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Poverty Reduction Strategies from an HIV/AIDS Perspective

Foreword

The Department for Policy and Methodology within Sida (POM) is responsible for leading and coordinating Sida's work on policy and methodological development and for providing support and advice to the field organisation and Sida's departments on policy and methodological issues relating to development cooperation. It links together analysis, methodological development, internal competence and capacity development and advisory support.

The department undertakes analyses and serves as a source of knowledge on issues pertaining to poverty and its causes.

Learning and exchanges of experiences and knowledge are essential to all aspects of development cooperation. This series of Working Papers aims to serve as an instrument for dissemination of knowledge and opinions and for fostering discussion. The views and conclusions expressed in the Working Papers are those of the authors and do not necessarily coincide with those of Sida.

HIV/AIDS has fundamental implications on virtually all aspects of social and economic development in the worst affected countries and constitutes one of the most difficult obstacles to human development facing the world today. The present study provides a review and analysis of poverty reduction strategies (PRS) from eight countries, primarily in sub-Saharan Africa, from an HIV/AIDS perspective. It examines the extent and manner in which HIV/AIDS is taken into account in these strategies with regard to the three main perspectives; prevention, treatment and consequences.

It is our hope that the study will stimulate reflection and discussion.

Stockholm. April 2005

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Head of the Department for Policy and Methodology

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Executive Summary

- HIV/AIDS is a major threat to development and has brought with it terrible consequences in all sectors of societies. In the worst affected countries, in sub-Saharan Africa, HIV/AIDS constitutes a threat for entire nations.
- The objective of this report is to review and analyze poverty reduction strategies from an HIV/AIDS perspective with regard to three main dimensions: prevention, treatment and consequences. The eight countries under examination are Cambodia, Ethiopia, Malawi, Mozambique, Rwanda, Tanzania, Uganda and Zambia. The review is based on three documents: the Poverty Reduction Strategy Paper (PRSP), the latest Progress Report (PR) and the Joint Staff Assessments (JSAs).
- As regards the different dimensions, the authors' analyses give a clear indication that most efforts focus on prevention. This is particularly true in the early years of the development of the disease. As the number of people who develop AIDS increases, more attention is given to treatment and consequences. In general, treatment is the dimension least touched upon in the reports.
- The main findings in relation to prevention show that the reviewed countries have established national prevention targets for HIV/AIDS but that these are often not directly related to the Millennium Development Goals (MDGs), even if more attention has been given to the attainment of MDGs in the most recent PRs. Whether or not emphasis is put on the attainment of MDGs seems to be dependent to some extent on whether the country expects to achieve the goals.
- As regards treatment, the countries with the highest HIV/AIDS prevalence rates give due emphasis to treatment in their reports. On the other hand, the countries with the lowest prevalence rates give less attention to this issue. No sign of efforts to promote family and community-based care over time can be seen, and psychosocial care for people living with HIV/AIDS (PLWHA) is available only in three of the reviewed countries. In general, anti-retroviral therapy (ART) for AIDS is available to a very limited extent and few governments have worked actively to decrease the price of anti-retroviral drugs (ARDs).
- Concerning consequences, gender in relation to HIV/AIDS is recognized in five out of eight cases in the PRSPs and only in one country is stigma resulting from HIV/AIDS brought up as an issue. The two-

way link between HIV/AIDS and poverty is identified in less than half of the reports. In most cases HIV/AIDS is seen as a key contributor to poverty but the reports rarely stress the role of the potential of HIV/AIDS interventions to reduce poverty.

- Although monitoring targets for HIV/AIDS are in place in most countries, they are often not detailed enough to assess whether or not a specific measure has been implemented. This, and the fact that PRs rarely include detailed follow-ups of PRSPs, creates a risk that the initial policy commitments made in PRSPs evaporate before implementation. Moreover, implementation of adequate monitoring targets and systematic follow-ups of the HIV/AIDS strategies are urgently needed.
- HIV/AIDS measures are often linked to the national budget. However, few reports offer detailed descriptions of HIV/AIDS expenditure broken down into different actions. Efforts should be made to provide more detailed costing of HIV/AIDS measures in order to ensure implementation and transparency.
- The majority of the reports state that HIV/AIDS is treated as a cross-cutting issue. However, a HIV/AIDS perspective is often lacking in growth projections, descriptions of the determinants of poverty etc. Governments in the most seriously affected countries should make an effort to apply a HIV/AIDS perspective to all actions and analyses.
- There are indications of a risk that coordination difficulties will be created by the adoption of multi-sectoral approaches to fight HIV/AIDS, which involve all stakeholders in society. Governments should make an effort to increase co-operation and information sharing, including financial information, with civil society organizations and the private sector.
- Overall, the connection between international commitments and national strategies are often lacking in the reports. Hence, there is a need to improve the links between long-term international declarations and short-term and medium-term national strategies. Such efforts should be encouraged and requested by the international community.

1. Introduction

HIV/AIDS is perhaps best described as a major development crisis and one of the most important challenges to humankind in present time. Since the discovery of the pandemic in the 1980s, it has brought with it terrible consequences. It has killed millions of adults in the prime of their lives, separated families, destroyed and impoverished communities, and made more than 14 million children orphans. In some countries, life expectancy has fallen by more than 20 years and, in the worst affected countries in sub-Saharan Africa, HIV/AIDS constitutes a threat for entire nations.[1]

Since the adoption of the Declaration of Commitment (DoC) on HIV/AIDS in 2001 at the United Nations General Assembly Special Session (UNGASS) dedicated to HIV/AIDS, the HIV/AIDS epidemic has worsened. The report of the Secretary-General to the fifty-eighth session of the General Assembly, on progress towards implementation of the DoC, emphasizes that assertive political leadership and effective action is required to prevent a major expansion of HIV/AIDS and it recommends that all countries develop and implement national strategies to promote the delivery of comprehensive prevention, treatment, care and support to people living with or affected by HIV/AIDS.[2]

Against this backdrop, this report sets itself the task of reviewing and analyzing poverty reduction strategies from eight countries, primarily in sub-Saharan Africa, from an HIV/AIDS perspective. More specifically, the objective is to examine the extent and manner in which HIV/AIDS is taken into account with regard to the three main perspectives: prevention, treatment and consequences. The countries under review are Cambodia, Ethiopia, Malawi, Mozambique, Rwanda, Tanzania, Uganda and Zambia. These countries have been selected on the basis of the fact that they are all severely affected by HIV/AIDS and because Sida (Swedish International Development Cooperation Agency) works actively with poverty reduction in these nations.

The review is based on three main documents specific to each country: the Poverty Reduction Strategy Paper (PRSP), the latest Progress Report (PR) and the Joint Staff Assessments (JSAs). In brief, the PRSP process was introduced in 1999 to support country-driven efforts to prepare effective growth and poverty reduction strategies that would be

1 http://www.imf.org/external/np/exr/facts/hivaids.htm. [2005-03-14].

2 UN Economic and Social Affairs (2004, p. xiv).

endorsed at a high political level in developing countries.[3] PRSPs provide the operational basis for concessional lending by the International Monetary Fund (IMF) and the World Bank, and for debt relief under the Heavily Indebted Poor Countries (HIPC) Initiative. The PRSPs are updated annually with PRs, which report on advances made in the PRSP implementation process, and this document is seen as an essential input for pre-budget consultations. JSAs are assessments made by the staff of both the World Bank and IMF of the strengths and weaknesses of a country's PRSP and PRs. They consider whether the documents provide a sound basis for concessional assistance, as well as for debt relief.[4] For more detailed information about the three documents, see Appendix A.

To be able to fulfill the purpose of this report and ensure a systematic analysis, we have applied a classification system based on indicators selected from the DoC which are in line with the three perspectives of focus (prevention, treatment and consequences). See Table 3 in Appendix C for an overview of the indicators. This approach has allowed us to make a systematic review of each country and a consistent comparison between the countries. It should be mentioned that the analyses in this report are solely based on the descriptions included in the country-specific documents. Even if these reports are informative, it should be acknowledged that they cannot provide a complete picture of the countries' efforts in combating HIV/AIDS and poverty. The report contains three main chapters. It begins with a general discussion of the main aspects, implications and impacts of HIV/AIDS on development and poverty reduction including prevention, treatment and consequences. In the second chapter, country-by-country narratives are provided in which the documents from each country are reviewed. Finally, there is a brief discussion of the main findings and suggestions for improvements of the PRSP process.

3 Bonnel et al. (2004, p. i).

4 http://www.imf.org/external/np/jsa/joint.asp [2005-03-10].

2. Main Aspects of HIV/AIDS

It is a fact that the AIDS epidemic has had, and will continue to have for many decades, devastating consequences for virtually every sector of society.[5] The major impacts of AIDS often come several years after a country has reached a high level of HIV prevalence. Even with a reduction in the prevalence rate in the population, the impacts may increase for a long period of time. Economic growth and prosperity hinge on a healthy human resource base, which is currently threatened by the HIV/AIDS epidemic in the worst affected countries, primarily in sub-Saharan Africa. AIDS kills people in the prime of their working and family lives and accordingly the economic impacts of AIDS represent a grave threat to development efforts. Today, about one in 12 African adults is living with HIV/AIDS, while one-fifth of the people infected with HIV live in Asia.[6] Given the devastating impact of AIDS on all levels of society and poverty reduction, strategies need to be adjusted and expanded accordingly. Unless this happens, AIDS will continue to erode human development achievements, deepen poverty, and further hamper access to education, health and viable livelihoods. This chapter provides a brief summary of the main aspects, implications and impacts of HIV/AIDS on development and poverty reduction in light of the three dimensions: prevention, treatment and consequences.

2.1 HIV/AIDS and Poverty

There is a clear link between HIV/AIDS and poverty. Although this inter-relationship is complex, the fact that HIV/AIDS leads to poverty and that poverty, in turn, directly or indirectly creates vulnerability to HIV/AIDS holds. Indeed, poverty is one of the major underlying factors driving the epidemic.[7] Still, it is not possible to claim that AIDS is a disease that only affects poor people. In general, HIV/AIDS has a magnifying effect on poverty, as it exacerbates existing problems and creates new ones.

On the one hand, HIV/AIDS exacerbates the poverty situation at the individual and household level, as well as the community and national

5 UN Economic and Social Affairs (2004, p. 1).

6 WHO (2004, p. 1).

7 While it is primarily in sub-Saharan Africa that the consequences of full-scale AIDS epidemics are seen, the impact is severe even where HIV prevalence is relatively low, and one of the most direct impacts is on poverty. Thus, a recent set of studies jointly undertaken by UNAIDS and the Asian Development Bank estimated, for instance, that AIDS will slow the rate of poverty reduction in Cambodia by 60 per cent every year between 2003 and 2015 and in Thailand, by 38 per cent annually. Source: Speech given by Dr. Peter Piot (UNAIDS Executive Director) at London School of Economics (LSE), London, UK [2005-02-08].

level. HIV/AIDS leads to poverty primarily by eliminating the productive sector of society, the 15–45 year age group, which leads to premature loss of human capital. On the other hand, people living in a state of serious and worsening poverty are more vulnerable to HIV infection due to a number of factors, for example less access to HIV information, education, health care services and means of prevention. Moreover, once infected with HIV, they are more vulnerable since they cannot afford antiretrovirals (ARVs) or even access less expensive treatment and care, nor can they and their families withstand the HIV-related impoverishment caused by loss of the ability to work and by the costs of care. In addition, they may have poor access to health care facilities, due to financial and/or supply constraints. In many countries with high HIV/AIDS prevalence rates, free health services receive inadequate resources as a result of overall national poverty. Their reduced access to health implies that poor people develop AIDS faster.[8] Vulnerability to infection and impact is also greater in societies characterized by inequality, discrimination, social exclusion, conflicts, and the displacement of people. For instance, in their search for income for subsistence and survival, people living in poverty participate in labor migration, which results in the breakdown of male and female relations, increases the likelihood of multiple or casual sexual partners, and the risk of HIV infection. It is also clear that women are more vulnerable to HIV/AIDS and disproportionately affected by the epidemic. For instance, women in poverty can be forced to enter into high risk sexual relationships, into bartering sex for subsistence.[9] Another vulnerable group for HIV/AIDS infection is the group of orphans and street children. As a direct consequence of HIV/AIDS, this group has increased to about 20 per cent of the young in the worst-affected countries.[10]

2.2 Macro Level

Through its broad economic impact, HIV/AIDS has become an issue for macroeconomic analysis and policies. Preventing the spread of the virus will have direct implications for key economic indicators such as economic growth and income per capita, as well as for economic development more generally.[11] Below, some of the aggregate macroeconomic impacts of HIV/AIDS are listed:[12]

- Public spending may be diverted from investments in physical and human capital to health expenditures, leading to slower growth of GDP over time.
- A shrinking tax base and increased government expenditure imply lower government revenues.
- Increased health expenditure leads to a decline in savings and capital accumulation which has an impact on long-term economic growth.
- Lack of savings and investments implies slower employment creation in the formal sector (particularly if it is capital intensive).
- Increasing labor costs as a result of slowed or reversed growth in labor supply, especially of skilled labor (due to increased mortality and number of ill people), lead to higher production costs.
- Higher production costs lead to a loss of international competitiveness

8 It is estimated that, without treatment, HIV will develop AIDS in ten years. Source: http://www.unfpa.org/aids_clock/main.htm [2005-03-15].

9 E.g. Malawi's PRSP (2002, p. 89).

10 IMF (2004b, p. 152).

11 IMF (2004a, p. 41).

12 This list draws on the authors' analysis and findings from previous research, mainly Thiis (2004, pp. 2-3).

which can result in foreign exchange shortages and deterioration in the terms of trade.

- Pension liabilities will decrease as a result of early mortality in the labor force.
- HIV/AIDS increases business risk which implies that a higher rate of return is requested by investors, which may lead to a decrease in Foreign Direct Investments (FDIs).
- A decrease in the growth rate of per capita income may deepen the poverty of the most seriously affected countries by selectively impoverishing the individuals and families which are directly affected by the disease.[13]

In sum, AIDS erodes the foundations of economic growth. Beyond its effect on GDP, the HIV/AIDS epidemic is also likely to exacerbate income inequality. However, the longer term impact of HIV/AIDS on welfare and development is, according to UNAIDS, more serious than the economic analyses suggest. Estimates of AIDS' impacts on economic performance usually do not take into account the loss of "social capital" or the long-term attrition of human capital, as children's education, nutrition and health suffer directly and indirectly as a consequence of HIV/AIDS. Among others, UNAIDS has expressed concerns that AIDS may reduce the means and the incentives to invest in human capital, primarily by the public sector. In the long run, the diminished investment in human capital may delay social and economic development, and cause a cumulative weakening from generation to generation of human capital.[14] Moreover, the effects of smaller investments in human capital will probably affect economic performance for decades to come, well beyond the time frame of most economic analyses.

2.3 Public Sector

"If we had seen real leadership in sub-Saharan Africa a decade ago – matched by equally real leadership from donor countries, […] – the continent would not have over 25 million people living with HIV today".[15]

HIV/AIDS has significant implications for the public sector, in particular for government budgets and service delivery, as it has the potential to corrode institutional capacities. Moreover, where national institutions are weak, AIDS is further undermining the capacity to respond.[16] Governments witness reduced growth in tax revenues as economic growth slows, while budgetary demands for health care and social welfare increase. Higher mortality erodes the government's human resource base, undermines domestic revenue collection, raises costs and causes disruptions to the delivery of a wide array of public services.[17] According to a recent report, an effective and functioning public sector is vital for the delivery of essential goods and services and developing successful national AIDS responses.[18] The HIV epidemic has particularly profound effects on health services in developing countries, as the health-care systems were already poor in many of the highly impacted countries before

13UN Economic and Social Affairs (2004, p. 81); Thiis (2004 pp. 2-3).

14 UN Economic and Social Affairs (2004, pp. 69, 73).

15 Source: Speech by Dr. Peter Piot, UNAIDS Executive Director, at London School of Economics (LSE), London UK [2005-02-08].

16 Thiis (2005, p. 3).

17 UNAIDS (2004a, Ch. 3, pp. 56 ff).

18 Thiis (2005, p. 3).

the epidemic struck. HIV/AIDS poses enormous additional demands on the health sector, straining health budgets and health insurance schemes. In addition, health-care workers are falling ill and dying and the HIV positive patients are crowding out patients suffering from other life-threatening diseases. Thus, while the demand is steadily increasing, the supply of available health services is gradually being depleted. As governments become increasingly hard-pressed to provide health care through the public sector, health care costs must increasingly be borne by the private sector and by households and individuals.[19] In general, both the private sector and the government face the same AIDS-related employment costs, including increased training and recruitment costs, and changes to the structure of health insurance and pensions. However, the impact on the government personnel costs is likely to be larger because governments typically offer more comprehensive benefits to its employees. [20]

2.4 Private Sector

HIV/AIDS has adverse effects on the private sector because it disrupts activity, raises the cost of providing benefits, reduces productivity and increases training costs, as workers have to be replaced, retire or die.[21] A recent UN report claims that, while disruptions caused by illness and death are the primary cost of HIV/AIDS to small companies and the informal sector, the impact on medical and death-related benefits is more important for larger companies. Ultimately this will lead to declining profits. According to the same report, the magnitude of the impact on firms depends primarily on five factors (1) the number of employees infected; (2) their role in the company; (3) the structure of the production process and its ability to cope with the loss of employees; (4) the health-care benefits provided by the company; and (5) the effect of HIV/AIDS on the business environment. Another consequence of the epidemic on the private sector is that the demand for goods and services may decline since afflicted households have less income and lower consumption levels.[22] Faced with rising costs and a deteriorating and uncertain economic outlook, companies may relocate their production or, in the case of foreign investment, stop investing in countries with severe HIV/AIDS epidemics.[23]

Furthermore, the disease affects business enterprises in both the agricultural and non-agricultural sectors. The great majority of the population in the countries most affected by HIV/AIDS lives in rural areas and is often heavily reliant on agriculture as a source of income. In addition, these countries are often dependent on agricultural exports to secure reserves of foreign exchange that are needed to pay for raw materials and essential imports for development. HIV/AIDS is having a crushing effect on agricultural production and the economic viability of small firms and commercial agricultural enterprises. Among the consequences of the loss of farm workers are the reductions in land under cultivation, the shift to less labor-intensive crops, a decline in crop yields, and a shortage of labor during periods of high labor demand. In addition, the epidemic leads to loss of knowledge of farming methods and a reduction in skilled and experienced labor. Other important impacts of the HIV/

19 UN Economic and Social Affairs (2004, p. xiii). For a discussion of responsibilities and relations between the public and the private spheres see Whiteside and Barnett (2002, p. 70 ff).

20 UNAIDS (2004a, pp. 56 ff).

21 In a recent cost-benefit analysis of six firms in Botswana and South Africa, Rosen et al. (2003) estimated that AIDS was responsible for 1 to 6 per cent of labour costs per year and concluded that investments in prevention and treatment would result in a net gain for most companies. Source: UN Economic and Social Affairs (2004, p. 56).

22 UN Economic and Social Affairs (2004, p. xii).

23 IMF (2004b, p. 152).

AIDS epidemic on agriculture are food insecurity caused by the reduction in production, and loss of income sustained by household members employed in the sector. In addition, the epidemic may affect traditional coping mechanisms that are often found in rural areas. As the number of AIDS cases increases, the need for assistance may overwhelm the support system, and the traditional coping mechanisms may begin to break down. Faced by chronic or other sicknesses, the poorer households are more likely to leave land uncultivated (rich households with resources to hire replacement labor are less likely to resort to fallowing). According to UNAIDS, the future impact of HIV/AIDS on agriculture will depend, among other things, on finding ways of reducing the amount of labor by introducing less labor-intensive methods of production, and increasing yields with non-labor inputs.[24] It is also worth mentioning the informal economy, which has long been a dynamic source of employment and income growth, absorbing most of the growing labor force in many developing countries. In an ILO report it is stated that the much smaller size of informal enterprises will make it much more difficult for them to replace a skilled or semi-skilled worker in the event that the employee falls sick or dies and, for this reason, they are also much more vulnerable to the impact of HIV/AIDS than large enterprises.[25]

2.5 Household Level

Households feel the direct impact of the HIV/AIDS epidemic through its social and economic consequences. Indeed, it can be claimed, as it is in a recent UN report, that households and families bear most of the burden, since households are the primary units for coping with the disease and its consequences through the means and strategies that are at hand. According to a report from the UN, in addition to social and psychological consequences, three kinds of economic impacts of HIV/AIDS can be distinguished at the household level:

- The loss of the income of a family member, particularly if she/he is the breadwinner
- The increase in household expenditures to cover medical costs
- The indirect cost resulting from the absenteeism of members of the family from work or school in order to care for the sick[26]

The consequences of the epidemic create, in turn, a reduction in production, consumption and savings, the last-mentioned often becoming negative. Increased health care expenses reduce spending on other items, including food consumption (leading to malnutrition) and education. As the HIV infection is most common among young adults, the composition of families may undergo rapid changes. Severely affected countries show an increase in the percentage of female-headed, grandparent-headed and orphan-headed households. When a family member dies, the household may dissolve completely, and the children may be left on their own. This, in turn, is likely to affect the possibility for the children to attend school. The impact on children's education may also depend on the socio-economic status of the household. Thus, the poorer the household, the more likely it is to take the children out of the school system.[27] Orphans of AIDS victims are a particularly vulnerable group as they often live in poor households and studies show that they often have lower school

24 UN Economic and Social Affairs (2004, pp. xii-xiv, 61, 66).

25 ILO (2004, p. xii).

26 UN Economic and Social Affairs (2004, p. 39).

27 Ibid (2004, pp. xi, 47).

enrolment rates than non-orphans.[28] Since the burden of care usually falls on women, the impact of HIV/AIDS is particularly hard on them. Young girls have to care for sick family members and older women often assume responsibility for orphaned grandchildren.[29] HIV/AIDS may pose additional challenges at the household level since, in some places, disease carriers are stigmatized, which in turn has social and psychological consequences. Moreover, the stigma of the disease has to be endured not only by those who are ill but also by other family members, even after death.[30]

28 IMF (2004b, p. 152).

29 UNAIDS (2004b, p. 8).

30 UN Economic and Social Affairs (2004, p. 91).

3. Country-by-Country Narratives

In this section, eight country narratives are presented which summarize the information from each country's PRSP, PR and JSA. They start with a brief overview of the HIV/AIDS situation in the country, followed by a detailed summary of the contents of the documents studied, and end with an overall assessment of the extent and manner in which HIV/AIDS is treated in the documents.

3.1 Cambodia[31]

Rapid increases in HIV transmission have been observed in Cambodia since the first HIV case was reported in 1991. Although the prevalence rate among adults (15–49) has declined in recent years, the country still has one of the highest rates in Asia, estimated at 2.6 per cent at the end of 2003.[32]

Cambodia's response to HIV/AIDS in the reports

Even if it is not explicitly mentioned in the reports studied, Cambodia has, according to UN sources, mobilized an effective multi-sectoral response to HIV/AIDS.[33] A law on the prevention and control of HIV/AIDS was passed in 2002. The National AIDS Authority was set up in 1999 and a National Strategic Plan (NSP) for the period 2001–2005 is being implemented. The PRSP explains that the National AIDS Authority is responsible for the overall HIV/AIDS program of the country and it will guide the development of specific activities. It aims to lessen the vulnerability of women and girls to HIV/AIDS and to increase their status by seeking to offset prevailing discriminatory attitudes in society.[34]

In the PRSP, HIV/AIDS is included in two independent subsections: "Dimensions of poverty" and "Reducing Vulnerability and Strengthening Social Inclusion". Yet, HIV/AIDS is only once discussed as a cross-cutting issue. It is stated in the PRSP that HIV/AIDS is increasingly receiving priority attention from the government, non-governmental organizations (NGOs) and external partners due to a better understanding of the epidemic and increased recognition of its possible impact on human security, economic development and national stability.[35]

31 For the purpose of this country narrative on Cambodia, the following documents have been studied: The National Poverty Reduction Strategy (NPRS) 2003-2005 (referred to as the PRSP), the NPRS PR from 2004 (referred to as the PR) and two JSAs from 2003 and 2004.

32 For more detailed information on HIV/AIDS prevalence see Table 1, Appendix C.

33 http://www.unaids.org/en/geographical+area/by+country/cambodia.asp [2005-03-12].

34 PRSP (2002, p. 119).

35 Ibid (pp. 28, 42).

As regards the way the country deals with the HIV/AIDS issue, in the JSA of 2003 the World Bank and IMF staff state that the PRSP gives due emphasis to HIV/AIDS and has a strong focus on its impact on poverty, social vulnerability, and gender. Moreover, the report asserts that the response to date has managed to stabilize the epidemic but recognizes that continued political and multi-sectoral commitment to the problem is imperative for a continuation of this favorable trend. There is also a need for better coordination between the Ministry of Health (MoH) and the NGOs. Moreover, voluntary counseling and training remain limited and surveillance is also an area in need of expansion.[36] In the PR it is stated that the government is merging the PRSP targets for prevalence with the MDGs.[37]

Concerning the extent to which HIV/AIDS is taken into account, this can be assessed by analyzing the budgeted costs of the Action Plan for 2003–2005. In total, HIV/AIDS makes up 23 per cent of the funds earmarked for reducing vulnerability and 2.5 per cent of the total cost of the PRSP Action Plan.[38] There is no follow-up of these projected costs in the PR but HIV/AIDS is recognized as a continuing challenge to the health sector.

Prevention: In the PRSP it is stated that one of the priority areas for the MoH is to strengthen management, prevention and control of key diseases which disproportionately affect the poor. The goal for HIV/AIDS is set at a reduction in the infection rate from 2.8 to 2.5 per cent. In order to achieve this goal, service delivery strategies, including home and health centre-based care, and distribution of prevention commodities, will be extended. The actions against HIV/AIDS put an emphasis on outreach and community-based measures as well as on awareness-raising campaigns. As regards prevention efforts, progress indicators are set at a 10 per cent decrease in new HIV/AIDS infections in 10 target provinces by 2005. It is stated in the PRSP that public information and education has had a great impact on the general awareness of HIV/AIDS in the Cambodian population but behavioral change is still limited in some population groups. To cope with this issue, it is suggested in the PRSP that health education should be introduced under the guise of general awareness, while behavioral change communication (BCC) strategies should be targeted at those with risky behavior. Furthermore, it is stated in the PRSP that gender inequalities are fuelling the HIV epidemic in Cambodia.[39] Hence, empowerment of women is one measure used to decrease the risk of HIV/AIDS infection. The PR recognizes HIV and trafficking as factors that increase gender disparities which represent barriers to poverty reduction. Further, the PR acknowledges that there has been an increase in transmission among women, especially housewives, an issue which is being addressed by the government.[40] One action undertaken to improve the situation is to introduce gender-specific indicators at the National Institute of Statistics. In the PRSP, the target set to assess the overall measures in the area of prevention is an HIV prevalence target rate (age 15–49) for 2005 of 2.3 per cent. The PR further recognizes that one of the achievements in the health sector is that the HIV prevalence rate in the adult (15–49) population fell from 3.3 per cent to 2.6 per cent between 1997 and 2002. According to the PR,

36 JSA (2003, p. 11).

37 PR (2004, p. 42).

38 Allocated resources to HIV/AIDS are USD 40 million, the budget for reduction in vulnerability is set at USD 174 million. The total cost of the NPRS Action Plans for 2003-2005 is estimated at USD 1,584 million. Source: PRSP (2000, p. 137).

39 PRSP (2002, pp.118-119).

40 PR (2004, p. 94).

the reduction in transmission rates was achieved through HIV/AIDS education, the 100 per cent condom use programs, and progress made in the use of condoms in the sex industry. According to a statement in the PR, a linear trend extrapolation would suggest that Cambodia, with this accomplishment, will meet its Millennium Development Goal (MDG) target of 1.8 per cent in 2015,[41] which was also recognized in the JSA of 2004.

Treatment: Regarding the care of people living with HIV/AIDS (PLWHA), the PRSP stresses that home-based and community care are the most relevant approaches. A campaign is to be launched to make people take care of and provide social support for PLWHA. The government acknowledges the extra burden that the epidemic places particularly on women and the need for community-based support services. Since the number of AIDS patients is rapidly increasing, there is a need to increase the number of institutional facilities to cater for all the needs for care. The PR does not discuss whether or not these actions have been undertaken, but states that a number of NGOs are implementing support programs for PLWHA and infected families. Although not mentioned in the PR, the MoH appears to have revised its strategic plan for HIV/AIDS in 2004 to take into consideration expanded prevention needs, new developments, and needs for comprehensive care and treatment, including the provision of anti-retroviral therapy (ART).[42]

Consequences: Based on a study made by the World Food Program (WFP), the general consequences of HIV/AIDS are discussed thoroughly and informatively in the PRSP. In addition, a separate section elaborates in general terms on the two-way link between HIV/AIDS and poverty. The PRSP also stresses that women are not only the ones most directly affected by HIV/AIDS – they are also affected indirectly because they bear the primary responsibility for caring for family member with HIV/AIDS. It is also recognized that the spread of HIV has dramatically increased life-threatening illnesses associated with the disease, such as tuberculosis (TB), which are particularly burdensome for poor people. Furthermore, it is stated in the report that statistics show that 30,000 children have been orphaned because of AIDS since the first case of the epidemic.[43] The vulnerability of people affected by HIV/AIDS and orphans is recognized as one of the priority issues in the strategy to reduce vulnerability and strengthen social inclusion. As regards PLWHA, the PRSP brings up the subject of social exclusion. It is stated that HIV/AIDS has stripped most of its victims of their future hopes and their ability to live on an equal basis as ordinary citizens.[44] In the PR, little is stated concerning consequences of HIV/AIDS. In relation to vulnerable groups with a high HIV transmission risk, it is stated that Cambodia has become a sending, receiving and transit country for the trafficking of women and children to Thailand. The JSAs do not include any information directly related to the consequences of HIV/AIDS.

Assessment: It is worth noting that the PRSP and the PR sometimes repeat the same sentences, both in the same report and in the two separate reports. This gives the impression that the reports include more information on HIV/AIDS than they actually do, which could indicate lip service. In general, it is interesting to observe that the government

41 Ibid (2004, p. 89).

42 http://www.unaids.org/en/geographical+area/by+country/cambodia.asp [2005-03-12].

43 PRSP (2002, pp. 27-28, 118).

44 The PRSP mentions a story of a 26-year old female AIDS victim who was banished by her family and became homeless on the streets in Phnom Penh in 2000, which had been reported by the Phnom Penh Post July 19 – August 1, 2002 issue.

stresses the issues of gender and HIV/AIDS and social exclusion of PLWHA, as well as the linkage between the disease and poverty. The rationale for this focus could be due to the nature of the HIV/AIDS epidemic in Asia, where the disease is concentrated among injecting drug users, men who have sex with men, sex workers, clients of sex workers and their immediate sexual partners.[45] In this milieu it is probable that stigma and discrimination is an issue that deserves substantial attention. Compared with the other country documents studied, the Cambodian strategy is particularly strong on gender and it recognizes both direct and indirect consequences for women with HIV/AIDS. The reason for giving gender and HIV/AIDS such importance could be because Cambodia is a transit and sending country for young girls who work in prostitution in Thailand and this group is likely to be highly exposed to HIV, as described above. Concerning the three dimensions, discussions of them are to some extent included in the PRSP. However, the only target that exists is related to prevention. There are well-written sections on treatment and consequences but concrete targets for the dimensions are lacking. The discussion of consequences in the PRSP is at a general level and would have benefited from being better rooted in the specific context of Cambodia. Finally, it is interesting to see that the issue of HIV/AIDS is given less attention in the PR compared to the PRSP, which could be a consequence of the decrease in the prevalence rate over the last few years. The JSAs solely give general comments on HIV/AIDS.

3.2 Ethiopia[46] (Federal Republic of)

Given its large population, Ethiopia has the third largest number of PLWHA in the world.[47] Since the first AIDS case was diagnosed in Ethiopia in 1986, the epidemic has spread to all segments of society. Estimates for the end of 2003 show a prevalence rate of 4.4 per cent among adults (15–49).[48] Ethiopia's epidemic is most severe in urban areas. The effects of the disease are further augmented by deep poverty and the post-conflict situation after the war with Eritrea in 1998. However, one encouraging sign is the trend of a decline in the HIV prevalence rate among pregnant women in the capital.[49]

Ethiopia's response to HIV/AIDS in the reports

In 1998, the government approved a HIV/AIDS policy with the overall objectives of preventing the spread of the epidemic and decreasing its socio-economic consequences. Thereafter, a strategic framework for the national response to HIV/AIDS, for the period 2000–2004, has been developed. In this framework, the main component is prevention and the key element is to reduce the level of transmission to 25 per cent by the end of 2004. Moreover, the government has a multi-sectoral approach for combating HIV/AIDS and in the PRSP the disease is treated as both a cross-cutting issue and a sub-thematic issue under the second of the four areas entitled "Improved Human Development". The HIV/AIDS policy includes strategies such as intensifying efforts for risk reduction, BCC, condom promotion and distribution, Sexual Transmitted Infections (STI) control, and Voluntary Counseling and Testing (VCT).[50] It

45 UNAIDS (2004b, p. 5).

46 For the purpose of this country narrative on Ethiopia, the following documents have been studied: The Sustainable Development and Poverty Reduction Program (SDPRP) (referred to as the PRSP) of 2002, the Annual Progress Report of 2004 (referred to as the PR) and the JSA of 2004.

47 http://www.worldbank.org [2005-03-13].

48 For more detailed information on the prevalence rate see Table 1, Appendix C.

49 In Addis Ababa, it is estimated more than one in six adults is infected. Source: UNAIDS (2004a, p. 26).

50 PRSP (2002, pp. 31, 34, 123).

is stated in the PRSP that the poverty reduction strategies are consistent with, and serve as vehicles for, achieving the MDGs.[51] Both the PR and the JSA state that the government has made a strong effort to implement the PRSP. However, a few problems remain, such as the lack of reliable information and a clear monitoring and evaluation (M&E) system to measure progress on HIV/AIDS issues.

As regards the extent to which HIV/AIDS is taken into account in the PRSP, the estimated cost of the whole HIV/AIDS program period 2002/3–2004/5 is expected to reach Ethiopian Birr (EBR) 0.9613 billion (USD 109 million). Of the total government expenditures during the fiscal year 2003/04 (USD 2655 million), the total costs of HIV/AIDS the same year (USD 37.8 million) correspond to 1.4 per cent.[52] In the PR it is stated that, while the PRSP addresses HIV/AIDS in a comprehensive way, absorptive capacity for HIV/AIDS-related funding is limited and disbursements are lagging behind the amounts envisioned by the PRSP. The same report states that the projected level of financing is inadequate to allow Ethiopia to reach its PRSP and MDG goals. In order to achieve these objectives, the country requires higher spending and higher external financing.[53]

Prevention: Apart from the health and education sectors, HIV/AIDS is primarily given attention in the chapter on cross-sectional issues in the PRSP. The fifth cross-cutting issue is "HIV/AIDS, Development and Poverty Reduction". As mentioned above, for the medium term the goal of combating HIV/AIDS has primarily been set at a reduction in the level of HIV transmission by 25 per cent within 5 years. This will be achieved by approaching the rural community through the market place; supporting health institutions at all levels, supporting the formulation of anti-AIDS clubs, VCT, ensuring the rights and privileges of PLWHA, etc. In the PRSP it is also recognized that women have greater vulnerability to HIV/AIDS than men due to epidemiological, biological and socio-cultural reasons. In recognition of Ethiopia's poor health status, the first Health Sector Development Program (HSDP I) was launched in 1997/98, including a multi-sectoral effort to combat the ravages of the HIV/AIDS pandemic.[54] Thereafter a second program was launched (HSDP II) which includes the 1998 HIV/AIDS policy, the PRSP of the year 2000, the MDGs, etc. It is stated in the PR that the HSDP II program is under implementation and that the focus areas are poverty-related diseases, such as HIV/AIDS, malaria and TB. In addition, the health sector was successful in securing additional funds from donors in the year 2003. For instance, a two-year USD 55 million grant was obtained from the Global Fund for the nation-wide implementation of the HIV/AIDS program.[55] When describing the health sector, the JSA reports that HIV/AIDS activities have increased both in scope and content.[56] In the PRSP it is stated that not much can be said about the impact of HIV/AIDS on education services in Ethiopia since this field has not yet been well studied. However, concerning secondary education it is stated that a study on the impact of HIV/AIDS on the sector will be undertaken.[57] The PR shows advances in this sector: among other things a task force has been established in the Ministry of Education (MoE) to coordinate

51 JSA (2004, pp. 1,2).

52 PR (2004, pp. 56-57); PRSP (2002, p. 133). 8.9 EBR/USD (Exchange rate as of February 12, 2004). Source: http://www.oanda.com [2005-03-13].

53 PR (2004, pp. 45, 102, 111-112).

54 PRSP (2002, pp. 98, 99, 123).

55 PR (2004, pp. 74, 76, 100, 102, 105).

56 JSA (2004, pp. 7-9).

57 PRSP(2002, p. 94).

and to promote HIV/AIDS education, there are regional educational radio programs on HIV/AIDS, and anti-HIV/AIDS clubs have been established in schools, etc.[58] The main achievement, as reported in the PR, was that the goal of maintaining the HIV prevalence rate at 7.3 per cent had been met. For the fiscal year 2002/03, the rate had even diminished to 6.6 per cent. The fiscal year 2002/03 also witnessed enhanced community and stakeholder participation, increased awareness, extended media coverage, and the involvement of religious leaders and opinion makers in openly discussing HIV/AIDS, etc. Moreover, the PR claims that the BCC efforts have contributed to changes in reproductive behavior.[59] In the JSA it is stated that awareness of HIV/AIDS prevention and control has been substantially increased and that the emphasis has been shifted to behavioral change interventions. It is also stated that the government did a laudable job in integrating the MDGs into the PRSP goals, even if significant increases in external assistance over the next decade will be needed if the MDGs are to be met.[60]

Treatment: Where treatment is concerned, important progress has been made in the health sector. This sector has, for instance, developed and executed a policy on the supply and use of anti-retroviral drugs (ARDs). The PR claims that policy measures concerning ARVs have been fully introduced with necessary preparations, including training and introduction of the policy to 340 health professionals and selected public and NGO-based drug outlet institutions. In addition, anti-viral services for AIDS patients have been started in selected and controlled drug stores and health facilities. Moreover, the Prevention of Mother to Child Transmission (PMTCT) service guidelines have been finalized and included in the policy for and use of ARVs. PMTCT has started on a pilot basis, and the national plan for the expansion of PMTCT has been made operational.[61] In the JSA, World Bank and IMF staff report on advances in the health sector in respect of treatment, and on an increase in the number of communities receiving emergency AIDS funds, and on the adoption of a favorable policy for the import of ARVs.[62]

Consequences: According to the PRSP, the impacts of HIV/AIDS can be grouped into demographic, economic, and social impacts as well as consequences on social service provision. Concerning the demographic impacts, the MoH stated in 2000 that the number of AIDS deaths was estimated at 1.2 million since the beginning of the epidemic. As the economically active age group of the population is highly affected, higher death rates and ill-health in these age groups will result in an increased dependency ratio. As regards the economic impact, the PRSP provides a comprehensive analysis of the impact that HIV/AIDS will have at the household level as well as at the community level. The PRSP also considers the impact on agriculture and industry and the link between HIV/AIDS and poverty is discussed. In the industrial sector, a survey of 15 firms in Ethiopia showed that, over a five-year period, 53 per cent of all illnesses among staff were AIDS related. These consequences will be an obstacle to expansion of employment and to poverty reduction. In the health sector, the rapid increase in the number of AIDS cases throughout the country results in the crowding out of patients suffering from other conditions. Hence, HIV/AIDS is currently causing the death not only of those who are infected with the virus but also of uninfected individu-

58 PR (2004, p. 71).

59 Ibid. (2004, pp. 10, 94).

60 JSA (2004, pp. 4, 5).

61 PR (2004, pp. 75, 90-92).

62 JSA (2004, p. 7).

als. According to the MoH, AIDS patients occupied as many as 42 per cent of all hospital beds during the year 2000 in Ethiopia. This figure is expected to be 54 per cent by 2004, according to a study conducted by the MoH in 2000.[63]

Assessment: Ethiopia's PRSP clearly and to a relatively large extent considers the three dimensions, especially prevention. The fact that the term prevention is used frequently throughout the reports is an indicator of this dimension's considerable importance compared to the other two dimensions. When discussing the consequences of HIV/AIDS in the PRSP, it is recognized that HIV/AIDS is increasingly becoming a threat to Ethiopia's development and poverty reduction endeavors. Despite the serious impact of the epidemic on efforts to enhance growth and poverty reduction, this aspect is discussed to a relatively small extent in the PRSP and the report makes reference to HIV/AIDS in a broad context rather than related to country-specific conditions. However, the PRSP does include a valuable discussion of HIV/AIDS in relation to gender, and of ARVs. Where the latter are concerned, a favorable policy for imports was also adopted. The PR does not include any information directly related to the consequences of HIV/AIDS and, in general, the JSA does not provide a detailed analysis of the HIV/AIDS situation.[64] The PRSP has a clear-cut approach for reporting the specific budget expenditures related to HIV/AIDS which is easy to follow since it is broken down into the specific program activities. However, the planned amount of financing to reach the goals does not seem to be sufficient to reach the PRSP goals for HIV/AIDS or the MDGs, which is also clearly stated in the PR, despite the fact that the goals of the PRSP have been clearly linked to the MDGs.

3.3 Malawi[65]

Malawi is one of the poorest countries in the world, with high income inequalities and recurrent episodes of food insecurity that exacerbate the HIV/AIDS epidemic. In addition, Malawi has one of the highest HIV prevalence rates in sub-Saharan Africa, estimated at 14.2 per cent for the adult population (15–49) at the end of 2003.[66] This rate is significantly higher in urban areas (25 per cent) than in rural areas (13 per cent).[67] The epidemic penetrated the country in the early 1980s and there is still no sign of an overall national decline. As a consequence, life expectancy at birth has dropped below 40 years.[68]

Malawi's response to HIV/AIDS in the reports

In Malawi's PRSP, HIV/AIDS is defined as an overarching goal under the cross-cutting issues, while it is treated as sub-goal under the four strategic pillars. In sum, HIV/AIDS is discussed in many different contexts in the PRSP (see Figure 1 in Appendix C for a detailed overview). To address HIV/AIDS, the government has designed a national strategic framework for the period 2000–2004, which is being coordinated by the National AIDS Commission (NAC). This framework forms the basis for policy development, operational programs, projects and activities, and has three main objectives: (1) to reduce the incidence of HIV/AIDS, (2)

63 PRSP (2002, pp. 42, 126).

64 JSA (2004, p. 2).

65 For the purpose of this country narrative on Malawi, the following documents have been studied: The Malawi Poverty Reduction Strategy Paper (MPRSP) of 2002 (referred to as the PRSP), the PR of 2003 and the JSA of 2003.

66 For more detailed information on HIV/AIDS prevalence see Table 1, Appendix C.

67 PRSP (2002, p. 86).

68 UNAIDS (2004a, pp. 20-21, 25).

to improve the quality of life for those infected, and (3) to mitigate the economic and social impacts of the disease. The PR claims that there is little mainstreaming of cross-cutting issues in the pro-poor activities and in the implementation of institutions.[69] The JSA in turn notes that implementation of the sectoral and policy reforms has been initiated, but that the pace is slower than envisaged in the PRSP. Moreover, the 2003/04 budget has attempted to mainstream HIV/AIDS by making budgetary provisions in the core activities of the ministries and departments. In addition, the fully staffed NAC has been operational since the end of 2001 and the government has created a new Ministry of State responsible for HIV/AIDS. The JSA further discloses that, in 2003, the World Bank approved a grant of USD 35 million for the Malawi Multi-Sectoral AIDS Project (MAP).[70]

The extent to which HIV/AIDS is taken into account in the poverty analysis is assessed by studying the costings for HIV/AIDS. In total, the cross-cutting goal to combat HIV/AIDS makes up 1.6 per cent (USD 8.99 million) of the total costings and about 2.3 per cent of the PRSP costings in 2002/03. The PRSP provides a detailed breakdown of costings in which it is observed that HIV/AIDS receives more resources than any other of the cross-cutting issues, i.e. about 40 per cent of the total costings. [71]

Prevention: Preventive actions to combat HIV/AIDS are first discussed in the PRSP under the objective of improving agricultural production. In particular, the negative effect of HIV/AIDS on productivity and food security for farmers is discussed. Under the second pillar, "Human Capital Development", HIV/AIDS is dealt with quite extensively. The overall goal is to ensure that the human capital of the population is developed to fully participate in the socio-economic progress of the country. This will be achieved through the provision of basic education including HIV/AIDS prevention messages, an Essential Healthcare Package (EHP) addressing sexually transmitted diseases, etc.[72] In the PRSP it is stated that basic education will be given high priority and one of the goals is to implement a sector-specific strategic plan for HIV/AIDS, involving prevention and mitigation among teachers and pupils.[73] However, in the JSA it is stated that this plan is yet to be implemented.[74] The first subject addressed under the cross-cutting issues is HIV/AIDS and it is stated that the primary objective is to reduce the incidence of HIV/AIDS. This involves preventing HIV infection among youths by integrating HIV/AIDS in school curricula at all levels, encouraging people to abstain from extra-marital sexual activities, increasing condom distribution, and by improving the implementation of HIV prevention activities, etc.[75]

Treatment: The second primary objective under the goal to combat HIV/AIDS is to improve quality of life of PLWHA. The main strategy under this objective is to advance the management of HIV-related conditions, including guidelines for treating opportunistic infections (OI) and improved care at hospital and community levels. In addition, the government wants clear guidelines and policies for ARDs, including negotia-

69 PR (2003, p. 41).

70 JSA (2003, p. 7).

71 The costings are not budgetary allocations but indications of the cost for groups of activities. The total costings for 2002/03 are estimated at Malawi Kwacha (MWK) 41,332 million (USD 0.56 million) and the total costings of the PRSP the same year to MWK 28,988 million (USD 0.39 million). Source: PRSP (2002, pp. 101-104). 0.01354 MWK/USD. (Exchange rate as of 30 April, 2002). Source : http://www.oanda.com [2005-03-15].

72 PRSP (2002, pp. xii, 30).

73 Ibid (2002, pp. 49, 50, 52).

74 JSA (2003, p. 5).

75 PRSP (2002, pp. 49, 50, 52).

tions to reduce price in order to increase accessibility for poor people, and standards and regulations on the management and control of drugs to ensure availability and access. Another objective is to mitigate the economic and social impacts of HIV/AIDS through different strategies. Among these are the provision of support to those indirectly affected by HIV/AIDS, work with herbalists and traditional healers, the inclusion of a budget line for HIV-related interventions in all line ministries, and improving the management and co-ordination of the HIV/AIDS response through strengthening the National AIDS Secretariat and District AIDS committees etc.[76] HIV/AIDS is also touched upon in the health sector through the implementation of an EHP, which will address the major causes of morbidity and mortality, including HIV/AIDS.[77] However, in the JSA the staff express concern that implementation is too slow.[78]

Consequences: The PRSP recognizes that the spread of HIV/AIDS is threatening to undermine all attempts to reduce poverty in Malawi, both directly through the prevalence of HIV/AIDS and indirectly through the resulting shortages of skilled human resources in all sectors. For instance, it is stated that about 70,000 children become orphans every year because of HIV/AIDS, adding to the already large number, estimated at about 850,000. In terms of health, life expectancy at birth has been reduced from 43 years in 1996 to 39 years in 2000, mainly due to the HIV/AIDS epidemic. A major problem behind the country's poor health indicators is the lack of qualified and adequately compensated medical staff. This problem is particularly acute in rural areas, and has been exacerbated by the HIV/AIDS pandemic and the internal and external brain drain due to low levels of remuneration and poor career prospects.[79] In relation to nutrition, HIV/AIDS is referred to as a factor causing malnutrition. Consequences of HIV/AIDS are also brought up in the PRSP in relation to the sad situation in the field of security and access to justice,[80] which is partly a result of the lack of financial and human resources and partly due to HIV/AIDS. Disparities between the sexes are still very pronounced in Malawi and this is one of the major causes of poverty. For instance, it is stated in the PRSP that females are disproportionately affected by labor constraints as they spend more time caring for their families, including the sick and HIV/AIDS patients. Evidence shows that HIV the infection rate among young females (aged 15–24) is about 4 to 6 times higher than the infection rate in their male counterparts. Moreover, gender-based violence has remained a persistent problem, leading to consequences such as drug, alcohol and sexual abuse, and the continuation of HIV infection, etc. HIV/AIDS is also referred to in connection with informal safety nets, which have become overstretched and vulnerable to shocks due to increased poverty and the HIV/AIDS scourge. Poverty-stricken extended families and communities are increasingly being put under unbearable pressure as they take care of HIV-infected chronically sick and AIDS-related orphans.[81] The JSA states that the educational and health sectors continue to face high attrition rates owing to HIV/AIDS and poor remuneration. However, the same report adds that training of health workers and students at the College of Medicine increased during the period under review.[82]

76 Ibid (2002, p. 88).

77 Ibid (2002, p. xiii).

78 JSA (2003, p. 7).

79 PRSP (2002, pp. 48, 58).

80 For instance, there are insufficient police officers, lawyers and judges. Source: PRSP (2002, p. 75).

81 Ibid (2002, pp. 8, 65, 86, 89).

82 JSA (2003, p. 5).

Assessment: Apart from the section in the PRSP covering the cross-cutting issues, HIV/AIDS is given most attention under "Human Capital Development" and "Good Governance". As regards the use of the three dimensions, treatment is considered to a much lesser extent in the PRSP than consequences and prevention. Overall, the government has made an effort to address HIV/AIDS as a cross-cutting issue even though the pace of implementation of measures to combat the disease has been too slow. The PR primarily focuses on economic achievements and accordingly it only considers HIV/AIDS issues to a small extent, and does not say anything about its consequences. The JSA, in contrast, considers this issue to a large extent compared to other countries' JSAs. Taken as a whole, Malawi's PRSP is close to a role-model when it comes to treating HIV/AIDS as a multi-sectoral issue, as can be seen in Figure 1 (Appendix C).[83] Throughout the entire PRSP, HIV/AIDS is discussed and integrated in a large number of sectors. In addition, the PRSP brings up issues that are specific for the country rather than keeping the discussion at a general level. Examples of this are the discussions of the problems related to brain drain and high attrition rates (especially in the social sectors), the pronounced disparities between men and women, the increasing number of orphans, the problems HIV/AIDS pose to the agricultural sector, etc.

Given the current levels of poverty and incomes in Malawi, it seems unlikely that most Malawians will be able to afford effective ARDs in the near future unless efforts aiming at that specific goal are substantially increased. Such an initiative could, for instance, come from the private sector or through increased stakeholder involvement, in particular concerning allocation of expenditures. Still, it should be noted that political ambitions to scale-up access to ART seem to be in place. However, in the long run one should also strengthen the struggle against HIV/AIDS by underpinning behavioral change. Such change is also likely to be achieved, judging from the fact that similar strategies are recognized to be of vital importance in the PRSP. A key problem identified in the PRSP is that the high infection rates among young women and men seem to continue to be growing in spite of the high levels of awareness of HIV/AIDS amongst the general population. On the basis of this information, one can conclude that general awareness is indeed crucial, but may not be highly effective unless it is complemented with increased testing and a change in behavior.

3.4 Mozambique[84]

Mozambique has a high HIV prevalence rate, estimated at 12.2 per cent for adults (15–49) at the end of 2003, with the majority of new infections occurring among those under 29 years old.[85] Without an aggressive response to HIV/AIDS, it is projected that life expectancy will fall from 50 years in 2002 to 36 years by 2010, and HIV prevalence will reach 16.8 per cent in 2010.[86]

Mozambique's response to HIV/AIDS in the reports

Although it is not brought up in the PRSP, the PR states that the government adopted a multi-sectoral approach to HIV/AIDS in 1998. To sup-

83 UNAIDS and the World Bank (2001, p. 21).

84 For the purpose of this country narrative on Mozambique, the following documents have been studied: The Action Plan for the Reduction of Absolute Poverty (2001-2005) of 2001 (referred to as the PRSP), the latest PR — 2004 (referred to as the PR) and two JSAs, of 2001 and 2003.

85 For more detailed information on HIV/AIDS prevalence see Table 1, Appendix C.

86 These projections are based on the 2002 epidemiological survey conducted in Mozambique. Source: PR (2004, p. 25).

port this approach and the fight against HIV/AIDS, a technical group was set up in 1999 with representatives of eight ministries. This group publishes data on HIV/AIDS and has compiled data for the 2002 epidemiological survey.[87] To combat the disease, the NAC in Mozambique, chaired by the Prime Minister, was established in 2000. In the same year, a NSP (2001–2003) was launched which gave preference to the approach of family reinsertion for preventing and combating the disease. The NAC established a Partners' Forum in 2003, but civil society's weak institutional and technical capacity, as well as lack of financial resources, has limited its effective involvement.[88] UNAIDS reports that more than USD 500 million has been committed by the Global Fund, the Clinton Foundation and the World Bank's MAP for the next five years for combating HIV/AIDS. In addition, the country will benefit from the US Emergency Plan for AIDS Relief (PEPFAR).

In the PRSP, HIV/AIDS is not explicitly treated as a cross-cutting issue but appears in various subsections. It is mentioned particularly frequently in relation to the fundamental areas of action in the context of health and education, as well as in relation to the demographic context of poverty. Quite a few detailed targets for HIV/AIDS are presented in the PRSP. In addition, it is mentioned that HIV/AIDS is not taken into account in certain instances, such as in macroeconomic projections. Yet, HIV/AIDS is not recognized as one of the fundamental or complementary areas of action, nor is it mentioned in the discussion on determinants of poverty or as a key factor to explain regional differences. In the JSA (2001), the PRSP is criticized because it says too little about the broader cross-sectoral actions contained in the National Strategy against STD/HIV/AIDS. The report suggests further development of the poverty analysis, particularly including HIV/AIDS, by using a broader approach.[89] The latest JSA states that satisfactory progress is being made in response to HIV/AIDS. In the PR, an informative section including projections of the demographic and macro-economic impact of HIV/AIDS is also included.[90]

As regards the extent to which HIV/AIDS is considered in the reports, actions to combat HIV/AIDS are mainly included in the educational and health sectors' indicative projected budgets.[91] The table with budget projections is informative and detailed and it gives the average unit cost for specific actions. In total, HIV/AIDS actions make up 0.21 per cent of the total spending on education for the years 2001–2005.[92] In the area of health, approximately 4–5 times more resources are focused on prevention than on reduction of the impact of HIV/AIDS. Total expenditure to combat HIV/AIDS is budgeted at 26 per cent of the total health sector expenditure for the period 2001–2005.[93] The PR reveals that 70 per cent of planned expenditure on HIV/AIDS has been implemented. Considering the total expenditure on HIV/AIDS as a percentage of total expenditure (excl. debt interest), the expenditure has declined from 0.5 per cent in 2001 to 0.2 per cent in 2003. However, the corresponding figure for 2004 is expected to increase to 0.7 per cent.[94]

87 Ibid.

88 http://www.unaids.org/en/geographical+area/by+country/mozambique.asp [2005-03-14].

89 JSA (2001, pp 7-9).

90 PR (2004, p. 25ff).

91 PRSP (2001, p. 128).

92 Total expenditure on education for 2001-2005 amounts to 11997 billion Mozambique Metical (MZM), which is approximately equivalent to USD 670 million (Exchange rate as of April 2001. Source: http://www.oanda.com.

93 Total expenditure on health for 2001-2005 amounts to 8826 billions, which is approximately equivalent to USD 490 million (Exchange rate as of April 2001). Source: http://www.oanda.com.

94 PR (2004, p. 113).

It is interesting to note that budget allocations for HIV/AIDS decreased in 2003. However, based on the information from the PR, it is difficult to state with certainty whether the numbers are completely comparable between the different years.

Prevention: HIV/AIDS is one of ten components in the education program. The principal measures in the program include education material on prevention of HIV/AIDS in the school curricula, to produce and disseminate informational material on HIV/AIDS for students and teachers, and to undertake a survey of the impact of HIV/AIDS on the education sector. The PR states that measures in the education sector are yet to be expected. The strategy in the health sector has different components: one of them is to combat HIV/AIDS. Measures included in the program are to assist PLWHA and to reduce the impact of HIV/AIDS. The main actions are directed towards prevention and include carrying out essential and high quality preventive measures (targeting people with irregular sexual partners), setting up and operating confidential VCTs, information campaigns, etc. In the operational matrix in the PRSP, these actions are included together with detailed targets and information on the current status of targets.[95] According to the PR, the interventions for combating HIV/AIDS probably represent the most active part of the health sector in the last few years, with the opening of new services, almost monthly. Still, the notification of HIV/AIDS cases remains an issue of concern. Although they started to increase in 1998, notified cases represent only 13 per cent of the new expected cases. It is further stated in the PR that programs of action in the area of HIV/AIDS are being adopted for prevention and for ensuring treatment of STDs, for controls of blood transfusions, and an increase in VCTs. New services such as three testing laboratories have also been established. Other plans are to review the NAC's Country Strategic Plan, and to expand interventions in campaigns against HIV/AIDS in the public and private sectors, as well as in civil society. It is further discussed to what extent Mozambique is on course to meet the MDGs for HIV/AIDS but the answer to that question is inconclusive and stresses that it is too early to determine the real impact of the NSP. In addition, an unusual preventive measure described in the PR is worth mentioning: a national festival of school games which has been organized with the aim of increasing the awareness of youth of the dangers of HIV/AIDS.[96]

Treatment: The PRSP's health program includes the treatment of PLWHA and the goals of the program are to reduce the impact of HIV/AIDS and to ensure care of PLWHA. In order to achieve these objectives, the government wants to ensure access to essential health care, create and operate care centers for daily hospital care, and guarantee the distribution of condoms to PLWHA. More specifically, the targets are to provide 30,000 clinical treatments during 2003, home care for 9,500 PLWHA and their families, psychological, medical and social care in all health centers in the districts, etc. However, it is difficult to assess if these goals have been met, based on the information provided in the PR. What is mentioned, though, is that certain home care services for PLWHA have been implemented. In addition, a nutrition guide has been distributed to the same group.[97]

Consequences: The PRSP recognizes the enormous challenge the disease poses to the health system, which is already overstretched. Further, it is stated that two studies of the disease's impact on macro economic projections will be finalized, as well as the above-mentioned study of the

95 PRSP (2001, p. 5 (Annex)).

96 PR (2004, pp. 64, 78)

97 Ibid. (2004, p. 62).

impact of HIV/AIDS on the education sector. In the JSA of 2001, it is pointed out that the likely impact of AIDS is not yet fully understood and quantified by the country.[98] However, in the PR an effort has been made to understand the impact of the disease, based on information from the 2002 epidemiological survey. It is concluded that there will be an increase in the number of orphans due to AIDS and this will continue if no intervention is put in place. Furthermore, the disease will cause a reduction in life expectancy, a change in the population structure, a reduction in school population, etc. The latter consequence will further decrease human capital accumulation and, in the long run, affect the growth rate of the economy. In relation to the result of a Computable General Equilibrium (CGE) analysis described in the PR, reduction in growth due to HIV/AIDS is discussed and it is mentioned that the impact of HIV/AIDS will accumulate over time. The PR further notes that research on HIV/AIDS and economic growth is far from drawing final conclusions on the magnitude of the impact of the disease and on the relative importance of the various channels through which this impact may occur.[99]

Assessment: Judging from the information in the reports, the government of Mozambique seems to consider HIV/AIDS as a serious threat to development. The PRSP is very informative and has an appropriate structure with all targets and measures of its current status collected in the operational matrix. In addition, the budgetary projections include costings divided by actions to fight HIV/AIDS, which is unusual. Unfortunately, these targets are not followed-up in the PR, which constrains their usefulness. In terms of structure of the reports, the PRSP does not include HIV/AIDS in the discussion of poverty and regional differences; it is mainly included in the educational and health sector budgets. However, there is one footnote which indicates that the government is aware of the fact that considering the impact of HIV/AIDS in terms of GDP growth only provides a partial insight into the social and economic costs of the disease. This may also represent proof of the fact that HIV/AIDS is recognized as a cross-cutting issue although it is not discussed as one throughout the report. Nevertheless, the way in which HIV/AIDS is treated changes in the PR as a result of comments made by the World Bank and IMF that this issue deserves more attention. From being mostly dealt with in relation to education and health in the PRSP, a more profound analysis of the consequences of HIV/AIDS is included in the PR. All three perspectives are dealt with in the PRSP and the PR, even if consequences are mostly elaborated upon in the PR. As regards treatment, this area is not given the same priority as prevention and consequences, and ART is not mentioned in any of the reports. One indicator of the importance given to the different dimensions is resource allocation. The budget of the PRSP shows that substantially more funds are allocated to prevention than consequences.

3.5 Rwanda[100]

Rwanda is one of the poorest countries in the world. It has emerged from a period of mass displacement, war and genocide to face the HIV/AIDS epidemic, which further threatens the survival of its population.[101] The genocide dramatically increased the prevalence of HIV during the mid-

98 JSA (2001, p. 4).

99 PR (2004, pp. 30-31).

100 For the purpose of this country narrative on Rwanda, the following documents have been studied: The Poverty Reduction Strategy Paper of 2002 (referred to as the PRSP), the PRS Progress Report of 2004 (referred to as the PR) and the JSA of 2004.

101 Rwanda is ranked as 159 of 175 countries on the HDI. Source: Human Development Report (2004, p. 237).

1990s, partly as a consequence of large-scale population movements and the use of rape as a weapon. At the end of 2003, the HIV/AIDS prevalence rate for adults (15–49 years) was estimated at 5.1 per cent.[102]

Rwanda's response to HIV/AIDS in the reports

Until 2002, HIV/AIDS was treated as a health issue in Rwanda's Interim PRSP. In the PRSP, however, HIV/AIDS is regarded as a cross-cutting issue and the process of mainstreaming interventions against the pandemic into a national strategy of multi-sectoral interventions is underway.[103] In this revised strategy, the MoH is responsible for treatment and research while the NAC is in charge of sensitization and resource mobilization at all levels of society.[104] The proposed HIV/AIDS program consists of eleven main areas of intervention including prevention of HIV transmission, education, communication, provision of VCT, promotion of the use of protection, PMTCT, etc. The PRSP strategy consists of six broad areas of priority intervention and HIV/AIDS is most extensively incorporated in the second area on human development. The government explains in the PRSP that it hopes to reduce the costs of spreading awareness of HIV/AIDS with the help of non-state actors. The actions in the PRSP include strategies to combat HIV/AIDS, bearing both long-term and short-term challenges in mind.[105] In the PR, the main advances during the first period of implementation are the emerging clusters between government agencies and ministries with the primary aim of harmonizing donor support for government priorities, and the decrease in the price of ARVs.[106] The JSA states that these clusters indeed played a major role in harmonization and that significant progress has been made, especially in the education and HIV/AIDS cluster.[107] The PR confirms that a multi-sectoral approach has shifted the focus on the epidemic from solely being a health issue to becoming an economic and national challenge.[108] The JSA makes a comparable assessment but adds that substantial progress is still required.[109]

The program cost for the multi-sectoral interventions against HIV/AIDS in the PRSP is estimated at USD 68 million over five years.[110] While, the PR recognizes that HIV/AIDS has to be addressed as a major problem, the report expresses concern over the overwhelming attention it receives from donors – with the risk that other parts of the health sector will be neglected.[111] The same problem is stressed in the JSA, in which it is stated that a certain operation, currently under preparation, will assist the government in addressing this issue.[112]

Prevention: Actions to combat HIV/AIDS are mostly integrated in the health sector in the PRSP. This is particularly true in relation to the planning and the preventive actions. Some of the preventive actions include targeting of high risk groups for HIV infection, nationwide distribution of condoms, dissemination of health messages in radio shows, etc.[113]

102 For more detailed information on HIV/AIDS prevalence see Table 1, Appendix C.

103 This also had the effect that the health sector policy needed to be revised. Source: PRSP (2002, pp. 69, 71).

104 PR (2004, p. 27).

105 PRSP (2002, pp. 9,10, 34, 71-72).

106 PR (2004, pp. 16, 60).

107 JSA (2004, pp. 2, 7).

108 PR (2004, pp. 27, 28).

109 JSA (2004, p. 4).

110 PRSP (2002, p. 71). For 2002, the total expenditure is 182.6 billion Rwanda Francs (RWF), which is equal to 0.3238 USD ?????????? (exchange rate as of March 2005). Source: http://www.unido.org/Data/Country/Exchange.cfm?c=RWA. [2005-03-15].

111 In short, the health sector has serious under funding issues. PR (2004, p. 29).

112 JSA (2004, p. 5).

113 PRSP (2002, pp. 44-45).

The PR provides information on the follow-up of some advances in the prevention program. For instance, the program for sero-positive mothers was extended to 10 provinces of the country in 2002 compared to 5 provinces in 2001, and the radio dramas continued the campaign for disease prevention.[114] In the PRSP it is stated that the education sector has mainstreamed teaching about HIV/AIDS and there is a separate section under the education sector called "HIV/AIDS Programme in schools". This program has two main objectives, i.e. to prevent the spread of HIV/AIDS among learners and educators, and to provide social support and care for learners and educators infected and affected by the disease. Actions planned are incorporation of HIV/AIDS education and counseling in the school curriculum and teacher training, national media campaigns targeting youth, anti-AIDS clubs in secondary schools, etc. In addition, the MoE will undertake a study of the impact of HIV on education. Moreover, an HIV/AIDS coordinating unit was created in the MoE.[115] The PR reveals that HIV/AIDS education efforts are estimated to have increased awareness of the disease to 70 per cent of the population. The report further notes that three of the actions mentioned above have been implemented: the preparation of HIV/AIDS material and teacher's guide for primary and secondary schools; education on HIV/AIDS; and the establishment of anti-AIDS clubs. In addition, in 2002, 84 teachers were trained in HIV/AIDS sensitization to study the impact of HIV/AIDS on the education sector.[116] In 2000 Rwanda's Gender Action Plan was adopted. One of the main areas of action is HIV/AIDS and reproductive health, which will be stressed through a multisectoral approach to combat the disease. In the PRSP, HIV/AIDS is also considered to a small extent in the chapter on social capital to support vulnerable groups particularly at risk from HIV/AIDS, such as widows who have lost their assets and child-headed households.[117]

Treatment: Studying the epidemiological fact sheets for Rwanda, the number of adults (15–49) with advanced HIV infection receiving ART in June 2004 was 2,140 people. However, it is estimated that 36,000 people were in need of treatment in 2003.[118] Treatment of HIV/AIDS is to some extent also incorporated in the PRSP in connection with the security and demobilization program.[119] The PR stresses developments in the health sector concerning the treatment of HIV/AIDS. These include the interventions of disease control and development of the health system, as well as strengthening the association of PLWHA. One major step forward is that the price of ARDs has been reduced continuously. It fell from an average of RWF 160,000 (USD 28,37) per month in 2001 to a minimum of RWF 30,000 (USD 5,32) per month in 2002. This decrease (of over 18 per cent) has increased accessibility to the drugs by the relatively poor. Moreover, in 2002, some private sector enterprises and organizations started programs to assist and cover the ARV costs of their employees.[120]

Consequences: In the PRSP it is stated that one of the main reasons why incomes in Rwanda have fallen since the mid-1980s is the decline in agricultural productivity. The strategy further recognizes that this is most likely a consequence of HIV/AIDS, as it is the active adult population with the highest levels of farming skills that is most seriously affected

114 PR (2004, pp. 26-28).
115 PRSP (2002, p. 51).
116 PR (2004, pp. 25, 63).
117 PRSP (2002, p. 68).
118 UNAIDS, UNICEF and WHO (2004, p. 9).
119 PRSP (2002, p. 59).
120 PR (2004, pp. 27, 28, 60).

by the disease. Both adult and child health have deteriorated in Rwanda, resulting in worse outcomes than the African average. In the PRSP, it is acknowledged that malaria and HIV/AIDS are seriously debilitating conditions, which not only result in increased family expenses on health care but also in increased mortality.[121] Moreover, there is a shortage of health agents as well as financial access to health care services, especially for poor people in rural areas. The PR further claims that, since youths below 25 constitute more than half of the population, efforts to address challenges in education and health will have a widespread positive impact on the economy.[122]

Assessment: Rwanda's PRSP is to some extent, but not to a large extent, influenced by the three dimensions: prevention, treatment and consequences. In the PRSP and the PR, the preventive actions to combat HIV/AIDS are given most attention and are mainly included in the health sector, a natural result of the fact that HIV/AIDS was primarily treated as a health issue prior to 2002. In the JSA, HIV/AIDS is only considered at a more general level. Taken as a whole, the impression is that the reports do not have a particular focus on these dimensions but are rather reflected upon occasionally.

The multi-sectoral approach has led to a change in the scope of the treatment of the pandemic in the strategy, i.e. from being a health issue to becoming an economic and national challenge. Examples of this are that country specific issues are taken up to a large extent in the PRSP, such as gender-related issues (sero-positive mothers, rape as a weapon during the genocide), the decline in agricultural productivity, and problems in the health sector (shortage of health workers and the fact that HIV/AIDS patients crowds out other patients by occupying hospital beds). In the PRSP, it is also recognized that a great challenge lies in changing behavior to address the HIV/AIDS pandemic.[123] Concerning treatment, one major step forward is the reduced price of ARVs, which is probably due to the strong political commitment and the involvement of the private sector. In addition, the country has been successful in finding an effective method for donor harmonization through the clusters, which is especially true for the HIV/AIDS cluster. This method could potentially be transferred to other countries. Moreover, a detailed follow-up of what has been accomplished concerning HIV/AIDS hitherto is included in the PR. Even though the enumerated advances indicate a positive trend, it may not be enough to reverse the fact that Rwanda is amongst the nine countries in Africa where life expectancy at birth has dropped below 40 years.[124] All in all, Rwanda still has a long way to go to combat HIV/AIDS and additional progress is needed for this issue to be incorporated into all areas of society.

3.6 Tanzania[125] (United Republic of)

In Tanzania, the HIV/AIDS prevalence rate has increased from 1.3 per cent in 1985 to 8.8 per cent at the end of 2003.[126] In general, more people are infected on the mainland than on the island territory of Zanzibar, and women are significantly more infected than men. HIV/AIDS awareness among the population is high (above 80 per cent) but behavior change is very slow.[127]

121 PRSP (2002, pp. 18, 19).

122 PR (2004, p. 5).

123 PRSP (2002, p. 28).

124 UNAIDS (2004a, ch 3. p. 25).

125 For the purpose of this country narrative on Tanzania, the following documents have been studied: The PRSP of 2000 (referred to as the PRSP), the latest PR — of 2004 (referred to as the PR) and two JSA, of 2000 and 2004.

126 For more detailed information on HIV/AIDS prevalence see Table 1, Appendix C.

127 http://www.unaids.org/en/geographical+area/by+country/united+republic+of+tanzania.asp [2005-02-02].

Tanzania's response to HIV/AIDS in the reports

In Tanzania's PRSP, HIV/AIDS is mostly mentioned in the chapter on the status of poverty and under the health section in the chapter on poverty reduction. However, in the budget it is included as a separate item. Given that the participants at the Zonal Workshop (in which the grassroots' views were communicated) expressed a sense of alarm concerning HIV/AIDS, and given that a specific study on HIV/AIDS provided background information for the preparation of the initial draft of the PRSP, it is surprising that the document is largely silent on the strategy to combat HIV/AIDS. What is included though is a footnote which indicates what the expenditures on HIV/AIDS will fund. These are awareness campaigns, development of strategic plans to combat HIV/AIDS, preventive measures such as provision of condoms, and studies and monitoring/surveillance of the incidence and impact of the pandemic, as well as actions taken to fight it.[128] The lack of a more detailed HIV/AIDS strategy is an issue recognized in the JSA, where it is claimed that the PRSP could have included stronger analyses and policy actions on the impact of AIDS.[129] In the PR, HIV/AIDS is dealt with as a cross-cutting issue. This is probably due to the transformation of the institutional framework of the National AIDS Control Program (NACP). This is a program which falls under the MoH and is run by the centrally placed Tanzania Commission for AIDS (TACAIDS) and the Zanzibar AIDS Commission (ZAC) under the Prime Minister's Office. These multi-sectoral bodies are responsible for guiding national efforts to fight HIV/AIDS.[130] The Prime Minister launched the National AIDS Policy at the end of 2001. The PR explains that, under TACAIDS, a Multisectoral Strategic Framework (NMSF) on HIV/AIDS was launched in 2003 which translates the national policy on HIV/AIDS. This program provides strategic guidance for the planning of programs, projects and interventions by various stakeholders and is in line with the international commitments incorporated in UNGASS. The national response initiative enjoys good partnership with development partners, civil society organizations, the private sector, and faith-based organizations. In recognition of this partnership, development partners and the government have signed a Memorandum of Understanding (MoU). The main thrust of the MoU is to enhance and harmonize partnership between the government and development partners through a common program for work on planning, management, resource mobilization and allocation, and monitoring and evaluation. A network of AIDS service organizations has been formed and PLWHA are in the process of forming their own council to cater for the welfare of all PLWHA. In order to ensure that communities at the grassroots level have sustained HIV/AIDS interventions, local government authorities are being supported in developing comprehensive HIV/AIDS programs. Technical assistance will be provided for local governments by Regional Facilitating Agencies (RFAs). The PR includes a table with the objectives, achievements and planned actions in different sectors for HIV/AIDS.[131] It is also mentioned in the report that there is a need to shed light on how different cross-cutting issues (such as HIV/AIDS and the environment) are linked. In the most recent JSA, the World Bank and IMF state that the Health Sector Strategic Plan (HSSP) has many of the essential ingredients of a strong health program.

128 PRSP (2000, p. 25).

129 JSA (2000, p. 5).

130 http://www.unaids.org/en/geographical+area/by+country/united+republic+of+tanzania.asp [2005-02-02].

131 Some of the undertaken or projected measures are mentioned below, for more detailed information see PR (2004, pp. 65-69).

As regards the policy on HIV/AIDS, it is stressed that paramount to this effort will be the effective utilization of existing resources, and M&E of results which will leverage additional financing.

As regards the extent to which HIV/AIDS is addressed in the PRSP, it is first recognized as one of the seven priority areas for financial interventions.[132] Moreover, resources allocated directly to HIV/AIDS are increasing with time, from zero in 1999/00 to 0.9 per cent of total discretionary recurrent expenditure in 2002/03.[133] In addition, HIV/AIDS is included in the health and priority sector expenditure. With respect to the focus of public expenditure, the JSA of 2000 suggests that the authorities should provide more concrete details and prioritization of these initiatives. In the PR, a follow-up is made of priority expenditure in each sector, which reveals that the actual expenditure on HIV/AIDS for the years 2001/02 and 2002/03 falls short of budgetary projections. Hence, it is possible to conclude that HIV/AIDS interventions are still not sufficiently funded. However, according to the PR's projections, future budgeted expenditure on HIV/AIDS will increase dramatically, from an expenditure of 5.3 billion Tanzanian Shillings (TZS) (50.3 million USD) in 2002/03 to 58.7 billion TZS (557 million USD) in 2004/05.[134] Efforts to mainstream HIV/AIDS in the budget process in the public sector have been initiated and aim at ensuring regular budgetary allocations for HIV/AIDS activities. Codes for tracking HIV/AIDS related activities have been developed and will be applied in the financial year 2004/05, and TACAIDS has developed its three-year Midterm Expenditure Framework (MTEF), action plan and budget.

Prevention: One of the national goals in the PRSP is to reverse the decline in life expectancy from 48 years to 52 years by the year 2010. Special efforts will be made to raise the share of districts with active HIV/AIDS awareness campaigns to 75 per cent by 2003 and HIV/AIDS awareness will be promoted through peer education in schools. In the PR, it is mentioned that, despite the implementation of these efforts, data from blood donors have shown a steady increase in HIV prevalence since 1996 and therefore the government states in the PR that more serious and targeted interventions are needed. Measures are primarily directed towards increasing individual and community awareness of the risk of HIV infection and its implications. In the scaling up of efforts, a national M&E framework for the national response has been developed and a core team of trainers has been prepared. Moreover, in an advocacy forum for religious leaders in 2002, the participants unanimously agreed to use their strategic leadership in the communities to further promote awareness, care and support, and impact mitigation in order to fight the epidemic. In addition, a protocol for the Tanzania HIV Indicator Survey (THIS) has been developed and will be carried out in late 2003. This study will provide information on HIV prevalence in the community. Moreover, increased efforts are also reflected in the raising of projected expenditure on HIV/AIDS, although its proportion of total expenditure remains constant.

Treatment: The PRSP is largely silent on the treatment of sero-positive individuals. However, the PR mentions that plans for introducing ART are at an advanced stage. The report further recognizes that there is considerable potential for more involvement by the private sector in the national response to the epidemic. The government is developing plans for mainstreaming HIV/AIDS interventions into routine activities

132 The other six areas are: education, health, agriculture, roads, water and judiciary.

133 Total recurrent expenditure amount to 945 872 million TZS, which is approximately equivalent to USD 1193 million (exchange rate as of Feb 2000). Source: http://www.oanda.com

134 PR (2004, pp. 15, 35).

through the multi-sectoral approach, including workplace interventions and integration of HIV/AIDS control activities in the ministry's MTEF. Nevertheless, many private enterprises already have workplace HIV/AIDS interventions, including provision of ART. Furthermore, the PR includes one section on care and treatment for PLWHA. It is stated that the government and the Clinton Foundation have formulated a draft "Care and Treatment" program that aims at providing care and treatment for about 400,000 PLWHA in five years at an estimated cost of about USD 535 million. To ensure sustainability and continuity, the program will be integrated into the existing systems. A second five-year program will be developed in the course of implementation of the first program.

Consequences: The PRSP states that the number of orphans is increasing due to HIV/AIDS. In addition to the apparent breakdown of the traditional family system, when the number of dependent persons per productive family member escalates, this has increased the need for safety-nets. In the PR, it is mentioned that HIV/AIDS will exacerbate food insecurity and the nutritional status of children under –five years. It is also recognized that HIV/AIDS and related diseases represent a huge burden to the health care system. More than 30 per cent of the resources are spent on diseases related to HIV/AIDS. The government will scale up efforts to give priority to measures that have an impact on the welfare of those affected by HIV and it is acknowledged that certain vulnerable groups, including AIDS sufferers and orphaned children, need special attention.

Assessment: In general, the way the HIV/AIDS issue is being treated in Tanzania changes dramatically over time from the PRSP to the PR. In the PRSP, HIV/AIDS is recognized as a threat to the nation, and the budget allocates funds for HIV/AIDS, but an overall strategy and an analysis of the impact of the disease are lacking. However, in the PR the approach changes dramatically and the government's development of multi-sectoral bodies as well as a multi-sectoral framework indicates a strong political commitment to fight HIV/AIDS. The government's cross-cutting approach was developed in line with Tanzania's commitment in UNGASS, which can be an indication that this multilateral commitment has been important for the development of the struggle against HIV/AIDS in Tanzania. Based on the information in the PR, it appears that the struggle against HIV/AIDS is rooted in civil society organizations, the private sector and faith-based organizations. The MoU is a welcome initiative to coordinate all stakeholders' efforts. Many specific targets and a good follow-up of what has been done in the area of HIV/AIDS are included in the PR. As regards the three dimensions, the country seems to have made progress regarding treatment both with respect to ART and to care and treatment programs for PLWHA. Measures to prevent the transmission of the disease are also being undertaken but the indication of an increasing number of affected people is a matter of concern. As regards consequences, they are discussed to some extent in the PRSP and the PR but an exhaustive analysis is lacking. In general, Tanzania provides a good example of how extensively a strategy can change over time.

3.7 Uganda[135]

In the words of UNAIDS: "No country has so dramatically reversed its epidemic as Uganda, where national prevalence dropped from 12 per

135 For the purpose of this country narrative on Uganda the following documents have been studied: Uganda's Poverty Eradication Action Plan of 2000 (referred to as the PRSP), the PR of 2003 and the JSA of 2003.

cent in the early 1990s to 4.1 per cent in 2003." [136] This reduction in the prevalence rate is primarily described as a result of a strong national commitment to awareness and health promotion in respect of HIV/AIDS.[137]

Uganda's response to HIV/AIDS in the reports

In the PRSP the issue of HIV/AIDS is included in the health sector program and the government mostly explains the situation in the country in general terms. Some more specific statements are included. For example, it is explained that instances of land access restrictions for single women have the result that finding a partner becomes a matter of survival and, under such circumstances, women take sexual risks which they would otherwise avoid. However, the PRSP does not elaborate to any great extent on how the government plans to combat HIV/AIDS, and in general the document contains few details. The only focus of the HIV/AIDS strategy is on prevention which also includes numeric targets for a decline in the prevalence rate. In 2001 the country embarked on the World Bank funded MAP. By mainstreaming HIV/AIDS prevention and control in different sectors into national plans, all parts of the country have been encouraged to play a role in the struggle against HIV/AIDS.[138] It is explained in the PR that this framework guides the implementation of all the policies on HIV/AIDS and mainstreams HIV/AIDS issues into the development of sector policies.[139] This development is reflected in the PR in which HIV/AIDS is treated as a cross-cutting issue. In addition to being integrated in each chapter, HIV/AIDS is also included as standalone subsection in the PR and it is recognized as one of the policy issues with a significant impact on the improvement of the quality of life of the poor. Comparing the PRSP and the PR, it is evident that the latter treats HIV/AIDS as an issue not exclusively affecting the health sector but rather as a threat to the whole nation. It is also stated in the PR that, although HIV/AIDS prevalence rates stagnated during the period 2000–2002, considerable progress has been made in the national response to the epidemic. Despite geographical disparities, capacity has been developed at national, central and grassroots community levels. Most line ministries and districts have designed integrated HIV/AIDS strategies and developed appropriate budget lines. In addition, resources have been mobilized by both government and civil society to help run HIV/AIDS programs at district level, and help the poor to access such services. However, an overall lack of coordination with many on-going initiatives is also acknowledged in the PR. In addition, increased support programs that go beyond increased awareness and knowledge of AIDS are suggested in the same report.[140]

In terms of resource allocation it is difficult to establish to what extent HIV/AIDS is taken into account in the PRSP since HIV/AIDS is not dealt with separately in the budgetary projections. Instead, this item is included in the overall health budget. Health, however, is one of the performance indicators of the PRSP program, which reflects both the high priority the government attaches to this sector and the relatively well-developed strategies available in this sector. It is mentioned in the PRSP that there is an unconstrained costing for the AIDS program, which will be implemented through the various sectoral programs.[141] The PR does not contain any information on budgetary allocations.

136 UNAIDS (2004c, p. 12). For more detailed information on HIV/AIDS prevalence see Table 1, Appendix C.

137 http://www.unaids.org/en/geographical+area/by+country/uganda.asp [2005-03-12].

138 Ibid

139 PR (2003, p. 117).

140 Ibid (2003, p. 97).

141 PRSP (2000, p. 25).

Prevention: In the PRSP, one of the targets of the health sector strategy is to reduce HIV prevalence by 35 per cent by 2004/05. It is interesting to observe that this target appears twice in the report but, on the second occasion, it is set at 25 per cent.[142] There is no follow-up of this goal in the PR and therefore it is difficult to establish if it has been met. However, it is stated that the government is continuing its efforts to improve the quality of life of the poor by raising public awareness of AIDS. However, the PR reveals that the prevalence of HIV/AIDS has remained constant at between 6–7 per cent during the period under examination (from the previous PR). In the JSA of 2003, concern is expressed over the fact that HIV/AIDS indicators have not improved according to expectations and over recent evidence of stagnation in HIV/AIDS prevalence rates after a decade-long downward trend.

Treatment: The PRSP does not include any information on treatment and in the PR only indirect attention is directed to this perspective. Although not directly related to treatment of PLWHA, it is stated in the PR that various government and non-government agencies have carried out sensitization programs aimed at creating awareness of the rights of PLWHA (among other groups). There is also evidence that increased attention is being paid to vulnerable persons in sectoral and district development programs although it remains unclear whether or not this has resulted in better livelihoods for this group of the population.

Consequences: As regards the consequences of HIV/AIDS, this is not elaborated upon extensively in the PRSP even if it is mentioned that targets for child mortality will be difficult to achieve because of HIV/AIDS. In the PR, the consequences of HIV/AIDS are given more attention. It is stated that the epidemic poses a threat to the economy and security of the country and it is recognized as one of the major challenges to human development at individual, community and national levels. More generally, it is explained that food insecurity, degraded livelihoods, increased vulnerability and adverse socio-economic impacts have been identified as both the cause and consequence of HIV/AIDS. Furthermore, it has been observed that HIV/AIDS has not necessarily had the same impacts on all livelihood groups in Uganda. Overall, the epidemic has caused a reduction in labor supply and productivity, high opportunity costs of work because of the time and money attending to the sick, increased dependency ratios, loss of assets, low agricultural investments etc. Further, the PR recognizes that the epidemic poses a major challenge to the health sector. The already overstretched health system is overburdened in respect of care and treatment, particularly in the public sector whose clients are mainly the poor. In the education sector, the disease has affected both students and parents on the demand side, and teachers on the supply side. As a result, increasing drop-out rates, absenteeism, and poor school performance have become common. Furthermore, HIV/AIDS has had a negative impact on the implementation of policies and programs in the various sectors due to the effects of the disease on the workforce. Another consequence is the already high number of orphans without care and/or protection of one or both parents, which increases the risk of children becoming street children, beggars, thieves, or a target for abuse and exploitation. Hence, the number is expected to increase over the next decade. However, a policy and plan to address the challenge of orphans is expected to be completed in February 2004.[143]

142 One reason for the difference could be the fact that the time span of the target is not stated in the latter case. Source: Ibid (2000, pp. 12, 35).

143 PR (2003, p. 130).

Assessment: The PRSP deals with HIV/AIDS to a surprisingly small extent given the fact that Uganda is well-known for having reduced its HIV/AIDS prevalence rate substantially. The reason for this could be that the PRSP was released prior to UNGASS and before the country embarked on the multi-sectoral response to HIV/AIDS. In addition, it is likely that a detailed strategy is only included in National Strategic HIV/AIDS Framework. Therefore, it is difficult to discern how the country actually works with HIV/AIDS from the documents studied and even more so because the reports discuss the issue at a general level. The overall impression is that the PR includes much more information on HIV/AIDS than the PRSP since the former includes a detailed discussion of the consequences as well as preventive measures. Concerning the different perspectives, one can observe that the focus lies on prevention in the PRSP while it shifts towards consequences in the PR. It is likely that this shift correlates with the maturity level of the disease in the country. Treatment is hardly touched upon in any of the reports.

3.8 Zambia[144]

The HIV/AIDS prevalence rate in the adult population (15–49) in Zambia was estimated to be as high as 16.5 per cent at the end of 2003.[145] HIV/AIDS adds a further dimension to poverty in Zambia, a country which already has the highest level of income poverty and the fourth largest level of human poverty in the Southern Africa Development Community (SADC) region.[146]

Zambia's response to HIV/AIDS in the reports

Zambia's PRSP covers the period 2002–2004 and, as regards HIV/AIDS, the current framework is coordinated by the National HIV/AIDS Council. The government's overall objective as regards HIV/AIDS is to reduce new infections and the socio-economic impact of the disease. Since the first AIDS case in 1984, four national plans have been developed in response to the epidemic.[147] With regard to HIV/AIDS, the PR states that there has been an intensification of the efforts being made throughout society for combating the pandemic through the multi-sector response adopted by the government. It is further stated that the MDG indicators are an integral part of the PRSP monitoring indicators. According to the assessment in the PR, it seems likely that most of the MDGs will be attained.[148] However, the JSA states that, although efforts to combat the HIV/AIDS pandemic have been somewhat strengthened, program execution is still too slow and a lot more remains to be done.[149]

For the period 2002–2004, the overall allocation of PRSP expenditures with regard to HIV/AIDS represents 7.9 per cent (USD 94.6 million) of the total PRSP budget of USD 1,200 million. Compared to allocations to other sectors, HIV/AIDS receives the sixth highest spending of a total of nineteen sectors.[150] In addition, for the period 2002–2003, Zambia received a number of grants for strengthening its efforts to eradicate HIV/AIDS, for example from the Global Fund to Fight HIV/AIDS, the World Bank's MAP grant, African Development Bank support, and various bilateral arrangements.[151]

144 For the purpose of this country narrative on Zambia, the following documents have been studied: The PRSP of 2002, the PRS Progress Report of 2004 (referred to as the PR) and the JSA of 2004.

145 For more detailed information on HIV/AIDS prevalence see Table 1, Appendix C.

146 After Angola, Mozambique and Malawi. Source: PRSP (2002, pp. 10, 21).

147 PRSP (2002, pp. 109, 133, 198).

148 PR (2004, pp. 19, 20, 44).

149 JSA (2004, pp. 11-12).

150 PRSP (2002, p. 128).

151 PR (2004, p. 44).

Prevention: Due to its characterization as a cross-cutting issue, HIV/AIDS is mentioned in many sectors throughout the PRSP. The education sector gives due importance to HIV/AIDS, for instance through the development of a comprehensive HIV/AIDS program under the Basic Education Sub-sector Investment Program (BESSIP), which aims at increasing access to upper basic education and improving quality and relevance.[152] In the PR, developments in this sector are reported in respect of the strategies for mitigating the impact of HIV/AIDS on MoE staff, pupils and teachers.[153] According to the PRSP, the health sector will mainly focus on HIV/AIDS through the National HIV/AIDS strategic framework and the basic health care package. In the PRSP, there is a separate nutrition policy in which one strategy is to strengthen nutritional care practices for the poor, those infected with HIV/AIDS, and vulnerable groups. In the PRSP, HIV/AIDS is also mentioned to a small extent in connection with the interventions for rural development.[154] The sector area goal for HIV/AIDS is to reduce incidence, infections and the socio-economic impact of HIV/AIDS. This will be monitored through indicators such as HIV/AIDS incidence, number of STI cases, expenditure on ARVs, etc. There are two types of priority programs for HIV/AIDS, the first and second level priority programs. The first objective under the first level priority programs is for instance to reduce new HIV/AIDS infections by promotion of safe sex practices among high-risk groups through communication, mass media, peer education, drama, improved free condom distribution by the government, etc.[155] In the PR, it is stated that the capacity to manage HIV/AIDS interventions to reduce the number of infected people has been strengthened and that sensitization workshops, awareness campaigns, etc. were being conducted.[156] The PR further states that the majority of the population is aware of how HIV/AIDS is transmitted and how it can be avoided, and that the prevalence rate among the adult population (15–49) is estimated at 16 per cent.[157] However, the JSA claims that greater efforts are needed to effectively mainstream anti-HIV/AIDS initiatives in a multi-sectoral context. In both the PR and in the JSA, M&E systems and better co-ordination among stakeholders are seen as key areas requiring support.[158]

Treatment: Under the first level priority programs described in the PRSP, some objectives include improving community home-based care, the quality of life for PLWHA through ART, and improved quality of life for orphans and vulnerable children (OVC). Since the 1990s, treatment including ARVs has been concentrated in the private sector, with the public sector providing laboratory support. Under the second level priority programs, one objective is prophylaxis against TB and the promotion of positive and healthy living among the asymptomatic HIV positive people.[159] In the PR, encouraging results on HIV/AIDS mitigation are observed by an increase in VCT centers, provision of ARVs in public hospitals, and expansion of community home-based care.[160] In contrast to what was stated in the PR, it is claimed in the JSA that there

152 PRSP (2002, pp. 78-81).

153 PR (2004, p. 32).

154 PRSP (2002, pp. 49, 61, 87-88).

155 The MoH will also distribute approximately 18 million free condoms annually in government health clinics and to partner NGOs and CBOs.

156 PR (2004, pp. 32, 44, 45).

157 Here the PR draws on data from Zambia's Demographic Health Survey 2001/02 report.

158 JSA (2004, pp. 6, 8, 9); PR (2004, p. 58).

159 The reason why HIV/AIDS is incorporated in this program is because the TB case rate has increased nearly five-fold since the advent of the HIV/AIDS epidemic. Source: PRSP (2002, pp. 109).

160 PR (2004, pp. 13,14).

was a limited increase in the number of VCT Centers.[161] Concerning the health sector, the PR states that the purchases of essential health drugs, including ARVs, only cater for 6,600 patients compared to the target of 10,000. Moreover, only 0.1 per cent of persons with HIV infections receive ARVs and only 3.1 per cent of pregnant HIV positive women. The low rate could be a result of the high cost of administering and making ARDs available.[162] However, the JSA provides a different picture of the PRSP implementation progress by claiming that significantly fewer resources than planned were released to acquire essential health drugs, such as TB, STI and ARVs. In addition, it states that there was only a limited increase in the provision of preventive TB vaccines and in the provision of ARVs in public hospitals.[163]

Consequences: In the PRSP, there is growing recognition of the two-way link between HIV/AIDS and poverty. It is stated that economic growth and prosperity hinge on a healthy human resource base, which is currently threatened by the epidemic. Furthermore, the increase in HIV prevalence in rural areas poses a serious threat to agriculture and food security. Labor time is reduced by sickness or the need to care for sick family members, and assets such as land, equipment and livestock are sold to raise funds to look after the sick.[164] Moreover, it is estimated that 1.2 times as many women are afflicted with AIDS as men, due to factors such as biology, gender roles, resources and cultural norms. Statistics also show that the number of teachers has been steadily decreasing.[165] According to the PRSP, this development is mainly due to the decision of the MoE to stop recruiting untrained teachers. In addition, teachers are among the four largest HIV/AIDS infected groups in Zambia. About 1,000 teachers die from the pandemic each year. Due to HIV/AIDS, about 600,000 children have become orphans, contributing to high dropout rates in schools. This in turn affects the quality of the labor force.[166] In the JSA, it is claimed that while the gains in learning achievements and enrolments are encouraging, they may be at risk owing to the teacher employment crisis and the high attrition rate of teachers due to HIV/AIDS.[167] Few of the general health indicators have improved in Zambia over the last ten years and the alarming levels of HIV/AIDS will inexorably consume more resources at the expense of other life-threatening diseases such as malaria and cholera. Although the epidemic shows signs of stabilization in urban areas, the rates continue to rise in some rural areas.[168]

Assessment: In Zambia's PRSP, most weight is placed on prevention strategies and thereafter on consequences and treatment. The JSA mostly focuses on economic achievements. However, HIV/AIDS is also considered to some extent. The overall assessment is that combating HIV/AIDS has been incorporated to a large extent in the national goals and objectives in the PRSP and it is recognized that poverty reduction efforts cannot bear sufficient fruit unless complemented by simultaneous efforts to address the high debt burden and HIV/AIDS.[169] Moreover, in the PRSP there is a growing recognition of the two-way link between HIV/AIDS and poverty, as mentioned above. However, the high levels of

161 JSA (2004, p. 8).
162 PR (2004, pp. 18-19, 34-35).
163 JSA (2004, p. 8).
164 PRSP (2002, pp. 23-24, 56, 82-83, 109).
165 In 1996, there were 40,488 teachers in public schools and, by 1999, 37,117. Source: PRSP (2002, pp. 76, 77).
166 PRSP (2002, pp. 76-78).
167 JSA (2004, p. 6).
168 PRSP (2002, pp. 82-84, 109).
169 Ibid (2002, pp. 28, 109).

poverty, debt burden and incidence of HIV/AIDS are mutually reinforcing and together constitute a tripod of barriers to Zambia's development. Even though these obstacles will continue to affect Zambia for many years, considerable hope for the future is traced in the PRSP concerning the struggle against HIV/AIDS, indicating that the tide may be turning. A more concrete signal of a positive trend is that the overall prevalence of positive tests appears to be stable. According to the PRSP, this is attributable to a behavioral change, which is often considered a prerequisite for a long-term successful HIV/AIDS strategy. Furthermore, by analyzing Zambia's HIV/AIDS response, it is apparent that whether a development should be interpreted as positive or not may also be dependent on the author of the report. For example, while the PRSP and the PR seem to have the conviction that it is likely that Zambia will achieve most of the MDGs, the JSA states that, even though efforts to combat the HIV/AIDS pandemic have been somewhat strengthened, program execution is still slow and a lot more remains to be done. The same pattern is seen concerning the provision of ARVs, i.e. the JSA provides a different picture of the PRSP implementation progress than the PRSP and PR. In particular it is claimed that significantly fewer resources than planned were released to acquire essential health drugs and that there was only a limited increase in the provision of TB vaccines and provision of ARVs in public hospitals. Hence, it is suspected that Zambia may be trying to paint an overly rosy picture of its PRSP implementation process to ensure that funds keep flowing in.

4. Summary and Conclusions

In this summary and conclusions, the main lessons learned from the desk review, as well as general conclusions, are presented. In an attempt to systematically summarize the findings, selected indicators from the UNGASS DoC (perceived as particularly relevant for the purpose of this study), in combination with the overall focus on prevention, treatment and consequences, provide the framework for analysis. The chapter starts with a presentation of statistics collected from a word-count, with the objective of providing a general overview of the extent to which HIV/AIDS is included in the reports. Thereafter, the main findings of the review are discussed. The final section elaborates upon some of the problematic issues identified during the review as well as suggestions for improvements to the PRSP implementation process.

4.1 General Overview

To provide a general picture of the extent to which HIV/AIDS is included in the reports, the results from a word-count are presented in Table 2 (see Appendix C). Even though the table is rather self-apparent, some particularly interesting findings are discussed in some depth in this section. Before presenting the results, it is worth pointing out that this kind of analysis inevitably requires making some assumptions, even if they are not necessarily correct. We have made the assumption that a greater frequency of a particular word in the reports implies greater government commitment. However, while doing this it was kept in mind that, even if the word HIV/AIDS, for instance, has been mentioned many times throughout the reports, this does not automatically imply that the way in which HIV/AIDS has been dealt with is the most favorable way. Due to these potential sources of errors, the general overview should primarily be viewed as a first indicator of the extent to which different topics have been given attention, and it is complemented by an in-depth analysis in the next section.

An analysis of the results from Table 2 reveals that, in all but one country, the word HIV/AIDS appears frequently in the PRSPs. Uganda was the exception, which could be due to the fact that Uganda's PRSP is more of a strategic document which does not provide detailed information but rather refers to sectoral plans. Since the PRs provide information on advances made in the implementation of the PRSPs, they are naturally less detailed in character and include fewer references to HIV/AIDS than the PRSPs. For instance, in the case of Malawi the

word HIV/AIDS appears 176 times in the PRSP and only three times in the PR. However, there are two cases (Tanzania and Mozambique) in which HIV/AIDS appears more frequently in the PR than in the PRSP. This result can be due to the fact that these two countries released their PRSP prior to UNGASS. Regarding the JSAs, one common feature traced is that HIV/AIDS is mentioned to a small extent. The exception is Malawi where HIV/AIDS is mentioned 10 times. This can probably be explained by the fact that Malawi is one of the countries that has been hardest hit by the epidemic and that, prior to the PRSP of 2002, it has had rather a weak strategy for HIV/AIDS. Hence, the JSA probably found it important to comment on progress made in the area of HIV/AIDS. Still, in most cases, the JSAs put stronger emphasis on aspects of the PRSPs such as macroeconomic development and poverty reduction, while HIV/AIDS is only commented on briefly.

Turning to the three dimensions, the word-count gives a clear indication that most efforts focus on prevention of the disease, which is particularly true for Ethiopia and Malawi. This result is further supported by the outcome of Figure 2 (see Appendix C), which is based on the number of lines explicitly dedicated to HIV/AIDS and the various dimensions in the reports.[170] According to the word-count, consequences are mentioned to a smaller extent than treatment. However, it should be noted that there are many synonyms of the word "consequences" and therefore the result from the word-count might not provide an exhaustive picture of the extent to which consequences of the disease are actually discussed. Overall, the impression is that consequences are more extensively discussed in the report than treatment, which is supported by the results in Figure 2 in Appendix C.

As revealed in Table 2, the reports usually make few references to ART. Indeed, a comprehensive discussion of this matter is only included in the case of Zambia and, to some degree, Malawi. However, in the case of Rwanda and Ethiopia (and to some extent Tanzania and Mozambique), the process of introducing ARVs did not gain momentum until the PRs were published in 2004, i.e. two years after the PRSPs were written.

4.2 Comparative Analysis and Main Conclusions

In this section the results of a comparative analysis of the PRSPs and the latest PRs are discussed, in total 16 documents.[171] The comparative analysis builds on indicators inspired by the DoC on HIV/AIDS. In the following we have separated the main results on the basis of the three dimensions. In addition, we have included some general indicators at the end of this section. For a complete overview of the comparative analysis see Table 3 (Appendix C).

The main results on prevention:

- Prevention is the dimension that is most extensively addressed in the reports
- Overall the countries have established national prevention targets concerning HIV/AIDS but these are generally not in line with the MDGs
- An increase in private sector response is traced in more recent years

170 NB this figure was obtained by extracting and summarizing the information on HIV/AIDS in the reports and subsequently classifying it into the three dimensions. Thereafter the number of lines dedicated to each dimension was counted. The result is presented in Figure 2.

171 Here we decided to exclude the JSAs from the analysis since these documents rarely give detailed information on strategies regarding HIV/AIDS.

Prevention is the dimension most extensively addressed in all the reports and 63 per cent of the reports have set their prevention targets in numeric terms. It appears as if prevention is the measure recognized as most important in the early years of the development of the disease. However, as the number of people who develop AIDS increases, it seems as if more attention is given to the treatment of patients as well as to the consequences of the disease. One example is Uganda's PRSP, which only contains a prevention target, as opposed to the latest PR in which more focus (although still not sufficient) lies on the consequences of combating HIV/AIDS.

Only in 31 per cent of the reports studied is the formulation of the national prevalence rates explicitly in line with the MDGs. Concerning MDGs as monitoring indicators, we observe that the PRs pay more attention to the attainment of the MDGs than the PRSPs, which could be due to the increasing recognition of the MDGs as objectives for poverty reduction in recent years. However, in some instances it appears as if the inclusion of MDGs is more of an obligation than an issue which has gained strong political commitment. Whether the emphasis is put on the attainment of MDGs or not seems dependent to some extent on a country's expectations of achieving the goals. In the case of Cambodia for instance, focus is put on the sixth MDG (to combat HIV/AIDS, malaria, and other diseases) and this is probably due to the fact that the country is expected to reach this goal.

31 per cent of the 16 reports mentioned that the private sector has responded to HIV/AIDS in the work setting. The latest PRs indicate more private sector participation in recent years than during the time of the publication of the PRSPs (approximately between the years 2000–2002). This is also confirmed in a document by UNAIDS, which reports that the business sector is beginning to lead the way in the response to the epidemic and more companies in the most seriously affected countries are providing ART for their employees.[172] An example of this can be seen in the case of Zambia. However, there are also of course voices claiming the opposite, such as the 2003–2004 report of the World Economic Forum (WEF). This report includes a review of the business response to HIV/AIDS, which indicates that business leaders are reluctant to increase their efforts because they do not recognize HIV/AIDS as a direct threat to their businesses.[173] Given the huge impact HIV/AIDS has on companies' profits, prevention programs in the private sector against HIV/AIDS have proven to be cost-effective in many countries.[174] Nevertheless, there is huge potential in involving the private sector in the struggle against HIV/AIDS to a greater extent than is currently seen in the PRSPs and PRs. According to the DoC, prevention and care programs in the workplace to provide supportive environments for PLWHA should be implemented by 2005.[175] This can only be realized through stronger commitment by the private sector and encouragement by the governments. Further, it is important that companies adopt broad strategies, including an estimate of the risks that HIV/AIDS pose to the company, provision of VCT, and non-discrimination policies.[176] An effort should be made to increase private sector involvement in this field. However, it is imperative that such an endeavour does not take away the overall

172 UNAIDS (2003, pp. 20, 27).

173 http://www.weforum.org/pdf/Initiatives/GHI_AfricaSnapshot.pdf [2005-03-15].

174 UNAIDS (2003, p. 26).

175 UN (2001, p. 20 §49).

176 The ILO "Code of Practice on HIV/AIDS and the world of work" provides a set of guidelines, based on international standards, for ways in which a company's response to HIV/AIDS can be formulated in practice. Source: UNAIDS (2003, p. 10).

responsibility from the government. Rather, the establishment of effective collaboration between the private and the public sector is crucial to successfully combat HIV/AIDS.

The main results on treatment are:

- Treatment is the dimension least attended to in the national strategies
- ART for AIDS has been available to a very limited extent in the countries studied
- Few countries have worked actively to decrease the price of ARVs
- There is no sign of strengthening efforts to promote family and community-based care over time
- Psychosocial care for PLWHA is available only in three of the countries reviewed

As regards the different methods of treatment, the desk- review indicates that developments in this area differ substantially between the countries reviewed. Zambia and Malawi, the countries with the highest HIV/AIDS prevalence rates amongst the countries under review, give due emphasis to treatment in their reports. On the other hand, the countries with the lowest prevalence rates (Uganda and Cambodia) give less attention to this issue. In general, treatment is the dimension that is least developed in the national strategies and it appears as if implementation in this area has been weak (e.g. Zambia). Hence, governments should make an effort to strengthen M&E systems to ensure closer follow-up of efforts concerning treatment.

In many cases it is not clear whether the responsibility for ARDs rests with the government or with other stakeholders in society, such as the private sector, the donor community, etc. In addition, the responsibility for the payment of ARDs differs between countries. In the case of Malawi, the government focuses its efforts on decreasing the price of ARDs to enable poor people to afford them. Through this method, accessibility can indeed be increased but the final payment for the essential drugs could still fall on the individuals, who may or may not afford the drugs at the lower price depending on their financial situation. In the case of Tanzania, however, the care and treatment program is financed by external donors.

Only in a few countries have the governments worked actively to decrease the price of ARVs, and highly active ART for AIDS has been available only on a very limited basis in the countries studied. This finding was somewhat surprising given the high prevalence rate in these countries. According to estimates from UNAIDS, in low- and middle income countries mortality rates for 15–49 year olds living with HIV are now up to 20 times greater than death rates for people living with HIV in industrialized countries, information which reflects the stark differences in access to ART. However, according to a recent UNAIDS publication, with the establishment of differential pricing schemes for the drugs, this picture is beginning to change. Nevertheless, low-income countries cannot be expected to meet, from their own resources, the cost of extending treatment to all who need it.[177] However, a remedy for this situation could be the creation of stronger links between the government and the private sector, as mentioned above. Moreover, in formulating stronger treatment policies, it might be necessary to have greater and continuous involvement of PLWHA in order to understand their specific needs. In some countries this has already been initiated. In Tanzania for

177 UN Economic and Social Affairs (2004, p. 78).

instance, PLWHA are in the process of forming their council to cater for the welfare of all PLWHA.

The main results on consequences are:

- In the PRSPs, gender in relation to HIV/AIDS is recognized in five of eight cases
- Only in one country is stigma resulting from HIV/AIDS brought up as an issue
- The two-way link between HIV/AIDS and poverty is identified in less than half of the reports.

There is no such thing as a single HIV/AIDS epidemic, nor is there an 'African' HIV/AIDS epidemic. On the contrary, there is tremendous diversity across the continent in the levels and trends of HIV infection.[178] However, underlying this diversity we found striking consistencies in the eight countries' strategies, for instance gender in relation to HIV/AIDS was mentioned in 63 per cent of the reports. Yet, despite the relatively large weight this topic has been given in these reports, it appears as if it is often an issue that the countries include in their PRSP because it ought to be included, rather than integrating this issue in its strategy by formulating targets and goals. In many cases, the effects on women of different HIV/AIDS policies is overlooked. The Cambodian PRSP, however, gives a good example of how a gender perspective can be integrated in the HIV/AIDS strategy. For instance, the report brings up indirect effects on women of different HIV/AIDS strategies.

Stigma resulting from HIV/AIDS is only mentioned in Cambodia's PRSP, in which social exclusion is given due emphasis. The cause of this neglect in the remaining reports could be because the PLWHA in Asia are mostly part of the marginalized groups in society. Hence, it is likely that HIV/AIDS carries greater stigma in Asia than in sub-Saharan Africa.[179] In general, HIV/AIDS is widespread in all groups in society in most countries in sub-Saharan Africa. This fact, together with the low notification rate in some countries, is likely to contribute to the situation that less focus is given to stigma related to HIV/AIDS in the reports of the countries in sub-Saharan Africa.

As can be seen in Table 3, the two-way link between poverty and HIV/AIDS is recognized in 44 per cent of the reports. In most cases, HIV/AIDS is seen as a key contributor to poverty but the reports rarely stress the role of the potential of HIV/AIDS interventions to reduce poverty. Thus, it is perceived as if analyses of the direct poverty-reducing impact of HIV/AIDS interventions are limited. To some extent, this reflects the general difficulty of modeling the impact of interventions and policies on poverty. However, similar types of analyses are included in forecasts of the future impact of HIV/AIDS (see e.g. Mozambique's PR), which indicates that this shortcoming is also due to lack of priority or of political will.

Consequences at the household level, including coping strategies for families living with HIV/AIDS, are normally discussed to a limited extent and unsystematically in the reports. However, it is essential to increase knowledge in this area in order to target the poorest and most vulnerable groups.

178 UNAIDS (2004, p. 6).

179 Ibid (2004b, p. 5).

The main results on the general indicators are:

- HIV/AIDS is commonly viewed as a cross-cutting issue in the reports
- Most of the reports have built in targets for HIV/AIDS in the monitoring system although follow-up is weak in the PR
- Three-quarters claim that HIV/AIDS activities are linked to the national budget
- Most of the reports claim that an institutional framework for HIV/AIDS has been implemented
- In most countries, governments cooperate with civil society in the struggle against HIV/AIDS

The treatment of HIV/AIDS as a cross-cutting issue is common in the PRSPs (50 per cent) but even more so in the PRs (75 per cent). This outcome most likely reflects the UNGASS commitment to implement multi-sectoral HIV/AIDS strategies by 2003,[180] which all of the studied countries have been successful in doing. However, despite this fact, HIV/AIDS expenditure is often budgeted under the health sector (e.g. in the case of Ethiopia). In addition, the impact of HIV/AIDS is rarely taken into account in discussions of coping strategies at the micro level, of macroeconomic implications, in growth projections and in descriptions of determinants of poverty. However, HIV/AIDS is often mentioned in relation to malnutrition and its increased burden on the health sector. These observations indicate that, even if HIV/AIDS is seen as a cross-cutting issue, this is not necessarily synonymous with treating it as such. In many cases it seems as if the governments acknowledge that HIV/AIDS should be treated as a cross-cutting issue because of international conventions. Nevertheless, the cross-cutting approach has not been successfully transformed into action. This in turn could be explained by the delay inherent in the learning process when one begins to see things from a new perspective. However, governments have to initiate and speed up this learning process by making an effort to apply a HIV/AIDS perspective to all actions and analyses.

In most countries (except for Malawi and Mozambique), monitoring indicators for HIV/AIDS are in place but are not detailed enough to assess whether or not a specific measure has been implemented. In addition, when targets and indicators have been formulated, a follow-up of them is often lacking in the PRs. This creates the risk that the PRSPs' initial policy commitments evaporate before implementation. To address this problem, enhanced and clearly stated links between policy commitments, budgetary allocations and monitoring indicators could be a first step in the right direction.[181] All in all, 69 per cent of the reports mention that they have a monitoring system which includes targets for HIV/AIDS. In many cases monitoring indicators are stated as long-term aims, such as a decrease in prevalence rates. Such goals should be complemented with intermediate objectives. In sum, the implementation of adequate monitoring targets and systematic follow-up of the strategies and actions in the PRs are urgently needed. One potential, and related, problem of more practical character is that the data required for follow-ups might not be available.[182] In these

180 UNAIDS (2004b, p. 7).

181 It is also possible to include detailed program descriptions as well as monitoring targets in other documents, since the PRSPs should focus on measures that require high level political endorsement in order to succeed. What is important is not where this kind of information is included but that it is included.

182 A joint study by UNICEF and the World Bank on PRSPs and NSPs in 19 countries in sub-Saharan Africa shows that the statistical capacity of the agencies responsible for the establishment of monitoring systems and the collection of data remain weak. Source: Bonnel et al. (2004, p. 18).

instances, the collection of new data should be encouraged. In addition, since there is a great need to strengthen the monitoring mechanism for HIV/AIDS programs, greater involvement in monitoring by civil society could improve both co-ordination and effectiveness.

In all countries' PRSPs, except for Uganda, the reports reveal that HIV/AIDS measures are linked to the national budgets. However, few reports offer detailed descriptions of HIV/AIDS expenditures broken down into different actions (exceptions are Ethiopia, Mozambique and Zambia). Most frequently, there is a single budget line for HIV/AIDS with no further details. As mentioned above, detailed costing of HIV/AIDS activities is vital in order to determine whether proposed activities are actually being implemented.[183] More detailed costing would also increase monitoring efficiency through increased transparency. One concrete example of this type of approach is found in the Tanzanian PR, in which it is explained that codes for tracking HIV/AIDS related activities have been developed.

63 per cent of the reports claim that an institutional framework for HIV/AIDS is being implemented. In general, it appears as if the "Three-Ones" principles are in the course of being implemented. These principles were agreed upon at the co-hosted high-level meeting in 2004, where UNAIDS, the UK and the US reaffirmed their commitment to strengthen national AIDS responses led by the countries affected themselves. Under these principles, they agreed on one HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; one National AIDS Coordinating Authority, with a broad-based multi-sectoral mandate; and one country-level Monitoring and Evaluation System.[184]

One result of the implementation of a multi-sectoral approach to HIV/AIDS is that the involvement of civil society has been scaled up. In 74 per cent of the reports, co-operation with civil society is mentioned. However, increased participation also implies more stakeholders and increased co-ordination difficulties, as in the case of Uganda and Cambodia. Coordination failures could also lead to less government control of the strategies and activities in the PRSPs that are being financed. In Rwanda's latest PR, the government expresses concern over the overwhelming attention that HIV/AIDS receives from donors, which potentially leads to neglect of other sectors. In general, most of the reports state that HIV/AIDS programs are financed to a great extent externally, which means that HIV/AIDS activities flow outside government budgets, but it remains unclear which measures that are financed and by whom. In order to address these issues, greater transparency and clarity on the sources of financing are needed in the costing of HIV/AIDS interventions as well as increased cooperation and information sharing, including financial information, between civil society organizations and the government.

4.3 Suggestions for Improvement of the PRSP Implementation Process

In this final section some of the problems identified during the review will be discussed and some suggestions for improvement of the PRSP implementation process will be provided.

– In sum, it is clear from the desk review that the PRSP process has started to add value by bringing HIV/AIDS into national poverty

183 Ibid (2004, p. 15).

184 http://www.unaids.org/en/about+unaids/what+is+unaids/unaids+at+country+level/the+three+ones.asp [2005-03-14].

planning processes. However, progress made in transforming stated objectives into programs is still slow. In addition, PRSP planned actions are, in many instances, not reflected in corresponding budgetary allocations, targets and indicators, which creates a significant risk of implementation slippage. Hence, implementation of the measures specified in the reports is a remaining challenge.

– Countries should respond to potential coordination failures which are inherent in the multi-sectoral approach and the fact that HIV/AIDS actions often go outside the government budget. Hence, more information should be gathered on different efficient coordination possibilities. The MoU in the case of Tanzania gives one example of coordination efforts. Another method which could potentially lead to better coordination is seen in the case of Rwanda, where a HIV/AIDS cluster group has been formed for coordination between the government and various ministries. According to the JSA, this cluster organization played a major role in the harmonization of HIV/AIDS efforts. Such a cluster could potentially be expanded to include more stakeholders in society, leading to positive side-effects such as increased understanding and coordination.
– It may seem paradoxical that a country like Uganda, which UNAIDS describes as the "beacon of hope"[185] due to its successful HIV/AIDS response, has a weak PRSP in terms of HIV/AIDS. Confronted with this fact, one can question how important the PRSP and the PRs actually are for measuring an effective national response to HIV/AIDS. According to the results from a joint UNICEF and World Bank review, a weak PRSP in terms of HIV/AIDS is not necessarily equivalent to a weak response by the country. Given that the PRSPs are meant to outline the countries' strategic goals, more detailed information is perhaps included in other documents such as the NSPs.[186] Nevertheless, since NSPs have not been reviewed in this report, the different roles of the PRSP and the NSP remain unclear. However, what is extremely important according to the same report, in terms of the roles of the different reports, is that governments put efforts into linking objectives at all levels from International Commitments to NSPs.
– In general, the connections between international commitments and national strategies are lacking in the reports. UNGASS DoC is only mentioned once in the Tanzanian PR. Even though the DoC is not a legally binding document, it is a clear statement of what governments intend to do and are committed to do in fighting the epidemic.[187] Still, this commitment is rarely mentioned in the reports, even if it appears as if governments' efforts to fight HIV/AIDS have been amplified after this session. Hence, a strong recommendation is therefore that international commitments, such as the DoC and the MDGs, should increasingly form the basis of national HIV/AIDS indicators. Harmonization of HIV/AIDS indicators on the basis of the MDGs is also important for avoiding duplication of monitoring indicators. Hence, there is a need to improve the links between long-term international commitments and the short-term and medium-term national poverty eradication strategies. If efforts are not explicit on these issues and are not designed to improve the situation, there is a risk that the international commitments will remain nicely formulated statements with

185 http://www.unaids.org/en/geographical+area/by+country/uganda.asp [2005-03-12].
186 Bonnel et al. (2004, p. 7).
187 UNAIDS (2001, pp. 3-4).

no real impact. These efforts should continue to be supported by the international community, which should request countries to explicitly disclose the links between national targets and international commitments.

– PRSPs have started to bring HIV/AIDS into the national poverty reduction planning arena. However, recognizing and analyzing the links between HIV/AIDS interventions and poverty reduction is a lingering challenge. It is crucial that HIV/AIDS is seen as a key contributory factor to poverty, especially for vulnerable groups such as young people and women and, at the same time, that poverty is a key determinant of HIV/AIDS (thereby creating a potentially vicious circle between HIV/AIDS and poverty). Recognizing the two-way link between HIV/AIDS and poverty is essential for determining the impact HIV/AIDS interventions have on different households and social groups. In particular, there is a strong need to strengthen the poverty reduction content of PRSPs by addressing the specific needs and rights of people affected by HIV/AIDS.[188]

188 Bonnel et al. (2004, pp. i, ii).

Appendix A:

The Poverty Reduction Strategy

Papers Process

Background to PRSPs, what the PRSPs are expected to include[189]

In the 1990s, a number of poverty reduction policy documents were produced by national governments but they were generally ineffective in generating the expected growth and poverty reduction for three reasons: first, the strategies were not broadly owned; second, the institutional changes required could not be achieved without high-level political endorsement, which the policy documents had no means of ensuring; and third, the cost of the programs was rarely provided, which made it difficult to ensure the availability of required financing. PRSPs were designed to address these shortcomings by: (i) offering a strategic vision of economic and social development; (ii) generating a growing sense of country ownership of poverty reduction strategies based on a broad participatory process involving civil society; (iii) describing the programs and policy changes required for implementation, including their costs and financing; and (iv) establishing a monitoring and evaluation system. These characteristics are at the heart of the "value added" of PRSPs.

In general, PRSPs are prepared by low-income country governments in collaboration with civil society and development partners.[190] PRSPs were introduced in 1999 to support country-driven efforts to formulate effective growth and poverty reduction strategies and to mobilize external assistance in support of these strategies. Since then, the PRSP process has led to a sharper focus on poverty reduction, increased ownership by national governments and increased support from a number of bilateral donors. As at the end of June 2004, PRSPs have been implemented in 42 countries, including 21 in sub-Saharan Africa.[191] In addition, PRSPs provide the operational basis for concessional lending by the Fund and Bank and for debt relief under the Heavily Indebted Poor Countries (HIPC) Initiative. Poverty Reduction Strategy Papers (PRSPs) are prepared by the member countries through a participatory process involving domestic stakeholders as well as external development partners, including the World Bank and IMF. Updated every three years with annual

189 Appendix B is based upon information from the IMF webpage. Source: http://www.who.int/3by5/en/ (www.imf.se) [2005-03-14].

190 http://www.who.int/3by5/en/ (www.imf.se) [2005-03-14].

191 Bonnel et al. (2004, p. i).

PRs, PRSPs describe the country's macroeconomic, structural and social policies and programs over a three-year or longer horizon to promote broad-based growth and reduce poverty, as well as associated external financing needs and major sources of financing.

Limitation of PRSP

It is at the implementation level that PRSPs have the greatest limitations. On one hand, most reviews of PRSPs stress the need for realistic expectations of what PRSPs can do. On the other hand, nearly all reviews highlight the need to expand the content of PRSPs in directions that depend on the priorities of the reviewer. In order to reconcile these two views, it is useful to start from the initial objective of PRSPs, which is to offer a strategic vision of economic and social development that would be endorsed at a high political level. This criterion can be used for determining what should be included in PRSPs.

Appendix B:

Tables and Figures

Table 1: Country HIV and AIDS estimates, end 2003*

	CAM	ETH	MAL	MOZ	RWA	TAN	UGA	ZAM
Adult (15–49) HIV prevalence rate	2.6%	4.4%	14.2%	12.2%	5.1%	8.8%	4.1%	16.5%
Adults (15–49) living with HIV	170’	1 400’	810’	1 200’	230’	1 500’	450’	830’
Adults and children (0–49) living with HIV	170’	1 500’	900’	1 300’	250’	1 600’	530’	915’
Women (15–49) living with HIV	51’	770’	460’	670’	130’	840’	270’	470’
AIDS deaths (adults and children) in 2003	15’	120’	84’	110’	22’	160’	78’	89’

*The numbers lie within a range and are not exact estimates.

Source: UNAIDS (2004) and UNAIDS, UNICEF and WHO (2004).

Table 2: Word-count PRSPs and PRs

Word/ Country	**CAM**	**ETH**	**MAL**	**MOZ**	**RWA**	**TAN**	**UGA**	**ZAM**
PRSP	**2002**	**2002**	**2002**	**2001**	**2002**	**2000**	**2000**	**2002**
HIV/AIDS	85	132	176	66	52	32	10	132
Anti-retroviral treatment*	0	2	3	0	1	0	0	15
Prevention	3	30	31	10	9	0	0	5
Treatment	1	10	3	3	3	0	0	13
Consequences	0	5	2	0	0	0	0	1
PR	**2004**	**2004**	**2003**	**2004**	**2004**	**2004**	**2003**	**2004**
HIV/AIDS	18	49	3	81	33	95	44	53
Anti-retroviral treatment*	0	5	0	1	6	3	0	16
Prevention	1	11	1	4	5	1	2	3
Treatment	0	4	0	2	2	6	1	0
Consequences	0	0	0	1	0	1	2	0
JSA	**2003**	**2004**	**2003**	**2001**	**2004**	**2000**	**2003**	**2004**
HIV/AIDS	2	5	10	7	2	3	1	10
Anti-retroviral treatment*	0	1	0	0	0	0	0	4
Prevention	0	0	1	0	0	0	0	0
Treatment	0	0	0	0	0	0	0	0
Consequences	0	0	0	1	0	0	0	0
JSA	**2004**			**2003**		**2004**		
HIV/AIDS	1			7		1		
Anti-retroviral treatment*	0			0		0		
Prevention	0			1		0		
Treatment	0			0		0		
Consequences	0			0		0		

*This category also includes the abbreviations ARV, ART, ARD, etc.

Table 3: Comparative analysis

	CAM		ETH		MAL		MOZ	
Prevention Indicators	**PRSP**	**PROG**	**PRSP**	**PROG**	**PRSP**	**PROG**	**PRSP**	**PROG**
Has the country national prevention targets?	Y	Y	Y	Y	N	N	Y	Y
Are targets in line with the MDGs?	Y	Y	Y	Y	N	N	N	N
Has the country a private sector response?	N	N	N	N	Y	N	N	Y
Treatment Indicators								
Is the government providing ARVs?	N	N	N	Y	Y	N	N	N
Government works actively to decrease price of ARVs?	N	N	N	N	Y	N	N	N
Is family and community-based care strengthened?	Y	Y	N	N	Y	N	Y	Y
Is psychosocial care for PLWHA available?	N	N	Y	N	N	N	Y	N
Consequence Indicators								
Is the gender issue recognized in relation to HIV/AIDS?	Y	Y	Y	N	Y	N	N	N
Is stigma due to HIV/AIDS recognized?	Y	N	N	N	N	N	N	N
Is the two-way link (HIV/AIDS- Poverty) recognized?	Y	N	Y	Y	Y	N	N	Y
General Indicators								
Is HIV/AIDS treated as a cross-cutting issue?	N	N	Y	Y	Y	Y	N	N
Is there a monitoring system with targets for HIV/AIDS?	Y	N	Y	Y	N	N	N	N
Are HIV/AIDS activities linked to national budget?	Y	N	Y	N	Y	Y	Y	Y
Is an institutional framework for HIV/AIDS mentioned?	Y	N	Y	Y	Y	N	N	Y
Is civil society cooperation on HIV/AIDS mentioned?	Y	Y	N	Y	Y	N	Y	Y
	RWA		**TAN**		**UGA**		**ZAM**	
Prevention Indicators	**PRSP**	**PROG**	**PRSP**	**PROG**	**PRSP**	**PROG**	**PRSP**	**PROG**
Has the country national prevention targets?	N	Y	N	N	Y	Y	Y	N
Are targets in line with the MDGs?	N	N	N	N	N	N	N	Y
Has the country a private sector response?	N	Y	N	Y	N	N	N	Y
Treatment Indicators								
Is the government providing ARVs?	N	Y	N	N	N	N	Y	Y
Is the government working actively to decrease the price of ARVs?	N	Y	N	N	N	N	Y	Y
Is family and community-based care strengthened?	N	N	N	Y	N	N	Y	Y
Is psychosocial care for PLWHA available?	Y	N	N	N	N	N	N	N
Consequence Indicators								
Is the gender issue recognized in relation to HIV/AIDS?	Y	N	N	N	N	Y	Y	N
Is stigma due to HIV/AIDS recognized?	N	N	N	N	N	N	N	N
Is the two-way link (HIV/AIDS- Poverty) recognized?	N	N	N	N	N	Y	Y	N
General Indicators								
Is HIV/AIDS treated as a cross-cutting issue?	Y	Y	N	Y	N	Y	Y	Y
Is there a monitoring system with targets for HIV/AIDS?	Y	Y	Y	Y	Y	Y	Y	Y
Are HIV/AIDS activities linked to national budget?	Y	Y	Y	Y	N	N	Y	Y
Is an institutional framework for HIV/AIDS mentioned?	Y	Y	N	Y	N	N	Y	Y
Is civil society cooperation on HIV/AIDS mentioned?	Y	Y	N	Y	N	Y	Y	Y

Figure 1: HIV/AIDS in Malawi's PRSP

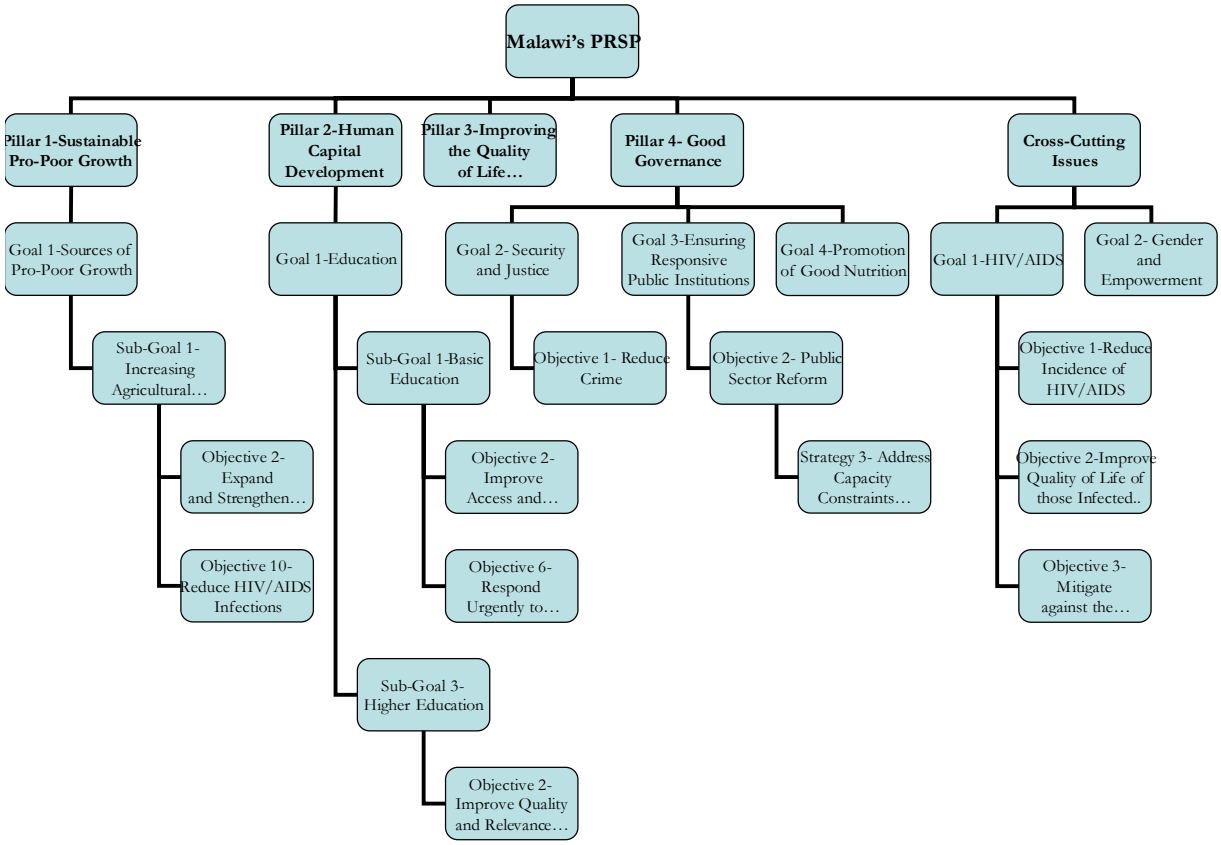
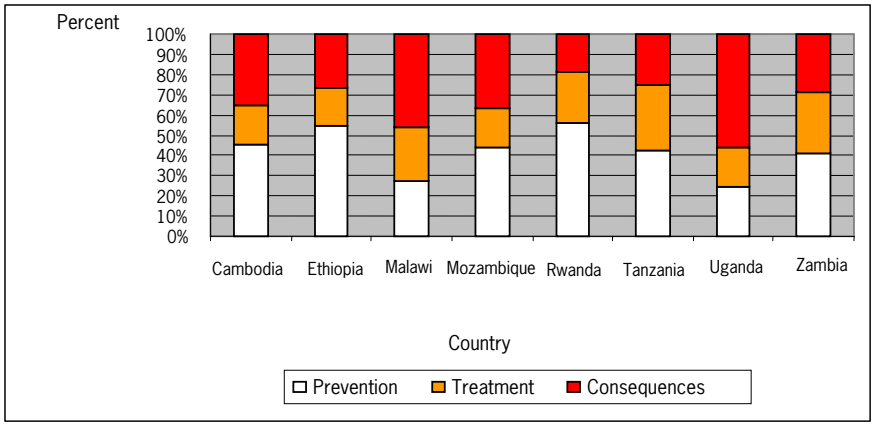


Figure 1 is an overview of all the sections in the PRSP where HIV/AIDS is mentioned. The structure of the report can be described as follows: The PRSP is sorted into five main parts, the four pillars and the cross-cutting issues. Under each of these main components there are a number of Goals, Sub-Goals, Objectives and finally, Strategies.

Figure 2: The weight given to the three dimensions in the reports



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http://www.worldbank.org [2005–03–13]

6.1 Country Specific Documents

Cambodia

Poverty Reduction Strategy Paper Progress Report
Prepared by the member country, October 22, 2004

Joint Staff Assessment of the Poverty Reduction Strategy Paper Progress Report
Prepared by the staffs of the IMF and World Bank, October 22, 2004

Joint Staff Assessment of the Poverty Reduction Strategy Paper
Prepared by the staffs of the IMF and World Bank, January 23, 2003

Poverty Reduction Strategy Paper
Prepared by the member country, December 20, 2002

Ethiopia (The Federal Democratic Republic of)

Joint Staff Assessment of the Poverty Reduction Strategy Paper Annual Progress Report
Prepared by the staffs of the IMF and World Bank, March 11, 2004

Poverty Reduction Strategy Paper Annual Progress Report
Prepared by the member country, February 12, 2004

Poverty Reduction Strategy Paper
Prepared by the member country, July 31, 2002

Malawi

Joint Staff Assessment of the Poverty Reduction Strategy Paper Progress Report
Prepared by the staffs of the IMF and World Bank, November 7, 2003

Poverty Reduction Strategy Paper Progress Report
Prepared by the member country, October 27, 2003

Malawi Poverty Reduction Strategy Paper (PRSP)
Prepared by the member country, April 30, 2002

Mozambique (Republic of)

Poverty Reduction Strategy Paper Progress Report (Review of the Economic and Social Plan for 2003)
Prepared by the member country, May 18, 2004

Joint Staff Assessment of the Poverty Reduction Strategy Paper
Prepared by the staffs of the IMF and World Bank, July 9, 2003

Joint Staff Assessment of the Poverty Reduction Strategy Paper
Prepared by the staffs of the IMF and World Bank, August 28, 2001

Poverty Reduction Strategy Paper
Prepared by the member country, April 30, 2001

Rwanda

Joint Staff Assessment of the Poverty Reduction Strategy Paper Progress Report
Prepared by the staffs of the IMF and World Bank, August 23, 2004

Poverty Reduction Strategy Paper Progress Report
Prepared by the member country, August 23, 2004

Government of Rwanda Poverty Reduction Strategy Paper (PRSP)
Prepared by the member country, June 30, 2002

Tanzania

Poverty Reduction Strategy Paper Progress Report
Prepared by the member country, September 7, 2004

Joint Staff Assessment of the Poverty Reduction Strategy Paper Progress Report
Prepared by the staffs of the IMF and World Bank, September 7, 2004

Poverty Reduction Strategy Paper Joint Staff Assessment
Prepared by the staffs of the IMF and World Bank, November 2, 2000

Poverty Reduction Strategy Paper
Prepared by the member country, October 1, 2000

Uganda

Poverty Reduction Strategy Paper Annual Progress Report
Prepared by the member country, September 22, 2003

Joint Staff Assessment of the Poverty Reduction Strategy Paper Annual Progress Report
Prepared by the staffs of the IMF and World Bank, September 22, 2003

Poverty Reduction Strategy Paper Progress Report
Prepared by the member country, March 31, 2002

Poverty Reduction Strategy Paper Progress Report Joint Staff Assessment
Prepared by the staffs of the IMF and World Bank, March 9, 2001

Poverty Reduction Strategy Paper
Prepared by the member country, March 24, 2000

Zambia

Poverty Reduction Strategy Paper Progress Report
Prepared by the member country, July 1, 2004

Joint Staff Assessment of the Poverty Reduction Strategy Paper Progress Report
Prepared by the staffs of the IMF and World Bank, July 1, 2004

Poverty Reduction Strategy Paper
Prepared by the member country, March 31, 2002

Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARD	Anti-retroviral Drugs
ART	Anti-retroviral Therapy
ARV	Anti-retroviral
BCC	Behavioral Change Communication
BESSIP	Basic Education Sub-sector Investment Program
DoC	Declaration of Commitment
EHP	Essential Healthcare Package
FDI	Foreign Direct Investments
HIPC	Heavily Indebted Poor Countries
HIV	Human Immunodeficiency Virus
HSDP	Health Sector Development Program
HSSP	Health Sector Strategic Plan
IMF	International Monetary Fund
JSA	Joint Staff Assessment
MAP	Multi-Sectoral AIDS Project
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MoE	Ministry of Education
MoH	Ministry of Health
MoU	Memorandum of Understanding
MTEF	Mid-term Expenditure Framework
NAC	National AIDS Commission
NACP	National AIDS Control Program
NGO	Non-Governmental Organization
NMSF	Multi-sectoral Strategic Framework
NSP	National HIV/AIDS Plans
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission

PR	Progress Report
PRSP	Poverty Reduction Strategy Paper
RFA	Regional Facilitating Agencies
RGC	Royal Government of Cambodia
SADC	Southern Africa Development Community
Sida	Swedish International Development Cooperation Agency
STD	Sexual Transmitted Diseases
STI	Sexual Transmitted Infections
TACAIDS	Tanzania Commission for AIDS
TB	Tuberculosis
UNAIDS	United Nations AIDS Commission
UNGASS	United Nations General Assembly Special Session of HIV/AIDS, 2001
UNICEF	United Nations Children's Fund
USD	United States Dollar
VCT	Voluntary Counseling and Testing
WEF	World Economic Forum
WFP	World Food Program
WHO	World Health Organization

Halving poverty by 2015 is one of the greatest challenges of our time, requiring cooperation and sustainability. The partner countries are responsible for their own development. Sida provides resources and develops knowledge and expertise, making the world a richer place.

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