Unit 2: The Impacts of HIV/AIDS

Learning Objectives

How does HIV/AIDS affect individuals and societies as a whole?

After studying this unit, you should be able to:

- Understand the impacts of HIV/AIDS on vulnerable groups;
- Understand the impacts of HIV/AIDS on social and economic development;
- Understand the impacts of HIV/AIDS on democracy and good governance;
- Understand the link between HIV/AIDS and Human Rights.

Introduction

The impact of the HIV/AIDS pandemic is felt hardest by the individuals who are infected or affected by the disease, and in particular by individuals who are especially vulnerable to HIV infection due to stigma and discrimination, poverty, a lack of access to education, health and other services that promote HIV awareness. However, the impact of HIV/AIDS goes beyond the individual or household level – it affects nations as a whole. HIV/AIDS represents a heavy burden for public finances, particularly for the health sector, but it also has severe implications on education, food security and the workplace, as well as the democratic development of a country.

Unit 2 aims to give a deeper, more meaningful understanding of the impact of HIV/AIDS on various groups who are vulnerable to HIV infection or death due to AIDS outcomes. Emphasis will also be given to the importance of upholding Human Rights, as integrating internationally agreed upon standards is a key step in developing relevant HIV-related law and achieving policy reform. The unit will also demonstrate the unique ability of HIV to undermine areas such as social and economic development, as well as democracy and good governance.

HIV/AIDS – Impact on Vulnerable Groups

HIV/AIDS does not discriminate, yet it disproportionately infects and affects vulnerable groups. Of particular concern are children and youth; women; men who have sex with men; injecting drug users; sex workers; persons with disabilities; prisoners; soldiers; migrant workers; and refugees.

Poverty and the marginalization associated with it can increase vulnerability. Poverty can, for example, force girls or women to trade sexual favors for food to feed their families, or prevent individuals from buying condoms. It can keep adolescents out of school, depriving them of an opportunity to learn how the virus is transmitted, and putting them at a greater risk of drug abuse and other risky behaviours such as unprotected sex. It can exacerbate family tensions that lead to domestic violence or abandonment of financially dependent women. Addressing the underlying causes of vulnerability to infection, including poverty and gender inequality, is critical to ending the epidemic (UNFPA,2008).

How HIV/AIDS affects Children and Youth

Every day about 1,800 children become infected with HIV, and the majority of them are newborn. In 2007, there were approximately 2.5 million children under the age of 15 living with HIV worldwide. It is also estimated that as of 2005 15.2 million children under 18 lost one or both parents to AIDS, and that millions more are at risk of experiencing poverty, homelessness, school drop-out, discrimination, loss of opportunities and an early death. (Unite for Children, Unite Against AIDS). Nearly 90% of all HIV-positive children live in sub-Saharan Africa (UNAIDS, 2007).

> *"AIDS is redefining the very meaning of childhood for millions, depriving children of many of their human rights – of the care, love and affection of their parents; of their teachers and other role models; of education and options for the future; of protection against exploitation and abuse. The world must act now, urgently and decisively, to ensure that the next generation of children is AIDS-free."*
>
> **UNICEF, A Call to Action: Children, the missing face of AIDS**

Children are infected and affected by HIV/AIDS in varying, and unique ways. Although the majority of children are infected through mother-to-child transmission (MTCT), it

does not negate the overwhelming amount of children infected through sexual abuse and exploitation, primarily among orphaned children, as well as voluntary sexual activity among young adults aged 15-24.

An HIV-positive pregnant woman can pass on the virus to her baby in the womb, during birth, or post-natally through breastfeeding. If the woman does not breastfeed, the risk of mother-to-child-transmission (MTCT) of HIV is around 15-30%. With prolonged breastfeeding, the risk is augmented to as high as 30-45%. However, transmission can be significantly reduced with intervention. If a short course of antiretroviral drugs is given to mother and baby around the time of delivery, combined with replacement feeding, the risk for transmission can be reduced by up to 50%. Although the universal access has not been achieved, the percentage of HIV positive women receiving antiretroviral drugs to prevent mother-to-child transmission increased from 14% in 2005, to 33% in 2007. In this same period the number of new infections among children fell from 410,000 to 370,000 demonstrating the importance of the prevention of MTCT (UNAIDS Press Release, July 2008).

Despite the argument that provisions of these treatments are not economically feasible, compared to the long-term costs of treating new HIV patients, combined with the loss of future economic and social growth, the costs of preventing MTCT is relatively inexpensive.

Orphaned and otherwise vulnerable children (OVC) face special challenges as they are often excluded from accessing health care and education facilities. Furthermore, the loss of parents, adult relatives, teachers, health care workers and other caregivers are unduly undermining the development and protection of children – ultimately, orphaned and vulnerable children live in communities weakened by HIV/AIDS as their schools, health care systems, households and social support networks have also been affected (UNICEF, 2004).

The myriad of challenges facing children orphaned and made vulnerable by HIV/AIDS can be summarized in the following ways (UNICEF, 2004):

- **Economic hardships.** With the onset of HIV/AIDS in the household, savings may be spent on the care of parents rather than educational and health needs of children. After the death of parents, children may also be deprived of inheritance such as money or property that is rightfully theirs;
- **Lack of love, attention and affection.** Ill parents may be unable to give consistent and responsive care to their children. Illness in the household may also lead to reduced interpersonal relationships between children and their parents' affection and comfort. The premature death of parents also results in the loss of life and survival skills. These skills are no longer passed from one generation to the other, and children are forced to take on responsibilities for which they may be unprepared;
- **Withdrawal from school.** Related to declines in economic stability in the household, or increased pressure to care for siblings and ailing parents, children may be forced to withdrawal from school;
- **Psychological distress.** Illness and death of parents, or other family members can cause extreme emotional distress among children. Without support and grief counseling children can also succumb to increased fatalism, or stigma, discrimination and isolation related to their orphan status. Orphaned children are also more likely to be rejected by their extended families due to their parents dying of AIDS;
- **Malnutrition and illness.** Orphaned and vulnerable children are less likely to meet their basic needs due to limited economic resources, which include access to nutritious food and medical care;
- **Increased abuse and risk of HIV infection.** It has been noted that orphaned and vulnerable children, in particular girls, are at an increased risk to sexual exploitation due to poverty, hunger, and armed conflict (UNICEF, 2004). These scenarios may force young girls into survival sex-work and/or harmful child labor in order to obtain money, food, shelter or "protection" for themselves or younger siblings left in their care. Sadly, this exacerbates and perpetuates the cycle of HIV.

HIV is increasingly a disease of the young. 40% of all new HIV infections worldwide are among young people, aged 15-24. Prevalence rates are highest in sub-Saharan Africa,

and three out of four young people who contract HIV in sub-Saharan Africa are young women. Statistics show that the majority of young people become sexually active at a young age, but they are not monogamous and few wear condoms on a regular basis. Youth who experiment with alcohol and drugs, particularly injecting drugs, put themselves further at risk. In sub-Saharan Africa sexual relationships between older men and teenage girls play a large role in the high HIV infection rate among young women. Often referred to as a "sugar daddy" relationship, this can be defined as a relationship in which the man is at least 10 years older than his non-marital sexual partner and where the young girl receives some material assistance in the form of gifts. A study titled *Cross-generational and Transactional Sexual Relations in Sub-Saharan Africa* has shown that the older a man is than his female partner and the more money and gifts he gives her, the less likely they are to use condoms, which increase the risk for HIV-infection.

Young street children, refugees and migrants are also at a particular risk, as they are often excluded from health services, exposed to unprotected sex (whether in exchange for food, protection or money, or as a result of violence), or use illicit drugs. Street children are in great need of HIV prevention, care and treatment services, but rarely receive them. For example, care for orphans and vulnerable children often evolve from home-based care programs, thereby excluding children living on the streets. They are also less likely to use testing and counseling or treatment services, as this often depends on consent from a parent or guardian and a stable, supportive home life. Organizations such as the Consortium for Street Children, the International HIV/AIDS Alliance, Street Kids International etc. therefore try to take this into account when addressing this vulnerable group.

Ignorance and misconceptions about HIV/AIDS and how it is spread is the primary reason why young people are particularly vulnerable to HIV. For example, many youth believe that someone who looks healthy cannot have HIV. Therefore, comprehensive prevention strategies for keeping adolescents and young people free of infection by building their knowledge to avoid behaviours that put them at risk are of great importance.

In 2005 UNICEF and other partners launched the UN-wide campaign called "Unite for Children, Unite against AIDS". The campaign has four priority areas:

- **Prevent mother-to-child transmission** - Target: By 2010, offer appropriate services to 80% of women in need;
- **Provide pediatric treatment** - Target: By 2010, provide either antiretroviral treatment or cotrimoxazole (used in the treatment of bacterial infections), or both, to 80% of children in need;
- **Prevent infection among adolescents and young people** – Target: By 2010, reduce the percentage of young people living with HIV by 25% globally; and
- **Protect and support children affected by AIDS** – Target: By 2010, reach 80% of children most in need.

Nonetheless, many national and international political responses to AIDS still neglect to take the special challenges children and youth face with regards to HIV/AIDS in consideration. Parliamentarians are in a key position to advocate and mobilize action focusing on children and youth, to advance policies, laws and budgetary allocations for the necessary services and education to prevent MTCT and infection among young people; strengthen support to orphans and other vulnerable children and youth, as well as their families and caregivers; and break the silence and ignorance regarding HIV/AIDS by publicly speaking out on how HIV/AIDS affects children and youth. UNICEF and its partners have prepared a tool kit called *"What Parliamentarians Can Do About HIV/AIDS – Action for Children and Young People*" that can serve as a useful resource for parliamentarians in addressing these challenges HIV/AIDS pose on children and youth.

Box 1

Uganda Parliamentary Forum for Children

The Uganda Parliamentary Forum for Children (UPFC) is a platform where MPs from different political affiliations collectively lobby for the rights of children in situations of competing needs and priorities where children's rights are often neglected. As a child rights pressure group within Parliament, UPFC lobbies and advocates for laws that ensures the welfare, protection and

development of children. Primary considerations are:

1. Refugee ad internally displaced war affected children
2. Children in institutional care
3. Fostered/adopted children
4. Street children
5. Child headed households
6. Orphans under care of grandparents
7. Children in conflict with the law
8. Children with disabilities
9. Children experiencing abuse
10. Children affected HIV/AIDS
11. Working children.

The UPFC operates in the public policy arena. With a small secretariat based in the Parliamentary Building, an executive committee of 8, and a General Assembly, constituted by its registered membership of about 110 MPs.

Source: www.upfc.org and www.upfc.go.ug/index.php?option=com_content&task=view&id=6&Itemid=9

How HIV/AIDS Affects Women

Currently, women make up half of all HIV/AIDS cases globally. In 2007 UNAIDS estimated that 15.4 million women were living with HIV. In fact, some sources suggest that women now represent an increased risk of infection of a 3:1 ratio over their male counterparts. Of the total number of adults living with HIV in sub-Saharan Africa, 61% were women.

There are a variety of biological, social, economic and legislative factors which increase infection rates among women. Although it is important to note that is impossible to make universal statements concerning women's experience with HIV/AIDS, it is possible to demonstrate concerns unique to women and girls. Factors which increase vulnerability are not static, which means they are not faced by all women, and are felt more or less by women depending on their autonomy in the home, and are further influenced by their class, age, and ethnicity. Generally, the challenges faced by women can be summarized in the following ways:

- **Economic inequality.** Women often fear HIV testing, as HIV-positive status may result in abuse or abandonment. Where women have little to no financial resources,

this outcome serves as a barrier to testing and consequently treatment. Sustainable economic and income generating opportunities need to be continually available to women, as well as increasing the control women have over financial resources to allow women to leave abusive situations if necessary. This logic extends to the improvement of legal measures which protect women from domestic abuse, the prosecution of marital rape, and strengthening inheritance laws (See Unit 10);

- When women are **widowed due to AIDS** local legislation and limited legal status, including the ability to inherit and own property and financial resources increases the economic vulnerability of women, this is true after the death of male landholders. Loss of land and resources for agricultural production reduces the opportunities for income generation, this further increases vulnerability to HIV due to poverty;
- **Biological vulnerability.** Although this explanation should not be misconstrued as characterizing women as "weak," women face unique biological vulnerabilities. The vagina is a larger, more delicate membrane and consequently more susceptible to HIV infection. Furthermore, semen which comes into contact with the vagina during intercourse contains a higher concentration of HIV than vaginal fluids, making women 2-4 times more likely of contracting HIV than her male counterparts;
- **Abuse of sexual and reproductive rights.** Often times, women lack the ability to negotiate safer sex in the home due to socio-cultural beliefs which continue to subordinate women;
- **Comprehensive knowledge of HIV among women remains low.** Women may face **unequal access to education** which may limit their understanding and ability to prevent HIV infection in the first place. Compounding this problem is the fact that girls living in households that are infected/affected by HIV/AIDS are twice as likely to be withdrawn from school;
- **Burden of care.** If and when a woman becomes infected with HIV, inadequate access to treatment and support compound her psychological and physical burden of HIV/AIDS care. Referred to as "triple jeopardy", more often than not, women will not only be infected, as will their partners and children which may be born after the onset of infection. She must then care for all of these parties, often with limited resources. Many care givers experience **high levels of stress**, impacting their well-being especially if they are also HIV-positive;

- **Stigma, rejection, and violence.** At the root of this issue are the sexual double standards faced by women. In many contexts, the social and cultural value surrounding female purity means that women and girls living with HIV/AIDS are subjected to greater discrimination than men. Cases where women are "blamed" for their infection can lead to heightened levels of domestic abuse, abandonment by spouses or in-laws, or dismissal from paid employment. Internalized stigmas may also undermine confidence to leave a physically or sexually abusive relationship, and increase the risk of infection;
- **Unequal access to health care.** Women are less likely to seek or receive medical care and treatment as their needs may be overshadowed by the needs of male family members, especially when economic resources are limited. This can limit rates of testing and treatment of HIV, other sexually transmitted diseases, and opportunistic infections and can ultimately exacerbate rates of death due to AIDS among women;
- Women and girls face **higher rates of malnutrition** compared to their male counterparts. In low resource settings, women and girls may be forced to skip meals or eat less, jeopardizing health. This is especially dangerous as HIV infection can progress more rapidly to the AIDS stage without treatment, including proper nutrition. HIV infection among women may also **limit the overall food security** of the household, as women are often responsible for agricultural production at the household level (FAO, 1999). Ill women are often unable to meet these demands;
- Even among women who are able to access health care facilities and HIV-testing, fear of disclosing a positive status to her partner can **limit adherence to treatment.** Asking her husband for funds to pay for treatment, utilizing options like using powdered milk to prevent mother to child transmission, or insisting condom use to reduce repeated exposure are "obvious" indicators that a woman is HIV positive, which could lead to abuse or abandonment.

Parliamentarians have an important role in addressing gender inequalities to ensure laws that protect the rights of women are passed, for example on issues such as domestic violence, equality in marriage, HIV-related discrimination and inheritance rights. Parliamentarians are also in a position to ensure that sufficient funds are allocated to

AIDS programs that focus on or take women into consideration, for example legal aid services and other forms of support that uphold women's rights. Parliaments can further ensure that specific services for women, including education, sexual and reproductive health, antenatal care, prevention of mother-to-child transmission and antiretroviral therapy are also made available. In addition parliaments should advocate for women to be adequately represented in policy and decision-making on AIDS, for example in AIDS forums and national AIDS coordinating bodies - and also in Parliament itself.

HIV/AIDS and other vulnerable groups

Men Who Have Sex With Men (MSM)

HIV was first diagnosed within the gay community in North America and Europe. Although the HIV/AIDS pandemic is now generalized, immense stigma and discrimination is still faced by those who either identify themselves as gay, or men who have sex with men. In recent years, the term "men who have sex with men" has emerged to describe a specific behavior rather than target a group of people. It includes men who identify themselves as being gay, bisexual, or transgender although not all men who have sex with men identify themselves in these ways. The risk of HIV infection among MSM is significant as it often involves anal sex, which, if unprotected, can pose a higher risk to both partners than vaginal sex. However, it also includes men who also have sex with women and overlap with other risk groups, such as men who sell and/or buy sex and men engaged in unsafe injecting drug use, which constitutes an important "epidemiological bridge" for HIV transmission into the general population. This makes it crucial to reach this group with effective HIV preventive interventions.

In many parts of the world, efforts targeting MSM have been severely hampered by widespread stigmatization and denial due to cultural, social or religious beliefs which stigmatize men who have sex with men. A number of countries even criminalize same sex acts, which often lead men to avoid accessing services for prevention, due to fear of reprisal. It is estimated that fewer than one in twenty men who have sex with men (MSM) globally have access to HIV prevention, treatment and care, which may also result in a lack of understanding on how HIV is transmitted, and other health risks

associated with unprotected sex. In areas where cultural, social and religious attitudes discriminate against MSM, policy can become a politically sensitive issue and politicians may be reluctant to implement or support programs that may result in public criticism or lack of support. This can lead to further stigmatization and marginalization for this group.

Although there are many initiatives targeting this group, more work needs to be done to ensure that men in need are able to access the resources required for HIV prevention and care easily, privately, and without judgment. It is also important for governments to include MSM into national HIV prevention and treatment strategies as well as to openly support front-line organizations which offer prevention, treatment and support to MSM. Parliamentarians can play an important role in assuring that legislation is changed to acknowledge and accept the prevalence of MSM, decriminalize male-male sex, and provide protection to those who have been discriminated against, or subjected to violence based on sexual orientation.

Injecting Drug Users (IDUs)

Outside of sub-Saharan Africa, Injecting Drug Users (IDUs) account for nearly one-third of new HIV-infections. However, less than 20% actually receive or have access to prevention and treatment services. In Eastern Europe and Central Asia, where the epidemic is rapidly increasing among this population, prevention programs targeting IDUs have less than 10% coverage. New HIV epidemics among injecting drug users are now being documented in both Asia and sub-Saharan Africa, however prevention and treatment programs in these regions are rare, or virtually non-existent.

HIV is transmitted among IDUs through the shared use of contaminated needles and syringes. Poverty is a contributing factor that limits the ability to access clean needles for personal use. Unprotected sex due to the influence of drugs is also associated with HIV infection rates among IDUs. Due to the illegality of drug use, IDUs face stigmatization and discrimination among health care workers, and are thus are excluded from facilities which offer HIV prevention and treatment programs. It also discourages users from accessing such programs, even when available, for fear of arrest and

reprimand. In addition, IDUs are often unable to access programs that combat drug dependency and promote rehabilitation furthering the risk for future HIV infection.

HIV/AIDS programs which target IDUs should be comprehensive and offer a range of drug treatment options, including drug substitution options, harm reduction strategies including needle exchange and sterilizing kits, voluntary HIV testing and counseling (VCT), prevention measures such as safer sex education, access to primary health care, and antiretroviral treatments (UNAIDS, 2008). To accomplish effective programming, parliamentarians should demonstrate and advocate for the importance of such programs, as well as to review legislation in order to protect the rights of IDUs.

Box 2

The Warsaw Declaration: A Framework for Effective Action on HIV/AIDS and Injecting Drug Use

In 2003, the Government of Poland hosted a policy dialogue, sponsored by UNAIDS, Health Canada, the Open Society Institute and the Canadian International Development Agency (CIDA), to address the HIV/AIDS epidemic among injecting drug users (IDUs). The participants included government representatives responsible for HIV/AIDS and addressing injection drug use from countries such as Poland, Tajikistan, Ukraine, Brazil, Indonesia, Thailand, Canada, Switzerland and the United Kingdom. Representatives from the World Health Organization, UNAIDS, UNDP and the United Nations Office on Drugs and Crime also participated together with a few non-governmental organizations, such as the Dutch National Interest Group of Drug Users, the Canadian HIV/AIDS Legal Network and the Monar Krakow Drugs Project.

During this policy dialogue, the participants adopted the Warsaw Declaration on HIV/AIDS and injection drug use. Its purpose is to provide a framework for "mounting an effective response that will slow end eventually stop the HIV/AIDS epidemic among injecting drug users worldwide". It calls for decisive policy action at the regional and national levels to ensure an effective response to improve the health and social conditions of IDUs, as well as to ensure their rights and reduce their vulnerability to HIV infection.

Source: www.aidslaw.ca/publications/publicationsdocEN.php?ref=760

Sex Workers

Poverty is overwhelmingly the root cause for exchanging sex for economic gain or survival. It becomes very difficult to follow prevention measures that call for a reduction in the number of sexual partners, when sex 'buys' food, shelter, or safety. Survival sex workers can be defined as "female, male and transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally,

and who may or may not consciously define those activities as income-generating" (UNAIDS, 2006).

> "*With regard to adult sex work that involves no victimization, criminal law should be reviewed with the aim of decriminalizing, then legally regulating, occupational health and safety conditions to protect sex workers and their clients, including support for safe sex during sex work. Criminal law should not impede provision of HIV prevention and care services to sex workers and their clients.*"
>
> **International Guidelines on HIV/AIDS and Human Rights**

Impoverished women and girls are vulnerable to sex-trafficking as they may be kidnapped, coerced, or sold into the sex-industry. HIV and AIDS is also leading to an increased number of women turning to the sex industry after there partners die, due to inheritance laws and customs seen in areas of Africa, as well as Southeast Asia. With limited income opportunities, widowed women turn to the streets to earn cash, food, or shelter from men for sex (AIDS Agenda, 2003). In many countries and regions, HIV-prevalence among sex workers and their clients is relatively high. For example, In India 8% of the sex workers are believed to be HIV positive, in China sex workers and their clients account for 20% of the total number of people living with HIV. Studies have also found that 33% of sex workers under 19 years of age in Russia, and as high as 73% among all female sex workers in Ethiopia are HIV-positive (www.avert.org/prostitution-aids.htm).

Much like other vulnerable groups, sex-workers are discouraged from accessing HIV prevention and treatment programs due to marginalization, stigmatization, and violence. Sex workers also risk criminal prosecution for prostitution, soliciting, pimping, brothel-keeping, and trafficking, which further discourages them from accessing HIV services. Legislation needed to protect the rights of women and men engaged in the sex-industry is often weak, leaving sex-workers vulnerable to abuses such as rape and coerced sex. Without firm legislation to protect sex-workers from these abuses, they ability and right to demand safer sex is undermined, increasing the risk of HIV infection for both the sex worker and the client. Establishing clear legal consequences will help to protect sex workers from violence and discrimination, thus decreasing rates of HIV infection. Parliamentarians have a very important role to play in this regard, as well as to

demonstrate a public commitment to addressing HIV among sex workers and the unique challenges they face.

Prisoners

In many countries, rates of HIV infection among prison inmates are significantly higher than infection rates within the general population, as people who are at higher risk of contracting HIV, including people who inject drugs, sex workers and more generally the poor and marginalized, are over-represented in prisons. Inside the prisons, the spread of HIV is largely attributed to unprotected sex, injecting drug use and tattooing, with minimal access to preventive measures such as condoms and sterile injecting equipment. The reality of forced sex among prisoners also contributes to increased infection rates.

> *"Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation"*
>
> **United Nations Basic Principles for the Treatment of Prisoners (Principle 9)**

Although this evidence exists, some countries are still slow to initiate prevention, treatment, care and support programs in prisons. Furthermore, in many countries prison systems simply do not have sufficient financial resources to improve prison conditions or allows for the provision of necessary HIV-services, such as HIV education, voluntary HIV testing and counseling, condom provision and drug-dependence treatment. Mandatory HIV-testing and the separation of HIV-positive prisoners can be counterproductive, since it is costly, inefficient and can have negative health consequences for segregated prisoners, nor does it reduce the spread of other sexually transmitted, opportunistic and blood-borne infections, such as Hepatitis C. Poor health conditions and overcrowded prisons can further contribute to HIV transmission, due to increased drug use in response to stress or boredom, creating a situation where prison violence, sexual coercion and rape are possible.

It is important for parliamentarians to ensure that prisoner's rights, including the right to antiretroviral therapy, are respected and that prevention and treatment programs address this vulnerable group are increased, both inside the prisons as well as when they return to their communities.

Box 3

Malawi National HIV/AIDS Policy – Policy Statements for Prisoners

- Government shall ensure that prisoners are not subjected to mandatory testing, nor quarantined, segregated or isolated on the basis of HIV/AIDS status;
- Government shall ensure that all prisoners (and prison staff as appropriate) have access to HIV-related prevention information, education, voluntary counseling and testing, means of prevention including condoms, treatment (including antiretroviral therapy), care and support;
- Government shall ensure that prison authorities take all necessary measures, including adequate staffing, effective surveillance and appropriate disciplinary measures, to protect prisoners from rape, sexual violence and coercion by fellow prisoners and warders, and juveniles shall be segregated from adult prisoners to protect them from abuse;
- Government shall ensure that prisoners who have been victims of rape, sexual violence or coercion have timely access to effective complaints mechanisms and procedures and the option to request separation from other prisoners for the purposes of their own protection.

Source: Malawi National HIV/AIDS Policy, 2003

People with Disabilities

People with disabilities are among the poorest, most stigmatized and most marginalized groups in the world. Barriers to health and rehabilitation services, education and employment can also trap them in a circle of poverty. Although nearly one person in ten, as many as 600 million people worldwide, live with a physical, sensory, intellectual and mental health impairment, individuals with disabilities are rarely included in HIV prevention and AIDS outreach methods. This is due to that it is often assumed, often wrongfully so, that disabled individuals are not sexually active and hence do not risk contracting HIV. They are as likely to be sexually active as their non-disabled peers, sex between men also seem to occur at the same rate, and they are as likely to use drugs and alcohol as non-disabled people. However, individuals with disabilities are more likely to become victims of violence or rape, but less likely to obtain police intervention, legal protection, or prophylactic care.

There are unique challenges to reach disabled people with HIV/AIDS programs and services due to often low literacy rates and limited education levels, inaccessibility to

HIV messages because of blindness or deafness, and because health facilities are not always accessible to people with physical disabilities. Nearly 80% of the people with disabilities live in the developing world and make up a significant part of a country's population, for example in South Africa it is estimated that 12% of the population have some form of disability. Therefore the AIDS pandemic cannot be addressed without successfully including individuals with disabilities in national strategies for HIV/AIDS prevention, treatment and care. Parliamentarians can ensure that the rights of people with disabilities are respected and necessary legal revisions are made to make them less vulnerable. They can also advocate for the inclusion of this group during the development of HIV/AIDS policy and strategies that will affect them.

Migrant and Mobile Workers

Many millions of people have left their homes to seek opportunities in new cities or even in new countries. With increased mobility comes increased vulnerability to exploitation and abuse, as well as to HIV infection. Factors influencing vulnerability include gender, age, economic status, whether migration is forced or voluntary, living circumstances, the stage of the migration process, the attitudes of the host community, and the availability of services. Migrants also face a wide range of human rights abuses since they often fall through the cracks of legal protection. Documented abuses against migrants around the world include labor exploitation, discrimination, physical and sexual abuse, arbitrary arrest and detention, trafficking into forced labor, and denial of the right to seek asylum. However, many migrants are prevented from seeking redress for human rights abuses due to isolation, language barriers and lack of legal status (UNAIDS, 2008).

Increased rates of HIV infection can especially be observed among men, as they may be more likely to participate in high-risk behaviours such as purchasing commercial sex, often unprotected, which they may not have otherwise done in their own communities. Drug use and needle sharing also become more common in all-male, migrant communities.

Migrants are often falsely seen as a threat to public health rather than as a vulnerable population, and little has been done by governments to ascertain or meet their special

needs in terms of prevention, treatment, and care. The International Labor Organization (ILO) estimates that there are over 100 million migrant workers, including their families, and that 30 million migrant workers that are found in irregular situations, that is without a valid work permit. As an increasing number of migrant workers become HIV-positive, parliamentarians have an important role to make sure that migration issues are addressed more adequately and effectively, not only to ensure it benefits home and host countries, but primarily to uphold the rights and dignity of all migrants.

Box 4

Links between HIV/AIDS and Mobility

The International Organisation from Migration (IOM) has cited four primary ways in which mobility and the spread of HIV/AIDS are linked:

- Mobility often encourages people to engage in risky or vulnerable behavior;
- Mobility often isolates people, making them difficult to reach and stay in contact with for health education, testing, condom provision or treatment;
- Mobility can provide opportunities for sexual networking, drawing migrants into urban areas;
- Mobile populations can display high percentages of HIV/AIDS because they often include people marginalized socially, economically, or politically.

Source: *Migrant Workers*, 2007

Research has shown that long-distance truck drivers are among the groups most at risk from HIV/AIDS. Displaced from their home, families and social environments, many of them tend to engage in dangerous behavior, including multiple sex partners and drug use. This is the case in Pakistan, where sex with both male and female sex workers without condoms, combined with drug use, is common among truck drivers. This makes them particularly vulnerable to HIV infection, and also puts their families at risk. A recent study by Constella Futures examined HIV vulnerability along the transport corridor linking Kenya's port city of Mombasa to Kampala, Uganda. Along this route, the researchers found that truckers accounted for 30% of the clients of female commercial sex workers. About 2,400 trucks park overnight between Mombasa and the Ugandan border at 39 highway stops, which attract approximately 5,600 commercial sex workers. This study, and others, therefore shows the importance of raising the awareness off HIV/AIDS and addressing preventive measures among this group. However, the study also stresses to go beyond the truckers and involve communities surrounding highway

stops, as well as the families of truck drivers to stop to be able to reduce the spread of HIV further.

HIV/AIDS in Conflict Situations

The relationship between conflict and the spread of HIV is influenced by factors such as population mobility, existing prevalence of HIV infection and levels of sexual interaction. When armies move across new territories and populations are destabilized, civil and international conflicts can expand the spread of HIV. Simultaneously, the epidemic contributes to national and international insecurity through high levels of HIV infection among military and peacekeeping personnel.

Refugees and Internally Displaced Persons (IDPs)

In 2005, more than **44 million people**, primarily in low-income countries, were forcibly displaced by conflict, violence, crisis or persecution due to race, religion, nationality, political opinion or membership of a particular social group (World Refugee Survey, 2006). It is estimated that 8-10% of people living with HIV/AIDS are affected by conflict, humanitarian crisis and/or displacement (UNICEF and UNHCR, 2006). IDPs are defined as persons or groups of people forced to leave their homes, particularly to avoid armed conflict, generalized violence, human rights abuses or natural disasters. However, unlike refugees they have not crossed a state border (UNHCR, 2007).

During conflict and displacement people are often left in conditions of powerlessness and poverty. In these situations, the focus for refugees and IDPs becomes meeting their basic needs such as food, water, and shelter. Where these resources are scarce, the vulnerability of women and girls increases as they are often forced to exchange sexual services for money, food, or protection. Risks due to exposure of multiple sexual partners, lack of condom availability or use, lack of care for STIs, sexual abuse or even rape exacerbate HIV infection among refugee and internally displaced women (UNHCR, 2007).

In addition to the vulnerability of being economically and socially displaced, refugees and IDPs face an increased rate of HIV infection. Often time's refugees and IDPs are

marginalized among the population with whom they are integrating with; they are seen as outsiders, threats to national security, and excluded from health care and education services, furthermore they are often seen as carriers of HIV and other diseases (CRIAW, 2003). Due to there insecure status, even when HIV prevention and treatment programs are established, refugees and IDPs may be excluded from accessing them as they might not have valid identification, medical records, or funds to pay for treatment (UNHCR, 2008). The influx of refugee and IDPs may also overwhelm existing facilities where health services may already be limited (UNHCR, 2007).

Contributing Factors for HIV in IDP Populations

Factors which contribute to increased rates of HIV infection are dependent on a host of often overlapping factors:

- Loss of livelihood, poor nutrition, and food insecurity;
- Poor living conditions of refugee camps;
- Reduced or no availability of education and health care, including sexual health and few reproductive health care programs;
- Quality of care and responses, including unsafe blood supply, reuse of syringes and reduced medical equipment and staff;
- The prevalence of HIV in the general population prior to influx of refugee population;
- Increased high-risk behavior, such as unprotected sex and drug use, resulting from living in a conflict affected region (UNHCR, 2007).

Military, Militia, Rebels and Peacekeepers

Evidence suggests that male military and police officers often engage in the most risky behavior and with high numbers of sexual partners. This is because most are single, young, and often posted far from wives or girlfriends for long periods of time. It has also been argued that military culture encourages risk taking and machismo, including risky sex. Consequently, soldiers have become increasingly implicated in the increasing rates of HIV.

The issue of men who have sex with men is a controversial and sensitive issue within the military, leaving it largely unaddressed. As such, condoms and risk reduction

strategies are not popularized among men who may engage in this activity. During peacetime, STI rates are estimated to be two to five times higher among military personnel than in comparable civilian populations, and in times conflict these rates can be more than 50 times higher. In some developing countries with HIV prevalence rates of 20%, it is thought that as many as 50% of military personnel could be infected. In South Africa, seven out of ten military deaths are AIDS-related and Uganda has lost more soldiers to AIDS than during the two decade fighting against the Lord's Resistance Army (*HIV/AIDS and the Military*, PlusNews, 2006).

Deployed in foreign countries, soldiers, as well as peacekeepers, may participate in behaviours such as purchasing sex, or engaging in unprotected casual sex as they experience feelings of "freedom" from social norms and customs their own countries. An unequal balance of power, such as financial security, allows soldiers or peacekeepers to negotiate unprotected or paid sex among local people. This "power" also leads to coerced or forced sex. Rape and sexual abuse are increasingly used as weapons of war by warring militias and rebel groups, and sometimes also by military personnel and police. This leaves women and young girls particularly vulnerable during times of conflict. Rape is not only used as an act of violence that targets sexuality, but as a tool to show power and to control civilian populations. It functions to overpower and humiliate both the women and men within the targeted community. Victims are often subjected to multiple human rights abuses, which serve to further traumatize them. Recently in Darfur, it has been largely documented that women residing in camps are at risk of rape if they leave to collect fuel, food, or water by patrolling Jangaweed militia. In the Democratic Republic of the Congo, as the five-year conflict rages on, women and girls continue to be sexually assaulted by members of the many warring militias, many of whom are infected with HIV/AIDS. Sexual violence is an extremely sensitive topic. Women and girls often do not admit to being sexually abused, for fear of social stigmatization and disbelief that the authorities will take action (Women's eNews, 2008)

Parliamentary action to protect vulnerable groups

As the previous section has outlined, there are multiple reasons why an individual becomes more vulnerable to HIV infection. Parliamentarians are in a key position to

ensure that vulnerable groups have the same rights and access to HIV/AIDS related prevention, treatment and care. In summary, parliamentarians have the responsibility to:

- Provide political leadership by speaking out about the particular challenges faced by the various vulnerable groups;
- Offer public support for preventive measures, programs for vulnerable groups, national AIDS councils/commissions, community organizations and donors;
- Undertake legislative reforms to ensure that laws include and protect the rights of vulnerable groups, including repealing laws that criminalize certain behaviours such as men who have sex with men or sex workers, as well as removing other legal barriers to prevention and care;
- Advocate for policies and practices that prevent discrimination, intolerance and human rights violations;
- Ensure that sufficient funds are included in the national budget to address the challenges of various vulnerable groups;
- Hold their governments accountable to the commitments made through the Declaration of Commitment on HIV/AIDS (2001) and the Political Declaration on HIV/AIDS (2006), among others, which address some of the special situations vulnerable groups face.

Source: *Taking Action Against AIDS* , 2007

Socio-Economic Impacts of HIV/AIDS

There is no region of the world where HIV/AIDS is not a serious threat to the population. The AIDS pandemic, previously seen as mainly a health crisis, has become a major threat all sectors of socio-economic development and reversing decades of health, economic, and social progress, reducing life expectancy by years, deepening poverty, and contributing to and exacerbating food shortages. AIDS is undermining progress towards the Millennium Development Goals (MDGs), particularly those related to poverty reduction, achieving universal primary education, promoting gender equality, reducing child mortality and improving the health of mothers (The Millennium Development Goals Report, 2006). AIDS affects both the rich and the poor, but the hardest-hit countries are

among the poorest in the world. More than 60% of people living with HIV inhabit the world's poorest region, sub-Saharan Africa. However, within Africa, the poorest countries do not necessarily have the highest prevalence rates, for example Botswana has one of the highest levels of economic growth within Africa, yet one of the highest prevalence rates of approximately 30%. Even so, poverty increases vulnerability to HIV/AIDS and aggravates the devastation of the epidemic, and threatens economic gains. Poverty can deprive individuals of the means to cope with HIV/AIDS, the poor often lack the knowledge and awareness that would enable them to protect themselves from the HIV, and if they become infected, they are less able to gain access to care and life-prolonging treatment (UNDESA, 2005).

Impacts at Household Level

The impact of HIV/AIDS on households can be very severe particularly in the poorest sectors of society. The direct cost of HIV/AIDS can be measured in the lost income of those who die, who are unable to work or lose their job because of their illness or because they have to care for a family member that is sick. In Botswana, for example, it is estimated that every income earner is likely to acquire one additional dependent over the next ten years due to the AIDS epidemic. Consequently, households which might have otherwise stayed above the poverty line are pushed below it. This can lead to further risks for HIV transmission as breadwinners have to find work away from their families, and in some cases, women may be forced to turn to sex work. Reduced earnings at the household level leads to reduced access to resources such as condoms needed for prevention, nutritious food, and antiretroviral drugs.

The financial burden of families to take care of a person sick with AIDS is not only an emotional strain for household members, but also a major strain on household resources. It is estimated that, on average, HIV-related care can absorb one-third of a household’s monthly income. In addition, the cost of death can also be considerable, with some families in South Africa spending three times their total household monthly income on a funeral.

AIDS is removing an entire "middle generation" of Africans, and is causing undue suffering to the generations of children and elderly left behind. As a consequence, an increased burden is placed on the remaining members; often without the physical capacity or skills to provide for themselves, they are suffering. For example grandparents, mostly grandmothers, are often burdened with the care of orphaned children.

Impacts on Education

"*Without education, AIDS will continue its rampant spread. With AIDS out of control, education will be out of reach*".
Peter Piot, Executive Director of UNAIDS

Children, most often girls, may be forced to abandon their education as many households affected by AIDS may not be able to afford to send their children to school, as necessary school fees are diverted to paying for treatment or medicine. If both parents are sick or dead, children are often forced to concentrate on survival and raising their siblings rather than on education. Studies have suggested that young people with little or no education may be 2.2 times more likely to contract HIV as those who have completed primary education (The World Bank, 2002).

Infection rates among teachers are also high in many countries. The sicknesses associated with HIV/AIDS can lead to absenteeism or permanent withdrawal of teachers, leaving students without teaching staff, or with staff who are overworked or inadequately trained. HIV/AIDS exacerbates the shortage of teachers, exacerbating the "brain drain." The added strain on both uninfected and healthy teachers has caused many qualified and healthy teachers to choose to work elsewhere, in better conditions for higher salaries. The loss of qualified teachers due to death and migration further disables the education system's ability to prevent the spread of HIV/AIDS.

There are numerous ways in which AIDS can affect education, but equally there are many ways in which education can help the fight against AIDS. The role that education can play in slowing or even halting the spread of HIV/AIDS should not be underestimated (See Unit 1 – An Introduction to HIV/AIDS). Due to the existence of stigma and stereotypes about HIV infections in many societies, strong education

systems are necessary to teach populations about the reality of HIV/AIDS. Of all the factors that can influence the spread of HIV/AIDS, many international institutions recognize that education is the single most effective and cost-effective strategy.

Formal education is an effective way to provide individuals with the skills that might enable them to move out of poverty and reduce the likelihood of entering into high-risk survival strategies, such as sex work. Formal education can also act as a place of socialization and community integration; in particular for AIDS orphans. For orphans who are able to continue formal education, school settings allow them to observe social norms as well as form relationships with adults and peers. Education can also be a powerful medium to combat the stigma and discrimination about HIV/AIDS starting from a very young age.

As HIV/AIDS advances in a country, it is increasingly important to extend education to the population to ensure that the necessary knowledge to fight the epidemic is available and accessible on all levels. The ability of education to effectively halt the spread of HIV/AIDS has been recognized by many international institutions such as UNAIDS, WHO and the World Bank, as a tool that can be used by all levels of society to enact positive behavior change.

Impacts on Health Care

A strong public health care system, like a strong education system, can play a critical role in stopping the spread of HIV/AIDS. A major challenge for many countries is a lack of funds to spend on public health but these funds, if made available, could alter the national spread of HIV/AIDS and allow individuals to live longer, healthier lives. A strong and well-funded national health care system can enable the effective treatment of people who have contracted HIV, or who are suffering from AIDS. The ability of a government to provide funding and resources to the health care system can have a dramatic impact on the health and well-being of the population.

While government initiatives and strong public health care systems can impact the spread and severity of HIV/AIDS, HIV/AIDS places a considerable burden on systems

that are already overburdened by lack of funding, ailing infrastructure, or historical factors such as structural adjustment programs. In the past, structural adjustment programs were initiated by the World Bank and International Monetary Fund to restructure national spending in order to reduce debt burdens. These programs required countries to implement fiscal cut backs in areas such as health care and education in favor of debt repayment. With declines in already inadequate health care and education systems, structural adjustment programs had a devastating impact on the general population unable to afford private care and education; their legacy continues to be felt today.

Like teachers, many hospital workers are infected and affected among countries with the highest prevalence rates. Sickness often translates into absenteeism or death, leaving hospitals and clinics understaffed, and/or with workers who are not properly trained to handle the needs of patients with HIV/AIDS. Again, this is exacerbated by a large "brain-drain" out of countries hardest hit by the epidemic, which further reduces the number of trained workers able to effectively treat patients.

An additional fact remaining for many infected individuals is that even with the best run medical facilities, ARV therapy needed for the treatment of HIV is prohibitively expensive. As global rates of HIV infection continue to rise, already overstretched or under funded public health care systems are struggling with the burden of providing treatment (see Unit 1).

Impacts on Agricultural Sector and Food Security

In recent years, studies have demonstrated the links between HIV/AIDS and diminishing food security at the household level. Being 'food secure' means that there is an adequate supply of nutritious food, either domestically produced or imported, to which the population has access. This access is acquired through adequate incomes to purchase food, means to directly produce food, or both.

In many developing countries, the agricultural sector is often the largest contributor to the economy, but also the sector most affected by HIV/AIDS. For example, in Africa

80% of the population depends on small-scale, subsistence agriculture to generate income or to meet their basic food needs. Recent figures show that within the rural sector, **seven million agricultural workers have died from AIDS in the last two decades**. It is projected that another 16 million will die in the next twenty years (UNAIDS, 2003).

Food security at the household level is increasingly unstable as more people in the rural sector become infected with HIV and AIDS. Poor health due to infection results in the diminishing ability to produce food or acquire income to purchase food. When people fall ill, they areas they can cultivate may shrink. They may also be forced to resort to cultivate crops that are less labor intensive. As a result crop yields decline, and there are marked reductions in agricultural productivity in turn limiting access to home grown food and consequently leading to food gaps. For example, in Zambia households with a chronically ill head of household experienced a 53% reduction in food production by limiting acreage cultivated, as opposed to households where no members were ill (UNAIDS, 2004).

As the numbers of laborers within household decline due to illness, so does the income generated from the sale of agriculture produce and off-farm labor. Compounding the problem is the fact that diminishing financial resources are being diverted to pay medical bills and health care expenses, and finally funeral expenses leaving little income for adequate nutrition (HACI, 2004). Hunger may also drive people into increasingly high-risk activities in order to survive. Increasing poverty and food shortages in the rural sector are said to be causing higher rates of migration to urban areas in search of income. Women and girls are especially vulnerable, as chronic underemployment within the urban sector is forcing them into survival or commercial sex (UNFPA, 2003).

Impacts on the Economy and the Labor Force

The devastating consequences of HIV/AIDS on individuals and families will ultimately affect a country's overall economic performance. UNAIDS defines the economic impacts of HIV/AIDS as the loss of resources which are diverted to the costs of preventing and treating HIV/AIDS, as well as the loss in economic productivity due to illness and

absenteeism. These economic losses are felt in all regions affected by HIV/AIDS. For example, HIV/AIDS is ravaging emerging economies such as China, India, and Russia. The growing epidemics in these countries in transition threaten to reverse recent gains in social and economic development. However, the economic loss will be the most detrimental in the developing world, or regions and communities with already scarce government resources and weak social programs. In countries continuing to struggle with development challenges, debt and declining trade, HIV/AIDS will aggravate the situation further. Therefore HIV/AIDS also threatens the foundations for future economic development in many developing countries.

> *"The social and economic impact of the disease is intensified by the fact that AIDS kills primarily young and middle-aged adults during their most productive years."*
> **Source: HIV/AIDS in the Workplace, 2002**

HIV/AIDS is also affecting the quantity and quality of skilled labor, in addition to doctors and teachers, engineers, managers, technicians and other educated and skilled professional are being reduced by the AIDS epidemic. Coupled with increased absenteeism due to illness and its resulting declines in productivity is a severe international "brain-drain" of the most highly skilled groups to other labor markets. For example, Africa has been experiencing an exodus from the health, education, and private sectors to meet the demands in the West, which has had serious implications on some countries' abilities to respond to the epidemic. Loss of skilled labor, and an inability to effectively train replacement staff, also leads to losses of tacit knowledge or skills gained from work experience, which will ultimately affect the level of productivity within the workplace. Organizational disruption due to high turnover rates and absenteeism will also lead to declines in productivity and managerial effectiveness (UNAIDS/IOE, 2002).

Individuals typically infected with HIV are usually between the ages of 15 and 49, which is the peak of their economically productive lives. Within the household, ill health due to HIV/AIDS leads to reduced earnings and higher expenditure on health care. The decreased disposable income can also lead to a loss of confidence in the future, and consequently a decreased willingness to save and invest. In the long run, this will result

in reduced consumption, leading to declining consumer markets, and ultimately a decline in national investment.

HIV/AIDS can also lead to the loss of foreign investment in areas experiencing high prevalence rates, as private enterprises are compelled to relocate**.** Lower productivity due to HIV related illnesses may push foreign investors out, who may relocate to regions with lower HIV prevalence leading to a direct decrease in foreign investment (UNAIDS/IOE, 2002).

In addition, HIV/AIDS can have a negative impact on government income, as incoming tax revenues fall at the same time as government expenditure is increased on HIV/AIDS prevention, treatment, care and support. Increased HIV prevalence rates can slow down economic growth and lower the Gross Domestic Product (GDP). For example, UNAIDS has estimated that with a HIV prevalence rate of 20% or over can lower a country's GDP as much as 2% a year. Overall, socio-economic problems, such as slow or fluctuating economic growth, unemployment, poverty and inequality, and scarce national resources all contribute to HIV/AIDS, and limit the effectiveness of national and community level responses.

However, the provision of anti-retroviral therapy, although costly, can improve the productivity of workers, and reduce levels of absenteeism and death, thus sustaining economic productivity in the long-term. A recent study in South Africa has suggested that the effects of HIV/AIDS on economic growth can be reduced by 17% if ARV coverage is expanded to reach 50% of those in need. Not responding at all has proven devastating losses in economic productivity in both the private and public sector (UNAIDS/IOE, 2002). This is one of many reasons why parliamentarians should advocate for increased spending on ARV treatment at the national level.

HIV/AIDS in the Workplace

In the workplace, employers are faced with declines in productivity due to loss of labor related to HIV/AIDS related illness, absenteeism and death (UNAIDS/IOE, 2002). In southern Africa, for example, it is estimated that more than 20% of the economically

active population is infected with HIV. Comparative studies of East African businesses have also shown that absenteeism can count for as much as 25-54% of company costs. In response, employers must develop strategies to cope with loss of labor, skills, and knowledge among employees, hiring and training new staff, increasing or developing health care insurance plans, as well as combating issues of stigma and discrimination in the workplace.

In response to this challenge, in 2000 the International Labor Organization (ILO) created its Program on HIV/AIDS and the World of Work (ILO/AIDS) to**:**

- Raise awareness of the social, economic and development impact of AIDS through its effects on labor and employment;
- Help governments, employers and workers support national efforts to control HIV/AIDS; and
- Fight discrimination and stigma related to HIV status.

ILO has also developed The Code of Practice (See Box 4), a framework for action related to the workplace, which contains key principles for policy development and practical guidelines for programs at enterprise, community and national levels.

Box 5

ILO Code of Practice on HIV/AIDS – Key Principles

Recognition of HIV/AIDS as a workplace issue - HIV/AIDS is a workplace issue, not only because it affects the workforce, but also because the workplace can play a vital role in limiting the spread and effects of the epidemic.

Non-discrimination - There should be no discrimination or stigmatization of workers on the basis of real or perceived HIV status.

Gender equality - More equal gender relations and the empowerment of women are vital to successfully preventing the spread of HIV infection and enabling women to cope with HIV/AIDS.

Healthy work environment - The work environment should be healthy and safe, and adapted to the state of health and capabilities of workers.

Social dialogue - A successful HIV/AIDS policy and program requires cooperation and trust between employers, workers, and governments.

Screening for purposes of employment - HIV/AIDS screening should not be required of job applicants or persons in employment and testing for HIV should not be carried out at the workplace except as specified in this code.

Confidentiality - Access to personal data relating to a worker's HIV status should be bound by

the rules of confidentiality consistent with existing ILO codes of practice.

Continuing the employment relationship - HIV infection is not a cause for termination of employment. Persons with HIV-related illnesses should be able to work for as long as medically fit in appropriate conditions.

Prevention - The social partners are in a unique position to promote prevention efforts through information and education, and support changes in attitudes and behavior.

Care and support - Solidarity, care and support should guide the response to AIDS at the workplace. All workers are entitled to affordable health services and to benefits from statutory and occupational schemes.

Source: www.ilo.org

The private sector has taken on an increased role in tackling the HIV/AIDS pandemic following the conclusion that the costs of introducing prevention and treatment measures for their workers, and in some cases dependants, could be lower than the costs of not doing so in the long run. Many companies have therefore introduced AIDS awareness and prevention programs, peer education programs, health checkups, including voluntary testing for HIV and other STIs, free counseling and support programs. Some companies are also providing free ARVs to their workers. The development of an official company policy, which clearly informs employees of their rights and responsibilities and how the company will deal with employees who either are, or become infected with HIV is also an important step. Such a policy should include a statement endorsing the company's commitment to addressing HIV/AIDS, a respect for the confidentially of HIV status and the establishment of non-discriminatory practices in relation to people living with HIV and AIDS (PLWHA). By cooperating with the public sector, for example National AIDS Councils as well as local civil society organizations, the private sector has in many cases become an important partner in the fight against HIV/AIDS.

Box 6

NGO partnerships with Unilever in Ghana

Fearing the devastating effects HIV/AIDS may have on workers on its oil palm plantations, Unilever has mainstreamed HIV/AIDS prevention in its routine health and safety system. The company has also developed a policy which sets out the company's stand on HIV and gives the same rights, responsibilities and benefits to PLWHA as other employees. The policy states that no compulsory testing for HIV is allowed; that medical information and records are to be confidential; that stigmatization is not allowed; and that HIV/AIDS cannot be a cause of termination. It also says that the company will pay for treatment for infected employees, as well

as their dependants.

Unilever works closely with the National AIDS Council in Ghana and several local community organizations and support associations to extend the reach of it activities and to avoid duplication. Some of their joint activities include peer counselor training; information, education and communication programs; condom service; voluntary counseling and testing services; and treatment centers.

Source: Adopted from presentation at Unilever, Tema, Ghana to the Parliamentary Centre September 27, 2007

How Parliamentarians can Address Socio-Economic Impacts:

In order to address and mitigate the socio-economic impacts of HIV/AIDS, parliamentarians need to look at HIV from a multisectoral approach and to ensure that policies, laws and budgets better take into consideration the challenges HIV/AIDS pose on their respective countries' social and economic development. Parliamentarians should ensure that:

- Poverty reduction measures are in place to lessen the burden at the household level;
- Education opportunities, in particular for girls, are increased as well as other programs to support the schooling of infected or affected children and youth;
- Funding is available through the budget to educate more health care workers and teachers;
- Policies are in place to improve working conditions of health care workers and teachers, as well as incentives for them to stay in developing countries;
- Antiretroviral therapy, together with necessary support and care, is made available to those in need;
- The "brain drain" situation is always addressed in discussions with donor countries;
- The link between HIV/AIDS and food security is addressed in a pro-active manner and to ensure that agricultural workers get necessary support;
- Labor laws and policies are in place to protect HIV infected workers; and
- The public sector works together with the private sector and civil society for a more effective and multifaceted approach and to avoid duplication.

Impact of HIV on Governance

The way HIV/AIDS is understood as a governance issue with serious ramifications for political and democratic stability is a fairly new phenomenon. For much of the pandemic's evolution, HIV has been labeled and treated as a public health crisis. Slowly, the realization that HIV/AIDS impacts social equality, economic prosperity and sustainable development became apparent. It is only in the last few years that policymakers have come to terms with the impact of HIV/AIDS on the democratic sphere.

In 2000, the United Nations Development Programme (UNDP) and Southern African Development Community (SADC) Regional Human Development Report warned of "…the slow collapse of the political, social, and economic systems in the worst affected countries if measures are not taken to mitigate the impact of AIDS". One of the most tangible ways that HIV/AIDS impacts governance is the immense stress the disease has placed on public sector services offered by governments. On the one hand, the demand for such services, particularly health care, education, and social services have increased dramatically to respond to the AIDS crisis. On the other hand, these very sectors have suffered greatly from the loss of skilled resources as countries lose their teachers, their healthcare providers and other public servants to the disease. This raises significant concerns as to whether government can maintain adequate public services, which in turn can lead to a lack of confidence and trust in the governance system of a country.

Poverty can also be a destabilizing factor in any country and unfortunately HIV is known to deepen poverty by depriving households of breadwinners and creating more vulnerable groups such as orphans. It can be argued that a robust economic performance that delivers a reasonable standard of living for a population is a strong pillar in the foundation of a healthy democracy. In this sense wealthier countries have an easier time maintaining democratic rule since inequalities are often the reason populations grown angry or apathetic with the democratic process. For emerging democracies, the negative economic impact of HIV/AIDS could have a destabilizing factor and unhinge democratic reform.

HIV/AIDS has become a human rights issue, which has serious implications for the good governance of a country. The rights of people living with HIV and AIDS (PLWHA) need to be enshrined in legislation to protect them in their place of work and within their communities. Furthermore, equal access to medical care and treatment is a serious concern for governments in order to ensure transparency and equal opportunity to all citizens. Many governments must rely heavily on foreign assistance when it comes to HIV/AIDS treatment programs; this dependency further undermines good governance and independence.

HIV/AIDS has also attacked political performance in many countries by eradicating the support base as well as some of its leaders who have succumbed to the disease. Not only has voter participation diminished in some constituencies because voters have either died, too sick, or tending to the sick to vote. Similarly, the number of by-elections, or unscheduled elections, as a result of elected officials dying in office or too sick to remain in office have increased, putting a strain on government budgets as well as on party finances to run elections.

Box 7

Average cost of by-elections in some countries in southern Africa

Average cost per by-election in:
- Tanzania mainland: US$416,000
- Zanzibar: US$45,000
- Zambia: US$235,849
- Malawi: US$78,889
- Lesotho: US$143,601

Source: *The Political Cost of AIDS in Africa*, IDASA, 2007

The erosion of the political base within political parties at local and regional levels is also making it increasingly difficult to field strong candidates for parliament and other political institutions at the national level, and hence affecting their ability to be fully representative.

Democratic regimes are therefore arguably at risk because of the pandemic. Democracies may face illegitimacy if the electoral processes by which democratic leaders are elected are undermined by the epidemic. HIV/AIDS has the potential to affect democracies by undermining the institutions, changing the political attitudes of voters and increasing skepticism and intolerance in civil society.

Impact of HIV on Parliaments

Given how generalized the pandemic of HIV/AIDS is in some countries, it goes without saying that some parliamentarians themselves, along with parliamentary personnel, are living with or affected by HIV.

In a number of countries (See Box 7), the number of elected officials who have died prematurely of illness is growing and many young politicians are unable to complete their mandates. The high turnover coupled with the cost of several by-elections during a legislative mandate take their toll on the legislature and its members. The impact of HIV/AIDS on people – both MPs and parliamentary support staff—and secondly, the potential loss of institutional memory, are of growing concern to legislatures.

Box 8

Impact of AIDS on Parliaments in the SADC Region

A recent study by IDASA looks at the political and economic cost associated with the loss of elected representatives and voters to AIDS in the Southern African Development Community, (SADC), which include Angola, Botswana, the Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, United Republic of Tanzania, Zambia and Zimbabwe.

While the cause of death is not recorded for the majority of these cases and instead attributed to "long" or "short illness", the study compares and analyses trends in deaths of elected leaders during the "pre-AIDS" period and during the "AIDS era" in the SADC region. The study observes that the frequent deaths of MPs and other political representatives as a result of illness have become more common in countries like Malawi, Tanzania, Zambia and Zimbabwe in the last 15 years. All these countries had severe HIV epidemics in the 1990s.

For example, in Zimbabwe, a succession of 29 by-elections had been held 2000-2005, with 19 having been caused by the death of MPs as a result of undisclosed illness. In the 20-year period before the advent of HIV/AIDS (1964-1984), Zambia held 46 parliamentary by-elections, of those 14 were a result of death and 32 were because of resignations and expulsion. In the period following the first reported AIDS cases, (1985 -2003), Zambia experienced an increase of by-elections, to at least 102. Of these, 39 resulted from the deaths of officials. While the cause of death is not recorded for the majority of these cases, the likelihood of death due to AIDS can be suspected. At least 27 out of the 39 people were in the vulnerable age range for AIDS-deaths and senior political officials in Zambia have revealed their concern for political parties which have lost key people to AIDS.

The increased number of by-elections can cause a growing number of power shifts in local representation in Parliament, which in turn can disrupt the continuity of its work. This risks diverting attention from key issues relating to HIV/AIDS, among others.

Source: *The Political Cost of AIDS in Africa*, IDASA, 2007

Parliamentarians are also affected by HIV/AIDS through their constituencies who are faced with requests to deal with sickness and medical bills, drug costs, funerals and the predicament of orphans and widows in their communities on a daily basis. In Kenya for example, it is reported that there are increased demands on the MPs to spend time attending to sick relatives, attend constituents' funerals for and participate in resource mobilizations to assist those affected or infected by the disease. The overall effect is that time spent by MPs as a result of HIV/AIDS has placed limits on their availability to participate in parliamentary deliberations leading to delays in passing essential legislation.

Impact of Governance on HIV/AIDS

While it is clear that HIV/AIDS can have a detrimental impact on governance and democratic development, the reverse is also true. Bad governance can exacerbate the spread and mismanagement of HIV/AIDS. Effective governance is now understood as a key and decisive factor in the outcome of efforts to respond to the epidemic globally and within individual countries. The 2006 UNGASS report concluded that sound governance is essential for an effective response to AIDS.

Good governance represents the complex relationships and norms that shape the interactions between the state and non-state actors in the decision-making process. It presupposes that citizens can have influence and oversight of the policymaking process and that government will act in a responsible and open manner. The concept brings to mind certain principles including transparency, accountability and participation (See Unit 9). In the context of HIV/AIDS, these principles, if applied correctly, ensure an effective response to the pandemic.

Strong political leadership is essential in the fight against HIV/AIDS, as the government potentially has the most power to evoke positive change within a nation if it makes a firm commitment to control the spread of HIV/AIDS and provide care and treatment for those already infected. The government can serve as a role model, because it has the power to elicit a response from the population. Another factor influencing the strength of response is whether and to what extent governments viewed HIV as a public health

crisis or as a development issue. The strength of viewing HIV in terms of the latter is that this approach will evaluate the impacts of HIV/AIDS in terms of its overall socio-economic impact and not only in terms of health problems. As such, responses will reflect a comprehensive, multisectoral approach, which includes participation of non-state actors.

Box 9

Uganda Pioneers a Successful Multisectoral Approach

Uganda is often used as an example when exemplifying a successful approach to reduce HIV prevalence. UNAIDS reports that the percentage of the population living with HIV/AIDS dropped from more than 30% in the early 1990s to rates which have stabilized around 6.3% in 2007 (UNGASS 2008). Uganda has also demonstrated declines in infection rates among pregnant women, determined by monitoring prenatal testing (USAID, 2002). Although some skeptics have attributed the decline to statistical bias, or "AIDS death rates" the report compiled by USAID attributes the declines to behavioral changes, which can be validated by qualitative studies and linked to the government's proactive and timely response to the epidemic (USAID, 2002).

President Museveni has not only been involved with the larger strategies of multisectoral coordination, but also more intimately as a figurehead for the cause. Soon after taking office in 1986, he embarked on a nation-wide tour, highlighting the urgency of HIV/AIDS and promoting openness, communication, and strong political leadership at the local level. President Museveni has even gone so far as to suggest that preventing the disease was a patriotic duty (USAID, 2002).

Considering Museveni's involvement, it is no surprise that the Ugandan AIDS Commission (UAC) was launched directly from the President's office, rather than being left to the purview of the Ministry of Health. The UAC has drawn its members from government ministries, parliament, NGOs, faith-based organization, and field workers, which truly highlights the spirit of a multisectoral approach. Thus, President Museveni coordinates, not only national responses among all levels of government, but has been directly involved in the support and recognition of grassroots organizations in his effort to halt the progression of HIV/AIDS.

Sources: *UNGASS Country Progress Report Uganda*, 2008, and *What Happened in Uganda?*, USAID 2002

The level of political commitment can also be demonstrated through its economic commitment. Strong leadership on the HIV/AIDS front must also ensure adequate allocation of resources, which is sustainable in the long run. Minimizing reliance on donor funding can also be a beneficial strategy for long term planning as unstable or limited funding can undermine the effectiveness of prevention and treatment strategies.

Box 10
Key Elements for Effective Governance of the HIV/AIDS Response

a) Political leadership and commitment;
b) Adequate capacities of relevant state institutions (including Parliament);
c) Adequate domestic spending on HIV prevention, treatment and care in the context of the national budget;
d) Efficient delivery of primary healthcare and other basic social services;
e) Decentralization of authority, decision-making and resources to the local level;
f) Genuine involvement of civil society in budget formulation, monitoring and tracking of public expenditures on AIDS;
g) Involvement of the private sector as a partner in respond to AIDS;
h) Incorporation of HIV/AIDS concerns into broad social and economic policies as development priorities, including linking AIDS action to poverty reduction (multisectoral approach);
i) A clearly defined national AIDS strategy and legal framework that provides guidelines for implementation and ensures the proper coordination of development efforts involving all governance actors;
j) Improved regional integration and better harmonization of AIDS strategies, policies and action programs;
k) Long-term reliable funding from international donors for AIDS programs and aid and debt reduction to ensure adequate AIDS financing within recipient countries;
l) Trade liberalization and equitable and affordable access to HIV drugs;
m) International human rights standards.

Source: ***Governance of HIV/AIDS Responses- Issues and Outlook*****, UNDP/IDASA, 2007**

HIV/AIDS - Impacts on Human Rights

It is critical to have a human rights-based approach in the fight against HIV/AIDS in order to prevent the spread of HIV and to reduce AIDS-related stigma and discrimination. A lack of respect for human rights fuels the spread and worsens the impact of the disease. Simultaneously, HIV can undermine the progress in the realization of human rights.

> *"The full realization of all human rights and fundamental freedoms for all is an essential element in the global response to the HIV/AIDS pandemic."*
>
> **Political Declaration on HIV/AIDS, 2006 (Paragraph 11)**

HIV/AIDS is most commonly linked with economic, social and cultural rights, such as the right to healthcare, education, employment, and adequate housing. The linkage

between HIV/AIDS and civil and political rights, such as freedom of expression and association, right to information and right to privacy, is more recent. However, many abuses of civil and political rights pose a great risk of increasing the spread of HIV, for example violence and discrimination against women, marginalized groups and people living with HIV/AIDS; harassment and imprisonment without due process of outreach workers and vulnerable groups seeking HIV/AIDS information or services; and censorship of health information.

Box 11

Human Rights Abuses Towards PLWHA Persist in China

China has been observed by organizations like Human Rights Watch (HRW) to deny rights to HIV/AIDS activists and people living with HIV/AIDS (PLWHA). Numerous abuses, such as the unlawful detainment of activists, and severe travel and entry restrictions on those living with HIV/AIDS have been imposed. With rates of HIV infection on the rise, China cannot afford to suppress the activities of front-line respondents, nor can it deny HIV by continuing to overlook the importance of unrestricted HIV prevention, education, and much needed treatment programs.

In recent years, the Chinese government has strengthened legislation related to AIDS, including expanding access to antiretroviral drugs, providing legal protection from discrimination, and scaling up methadone therapy for injection drug users (IDUs). However, the gap between policy development and implementation is still substantial. According to HRW, AIDS activists continue to be intimidated and detained by Chinese security forces, and those groups most vulnerable to infection, for example IDUs, men who have sex with men, and sex workers, are routinely harassed and abused by the police. HRW and other similar organizations therefore urges China to focus its efforts on stopping HIV transmission, not on limiting the freedom of movement, expression and speech of PLWHA.

Source: Human Rights Watch (www.hrw.org)

Why Human Rights are Important in the Fight Against HIV/AIDS:

Human rights are essential in the **protection of human dignity**. Where human rights are not protected individuals are both vulnerable to HIV infection, and HIV-related illnesses. This is especially true of vulnerable groups, as their already marginalized position heightens their risk for infection. Those who are infected may face stigma and discrimination, hindering their ability to access life saving drugs; if not provided with treatment they are being denied their right to live with dignity.

Human rights are critical in **protecting individuals from workplace-based discrimination**. This is important as it ensures that individuals are not wrongfully dismissed, garnering them legal protection and job security. Economically, it ensures that individuals have income security at the household level and thereby protecting them from future vulnerability due to poverty.

Human rights are essential to **protecting the quality of care** for HIV infected individuals. All persons, regardless of HIV status are entitled to the best quality of care available according to the Convention of Human Rights and Freedoms, and should not face discrimination or prejudices from health care professionals. Access to high quality and consistent health care is essential in protecting individuals from HIV infection as well.

Human rights laws are essential in **protecting the rights of traditionally criminalized groups**, such as sex workers, injecting drug users and men who have sex with men. Stigmatization of these groups pushes their existence out of public view, thus making it even more difficult to provide outreach, prevention and treatment services. Although controversial, governments and law makers have the responsibility to protect these groups from harassment and abuse, and to initiate harm reduction programs specific to the needs of these groups, including equal access to employment, housing and health care.

Human rights **protect the freedom of expression and assembly**, which is essential to mobilizing effective responses to HIV/AIDS among people who are infected and affected. By suppressing the rights of people to form associations and support groups, governments are minimizing effective frontline responses to the disease. Disallowing organizations to raise awareness within their communities, allows HIV/AIDS to remain invisible, further adding to the stigma associated with the disease.

Human rights **protect women and children by ensuring social and economic equality**. The unequal status of women compromises their income-earning opportunities, forcing reliance on men or high-risk survival strategies. Their status also

hinders the ability to negotiate safer sex. These factors all contribute to the spread of HIV among women. By upholding human rights, women can enjoy the protection of their health and access to treatment when needed (*Taking Action Against AIDS*, 2007).

Human rights law and HIV/AIDS

In 1998 OHCHR and UNAIDS published the *International Guidelines on HIV/AIDS and Human Rights*, which is a framework for a rights-based response to HIV/AIDS. This guideline, reissued in 2006 (See Unit 5 – Legislative Role of Parliamentarians), is a tool for states to design, coordinate and implement effective national HIV/AIDS policies and strategies, aimed at:

- Improving government capacity for multisectoral coordination and accountability;
- Reforming laws and legal support services, with a focus on anti- discrimination, protection of public health, and improvement of the status of women, children and marginalized groups; and
- Supporting and increasing private sector and community participation to respond ethically and effectively to HIV/AIDS (OHCHR, 2006).

Country responses and the respect given to human rights laws are varied. While some countries have advanced effective prevention, treatment and care programs, others have left legislation on HIV and related issues, such as gender-based violence, and HIV-based discrimination unchanged for many years. In some cases, legislation that fails to protect human rights and advance evidence-informed prevention and treatment have been passed, for example mandatory or compulsory HIV-testing of certain people or in certain situations. Countries like Brazil, which have placed human rights at the centre of their AIDS responses, have been able to see the epidemic slowed down or averted. However,

> *"All too often, individuals and communities are denied the opportunity to discuss the difficult issues surrounding HIV/AIDS, to organize themselves into self-help groups and to take the necessary measures for protection from HIV infection. In an environment where human rights are not fully respected, the likelihood of vulnerability to infection and further exclusion increases dramatically."*
> **Mary Robinson, Former UN High Commissioner for Human Rights**

as of 2003, only one third of countries worldwide, and almost half of governments in sub-Saharan Africa, had yet to adopt basic legislation specifically outlawing discrimination against people living with HIV/AIDS.

Making HIV/AIDS a national priority through firm, effective policy and budgeting considerations is an important first step to upholding human rights. This has become even more important since the governments of all United Nations Member States committed themselves through the 2006 Political Declaration on HIV/AIDS, to "overcoming legal, regulatory or other barriers that block access to effective HIV prevention, treatment, care and support, medicines, commodities and services."

Parliaments and a Human Rights-Based Approach to HIV/AIDS

Parliamentarians have an important role to ensure that governments ratify and uphold their commitments to human rights, and in particular HIV-related human rights, such as:

- The right to life;
- The right to liberty and security of the person;
- The right to the highest attainable standard of mental and physical health;
- The right to non-discrimination, equal protection and equality before the law;
- The right to freedom of movement;
- The right to seek and enjoy asylum;
- The right to privacy; the right to freedom of expression and opinion and the right to freely receive and impart information;
- The right to freedom of association;
- The right to marry and found a family;
- The right to work;
- The right to equal access to education; the right to an adequate standard of living; the right to social security, assistance and welfare;
- The right to share in scientific advancement and its benefits;
- The right to participate in public and cultural life; and
- The right to be free from torture and other cruel, inhuman or degrading treatment or punishment (The Universal Declaration of Human Rights, OCHRC 1996-2005)

Although many national governments are signatories on such international treaties, the extent to which they implement the guidelines within them vary according to national priorities.

Parliaments are in a critical position to enact new or reform existing legislation as to ensure that it protects human rights and advances effective HIV prevention, treatment and care programs. They should also make sure to assess how laws are being applied in practice, if any barriers exist to fully implement the law, and to advocate for actions to take place in order to implement and enforce all laws according to evidence and human rights principles.

Parliamentarians should also put pressure on governments to achieve objectives and time-bound commitments, such as those stated in the *Millennium Declaration* (2000), the *Declaration of Commitment on HIV/AIDS* (2001) and the *Political Declaration on HIV/AIDS* (2006), where the centrality of human rights and a rights-based approach in national responses to HIV are stressed. They also have a role to play in assisting with the implementation of the *International Guidelines on HIV/AIDS and Human Rights* as they can act as reliable intermediaries between the communities and the national government. This includes having an understanding of the AIDS epidemic on the ground, knowing who the vulnerable groups are, identifying human rights violations, in relation to HIV or otherwise, as well as addressing these violations. Parliamentarians also have the responsibility to see that government act swiftly to implement national and regional treatment, prevention and support programs.

Unit 2: Questions

Please answer each of the following questions. If you are taking this course in a group you may then meet to discuss your answers.

1. What groups are particularly vulnerable to HIV, and why?
2. Identify the most affected groups in your region/country/your own constituency?
3. How does HIV/AIDS affect the economy in countries with high HIV prevalence?
4. How does HIV/AIDS impact social development in your country/constituency?
5. What are the impacts of HIV/AIDS on public, political and private institutions in your country?
6. What is the importance of a human rights-based approach? Who does it protect?
7. Which Human Right declarations of importance to addressing HIV/AIDS have your government signed/not signed?

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