AIDS in the Context of Development

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Acronyms

AIDS	acquired immunodeficiency syndrome
AIDSCAP	AIDS Control and Prevention Project
CBO	community-based organization
DFID	Department for International Development (United Kingdom Government)
FAO	Food and Agriculture Organization of the United Nations
FOCUS	Families, Orphans and Children under Stress
GNP	gross national product
HDI	Human Development Index (UNDP)
HIPC	Heavily Indebted Poor Country
HIV	human immunodeficiency virus
ICRW	International Center for Research on Women
IDU	intravenous drug user
IGAC	Insiza Godlwayo AIDS Council
ILO	International Labour Organization
IMF	International Monetary Fund
KAP	knowledge, attitude and practice
MAP	Monitoring the AIDS Pandemic
NACP	National AIDS Control Programme
NGO	non-governmental organization
OPEC	Organization of Petroleum Exporting Countries
PTM	Pink Triangle Malaysia
SAP	structural adjustment programme
STD	sexually transmitted disease
TASO	The AIDS Support Organization
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNRISD	United Nations Research Institute for Social Development
USAID	United States Agency for International Development
WHO	World Health Organization
WHO/GPA	World Health Organization/Global Programme on AIDS

Acknowledgement

Foreword

Social and economic development are essential elements in the battle against AIDS. As the history of other devastating epidemics has shown, vulnerability is magnified by poverty, discrimination and despair. And people's capacity to deal with the threat of disease is fundamentally shaped by the social and economic conditions in which they live.

A vigorous public response to HIV/AIDS goes hand in hand with wide-ranging efforts to improve levels of living for the majority of the population of the developing world. Infection rates will fall, and care improve, when many more people are able to find decent work without leaving their families and communities; when women are empowered; when living standards increase, generated by renewed economic growth and rising wages; when the quality and coverage of the public health and education systems improve significantly; and when new opportunities are created for civic action in a tolerant and democratic context.

In the following pages, Joseph Collins and Bill Rau remind us of the desperate economic and social conditions that form the backdrop for the spread of AIDS in many parts of the developing world. They highlight important responses by local people, who are dealing with the epidemic in innovative ways. And they ask hard questions about the effectiveness of approaches currently underlying some national and international HIV/AIDS programmes.

The paper closes with a partial agenda for further social science research on AIDS in the context of development. The kind of research that leads to policy and programme decisions deserves high priority, and UNAIDS and UNRISD are committed to fostering its development and application.

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Summary/Résumé/Resumen

Summary

The AIDS pandemic is destroying the lives and livelihoods of millions of people around the world. An estimated 15,000 people are being infected every day, and the rate is set to rise. The situation is worst in regions and countries where poverty is extensive, gender inequality is pervasive, and public services are weak. In fact, the spread of HIV/AIDS at the turn of the twenty-first century is a sign of maldevelopment—an indicator of the failure to create more equitable and prosperous societies over large parts of the world.

This paper was commissioned by UNRISD, in collaboration with UNAIDS, to provide background for new comparative research on HIV/AIDS as a problem of development. Moving away from an epidemiological or behavioural focus on the pandemic, the essay begins by considering AIDS in the context of widespread and worsening poverty. Two strategies adopted by desperate people, attempting to improve their income, are particularly conducive to the spread of HIV/AIDS. The first is migration in search of work, whether within countries or across borders. The second is poverty-driven commercial sex work. Both place men and women in particularly high-risk situations, in which institutions providing normal support for stable family relations are absent. And both would be largely obviated if adequate opportunities for making a living were available at home.

For some, HIV/AIDS infection is the first major disaster in their lives. But for many more, the disease is just an additional problem on top of many others. The paper discusses the series of shocks which, during the past few decades, have seriously exacerbated the already precarious living conditions of large numbers of people and made them more susceptible to disease. In addition to natural disasters, these shocks include debt crises and structural adjustment programmes that have intensified economic recession, reduced employment and limited the coverage and quality of social service provision in many parts of the developing world. Wars and civil violence have further weakened economies, uprooted populations and diverted much-needed resources from health care. It is important to realize that, in this context, taking care to avoid HIV/AIDS may seem a less immediate concern for many people than simple survival.

From the beginning of the AIDS epidemic, NGOs and community groups have played a critical role in dealing with it. Their importance has been acknowledged by governments, donors and international agencies, which have provided limited, but much-needed, support. Nevertheless, efforts by the broader national and international community to learn from popular initiatives and to adapt their own programmes accordingly have been only partially successful. The third section of the paper by Collins and Rau therefore provides examples of vigorous community responses to the pandemic, and the fourth looks critically at three interrelated approaches formulated by public health and donor agencies to expand and improve their efforts: integration of HIV/AIDS prevention and care with existing sectoral programmes; mainstreaming of prevention and care into normal bureaucratic activities (including planning, budgeting and evaluation); and scaling up effective initiatives to cover a wider area or a larger number of people.

A central conclusion of their study is the importance of understanding not only the *content* of successful programmes, but also the *process* through which they have been developed. If the HIV/AIDS epidemic is to be brought under control, networks of social solidarity and broad-based political action must be strengthened. And opportunities for a decent livelihood must improve. At the heart of this effort is recognition of the skills, resources and knowledge of all groups—men and women, young and old, impoverished and powerful. Top-down, technocratic responses are unlikely to be effective in meeting the extraordinary challenges of the rapidly advancing pandemic.

The paper ends with suggestions for further social science research on HIV/AIDS and development. This includes documenting and analysing global processes that drive the pandemic, so that HIV/AIDS can be integrated into international debates on major development issues. Thus it is important to ask what changes in global trade and financial policy would be required to ensure a renewal of economic growth in developing countries, and what changes in national policies would be necessary to improve the distribution of benefits from growth. It is also extremely important to evaluate global development goals, including those agreed by the OECD Development Assistance Committee and others set at international summits, in the light of the worsening pandemic. It is likely that HIV/AIDS will be the biggest obstacle to achieving these goals—and in fact that it will not be possible to meet them at all unless there is a much more effective response to AIDS.

At national and local levels, new social science research—closely linked to the needs of policy makers and advocates—is urgently needed on the progress of the pandemic in specific circumstances: it is important to know who is affected, why and how; and to devise ways to lessen the vulnerability of particular groups. Although significant efforts have been made to document the social and economic impact of AIDS in some regions and communities, a great deal remains to be done.

It is also important to explore the social, political and institutional factors that seem to have made some national responses to HIV/AIDS more effective than others. Improving the debate on health sector reform, by relating it squarely to the issue of HIV/AIDS, is central to this effort. What elements of recent reform experiences have had a detrimental effect on ability to deal with the epidemic in particular countries? And what steps would be required to improve the response to HIV/AIDS?

Finally, new analysis of concrete attempts by community groups and NGOs to deal with the epidemic is essential. By working closely with these groups, researchers can help them analyse the problems they face. At the same time, research can play an important role in building broader networks for the exchange of experiences and, ultimately, for facilitating the comparative analysis of responses to HIV/AIDS in different social contexts.

Additional suggestions for future work will be found in the paper, which also contains a bibliography chosen for its relevance to HIV/AIDS in a development context.

Since 1970, Joseph Collins (Jcollins@cruzio.com) has researched and written about world hunger and other issues in inequitable development. He is the co-founder of the Institute for Food and Development Policy. His books include **Food First, World Hunger: Twelve Myths**, and **Chile's Free-Market Miracle: A Second Look**. Since 1994 he has been a consultant in community-based responses to HIV/AIDS and HIV/AIDS policy issues in a number of countries in Africa, Latin America and Asia.

Bill Rau (brau42@yahoo.com) has worked on development issues for over 30 years and on policy and socioeconomic themes relating to HIV/AIDS for eight years. Currently, he works as an independent consultant on HIV/AIDS and policy process issues. He is the author of **From Feast to Famine** and numerous studies on development processes and outcomes.

Résumé

La pandémie du sida détruit les vies et les moyens de subsistance de millions d'individus dans le monde. Quelque 15 000 personnes sont chaque jour infectées, et ce taux ne fait qu'augmenter. La situation est pire dans les régions et les pays où la pauvreté est étendue, l'inégalité des sexes frappante et les services publics faibles. En fait, la progression du VIH/sida au début du vingt-et-unième siècle est un signe de mauvais développement, un indicateur de l'incapacité de créer des sociétés plus équitables et plus prospères dans une grande partie du monde.

Cette étude a été commanditée par l'UNRISD, en collaboration avec l'ONUSIDA, afin de servir de toile de fond à une nouvelle recherche comparative sur le VIH/sida en tant que problème de développement. En s'éloignant d'une approche épidémiologique ou behavioriste de la pandémie, le rapport commence par examiner le sida dans le contexte d'une pauvreté très répandue, qui ne fait qu'empirer. Deux stratégies adoptées par des gens désespérés, qui tentent d'améliorer leurs revenus, sont particulièrement propices à la progression du VIH/sida. La première est la migration en quête d'un travail, au sein d'un même pays ou à travers les frontières. La deuxième est la prostitution motivée par la pauvreté. Ces deux stratégies exposent grandement hommes et femmes à des risques, en l'absence d'institutions fournissant un soutien normal en vue de relations familiales stables. Elles auraient été toutes deux largement évitées s'il existait des perspectives satisfaisantes de gagner sa vie chez soi.

Une infection à VIH/sida est pour certains la première grande catastrophe de leur vie. Mais pour de nombreux autres, ce n'est qu'un souci supplémentaire venant s'ajouter à une longue liste de problèmes. Cette étude examine la série de chocs qui, durant les quelques décennies passées, ont gravement exacerbé les conditions de vie déjà précaires d'un grand nombre de personnes et les ont rendues plus vulnérables aux maladies. Outre les fléaux naturels, ces chocs comprennent les crises de la dette et les programmes d'ajustement structurel qui ont aggravé la récession économique, réduit l'emploi et limité la couverture et la qualité des prestations sociales dans plusieurs régions du monde en développement. Les guerres et la violence civile ont de plus affaibli les économies, déraciné les populations et détourné de leur but les

ressources si nécessaires aux soins de santé. Dans ce contexte, il est important de comprendre que, pour nombre de personnes, s'efforcer d'éviter le VIH/sida peut sembler un sujet de préoccupation moins immédiat que la simple survie.

Les ONG et les groupes communautaires ont joué, dès le moment où l'épidémie du sida a éclaté, un rôle essentiel pour y faire face. Leur importance a été reconnue par les gouvernements, par les donateurs et par les organismes internationaux qui out fourni un soutien limité, mais essentiel. Néanmoins, les efforts plus généraux de la communauté nationale et internationale pour tirer des leçons des initiatives populaires et adapter leurs propres programmes en conséquence n'ont été fructueux qu'en partie. La troisième partie de cette étude par Collins et Rau fournit ainsi des exemples de réactions vigoureuses de la part de la communauté face à la pandémie, et la quatrième examine de manière critique les trois approches étroitement liées formulées par les organismes de santé publique et les bailleurs de fonds pour élargir et accroître leurs efforts: l'intégration de la prévention et des soins du VIH/sida dans les programmes sectoriels existants, leur prise en compte dans les activités bureaucratiques normales (notamment la planification, les prévisions budgétaires et l'évaluation), ainsi que l'augmentation proportionnelle d'initiatives efficaces afin de couvrir une région plus vaste ou un nombre plus grand de personnes.

L'une des conclusions centrales de leur étude est qu'il est important de comprendre non seulement le *contenu* des programmes fructueux, mais également le *processus* par le biais duquel ils ont été mis au point. Pour que l'épidémie du VIH/sida soit endiguée, des réseaux de solidarité sociale et une action politique généralisée doivent être renforcés. De même, les perspectives pour des moyens de subsistance décents doivent être améliorées. La reconnaissance des capacités, des ressources et des connaissances de tous les groupes, hommes et femmes, jeunes et vieux, pauvres et puissants, est au cœur de cet effort. Les réponses de type technocratique, du haut vers le bas, ont peu de chances de se révéler efficaces, face aux défis inouïs de la pandémie qui progresse rapidement.

L'étude s'achève en fournissant des suggestions pour de nouvelles recherches en sciences sociales sur le VIH/sida et le développement. Cela comprend l'inventaire et l'analyse des processus globaux qui font avancer la pandémie, afin que le VIH/sida puisse être intégré dans les débats internationaux sur les principales questions de développement. Il est par conséquent important de se demander quelles modifications seraient requises dans le commerce mondial et dans les politiques financières afin de garantir un renouveau de la croissance économique dans les pays en développement, et quels changements dans les politiques nationales seraient nécessaires afin d'améliorer la distribution des bénéfices résultant de la croissance. Il est également extrêmement important d'évaluer les objectifs globaux en matière de développement, notamment ceux fixés par le Comité d'aide au développement de l'OCDE et les autres objectifs arrêtés lors de sommets internationaux, à la lumière d'une pandémie qui ne fait que s'aggraver. Il est probable que le VIH/sida est le plus grand obstacle à l'accomplissement de ces objectifs et qu'il ne sera pas possible en fait de les réaliser, à moins de disposer d'une réaction beaucoup plus efficace au sida.

Aux niveaux local et national, de nouvelles recherches en matière de sciences sociales—des recherches étroitement liées aux besoins des dirigeants et des militants—sont instamment requises concernant les progrès de la pandémie dans des circonstances précises: il est important de savoir qui est affecté, pourquoi et comment; et de concevoir des moyens de diminuer la vulnérabilité de certains groupes. Bien que des efforts significatifs aient été déployés pour enregistrer l'effet social et économique du sida dans certaines régions et communautés, le chemin à parcourir est encore long.

Il est également important d'explorer les facteurs sociaux, politiques et institutionnels qui semblent avoir rendu certaines réactions nationales au VIH/sida plus efficaces que d'autres. Améliorer le débat sur la réforme du secteur de la santé, en le liant complètement à la question du VIH/sida, est essentiel à cet effort. Quels éléments des expériences de réforme récente ont eu un effet néfaste sur la capacité de faire face à l'épidémie dans certains pays? Et quelles mesures devraient être requises pour améliorer la réaction au VIH/sida?

Enfin, une nouvelle analyse des tentatives concrètes de la part des groupes communautaires et des ONG pour faire face à l'épidémie est cruciale. En collaborant étroitement avec ces groupes, les chercheurs peuvent les aider à analyser les problèmes auxquels ils sont confrontés. Dans le même temps, la recherche peut jouer un rôle important dans l'établissement de vastes réseaux pour échanger des expériences et, en fin de compte, pour faciliter l'analyse comparative des réactions au VIH/sida dans des contextes sociaux différents.

On trouvera des suggestions supplémentaires pour des travaux futurs dans cette étude qui comprend également une bibliographie choisie en fonction de sa pertinence par rapport au VIH/sida dans un contexte de développement.

Depuis 1970, Joseph Collins (Jcollins@cruzio.com) s'est attaché à étudier et écrire sur des questions liées au développement inégal et plus spécialement sur la faim dans le monde. Il est co-fondateur de l'Institute for Food and Development Policy. Il a notamment écrit **Food First, World Hunger: Twelve Myths**, et **Chile's Free-Market Miracle: A Second Look**. Il est, depuis 1994, consultant pour les questions politiques touchant au VIH/sida dans de nombreux pays en Afrique, Amérique latine et Asie. Il travaille également sur les réponses des communautés de base face à ce fléau.

Bill Rau (brau42@yahoo.com) s'est attelé aux questions du développement durant plus de trente ans, ainsi qu'aux politiques et aux thèmes socioéconomiques liés au VIH/sida depuis huit ans. Il est actuellement un consultant indépendant pour les questions et les processus politiques liés au VIH/sida. Il est l'auteur de **From Feast to Famine**, ainsi que de nombreuses études consacrées au processus ainsi qu'aux résultats du développement.

Resumen

La pandemia del SIDA está destruyendo la vida y los medios de vida de millones de personas en todo el mundo. Se calcula que cada día se infectan aproximadamente 15.000 personas y este índice aumentará. La situación es más grave en las regiones y países con una pobreza extensa, una desigualdad generalizada en la distinción por género y unos servicios públicos precarios. En realidad, la propagación del VIH/SIDA en el umbral del siglo XXI es señal de un desarrollo negativo—un indicador de la incapacidad de crear sociedades más equitativas y prósperas en gran parte del mundo.

UNRISD encargó la realización de este estudio, en colaboración con ONUSIDA, a fin de facilitar antecedentes para la nueva investigación comparativa del VIH/SIDA como problema del desarrollo. Alejándose de un planteamiento epidemiológico o conductual de la pandemia, este estudio empieza considerando el SIDA en el marco de una pobreza generalizada y cada vez mayor. Dos estrategias adoptadas por personas desesperadas, al intentar mejorar sus ingresos, conducen particularmente a la propagación del SIDA. La primera es la migración en busca de trabajo, ya sea a nivel nacional o transfronterizo. La segunda es la prostitución impulsada por la pobreza. Ambas conducen a los hombres y las mujeres a situaciones de alto riesgo, en las que no hay instituciones que ofrezcan un apoyo normal a las relaciones familiares estables. Y ambas se soslayarían considerablemente si se facilitaran a estas personas oportunidades adecuadas para ganarse la vida en casa.

Algunos consideran que la infección por el VIH/SIDA es el principal y primer desastre de sus vidas. Pero para otros muchos la enfermedad es solamente uno de sus muchos problemas. El estudio trata los diversos impactos que, en las últimas décadas, han exacerbado las condiciones de vida ya precarias de muchas personas, haciéndolas más propensas a la enfermedad. Además de los desastres naturales, estos impactos incluyen crisis de deuda y programas de ajuste estructural que han intensificado la recesión económica, reducido el empleo y limitado la cobertura y calidad de la prestación de servicios sociales en muchas zonas del mundo en vías de desarrollo. Las guerras y la violencia civil han debilitado aún más las economías, han desarraigado a las poblaciones y han desprovisto al sector de la atención de la salud de recursos muy necesarios. En este contexto, es importante comprender que, para muchas personas, preocuparse por evitar el VIH/SIDA puede parecer menos importante que la simple supervivencia.

Desde los comienzos de la epidemia del SIDA, las ONG y los grupos comunitarios han jugado un papel muy importante en la lucha contra la misma. Su importancia ha sido reconocida por gobiernos, donantes y organismos internacionales, cuyo apoyo ha sido limitado, pero muy necesario. No obstante, los esfuerzos desplegados por la comunidad nacional e internacional más amplia para aprender de las iniciativas populares y, en consecuencia, adaptar sus propios programas, solamente han tenido un éxito parcial. Por tanto, la tercera sección del estudio de Collins y Rau contiene ejemplos de las enérgicas respuestas de la comunidad a la pandemia y, en la cuarta sección, se examinan críticamente tres planteamientos interrelacionados formulados por organismos de salud pública y donantes para ampliar y mejorar sus esfuerzos, es decir, la integración de la prevención del VIH/SIDA y su atención en los programas sectoriales actuales; la incorporación de la prevención y la atención en las actividades burocráticas habituales

(inclusive la planificación, presupuestación y evaluación); y la ampliación de iniciativas eficaces para abarcar una zona más extensa o a un mayor número de personas.

Una conclusión central de su estudio es la importancia que reviste comprender no sólo el *contenido* de los programas de éxito, sino su *proceso* de elaboración. Si desea controlarse la pandemia del VIH/SIDA, deben reforzarse las redes de solidaridad social y la acción política de base amplia, y deben mejorar las oportunidades de unos medios de vida decentes. La clave de este esfuerzo es el reconocimiento de las capacidades, los recursos y los conocimientos de todos los grupos—hombres y mujeres, jóvenes y viejos, pobres y ricos. Es improbable que las respuestas tecnócratas verticalistas sean eficaces a la hora de hacer frente a los grandes desafíos de esta pandemia que se propaga rápidamente.

Al final del estudio se propone que las ciencias sociales realicen una investigación más profunda del VIH/SIDA y el desarrollo. Esto incluye documentar y analizar los procesos generales que impulsan la pandemia, de modo que el tema del VIH/SIDA pueda integrarse en los debates internacionales sobre las principales cuestiones del desarrollo. Así, es importante preguntar qué cambios sería necesario introducir en el comercio y la política financiera mundiales para asegurar un nuevo crecimiento económico en los países en desarrollo, y qué cambios deben operarse en las políticas nacionales para mejorar el reparto de los beneficios del crecimiento. También reviste gran importancia evaluar los objetivos mundiales en materia de desarrollo, inclusive los acordados por el Comité de Asistencia para el Desarrollo de la OCDE y otros organismos en las cumbres internacionales, a la luz de la agravación de la pandemia. El VIH/SIDA posiblemente sea el mayor obstáculo para alcanzar estos objetivos—y en realidad no podrán lograrse, salvo que se responda al SIDA de un modo mucho más eficaz.

A nivel nacional y local, urge que las ciencias sociales realicen una nueva investigación—estrechamente vinculada a las necesidades de los responsables de la formulación de políticas y los defensores—sobre los progresos de la pandemia en circunstancias concretas. Es importante saber a quiénes afecta, cómo y por qué, al igual que idear modos de reducir la vulnerabilidad de determinados grupos. Aunque se han desplegado importantes esfuerzos para documentar los impactos sociales y económicos del SIDA en algunas regiones y comunidades, aún queda mucho por hacer.

También es importante estudiar los factores sociales, políticos e institucionales que parecen haber logrado que algunas respuestas nacionales al VIH/SIDA sean más eficaces que otras. Para este programa es fundamental mejorar el debate sobre la reforma del sector de la salud, relacionándolo debidamente con la cuestión del VIH/SIDA. ¿Qué elementos de las últimas experiencias de reforma han afectado negativamente la capacidad de enfrentarse a la pandemia en países concretos? Y, ¿qué medidas deberían adoptarse para mejorar la respuesta al VIH/SIDA?

Por ultimo, es fundamental analizar nuevamente los esfuerzos concretos desplegados por los grupos comunitarios y las ONG para hacer frente a la epidemia. Al trabajar en estrecha colaboración con estos grupos, los investigadores pueden ayudarles a analizar los problemas a

que se enfrentan. Al mismo tiempo, la investigación puede desempeñar un papel importante en la construcción de redes más amplias para el intercambio de experiencias y, en última instancia, para facilitar los análisis comparativos de las respuestas al VIH/SIDA en diferentes contextos sociales.

Este estudio contiene otras propuestas para un trabajo futuro, e incluye igualmente una bibliografía elegida por su relación con el VIH/SIDA en un marco de desarrollo.

Joe Collins (jcollins@cruzio.com). Desde 1970, ha hecho investigación y escrito sobre el hambre en el mundo, y otros asuntos sobre la desigualdad en el desarrollo. Es cofundador del Institute for Food and Development Policy. Sus libros incluyen **Food First, World Hunger: Twelve Myths**, y **Chile's Free-Market Miracle: A Second Look**. Desde 1994 ha sido consultor en respuestas comunitarias de base para VIH/SIDA y en políticas sobre VIH/SIDA en varios países de Africa, América Latina y Asia.

Bill Rau (brau42@yahoo.com) ha estudiado las cuestiones de desarrollo durante más de 30 años y los temas políticos y socioeconómicos relacionados con el SIDA durante 8 años. Actualmente, trabaja como asesor independiente en materia de VIH/SIDA y cuestiones de procesos políticos. Es autor de **From Feast to Famine** y de numerosos estudios sobre los procesos y resultados del desarrollo.

Introduction

Since the beginning of the pandemic, over 50 million people have become infected with human immunodeficiency virus (HIV); about 34 million are living and over 18 million have died from acquired immunodeficiency syndrome (AIDS). HIV infects an average of 15,000 persons a day, about 10 every minute. Almost 95 per cent live in developing countries. The proportion of women getting infected is becoming more and more significant—with 55 per cent of the infections in sub-Saharan Africa in 1999 occurring among women.[1]

Every year the disease takes new directions. South Africa now has the fastest growing epidemic. The number of HIV-infected people is rapidly increasing in Asia—India alone has over 4 million people living with HIV/AIDS, the largest number in any single country. In Eastern and Central Europe the epidemic is concentrated in risk groups, such as intravenous drug users, with subsequently alarming HIV rates.

From the late 1980s onward, infant mortality has seen an unprecedented increase in some countries through transmission from mother to child. The consequence of increased deaths of young people in some countries of Africa has been to decrease life expectancy at birth by 15 to 20 years in southern Africa, and 5 to 10 years in other parts of sub-Saharan Africa,[2] effectively wiping out decades of effort toward development in these countries. Infection rates are particularly high among young adults—who constitute the bulk of the workforce and of the current generation of parents.

Against this reality of a rapidly spreading epidemic in many countries, some two decades of prevention interventions have met with limited success. Whatever successes there might be are not to be lightly dismissed. The reasons for the successes, however, are not well understood and thus not readily applicable elsewhere. To date, most prevention efforts have focused on increasing individual awareness about risks of transmission and promoting individual risk reduction through a variety of means. Far less attention has been given to either understanding or designing prevention programmes in light of the social and economic context in which individuals live. It is commonplace for HIV/AIDS programme managers to acknowledge poverty as a causative factor, but to then say that "poverty" is beyond the scope of their programmes. Analyses hardly exist of the causes and manifestations of impoverishment as factors contributing to HIV/AIDS transmission. Thus, there is little conceptual or programmatic guidance for moving beyond the simple acknowledgment of poverty as a contributing factor in HIV/AIDS risk.

This paper discusses HIV/AIDS not as an isolated disease event, controllable through individual actions. Rather, it looks at HIV/AIDS in a socioeconomic, historical and political context. We argue that economic and social changes over the past three decades, in particular, have created an enabling environment that places tens of millions of people at risk of HIV infection and makes effective governmental and non-governmental responses more difficult.

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[1]   Data from UNAIDS.

[2]   **Healthy Life Expectancy**, WHO, 2 June 2000.

At the same time, there is substantial analysis from development studies on which to draw in designing socially relevant HIV/AIDS prevention and care programmes. Also, numerous local initiatives provide substantive learning models for blending HIV/AIDS into a wider developmental context that can sustain an enabling environment for improvements in social welfare, including reducing the risks and impacts of HIV/AIDS.

Despite the relatively lengthy bibliography in this paper, the reality is that very few researchers have focused on the socioeconomic dimensions of HIV/AIDS. In order to encourage more such research, we have suggested a number of topics for further study and discussion.

The Socioeconomic Context Driving the Pandemic

HIV/AIDS is a development issue

From the outset, policymakers as well as the concerned public worldwide have categorized the HIV/AIDS pandemic as a medical and health problem. Virtually all of the financial resources mobilized in the name of combating the pandemic have been focused on either biomedical issues or behaviour.

In the latter case, HIV/AIDS prevention efforts have sought to change the behaviours of individuals, paying too little (if any) attention to the socioeconomic context in which people live. Countless surveys of people's knowledge, attitudes, beliefs and practices point to a persistent and dangerous gap between many people's awareness, attitudes and knowledge with regard to HIV/AIDS and their practices. Is it not most likely that this gap between what people know and how they act is sustained by the social and economic realities that constrain individual actions (Painter, 1996)?

Responses to the epidemic illustrate this gap. On one level, local activists have sought to deal with the impact of the HIV/AIDS epidemic on individuals and social groups. As the epidemic grew, activists linked up with public health authorities in order to draw in more responses. The public health response, however, has taken forms and followed directions heedless of (if not in conflict with) socioeconomic realities. Top-down analyses and decisions about prevention have shaped public health responses. While the urgency spawned by an epidemic often requires quick decisions and implementation, and while the HIV/AIDS epidemic is of urgent concern in many countries and to many social groups, HIV/AIDS is now too pervasive and too deeply embedded in society to be "managed" through top-down public health approaches alone. Placing the epidemic in the context of a set of development issues and drawing on the resources and experiences of local initiatives might at first appear to step back from the urgency demanded by an epidemic; but in fact, it is the only effective response.

This section seeks to bridge the gap between public health responses to HIV/AIDS and some of the social and economic realities of groups affected by the epidemic. It seeks to show that initiatives that seek to change behaviour are insufficient to stem the epidemic, for the determinants of the epidemic go beyond individual volition.

After almost two decades, only bits and pieces

A thorough review of the relevant literature[3] suggests that little work has been carried out on the socioeconomic context of the rise of the HIV/AIDS pandemic. What has been done has been almost exclusively by individual researchers, mostly in isolation from each other. Research, therefore, has not been co-ordinated and systematic; the result is what Desmond Cohen of the United Nations Development Programme (UNDP) has dubbed "bits and pieces".[4] As already stated, financial resources made available for this type of research appear to have been remarkably inadequate.

Disease and development before AIDS

Before the era of AIDS, we find some research on the development context of disease. Hughes and Hunter in their article **Disease and "Development" in Africa**, published in 1970, are thought to have coined the term "diseases of development" (Hughes and Hunter, 1970:443). They were part of a revisionist movement among historians of medicine, whose research challenged the prevailing paradigm that colonialism in Africa had ushered in a new public health era that freed the tropics from its high natural burden of infectious disease. The findings of revisionist researchers led to quite a different view of the impact of colonialism. Colonial "development"—Hughes and Hunter themselves used quotation marks—often spread disease, altered ecology, disrupted social relations, and created major public health problems.

In this perspective, disease is socially produced. As anthropologist Brooke Schoepf explains, "a biological event (such as the presence, introduction or evolution of a pathological agent) triggers disease which is amplified and given direction by the social forces set in motion by economic change" (Schoepf, 1991:750).

Two studies published by anthropologists in 1947 traced the spread of tuberculosis from the mining camps in South Africa throughout the southern half of the continent by migrant labourers returning to villages (Kuper, 1947 and Schapera, 1947). Schoepf provides several additional examples of the social production of disease in Zaire. In one, African men conscripted in 1918 to fight against German armies on the eastern border of the Belgian Congo returned to the mines with influenza. As the epidemic raged, the mine labour camps were half emptied, and survivors fleeing death carried the disease to their villages.

Schoepf presents additional historical cases containing elements relevant, she argues, to understanding the spread of HIV/AIDS and policies advocated to limit that spread. One, for instance, has to do with schistosomiasis (a severe endemic disease of humans marked by blood loss and tissue damage) in the rural hinterland of Lumbumbashi (colonial Elisabethville in the Belgian Congo), formerly the site of the Union Miniere du Haut-Katanga, a copper consortium of Belgian, British, US and South African capital. In order to provide hydroelectric power for running the copper mines and smelters, a dam was built on the Lufira River. The gently sloping valley above the falls became a shallow catchment basin. The basin was ideal for reproducing snails that bore bilharzia, a parasitic infection that leads to severe pain and eventually death of

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[3] See Bibliography.
[4] At a seminar on the issues raised in the first draft of this paper, UNAIDS, Geneva, 31 May 2000.

the human host. Colonial researchers monitored the spread of bilharzia over several decades. Schistosomiasis became endemic throughout the area and by the 1960s constituted a major health problem. The spread of schistosomiasis was attributed not only to labour migration that had introduced the disease-causing parasites, but to the inhabitants' "cultural practices" that spread the vector locally. Schoepf comments:

> What were these cultural practices? People used the shallow lake as they formerly had used the flowing river: to catch fish, swim, wash clothes, bathe, and the like. Not having been effectively warned, they urinated in the water or defecated along the shore. Without preventive measures (a vaccine or molluscicides [an agent for destroying mollusks, such as snails]) or a safe cure to offer, researchers blamed the people whose situations of everyday life placed them at risk in the new conditions created by colonial mining development and labour migration.

The relevance of the development context

The different socioeconomic development realities of different countries appear to be highly relevant to understanding the spread of HIV. Josef Decosas (1996b:S69) sees it this way: "HIV has been with us for long enough to reveal global patterns of distribution which can be linked to currently accepted indicators of social development." By such indicators, he is referring to the Human Development Index (HDI), fashioned during the 1990s by the UNDP in its annual **Human Development Report**. The UNDP launched the HDI as a critique of the tradition, in vogue since "international development" was first discussed in the late 1940s, of measuring a country's development status solely by its economic performance and quantifying that performance in terms of economic output (gross national product (GNP) per capita). The HDI is a composite index constructed from four variables: life expectancy at birth, adult literacy rate, mean years of schooling, and an adjusted measure of per capita economic production. There is an emerging international consensus to accept the HDI as the most appropriate measure for gauging the relative status of a country's development, and to agree with the UNDP that "the purpose of development is to create an enabling environment for people to enjoy long, healthy and creative lives".

In 1996, Decosas grouped together countries with HDI values within a range of 0.05 units. He then plotted them in relation to the average estimated adult HIV prevalence. He observed a strong association (the correlation coefficient was –0.715) between developmental status and HIV prevalence: countries with relatively higher HDI values were countries of very low HIV prevalence. Decosas emphasized that it was not the case that the virus was only recently introduced into the countries with very low prevalence. Both the countries at the top of the HDI scale (primarily in Europe) and most countries at the low end of the scale (primarily in sub-Saharan Africa) have "mature" epidemics.

He went on to argue that the risks to countries or societies of experiencing serious AIDS epidemics are clearly not equal. The dramatic difference in HIV prevalence between, for instance, many European and sub-Saharan African nations could never be explained by whatever differences there might be in sexual behaviour patterns. "The only way this difference can be explained is by invoking a number of powerful co-factors that facilitate the transmission

of HIV" (Decosas, 1996b:S70). He views these co-factors as rooted in "uneven or dysfunctional social development" (Decosas, 1996b:S73).

Poverty and HIV/AIDS

Poverty is most often cited by those who do comment on the socioeconomic context of the spread of HIV. Poverty is seen as a key factor leading to behaviours that expose people to risk of HIV infections. Medical anthropologist Paul Farmer, who has worked extensively in Haiti, argues that poverty cannot be considered as just another co-factor alongside biological considerations, gender inequality and cultural considerations. "All of the biological factors predisposing girls and women to increased risk of infection—from chronic anemias to genital mutilation and early first coitus—are aggravated by poverty" (Simmons et al., 1996:53). Similarly, UNDP and UNAIDS argue that poverty aggravates other factors that heighten the susceptibility of women:

> A lack of control [by poor women] over the circumstances in which intercourse occurs may increase the frequency of intercourse and lower the age at which sexual activity begins. A lack of access to acceptable health services may leave infections and lesions untreated. Malnutrition not only inhibits the production of mucus but also slows the healing process and depresses the immune system (UNDP, 1992:4, see also UNAIDS, 2000c).

However, innumerable studies remind us that the relationship between poverty and HIV transmission is not simplistic.[5] While most people with HIV/AIDS are poor (World Bank, 1997:28),[6] many of the non-poor are also infected and affected.[7] In some countries of sub-Saharan Africa there is some very partial data indicating that the likelihood of HIV infection correlates positively with income, educational level and occupational status.[8] This is an area that needs research, especially since the World Bank (1997:207) and others think that this correlation might lessen over time; those with higher incomes, it is thought, have significantly fewer constraints to ceasing to engage in risk behaviours.

In **Infections and Inequalities,** Farmer (1999) analyses risk of infectious disease in terms not only of poverty but also of inequality, that is, "unequal social and economic positioning". Richard Wilkinson, in his research on health in industrial countries, also concludes that inequality is pivotal in determining health outcomes. In **Unhealthy Societies: The Afflictions of Inequality**, he writes: "It is now clear that the scale of income differences in a society is one of the most powerful determinants of health standards in different countries, and that it influences health through its impact on social cohesion" (Wilkinson, 1996). For Wilkinson, social cohesion is roughly equivalent to "community strength". In strong communities, people are more likely to be involved in social and voluntary activities, and individualism and the values

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[5] See UNAIDS/FAO, 1999 and UNAIDS, 2000b.

[6] The World Bank calculates, based on a knowledge of income distribution and infection rates across countries in sub-Saharan Africa, that many more poor people are infected than non-poor people and posits that such would be the case, although with less striking magnitudes, in other developing regions.

[7] It should never be forgotten, however, that poor people infected with HIV are considerably more likely to become sick and die faster than the non-poor since they are likely to be malnourished, in poor health, and lacking in health attention and medications.

[8] Communication from Desmond Cohen, UNDP HIV and Development Programme, May 2000. See also World Bank, 1997:207.

of the market are restrained by a social morality. Tony Barnett and Alan Whiteside pick up on Wilkinson's work. They hypothesize, however, that a society's susceptibility to HIV and vulnerability to the impact of HIV/AIDS are determined by the degree of social cohesion and the overall level of wealth. Societies with low social cohesion *and* low wealth will be most severely susceptible and vulnerable, according to their hypothesis (Barnett, Decosas and Whiteside, 2000:1098–1111).

The relationship between poverty and HIV/AIDS is "bi-directional":[9]

- Poverty is a factor in HIV transmission and exacerbating the impact of HIV/AIDS.
- The experience of HIV/AIDS by individuals, households and even communities that are poor can readily lead to an intensification of poverty and even push some non-poor into poverty. Thus HIV/AIDS can impoverish or further impoverish people in such a way as to intensify the epidemic itself.

The extent of impoverishment in the world today is truly staggering. According to an internationally adjusted standard of absolute poverty, sub-Saharan Africa has four times as many poor people as non-poor (World Bank, 1997:208). Around the globe, 1.2 billion people are forced to live on less than one dollar a day (World Bank, 2000a).

Poverty and gender are inextricably intertwined. Women and girls are disproportionately represented among the poor. Seventy per cent of the world's poor are women. It is *poor* women who are most susceptible to HIV infections, for gender alone does not define risk (Farmer, 1996:261–283).

The following paragraph by Jodi Jacobsen dramatizes the interconnectedness of poverty, gender and HIV/AIDS. It reads as if it had been written to describe HIV/AIDS in women; in fact she writes of poverty:

> Two out of three women in the world presently suffer from the most debilitating disease known to humanity. Common symptoms of this fast-spreading ailment include chronic anemia, malnutrition, and severe fatigue. Sufferers exhibit an increased susceptibility to infections of the respiratory and reproductive tracts. And premature death is a frequent outcome. In the absence of direct intervention, the disease is often communicated from mother to child, with markedly higher transmission rates among females than males. Yet, while studies confirm the efficacy of numerous prevention and treatment strategies, to date few have been vigorously pursued. The disease is poverty (Jacobson, 1992:3).

Impoverishment often results in undernourishment and the lack of hygienic living conditions, including clean water. Malnourished bodies are more susceptible to a whole range of illnesses and therefore infectious diseases, including those that are sexually transmitted.[10] Poor people also often lack access to health services. The appalling state of sexual health of the poor, especially very high rates of untreated sexually transmitted diseases and non-specific bacterial

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[9] This term (which we prefer) and "bi-causal" are used in some UNDP publications.

[10] Once infected with HIV, the onset of AIDS is likely to be quickened by malnutrition, repeated infection and unsanitary living conditions.

and parasitic vaginal infections among women is often cited as an important co-factor in the susceptibility of many women in sub-Saharan Africa to HIV infection. A population-based study of the women in a village in India found very high rates of genital infections. One of the poor women, it turns out, had gone to the clinic prior to the study and complained of "weakness". She was not examined but given only some vitamins. Again, gender and poverty are inextricably intertwined, compounding each other; in most countries, a poor woman is the least likely person to have access to proper medical attention. Even in receiving medical services, the likelihood of coming into contact with unsterile syringes is inversely proportional to one's social status.

Farmer writes: "Through myriad mechanisms, it [poverty] creates an environment of risk." He faults much of the writing on HIV/AIDS for obscuring the ways in which poverty drives so much of epidemic and instead focuses on "risk behaviors". For "these terms, unless carefully contextualized, also exaggerate individual agency, and leave unacknowledged and unexplained the ways in which large-scale social and economic factors structure risk for individuals and groups, particularly those who are systematically marginalized from power and from access to the goods, services, and opportunities which power ensures" (Simmons et al., 1996:54).

Perhaps more than anywhere else, the wealthiest country in the world (in which at least 20 per cent of the people nevertheless live in poverty) (UNDP, 1999b:149) highlights the fact that poverty is driving HIV infection. "Urban poverty in the United States has created the perfect machinery for the continued propagation of HIV," notes Robert Fullilove. "Inner city poor neighbourhoods often shelter a vigorous drug trade, numerous opportunities for strangers to engage in drug-mediated, unprotected sex, and numerous locations where these and other risk behaviours go virtually unchallenged."

In the United States, HIV has moved almost unimpeded through poor communities of colour. By the end of 1999, African Americans, who comprise approximately 12 per cent of the US population, made up more than 26 per cent of the country's poor and accounted for 37 per cent (CDC, 2000) of all reported cases of HIV/AIDS. In absolute numbers, blacks have outnumbered whites in new AIDS diagnoses and deaths since 1996 and in the number of persons living with AIDS since 1998 (CDC, 2000). The cumulative incidence of HIV/AIDS was more than 20 times higher for black women than for white women and seven times higher for Hispanic women (US Census Bureau, 2000).

Anthropologist Martha Ward, however, gives us an important reminder about any focus on ethnicity.

> The collection of statistics by ethnicity rather than by socioeconomic status
> obscures the fact that the majority of women with AIDS in the United States
> are poor. Women are at risk for HIV not because they are African-American
> or speak Spanish; women are at risk because poverty is the primary and
> determining condition of their lives (Ward, 1993a:414).

Farmer comments on "the strikingly patterned U.S. epidemic." "Understanding [it] is less a matter of knowing one's geography, and more a matter of understanding a limited number of events and processes—the 'synergism of plagues' discussed by Roderick Wallace—that range from unemployment to the destruction of houses by fires."[11]

If on a worldwide basis poverty constitutes the primary risk environment for HIV infection, should we not be asking what causes poverty? Nevertheless, this question is seldom raised now. For, while poverty is often cited in relation to HIV/AIDS, it has become something of a throwaway explanation. We can't do anything about poverty, we are told, so it makes more sense to concentrate on what we know best: individual behaviour change.

When we call people "poor" we are in danger of forgetting that they are made poor. Poor people are really *impoverished* people. They are impoverished by inequitable socioeconomic structures—on the household level, on the village level, on the national level, and on the international level of trade and commerce. This becomes clear as we look at AIDS as one in a series of "shocks" experienced by the majorities of people in developing countries.

Many poor people desperately seek out livelihoods that offer the promise of survival, or even something better than mere survival, for themselves and those who are dear to them. Often this involves migrating from their villages to towns and cities and other places where they hope to find employment. For some women the pressures of poverty may lead them to engage in sexual transactions in order to support themselves and their families. Poverty-driven migration for work and commercial sex work are two of the activities most commonly linked with risk for HIV infection. Therefore it is important to look more closely at them here.

Poverty-driven labour migration

In much of the underdeveloped world, migration is a key livelihood strategy of many millions of people, mostly young people and especially young men, who face the prospect of unending poverty in their home areas. They travel in search of jobs, some within their countries and others across international borders, some to towns and cities and others to plantations and mines.

The dislocation of so many millions from their rural homes stems from gross inequities in socioeconomic development. In many countries, the development paradigm, often imposed by and for colonial powers and pursued since by neo-colonial elites together with transnational corporations and international development agencies, has focused on exporting agricultural products and minerals. The plantations, mines and industries, though development enclaves from one point of view, have required and attracted massive quantities of labour from the traditional rural areas. In country after country, elite-controlled governments, often with international support, have pursued economic and social services policies that are urban-biased, favouring those who live and work in cities to the disadvantage of rural populations (Cohen,

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[11] Simmons et al. (1996:21), citing Roderick Wallace, "A synergism of plagues: 'Planned shrinkage,' contagious housing destruction and AIDS in the Bronx", **Environmental Research**, 47, 1988:1–33. Wallace examines the impact of urban decay initiated by the city government on the spread of HIV/AIDS among poor minority groups living in the Bronx, New York City.

1998c:4). Perhaps the most palpable measure of the inequalities in power in the countryside in most countries has been the concentration of land and other productive resources, from water to credit, in the hands of the minority. A 1978 survey in 20 Latin American and Asian countries revealed that the landless and near landless comprised 50 to 90 per cent of the population (Esman, 1979). As there has been so little effort to alter land tenure inequities over the past two decades, it is likely that the situation has worsened. In some places, large-scale infrastructure projects, roads and, perhaps most notoriously, dams built for power generation or irrigation, both invariably for export-oriented projects and other economic development projects in the interests of elites, have displaced farmers and thereby forced whole rural communities to migrate in search of livelihoods elsewhere.[12]

Decosas and Adrien note that labour migrants have higher infection rates than those who do not migrate, independent of the HIV prevalence at the site of departure or the site of destination (Decosas and Adrien, 1997:S78). The epidemiological relationship between migration and HIV status in villages in northern Senegal was described by Kane et al. (1993:1261–1265). Their study in the early 1990s found that 27 per cent of the men who had previously travelled in other African countries and 11.3 per cent of spouses of men who had migrated were infected with HIV. Of the 414 men living in neighbouring villages and selected as the control group because they and their spouses had not travelled outside Senegal in the last 10 years, only one man and one woman were infected with HIV. High HIV prevalence rates in areas of high out-migration have been documented in Mexico (Santarriaga et al., 1996), Senegal (Pison, 1993:196–200) Ecuador (near Cuenca) and southeast Ghana (Decosas, 1996:S69–S74). Rural communities in West Africa known for out-migration (mostly to the southern areas of Côte d'Ivoire) such as the area of Tambacounda in Senegal, Sikasso in Mali, the district of Manya-Krobo in Ghana, the area of Mono in Benin and the Otukpo Local Government Area in Nigeria are recording HIV infection rates two to three times the national rates (Decosas, 1999:3). Using 1993 data, a study of migrants in Kenya concluded:

> Independent of marital and cohabitation status, social milieu, awareness of AIDS, and other crucial influences on sexual behavior, male migrants between urban areas and female migrants within rural areas are much more likely than non-migrant counterparts to engage in sexual practices conducive to HIV infection. In rural areas, migrants [returning] from urban places are more likely than non-migrants to practice high-risk sex (Brockerhoff and Biddlecom, 1999:833).

Repeated or "circular" migration is the rule. Migrant labourers stay for a period of several months to several years at their destination and return for visits to their places of origin (Decosas and

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[12] Frequently cited in the scant research to date on "development" projects and the creation of a context for the spread of HIV is the case of the Volta River Dam in Ghana, built to generate the huge amount of electric power used to process bauxite into aluminum for export. Construction of the dam in the 1960s necessitated some 8,500 square kilometres to be cleared for the dam's reservoir. This displaced thousands of farmers, many of them women. Some men took up fishing; some migrated downriver to jobs on the construction site. But many women farmers ended up as service workers in the hotels and bars built to cater to the construction workers. "From there it was only a small step into the business of prostitution", writes Decosas, 1996a. A generation later the fatherless daughters of the migrant construction workers who built the huge dam had little choice but to follow their mothers into the business of selling sex. In the mid-1990s, HIV prevalence in the area surrounding the dam was found to be five to 10 times higher than in the rest of Ghana. In addition, many commercial sex workers migrated from the region to urban areas such as Accra and Kumasi, creating a fertile ground for the spread of HIV. See also Topouzis, 1998:45.

Adrien, 1997:S79). Their visits home also place their partners there at risk. Thomas Painter, in his research on "livelihood mobility" in West Africa to the coastal areas of the region (Ghana, Togo and Côte d'Ivoire), reports: "Typically these individuals are men, often married, who spend 3–9 months each year in coastal areas having higher risks of HIV infection. They spend this time unaccompanied by female partners from their home communities …" (Painter, 1996:652f).

Painter attributes the century-old phenomenon of labour migration in West Africa—now involving some 200 million people—to the region's "uneven and inequitable socioeconomic development". This, in turn, he sees as resulting from the uneven distribution of natural resources (fertile soil, water and mineral deposits) compounded by the cumulative impact of "choices made by individuals, groups, communities, by private capital, governments, international development assistance organizations, and, finally the impact of market forces within a global economy" (Painter, 1996:646). As a consequence, he notes, throughout sub-Saharan Africa there is a highly uneven distribution of investment, marketing and transport and communications infrastructure, as well as education, health and other social services.

Labour migration is to a large extent gender-segregated: men follow different routes and have different destinations than women (Decosas and Adrien, 1997:S79). "Gender segregation destructures societies and renders them more vulnerable to epidemics of HIV" (Decosas, 1999a:7).

While there are far fewer female migrants than male migrants, several case studies point to the same basic theme of rural impoverishment leading to migration in search of a livelihood. Decosas gives an example of female migrants: the girls from Manya-Krobo, Ghana, who (at least several years ago) boarded buses to Abidjan and Bouaké to become sex workers (Decosas, 1999a:6). In Thailand, the mechanization of agriculture in practice favoured the employment of males over females, leaving young rural women with few opportunities, outside of migration to the cities and coastal resorts, to fulfil their traditional gender roles of supporting parents and younger siblings. Ann Danaiya Usher draws the links between environmental devastation in Thailand and the out-migration from the northeast of so many adolescent women to work in the sex industry in the cities (Usher, 1992:13–49). Moreover, in the cities and coastal resorts, "commercial sex work offers them financial resources that would be far beyond their reach in any other line of work" (Wawer et al., 1996:460). Commercial sex work remittances thus may secure the subsistence of the rural household, provide consumer goods, educate siblings, upgrade family economic level and status in the village, and thereby satisfy traditional female responsibilities for the domestic economy. A study of Bangkok masseuses (commercial sex workers in massage parlours) commissioned by the International Labour Organization (ILO) concluded that, in the women's view, theirs was an entrepreneurial decision, "a perfectly rational decision within the context of their particular social and economic situation".[13]

UNAIDS and UNDP studies point out the difficulties that arise when analyses of HIV prevalence among mobile populations focus too narrowly on migrants per se (UNAIDS/

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[13] Wawer et al. cite Phongpaichit, 1982. Wawer et al. state that the sex workers interviewed for their study told them that "they did not insist on condoms because their fear of poverty is greater than their fear of AIDS".

UNESCAP/UNDP, 2000 and UNAIDS/UNDP, 2000). The public policy response to the publication of such studies is often the search for the index case among groups who are already stigmatized and living on the margins of public acceptance. "From a public health perspective, however, the key link between human mobility and the epidemic profile of HIV is not the origin of the migrant, but the conditions of life during the journey and at the site of destination" (Decosas and Adrien, 1997:S78).

And what typically are those conditions? The long absence from the social control of the home environment, housing in single-sex hostels, lack of access to medical care for sexually transmitted diseases, alcohol and other substance abuse related to loneliness and boredom, and "a dysfunctional symbiosis between sex work and migrant labour".[14] Decosas makes a critically important comment about the likely asymmetrical pattern of sexual networking: These labour sites typically have a vast excess of young men who obtain sexual services from a very small number of female sex workers. The men may not be sexually very active. During their six-month stay on a plantation or at a mine, several of the men may buy the services of a female prostitute only once each payday. Each time they do, however, they have a partner who has sexual intercourse with 15 to 30 men in the same day (Decosas and Adrien, 1997:S78). "The probability of exposure to a sexually transmitted infection is very high" (Decosas, 1999a:5).

Gabriel Rugalema et al. (1999:29ff), in their study of several commercial agro-estates in Kenya, graphically describe the "physical, social and economic" living conditions that they argue contribute to the susceptibility of workers who come to the estates. They stress that the living quarters are crowded and lack privacy. "As for those who are unmarried or have left their spouses in a rural area, sharing an accommodation is fairly common. A worker sharing a room with two or three others is unable to invite a sexual partner in the house and goes outside the camp for sexual gratification" (Rugalema et al., 1999:30). Workers who were interviewed said that the lack of room to accommodate families was a reason they left their families behind. They also said that taking care of family land is also a factor that makes it necessary for the family to split. "Separation of spouses (fragmented families) was mentioned as one of the factors which drive agro-estate workers into casual sex. It has to be understood that the majority of those who work in the agro-estates are migrants from various districts of the country" (Rugalema et al., 1999:31).

Rugalema et al. also cite the lack of satisfactory recreational facilities (and even electricity that could be used for music or video) as contributing to widespread boredom related to the "very common" alcohol abuse viewed by the workers interviewed as encouraging risky sexual behaviour, both "casual sex" and visits to commercial sex workers (Rugalema et al., 1999:31).

Labour migration has expanded the demand and supply sides of the commercial sex industry. Many men away from either their "normal" sex partners or from the oversight of home societies avail themselves of alcohol, drugs and commercial sex workers. Nearly half of India's goods are transported by millions of trucks. Sexual activity along their routes is common and pervasive. According to an article in the **Harvard AIDS Review**, "India's long-distance truckers average

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[14] Decosas and Adrien, 1997:S79, cite Abdoo et al., 1992:1535–1539; Decosas et al., 1995:826–828; and Brontman et al., 1996.

200 sexual encounters each year; at any given time, 70 per cent of them have STDs [sexually transmitted diseases]" (Harvard University, 1995). They also transport HIV between commercial sex work groups and back to their home areas.

As noted above, most labour migration is circular, that is, workers eventually return to their home villages. Numerous studies show that when male migrants return to their villages, they have money to spend and are entering a local society where there is a relative scarcity of young men. They look for a wife; and at this time, they are sexually active in a context characterized by unequal relations with women. One author, Decosas, writes, "There is again a situation of the asymmetry of networking, this time in the other direction: a small number of men with a high probability of being HIV-infected have many female partners, and a large number of women have occasional intercourse with one or the other of these men. It is not on the same scale as the commercial networks in the cities and gold mines, but it is a pattern that increases the vulnerability to HIV infection. This can explain the rural enclaves of high HIV prevalence sprinkled throughout Africa" (Decosas, 1999:5f).[15] Also, of course, some men come home to their spouses, quite possibly infecting them. Women in rural Tanzania a few weeks before Christmas told researchers that they lived in fear of their husbands coming home for Christmas since they thought they would be "bringing AIDS" (Collins, 1994). In some places female sex workers return, also with some money, and in search of a husband. Like men, they too have the means to afford a certain amount of trial and error.

There are apparently no studies of the social impact of massive labour migration, especially of men, on so many rural areas around the world. Not known, for instance, are the patterns of sexual networking that emerge in villages when many of its young men are absent for months or more at a time (Decosas and Adrien, 1997:S79).

Some studies of labour migration as a co-factor in the transmission of STD bring out some of the implications for public policy. Even in the face of ongoing massive labour migration, especially in the era of HIV/AIDS, it is imperative to improve the living conditions of migrant workers (Barnett, Decosas and Whiteside, 2000:last page). Investments in better housing (affording at least adequate privacy), recreational facilities and activities, and basic health service should make good business sense. Moreover, Decosas argues that the gender segregation of labour migrants is often unnecessary and economically counterproductive. He gives the example of the Société de Grand Bereby, a transnational rubber plantation in Côte d'Ivoire as a positive case in point. The company employs about 3,000 migrant workers from Burkina Faso. The workers now live in villages spread throughout the plantation, each consisting of a group of family houses, a school and a health centre. Many workers' families now accompany them, and their migration cycles tend to be longer, staying several years before returning home. "The company found that this is a good investment to maximize profits. It had noted rising costs because of the high rate of HIV infection among its workers" (Decosas, 1999:7).

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[15] See also Painter, 1996:652ff.

On the macro policy level, it is urgent to counter longstanding urban-biased priorities. Policies and programmes are needed that result in farming and other rural economic activities affording decent livelihoods, together with the generation of more employment opportunities in the countryside for young people. Employment needs to be located closer to where people live with their families (Cohen, 1998c:5).

At a more micro level, traditional social patterns that regulate, albeit with limited success, youth migration and sexual behaviour may be strengthened so as to reduce risks (Adams, 1981:332 and Barrett and Browne, 1999). To fashion more effective responses to epidemics, more work needs to be done on local conditions and realities, including the issue of social controls and learning.

The better social scientists analyse how the current processes and conditions of labour migration facilitate the transmission of HIV infection, the more policy makers are likely to concur with a key conclusion of Daphne Topouzis in her review of the implications of HIV/AIDS for rural development policy: "Given that many problems arising from the epidemic are not specific to HIV/AIDS, policy and programme responses need not be HIV/AIDS-specific but must address the root causes and consequences of the wider challenges to rural development. In other words, a development rather than an AIDS-specific focus is critical …" (Topouzis, 1998:19).

Poverty-driven commercial sex work

In the absence of alternative opportunities to earn a livelihood for themselves and their families, millions of people sell sex. In no other area is the evidence for the economic determinants of HIV-risk behaviour clearer than it is in sex work. Tawil et al. observe: "Evidence from all regions of the world suggests that the overwhelming motive behind the exchange of sexual services for the provider is economic opportunity."[16]

A 1993 study of 678 female commercial sex workers in three urban centres in Thailand found that a distinct majority came from the economically neglected rural areas of the northern region, where cultural norms place the burden on women for support of parents and for sponsoring any younger siblings who go on to higher education. The study concludes: "In its simplest form, the explanation for the exodus of younger women from the North and Northeast to cities and resort areas is that it enables them to fulfil these traditional gender roles. Commercial sex work offers financial resources that would be far beyond their reach in any other profession" (Wawer et al., 1996:456).

For many, sex work is a desperate survival strategy. For others, it can sometimes be more of a lucrative alternative to existing poorly remunerated employment "opportunities". In Thailand, for example, an ILO study found that some female sex workers were able to generate incomes

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[16] Tawil et al., 1995:1301; M. Thant, "The economic implications of AIDS in Asia: Equity considerations", in D.E. Bloom and J.V. Lyons (eds.), **Economic Implications of AIDS in Asia**, UNDP, New Delhi, 1993:135–139; J. Anarfi, "Sexual networking in selected communities in Ghana and the sexual behaviour of Ghanian female migrants in Abidjan, Côte d'Ivoire", in Dyson T. Lihge (ed.), **Sexual Behaviour and Networking: Anthropological and Sociocultural Studies on the Transmission of HIV**, International Union for the Scientific Study of Population, 1992:233–247; and Ford and Koetsawang, 1991:405–414.

25 times as high as the median level that could be expected from other potential occupations such as work in textile mills (Phongpaichit, 1982). As Tawil et al. comment: "The absence of employment opportunities to generate incomes of comparable magnitude or of educational opportunities that might lead to such employment, is why some may choose to remain in sex work" (Tawil et al., 1995:130).[17]

In discussing the poverty-driven selling of sex, we should remind ourselves that, while there are many millions of women and men who engage in commercial sex work on a regular basis, even more people not thought of as "commercial sex workers" find themselves needing to exchange sex for money or goods on an occasional basis (Cohen, 1998a:6). Anecdotal evidence from several regions suggests that poverty and increased burdens, such the imposition in the 1980s of fees for primary schooling, have caused many mothers to turn to sexual transactions in order to obtain desperately needed money. Many also report that in societies shot through with social inequalities, so-called "sugar daddies" (older men with money) procure the sexual services of young girls in exchange for gifts or spending money.

Indeed, the economic attractions of the exchange of sex for money should be understood in the context of the perceptions and aspirations of the majority in lower positions in increasingly unequal societies. This is true even if they are not living in poverty, strictly speaking. The intense commodification/monetization of most societies over the last quarter-century has served to step up the financial pressures on many people. As noted above, today's globalized consumerist culture surely makes untold numbers of people acutely aware of their *relative* poverty. Nicolas Ford and Supora Koetsawang in their study of the context of HIV transmission in Thailand and the motivations for commercial sex work suggest that "the conspicuous opulence, advertising and lavish department stores of Bangkok may also be expected to foster increasingly consumerist desires".[18]

Sex work that is poverty driven is likely to foster behaviours that are more risk-taking than might otherwise be the case.[19] After all, it is *unprotected* sex work that is the issue. Poverty is a compelling reason to accept a client who refuses to use a condom. The journal article by Wawer et al. on their study of commercial sex workers in Thailand cites the response of one woman worker because it was so typical: "Sometimes I will allow it (sex without condom). Sometimes not. If I have no alternative, no money to buy food, I would accept" (Wawer, 1996:459). Sex workers who are poor are likely to work in low-class establishments or on the street. They are less likely to have access to treatment for other sexually transmitted infections, with such untreated infections being a key co-factor in susceptibility to HIV. Their clients are less likely to be aware or to take seriously the risks of HIV and other sexually transmissible infections and to

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[17] See also Ford and Koetsawang, 1991.

[18] Ford and Koetsawang, 1991:408, cite P. Prasartkul et al., **Rural Adolescent Sexuality and Determinants of Provincial Urban Premarital Adolescent Sex**, Publication No. 113, IPSR, 1989.

[19] Given the importance in a growing number of countries of intravenous drug use in the transmission of HIV, it is especially relevant to note that the risk-taking behaviour in drug use is also frequently caused by economic factors. "The conditions that affect initiation, mode of administration and access to treatment facilities may be shaped by economic considerations. For example, intravenous drug use can become more common than other modes of administration when it is perceived to be a less expensive way to get 'high'" (Tawil et al., 1995).

comply with the precaution of condom use. Their own poverty might well play a role here. In a stunning indication of risk-taking behaviour induced by a desperation born of poverty, some commercial sex workers reportedly have opposed the use condoms because they feared it would delay their clients' ejaculation, thereby prolonging penetrative sexual intercourse and reducing the total potential number of clients (Ford and Koetsawang, 1991:407).

Poverty, as already noted, exacerbates gender inequality; poor women are less likely than better-off women to be able to persuade clients to use condoms. In low-class brothels in Ecuador and Honduras, for example, women avoid asking clients to use condoms because, they have told researchers, their customers will exclaim "What! Do you have AIDS?" and give their patronage to others. "We cannot afford that", sex workers say.

People whose livelihood strategies expose them to a high risk of infection are, precisely because they are impoverished, less likely to take seriously (or be able to take seriously) the threat of an infection that is fatal years from now: they are struggling with day-to-day survival for themselves and their families. As Cohen (1998a:5) states: "Even if the poor understand what they are being urged to do [to avoid behaviours that expose them to HIV infection], it is rarely the case that they have either the incentive or the resources to adopt the recommended behaviours. Indeed, to take the long-view in sexual or other behaviours is antithetical to the condition of being poor. For the poor it is the here and now that matters." Anthropologist Martha Ward offers us the same observation more dramatically: "For poor women AIDS is just another problem they are blamed for and have to take responsibility for. They ask, 'How am I going to take care of my family? I have to put food on the table now.' 'You think AIDS is a problem! Let me tell you—I got real problems'" (Ward, 1993b:61).

Farmer spoke with women engaged in unprotected sex work in Harlem (New York City) and in Bombay. He writes: "It seems fair to assert that the decisions made by the women profiled were linked to their impoverishment and their subordinate status as women. Furthermore, it is important to remember that Darlene and Guylene and Lata were born into poverty. Their attempts to escape poverty were long bets that failed—and AIDS was the form their failure took" (Farmer, 1996d:22).

The development goal is how to reduce dependency for so many on sex work—and the impoverishment of so many that makes sex work synonymous with risk-taking behaviour.

AIDS is only one in a series of "shocks"

For some, HIV/AIDS is the first major disaster in their lives. For many more, HIV/AIDS is just one more problem on top of many others (Farmer, 1996d:21). Rugalema, a Tanzanian social scientist, investigated the impact of AIDS in a village in the severely affected northwestern part of his country. "But what did the villagers think about AIDS?", he asks.

> In general, they did not think of AIDS as something terribly new. Rather, they saw it in the wider context of other crises predating it. During and for a few years after World War II, the study area was struck by famine (*eifa*) partly due to drought and partly due to rationing imposed by the British colonial government in Tanganyika …. Most households had to dispose of their assets, and the most common asset disposed of was corrugated-iron roofing sheets …. The 1944–1947 famine was thus named *eifa lya ikambula mabati* ("the famine in which iron sheets were removed from the houses") ….

> In the early 1970s, drought led to widespread food shortages (*enjala*) in the area particularly in 1973–1974. This was a generalised hunger throughout Tanzania and the situation was made worse by the world oil price shock …. A few years later there was *olushengo lwa Amin* (Amin's war), that is, the 1978–1979 war between Uganda and Tanzania. Although the village is about 72 kilometres from the border it not only received some of the displaced people from the border villages but it suffered the economic disruption wrought by the war. Much of the period from 1970 has been characterized by poor national economic performance and consequently the decline of the coffee crop in the area. The economic downturn has continued with only brief hiatuses in some years.

> In the village AIDS is viewed in the context of all these problems (Rugalema, 1999:69f).[20]

Oil price hikes, debt crises and structural adjustment programmes

For Tanzania and most developing nations, the 1970s and 1980s were characterized by a series of shocks—many of them external in origin—that exacerbated the already precarious living conditions of most people, making them more susceptible to STDs and intensifying the impact of HIV/AIDS. In addition to droughts and/or flooding in some countries and armed conflicts in or involving many countries, three related shocks are frequently cited: oil price hikes, debt crises and structural adjustment programmes.

The Organization of Petroleum Exporting Countries (OPEC) oil embargo of 1973 quadrupled oil prices, producing a doubling of commodity prices in the industrialized countries and a 43 per cent increase in the cost of exports. The resulting recession in the industrialized world led to significant decrease in demand for developing country products. Most developing countries faced steep increases in prices of their imports, just as the prices and volume of their exports fell.

Initially, most developing countries responded to this loss of income by obtaining foreign credits to pay for vital services and for importing such essential items as food, medicine, fuel, agricultural inputs and raw materials, as well as luxury products. Credit was readily available, especially from international private banks that needed to lend the vast amounts of funds placed with them by OPEC members. Because prevailing interest rates in the industrialized countries (particularly the United States) determined the interest rates on their loans, when soaring inflation due to a second oil shock in 1979 drove interest rates upward (as high as 16 per cent in the United States in 1981), developing country borrowing could no longer be sustained. Debtor countries borrowing at flexible rates or seeking to refinance loans found themselves with enormous, unpredictable interest payments. An international recession in 1980–1981 further decreased demand for developing country commodity exports.

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[20] For even more historical detail on the socioeconomic context of the same district (Bukoba), see Kaiijage, 1993:279–300.

In 1982, as a number of countries defaulted on loan payments, lenders decided that further loans to developing countries were too risky; and they severely curtailed further lending. Rocked by economic crisis, many developing countries were forced to turn to the International Monetary Fund (IMF) for loans to cover payments on foreign debts or else face a total freeze, even on short-term import credits. This debt crisis, in short, made it possible for the industrialized countries to impose a package of economic and social policy "reforms", commonly referred to as structural adjustment programmes (SAPs). Renewed lending by the World Bank, bilateral agencies and private international banks was conditioned on borrowing countries carrying out of some form of structural adjustment. The timing of the debt crisis was particularly fortuitous. By the late 1970s, major donors had become disillusioned with single-issue projects. Most had failed to yield anything near projected results. Host country economic and sector policies were identified as constraints to project "success". Increasingly, policy reform became the mantra of donor agencies (Rau, 1991:100–101), and the debt crisis provided the opportunity to impose these reforms.

Informed by a neoliberal, free-market ideology, these policy changes focused on reducing domestic consumption, shrinking the public sector through privatizations and cutbacks in government services, and orienting economic activity even more toward export than toward domestic needs. By earning more and consuming less, the countries would theoretically have more money to make payments on their loans; and, eventually, the renewed confidence of lenders would mean that more could be borrowed. It is noteworthy that further borrowing was not made conditional on reductions in the sizable expenditures by many of these countries on imported military hardware; but adjustment-related currency devaluations meant that economies had to export more in order to pay for it.

The expansion of SAPs—and the resulting shocks felt by most people in these countries—was rapid. Over the course of the 1980s, 32 of 44 sub-Saharan African countries entered into a World Bank SAP. Worldwide, a total of 89 countries entered into World Bank and/or IMF structural adjustment agreements between 1980 and 1991 (Bello et al., 1994).

With the structural adjustment programmes in place, renewed lending plus accumulated interest resulted in spiralling debt in the developing world. While in 1979 there was a net flow of $40 billion from industrialized to developing countries, interest payments on existing loans soon outstripped new loans; and by the end of the 1980s $60 billion was being transferred from the developing world to the OECD countries annually (Kanji and Manji, 1991:985–993).

Ironically, despite the fact that these policy reforms were supposed to help achieve economic growth, macroeconomic performance was less than stellar. For example, the economies of the 44 lowest income countries in sub-Saharan Africa grew at an average annual rate of 1.2 per cent between 1965 and 1980; between 1980 and 1987 there was an average annual *decrease* of 1 per cent in this index (UNDP, 1990). Terms of trade moved against many countries exporting primary products, making it all the more costly to import needed supplies and equipment.

In the 1980s, in most countries in the developing world, poverty and unemployment increased and income distribution worsened. In sub-Saharan Africa, per capita income fell by over one quarter. In 1985, almost one third of the population of the developing countries was living below the World Bank-defined poverty level.

Building on the debate on the impact of structural adjustment, initiated by the United Nations Children's Fund (UNICEF), some researchers have argued that adjustment-related policy changes in the 1980s fostered situations promoting behaviours that could place greater numbers of people at increased risk of HIV infection (Sanders and Sambo, 1991:157–165; Anonymous, 1990:885–886; Cornia et al., 1987; and Lurie et al., 1995:541f).

In general, SAPs have links with the HIV/AIDS pandemic in several ways:

- They have often caused or intensified economic recessions and led to increased poverty and class and gender inequality.
- They have further undermined the rural economy, at the cost of livelihoods and nutritional status.
- SAPs have fostered the development of transportation infrastructure to support the heightened export orientation of the economy. Numerous studies from countries in Africa and India document high HIV prevalence along the truck routes.
- They have increased labour migration and urbanization. Both of these phenomena, as already emphasized, preceded SAPs but were increased by the emphasis on export-oriented growth and the further undermining of the rural subsistence economy. The annual urban population growth rate for sub-Saharan Africa between 1960 and 1990 was 5.2 per cent, higher than any other region in the world (UNDP, 1991). Thailand, which entered into five IMF or World Bank structural adjustment loans between 1980 and 1991 (Bello et al., 1994), is a case in which policies further impoverished rural areas and focused resources on the principal urban centres, encouraging millions of Thai men and women to migrate to the cities.
- SAPs have also mandated cutbacks in spending on health care and other social services. Between 1980 and 1985 there was a 26 per cent decline in spending on health, education, and other social services for low-income people (UNDP, 1990). In all low-income countries (excluding India and China), health spending dropped from 5.5 to 2.8 per cent of (shrinking) national budgets over the same period (UNDP, 1990). Levels of per capita social spending were extremely low before the debt crisis and structural adjustment, so these figures are even more telling. At the beginning of the 1990s, the average annual per capita expenditure on health by African governments was a mere $2 (Weeks, 1992:208–213). In many countries during this period, governments agreed to charge fees for previously free medical services. For example, when the World Bank directed Kenya to implement a charge of $2.15 for STD services in public clinics, attendance fell 35–60 per cent (Moses et al., 1992:463–466). Similar decreases in clinic utilization in the wake of the introduction of, or increases in, user fees have been reported in Ghana, Mozambique, Zaire and Zimbabwe (Bethune et al., 1989:76–81; Waddington and Enyimayew, 1989:17–47; and Logie, 1993:950ff). In many countries, most notably in sub-Saharan Africa, nothing could have been more inappropriate than decreasing access to health services, given the already very high rates of untreated STDs (Grosskurth et al., 1995:530–536) and non-specific bacterial and vaginal infections, now recognized to be a leading factor in the spread of HIV infection. Cutbacks in funding for pubic clinics reportedly also encouraged the re-use of disposable syringes, potentially contributing to HIV transmission (Mann et al., 1986:654–657).

Understandably, the World Bank has been defensive about any alleged links between structural adjustment and HIV/AIDS. World Bank economist Christine Jones offers perhaps the Bank's most comprehensive attempt at a defence (Jones, 1998). Nevertheless, a close reading reveals crucial flaws in the defence and also suggests that Jones herself is troubled by a number of findings. She admits that if the poorest of the poor were further *impoverished* by structural adjustment in a number of sub-Saharan African countries, this "could have worrisome implications for the spread of HIV". She also notes that adjustment programmes could reduce household incomes in the short term, although perhaps not in the medium term. But impoverishment, even over the short term, can place millions of people at significant risk of HIV infection. Jones also notes that the World Bank's own evaluation of adjustment-related lending in 1995 found that *inequality* was worsened in about half of the countries reviewed and that inequality "could lead to an increased prevalence of AIDS if "those members of the population who are adversely affected are more likely to engage in behavior that puts them at greater risk for contracting HIV".

She also comments that "increasing inequality could reduce educational or health services [available] to the poor, that lower their risk of infection". Finally, Jones admits that the data are not complete enough to settle these issues. For instance, on the crucial issue of whether structural adjustment further marginalizes women (promoting the spread of HIV in a number of ways), she concludes: "Obviously this is an area in which considerably more research is needed, but also one in which it is very difficult to generate data of the sort needed to test these hypotheses systematically." Yet a number of journal articles based on first-hand familiarity with countries undergoing structural adjustment have noted links between adjustment policies and the spread of HIV.

A literature search found no published response to Jones' article. Nevertheless the question cannot be settled by arguing specific points. At both individual and social levels, HIV/AIDS is associated with numerous, interlinked causative factors. For this paper, the main point is that SAPs came at a time when households, communities and governments were already susceptible to the disease; and SAPs fully merged with, and exacerbated, prevailing patterns of susceptibility.

The association, since the early 1980s, of international financial institutions with the imposition of so-called "user" fees for health care and other social services—even in countries in which the majority of people are impoverished—has been especially unfortunate. When it comes to the treatment of STDs, who truly is the "user"? Is it not the society at large that benefits from adequate attention to these diseases? And in that case, shouldn't society as a whole be considered the "user", and pay the bill for care?

The heightened shock for women

Women have experienced the greatest losses and burdens associated with economic and political crises and shocks. Inequities in gender run parallel to inequities in income and assets. It is well established that young women are both physiologically and socially more vulnerable to HIV than young men. Married women often have little control over the sexual behaviour of their husbands, or protection from the consequences of male behaviour. Of course, not all women are

affected equally. As Schoepf observes: "Macroeconomic conditions operating in a context of pervasive gender inequality have different effects upon the lives of women in different regional, class and family circumstances. Different circumstances also produce different negotiating strengths among women as well as different HIV risks" (Schoepf, 1993b:57).

Few authorities have given sufficient attention to the existence of, and changes in, gender inequalities. Few have actually come out and said, "The sexual behaviour of men is the driving force behind the rapid spread of the epidemic, particularly to rural areas". This paper has considered some of the macroeconomic and social reasons that place both men and women in situations where they are susceptible to STDs, including HIV infection. We have taken a step back from behavioural explanations.

But, in the area of gender, it is important to link the structural analysis of development with behavioural studies and insights. The lack of full discussion about male sexual behaviour contains a gender bias—a reluctance to point out male sexual attitudes and assumptions that condition behaviour; little research on how women are affected by the growing number of responsibilities associated with the epidemic; too few insights on the cultural assumptions, rationales and traditions used by men to justify their sexual behaviour.

Gender bias permeates the HIV/AIDS arena. It lurks especially in aid agencies. Discussions of male sexual behaviour are felt to be threatening, for aid agencies are invariably internally gender biased and, while they are so politically correct that gender is rhetorically acknowledged, it is not adequately examined. Thus, there is an uneasy quiet, almost unspoken truths, hovering on the edges, but rarely brought into the centre. Similarly, gender bias is built into mainstream development that, conceptually and in practice, has been constructed primarily by men.

We have already discussed some of the links between gender inequalities and HIV/AIDS susceptibility and vulnerability.[21] Here we place a sample of the linkages in the context of structural shocks.

- *Breakdown of household regimes and attendant forms of security:* Decades of changes in economic activity and gender relations have placed many women in increasingly difficult situations (Rugalema, 1994). HIV/AIDS has accelerated the process and made "normal" sexual relations very risky. Women whose husbands have migrated for work are said to fear the return of the men, knowing they may be HIV-infected. Although poorly documented, the range and depth of women's responsibilities have increased during the era of AIDS. More active caregiving for sick and dying relatives has been added to the existing work load.[22] Children (girls first) have been withdrawn from school, both to save on costs and to add to labour in the household. Thus HIV/AIDS is facilitating a further and fairly rapid differentiation along gender lines.
- *Loss of livelihood:* Whether women receive remittances from men working away from home, are given "allowances", or earn income themselves, AIDS has made

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[21] See Long and Ankrah, 1997.

[22] See, for example, Anne Outwater, "The socioeconomic impact of AIDS on women in Tanzania", in Long and Ankrah, 1997.

the availability of cash more problematic. In Malawi, women and men have increasingly taken on work on farms of larger and/or wealthier farmers in order to earn income or in-kind payments, often neglecting production on their own holdings (Whiteside, 1999:13).[23]

- *Loss of assets:* Again, although poorly documented, fairly substantial investments in medical care occur among many households affected by HIV/AIDS. These costs may be met by disinvestment in assets. Household food security is often affected in negative ways (Kusimba et al., 1996:27–43). Furthermore, in many parts of Africa, women lose all or most household assets after the death of a husband.

- *Survival sex:* Low incomes, disinvestment, constrained cash flow—all place economic pressures on women. Anecdotal evidence and some studies indicate that these pressures push a number of women into situations where sex is coerced in exchange for small cash or in-kind payments (ICRW, 1996:6–7). Along the Thailand-Burma border, many sex workers are young women, caught up in the "green harvest": their work is a means to repay loans made to their families by money lenders, who recruit young women for the sex industry. Most of the young women return home HIV-positive (Sakboon, 1996:A4+ and Bond et al., 1996).

These and other structural biases facing women in education, employment and legal rights add to the shocks that have disrupted social institutions over the past decades.

Militarism and armed conflict

Wars and civil violence have contributed to situations of increased susceptibility to HIV/AIDS, but epidemiological data is usually lacking in affected areas. Thus, data from the early 1990s continues to be cited to describe the HIV/AIDS situation in Congo. It is worth noting, however, that literally *all* the countries of eastern and southern Africa have been engaged in or have experienced repercussions from wars or major civil violence since the mid-1970s. It is in these regions of Africa that the epidemic is most severe.

Warfare represents a major opportunity cost for Third World countries. Resources flow to arms and equipment purchases, military salaries, replacement costs, and hundreds of other large and small expenditures. In the middle and late 1980s, these resources could have been used for desperately needed improvements in access to health care, especially STD treatment and other forms of HIV prevention. And as the epidemic has grown more serious, military expenditures in many countries continue to divert needed resources from health care, including support for home health care. In 1999, for example, Zimbabwe was spending about 70 times more on its military presence in Congo than it was on HIV/AIDS prevention (Sayagues, 1999). As the following table shows, military expenditures in the early 1990s exceeded health investments in almost every country selected for comparison—whether in Africa, Asia or Latin America.

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[23] "In the 1970s, similar processes were at work among low-income rural households in Zambia", Bill Rau, personal observations.

Table 1: Military vs. health expenditures in various regions, early 1990s

	Military expenditures (as % of GDP)		Health expenditures (as % of GDP)	
Region	**1990**	**1996**	**1990**	**1995**
Africa				
Burundi	3.2	4.9	1.7	1.0
Ethiopia	10.4	1.8	2.3	1.7
Kenya	3.3	1.6[a]	2.7	----
Mozambique	10.1	3.4	4.4	----
South Africa	3.6	2.1	3.2	----
Zambia	3.7	1.1	2.2	2.9
Zimbabwe	4.5	2.7	3.2	1.7
Asia				
Bangladesh	1.5	1.7	1.4	1.2
China	1.6	1.1	2.1	----
India	2.9	2.5	1.3	0.7
Indonesia	1.5	1.3	0.7	0.7
Malaysia	4.6	2.4	1.3	1.3
Nepal	1.8	0.8	2.2	1.2
Pakistan	7.1	5.6	1.8	0.8
Philippines	1.6	1.6	1.0	----
Sri Lanka	2.3	6.0	1.8	1.4
Thailand	3.2	1.9	1.1	2.0
Latin America				
Brazil	1.4[b]	1.9	2.8	1.9
Dominican Republic	1.1 [c]	1.1	2.1	----
El Salvador	2.8 [b]	0.9	2.6	2.4
Honduras	1.6 [b]	1.1	2.9	2.8

Service in the military also presents HIV risks, both for military personnel and for the civilian population with whom they come into contact. Some African military forces have HIV prevalence rates of 50 per cent or more. It is not uncommon for soldiers to engage in rape and coerced sexual relations. Furthermore, occupying forces frequently turn to local sex workers and can thus both acquire and spread HIV. During the 1980s, for example, thousands of US troops were stationed in Honduras. Sexual relations were common with impoverished rural girls and women (known as *las gringueras*). When the US troops departed, some of these women moved to other places of demand, including the city of San Pedro Sula, which has become an epicentre for HIV/AIDS in the country. Today, Honduras has the highest HIV/AIDS prevalence of any country in Central America and the highest number of abandoned women living with AIDS.

Displaced and refugee populations numbering in the hundreds of thousands (and more) have had their lives disrupted by military actions. During the 1994 genocide in Rwanda, "'virtually every adult woman or girl past puberty who was spared from massacre by the militias had been raped'—along with many younger children" (Anonymous, 1995:3). As many as 5,000 Rwandan

women have had children as a result of being raped; and many of these children have been abandoned (Refugee Policy Group, 1997:box 4.3). Also, life in refugee camps is notably precarious for women and girls. For example, a high incidence of rape was reported among Somali refugees in Kenya in 1993. Given the high prevalence of HIV/AIDS among soldiers and the violence of rape, clearly rape has become a mode of transmission of HIV.

Communities hosting refugees can become centres of sex work. Demand, opportunity and resources exist to foster this kind of employment. It is reported that in communities around Kigoma, Tanzania, women and adolescent girls—some escapees from refugee camps—engage in commercial sex.[24]

The shock of disillusionment

Many shocks have been reviewed at aggregate levels. Less evidence exists on what might be called sub-shocks—the repercussions of larger changes. For example, agricultural marketing reforms have produced a ripple effect of shocks for market-oriented small-scale farmers. These include:

- reductions, delays or elimination of credit;
- delays in supplying hybrid seeds and fertilizers;
- disruptions in agricultural extension and veterinary advice;
- delays in collection of crops;
- crop losses for lack of storage; and
- delays in payment for crops.

One observer notes: "Farmers have struggled on a daily basis to overcome the combined shocks of cattle disease, years of drought, and marketing reforms. The onslaught of HIV/AIDS has further impaired household responsiveness as it cuts into available labour and household resources" (Waller, 1997:33). To cope with these shocks, small-scale/low-asset farmers have sold their own labour to other farmers, working for low wages or in-kind payments during peak labour periods. In Zambia and Malawi, work on the farms of others affects the ability of rural people to tend to their own production, not infrequently contributing to further impoverishment.[25]

For young people, these shocks add to real or perceived insecurity and highlight the low returns that can be expected from agriculture. Any hope that younger generations can improve their material well-being from rural enterprise is further eroded. At the same time, long-established patterns of migration to employment centres have not provided as much opportunity as in the past. Schooling also has become less of an assurance of advancement than it used to be. These structural shocks have affected expectations, hopes and commitment to work within the prevailing economy from the 1980s onward. The system has not been working for many young people, who have increasingly turned to alternative forms of income generation and/or social support.

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[24] "AIDS Pandemic Grips Tanzania," **Africa News Service**, 26 January 2000.
[25] Bill Rau, 1980s, personal observations, and Whiteside, 1999.

Paul Richards makes this point about young men in Sierra Leone, some of whom have been involved in the war there and in neighbouring countries since the late 1980s. Young men from Burkina Faso, Sierra Leone and other West African countries found opportunities to gain income from migrant labour constricted by economic crises in labour absorbing countries (Côte d'Ivoire and Nigeria). They also confronted dwindling possibilities to work in their home areas (where very limited opportunities existed). The shocks that ran through the system included:

- loss of income;
- loss of self-respect and confidence; and
- rejection of the "marginal" and unemployed, who were—in increasing numbers—becoming street people, thieves or beggars.

Overall, growing disillusionment and social rejection made the long-term prospects of dying from AIDS far less frightening than the immediate need for food or companionship, or for social acceptance in a military unit. Richards writes: "HIV/AIDS cuts short the normal life expectation, and already [c. 1999] young people in Tanzania make it clear that they have to work with the space they will get. Life has to lived to the full, but perhaps over 30–40 years rather than a normal three score years and ten" (Richards, 1999). He continues: "If we simply treat HIV/AIDS as a disease, rather than seeing it as an integral and important element in a social maelstrom of youth, then we shall continue to misunderstand the significance of HIV/AIDS for Africa, and continue to under-estimate the efforts of those who seek constructive change rather than opportunistic exploitation of crisis scenarios."

A study of young people in central Ghana uncovered similar attitudes that, while they may not be fully generalizable, definitely reflect the situation in which some young people seem to find themselves. There is a tendency to ask: "Why should I change my sexual behaviour when I see little hope for improvement in life's opportunities?" "Such attitudes toward death in the era of AIDS point to apparent misunderstanding, or lack of motivation for behavioural change, in the existing socioeconomic circumstances" (Awusabo-Asare et al., 1999:125ff). It seems that such attitudes are not statements of fatalism, but of disillusionment and realism.

In sum, dramatic and prolonged shocks have shaped the environment in which HIV/AIDS has found fertile ground. Several of the shocks noted here are a direct outcome of development paradigms pursued by international donor agencies. Other shocks reflect deep structural factors (some social and cultural, others political and economic) that have made many societies and specific groups in society especially vulnerable to conditions conducive to HIV transmission.

In this section we have touched on some of the principal ways that certain socioeconomic conditions have been generated by national and international development policies and have contributed to the HIV/AIDS pandemic. The latter is one more disaster visited on impoverished people. It calls into question what in so many countries and international arenas has been called "development", as well as the means used to achieve it. As Roland Msiska, a former senior policy maker in Zambia who works on HIV/AIDS, has stated: "Is HIV a symptom of

development gone wrong? If the answer is yes, then we need to tackle the disease 'development,' as we deal with the symptom 'HIV'" (Barnett and Whiteside, 1999b).

Popular Initiatives, HIV/AIDS and Development

From the beginning of the AIDS pandemic, non-governmental organizations (NGOs) and community-based organizations (CBOs) have been in the forefront of working with community groups and local authorities. Their roles have been acknowledged by government, donor and international agencies; and some support has been provided to them. Rarely, however, have larger entities sought to learn from NGO/CBO experiences and to structure their own programmes in ways that would either offer reasonable levels of support for field initiatives or effectively improve the environment for these initiatives to expand. Mark Schoofs, a writer for the **Village Voice** in New York City, reported on the AIDS epidemic in southern Africa. He noted that "below the radar of government, in individual communities there are astonishingly vigorous responses to AIDS" (Schoofs, 1999)—a finding shared by Elhadj Sy, the UNAIDS representative in southern Africa.[26] Here we offer some examples from below the radar.

This section highlights effective initiatives for HIV/AIDS prevention, care and mitigation that have operated, in whole or part, on the basis of four principles:

- acceptance of the reality that numerous people have been both marginalized and exploited by development efforts, so that trust in state and private sector institutions and approaches has either disappeared or is severely strained;
- recognition that lower income groups, marginalized workers and many adolescents do live in social and cultural structures that serve their needs, as best as can be achieved;
- willingness to learn from and build on the positive responses to HIV/AIDS that arise from society, and to blend these in a flexible manner with the best that public health has to offer; and
- creation of enabling environments to support positive responses, in national and sectoral policies and programmes.

Working in marginalized communities

Pink Triangle Malaysia (PTM) has intentionally created links with marginalized communities— gays, intravenous drug users (IDUs), sex workers and transgender people. These groups are stigmatized by law, custom or prevailing social norms. Operating in an active commercial district of Kuala Lumpur, PTM has used its experience and contacts with the gay community to establish contact with drug users and to build a relationship of trust. As it noted: "The IDU community is not an easy one to get to know. IDUs … form close-knit peer groups or 'comradeship.'"

PTM recognized that dialogue and trust would emerge through first addressing the immediate needs of drug users. Unless that occurred, HIV education would not find a willing audience. A member of the group explained that "drug users in this area were homeless, economically disadvantaged, lived in very unhygienic conditions and were very often hungry. Harm

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[26] Sy's comment was made during an oral presentation to the Conference of Health Ministers of the Commonwealth Regional Health Community, Victoria, Seychelles, October 1999.

Reduction information is ineffective if given to a man who hasn't had a proper meal for 5 days"
(Narayanan, n.d.).

Also, PTM applied several basic principles of development practice in its work with IDUs.
These included

- providing care and support services in places considered safe by drug users;
- recognizing that members of the IDU community were capable of actively
  participating in the project and adopting behavioural changes; and
- involving other stakeholders.

While providing basic medical services and helping to meet basic needs for food and shelter,
PTM also involved drug users in established community activities. The impact of the
programme on HIV/AIDS has not been established—and is likely to be uneven over time.
Nevertheless, those involved in the effort feel that HIV/AIDS awareness has been raised, care
for STDs and HIV/AIDS has improved, and the general health and hygiene of clients is better
than it was before. Increased self-esteem is reflected in growing willingness to speak with
others and to request rehabilitation/detoxification services.

None of these successes provides a breakthrough for HIV/AIDS prevention in Malaysia. The
effort is young and small, and it exists in an environment that is not open to work with IDUs.
Nonetheless, the approach has motivated some users to attempt to alter structures that have
kept them socially marginalized—in such areas as employment and legal rights—and to change
behaviours that contribute to the transmission of HIV.

The effectiveness of PTM's work with drug users has carried over into work with other
marginalized groups, namely transgender people and sex workers—often one and the same.
The head of that programme has written: "One of the main objectives of the transgender
support programme was to build up the community." There was active involvement of
transgender sex workers in the programme, including service on the board of directors. "This in
turn led to many new developments. One major outcome was the setting up of a 'Transgender
Fund' by the community itself", the programme head continued. This initiative provides people
living with HIV/AIDS with financial support for hospitalization, bail when arrested and
funerals. "In developing a transgender fund, the community was being empowered by itself
providing the relevant services and welfare, and strengthened in dealing with a discriminatory
society" (Slamah, 1999).[27]

The key, overall lesson stressed by PTM is that the "principles of community mobilization for
HIV/AIDS prevention and care can be applied successfully to a traditionally hard-to-reach
group of people, even when their behaviour (in this case, intravenous drug use) leaves them
outside the protection of the law. Another important lesson is that members of one
marginalized community—if they have already gone through their own mobilization process—

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[27] See also UNAIDS, 1999d.

may be extremely effective at reaching out to another, even more marginalized community" (UNAIDS, 1999d).

Community support to affected households

Countries in eastern and southern Africa with a high prevalence of HIV/AIDS also report large numbers of "AIDS orphans", children who have lost their mothers or both parents to HIV/AIDS. There is both anecdotal evidence and wishful thinking that the hundreds of thousands of children who have been affected by the epidemic are being integrated into extended family structures. There is also anecdotal evidence that many extended families find it extremely hard to provide for the children. It is increasingly common for elder orphaned children to assume responsibility for their siblings (Kusimba et al., 1996).

While the difficulties faced by households caring for orphaned children are very real, most of the effective community responses to the AIDS epidemic have sought to work with and within local social and cultural structures to support those households. Urassa et al. conclude that prevailing social systems in the Kisesa area of Tanzania have provided for large-scale fostering of children. Over one third of the children in Kisesa at the time of the study did not live with at least one biological parent and nearly half of all households had at least one foster child. They argue that the flexibility of the existing system allows for coping with the likely increase in children orphaned by HIV/AIDS. "The challenge, and probably the only feasible intervention, is to develop community-based support systems which focus on the most vulnerable house-holds and extended families, using only limited external support" (Urassa et al., 1997:141–153).

This conclusion parallels that reached by researchers in another part of Tanzania. Although the impact of illnesses and deaths on households was severe, there was evidence to show that households adapted to the losses over a period of two to three years. Very low-income and low-asset households were the most vulnerable and, given the resource constraints of communities and the government, they were the appropriate targets for support interventions (World Bank, 1997).

How can community support mechanisms be fostered? In some instances, communities have responded with existing local resources. This has been the case where religious groups, self-help groups, micro enterprises and/or community development initiatives are well established. In other cases, additional resources have been sought to support community networks. In Malawi, for example, village orphan committees monitor the situation and organize local resources, when possible, to assist children. Some of the orphan committees are highly motivated, others less so. The well-run committees are able to count on assistance from an NGO project that offers guidance and some financial help. In other cases, committees utilize existing government resources, such as the technical expertise of agricultural extension workers, to develop gardens and small livestock for orphaned children.

Similar initiatives exist in Zambia. While providing for the immediate needs of orphans, a number of community initiatives have sought to increase opportunities for children to care for themselves. Community schools—which emerged independently of the HIV/AIDS situation— are one response to curtailed government support for education. The schools provide rural and

urban communities with the possibility to educate children unable to afford a place in public schools, including many children orphaned by HIV/AIDS.

In the rural central part of Zambia, the Salvation Army Chikankata Hospital has led the organized response in working with and providing support to communities affected by HIV/AIDS (Mutonyi, 2000 and Salvation Army Chikankata Hospital, 2000). As early as 1987, the hospital saw an increasing number of people with symptoms of HIV/AIDS. Although people in the hospital's catchment area had long been involved in out-migration for work, social structures remained firmly in place. The hospital staff, through a concept of shared responsibility, initiated a programme of home-based care that built on and strengthened social structures. This led, in turn, to the AIDS Care and Prevention Programme that has been studied and replicated by other service organizations in Zambia and neighbouring countries. The programme incorporates diagnosis and counselling for affected individuals; provides home-based care, education and counselling for families and communities; attempts to strengthen food security; and related concerns.

As the incidence of sickness and death from HIV/AIDS increases, home-based care must be supplemented to a greater extent by community assistance. A key element in the Chikankata strategy is therefore work with local communities, defined not only in geographical terms but also in relation to patterns of association, and shared interests and concerns. When local people first discovered that information and services were available through the programme, "community leadership began calling the [hospital] team to come and help provide more information on HIV/AIDS to the entire community" (Mutonyi, 2000). This, in turn, led to the establishment of a community counselling programme.

The counselling programme was not focused on individuals but reflected classic community development principles: dialogue, self-awareness, mobilization of resources, and problem solving. As the Chikankata staff explain, the programme "promoted the transfer of responsibility for behaviour change from the programme implementers to the community." From the beginning, "all the community members or participants are recognized as thinking, creative people with the capacity for action." Chikankata trained facilitators. They were resource persons for communities, fitting into existing structures and not trying to create new ones or to work from a set agenda. One outcome was the abandonment of ritual cleansing through sexual intercourse with a surviving spouse by a brother of the diseased husband—a high-risk behaviour. Another was the willingness of community members to take part in the direct care of people living with HIV/AIDS, a role formerly believed to belong to relatives.

Not surprisingly, the counselling programme stretched into other aspects of community life. School children and teachers were given access to information about HIV/AIDS and sexual behaviour. Teen pregnancies at the participating schools dropped, as did pregnancies among out-of-school young women.

One of the discoveries of the Chikankata process was that the strategy of the counselling programme already existed in the community "as a traditional practice of care". By legitimizing social and cultural norms and processes, the counselling programme tapped into the strengths of surrounding communities, not by trying to re-invent past practices but by integrating contemporary issues into community processes. It was then that social mobilization drew out the creativity of groups, encouraged them to share and absorb information, and helped them to examine accepted realities. Those who work with Chikankata speak in terms of "constructive reorganization and mobilization of valuable resources within the community".

A similar response to the epidemic, somewhat more medically directed, was organized in the Chiang Rai area of northern Thailand. Hospital staff recognized that they lacked the resources to admit and treat all the people with HIV/AIDS symptoms. In a remarkable twist, the medical staff "began to look into traditional herbal medicine to find palliative treatments" for use at the household level. They found that Buddhist monks had a good knowledge of herbal treatments, and "the medical staff collaborated with the monks to expand their knowledge of palliative care for AIDS patients" (Hsu, 1999). The home-based care programme for people with AIDS blended support from several complementary sources: medical and social service teams, monks and trained community caregivers, and local leadership. Prevention messages were integrated into the sermons and introduced into neighbourhood schools.

In Zimbabwe, with one of the highest HIV/AIDS prevalence rates of any country in the world, rural and urban groups lead the care and support initiatives. In one rural area the initial explanation for HIV/AIDS was revenge, expressed in terms of "bewitching". As AIDS struck deeply into the community, the divisiveness of witchcraft was replaced with a search by peasant farmers for means to deal with the rising number of sick people and broken families. The Insiza Godlwayo AIDS Council (IGAC) was formed, with training on start-up, home care and community mobilization provided by another NGO.[28] Now, community members offer a range of services: material support—soap, food, candles, blankets—and psychological support to family members who care for sick and dying relatives; financial aid for critical family needs and orphans' school fees; and prevention support (condom distribution and warnings against the material temptations offered by "sugar daddies"). Because food and income are critical to communities—and were even before the presence of HIV/AIDS—the group runs several agricultural income-generating activities, all of which are very small but yield revenue that can be shared among members in need.

As with other social initiatives noted in this paper, IGAC members are motivated by their commitment to holding their society together against great adversity.[29] As we saw earlier, the HIV/AIDS pandemic has become the latest in a series of crises or shocks against which communities have attempted to stand or adapt, some succeeding and others not. In rural Zimbabwe, the presence of the IGAC appears to have mobilized communities to build on the social norms that hold together, rather than splinter, the communities.

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[28] Most of the material on IGAC is taken from Schoofs, 1999.
[29] For a similar finding in the context of famine, see DeWaal, 1989.

Some outside observers doubt that the IGAC (and other local initiatives like it) can continue for long or even that they serve a positive purpose. They see the epidemic as too massive and local resources as too limited. They argue that the IGAC operates in a climate of neglect, not care and support, and that such limited efforts have little effect on people affected by the epidemic.

Another project in Zimbabwe, which was more conventionally structured when it first began, parallels the experience of the IGAC. The Families, Orphans and Children under Stress (FOCUS) programme originally trained and supported village-based volunteers to make regular visits to households with orphaned children. The programme quickly evolved, as community members identified new needs and initiated new activities. An assessment of the programme found that "although the initiative was started as a response to the HIV/AIDS epidemic at the community level, it has little emphasis on HIV/AIDS. It has expanded to include other concerns such as income generation and child welfare in general, not just specifically children orphaned by AIDS …" (Foster and Makufa, 1998:2). Although volunteers had no formal training, many became advocates in the bureaucratic and political systems of the country, pressing for improved delivery of services and attention to local needs. Like other initiatives noted here, the FOCUS initiative has drawn on community strengths and is flexible enough to address changing needs and approaches.

Community economics
Community structures include mechanisms for sharing assets, however meagre they may appear to outside observers. Funerals are occasions for materially assisting affected households (Pardthaisong, 1998). Income-generating activities, with and without outside stimulus, have been adopted to raise funds to assist households affected by HIV/AIDS. Community savings schemes are also deeply rooted in many societies, and these have been used to provide school fees for orphans and to pay medical or funeral expenses.

It is clear that local savings plans will not fill the gaps in household poverty nor cover the costs of obtaining health care and rebuilding assets sold off by affected households. Nevertheless, savings plans, local income-generation initiatives, and other efforts to sustain economic integrity can offer a buffer for low-income households when other sources of income fall or stop. In addition, they can complement other well-established and well-managed programmes designed to assist AIDS-affected households, such as subsidized school fees or food assistance programmes.

Recently, micro-finance approaches have been considered or introduced to support HIV/AIDS-affected households (Mageswary, 1999). Because micro-finance organizations have existed for nearly 20 years, there is some concern that established models may be imposed on communities, rather than being integrated into them (Donahue, 1999).

Innovative prevention
Much has been written about effective peer education projects in which trusted members of a social or occupational group offer information, goods and/or support to others in those groups. There have been projects to train members of almost every conceivable group as peer educators: primary and secondary school students, truck drivers and truckers' helpers, sex workers, hair-

dressers, taxi drivers, sports team members, farm workers, to name but a few. Responses to these projects are, in their initial stages, often positive. People appreciate and generally accept as credible the information they receive from colleagues and peers. The better peer education projects have a referral system for people who seek more information or specialized services, such as HIV testing and counselling.

Few prevention programmes have begun by addressing the causes and solutions to HIV/AIDS as set out by local communities themselves. Rugalema concludes on the basis of extensive experience in Africa that most communities are aware of HIV/AIDS and can establish reasons for its presence (Rugalema, 2000a). As noted earlier in this paper, inevitably the reasons have less to do with the sexual behaviour of individuals (although that is recognized as the immediate cause) and more to do with larger economic forces. Those forces might be ones that drive men out of their homes to seek work in urban areas or on agricultural estates, or the loss of hope among younger people for achieving some of the material prosperity and joy portrayed by middle-class advertising. They include the neglect (if not more subtle exploitation) by the state and commercial enterprises of lower income groups and natural resources.

Initiatives that credibly address a set of local concerns can move into addressing HIV/AIDS issues. For example, the Association des Jeunes du Peryssae pour le Développement in Burkina Faso supported women's literacy and income-generating projects before incorporating HIV/AIDS issues into those initiatives. Reading materials used in literacy classes now include information about HIV/AIDS, and reproductive health is discussed among the marketing groups (Grieg et al., 1999:13).

Organizations in Uganda are among the most experienced in terms of offering community-based prevention. The work of The AIDS Support Organization (TASO) is well documented. What is important for this study is the organization's very early link between HIV/AIDS care, support and prevention run by and for local communities. The TASO model has influenced other programmes in Uganda—and beyond—including the adoption of a community-based counselling approach supported by the National AIDS Control Programme (NACP). Trained local volunteers provide basic counselling for families and foster community involvement in care and prevention (Leonard, 1999).

Policy, advocacy and political mobilization

It is impossible to design an effective strategy for dealing with HIV/AIDS without entering the broader policy arena—a space that includes institutions ranging from church hierarchies to national governments and international agencies. And, in fact, the absence of clear national, sectoral or organizational policies has frustrated many NGOs and CBOs. While seeking to contribute to a more favourable environment for prevention and care, however, a number of civic organizations have been very effective in formulating policy recommendations, and in sensitizing and mobilizing decision makers. This has strengthened the confidence of local groups in their ability to engage in politics—an arena frequently co-opted by elites.

Two NGOs in Kenya provide examples of this phenomenon. Both organizations took advantage of changes in the overall political climate to organize meetings and discuss policy changes. In the process, both initiatives contributed to greater citizen participation in shaping national policies.

Monitoring the AIDS Pandemic (MAP) International is primarily concerned with providing essential medicines to communities, preventing the spread of disease (including of HIV/AIDS) and contributing to the development of healthy communities. It works in a nondenominational context of Christian values. By 1995, MAP and many other NGOs had come to the conclusion that religious groups had not sufficiently used their resources, skills and networks to promote HIV/AIDS prevention. The situation was made still more worrisome by the fact that, in several high-profile cases, religious authorities had spoken out against recognized prevention methods.

MAP sought to address both of these situations by working with church leaders of several denominations at the district level in Kenya. The initial plan was to sensitize the local leadership so that congregations would take a more active part in prevention and care. What emerged, however, was a much broader plan of action. As local church leaders began to talk with each other, they discovered that they shared a high level of frustration with the lack of leadership from church hierarchies on the question of how to deal with HIV/AIDS. Ministers reported presiding over a growing number of funerals and saw little church response to the epidemic.[30]

Over a two-year period, MAP gathered examples of the impact of HIV/AIDS on congregations. It organized planning sessions with local leaders and acted as a liaison between local and national leaders in each religious denomination. MAP acted as a facilitator, stimulating dialogue. The collective concerns of local church leaders were presented. Evidence of sexual behaviour by church youth was documented. The end result was that leaders of seven major denominations in Kenya signed a joint public statement, committing themselves to more, and more effective, action on HIV/AIDS prevention and care. On paper the statement appears vague. However, it opened the way for local congregations to design and implement much more effective programmes than had previously been the case. At local levels, too, church leaders continued their dialogue and collaboration.

While MAP was engaging religious communities in Kenya, another organization provided forums for programme managers, district HIV/AIDS committee members, HIV/AIDS activists and others to add their voices to national policy making. The Kenya AIDS NGO Consortium organized a series of problem identification and constituency-building workshops in the country's provinces. Over an eight-month period, the issues that concerned local prevention and care groups received extensive airing. Somewhat cautiously, district and provincial political leaders joined the discussions and, in many cases for the first time, heard of the seriousness of the epidemic in their regions.

Through a process of collaboration and consensus building at each of the workshops, the Consortium prioritized issues. The workshops also served to create or strengthen networking

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[30]   The MAP experience is summarized in Kiiti and Dortzbach, 1996.

among participants. The Consortium process gave both impetus and credibility to local groups meeting to discuss issues and define options for programme improvements. Because the workshops were announced as forums for discussion of national policies, some participants were sceptical that they — or the Consortium — had a role to play in what was considered the realm of senior politicians. But active discussion among participants overcame — at least for the group — concerns about engaging in policy work. Members knew that the Consortium Secretariat would carry the issues to the national level. At the same time, the Secretariat gained confidence in the willingness and ability of local groups to back policy initiatives. The growth of the network eventually tied the Consortium secretariat to all reaches of the country.

With its set of priority issues — often similar from one workshop to another — the Consortium staff began to formulate policy recommendations around the top three issues. Drafts of the recommendations were shared with district committees, members of the Consortium, the NACP, and activists in Nairobi. Policy action papers were written — and rewritten — and circulated to the Consortium membership.

Some 14 months into the process, the Consortium submitted its three policy issues and recommendations for policy responses to the government. By that time, the government had begun its own internal process to develop a national HIV/AIDS policy. Reports from within government and by the Consortium staff indicated that the input from the latter added momentum and coherence to the national effort. Since the NACP had been represented during several of the workshops, that link was well established. Informal relations, personal contacts, inclusion of the Consortium staff and executive committee members on panels drafting the national policy, and continued media reporting on the district- and provincial-level impacts of AIDS — all added to the momentum. The result was adoption by the government and Parliament of a national policy in 1997.

Shortly thereafter, the Consortium and a handful of related groups began a series of meetings to explain the policy and to help shape its implementation. This process has continued.

In Chiang Mai, Thailand, a group known as AIDS Organization has helped sustain support groups for people living with HIV/AIDS. In the process, both the support groups and AIDS Organization have lobbied politicians, informed clients of their legal rights, and worked to make social services more accessible. "In addition, members of AIDS Organization who are local AIDS activists have pushed for transparency in local politics and for a more integrated 'community' response — not just to AIDS, but to other socioeconomic problems linked to AIDS."[31]

Advocacy has been an essential element in moving stubborn bureaucracies and political parties. In Zimbabwe, for example, women's organizations have taken to the streets to pressure the government to import and assure the adequate distribution of female condoms. In Brazil, as early as the mid-1980s, gay activists and a small group of São Paulo state health officials joined forces to design the state's HIV/AIDS care programme. In time, the programme was adopted

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[31] Vincent J. Del Casino. Abstract prepared for the 7th International Conference on Thai Studies.

by other states and by the federal government. In Costa Rica and Panama, groups representing people living with HIV/AIDS became frustrated when they could not obtain support from the health care system for triple-therapy drugs, and they turned to the court system. In Costa Rica, the highest court ruled in favour of their demands. In Panama the suit was first rejected by the highest court. Then activists openly demonstrated in the streets and eventually returned to the judicial system. Finally, the government relented and agreed to provide triple-therapy drugs to seropositive people covered by the national insurance scheme (some 70 per cent of all those living with HIV/AIDS).[32]

Some commonalties

Emphasis in the preceding discussion has been placed on the strengths and abilities of communities to identify, develop and implement initiatives for HIV/AIDS prevention, care and mitigation. From an international public health perspective, community actions may appear too small, too scattered and too fragile to contain the HIV/AIDS pandemic. Such a concern is to some extent valid when initiatives are viewed individually. Nevertheless these initiatives collectively illuminate factors that strengthen the nexus between development and HIV/AIDS prevention and care.

These factors include:

Ownership
- local identification of prevailing problems and needs, around which options and solutions can be discussed; and
- identification of affected people and groups—women especially, and the numerous marginalized groups that are usually core transmitters or high-risk groups.

Process
- adoption of a long enough time frame for groups to build trust, to debate, to test options and to identify the range of skills and resources available; and
- training of facilitators—preferably from within communities, although this is not always necessary—to stimulate discussion, to offer new perspectives, to provide links to external resources, to keep a process moving.

Resources
- identification and use of community resources (including skills and money);
- very selective and very moderate insertion of external resources; and
- creation of a supportive economic, political and social environment that facilitates problem solving.

Three conclusions emerge from these examples. The first highlights the importance of an expanding civil society. Whether strengthening civil society involves steps into new realms—such as policy actions and advocacy once considered the exclusive prerogative of political parties and governments—or efforts to draw on long-established social norms and structures, the results are what we might call multisectoral, but more accurately, multifaceted.

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[32] The Central America examples are offered in Stern, 1999.

The second points to the reality that not all communities are alike. Their diversity yields numerous insights and examples for testing on a larger scale. But that diversity also makes developing and implementing prevention, care and mitigation programmes more complex and time consuming. Also, diversity means that some communities do not respond in a supportive way: stigma, fear or despair can be found in every country, in every region. Local leadership and supportive national policies and statements can help to alter those perceptions and can strengthen existing initiatives and offer fertile ground for new ones.

The third conclusion is that caution is in order when talking about household and community coping mechanisms. Inventiveness in the face of adversity is now widely recognized and cited by many agencies. However, in too many instances, the rhetoric about coping mechanisms has become an excuse for doing little or nothing to reduce the pressures on communities. This is especially the case for women who, in many countries, are more vulnerable to infection than men, have a far larger role than men in the care for family members infected with HIV, have responsibility for both the daily and long-term well-being of their children, and regularly experience active abuse and discrimination in their immediate and extended families.[33]

Conclusions like these have been known for years, and yet they have not been acted on by most development agencies. A number of important questions are therefore in order. How can elite-dominated economic and political systems be challenged to look at and accept alternatives? What can be done differently over the next decade to address HIV/AIDS in the context of community strengths, initiatives and needs? What hope is there that prevailing structures will accommodate community-based initiatives and/or allow a greater role for groups in civil society that seek change?

Sustainable human development and HIV/AIDS

If societies are to move toward (and eventually achieve) sustainable and human-centred development, not only will the HIV/AIDS pandemic have to be brought under control, but also the *means* by which control is achieved must concurrently engage all levels of society and funnel what is learned from this experience into developmental models for the future. According to the UNDP, "Human development is a process of enlarging people's choices. But such enhancement must be for both present and future generations without sacrificing one for the other" (UNDP, 1998b:14).[34] How this concept of development can be influenced by and applied to the pandemic remains relatively unexplored.

At the heart of the concept is recognition of the skills, resources, knowledge and actions of all groups—women and men, young and old, impoverished and powerful. Response to the pandemic has been ambiguous on this measure. On one hand, HIV/AIDS has been socially divisive. Already marginalized groups (sex workers, drug users, migrant labourers) are further

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[33] A similar point is made by Carolyn Baylies in reference to the international "partnership" to engage African countries more fully in HIV/AIDS activities. "It is a partnership which acknowledges the necessity for community interventions while side-stepping the matter of how the links with communities will be forged and resources allocated," Baylies, 1999:390.

[34] The fullest expression of the concept of sustainable human development is found in UNDP's annual Human Development Reports.

alienated and stigmatized when identified as the primary transmitters of the infection. As Cohen (1997) argues: "The problem is perceived as being not the virus but people …." Fear, ignorance, and discrimination have contributed to a suppression of discussion about the pandemic. Yet individuals and communities in countries around the world have quietly assumed the role of primary caregivers. And citizens' groups that number in the thousands have organized and led the response to HIV/AIDS. The range of organizations represented at the XIII International AIDS Conference, held in Durban, South Africa in July 2000, well illustrates the extent of this movement for change.

Whether divisiveness or solidarity prevails will determine, in part, the eventual relationship between HIV/AIDS and sustainable human development. The following section offers a basis for further discussion of this issue by reviewing prominent approaches being followed by most governments and international donors.

Official Programme Approaches to Dealing with HIV/AIDS

As noted above, there are organizations and initiatives that have approached HIV/AIDS prevention and care from a developmental perspective. These initiatives offer viable alternatives for promoting HIV/AIDS prevention, care and mitigation while also promoting more positive forms of social and political development. The goal is to learn from these examples and foster existing and emerging initiatives. To express it another way: the goal is to build on existing social capital so that such capital can grow. However, local HIV/AIDS initiatives that incorporate developmental assumptions and approaches have not been vigorously taken up by most national AIDS control programmes or international donors. This section looks at programme approaches that are being pursued by those agencies.

Shaping HIV/AIDS programmes
Denial by national leaders and narrowness of purpose among international agencies characterize many of the official responses to the HIV/AIDS pandemic. From early on, national governments and national leaders denied either the existence of HIV/AIDS or dismissed its potential harm. It was common to hear AIDS discussed as a disease of homosexuality and/or promiscuity, both of which were claimed not to exist in the speaker's society. Countries with substantial tourism revenue—the Dominican Republic, Kenya, Thailand for example—sought to suppress epidemiological data on HIV/AIDS for fear of discouraging tourist visits.[35] As evidence about the pandemic became more available and even as countries began donor-driven HIV/AIDS awareness programmes, national leaders often remained silent or undermined the prevention messages by publicly questioning the efficacy of condoms or the appropriateness of sex education for school children.

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[35] **The Standard**, Nairobi, 15 and 18 January 1985. See also Bill Rau, Steven Forsythe and Tom Mboya Okeyo, "An Introduction to Kenya's Epidemic", in **AIDS in Kenya: Socioeconomic Impact and Policy Implications**, FHI/USAID, Washington, DC, 1996 and Y. Porapakkham, S. Pramarnpol and S. Athibhoddhi, **The Evolution of HIV/AIDS Policy in Thailand: 1984–1994**, FHI, Washington, DC, 1996.

On the international agency side, from the mid-1980s onward, there was a scramble to raise money, design and implement interventions, and engage in research. The Global Programme on AIDS (WHO/GPA) was created within the World Health Organization (WHO). It set about providing technical assistance to countries that were building formal structures to lead national prevention efforts. Invariably, national AIDS programmes were weak and marginalized in the political process. Three- to five-year plans were shaped by WHO/GPA assistance, but many of them suffered from the drawback of being virtually identical, lacking country relevancy, and making inadequate reference to existing resource constraints.[36] Other multilateral, as well as bilateral, donor agencies initiated HIV/AIDS programmes in the late 1980s. Too often, these agencies modelled early programmes on public health programmes in North America and Europe. A number of relatively expensive behavioural and economic studies, designed and led by researchers from developed countries, were commissioned. These studies involved lengthy field presence and subsequent data analysis. Findings were at times used more to bolster academic credentials than as practical support for policy formulation.

The combination of national denial and donor-driven framing of responses to the pandemic left little room for debate, experimentation with interventions, or consultation with specialists from development disciplines.

However, as the pandemic accelerated in the 1990s, international donors and many of their national AIDS programme counterparts began talking about incorporating new partners and new resources into prevention and care efforts. Collaboration with NGOs and, to a lesser extent, CBOs was taken seriously by WHO/GPA, as well as by its successor, UNAIDS, which became operational in 1996, and by several bilateral programmes. But because donors held the purse strings, "collaboration" too often implied absorbing NGOs into donor plans and approaches. NGOs quietly complained about their subsidiary roles and about the narrow behaviour change/prevention projects they implemented, but they were not strong enough to operate without donor funding.[37]

What has occurred instead is a repetition of interventions, sometimes overlapping in time or space, without reference to one another. The lessons from HIV/AIDS initiatives that have sought to address underlying issues and the lessons from several decades of development practice have been largely ignored.[38] Thus caution is necessary in promoting (and perhaps even identifying) initiatives that have broadened the prevailing public health approaches to HIV/AIDS prevention. Development-oriented initiatives for addressing HIV/AIDS may be co-opted and distorted to fit external rather than local needs. Other initiatives may be

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[36] WHO/GPA, **External Review Report: Kenya National AIDS Control Program**, mimeo, 1992, vi. See also, National AIDS Control Programme, **1989–1990 Project Plan and Budget**, 22 and E.P.Y. Muhondwa, **Evolving Responses to the AIDS Epidemic: A Developing Country Perspective**, 4, paper presented at the Third USAID HIV/AIDS Prevention Conference, Washington, DC, August 1995.

[37] Bill Rau, interviews with NGO managers and personal observations, 1994–1997.

[38] In a review of the social development policies of national and donor agencies, Thin et al. (1997) observe: "[Recent evaluation reports] present a variety of generic 'lessons' which are in effect truisms that could have been found in any number of introductory guides to aid and development in the 1970s or earlier." A similar observation can be made about many of the "lessons learned" in HIV/AIDS interventions—the lessons have been known in a development context for decades.

misinterpreted in a rush to replicate them, so that new efforts do not devote enough time to involving communities and adapting to their cultures and social patterns.

To achieve a broadened response to HIV/AIDS, UNAIDS, international donors and many national governments have spoken about the desirability of multisectoral approaches. The intent has been to involve all government ministries and departments, private sector businesses and NGOs, and social and cultural groups in addressing the pandemic. To be sure, there is a need to broaden the response to HIV/AIDS, to draw on the skills and resources of a wide range of organizations, and to create a climate of social support for both prevention and care. However, advocates of multisectoral approaches to HIV/AIDS uncritically assume that government ministries, businesses, international donors and other sectors function in ways that enable social well-being. The reality is that many government ministries do not fulfil the mandate under which they were created. Small-scale agriculture has been neglected in favour of large-scale farms. Women's agencies are blocked from promoting the implementation of laws designed to expand opportunities for women. Ministries of labour have adopted corporate rationales for downsizing workforces. The list could go on and on. Thus, to broaden the response to HIV/AIDS and to build on the examples emerging from local groups and communities, government offices need to do what they were created to do.

Against this brief background, we look critically in the following pages at three interrelated approaches formulated by UNAIDS, as well as by public health and donor agencies, to expand and improve the response to HIV/AIDS:

- integration of HIV/AIDS prevention and care into existing sectoral programmes;
- mainstreaming of HIV/AIDS prevention and care into normal bureaucratic activities (i.e., planning, budgeting, evaluation); and
- scaling up effective initiatives to cover a wider area or a larger number of people.

In the public health field, integration has received the most attention and scaling up has received the least. The primary motivation for action has been financial—how to spread limited resources and achieve greater impact. Integration has also been seen as a means to better serve the reproductive health needs of women. Interestingly, development specialists addressed all three topics from the 1970s through the 1990s, but their analyses and examples are inadequately integrated into HIV/AIDS analysis (Lele, 1975 and Chambers, 1983).

Integration
The advantages of integrating service provision are that such an approach:

- more closely resembles the realities of daily life;
- allows for financial, infrastructural and management efficiencies by having all providers in a single location, sharing resources;
- is more efficient for clients, who can draw on multiple services at a single site and/or at a single time;
- provides a way to meet the needs of underserved populations—including women and adolescents; and

- reduces risks of stigma and discrimination associated with services that are specific to HIV/AIDS and other STDs.

Perhaps the most extensive consideration of integration in sectors can be found in the work of Alan Whiteside. Under his direction, several sets of **AIDS Briefs**,[39] covering most economic sectors and a number of professional disciplines, have been produced. The purpose of the briefs is to stimulate thinking and discussion (leading to planning) about how to incorporate HIV/AIDS issues into the activities of government bureaucracies, businesses and NGOs. One value of the briefs is that they recognize the depth in any organization at which planning must occur. They do not suggest dramatic changes in structures, but they recognize that new thinking and impact analyses are needed for organizations to engage in HIV/AIDS prevention and to assist in mitigating the impact of the epidemic. For some of the sectors, HIV/AIDS issues become an "add on", incorporated into existing procedures. Thailand's national response to the epidemic from the early 1990s onward best reflects the kind of sectoral integration discussed in the **AIDS Briefs**.[40] Nevertheless, the briefs have met with some difficulty in being used for planning.

Operational research undertaken by the Population Council looked at the effectiveness of integrating reproductive health services throughout health systems. The conclusions are mixed, especially for health systems that are already highly stressed. In many countries in Africa, integration of reproductive health services does not exist. A review of reproductive health services (family planning, prenatal care, delivery, HIV/AIDS/STD prevention and treatment) in rural sub-Saharan Africa found high demand but inadequate planning and implementation, as well as limited accessibility and quality through most channels available to rural people.

Integration across sectors has received less attention. Micro-credit and micro-finance programmes have been suggested as a means to lessen the impact on individual households of lost wages and extraordinary expenses due to HIV/AIDS, and UNAIDS has recently explored the potential of micro finance in this regard. Food aid, also, is being considered by the United States Agency for International Development (USAID) as a part of its "Life Initiative" to mitigate the impact of HIV/AIDS on individuals, affected households, and perhaps selected groups (such as orphans). Several countries have responded to the situation of "AIDS orphans" by providing school fee subsidies to certain low-income children. All these programmes are at pre-implementation or early implementation stages, so their effectiveness and appropriateness remain unknown.

There have been varying degrees of success in introducing HIV/AIDS education into primary and secondary school curricula. Opposition has been particularly strong in some countries, where religious authorities, parents' groups and politicians have blocked efforts by ministries of education and health to introduce such programmes. Where information on HIV/AIDS, or broader reproductive health information, has been integrated into school curricula, the results

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[39] **AIDS Briefs** were prepared with support from WHO/GPA and USAID. They can be found on the web: the 1997 compilation is available at: http://www.info.usaid.gov/regions/afr/hhraa/aids_briefs/introtxt.htm; the 2000 compilation is available at: http://www.und.ac.za/und/heard/AidsBriefs/AidsBriefs.htm.

[40] A summary of the response in Thailand is provided in Sittitrai, 1999.

are often good, at least in terms of student knowledge of sexuality and HIV/AIDS prevention, and, to some extent, in terms of behaviour change (Grunseit, 1997).

In Senegal, Thailand and Uganda, national HIV/AIDS programmes have worked with religious communities and authorities to gain early acceptance for prevention. Rather than shunning or confronting religious groups, as occurred in a number of donor-sponsored national programmes, efforts in these three countries have recognized religious authorities as credible and influential leaders of public opinion and repositories of cultural tradition.

Recently, several projects have been developed to use sports figures and sports settings to promote HIV/AIDS prevention. These high-profile events have probably added little in terms of spectator awareness about HIV/AIDS, but they may have contributed, in Kenya, to improving the environment for more open discussion about the epidemic and about sexual behaviour.[41]

Primarily central authorities have driven the attempts at integration noted here. In some instances, these authorities have responded to local situations or have recognized the importance of working within cultural and social structures that are credible with many people.[42] However, there is still much scope for top-down integration strategies to draw lessons from local-level initiatives.[43] In the context of HIV/AIDS, the disjuncture between national policy and local needs can be great. National programmes are largely shaped by public health biases that can run counter to local practices and interests, or create expectations that will not (or cannot) be met. In Thailand, for example, community involvement in care and support for people living with HIV/AIDS was found to be limited when community members felt that "professionals had expertise in relation to HIV and AIDS, and where there were accompanying beliefs that care should be provided in a 'top down' way …" (Aggleton and Warwick). People wanted professional health care, provided by government institutions; and they considered home care a poor alternative in this context. The same position has been taken by groups in Kenya, where rural people have insisted on their right to government-sponsored health care—accessible more frequently in urban than in rural areas.[44]

Initiating behaviour changes from outside social groups has proven to be one of the great challenges faced by HIV/AIDS prevention programmes. There are numerous contradictions between the immediate need to address an epidemic and the longer-term patterns of adaptation of social groups—many of which have become evident over the past 20 years of addressing the HIV/AIDS pandemic. Some of these contradictions are outlined in the following table.

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[41] Unpublished reports by Johns Hopkins University, Center for Communication Programs, 1999 and 2000.
[42] Interestingly, religious groups have taken the lead in seeking to build bridges between central authorities and popular beliefs (UNAIDS, 1998a).
[43] On the issue of development processes, see Cohen, 1997.
[44] Bill Rau, observation, Nairobi, Kenya, June 1997.

Table 2: Contradictions between immediate needs and long-term adaptations

Characteristics of social groups	Characteristics of public health systems
- Multiple needs and interests	- Single or limited interests
- Process-oriented	- Results and project-oriented
- Rely on practical life experiences and coping skills	- Medically driven, requiring scientific proof on specific issues and concerns
- Need time to process proposals and make changes	- Driven by the need for quick action
- Participation means discussion, consensus	- Participation means that the public will follow public health standards and guidance

Finally, it is worth noting that prior large-scale experiences with integration (such as integrated rural development programmes, women's issues and primary health care) have often not worked. Integrated rural development has been largely abandoned on the grounds that it is too complex and that elements of it are constrained by national policies and global economic conditions. Women's issues have become so "integrated" that they tend to dissipate in other programmes. Primary health care has been diluted in favour of several vertical programmes, and even these rarely work without extraordinary inputs from international donors (Wisner, 1988).

Mainstreaming

Mainstreaming is similar to integration but involves changes on a wider, structural scale. While integration can be project specific, mainstreaming entails absorption of HIV/AIDS prevention, care and mitigation into the regular processes of planning, budgeting and implementation. It implies creating awareness, throughout all sectors and all levels of society, of the implications of HIV/AIDS (for individuals, households, groups, companies, organizations and government). It assumes that once awareness about HIV/AIDS issues is achieved, those issues will become a functional component of an organization's work. One result should be that advocates do not have to struggle during every planning or budgetary cycle to gain attention and support for their cause. It means that HIV/AIDS is a core part of all thinking and operations.

To date, much of what has passed for mainstreaming has, in fact, involved little more than HIV/AIDS add-ons to existing programmes. Institutions have assumed that they have made HIV/AIDS a part of their work by offering an occasional "awareness-raising" talk for employees or dispensing condoms in the workplace. In Brazil, for example, employers provide health information to employees, but interviews with company managers revealed that HIV/AIDS was not considered a serious threat to business operations and that the "education" programmes were repetitive and superficial.[45]

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[45] Joseph Collins, **AIDS in the Workplace: Case Studies from Brazil and Zimbabwe**, report prepared for FHI/AIDSCAP, mimeo, 1996. See also, Richard Parker, **Historic Overview of Brazil's AIDS Programs and Review of the World Bank AIDS Project**, paper prepared for FHI/AIDSCAP, mimeo, 1995. The corporate response to the epidemic has been largely self-protective. With a handful of notable exceptions, companies have made few provisions to alter business practices in order to improve the environment for prevention. More often, there has been undisclosed testing of employees for HIV/AIDS (usually as a part of a physical examination associated with insurance coverage), and employees known or suspected of being HIV-positive have been forced to retire. Life insurance policies frequently include provisions that preclude payment if a person dies of HIV/AIDS. Living conditions at mines, estates and large construction projects have not been altered to reduce vulnerability. Trade unions and other workers' societies have not forced these issues and, in some cases, have joined the mainstream trend of ignoring the contribution of living and working conditions to HIV/AIDS susceptibility.

Effective mainstreaming must take into account the social and economic factors that are the context of HIV/AIDS. Thus it is not really mainstreaming to ask agricultural extension workers to include prevention messages in their meetings with farmers. Rather, mainstreaming implies training extension workers to recognize signs of agricultural stress due to labour shortages or asset constraints. Mainstreaming stimulates agricultural planners to promote labour-saving crops or labour-sharing systems. It should encourage agricultural and finance ministers and banks to loosen credit, increase farm prices, and reintroduce subsidies on basic foodstuffs. Mainstreaming involves doing — or doing better — what one is supposed to be doing anyway.

This seems to have been occurring in Thailand. An initially top-down national prevention programme gradually became aligned with national planning priorities. For instance, the 1992–1996 HIV/AIDS Prevention and Control Plan adopted a more multisectoral and multiministerial approach, emphasizing closer collaboration between public and private entities. By the time the 1997–2001 plan was being developed, Thai authorities recognized that the changing nature of the epidemic required placing prevention and care efforts in the national strategy for economic and social development (Karnpisit, 2000).

In Uganda, mainstreaming the response to the epidemic has entailed a blending of government (centralized and decentralized), private initiatives, and community responses and responsibilities. Other countries have made similar commitments. What sets Uganda apart is that, as the impact of the epidemic has grown, the government has accepted co-responsibility with NGOs and households for care of households. The government has acknowledged its own limitations, as well as the strengths of communities and community-based NGOs (Madraa and Ruranga-Rubaramira, 1988:49–57). It has not sought to shift its responsibilities to households by employing the rhetoric of household coping mechanisms.

UNDP and UNAIDS have been at the forefront of discussions about mainstreaming HIV/AIDS programmes. These organizations have stressed that there is no single solution or approach: "There is no known technique for mainstreaming which is applicable everywhere, at all times and under all conditions" (Cohen, 1999b:3). They go on to stress the importance of assuring that sectoral and programme decision makers understand, support and expect mainstreaming from their staffs. And they underline the need to strengthen national capacity for "applied socioeconomic research … on those structural conditions which often determine the speed of spread of infection and the pattern of effects of the epidemic" (Cohen, 1999b:3). There is also a need for research to identify and analyse examples of reasonably effective mainstreaming, though attention must be paid to keep this from becoming an academic exercise. In sum, while all organizations are now in favour of mainstreaming, they understand that it is not an easy or rapid achievement.

All the factors noted by the UNDP are important. They rest, however, on several substantive assumptions that may or may not hold true in specific policy contexts:

- the findings from socioeconomic research will in fact be relevant to decision makers;

- decision makers will act on the basis of the best available knowledge (in addition to political factors);
- bureaucracies will adapt in ways that allow them to hold staff accountable for effective mainstreaming;
- communities and marginalized groups will find relevant to their needs the programmes and projects developed and implemented as a result of mainstreaming; and
- mainstreaming will generate qualitatively different approaches to well-being (along the lines associated with sustainable human development), thereby reducing the susceptibility of many groups in the population to HIV/AIDS.

In a number of African countries (Kenya and Zimbabwe are examples), mainstreaming is occurring *ad hoc* and often from within government bureaucracies, through a combination of personal contacts and more formal mid-level working relations. These examples remain largely undocumented but reflect (i) a common understanding, in various sectors and departments, of issues and problems to be addressed; (ii) common goals across sectors; and (iii) reliance on existing skills and resources, rather than dependence on new resources. While a multisectoral response to HIV/AIDS is emerging, however, in most cases this does not generate (or cannot generate, because of bureaucratic constraints) new approaches to socioeconomic development.

At the donor level, mainstreaming has been achieved in an ironic sense: HIV/AIDS funding and projects have usually followed the normal bureaucratic channels. Although the epidemic has rhetorically been acknowledged as a threat to hard-won advances in social development indicators, or even as a threat to donors' national security, mechanisms for offering assistance have seldom been modified. Long-standing reporting and accounting requirements, and implementation procedures, remain in place; and traditional procurement processes continue to disrupt established programmes.

Scaling up

It has been difficult to scale up pilot projects and other small efforts. Yet there are good reasons to scale up effective initiatives. Standardization can encourage greater equity in provision of services and provide impetus for improving infrastructure. It can also promote an atmosphere for reducing discrimination and stigma. Scaling up introduces new expectations, reflecting national norms and goals. This can expand the provision of services in cost-effective ways. For example, a recent study focusing on the cost of scaling up home care visits by medical authorities found that per visit costs dropped dramatically as the programme expanded and matured (Lee, 2000).[46] One reason why this programme has been both effective and cost effective is that it intentionally involves community volunteers, a factor evident in many of the innovative community-based initiatives already cited. While one justification for drawing in volunteers is to help reduce costs, at another level inclusion of volunteers implies confidence in the skills that those people can bring to an activity.

In many instances, constraints to scaling up have nevertheless outweighed the opportunities that can be associated with it. Most frequently, external demands or expectations drive a kind of

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[46] Other evidence on home-based care supported by local health systems places costs much higher, although that conclusion emerged before the evidence offered by Lee.

standardization that jeopardizes flexibility and local control. Thus a discussion of scaling up must begin with a look at constraints imposed by outside agencies. These include:

- *Lack of political will and commitment*. This is a favoured explanation in the public health community: if only senior political leadership would strongly support HIV/AIDS prevention, a realistic national response could be put in place. Indeed, political leadership can be crucial to success; but the problem is leadership at all levels of society—not just at the highest levels—and in donor and recipient countries alike. Nor is rhetorical leadership sufficient. Functioning policies and programmes provide essential space in which activists, managers and technical specialists can work. This is a key lesson to be drawn from the experience of Thailand from the early 1990s onward.
- *Donor-driven models and bureaucratic standards*. Most donor agencies do not practice what they preach to developing countries. Speed of implementation, participation of targeted groups, flexibility in adjusting to local realities—these are mantras in the donor response to HIV/AIDS. Yet one is hard-pressed to find examples where donors have adopted their own standards.
- *Expert-driven programmes*. Public response to HIV/AIDS has been entrusted to organizations seen as best placed to deal with the nature of the disease—health ministries, international health agencies and the health components of bilateral aid agencies. This allocation of responsibility shapes the (largely public health-oriented) response which has sought to combine—sometimes successfully and sometimes not—medical, educational, community and bureaucratic interests and concerns. At least in the most conspicuous and best documented interventions, expert opinion has prevailed in determining what works and what does not. Lip service has been given to community involvement, but practitioners are deeply sceptical about fully involving community leadership, religious groups and popular health providers in programme design and control. Also, the experts lack experience in investigating the socioeconomic determinants of susceptibility and vulnerability.
- *Crumbling state capacity*. The institutional framework that would be required to scale up effective responses to HIV/AIDS has often been fractured, and even dismantled, under pressure from international donors. Thus, although strategic plans may be drawn up by national AIDS-control programmes, there may be no broader national development plans in which to insert them.[47] The kind of comprehensive thinking required for development planning, as well as the web of institutions associated with such an activity, frequently do not exist.

It is also important to note that scaling up innovative and effective HIV/AIDS programmes may not be appropriate in all situations. Some initiatives can best remain small. Replication can occur (as Chikankata has sought to do with its community-based care programme), but expanding the number of people involved or the area served by the original programme may distort it.

Where scaling up does seem to be feasible and appropriate, prerequisites include:[48]

- a solid model from which planners (at all levels, beginning in potential recipient communities) can learn;
- overt commitment by planners and programme managers to work with (and often within) communities;
- consensus on a process—the means of achieving results are as important as the results themselves;

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[47] Desmond Cohen, personal communication, 30 May 2000.
[48] See the think-piece by Binswanger, 1999.

- commitment from communities to invest their resources, as well as willingness on the part of outside agents to respect those investments; and
- the availability of facilitators—whether internal leaders or external agents— willing and able to advance the problem-solving process, challenge ideas and assumptions, identify appropriate external resources, and retain credibility.

Once these requisites are firmly in place, national governments and international agencies can make a contribution by providing:

- supportive policies;
- efficient infrastructure;
- well-trained service providers; and
- appropriate levels of financial resources.

Thus experiences from the field indicate that investment in social capital is *the* requisite on which other forms of capital investment can build, not only for scaling up HIV/AIDS prevention, care and mitigation programmes, but also for long-term, sustainable development.

An Agenda for Further Social Science Research

There is no shortage of issues for research by social scientists seeking to improve understanding of, and response to, the HIV/AIDS pandemic. The following list grows out of our own work for this paper, and it is also shaped by our discussions with social scientists already actively involved in research and its application in this field.

Two overarching concerns are reflected in the list. The first is the need for greater differentiation in the analysis of *who* is affected by the epidemic (distinguishing by gender, age, social position, education, occupation, rural or urban setting, and so forth), greater ability to distinguish the *reasons* for any distribution and trends that appear to be occurring, and a more concrete understanding of *how* HIV/AIDS affects households and societies as a whole. Second, there is a need to appreciate the socioeconomic, cultural and political factors that both strengthen and inhibit the capacity of particular societies to deal with the epidemic.

The list is then divided into three broad categories: (i) *contextual issues*, research about which can help policy makers, programme planners and managers, social scientists and activists understand and respond better to the numerous factors that are driving the pandemic; (ii) *impact issues* that remain critical to understanding effective approaches to mitigation, support for affected households and communities, and realistic international responses; and (iii) *programming issues*, where research can aid in the design and implementation of prevention, care and mitigation efforts.

Findings from too many of the research projects undertaken to date have not been relevant for programme design or policy development. Thus, beginning at the conceptualization and design stage of any social science research activity that deals with HIV/AIDS, researchers must work

closely with programme planners, policy makers and advocates to ensure that findings are relevant to their needs.

Contextual issues

The global context for HIV/AIDS

1. It is obvious that rapid and equitable economic growth is an essential element in slowing the AIDS epidemic. What changes in global trade, debt relief and commodity price policies would be required to ensure that fairly distributed economic growth can be achieved in developing countries? And what global socioeconomic conditions and policies are heightening the susceptibility of people—especially of people in developing countries—to the HIV epidemic?

   To answer these questions requires integrating HIV/AIDS thinking into international debates on major development issues. Research on specific country cases can highlight the role played by various international policies and institutions (including multinational corporations) in affecting the capacity of governments and NGOs to conduct effective prevention, mitigation and care programmes.

2. It is also extremely important to evaluate global development goals, including those agreed by the OECD Development Assistance Committee and others set at international summits, in light of the worsening pandemic. It is likely that HIV/AIDS will be the biggest obstacle to achieving these goals—and in fact that it will not be possible to meet them at all unless there is a much more effective response to AIDS.

Country and local context

1. To gain a clearer picture of the socioeconomic, cultural and political factors affecting the course of the epidemic, case studies of the development of HIV/AIDS in similar kinds of environments—say commercial farming areas —in three or four different countries could be very useful. Work like this should trace the profile of the epidemic in each case and document, for each stage, how different groups were affected, how society responded and what social changes have occurred. If a study of this kind is well done, it might be possible to distil lessons of use in other contexts.

2. Specific public policy approaches in countries like Uganda or Thailand, which have been relatively successful in containing the epidemic, could also be compared with those of countries where little has been accomplished. A similar exercise could focus on regions within a single country (comparing, say, the situation in Kerala with that in another Indian state). The challenge in this kind of work is to explain the social, political and institutional factors that make for more or less effective responses to HIV/AIDS.

3. At the same time, it would be useful to assess the implications of HIV/AIDS for national poverty reduction strategies, carrying further the work that is already in progress. Many countries are setting time-bound targets for poverty reduction and for progress in such fields of human development as literacy, life expectancy, child mortality and gender equality. The epidemic must be factored into these plans, so that there will not be a bias in projections or a limitation to actions in Heavily Indebted Poor Countries (HIPCs) that are preparing Poverty Reduction Strategy Papers.

4. It is urgently necessary to improve debate on issues of health sector reform by relating them clearly to the challenge of HIV/AIDS. What are the essential elements of public and private health systems that can successfully confront a rapidly expanding pandemic? Here the holistic nature of health care must be highlighted through case studies. What kinds of counselling and testing services, for example, would have to be in place before sharp reductions in the cost of AIDS drugs could really benefit most people who must live with the disease in developing countries? How can needed laboratory systems and staff training services be provided?

5. In most countries, civic organizations have taken a lead in promoting prevention and care. How have responses to the epidemic strengthened or weakened civil society in different countries and regions? What are the practical implications for governance of different approaches to HIV/AIDS? Here the experiences of the Philippines and Myanmar might usefully be compared.

6. There is a broad scope for new research on AIDS and the workplace. For example, the organizational cultures of different kinds of companies affect HIV prevention programmes. Unions and workers' groups also play an important role in determining whether HIV/AIDS is a workplace issue and how the epidemic is negotiated with management. In turn, the dynamics of labour/management relations affect the likelihood that people living with HIV/AIDS will be able to participate more broadly in the kinds of mobilization that can assert and protect their rights.

7. Labour migration is an essential element in the social and economic context of HIV/AIDS. It could be very useful to identify sites of labour migration where living conditions (privacy, the right for workers to be accompanied by their families, recreational facilities and opportunities, health services and so forth) are reasonable, and to analyse the costs and benefits of such situations from the perspective of AIDS prevention—as well as from the broader perspective of sustainable human development.

8. In a similar vein, case studies of the relation between construction projects and HIV/AIDS—and the way this symbiosis affects both workers and host communities—have immediate policy relevance. What factors seem to reduce susceptibility to HIV/AIDS? Projects that supposedly have taken steps to reduce susceptibility of workers and host communities—if there are such—should be included in the research.

Impact issues

In their review of HIV/AIDS impact studies, commissioned by UNAIDS in 1999, Barnett and Whiteside (2000b) note that most of these studies have been done by demographers and economists. The former have modelled effects of the epidemic on population structure and size, and the latter have focused on the estimation of costs (usually only direct costs)—for various sectors of the economy, for government programmes (particularly in the health sector), and for businesses and communities. The authors conclude that "social scientists other than economists and demographers now need to make their contribution to our understanding of impact issues".

This is certainly true; and we would suggest that a useful way to frame this contribution is by giving special attention to the complex processes of socioeconomic differentiation associated with the spread of HIV/AIDS in different countries and regions. The epidemic worsens poverty and deepens income inequality. But it does so in various ways, and these are often poorly understood. If public policy is to deal more effectively with the crisis, it is important to understand not only *who* is most vulnerable, but also *why* this is the case and *how* the impact of disease is transmitted to different members of society.

1. How, for example, does HIV/AIDS affect the life chances and livelihood of women in specific cultures and localities? This is more than a timely question for comparative social science research. It is an extremely practical subject of investigation, which must be linked to strategies for mitigating the impact of the epidemic on women themselves, and on households and communities. Practitioners dealing with HIV/AIDS in specific localities need the help of social scientists to gain insight into the mechanisms of differentiation that affect women.

2. Legal and institutional questions deserve greater attention—including elements of customary law and tradition. For example, there is the issue of survivor rights. Some countries, like Tanzania, have made specific reforms to these rights. Who do

these favour in practice, and how effective have they been in protecting women and children?

3. How do people—again, in specific social settings—finance care for those living with HIV/AIDS? Are shifts in land ownership occurring, as households give up access to land in return for needed resources? What are the conditions for such transfers? Are other fixed assets (including livestock in rural areas) changing hands? It is important to remember that increasing maldistribution of resources implies not only that some people lose, but also that other people win.

4. The impact of HIV/AIDS on the labour force must also be better understood. This is an essential element in analysing the impact of the epidemic on subsistence farming systems in various parts of the world. Household provisioning depends on unpaid labour. When family members are no longer able to carry out subsistence activities by themselves, are old and new forms of unpaid labour exchange filling the gap? And when this is not possible, are subsistence farmers becoming agricultural labourers? What are the implications of this for food security in the villages and regions under study?

5. In more general terms, how are rural economies coping with changes in the labour force? Is the lack of hands great enough at peak seasons to weaken or destroy local agriculture or change cropping patterns? How are rural wages evolving? Are more children involved in agricultural labour? More old people? More women? Specific case studies could highlight policy choices that should be considered by institutions ranging from agricultural ministries to social service providers.

6. It is also important to explore a number of issues related to human capital formation. What is happening, for example, to the capacity of key educational and training institutions, as they suffer the loss (through absence or death) of teachers and administrators? How are specific educational systems attempting to carry out their mandates despite the ravages of AIDS? And how are communities and households dealing with the loss of adults who play a key role in the informal process of education, imparting knowledge about certain trades or teaching skills gained over years of practical experience?

7. Human capital encompasses the capabilities and knowledge of both skilled and unskilled workers—neither of which can be costlessly replaced. Researchers should be involved in assessing the implications of human capital loss for the functioning of developing country economies—evaluating both the direct impact of HIV/AIDS on particular sectors and industries, and the systemic effects of changes in one sector on others. The assessment should also describe and evaluate the way these sectors and industries are attempting to respond to the loss of people with different skills and training.

Programming issues

1. NGOs have led the way in responding to the epidemic with pilot projects and effective small-scale initiatives. They often run into difficulties, however, if they attempt to scale up their efforts. By working closely with some of these groups, researchers could help them analyse the structural and resource limitations that arise when they try to expand their reach. Their ideas and experience could provide very useful lessons for others.

2. Case studies of attempts by governments to mainstream HIV/AIDS should also be prepared, so that the strengths and weaknesses of different approaches become clearer. A fuller examination of where, why and how mainstreaming has occurred would provide guidelines for other countries.

3. There are examples of large, internationally financed infrastructure projects that have incorporated an assessment of their potential impact on STDs (including HIV/AIDS) in their project design. The Chad/Cameroon oil pipeline is the first of these. It would be instructive to conduct a follow-up study of the project.

4. The European Commission has designed a "toolkit" to promote multisectoral assessments of HIV/AIDS impacts and appropriate programme responses. Researchers could identify projects in which the toolkit has been used and explore the strengths and weaknesses of this approach in different institutional settings.

   Work could also be done to evaluate other instruments that are designed to promote multisectoral responses to the epidemic; or to test new proposals,

such as the Guidelines for Studies of the Social and Economic Impact of HIV/AIDS (UNAIDS, 2000b).

5. Finally, there is room for research on the issue of how funds freed up by debt relief can be channelled into innovative development strategies that make a real contribution to the fight against HIV/AIDS—creating an overall economic and social context in which people's vulnerability is reduced and their chances of leading full and productive lives are greatly increased.

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