HOPE

BUILDING CAPACITY

LEAST DEVELOPED COUNTRIES MEET THE HIV/AIDS CHALLENGE

United Nations
Development Programme

Learning to cope. Creating hope.

Cover Picture:
Portrait of an Ethiopian woman in Nazareth.

FOREWORD

In spite of considerable efforts which have been made, the Least Developed Countries (LDCs), with a population of over 700 million, remain extremely vulnerable.

Although there has been remarkable progress in a small number of developing countries, it is now clear that without a significant acceleration in development efforts in LDCs, very few of the global development targets, including the Millennium Development Goals, can be met. The AIDS pandemic is worsening the prospect for success in many LDCs, particularly because of its effects on present and future human capacities of the most vulnerable countries, hampering their ability to generate real economic and social development.

In view of the continuing rapid spread of the epidemic, it is imperative to have a strong and innovative response. There has to be an active transformation of the current response as well as a clearer understanding of the driving forces behind the HIV/AIDS pandemic and the resulting human and institutional capacity crisis.

This document is a call for action. It forms an integral part of the cooperative efforts between UNDP and UN-OHRLLS and strongly encourages the international community and countries to urgently address the HIV/AIDS crisis and human capacity challenges facing LDCs.

UNDP is the UN's global development network, advocating for change and connecting countries to knowledge, experience and resources to help people build a better life. As a UNAIDS co-sponsor, UNDP is to ensure that national planning and governance systems for the HIV/AIDS response address emerging issues, bring about the required policy shifts and mobilise the global agenda to achieve the Millennium Development Goals. Similarly, the mandate of UN-OHRLLS includes mobilizing international support and resources for programmes and initiatives addressing the needs of LDCs in line with the Brussels Programme of Action. It is our firm belief that increased cooperation will create synergies and impetus to the benefit of LDCs in their bid to act against HIV/AIDS and to face the human capacity challenge.

We know that it is possible to take action and build new capacities that foster hope. We know that it is possible to fight stigma, discrimination and gender inequalities and to bring down infection rates and provide better treatment and care options. Working together, LDCs and the international community will be able to face the human capacity challenge that HIV/AIDS presents. We can, through innovative joint action, reverse the erosion of human capacity and achieve greater social and economic benefits for the women, men and children in LDCs and, in doing so, contribute substantially to the achievement of the Millennium Development Goals.

Anwarul K. Chowdhury
Under-Secretary-General
and High Representative, UN-OHRLLS

Picture:
Turning hope into results – Laos.

1. EROSION OF HUMAN CAPACITY: PERIL TO DEVELOPMENT

Roughly a quarter of the world's countries are classified as Least Developed Countries (LDCs), who remain the most vulnerable and weakest segment of the international community, of these 36 are in Africa, 13 in Asia-Pacific and one in the Caribbean. It is now clear that without achieving a huge acceleration in their development efforts, few global development targets can be met. The AIDS pandemic is worsening the prospects of LDCs as many of the hardest hit countries are facing massive financial and human resource constraints. These countries by definition have limited resources to generate sufficient economic and social development, and as such are at greater risk. HIV/AIDS is eroding these limited resources and affecting the most productive people so urgently needed for development. In other words, HIV/AIDS affects the present and future human and institutional capacities of countries and consequently their capacity to generate economic and social development.

The scale of the human capacity crisis caused by the pandemic in LDCs, with a combined population of 700 million, varies considerably. Some LDCs do not as yet have a full-blown epidemic. However, they must take the necessary steps to prevent the epidemic from spreading to the general population in order to safeguard their human capital and their long-term institutional capacities. A number of countries in the Asia Pacific and Africa regions have generalized epidemics which are already eliciting a heavy toll on their human resources. They are losing skilled staff essential for delivery of vital public services and thus cannot meet existing social service commitments, let alone mobilize the necessary staff and resources to respond effectively to additional burden wrought by AIDS.

In May 2001 the United Nations Conference on the LDCs adopted the Brussels Program of Action (BPOA) for the Least Developed Countries for the Decade 2001 to 2010 – that committed to the eradication of poverty and improvement of the quality of lives of the people. Succeeding in this BPOA is a clear prerequisite for the international community to be able to fulfil the broader Millennium Development Goals (MDGs) by 2015. Addressing HIV/AIDS is a central pillar of BPOA Commitment 3 – building human and institutional capacity. As the UN's global knowledge and capacity developing network , UNDP with its 166 Country Offices also supports the efforts of LDCs in building the necessary capacity required to achieve the MDGs.

Many LDCs have taken great strides to achieve the commitments of the BPOA and the MDGs, but are constrained by a myriad of challenges including a lack of human and institutional capacities, aggravated by the onset of the AIDS epidemic. The BPOA carefully formulates the link between HIV/AIDS, development efforts, and human and institutional capacities in the following way:

> *"LDCs' greatest assets are their women, men and children, whose potential as both agents and beneficiaries of development must be fully realized. Efforts at development of human capacities in LDCs have been affected by low school enrolment and low health, nutrition, and sanitation status and by the prevalence of the HIV/AIDS pandemic, particularly in Africa, and malaria, tuberculosis and other communicable diseases, as well as by natural and man-made disasters. Making steady progress in this area will be a major objective during the decade. An immediate priority is to focus greater effort on fighting HIV/AIDS, malaria and tuberculosis and their social and economic impact. At the same time, longer-term policies and strategies must be pursued in health, education, employment and rural development, with due consideration for cross-sector synergies."*

Clearly there is a need to initiate global action for LDCs to vigorously address the impact of HIV/AIDS and its effect on human and institutional capacities if BPOA and MDG commitments are to be met.

2. WOMEN AND GIRLS BEAR THE BRUNT OF THE BURDEN

"Women now account for nearly half of all adult infections. In sub-Saharan Africa, that figure is around 58 per cent. Among people younger than 24, girls and young women make up nearly two thirds of those living with HIV. And yet, one third of all countries still have no policies to ensure that women have access to prevention and care. Knowing what we do today about the path of the epidemic, how can we allow that to be the case?"

Secretary-General Kofi Annan at the XV International AIDS Conference, Bangkok, 11 July, 2004.

Deeper effects on women and girls

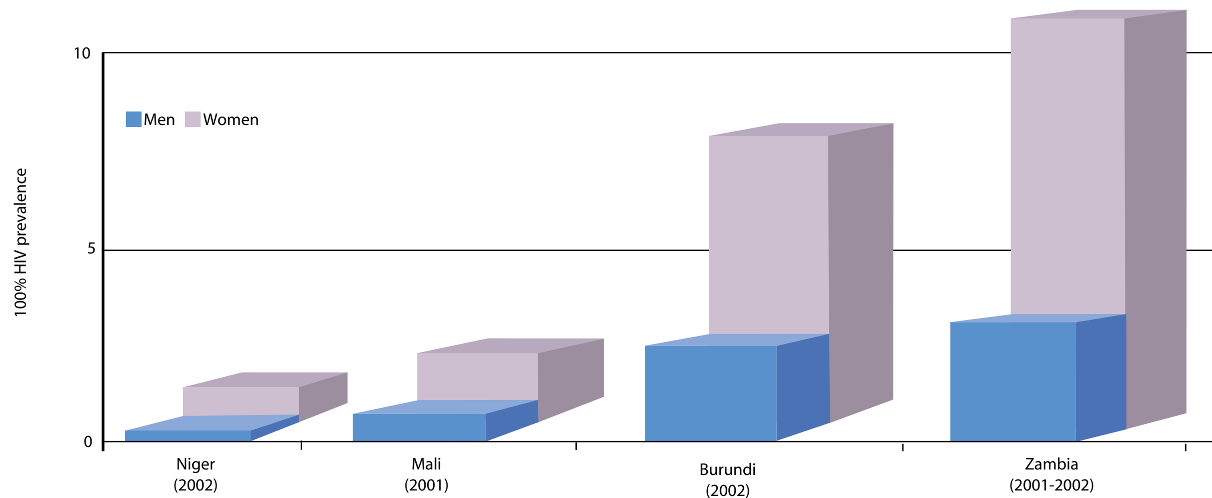
HIV/AIDS worsens inequality by impacting the female population hardest. Young girls are increasingly being affected by the disease. Effective responses must tackle the gender dimensions of the epidemic by promoting gender equality and empowering women. The epidemic creates a new cycle of vulnerability as women and girls bear the brunt of its impact on families and communities. Women are often tasked with the heavy burden of caring for those who are ill thus curtailing their educational and economic opportunities.

Globally women are increasingly becoming HIV-positive. In most LDCs heterosexual transmission is the dominant mode and the impact of AIDS on women continuous to increase. In many LDCs, women are 30 percent more likely to be HIV-positive than men and this tendency is even more pronounced among young people.

According to UNAIDS, a number of studies indicate that African women in the 15 to 24 year age bracket, on average, are 3.4 times more likely to be sero-positive than their male peers. Women may also hesitate to seek HIV testing and ultimately treatment, because they often fear that disclosing their HIV-positive status may result in physical violence, expulsion from their home or social isolation.

Picture:
AIDS puts heavy demands on the health systems of many countries. In some hospitals of Central and East Africa, 40% or more of beds are occupied by people with AIDS.
In a Tanzanian hospital, a woman cares for her husband who has AIDS.

HIV PREVALENCE AMONG 15-24-YEAR OLDS IN SELECTED LDCs, 2001-2003.



Source: UNAIDS 2004

To address declining income, families often resort to taking children, especially girls, out of school. However, HIV/AIDS is not the only reason for families to take their girls out of school. A number of studies have documented that a major contributing cause is escalating school fees, which AIDS-affected families often will be unable to pay.

A vicious cycle

Less educated girls and young women are less able to protect themselves against becoming HIV-positive fuelling a vicious cycle where gender disparities further contribute to the spread of HIV/AIDS.

The burden of care ultimately has a female face. In many LDCs, an estimated 90 percent of the care of AIDS patients occurs in the home, placing extraordinary strains on women. Older women typically face their own set of special challenges. When children are orphaned by AIDS, grandmothers often shoulder the burden of care. AIDS-related stigma and discrimination often lead to the social isolation of older women caring for orphans and ill children, and deny them economic and other necessary support.

Other serious indirect social effects occur when the partners or fathers of women die of AIDS. They may be left without inheritance - land, housing or other assets. For example, UNICEF reports that in a Ugandan survey one in four widows reported their property was seized after their partner died. A woman may also be prevented from using her property or inheritance for her family's benefit. This in turn hurts her ability to qualify for loans or agricultural grants. The denial of these basic human rights increases women's and girls' overall vulnerability, including the risk of sexual exploitation, abuse and HIV.

RESPONSES

Policies and programmes that abolish school fees for affected families will provide considerable mitigation improving the chances of children, especially girls, from AIDS-affected families to stay enrolled.

Securing human rights, including the right to inherit family property by women, is a clear action that will benefit women as well as children in affected societies. Intrinsically linked to the human rights issue is the need to address stigma and discrimination universally.

Through innovative efforts the care burden can be redistributed more evenly between men and women. It is important to keep gender equity and gender equality as a core goal for interventions providing assistance to AIDS affected families.

3. STOPPING HOUSEHOLDS FROM FALLING BEHIND

CHALLENGES

Household income and wealth decline

AIDS is not just a serious disease for most households, it is also a challenge to their survival. The economic effects are dramatic and include increased expenses, significantly decreased income and a decline in savings and investments.

According to UNAIDS, expenses increase when households have to care for a person living with AIDS. They have to pay for medicines, to take time off to provide care, and ultimately they face the expenditure of funerals. Farmers and other family businesses face increased costs of labour either in the form of salaries for newly hired replacement labour, or as an opportunity cost when activities are scaled back.

Sickness costs

Increased expenditures are paralleled by a decrease in income. Depending on who falls sick, households have to cope with different degrees of decline in either cash income or labour supply. In the 1990s, a comparative study reported by UNAIDS, tracked 300 AIDS-affected households in Burundi, Cote d'Ivoire and Haiti, two of which are LDCs. It found a steady decline in the number of economically active members per household, which was usually followed by a drop in per capita household consumption. In other countries such as Zambia, studies have documented that monthly income in AIDS-affected families fell by 66 to 80 percent when households had to cope with AIDS-related illnesses.

The combined loss of income and increase in expenditures often results in negative savings, leaving the family increasingly vulnerable in case of other unforeseen shocks. The household responses to this challenge differ between urban and rural settings. In urban settings, households often resort to informal borrowing and deplete their savings, while rural households tend to sell assets, migrate or rely more heavily on child labour.

Picture:
A woman lecturing to community members about AIDS and how to prevent it. The woman received her training from the United Nations Development Programme (UNDP).

RESPONSES

It is essential to mitigate the social and economic impact of AIDS on the affected households, especially in LDCs where safety nets are rare. It is also crucial to ensure that orphaned and other vulnerable children, including girls, can continue to attend school and that they are not left to fend for themselves. Families, and especially those taking care of orphaned children, need strategies such as community-based child care and home visits. Responding to demand, community-based child care centres are already becoming more common in a number of countries. Such centres can provide children with food and access to health care and enable children who have reached school age to go to school.

Home-based care providers need policies and support programmes that can help them lift the additional burden on families. Likewise, the economic impact on families can be addressed through national and macroeconomic policies designed to mitigate the additional challenges that HIV/AIDS places on families, especially on women. In many countries, community-based organisations and NGOs have played a key role in ensuring that home-based care and community-based responses have taken effective hold.

4. COPING WITH HUMAN CAPACITY LOSSES

CHALLENGES

Capacity is lost across all sectors

In many LDCs, the HIV/AIDS pandemic has seriously weakened institutional capacity for management and delivery of services. This is largely due to high attrition levels and the result of vacancies that cannot be filled. Malawi provides clear examples of this where in the Ministry of Labour and Vocational Training on average, 34 percent of the professional positions are vacant. In the Ministry of Health and Population as well as the Ministry of Water and Development, the figures are 61 and 59 percent respectively. Both women and men are forced to give up their jobs, though women tend to fall sick and leave at an earlier age than men, as they are often infected earlier. Research from Zambia and other LDCs confirms that many countries are facing the same dilemma.

Health services

AIDS causes between 19 and 53 percent of all government health employee deaths in African countries. In Malawi and Zambia, health workers' illness and death rates have increased five to six fold. In fact, the epidemic is quickly outstripping growth in the supply of health-sector workers at a time where services are strained through an increased burden of disease from AIDS and other infectious diseases.

In Malawi, records from the Ministry of Health and Population indicate that HIV/AIDS-related illnesses account for 60 percent of hospital occupancy. Such increase in demand will in itself be a serious challenge to the capacity of any health system. However, for the often under-funded and under-staffed health systems of LDCs such dramatic increase in demand contain a clear risk of a total break-down of the system.

Clearly, the pandemic seriously affects the supply side of health services. Health sector staff are lost at a higher rate than the replacement rate, thus depleting the sector of its valuable human resources.

In low prevalence LDCs the need to take action might initially appear to be less urgent. Although the early stages of the epidemic are often "invisible". Experiences in many countries have shown how quickly it can negatively impact on human resources.

Picture:
In a health clinic in Benin, a young boy gets medicine and a physical check-up while on his mother's lap.

Given their fragile economies and capacities, LDCs are likely to be more vulnerable to rapid increases in prevalence rates. Consequently, LDCs presently experiencing low prevalence rates must take the risk seriously and begin to plan how to limit the impending capacity challenge.

Education

The education sector faces a similar dilemma. Teachers and lecturers tend to belong to the most HIV-affected age group, although vulnerability patterns differ between countries. In Malawi and Uganda, teacher mortality rates were broadly compatible with general population rates, although they were higher among both primary school and male teachers, possibly due to greater mobility. Despite the differences it is clear that the capacity challenge from HIV/AIDS will make it very difficult for many LDCs to achieve the MDGs with regard to education and especially girls' education.

RESPONSES

Recognising the seriousness of the capacity challenge created by the AIDS pandemic, it is clear that LDCs need to quickly formulate and implement strategies mitigating the impact of HIV/AIDS on their human capital to maintain service delivery.

Clearly, actions are needed to protect existing human capacities in LDCs. These include actions to prevent the spread of the virus and increased efforts to protect existing human capacities. These include actions to prevent the spread of the virus, prolonging the productive lifes of people living with HIV/AIDS through treatment programmes including antiretroviral (ARV) therapy, and support systems for affected workers and their families.

Education sector programmes that revise training curricula and introduce multi-grade teaching can mitigate the impact of AIDS on the education sector. However, additional actions need to be taken to scale-up education efforts in order for LDCs to replace the human capital lost. These innovative investments will help make available the levels of human capital required to accelerate development.

LDCs will have to apply innovative strategies around prevention, treatment, and impact mitigation to their fullest to enable them to avoid the full impact of the pandemic. The strategies should be cross-sectoral in nature and tackle the underline causes of the spread and impact of the epidemic.

5. ENSURING INCOME AND PRODUCTIVITY IN LDCs

CHALLENGES

Decline in productivity

The combined impact of AIDS-related absenteeism, productivity decline, health expenditures, recruitment and training expenses, is thought to reduce profits by at least 6 to 8 percent. Comparative studies of East African businesses by UNAIDS have shown that absenteeism due to HIV/AIDS can account for as much as 25 to 54 percent of company costs.

The effects are even harsher for small businesses and the informal economy - both major sources of work in LDCs. Invariably workers lack health insurance or reliable access to medical facilities. Their livelihoods are heavily reliant on their labour and skills, additionally as workers in the informal economy, they have little access to HIV/AIDS workplace programmes.

Agriculture in peril

In most agricultural areas with high HIV-prevalence there is direct link between AIDS, food shortages and malnutrition. In some areas there is a strong gender dimension to the link between AIDS and food shortages. For instance, in Malawi households that lost females under age 60 were twice as likely to experience a food deficit as households in which men in the same age bracket had died.

Women with seriously ill husbands spend up to 50 percent less time doing farm work leading to a considerable loss in productivity. Following the death of male adults, households frequently turn to subsistence crops avoiding the high-value crops usually managed by men, further impoverishing the households.

RESPONSES

Recognising the seriousness of the capacity challenge created by the AIDS pandemic and the resulting impact on productivity across many sectors including agriculture, industry, service and the public sectors, it is clear that LDCs must to plan for and implement strategies that promote wider opportunities for the workforce and management to mitigate the decline in productivity.

Key actions will revolve around increased efforts to protect existing human capacities. These include strategies especially tailored for the informal sector workforce, such as prevention programmes and making ARV therapy available at affordable and sustainable costs.

In order to curb the impact of the pandemic on their human and institutional capacities and consequently their private and public enterprises, LDCs and their partners will need to apply these strategies early. If these strategies are pursued vigorously the crisis can be mitigated, thus improving the chances of achieving the MDGs.

Research in mining areas of southern Africa shows that migrant mine workers are two and a half times more likely to be HIV-positive than non-migrant workers. Thus, policies that allow migrant workers to move with their families can limit the spread of the virus and reduce the impact of HIV among miners and other migrant workers.

Some enterprises have already understood the human capacity challenge and are now training two staff members for each position in order to avoid disruption in production when staff members fall ill with AIDS. Widespread introduction of these experiences as policy options will assist LDCs in facing these capacity challenges.

Picture:
A small business Gambian entrepreneur sells fruits and vegetables.

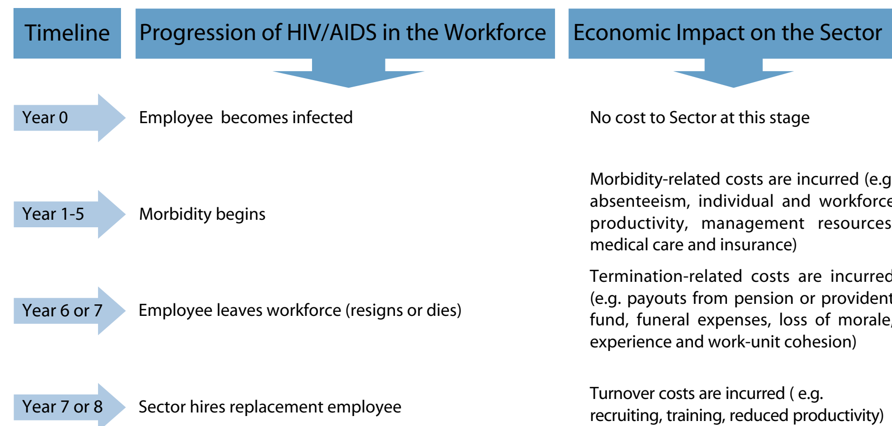
Picture:
In Bangladesh people publicly discuss capacity problems and regional development.

6. CAN LDCs COPE WITH THE CHALLENGE?

CHALLENGES

The full implications of AIDS are still ahead

Capturing the magnitude of the pandemic and its impact on economic growth and development is not easy. The lead-time between HIV infection and the onset of AIDS means that most LDCs have yet to experience the full implications of the pandemic. The progressive impact of HIV/AIDS on costs in a sector is illustrated in the figure below:



Source: UNECA

For LDCs such as Lesotho it is currently estimated that HIV/AIDS will curb annual economic growth, somewhere between one and one and a half percent. However, these estimates are made on the assumption of a surplus of manual labour. The long-term negative effect of HIV/AIDS on economic growth however, is expected to be much higher.

Serious impact on GDP and poverty

As AIDS took hold in Zambia, its economy shrank and GDP fell by more than 20 percent between 1980 and 1999 from US$ 505 to US$ 370. However, not all of this decrease can be directly attributed to AIDS. Concerning poverty, in Burkina Faso, for example, UNDP estimates that due to HIV/AIDS the proportion of people living in poverty will increase from 45 percent to nearly 60 percent by 2010.

In terms of diminishing economic growth, a vicious cycle occurs. The increased expenses for private companies associated with HIV/AIDS results in a decrease in company profits, which leads to lower capital investments, which in turn affects GDP per capita negatively, making it increasingly difficult for these countries to fulfil the commitments of the BPOA and for the international community to achieve the MDGs.

Brain drain exacerbates the crisis

An important factor deepening the human capacity problems in many LDCs and the consequent challenge to economic development is the issue of loss of man power, expertise and skills to more developed countries. The effects penetrate all economic sectors, though some sectors are harder hit than others. However, the issue is especially important to the health sector, which is a key player in any programme to bring treatment and care to broader segments of the population. The issue seriously contributes to the present capacity crisis in the health sector in many LDCs. For example, Zambia lost all but 50 of 600 doctors trained since independence.

The challenges are also affecting the private sector, which might see key staff such as engineers and information technology professionals leave for more lucrative employment abroad.

RESPONSES

HIV/AIDS needs to feature more dominantly in economic strategies as a cross-sector concern, specifying the respective roles and accountabilities of all sectors and levels of government, as well as civil society and the private sector. In many LDCs, HIV/AIDS is the single biggest obstacle to economic growth and reducing poverty. HIV/AIDS prevention and treatment need to be prioritized in national strategies for economic development and national poverty reduction strategies.

The brain drain issue should also be addressed in innovative ways. Obviously, neither the public nor the private sector in LDCs will be able to compete with developed countries' benefits and salaries. Thus, LDCs will have to combine financial and non-financial incentives, including re-skilling prospects to improve job satisfaction. LDCs also need to proactively engage in dialogue with developed countries to seek solutions to the ever increasing brain drain challenge. Strategies are also required to counter the tendency for many professionals across sectors to seek employment outside their professional area due to a combination of low pay and low job satisfaction.

7. WOMEN TAKE THE LEAD RESPONDING TO THE HUMAN CAPACITY CHALLENGE

CHALLENGES

Action is possible

This documents has underscored that AIDS is a terrible disease which has already led to the death and suffering of millions in several LDCs. By primarily taking its toll on the most productive age brackets, it also erodes the human and institutional capacities of societies. However, it is possible to take action and build new capacities that bring about societal transformation and that foster hope. It is possible to fight stigma, create awareness and eventually achieve fewer infections and better access to treatment. Despite the odds, women and men across LDCs are working to change the reality of their communities. They are responding by gradually building capacity that makes a difference. Not only are they are taking positive action, they are also moving others to join them by instilling hope, letting them feel they have a stake in the future. Women and men respond to the epidemic and decide to enable people to envision a better future and to make commitments they can act on.

In many of the most affected countries, women have learnt to cope and create hope by finding solutions in unique ways and by taking steps towards addressing and reversing the capacity challenge inflicted by HIV/AIDS.

Women make it happen

One example of a women taking formidable action is Ms. Catherine Phiri from Malawi. She proved that individuals can make a difference by supporting the development of a nation's human and institutional capacities. She founded the Salima HIV-AIDS Support Organization (SASO), which runs information programmes in communities and schools, promotes and distributes condoms, and mobilizes voluntary support and home-based care for AIDS patients. The organization also provides pre- and post-test HIV counseling and facilitates networking and information sharing. SASO volunteers nurture and care for more than 1,500 HIV/AIDS orphans in Malawi, ensuring in a modest way that the future human capacity of the country is safeguarded.

Catherine also helped found the Malawi Network of People Living with HIV/AIDS (MANET+) that support capacity development by engaging groups for people living with HIV/AIDS and helping overcome the shame and encouraging youth and adults to speak openly about the epidemic and show solidarity with those affected.

Finally, Ms. Phiri has also provided the government of Malawi with advice and technical support for the development of the Strategic Framework for the National Response to HIV/AIDS, the country's first comprehensive plan to mitigate the impact of the epidemic. This programme, supported by UNDP and the government, works through local leaders to provide all citizens with information, tools for prevention and promote support for people living with HIV/AIDS so that they can live longer, dignified and productive lives.

Ms. Pok Panhavichetr is another courageous woman. A former school teacher and survivor of the Khmer Rouge era, she has been leading Khana, the Khmer HIV/AIDS NGO Alliance since 1999. Khana was established in 1996 to build capacity among Cambodian NGOs, enabling them to respond to the HIV/AIDS epidemic. Khana supports a wide range of NGOs, implementing HIV/AIDS projects, building their capacities to manage projects and scale-up activities.

Under the leadership of Ms. Panhavichetr, Khana has built capacity of over 40 NGOs serving most of the country from remote provinces to city centers such as Phnom Penh and Sihanouk Ville. Some of the NGOs apply their increased know-how and capacity to provide care and support of people living with and affected by HIV/AIDS, while others focus mainly on prevention and community-based care activities primarily in rural areas of the country.

The people influenced and capacities developed continue to grow thus helping to increase the ability of the country's NGOs to prevent HIV and provide care and treatment to people living with HIV/AIDS.

These individual successes are serving as beacons at hope for many others.

8. HOPE AND RESULTS

HIV/AIDS, a development issue

Clearly, in order for LDCs to fulfil the commitments of the BPOA and to achieve the MDGs, both high and low prevalence countries need to maximize their human and institutional capacities. This can be approached through vigorous planning and taking early action to address the complex yet critical policy issues outlined below.

Workplace action

Supporting workplace prevention programmes for employees and management must become a priority investment. So should providing health care in workplace settings, and endorsing policies of non-discrimination. The ILO Code of Practice on HIV/AIDS and the world of work is a framework for action that can be used to establish policy development principles, and practical programming guidance. Through such forward looking actions countries will be able to limit the scope of the emerging human and institutional capacity crises.

Responding to the increased impact of HIV/AIDS on women and girls

Targeted prevention programmes such as advocating policies limiting school fees for affected families will provide considerable mitigation for households. Moreover, it will improve the chances of children, especially girls, from AIDS-affected families to stay enrolled. Additionally, securing human rights, including the right to inherit family property by women, is a clear action that will benefit women as well as children in the long run. In most countries, the support of civil society organisations and NGOs are critical to implementing these policies successfully.

Care and treatment options within the development context

Through direct action for prevention LDCs will be able to better protect their existing human capacities. However, introducing viable care and treatment programmes will protect the knowledge, skills and know-how of those who are infected, but do not currently have access to workplace programmes. While these are important, policies should be developed to mitigate the wider social and economic impact of the pandemic, enabling LDCs to decrease the negative effects on future generations. Priority should be given to mitigate the impact of the pandemic on orphans and other vulnerable children, especially with regard to protecting them from exploitation, abuse, and HIV/AIDS, while securing their continued school enrolment.

Addressing education and training

Initiatives with regard to training and education that maintain national capacity should be given priority. LDCs can adopt innovative approaches to capacity building including training of replacement staff and scaling-up existing educational efforts. Developing strategies to shorten the time needed to educate basic service providers is also a well tested approach, which ought to be further explored as policy for affected countries.

Mitigating migration of the workforce

In a number of LDCs, policies responding to the brain drain challenge will add additional value to capacity protecting initiatives. As such, LDCs can combine strategies of non-financial incentives and financial strategies to improve job satisfaction among workers to address the pull-effect from recipient countries.

Turning hope into results

Finally, most LDCs are in a position to turn hope into sustainable results by taking advantage of the growing international focus on HIV/AIDS and the related human capacity challenge. Active advocacy must be undertaken for LDCs to make strategic decisions now and take early action irrespective of the current stage and perceptions of the HIV/AIDS epidemic in their individual countries.

Picture:
Students participate in an HIV/AIDS awareness class. Adolescents, like these students, are a major target group for HIV awareness activities.

LEAST DEVELOPED COUNTRIES

1. Afghanistan
2. Angola
3. Bangladesh
4. Benin
5. Bhutan
6. Burkina Faso
7. Burundi
8. Cambodia
9. Cape Verde
10. Central African Republic
11. Chad
12. Comoros
13. Democratic Republic of Congo
14. Djibouti
15. Equatorial Guinea
16. Eritrea
17. Ethiopia
18. Gambia
19. Guinea
20. Guinea-Bissau
21. Haiti
22. Kiribati
23. Lao People's Democratic Republic
24. Lesotho
25. Liberia
26. Madagascar
27. Malawi
28. Maldives
29. Mali
30. Mauritania
31. Mozambique
32. Myanmar
33. Nepal
34. Niger
35. Rwanda
36. Samoa
37. Sao Tome and Principe
38. Senegal
39. Sierra Leone
40. Solomon Islands
41. Somalia
42. Sudan
43. Timor-Leste
44. Togo
45. Tuvalu
46. Uganda
47. United Republic of Tanzania
48. Vanuatu
49. Yemen
50. Zambia

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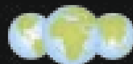

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