at least what is being observed are continuing losses of highly qualified people: men and women whom the resource-poor countries cannot afford to lose and moreover cannot afford to replace through investment in human capital. Since countries are heavily dependent on their cadres of educated and highly trained and experienced people for overall development, the losses continue to affect what can be achieved, including undertaking those activities in such fields as education and health that are important for the response to the epidemic.

What is clear is that certainly the largest number of those infected with HIV are poor and that the epidemic emphasizes the fault lines in society. The poor are in a situation which make it hard for them to avoid behaviours that lead to infection, and they have few of the resources needed for coping with the consequences of HIV and AIDS. For example, there are persistently high rates of illiteracy amongst adults **B** in most countries, higher for women than for men. It is still the case that more than 50 per cent of primary-age school children in sub-Saharan Africa are not attending school. In these situations, it is only too apparent that programmes intended to provide education and information largely fail to reach the poorest, and even where effective programmes have been established in schools (and these are few indeed) they do not reach the children of the poorest in most societies.

It has been well established that poverty has a gender bias and that the poorest are concentrated in female-headed households, especially in the rural areas. It is almost inevitable that such households should be characterized by risk behaviours that lead to high rates of HIV infection. It may not always be a lack of awareness of the risks, but that to put food on the table women and children, will engage in sex work that exposes them to HIV infection. Once infected, the poor have few of the resources for coping with the consequences in terms of morbidity and death, and thus surviving members of families are further impoverished. A process is set in motion whereby the poverty of the poor is further intensified with consequences for the next generation. As is well documented in all regions, there is a culture of poverty in which the children of this generation become the poor of the next.

Two aspects of this process are worth identifying separately. The first relates to the enormous growth in the numbers of children who have been orphaned by the epidemic. As noted above, there are currently more than 12 million children orphaned by AIDS, and their numbers are predicted to double in the coming decade (USAID). There are increasing numbers of children who have no family at all, as witnessed by the numbers of street children in many cities now across Africa. Children are being obliged to fend for themselves, in the absence of those socializing influences that are essential for the well-being of society.

Increasingly, children are not attending school, either to help out at home with sick parents, or simply as a reflection of the poverty that families increasingly endure. These are conditions that deny children their rights to education and health and at the same time generate social attitudes, behaviours and a lack of skill and educational endowments that will reverberate throughout society. The inter-generational effects on poverty and on social development may be hard to predict, but unfortunately it seems likely that they will have consequences in terms of internal security and lawlessness within societies. Meeting the needs of such children is something yet to be accomplished, but it is only too clear that unless their needs are met societies will have to address the consequent social disintegration and will require the tools and resources to do so. This is a clear example where poverty eradication will pay benefits in terms of crisis avoidance, while at the same time affecting those conditions of poverty that seem to generate high-risk sexual and drug-using behaviours (and which fuel the HIV epidemic, cohort to cohort).

The other aspect of this process that is deeply worrying for sustainable development and that has consequences for crisis management is what is happening to rural food and cash-crop production. A well-recorded effect of HIV infection within households is the loss of labour caused by sickness and death and the diversion of labour and other assets from directly productive uses. Assets are often sold to pay medical bills or women and children often have their assets appropriated by kin after the death of one or both parents. This is part of the poverty process that leads to further poverty for survivors and is often associated with changes in the ownership and access to land and housing. Increasing numbers of women and children find themselves without productive assets for survival **B** including especially food security and access to even basic health care.

This process is increasingly leading to further impoverishment of the rural population in many countries, with important consequences for health and nutrition. These elements, along with skills and education are important, in determining factor productivity; thus programmes aimed at reducing poverty through, for example, labour-intensive public works will have to deal with an impoverished workforce with extremely poor levels of nutrition and with a lack of basic education, which limits the effectiveness of vocational training. It is highly likely, for reasons explored above, that these populations of young and old workers will exhibit high rates of HIV infection which will again have implications for programme design and effectiveness (these issues are addressed in section 3).

Finally, it should be noted that since rates of HIV infection are highest in urban areas the effects on urban poverty are a mirror image of what is happening to rural communities. Urban poverty may be greater in many respects, given the fact that individuals and families are less able to draw on support from extended families and often have even fewer assets to dispose of in the face of needs for medical care and food. These developments raise the probability of an even greater degree of lawlessness and insecurity in urban centres as a direct reflection of the impact of the epidemic on the poorest. This state of affairs may be exacerbated through additional rural/urban labour migration, especially of males and children who will search in vain in most cases for productive employment. It follows that many African cities are already facing intractable economic and social problems **B** some caused by AIDS **B** but that these will worsen, both directly and indirectly, as a result of the effects of the

general epidemic on population distribution and deteriorating macro and sectoral economic performance.

It follows that crisis response and reconstruction will face more intractable problems in the future, in part because of the increasingly impoverished population whose needs are greater than ever and who will be even less able to respond to traditional instruments of support. Indeed, precisely because of the presence of HIV and AIDS in such populations, there will be a need to rethink not just the scale of programmes but also their content and implementation modalities. These issues are addressed in section 3.

2. HIV RISK, PREVENTION AND MITIGATION IN CRISIS-AFFECTED POPULATIONS

The data on the effects of crisis on HIV/AIDS are poorly documented, and the reverse relationship of the effects of HIV/AIDS on crisis is even less clear. Therefore, the following discussion is more an attempt at analysis than one based on strong empirical information. Some aspects, for example the relationship between conflict and HIV transmission, have been looked at more closely than other types of crisis.[8] Observations on relationships that are social and economic rather than medical, where efforts to collect data have generally been very limited, are rather more speculative because of lack of information.

It is fairly straightforward to list the factors that operate to raise the risks of HIV transmission under crisis conditions, but it is more difficult to measure the contribution of these factors to the observed (or presumed) level of HIV in a population. Data on HIV prevalence are usually inadequate for estimating the effects of specific crisis-related factors on populations, since the situation before a crisis is rarely known in any detail. Ex-ante and ex-post comparisons are fraught with difficulty in most cases, and made even more complex because many crises have origins that reach back over many years so that there is no clear division between non-crisis, crisis, and post-crisis.

Nevertheless, with these caveats it is possible to try to set out some of the factors that seem to operate in emergency situations. Thus, Khaw, et al. have listed what they see as the most important factors that operate to raise the risk of HIV transmission:

> AThese risk factors may differ from context to context but may include massive population displacement, disruption of family and social structures and mores, disruption of sexual networks, sexual interaction of emergency affected people with military or paramilitary personnel, the economic vulnerability of women and unaccompanied minors, the frequency of commercial sex work, the frequency of sexual violence and coercive sex, psychological trauma, the disruption of preventative and curative health services, unsafe blood transfusion practices at a time of increased blood transfusion requirements, the increasing use of illicit drugs and the high prevalence of sexually transmitted infections.@[9]

[8] Adrian J. Khaw, et al.: AHIV risk and prevention in emergency-affected populations: A review@, in *Disasters*, Overseas Development Institute, 2000.

[9] ibid., p. 182.

This list is extensive, but even so is incomplete. It also provides no indication of the relative magnitude of the various identified factors, many of which operate in non-emergency/crisis conditions and about which very little is known. Although some of these factors are potentially affected by policy interventions and programmes of assistance to populations, few actions seem to have been taken to reduce HIV risk. Thus, although the UN system did identify in 1996 the problems faced by refugee populations in terms of enhanced risk of HIV transmission, in practice very little seems actually to have been done to ameliorate the situation that vulnerable populations face. Guidelines were published by UNAIDS in 1996, after extensive consultations with other agencies, but apparently they were never operationalized by the UNHCR, the main agency involved in the emergency response globally. Exactly why the UN system never managed to establish a coherent and effective package of policies and programmes relating to the HIV risk facing such populations remains a mystery, given the full articulation of the problem in the 1996 Report.

2.1 Sexual transmission of HIV and crises

There is fairly extensive discussion in the literature of the enhanced sexual risk of HIV transmission under conditions of crisis **B** particularly in a conflict situation. There is evidence of rape and acts of coercive sex as elements in processes of ethnic cleansing and racism in countries such as Liberia and Rwanda. In these circumstances, the probability of HIV transmission to women and girls is extremely high, in part because of the much higher rates of HIV in military populations (this is not well documented but is often assumed to be higher by at least a factor of 2 than the general adult prevalence rate in many African countries **B** and sometimes very much higher). What are better recorded are very high rates of sexually transmitted infection (STI) in the military, and these significantly raise the rate of HIV transmission both in situations of coercive sex and in other conditions. This situation is especially unfortunate for young women, since there is clear physiological evidence that HIV is more easily transmitted to them than to old women or men (an important argument in general for trying to delay the age of sexual activity of young women, given their enhanced risk of infection).

Not only will HIV infection be higher for women and young girls but there will also be transmission to their babies. It has been known since the mid-1990s that there is a probability of HIV transmission of about 60 per cent from mother to child and that this is further raised by another 15 per cent during breast feeding. One consequence of higher HIV infection amongst women is that large numbers of babies who are also infected with the virus will die in their early years (before they reach the age of five). While it is possible to reduce mother-to-child transmission (MTCT) at a relatively small cost, unfortunately in practice such programmes are lacking in all parts of Africa. It follows that crisis-affected populations will exhibit higher rates of HIV infection concentrated on the working-age population of men and women (and young girls) but also increasingly in the under-five child population.

As documented above, those directly involved as combatants who have engaged in high-risk sexual behaviour, will have high rates of HIV infection, especially men and young boys but also young women who may have been coerced into participating in the conflict and forced into coercive sex. Increasingly, many of the combatants are child soldiers (an estimated 300,000 in 1999), which raises major problems with respect to their reintegration into civil society. It was estimated by the International Institute of Social Studies (IISS) in 1999 that no less than half the world=s conflicts were in sub-Saharan Africa involving about half of the countries in the region. It is in the nature of these conflicts that populations not directly involved will also be affected and be displaced **B** it is estimated that some 30 million Africans have been displaced by conflicts in this way over the past 30 years, and many are still unable to return to their homes and are living as refugees.[10]

The HIV rate amongst ex-combatants is clearly important for any activities relating to demobilization (disbanding) of forces and their reintegration. While some of the skills of those formerly in the military will be transferable to civil uses, this will not generally be the case. Furthermore, since increasing numbers of those involved in civil conflicts will be youth with low levels of education, there will be a need for extensive training programmes to equip them with the needed skills for insertion into employment. None of this will be easy to achieve in post-crisis conditions where economic activity will have been disrupted and where civil society organizations will have diminished capacity, in part caused by the losses of human capital due to HIV-related mortality. The special needs of demobilized populations in terms of their HIV status has scarcely figured in most of the post-crisis arrangements in Africa. The consequences for the success of these activities are unknown. It is an issue that is further addressed in section 3, since this has clear relevance for the activities of the ILO and its partners in reintegrating former combatants into decent work.

As noted above in section 1, HIV prevalence rates in sub-Saharan Africa are higher for women than for men, and women become infected at earlier ages than men. This has been generally explained in terms of the vulnerability of women as measured by their poverty, low levels of education, poor access to credit, high levels of undiagnosed and untreated STIs, and general powerlessness within families and communities. There is also increasing evidence in many parts of Africa of sexual abuse and coercive sex as part of the Anormal@ life of large numbers of women and young girls. All of these factors operate with increased effects during complex emergencies, with even more profound consequences directly for women and their children and indirectly for society as a whole. Thus, crises often disrupt productive activity as markets collapse and transport systems cease to function. Families are increasingly deprived of sustainable livelihoods by the general economic collapse, and many are displaced by the factors operating during conflict and disaster. In these circumstances, it is not surprising that women and young girls are forced into sex work as survival strategies, thus exposing them to higher risk of HIV transmission.

[10] Manuel Carballo; Carolyn Mansfield; Michaela Prokop: *Demobilization and its implications for HIV/AIDS*, International Centre for Migration and Health, Geneva, 2000.

One of the well-documented features of this situation is the different patterns of sexual interaction as traditional systems of sexual control and information collapse, new sexual partners are engaged with (some voluntarily, others coercively) and new sexual interactions take place between population groups (most obviously in the case of displaced people). One of the striking features of such situations is the much higher rate of labour mobility of both men and women and especially of youth. In part, this is the result of the economic distress facing crisis-affected populations who have few options other than to migrate to urban areas, where they are likely to face conditions that will lead to further sexual mixing. These are powerful factors in driving the HIV epidemic, in that population subgroups who may have had low rates of HIV are brought into contact with others where the incidence is higher. This is especially true for rural populations for whom their relative isolation and low rates of mobility under non-crisis conditions have offered a form of protection. These factors are likely to operate with greater intensity the higher the general level of HIV in populations prior to an emergency or crisis. For example, HIV rates in Kigali were already high at the onset of the genocide and were thought to be extremely high amongst the military, resulting in a rapid growth in the infected population both during and after the crisis.

Crisis conditions thus become instruments for changing sexual risks both for men and women, and an epidemic which may have been already present in the population is fuelled by the crisis, so that levels of HIV are permanently raised by the factors that operate, with consequences which undermine sustainable development, including security, in the long term. There are clear lessons here for what needs to be done in terms of crisis avoidance and crisis mitigation **B** lessons that have unfortunately not as yet been learned by agencies and other organizations involved in this area.

2.2 Public services and institutional collapse

Institutional collapse takes a multitude of forms and needs to be seen within the ongoing context of African economies that may have been declining for several decades. The region as a whole now has an increasing share of the global total of those in poverty, and many countries have witnessed falling rates of per-capita income since the 1970s.[11] In these circumstances, not only has there been a decline in the standards of governance, but also the level of confidence of the African people has fallen in the capacity of governments to address urgent social and economic problems. In part, the crises that have affected sub-Saharan Africa over the past 30 years have their origins in the failures of states to ensure sustained development, with disastrous consequences for their populations in terms of poverty and access to public services. Consequently, even a well-managed economy such as Botswana has failed to deal with a growing number of poor, and those living in poverty are estimated as being some 60 per cent of the total population. It is not surprising that in such circumstances HIV prevalence is as high as 38 per cent in adults in Botswana and shows few signs of falling. But at least in Botswana, unlike many other countries in the region, there are functioning public services for most people.

[11] The Bank estimated that in 1998 some 291 million people in Africa lived on less than US$ 1 per day and that 24 per cent of those living in poverty globally lived in Africa, *Attacking world poverty*, World Bank Development Report, 2000.

Typically, key public services such as primary health care and education are characterized by extremely poor provision and low quality. This reflects overall resource constraints, as well as corruption and the misallocation or theft of resources, and it is also an indicator of government priorities; whatever the reason, most Africans have extremely poor access to public services. Therefore, national AIDS programmes that have focused on public health interventions based on functioning public services have, unsurprisingly, had unimpressive outcomes. This needs emphasis, since it is yet another example where the Anormal@ state with respect to functioning public services and public administration in most African countries has been woefully inadequate for many years. In part, the way forward for more relevant and effective programmes for HIV/AIDS is dependent on a generally restructured and better-funded set of public services. Yet simultaneously the epidemic is systematically eroding human and organizational capacity as described above in section 1, so that conditions are worsening rather than improving.

What does all of this imply for HIV prevention, care and mitigation under crisis conditions? In the first place, it means not exaggerating the pre-existing level of public infrastructure and services and access to these by different population groups. There has been much literature on unequal access and urban bias, so many desperately poor people will have had only residual access at best to key public services, and most will have been excluded entirely from private markets by income constraints. It follows, for example, that destruction of public health facilities under conditions of conflict or natural disaster may not actually mean a great deal for many affected people. Often primary health care facilities are unstaffed, and where they are they have no drugs to offer patients. Even district and referral hospitals are similarly short of staff and have few drugs available for even the most common health conditions. Drugs provided by donors are often stolen and never reach their intended constituencies (often becoming part of the illicit supply to private markets). While national guidelines have often been published with respect to screening the blood supply for HIV, this will often not have been done due to resource constraints. In addition, access to condoms is often difficult, even in conditions of non-crisis.

Nevertheless, it is clear that complex emergencies further disrupt even residual public services so that conditions that affect HIV/AIDS are worsened. There will be more blood transfusions and even less screening of blood supplies; there will be greater sexual networking without the benefit of programmes for information, education and communication (IEC) and less access to condoms provided regularly by donors such as UNFPA; housing will have been damaged, together with destruction of the productive capacity to produce food, so that people are displaced; and education will be even more disrupted, with short-term and long-term effects on literacy and skills in the population.

2.3 Destruction of social capital

The effects of such experience are not confined only to physical and human capital but also to what is fashionably described as Asocial capital@. In its narrowest definition, this refers to the conditions that create or destroy family and community relationships which have their basis in forms of interdependence which have existed over long periods of time. Thus,

social capital includes traditional systems of care and support which have historical and cultural origins and which are very important for social continuity under conditions of instability. In a broader sense, it also refers to the structure of laws and rights which have important implications for the maintenance of those conditions within which Anormal@ life is possible **B** including laws relating to the protection of children, property rights, etc. Crises have a capacity to destroy social capital in ways that have important consequences for the HIV epidemic and thus for sustained development.

A number of examples will perhaps help to explain the important ways in which social capital is destroyed and which effect both on the HIV epidemic and responses to it in crisis situations. In most African countries, traditionally the members of extended families have responsibility for sexual and social instruction for adolescents so that parents are relieved of this responsibility. Such structures have been in a process of collapse for many years with increasing urbanization. Crises disrupt further these structures, and children are left without access to traditional mechanisms of sexual and social instruction **B** with no alternatives being put into place. The absence of any publicly provided IEC during crises simply exacerbates a serious gap in responding to both the epidemic and the effects of crisis on a young population. This population generally exhibits very high rates of unemployment and underemployment, and it is usually highly mobile as well as sexually active. All such conditions are favourable for HIV transmission and in part explain the high levels of HIV infection among those under the age of 25 in many African countries (UNAIDS estimates that at the end of 2001 one-third of those living with HIV globally were aged 15-24).

Equally worrying are matters relating to the care and support of children who have lost their parents. The HIV epidemic, as noted in section 1, has dramatically increased the number of children who have lost one or both parents, in addition to those orphaned for other reasons who were already growing in number independently of the impact of the HIV epidemic. Crises, especially those caused by conflict, raise the number of orphans so that societies are increasingly faced with complex and challenging problems of how to care for such children whatever the cause of their situation. Traditionally African social structures have provided mechanisms of support for children through extended families, but they are increasingly unable to cope with the huge numbers of children involved. This rising number of orphans, combined with other effects of crises on livelihoods (greater poverty and more food insecurity), adds to the increasingly common problem of street children and families headed by young adults.[12]

Also relevant is the matter of care for those experiencing illness caused by HIV, such as tuberculosis, where many societies now face a joint epidemic. In the past, extended families provided support for sick relatives, including both material and psycho-social support. One consequence of crisis is that these community insurance systems for dealing with private crises become increasingly inoperative because of the disruptions to economic and social life. Thus, an important mechanism for providing support to families in distress becomes less able to cope with the scale of the demands falling on it **B** due to the

[12] Monika Ayieko*: From single parents to child-headed households*, Study Paper 7, UNDP, 1998. For an excellent analysis together with country estimates of orphans, see Susan Hunter; John Williamson: *Children on the brink*, USAID, 2000.

intensification of poverty caused by AIDS as well as to the break-up of traditional structures caused by the displacement of people and the destruction of the community.

Largely overlooked in discussions on HIV/AIDS are issues relating to the role of the community in HIV prevention. At the centre of efforts to prevent HIV transmission are interventions to change sexual behaviour, and these have in general assumed that individuals have enough degrees of freedom to achieve what is required. Experience suggests that this is not at all the case, but that sexual behaviour depends on norms and conventions that arise from community conditions which constrain what individuals can do. If this analysis is correct, then crises which undermine social capital through the destruction of communities make it even harder to reduce risky sexual behaviour. It thus becomes even more desirable to sustain communities that are threatened by crisis, given their potentially critical role in changing group norms of acceptable sexual behaviour, as well as their role in respect of care and support for affected populations.

Finally, there are a multitude of issues relating to the ways in which the epidemic erodes laws and rights and the mechanisms for their observance. For example, it is often observed that the property rights of women and children are undermined by the behaviour of relatives, so that surviving family members are further impoverished by the asset stripping that often takes place on the death of the male head of household. Furthermore, one group with the highest rate of HIV is the police, so that protection of individuals and the implementation of laws is undermined by the loss of such human resources in many African countries. In Malawi it is estimated that the police force loses ten-15 trained officers a month to HIV-related illnesses **B** many of them only recently trained at considerable social cost.[13] There is also evidence that the administration of justice generally in many countries is being disrupted by the loss of law enforcement staff due to HIV and AIDS. What this suggests is that maintaining the structure for law enforcement is itself a major problem facing countries with mature epidemics. Thus, post-crisis reconstruction will need to address how to sustain this structure in ways that will permit a re-establishment of the rule of law and observance of human rights.

2.4 Case study: The conflict in Uganda and the transmission of HIV[14]

Uganda has a recent history of conflict and instability stretching over several decades, and it is also a country with a mature epidemic. UNAIDS estimated the average rate of HIV prevalence amongst women at 14 per cent in the late 1990s, but with a prevalence of 20 per cent in some sentinel sites. It is also a country where there are ongoing civil and armed conflicts **B** with continued involvement in the regional conflict associated with the power vacuum in the Democratic Republic of the Congo and internal disturbances particularly in the north of the country.

[13] For a detailed review of the impact on the Malawi police service, see *Impact of HIV/AIDS on human resources in the public sector in Malawi*, MIM/UNDP, January 2002.

[14] This case study is based on A.B.K. Kasozi*: Linkage of conflict to the spread of HIV/AIDS in Uganda, 1980-1999*, ActionAid Uganda (undated).

It has long been argued by epidemiologists and others that the high level of HIV prevalence in Uganda reflects the regional pattern of armed conflict in the region. In particular, it is suggested that the invasion in the early 1980s of Uganda by Museveni and the Tanzanian army along a corridor through the Kagera Region of Tanzania and along the eastern rim of Lake Victoria brought with it high levels of sexual violence against women and young girls that largely explains the high levels of observed HIV and AIDS in that region of Uganda (Rakai and Masaka especially). Subsequently, the pattern of HIV transmission elsewhere in Uganda reflected the movements of the military as the Amin regime collapsed, with contributions, as noted above, from the general displacement of population as economic activity collapsed and new patterns of sexual networking were established, especially in the southern and central districts of the country.

Thus, the conflict is widely accepted as playing a decisive role in the transmission of HIV in Uganda and is seen as a key factor in explaining the pattern of HIV within the country. The military is seen as playing an important role in the spread of the infection to the general population, so that it is feasible to measure more or less precisely through epidemiological data the timing of the epidemic as well as its causes. Subsequently, the mobility of population, and especially the existence of major truck routes across Uganda, are thought to have spread infection rapidly to previously low-prevalence populations. This pattern of HIV infection has been mapped for Uganda to the extent that the rapid spread of HIV is measurable and largely explicable in terms of the effects of conflict and associated labour mobility on sexual behaviour and on sexual networks.

As noted above, Uganda is still experiencing internal conflicts in districts such as Kitgum and Gulu, and ActionAid has recently funded PRA research to identify whether the asserted relationships between the conflict and HIV transmission can be confirmed or not (Kasozi). This is of interest not least because of the generally accepted position that conflict historically played a decisive role in Uganda in the spread of HIV, with ongoing impacts on the social and economic development of the country.

What are the conclusions regarding sexual and other behaviours and the spread of HIV that can be drawn from this research on the current conflicts?

- Conflict is positively associated with changes in sexual behaviour in ways that lead to the spread of HIV infection. These changes include coercive sex, including rape, between the military, rebels, etc. and the local population. There is also evidence of increased involvement of women and girls in sex work, as well as changes in behaviour that lead to more extra-marital sexual activity.

- Sexual norms and their observance are changed by the disruption of families caused by the conflict, so that HIV is more easily transmitted to the population. In part, this is due to the effects of conflict directly on the economic stability of families as units of production and consumption, and in particular the effects of mortality on family members.

- Conflict disrupts economic activity, displaces population, and thus leads to further impoverishment, causing changes in sexual behaviour that increase the risk of HIV

transmission. In these circumstances, activities that relate to HIV prevention are disrupted, including those related to access to health services and availability of condoms.

- Conflict leads to the destruction of health and other infrastructure as well as disruption of essential services, making the population more vulnerable to a whole range of diseases (not just HIV). This is reflected in the partial evidence relating to higher levels of HIV and AIDS in the general population, which suggests there is a positive relationship between conflict and HIV transmission.

- Nevertheless, there are opportunities for activities relating to HIV prevention and support for conflict-affected populations whenever there is a lull in the fighting, and NGOs active in the area have been effective in assisting the local population as and when possible.

2.5 Economic and social policy: Setting priorities

Crises have consequences for productive activities both in the formal and informal sectors. Some economic losses are more easily reversible than others - for example, costs that arise from cyclical shifts in external demand for marketable surpluses. But in other cases these losses are not so easily turned around, for example in those countries and regions that have suffered persistent environmental degradation where reversing such processes may take many years of effort. Populations that experience the effects of declines in economically sustainable activity will be characterized by higher rates of unemployment, some of it long term, and greater poverty. The consequences of this may be greater labour mobility, displacement of population, resorting to sex work by women and young girls, and many of the other effects detailed above.

Many of these consequences for HIV/AIDS are in a sense endogenous and arise from non-policy conditions such as natural disasters (hurricanes, floods, etc.). But this is obviously not the case for all crises, some of which may have their origins in policy failures and in other cases are the result of the interaction of poor policy making with other factors. An example of the latter would be the failure to establish effective flood defences in the face of risks of floods and/or an unwillingness to re-establish populations at risk of floods in other safer locations.

However, the types of policy failures of most interest for the present discussion are those that arise from decisions that exacerbate the underlying conditions that both cause crises and generate conditions in which HIV thrives. For example, it could be argued that one of the reasons why HIV infection is so high amongst women in Africa is their low rates of education so that prevention messages never reach them and their limited access to employment leaves them few options for income generation, hence the prevalence of sex work in conditions of extreme poverty. This reflects the failure of many governments to ensure that girls do in fact attend primary education and have equal access to secondary and vocational education as boys do. So failures in respect of basic health and education policy may be partly to blame for the scale and pattern of HIV infection and the subsequent social

and economic impacts, including effects on sectoral production (especially of food) and the contributon to the very significant impact of the epidemic on GDP (UNAIDS estimates that per capita income in half of the countries in sub-Saharan Africa is presently declining at between 0.5 and 1.2 per cent per annum as a result of AIDS).

Policy failures in respect of setting public expenditure priorities are partly to blame for the underlying structural conditions that drive the epidemic **B** especially the failure to create the conditions necessary for gender equality. Governments have a responsibility to reorient patterns of expenditure and other aspects of policy, so as to ensure that present inequalities are mitigated. Unfortunately, crises make it even less likely that governments will correct the previous failures, and indeed the probability is that their actions, faced by a crisis, will move them further away from long-term gender goals, and they may take actions that further worsen income and wealth inequality.

There is some evidence that conditions of extreme inequality of wealth and income are important in the spread of HIV, so policy action by governments faced by economic and other crises may well exacerbate the underlying forces that drive the transmission of HIV. This is most often the case where unemployment is driven to higher levels by cuts in government programmes, higher interest rates and tighter credit, restrictions on imports needed for production, higher prices for essentials, etc. Furthermore, there are obviously areas of public expenditure that are more important than others in terms of their impact directly on the HIV epidemic, such as screening the blood supply, reproductive health services, youth employment projects, care for infected people, feeding programmes for the poor, and supplies of generic drugs to those infected with HIV.

Governments faced with economic policy crises must examine the proximate and long-term effects of their actions. This includes explicit measurement of the effects of proposed changes on the progress of the HIV epidemic, so as to avoid both short-term and long-term consequences for society and the economy. There is no evidence that governments have seen the necessity for transforming their policy-making process in this particular way. The World Bank and the International Monetary Fund have often been instrumental in pressing governments in Africa to make cuts in budgets that have adverse social and economic effects - including worsening the conditions that favour the spread of HIV. Yet there is no indication that the Bank and the Fund have ever seriously adjusted their policy conditions in Africa to take account of the effects of their programmes on the progress of the epidemic, in spite of the mounting evidence that these cause sharp declines in real GDP, deepen poverty and increase unemployment, which are precisely the social and economic conditions under which the epidemic thrives.[15]

[15] For a review of some of these factors, see Desmond Cohen: *Socio-economic causes and consequences of the HIV epidemic in Southern Africa: The case of Namibia*, UNDP Issues Paper No. 31, 1998.

3. INTEGRATING HIV/AIDS INTO THE ILO=S CRISIS RESPONSE PROGRAMME

The ILO has considerable experience in responding to crises in many regions over the past several decades and has included in its institutional goals the establishment of a capacity for responding to the developmental impact of such events, with a concentration on Athe employment and decent work dimensions@ of crises; the latter are often overlooked in the national and international response. In fulfilment of this objective, the ILO established the Infocus Programme on Crisis Response and Reconstruction (IFP/CRISIS) with the remit that it:

> Atackle the employment and other decent work challenges of crises, to promote socio-economic reintegration of the crisis-affected groups and the reconstruction of their communities, and to strengthen the capacity of the ILO and its constituents to respond to crisis in a timely, comprehensive and effective manner. IFP/CRISIS works to devise lasting solutions to crises, through special attention to employment promotion, poverty alleviation, social dialogue upholding fundamental principles and rights, social protection and other socio-economic concerns.@ (*Crisis Response Rapid Needs Assessment Manual,* 2002)

The IFP/CRISIS Programme has developed an integrated approach to crises, and this is embodied in two generic manuals (*ILO Generic Crisis Response Modules* and the *Crisis Response Rapid Needs Assessment Manual*), together with a policy framework *(A Framework for ILO Policy and Action in the Conflict-Affected Context*). A description of activities and experience with responding to crises are admirably summarized in *Crises and Decent Work: A Collection of Essays* by the Director of IFP/CRISIS (Eugenia Date-Bah, 2001).

These documents, together with others contained in the bibliography, have formed the basis for the discussion that follows on the ways in which HIV/AIDS affects the ILO=s response to crisis. These comments are intended as a guide to the kinds of revisions that may be required if the activities of IFP/CRISIS are to be relevant and effective in sub-Saharan Africa. They are not a detailed statement of the specific revisions to manuals that may be required in the light of the foregoing analysis in sections 1 and 2, but are rather indications of the main areas where revision of practice may be desirable. These are intended as a guide for future activities by the Programme, so as to ensure that the ILO in response to crises in Africa takes more fully into account the implications of the HIV epidemic for its work in the region. It is clear that the way forward lies in increasing understanding of the issues within the ILO and in its relationships with its social partners. The aim is to ensure that the activities of the ILO respond to crises and fully integrate the subject of HIV/AIDS both in programme development and in programme implementation.

3.1 Typology of crises

A description of crises, their origins and their effects appears in many of the ILO publications, and particularly in the two manuals noted above. The manuals are very comprehensive and detailed and obviously reflect intensive and well-informed processes. They are seen as Ageneric@, i.e. they are applicable to all likely crisis situations and presumably are considered relevant for all regions. However, these assumptions can be questioned on at least two grounds:

- In sub-Saharan Africa, the scale of the impact of HIV and AIDS on the region is so great and the implications for sustained development so extensive that it is hard to see how generic manuals can have relevance for an effective programme response by the ILO. As will be made evident in the discussion that follows, many of the common assumptions of the manuals with respect to the analysis and response to crises need to be revisited and revised in the case of a region suffering from a mature epidemic of HIV which is undermining general development capacity (as described in section 1). It follows that in the case of sub-Saharan Africa there is a need for more specific programme guidance that takes fully into account the implications of AIDS and its consequences for ILO activities in respect of decent work in post-crisis conditions. No matter how comprehensive the manuals are, and they are generally very relevant and highly detailed, there is the key question as to whether they can deal adequately with crisis response under conditions where 20-35 per cent of the adult population is infected with HIV (and the consequences of this for development). Even under conditions where HIV prevalence is lower, there is still a need to modify activities to ensure that, for example, they do not exacerbate the conditions under which HIV is transmitted.

- In the various documents that were reviewed (see the bibliography), there is a description of crises, how and why they arise, and what are the likely consequences. None of the analysis relates specifically to a situation of a generalized epidemic such as HIV and AIDS, and as noted above there is an absence in the existing materials of any analysis of AIDS as a factor affecting the work of the Programme. This is explicable in terms of the pressures of work on the Programme and the decision of the ILO to set up a special unit to address HIV/AIDS. Nevertheless, this lacuna has consequences for the specific approach that is recommended for the Programme in responding to the epidemic, most obviously in sub-Saharan Africa but also in other regions where HIV prevalence is rising alarmingly (areas of South Asia, the Caribbean and some countries in the former CIS States).

  The existing manuals have a model of crises in which there is a Atrigger@, and this is likely to be applicable to most crises. The question is whether this model of how crises develop has relevance for a situation such as that facing sub-Saharan Africa, which is facing a deepening crisis due to HIV and AIDS that has emerged over several decades (possibly shorter in some cases). It is not a crisis where a Atrigger@ concept has much - if any - relevance, since what the region faces is a situation of persistent and cumulative losses of development capacity which exacerbates other ongoing problems such as poverty, environmental degradation, political instability, etc. In other words, does an epidemic such as AIDS in itself constitute a Acrisis@ at

some stage, and as such should it be treated as a separate category for purposes of analysis and programme response?

The key issue is how best to modify the present conceptual framework of the Programme in ways that better describe the reality of conditions in sub-Saharan Africa. One possible option for the Programme would be to identify HIV/AIDS as a separate crisis and to then develop programme materials and capacity to specifically address this issue. An alternative, and the one supported by this paper, is for a full integration of HIV/AIDS in existing approaches to crisis in the ILO, and more generally in the work of the ILO. The latter option is likely to be more effective in the long run in ensuring that HIV/AIDS is seen as central to ILO activities in the region.

3.2 Strategic programme objectives

The core principle of the IlO programme response to crises is that the absence of decent work is in many cases a contributing factor to the cause of crises, while the reconstruction of economic and social activity post-crisis has to also concentrate on activities that increase access to decent work. In pursuit of this core objective, the ILO utilizes its comparative advantage in the area of employment, social protection and poverty alleviation and draws on its long experience of working with its social partners to achieve common objectives. Furthermore, the activities that the ILO supports will be the outcome of comprehensive factual analysis (rapid needs assessment) so as to ensure that what the ILO does is well founded and relevant to the practical needs of affected populations.

In taking forward its programmes, the ILO uses as its basic framework that of Local Economic Development (LED), that is

> Adevelopment of a culture of participation and partnerships ... by promoting a common definition of priorities; raising public awareness; strengthening local oriented capacities, ... rebuilding the community fabric … . It focuses on an area-based approach, permitting the coverage and involvement of all the diverse groups based there. It also provides an approach to planning and implementing employment promotion through micro- and small enterprise development promotion which focuses on social dialogue and reconciliation throughout the programme@ (Date-Bah, 2001).

These are clearly well articulated and sensible core principles upon which to construct the ILO=s crisis response and in general seem to have well served the Organization and its development partners in many countries over recent decades. As can be seen from the bibliography at the end of this paper, there is a detailed set of ILO responses in particular crisis situations as a guide to those activities which experience suggests are likely to be relevant and effective B set within an LED approach. The relevance of some of these responses under conditions of a mature HIV epidemic is addressed below, but there is a more general issue - that of whether the LED approach is likely to be feasible where conditions are far from optimal, in particular where the HIV epidemic has thrived on the fault lines of society and where the effects of the epidemic have strengthened the forces making for social and economic divergence, leading to higher levels of social conflict.

It could be argued that LED approaches have been designed specifically to address situations where there is an absence of trust and community cohesion. There are in fact many conflict-affected countries in all regions where LED has been used as a means of strengthening trust and community cohesion, such that the presence of HIV/AIDS does not create a new set of conditions within which to operate but is yet another factor to be taken into consideration in any response to crisis. The objective would be unchanged: to ensure that LED is based on the reality of the situation as it is and not as we would like it to be. How best to create the conditions where LED is successful will, of course, be situation specific. It will often entail more roundabout ways of operating as a means of building social capital, so as to reduce levels of distrust through activities that can be seen to be in the interest of the Acommunity@ as a whole. Understanding how to proceed under these conditions will be more important than any set of blueprints on what to do, since what has to be created are conditions where activities can be effective and sustained.

Nevertheless, there are reasons for thinking that a LED approach will encounter additional problems in crisis-affected countries which are also facing severe problems caused by AIDS. Many of these problems flow from the analysis presented in section 1, but it is worthwhile identifying some of the ways in which the HIV epidemic undermines social and economic conditions (including elevated HIV prevalence amongst crisis-affected populations as detailed in section 2).

It is rarely the case that AIDS has generated higher levels of social harmony, but it has rather been an instrument of social conflict. This has been true at many different levels, including within families and communities and in enterprises and faith institutions. Governments in the region have generally given a very low priority to supporting an effective response to AIDS, and most governments in sub-Saharan Africa still have a view of the epidemic which focuses on its health dimension. Very few governments have understood that the epidemic undermines development capacity and is the cause of a deepening social and economic crisis. If anything, in many countries there is a Ahands-off@ approach to the epidemic, with weak political leadership and little coherence in the approach of key stakeholders to the complex problems of the epidemic.

It follows, as noted above, that LED approaches to crisis and reintegration of displaced populations cannot assume that social and economic structures will exhibit appropriate levels of common purpose, because AIDS is still seen as a highly stigmatized condition where individuals, families and even children are often discriminated against. This is true within rural communities as well as in the towns and cities and is also the case in many formal-sector enterprises in both the private and public areas of employment. Increasingly, social capital, as noted in section 2, is being eroded by the epidemic, leading to lower levels of social integration, greater isolation of children, increased feelings of anomie, and generally lower levels of trust.

These are not exactly the conditions within which it will be feasible to engage stakeholders and others in an integrated response to the complex employment, poverty and social protection issues at the centre of the ILO response to crises. A crisis will often have exacerbated conditions of social conflict and economic need, and AIDS will often unfortunately have added to the pressures faced by affected populations. Under these conditions of diminished social capital, losses of human resources due to conflict, disaster

and AIDS, it will be even more difficult to build the consensus upon which the ILO would hope to build its programme activities.

Mapping the structure of social and economic conditions and organizational capacity as part of needs assessment will be necessary, but not sufficient. Such an assessment would also have to specifically address conditions, social and economic, that arise from the presence of large numbers of people living with HIV and AIDS, together with an evaluation of the inter-personal and inter-organizational consequences of their presence in crisis-affected populations. Both building a map of a community based on reality and inducing stakeholders to come together for a common purpose will be made even harder in the presence of HIV and AIDS in the population, not least because AIDS is leading to a deepening of poverty and social exclusion and is thus fragmenting the base of an effective community response to common problems.

3.3 Non-traditional partners

The ILO has recently become a co-sponsor of UNAIDS and as such will now be directly involved in the governance of the UN system response to AIDS at the global, regional and country level. As a co-sponsor, it will need to coordinate its activities with those of the other UN agencies with a concentration on areas that relate to the ILO=s comparative advantage. Membership of UNAIDS will as such not change the areas of concentration of the ILO in the response to AIDS, but it will involve greater collaboration than previously with other parts of the UN system, and in particular with programmes that have not traditionally been partners of the ILO. This will mean forging new working relationships within the UN system so as to ensure that what the ILO does is consistent with the general strategy of UNAIDS. This is especially important at the country level where UNAIDS sees its role as being supportive of the national response to AIDS and where coordination mechanisms have been established in most African countries. The ILO will need to strengthen its role in such mechanisms and align its activities with those of the UN system and its development partners.

Different working modalities will be required as a consequence of the ILO=s membership of UNAIDS, and in particular the Organization will need to forge new relationships with other organizations, and departments within organizations, that are not part of the traditional array of ILO partnerships. Thus, the ILO will need to establish relationships with the UNAIDS Secretariat and staff at different levels (most obviously at the country level where UNAIDS often has a Country Programme Adviser). Within Governments in sub-Saharan Africa, the ILO will have to deepen its contacts with the National AIDS Programme, often located in the Ministry of Health, and with those departments elsewhere in Government that have direct involvement in responding to key issues such as orphan support and food security. The ILO will also have to engage with civil society organizations that have typically not been part of normal operations, such as AIDS support groups, networks of people living with AIDS (PWAs) or faith organizations with outreach programmes for those living with HIV and AIDS.

Strengthening the ILO=s response to crises in countries affected by AIDS will involve working differently, in part because AIDS requires new sensitivities in addressing the issues of affected people, who are often highly stigmatized and discriminated against, and in part because the ILO will need to develop and implement its response within new coordination frameworks. This entails thinking anew about the kinds of programmes that the ILO has in the past undertaken in crisis situations, and it means working with new non-traditional partners as well as working in new areas with its usual social partners, since HIV and AIDS raise issues that have not formerly been part of the traditional framework of discussion. Furthermore, some of these interrelationships will have to take place within emerging multi-sectoral responses to AIDS at the country level, where the ILO will have the opportunity to ensure that its primary concerns are reflected in the national response.

3.4 Developing and utilizing new sources of data

It is evident that working in a world of AIDS changes what is done in the response to crises, and this means developing and utilizing sources of data that are new and different from those that have usually been central to the ILO=s response at the country level. This will require revisions of the key generic manuals, but more than this it means ensuring that those involved in rapid assessment and in the delivery of ILO activities must become familiar with the relevant data **B** including data and information relevant to operating in a world characterized by AIDS.

This is not simply a matter of epidemiological data (HIV prevalence and HIV incidence) but also other data relevant to the ILO=s crisis response. In the case of the former, many countries do have sentinel site data which are regularly collected for both rural and urban populations. So it will often be possible to find information on the estimated HIV status of populations, some of which will directly relate to crisis-affected populations. But in many countries the data are weak and surveys may have small samples and be discontinuous, so it may not provide an accurate picture of the HIV status of the population. The data that are collected often provide estimates by age and gender, but that is the limit of the information generated by the surveys. Unfortunately, this means that information that will be directly relevant to the ILO=s crisis activities, for example on education and occupation, will typically not be collected.

Most Africans simply do not know their HIV status, and it is increasingly clear that many do not want to know, given the general absence of access to basic health care, including generic drugs for opportunistic infections, the low levels of psycho-social support, and ongoing stigmatization and discrimination within families and communities and in the workplace. This means supporting populations where basic data sets are very poor and where ongoing sensibilities exist relating to the HIV status of individuals and families. What data are available will often be partial at best, but it does mean that the ILO must become familiar with what is available and also must develop an understanding of the issues relating to ethical use of such data. It should be noted that UNAIDS produces Country Fact Sheets and that these need to become part of the data base used in rapid assessments along with other

relevant data.[16] In the case of the latter, there are increasing levels of information available on attrition within key public services, such as education and health, and these data need to be collected and used in programme responses.

Finally, and most importantly, there are the demographic effects of HIV and AIDS on countries in sub-Saharan Africa. In the most severely affected countries, adult mortality has increased by factors of 5 or 6, so that in many countries HIV-related mortality is now the largest single cause of death. There are also changes taking place with respect to fertility, although this is not as well documented and is less understood than the situation regarding mortality.

What is happening to demographic structures is central to the ILO=s concerns with its mandate in respect of employment generation and poverty eradication. Demographically there are reductions in population growth rates and unique changes in the structure of populations caused by AIDS. Thus increasing numbers of countries in sub-Saharan Africa are now projected to have smaller total populations as a result of the huge increases in adult and under-five mortality, but they will also display unusual age distributions (with a hollowed-out age pyramid with very few people in the working-age population and increasingly small numbers of those over the age of 60). Some of these changes have been documented by the UN Population Division for sub-Saharan Africa[17] which also presents projections with respect to dramatic declines in life expectancy. To take a stark example, that of Botswana where HIV prevalence is estimated at 38 per cent of adults, some 25 per cent of the total population is projected to die from HIV-related mortality by the year 2010.[18] One consequence of these demographic changes, as noted above, will be increasing numbers of children who have lost their parents and who will often be without education and skills and increasingly alienated from society. Thus what is happening to children, who are increasingly both the present and the future labour force in Africa, must have profound implications on what can be achieved by the ILO=s response to crises.

Understanding what these demographic changes mean for the ILO in terms of its crisis- response activities in Africa is a major task. For the whole population structure, its size and growth, its age distribution with falling numbers in the working population, increasing levels of poverty and social exclusion, the conditions within which programme activities are developed and delivered are immensely worsening. Hence, as the recommendation was made above (under section 3.1), countries characterized by severe epidemics such as AIDS cannot realistically be considered within Ageneric@ categories but may require separate modelling and different programme responses.

[16] The most comprehensive data base on HIV and AIDS is that of the US Census Bureau, and this is readily accessible for individual countries. As with other data sets, these require caution in their interpretation.

[17] *The demographic impact of HIV/AIDS*, Population Division, Department of Economic and Social Affairs, United Nations, 1998.

[18] *The impact of HIV/AIDS on current and future population characteristics and demographics in Botswana,* Abt Associates, South Africa, 1999.

3.5 How does AIDS change the effectiveness of traditional ILO instruments?

Much of what has been written above refers to the ways in which AIDS affects the work of the ILO=s IFP/CRISIS Programme and the need for a re-examination of its work in sub-Saharan Africa. But there are perhaps three issues which deserve separate analysis. What follows should be considered within the context of what has been written above about both the generalized impact of the epidemic on development and the specific effects on families, communities and countries. These comments should be seen also in the context of the specific responses to crises as set out in a short form in the *Crisis Response Rapid Needs Assessment Manual* (section 4.3).

3.6 Labour markets and employment

Labour markets and employment are rightly seen as at the core of the ILO=s response to crisis in Africa where unemployment and underemployment are often at the heart of the development problem. The absence of decent work is a major contributing factor to the pervasive and deepening poverty of the region and is also a major factor in the recurrent crises that affect many countries in the region. The HIV epidemic simultaneously destroys human capital and organizational capacity in both the formal and informal sectors. There is evidence, for example, that the sustainability of informal SMEs is adversely affected by AIDS in that the mortality of key personnel/owner managers leads often to the disappearance of the enterprise.[19] Similarly in many formal enterprises within the public and private sectors, losses of skilled and managerial personnel are creating immense problems with respect to maintaining the output of goods and services. Equally severe are the effects on rural production of food and cash crops, both for smallholder production and for commercial enterprises.[20]

What is increasingly clear is that economic activity is disrupted across all sectors by the losses of labour that are occurring due to HIV and AIDS. Many enterprises in both the public and private sectors are facing increasing problems of recruitment and retention of skilled and professional/managerial labour, with consequent results for the structure of employment B with posts unfilled and staff promoted to levels for which they do not have the requisite experience and training. Key personnel, such as extension workers in agriculture, are being lost to HIV-related mortality in many countries and are not being replaced, with important consequences for technical support to rural producers. The latter are themselves

[19] An interesting analysis of the ways in which the informal sector is affected by AIDS is the position paper for Kenya by Benjamin M. Nganda: *The impact of the HIV/AIDS epidemic on the informal sector in Kisumu and Kakamega municipalities*, UNDP, Nairobi, 1996.

[20] The research on the impact of AIDS on rural development is limited. Amongst the most important are Daphne Topouzis; Gunther Hemrich: *The socio-economic impact of HIV/AIDS on rural families in Uganda with an emphasis on youth*, UNDP Study Paper No. 6, 1994; *The effects of HIV/AIDS on farming systems in Eastern Africa*, FAO, 1995; G. Rugalema et al.: *HIV/AIDS and the commercial agricultural sector in Kenya*, FAO, 1999.

facing increasingly severe problems, especially the smallholder sector where losses of family labour cannot be effectively overcome through readjustment of labour inputs within households.[21]

The structure and functioning of labour markets are changed under the impact of AIDS, and these changes require analysis and documentation. For fairly obvious reasons, the ILO=s decent work objectives, if they are to be successful, need to relate to what is happening in the various labour markets that are targeted. These markets are changing under the impact of AIDS, leading to shifting demands and supplies for labour and changes in the underlying elasticities. Relative wages are changing under the impact of the altered labour market conditions, as are other asset prices (for instance, land). In these circumstances, relative product prices must also change to reflect adjustment in production costs and shifting patterns of demand.

The ILO=s crisis activities need to take into account what is happening to labour demand and supplies under the impact of AIDS. This is complex but is at the heart of activities to increase access to decent work. It means rethinking how best to achieve objectives under these changed conditions, and in particular it means looking again at one of the key instruments for achieving labour market objectives **B** that of labour-intensive technology. This figures prominently in the various manuals as a key instrument for achieving decent work, but its applicability is significantly changed in a world of AIDS. The situation is much more complex, given the ways that HIV and AIDS are affecting labour market conditions; labour-intensive technology is no longer quite so obviously the best way forward.

Several examples may help the discussion:

- Many smallholders are faced by increasing problems of labour supply, both in terms of quantity at key production points, and also of quality in terms of applicable skills and experience. This is the outcome of losses of family labour, especially male labour due to HIV-related mortality, and the diversion of the labour of women into caring activities. These smallholders thus face greater labour supply constraints which they are unable to fully remove given the skill and experience of the household, and cannot be relieved by accessing local labour markets, due to their budget constraints. It should be noted that such households are usually left more impoverished after the death of one or more household member, since savings and other assets will have dissipated as part of the coping process.

- Production studies for Africa carried out under the ILO Employment Programme in the 1960s came up with the rather unexpected conclusion that labour-intensive technologies were often not efficient. The explanation for this lay mainly with issues of supervision of labour where the key constraint facing producers was the availability of experienced supervisory staff. Failures of supervision often led to problems with product quality that external markets would not tolerate, hence the preference by producers for capital-intensive forms of production in the case of products where

[21] Gladys Mutangadura et al.: *Aids and African smallholder agriculture*, SafAIDS, Zimbabwe, 1999.

consistent product quality was essential for the enterprise. AIDS is disproportionately affecting categories of skilled and supervisory labour in many countries of Africa and as such is reinforcing the decisions to use capital-intensive technologies.

- It is unclear what is happening to those who have received vocational training, although it seems highly likely that their numbers will be reduced due to morbidity and mortality from HIV/AIDS. The capacity to train, as noted above, will also have been reduced as organizations engaged in training lose staff at all levels to HIV-related illnesses. Thus, technical capacity to train will be eroded with effects on the numbers of those with formal skills such as carpenters, mechanics or masons with knock-on effects for systems of apprenticeship (which further reduces the supply of those with scarce technical skills). Furthermore, the increase in the numbers of children who have been orphaned is already having effects on educational attainment, and this will in time adversely affect the supply of young adults able to acquire technical qualifications and skills. What the effects will be of these developments overall on labour market conditions is unclear, but the expectation is of a deepening shortage of those with appropriate skills and experience, with significant effects on the kinds of projects that are feasible during post-crisis reconstruction and in the long term on the capacity for development.

The automatic assumption that labour-intensive technologies and forms of production are to be preferred is far too simplistic. Even the caveat that this preference would be bound by cost-efficiency does not take sufficiently into account the complexity that producers in both the formal and informal sectors now face in countries experiencing mature HIV epidemics. What looks obvious may in fact on closer examination not be feasible. Indeed, in the case of smallholder production as detailed above, what is needed are technologies that are labour saving rather than labour using.[22]

3.7 AIDS and the productivity of labour: Public works programmes

This is a complex topic, and the following is intended simply as an indicator of the need to think deeply about the implications of the epidemic for the efficient use of labour in both the formal and informal sectors. It is clear from the foregoing that the HIV epidemic is diminishing the quality of the labour supply. In part, this is the outcome of the loss of skilled and managerial labour to AIDS, including the loss of experience that is often so important. It is also due to the fact that increasingly there is attrition within the education sector, often focused on staff who are experienced, which must be undermining the capacity of the sector to undertake its educational and training tasks. Finally, it is partly the result of lower rates of attendance of children in primary and secondary schools, especially of girls who are increasingly being withdrawn because of the effects of AIDS on family incomes (IIEP, 2000).

Changes are taking place in the quality of the labour force, thereby affecting productivity. Simultaneously, changes are also occurring in the quality of management and in

[22] *Aids and African smallholder agriculture*, op. cit., especially section 4.

the flow of savings to enterprises (and governments) which reduce their capacity to maintain the stock of assets (capital goods, buildings, farms and houses). Furthermore, an increasing proportion of the labour force is infected with HIV, which has effects over time on physical and mental capabilities. One consequence of this is the very much higher rate of morbidity and increasing disruption to production processes due to absences from work. A further consequence of HIV infection, often in conjunction with increasing levels of poverty, is a worsening of nutritional status, again with effects on labour productivity.

This combination of effects has great importance for labour productivity and indeed for factor productivity as a whole. Thus, activities aimed at decent work will need to be defined in terms of a labour force and a structure of production that are being radically changed under the impact of HIV and AIDS. The labour force will be increasingly without the skills and education that could have been assumed in the past (with implications for vocational education); many workers will be subject to spells of sickness which intensify over time, with effects on the continuity of production (and thus on cost); and workers will, because of their HIV status, often be subject to stigmatization and discrimination in the workplace with important consequences for the individual involved and for production.

Because of their HIV status, many workers will suffer from poor nutrition which will directly affect their productivity. In the case of the nutrition/productivity relationship, one is revisiting the old problem of efficiency wages, only in this case a more intractable version. It will, nevertheless, have important implications for activities that focus on labour-intensive public works as a means of reintegrating populations under post-crisis conditions. Public works may still be feasible where significant numbers of workers are infected with HIV, but special attention will have to be given to the related question of access to basic health care and adequate nutrition if these projects are to be successful. It should be noted that there is some research on the nutritional needs of HIV-infected persons, and this should be used in designing nutrition packages for those employed on public works programmes in areas where HIV is known to be high.

It is worthwhile drawing out some of these considerations as a guide to the factors that need to be taken into account when designing and implementing public works programmes. To give a few examples:

- It is ILO policy to design labour-intensive rural public works so as to avoid competing with peak demands in small-scale agriculture, although practice does not always achieve this desirable aim. Under conditions of high levels of HIV, it is even more important to avoid competing with the labour needs of small producers, given the need to ensure that basic food needs are met. The problem, as noted above, may not be shortages of unskilled labour in general, but that such projects which are seen as poverty reducing may not in fact reach the poorest. The latter, who are often female-headed households, may be so constrained by labour shortages, due to morbidity and death within the household, that they are either unable to work on small-scale projects and/or can do so only at the expense of food production. In these circumstances, more innovative approaches to poverty alleviation will be needed, which might include food-for-work and more limited part-time contracts for women.

- There may well be skilled-labour shortages as a result of HIV/AIDS, and this will need to be addressed in the design and implementation of projects. It is critical, therefore, that small-scale infrastructural projects be based on a survey of local labour market conditions so as to ensure that requisite stocks of labour are available (and will not simply be competed away from existing productive use). It is important under these conditions that the ILO and its partners ensure that wages and other conditions of employment are fair, but at the same time avoiding bidding up wages, etc. in ways that cause further disequilibrium in local markets. Similar factors and considerations also apply in the case of higher professional and technical labour, which will also in many cases be in extremely short supply.

It has long been seen as important that infrastructural investments contain a package of interventions that minimize their impact on HIV transmission. That such projects have the potential to increase HIV transmission is a recognized problem, especially in the case of large-scale dams, major bridges, irrigation schemes, etc. The reasons for this are self-evident: such projects cause greater labour mobility, especially of young men, and thus lead to the formation of new sexual networks and an expansion of sex work. Under these conditions, HIV transmission is accelerated unless such projects contain specific activities to limit the spread of HIV in the workforce. It has also been empirically demonstrated that such projects raise levels of HIV prevalence in local populations.

ILO crisis-related public infrastructure projects have the potential to increase labour mobility and raise local wages, with effects on HIV transmission through higher levels of sex work. Furthermore, as noted above, under conditions of high levels of HIV prevalence, there will be a need for care and support for those employed on such projects, given that a significant proportion of the workers will be HIV positive. It is important under these circumstances that HIV-specific interventions be designed as part of all such assistance packages. Projects should build links to local community-based organizations and NGOs that can help to deliver complementary services to avoid higher levels of HIV transmission through such activities as counselling and HIV testing, peer education programmes, and access to condoms. They should also ensure that there is increased access to basic drugs for STIs and treatment for generic illnesses such as tuberculosis.

In effect, such small-scale public works projects, while not losing sight of their main objective of poverty alleviation through employment generation, also become important in the local response to HIV/AIDS. Unless they do so, they run the severe risk of exacerbating the conditions in which HIV is transmitted, so that in the medium term the benefits of such projects are rapidly eroded due to the impact of the epidemic on sustainable development.

3.8 Micro finance and micro credit

The aim of this discussion is simply to raise questions about the ways in which micro-finance and micro-credit programmes are affected by AIDS. One of the most important instruments that is considered relevant to crisis response is that of micro finance and micro credit. In part this relates to the success of such programmes in achieving social objectives, including poverty reduction, in South Asia. Success in Asia is thus considered grounds for an expansion of such programmes to sub-Saharan Africa, although conditions are often entirely different in Africa. One of the significant differences is the scale of the HIV epidemic, which is of importance for the likely success of non-traditional instruments of finance and credit. It should be noted that there are indigenous forms of local finance and credit, and forms of social insurance, already operating in many regions of Africa.

The key question for our purposes is whether countries experiencing a mature epidemic of HIV are suitable places for the introduction of micro-finance and micro-credit instruments. There may be major problems with the use of such instruments under conditions of falling general living standards for many Africans B a proportion of which is directly caused by AIDS.[23] But it is not simply a matter of general trends in income per capita and the distribution of income and wealth, but more specifically one of household capacity to repay loans and credit even under subsidized supply.

Many financing institutions in Africa have taken action to reduce the risks that they face due to HIV and AIDS. Thus, insurance companies often impose an initial HIV test followed by regular retesting over a specified number of years so as to reduce their liabilities. Similarly, many institutions that are involved in lending for house purchases, where the liability is substantial and long term again require HIV testing before making a mortgage advance. Recently a micro-credit programme in Malawi announced that it was withdrawing from the country because of problems with respect to repayment of loans due to HIV and AIDS.

That HIV and AIDS have the capacity to undermine micro-finance and micro-credit schemes is self-evident. The epidemic is concentrated amongst the working-age groups of both men and women. In many countries, the infection rises with social class/occupation so that those who might qualify for such credit and finance programmes often have the highest HIV prevalence. But HIV infection is not confined to the well off; in fact, the largest number are the poor Bthose that subsidized programmes have as their target. But both categories will have problems with repayment of credit given the prevalence of HIV and the probability that 20 to 35 per cent of adults will die before they reach 35 years of age.

This brief review suggests that the epidemic can significantly affect the success rate of programme activities of credit and finance, no matter how desirable these seem in terms of

[23] The World Bank estimates that between 1990-99 real per capita income in sub-Saharan Africa increased at an annual rate of 0.1 per cent, compared with 2.8 per cent in the years 1965-80. For many Africans, the past decade must have meant declining real income, given the fact that the average will mask quite different experiences of the rich and the poor.

their ability to address the very real needs of the poor. In practice, such schemes will need to be tailored carefully to their target audience if they are to stand any chance of success. Populations characterized by high rates of HIV prevalence will prove increasingly unable to meet the conditions of such schemes, with the inevitable result that they will fail in their objectives. It is possible to design arrangements that will not have high failure rates, but this would have to be factored into the scheme from the outset B taking into account the projected morbidity and mortality of the client population.[24]

3.9 Conclusions: The way forward

This paper should be seen as a preliminary attempt to identify the relationships between other crises and HIV/AIDS and the implications for the ILO=s IFP/CRISIS Programme. There can be little doubt that the HIV epidemic does contribute to the causes of crisis in sub-Saharan Africa, so that one of the benefits from more effective responses to AIDS would be an amelioration of those conditions that lead to insecurity and instability in the region. Similarly, there is clear evidence that crises do contribute to the transmission of HIV and do further undermine the coping capacities of affected populations. A two-way relationship exists feeding on each other in ways that undermine both development capacity and social and economic conditions in a region that already accounts for more than a quarter of the global total of those living in poverty.

It seems unlikely that crises in Africa will diminish in number and intensity in the coming decade, and there is little evidence that the global community has managed to put in place policies and programmes that will contain the HIV epidemic in Africa. In these circumstances, it is essential that the ILO strengthens its capacity to respond to these dual problems and that it has in place effective programmes that integrate HIV/AIDS within its core activities. A start has been made and a dedicated capacity is now in place with the ILO becoming a co-sponsor of UNAIDS. These developments signal that the ILO is determined to bring its special expertise to bear on the issues raised by AIDS for sustainable development.

There is still much more that needs to be done in terms of integrating HIV so as to ensure that this issue is at the forefront of ILO programmes in Africa. In the final analysis, what is important are the capabilities of the staff and external contractors of the Organization who need to have a clear understanding of the issues raised by AIDS for development and an ability to apply analysis to problem solving within the region. The way forward lies with developing this capacity within the Organization through structured programmes that ensure that it is not business as usual. Bringing about this change in a working culture requires resources and will not be achieved easily.

[24] Discussions are under way between the ILO and the UNHCR to develop guidelines for micro finance in the context of crisis. It is unclear at this time whether these guidelines also take account of the implications of HIV/AIDS for their successful implementation.

ANNEX

Declaration of Commitment on HIV/AIDS: UN General Assembly Special Session on AIDS (25-27 June 2001)

HIV/AIDS in conflict-and disaster-affected regions

Conflicts and disasters contribute to the spread of HIV/AIDS

75. By 2003, develop and begin to implement national strategies that incorporate HIV/AIDS awareness, prevention, care and treatment elements into programmes or actions that respond to emergency situations, recognizing that populations destabilized by armed conflict, humanitarian emergencies and natural disasters, including refugees, internally displaced persons, and in particular women and children, are at increased risk of exposure of HIV infection, and, where appropriate, factor HIV/AIDS components into international assistance programmes.

76. Call on all United Nations agencies, regional and international organizations, as well as non-governmental organizations, involved with the provision and delivery of international assistance to countries and regions affected by conflicts, humanitarian crises or natural disasters, to incorporate as a matter of urgency HIV/AIDS prevention, care and awareness elements into their plans and programmes, and provide HIV/AIDS awareness and training for their personnel.

77. By 2003, have in place national strategies to address the spread of HIV among national uniformed services, where this is required, including armed forces and civil defence forces, and consider ways of using these services who are educated and trained in HIV/AIDS awareness and prevention to assist with HIV awareness and prevention activities, including participation in emergency, humanitarian, disaster relief and rehabilitation assistance.

78. By 2003, ensure the inclusion of HIV/AIDS awareness and training, including a gender component, into guidelines for use by defence personnel and other personnel involved in international peacekeeping operations, while also continuing with ongoing educational and prevention efforts, including pre-deployment orientation, for these personnel.

BIBLIOGRAPHY

A. Non-ILO

Abt Associates: *The impact of HIV/AIDS on current and future population characteristics and demographics in Botswana*, South Africa, 1999.

Ayieko, M.: *From single parents to child-headed households*, Study Paper 7, UNDP, 1998.

Bennel, P.; Hyde, K.; Swainson, N.: *The impact of the HIV/AIDS epidemic on the education sector in sub-Saharan Africa: A synthesis of findings and recommendations of three country studies (Malawi, Botswana and Uganda)*, University of Sussex, Feb. 2002.

Carballo, M.; Mansfield, C.; Prokop, M.: *Demobilization and its implications for HIV/AIDS*, International Centre for Migration and Health, Geneva, 2000.

Cohen, D.: *Socio-economic causes and consequences of the HIV epidemic in Southern Africa: The case of Namibia*, UNDP Issues Paper No. 31, 1998.

---: *Responding to the socio-economic impact of the HIV epidemic in sub-Saharan Africa: Why a systems approach is needed*, Working Paper, UNDP, 1999.

---: *Poverty and HIV/AIDS in sub-Saharan Africa*, UNDP Issues Paper 27, New York, 1998.

FAO: *The effects of HIV/AIDS on farming systems in Eastern Africa*, 1995.

Hunter, S.; Williamson, J.: *Children on the brink*, USAID, 2000.

International Crisis Group: *HIV/AIDS as a security issue*, Report, Brussels/Washington, June 2001.

Kasozi, A.B.K.: *Linkage of conflict to the spread of HIV/AIDS in Uganda, 1980-1999*, ActionAid Uganda (undated).

Kelly, M.J.: "Planning for education in the context of HIV/AIDS", in *Fundamentals of Educational Planning No. 66*, UNESCO/IIEP, Paris 2000.

Khaw, A.J. et al.: "HIV risk and prevention in emergency-affected populations: A review", in *Disasters*, Overseas Development Institute, 2000.

Malawi Institute of Management/UNDP: *The impact of HIV/AIDS on human resources in the public sector in Malawi*, Jan. 2001.

MIM/UNDP: *Impact of HIV/AIDS on human resources in the public sector in Malawi*, Jan. 2002.

Mutangadura, G. et al.: *Aids and African smallholder agriculture*, SafAIDS, Zimbabwe, 1999.

Nganda, B.M.: *The impact of HIV/AIDS epidemic on the informal sector in Kisumu and Kakamega municipalities*, UNDP, Nairobi, 1996.

Rugalema, G. et al.: *HIV/AIDS and the commercial agricultural sector in Kenya*, FAO, 1999.

Topouzis, D.; Hemrich, G.: *The socio-economic impact of HIV/AIDS on rural families in Uganda with an emphasis on youth*, UNDP Study Paper No. 6, 1994.

UNGASS: *Declaration of Commitment on HIV/AIDS*, 25-27 June 2001.

United Nations: *The demographic impact of HIV/AIDS*, Department of Economic and Social Affairs, Population Division, 1998.

WHO/AIDS: *AIDS epidemic update*, Dec. 2001.

World Bank: *Attacking world poverty*, World Bank Development Report, 2000.

B. ILO

2001

Date-Bah, E.; Walsh, M. et al.: *Gender and armed conflicts* (Working Paper 2, IFP/CRISIS, ILO, March 2001).

Date-Bah, E.: *Crises and Decent Work: A collection of essays* (IFP/CRISIS, ILO, August 2001).

ILO: *Crisis Response: Rapid Needs Assessment Manual* (IFP/CRISIS, ILO, October 2001).

---: *Crisis-affected peoples and countries: ILO's operational activities, mid-1997-March 2001* (IFP/CRISIS, ILO, May 2001).

---: *Crisis Response and Reconstruction Capacity-Building Training Workshop* (Final report, IFP/CRISIS, ILO, May 2001).

---: *Generic Crisis Response Modules* (IFP/CRISIS, ILO, September 2001).

---: *Issues in poverty and HIV/AIDS: A Framework for research and analysis* (mimeo draft, ILO Programme on HIV/AIDS and the World of Work, June 2001).

ILO: *One-and-a-half years implementation, September 1999-June 2001* (IFP/CRISIS, ILO, June 2001).

---: *Personnel policy on HIV/AIDS* (circular 576, series 1, ILO, July 2001).

---: *The labour market and employment implications of the HIV/AIDS epidemic* (GB.280/ESP/5, March 2001).

2000

Enarson, E.: *Gender and natural disasters* (Working Paper 1, IFP/CRISIS, ILO, September 2000).

ILO: *High-level research consultation on crisis* (IFP/CRISIS, ILO, May 2000).

---: *Platform of action on HIV/AIDS in the context of the world of work in Africa* (ILO, June 2000).

---: *Action against HIV/AIDS in Africa: An initiative in the context of the world of work* (ILO, October 2000).

---: *Crisis response and reconstruction: Tackling the employment challenges of crisis* (IFP/CRISIS, ILO, 2000).

Young, A.S.: *Perception of employers about HIV/AIDS in the world of work* (mimeo report of a pilot study of enterprises in South Africa, ILO, October 2000).

C. Other ILO documents

Hodges-Aeberhard, J.*: Policy and legal issues relating to HIV/AIDS and the world of work* (discussion papers on HIV/AIDS, ILO, November 1999).

Sehgal, Jag M.: *The labour implications of HIV/AIDS* (Discussion Papers on HIV/AIDS, ILO, November 1999).

ILO: *An ILO code of practice on HIV/AIDS and the world of work* (ILO, June 2001).

---: *Report of the Tripartite Meeting of Experts on HIV/AIDS and the World of Work* (GB.281/5, June 2001).

---: *A framework for ILO policy and action in the conflict-affected context* (Training and Employment Promotion for Sustainable Peace, ILO, 1999).

---: *Gender guidelines for employment and skills training in conflict-affected countries* (ILO, March 1998).

Selected outputs of the IFP/CRISIS since September 1999

Barakat, S.; Wardell, G.: *Capitalizing on capacities of Afghan women* (Geneva, December 2001).

Cohen, D.: *HIV epidemic and ILO response to other crises in sub-Saharan Africa* (Geneva, April 2002).

Date-Bah, E.: *Crises and decent work: A collection of essays* (Turin, Aug. 2001).

---: *Gender in crisis response and reconstruction* (March 2000).

---: *Economic aspects of post-conflict rehabilitation: The challenges of transformation,* OSCE Eighth Economic Forum (Prague, 11-14 April 2000).

---: *InFocus Programme on Crisis Response and Reconstruction and its Research Needs* (May 2000).

Enarson, Elaine: *Gender and natural disasters*, IFP/CRISIS Working Paper No. 1 (Geneva, Sept. 2000).

ILO: *Crisis-affected peoples and countries: ILO's operational activities mid-1997-March 2001* (Geneva, 2001).

---: *Crisis response capacity-building strategy and plan, 2000-2005* (Geneva, April, 2002).

---: *Tackling the employment challenges of armed conflict: Key ILO tools* (Geneva, Sept. 1999).

---: *Crisis response and reconstruction: An ILO InFocus Programme* (Geneva, Nov. 1999).

---: *Employment for peace in Sierra Leone* (Dec. 1999).

---: *ILO strategy and activities on employment and social concerns in crisis situations,* Second Item on the Agenda, Committee on Employment and Social Policy, GB.277/ESP/2 (Geneva, March 2000).

---: *Programme for employment recovery and reduction of economic vulnerability – A response to the floods of Mozambique* (Maputo, March-April 2000).

---: *Generic modules on ILO's response to crises* (draft, April 2000).

---: *Rapid Needs Assessment Manual* (draft, April 2000).

---: *ILO programme proposals in response to East Timor's employment and reconstruction challenges* (Geneva, June 2000).

---: *Report on Consultation with Workers' and Employers' Delegates* (June 2000).

ILO: *Framework for post-conflict employment promotion and socio-economic integration in South Lebanon* (IFP/CRISIS and ROAS, Beirut, July 2000).

---: *Report on high-level research consultation on crisis* (Geneva, Aug. 2000).

---: *Selected issues papers: Crises, women and other gender concerns* (Geneva, Feb. 2002).

Nyheim, D.; Sislin, J.: *Early warning: Employment and related ILO concerns* (Geneva, Jan. 2002).

Pain, A.; Goodhand, J.*: Afghanistan: Current employment and socio-economic situation and prospects (*Geneva, Feb. 2002).

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