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# THE 'AIDS AND MDGs' APPROACH: What is it, why does it matter, and how do we take it forward?



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and how do we take it forward?**

**January 2011**

# EXECUTIVE SUMMARY

*“Over the past three decades, the HIV/AIDS epidemic has reminded us of the fundamental linkages between health and development more broadly. It has shown us that, to tackle this deadly virus and its impact, it takes both the best that science and medicine can offer and attention to the basic conditions which shape vulnerability – be they poverty, gender inequalities, or discrimination against marginalized groups.”*

Helen Clark,  
UNDP Administrator  
August 2010

From the very early days of the global AIDS epidemic, many have recognized that effective responses must go beyond only providing health information, medical services, drugs and commodities. Early AIDS strategies in the United Nations family reflected these insights, including the World Health Organization’s (WHO) emphasis on ‘AIDS and human rights’ and the United Nations Development Programme’s (UNDP) focus on ‘AIDS and development’. By the mid-1990s, the relationship between the AIDS epidemic and a broad range of social and economic factors was institutionally reflected in the creation of UNAIDS – a multi-agency, joint UN programme to address the multi-dimensional drivers of the AIDS epidemic.

There have been many challenges to these multi-sectoral approaches. The characterization of AIDS as a global ‘emergency’ encouraged short-term responses with short-term impact. From the success of anti-retroviral therapy through ever-lengthening timelines for development of an effective vaccine, some have hoped that technology would provide a ‘magic bullet’ that would reduce or eliminate the need to address complex social phenomena. The need to ensure that policy is based on evidence has sometimes undermined commitment to approaches that are more difficult to measure.

More recently, several factors have worked together to challenge false dichotomies between ‘medical’ versus ‘multi-sectoral’ strategies or ‘vertical’ versus ‘horizontal’ responses to AIDS. The global HIV epidemic will be with us well beyond this generation, so we simultaneously need both short-term impact and long-term thinking. The global economic crisis of 2009 has once again increased attention to cost-effectiveness but with a recognition that the best strategies contribute not just to HIV results but to other health and development outcomes as well. There is an increasing commitment to ensuring that investments must strengthen health, social protection and other relevant systems while also delivering services and commodities.

These changes in the AIDS response landscape have created an opportunity to explore, strengthen and leverage the links between AIDS and other health and development issues. The term ‘AIDS and MDGs’ is gaining currency as an approach that leverages these links – effectively addressing both short- and long-term challenges and impacts of the HIV epidemic while contributing to the achievement of the wider MDG agenda.

This paper outlines three important pillars of an AIDS and MDGs approach:

1. Understanding how AIDS and the other MDGs impact on one another;
2. Documenting and exchanging lessons learned across AIDS and other MDGs; and
3. Creating cross-MDG synergy and increasing cost-effectiveness through intervention strategies that simultaneously address AIDS together with other MDGs.

The paper proposes broader policy level implications to move the AIDS and MDGs approach forward. These recommendations include:

1. **Map the HIV epidemic in relation to the broader MDG and development context.** Ensure that the ‘know your epidemic/know your response’ framework examines not just epidemiology but also structural factors that block progress on multiple MDGs and emphasize a picture of the HIV epidemic that is linked to an understanding of the current status of other MDGs .
2. **Explore a range of cross-MDG strategies and scale up promising intervention models.** Applying an HIV lens to a variety of programmes, such as social protection or environmental impact assessments, could maximize opportunities for synergistic action across multiple MDGs, including HIV.
3. **Ensure that countries’ policy environments support and sustain the impact of cross-MDG programmes.** In order to have greater impact and coverage, individual intervention programmes should be supported by broader country-level policies that carry the potential for far more sustained and systemic change (e.g., on gender equality) than can be achieved through individual programmes acting in isolation.
4. **Build AIDS and MDG partnerships by reaching out across sectors to engage a broader range of health and development actors.** Promote interdisciplinary and multi-sectoral action to successfully design and implement cross-MDG strategies and transfer lessons across fields.
5. **Generate best practice models by evaluating AIDS and MDG strategies against realistic timeframes.** Support further research in order to guide programme and policy development across a range of settings. Because effecting meaningful and measureable shifts in areas such as economic well being, education, or gender equality will require longer timeframes than those afforded by more conventional technical or biomedical interventions, it will be important to link the application of cross-sectoral approaches to robust budget lines that will support substantial, long-term action and project cycles.

Because the MDGs explicitly locate HIV within a broader international commitment to human development targets, an AIDS and MDGs approach provides a critical platform to galvanize resources, political will, and momentum behind a broader, systematic and structural approach to HIV, health and development. Moreover, because the Millennium Declaration reaffirms commitments to human rights, an AIDS and MDGs approach can catalyze greater attention to such rights and their role in achieving multiple MDGs and in translating human rights commitments into meaningful change.

# DEVELOPMENT CONTEXT

## THE MDGs



**MDG 1:**  
Eradicate extreme poverty and hunger



**MDG 2:**  
Achieve universal primary education



**MDG 3:**  
Promote gender equality and empower women



**MDG 4:**  
Reduce child mortality



**MDG 5:**  
Improve maternal health



**MDG 6:**  
Combat HIV/AIDS, malaria and other diseases



**MDG 7:**  
Ensure environmental sustainability



**MDG 8:**  
Develop a global partnership for development

## AIDS AND DEVELOPMENT: A CHANGING LANDSCAPE

At the Millennium Summit in September 2000, world leaders adopted the UN Millennium Declaration, committing their nations to a new global partnership to reduce extreme poverty and uphold the commitments in the Universal Declaration of Human Rights.[1] This partnership was subsequently reflected in a series of time-bound targets, with a deadline of 2015, known as the Millennium Development Goals (MDGs). Efforts to tackle AIDS and other infectious diseases, such as malaria, are captured in MDG 6. With respect to AIDS, MDG 6 has two explicit HIV targets: (1) halting and reversing the spread of HIV/AIDS by 2015; and (2) achieving, by 2010, universal access to HIV treatment for all those who need it.[2]

### Responding to a global emergency

Perhaps more than any other MDG, the global effort to address AIDS has been characterized by an emergency response. The lethality, pace and scale of the epidemic has understandably shaped this crisis response. Exacerbating the sense of crisis has been the limited efficacy of conventional biomedical and public health approaches, the bulwarks against disease throughout the 20th century. While an expanding array of biomedical tools (e.g., condoms and antiretroviral drugs), behavioural approaches, and increasingly, structural approaches<sup>1</sup> (what has been termed ‘combination prevention’) have yielded important progress, they have ultimately been unable to halt the epidemic’s course over the past 30 years.(see Snapshot on next page) It is clear that health sector interventions and biomedical technologies (either existing or in development) alone are inadequate to meet the challenge of the AIDS pandemic. But what is less clear is how best to complement and support these strategies by addressing underlying structural factors – not least because doing so requires action across a number of non-health sectors. The most successful programmes have combined biomedical technologies and behavioural interventions with multi-sectoral strategies that address human rights and the underlying socio-economic conditions that render a population more vulnerable to infection. It is these multi-sectoral strategies that are at the heart of UNDP’s mandate on AIDS, the new UNAIDS Outcome Framework and the MDGs themselves.[3]

1. Approaches that address the underlying social, economic and cultural factors that increase vulnerability to HIV. Such factors include, for example, income and gender inequalities, food insecurity, migration, and stigma and discrimination. These structural factors may also impede progress on other MDGs.

## SNAPSHOT: 30 YEARS OF A GLOBAL PANDEMIC

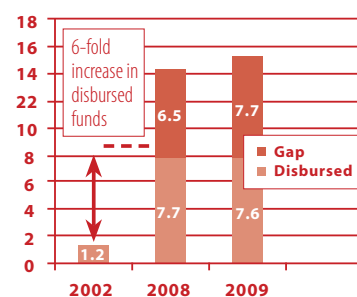
AIDS HAS BROUGHT DEVASTATING IMPACTS	THERE HAVE BEEN IMPORTANT SUCCESSES...	...BUT SERIOUS CHALLENGES REMAIN
<ul style="list-style-type: none"> <li>• 25 million total AIDS deaths [4]</li> <li>• 33 million people currently living with HIV, with most in sub-Saharan Africa [4]</li> <li>• 17.5 million children orphaned [4-5]</li> </ul>	<ul style="list-style-type: none"> <li>• 17% decrease in new infections globally between 2001 and 2008</li> <li>• Decline in HIV prevalence among young people in more than 16 of the 21 most affected countries [6]</li> <li>• 5.2 million people on antiretroviral therapy, a 12-fold increase since 2003 [7]</li> <li>• Increased coverage of prevention of mother-to-child transmission from 10% in 2004 to 45% in 2008</li> </ul>	<ul style="list-style-type: none"> <li>• Number of new infections is outpacing scale up of treatment (2 new infections for every person put on antiretroviral therapy) [8]</li> <li>• ART coverage reaches only 35% of all those in need (based on 2010 WHO guidelines)</li> <li>• Basic knowledge of HIV is poor among young people (40%) [4]</li> <li>• Only 40% of people living with HIV are aware of their status [4]</li> <li>• No vaccine or cure is expected in the foreseeable future</li> <li>• Uptake of safe medical male circumcision is unknown [9-12]</li> <li>• Vaginal microbicides and oral pre-exposure prophylaxis have yielded promising initial results; however, more studies are needed, roll-out of effective products will take time and ultimate uptake and efficacy are as yet unknown [13-15]</li> </ul>

## A shifting global response

Although AIDS is no less an emergency today than three decades ago, particularly in most-affected countries, the character of the global response is shifting. The recent flattening of AIDS-specific donor funding in the wake of the global economic crisis has raised concerns about how governments will meet the growing demand for HIV programmes while sustaining the important gains already made (Figure 1).

In addition, there is a need to support further progress in other critical MDG areas, such as maternal and child health. Recognizing this, the UN Secretary-General, Ban Ki-moon, released a joint action plan to improve the health of women and children at the 2010 MDG Summit in New York. The Gates Foundation recently announced a USD 1.5 billion programme for maternal, neonatal and child health.<sup>2</sup> [17] Simultaneously, there has been a movement among donors away from disease-specific programmes and funding toward health system strengthening, as embodied by initiatives such as the International Health Partnership+. Taken together, these shifts signal a changing landscape, one that presents new challenges and new opportunities.

## TRENDS IN DONOR FUNDING FOR AIDS



**Figure 1.** While disbursed AIDS funds from major bilateral and multilateral donors have increased dramatically between 2002 and 2008, disbursements dipped slightly in 2009 while the overall gap in need have increased (gap estimate for 2002 not calculated.) Source: UNAIDS and Kaiser Family Foundation 2010. [16]

2. In addition, the US government is increasing its policy and programmatic emphasis on women and children in its new Global Health Initiative (GHI), which aims to integrate sustained efforts on the President's Emergency Plan for AIDS Relief with expanded focus on other global health priorities, especially maternal and child health.

### The crisis and the opportunity

From the perspective of AIDS-specific funding, these shifts in health and development priorities could be viewed as movements that threaten the viability of the global AIDS response. However, as this paper argues, these shifts in the AIDS, health and development landscape may also signal an opportunity to critically evaluate lessons learned from nearly three decades of the AIDS response and to re-visit the fundamental linkages between HIV, health and development. As recent observers have noted, this shift from emergency mode to long-term response can open up space on the AIDS agenda for a commitment to better understanding and addressing the *root causes* of HIV. It could add momentum to the ongoing shift from individualized approaches regarding prevention, care and treatment to an approach that also emphasizes integrated health and development strategies that address key structural determinants of vulnerability. Such a shift may well be the “single most crucial factor that the AIDS response has been seeking”. [18]



# ISSUE ANALYSIS

## AIDS AND MDGs: A NEW MAP FOR A NEW LANDSCAPE

In this changing context, the term ‘AIDS and MDGs’ (or ‘AIDS plus MDGs’) is gaining currency as an approach that responds to this new landscape and its opportunities. AIDS and MDGs has been defined as “sharing lessons and building stronger links between the global HIV response and the broader health and development agenda”. [19] There are different interpretations of what this means in practice. For some, the idea is to strengthen health systems in efforts to accelerate progress within the health MDGs (4, 5, and 6). Others have understood AIDS and MDGs to refer to structural approaches to reducing HIV vulnerability, emphasising how the MDGs may contribute to and accelerate progress in addressing AIDS. Although these are important perspectives, they do not represent the whole picture. The *AIDS and MDGs approach is about deepening our understanding of the linkages between AIDS and the other MDGs, and generating cross-MDG lessons and intervention strategies that deliberately engage these intersecting relationships in order to catalyze greater progress for HIV, health and development.*

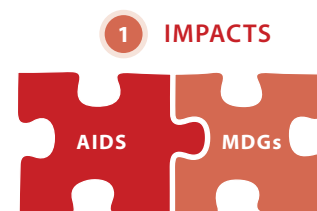
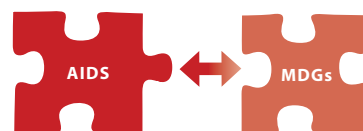
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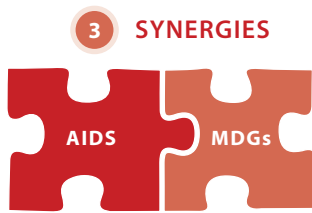
### PILLAR 1. Understanding how AIDS and the other MDGs impact on one another:

It is clear that AIDS and the other MDGs are fundamentally inter-related. An effective AIDS response is critical to the achievement of the other MDGs, particularly in high prevalence areas. Conversely, making a substantial impact on the AIDS pandemic depends on simultaneously advancing progress in other MDG areas. How these linkages unfold at the national and local level and in different epidemiological settings must be better understood and addressed.

### PILLAR 2. Documenting and exchanging lessons learned across MDGs:

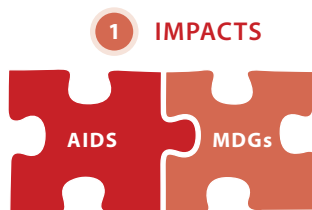
Too often, important lessons in one field remain limited to practitioners and policy makers operating within their own particular specialty or domain. Given the important intersections between health and development, much can be gained by more actively building bridges between sectors and disciplines in order to document and share lessons regarding what has worked, what has not – and why.





**PILLAR 3. Creating cross-MDG synergy:** To date, much of the effort to accelerate progress on the MDGs has focused on understanding and addressing individual MDGs in isolation from each other. To some extent this has been necessary for focusing efforts and harnessing the resources and political will to tackle each substantive area. However, there is increasing awareness that this approach does not reflect the reality of individuals or communities, and does not take advantage of potential synergies across MDGs. The third application of an AIDS and MDGs approach involves testing and promoting promising strategies that simultaneously address AIDS together with other MDGs as a more effective and cost-effective measure than tackling them in isolation.

The following section describes these three elements of an AIDS and MDGs approach, drawing from both academic literature and MDG country reports.



### Pillar 1. Understanding how AIDS and MDGs impact on one another

The phrase ‘know your epidemic and your response’ is often used in the context of national AIDS planning, referring to the importance of basing programming and policy on a robust understanding of the epidemiological and behavioural dimensions of a country’s HIV epidemic and the scope, scale and effectiveness of the current response. However, it is increasingly apparent that knowing only these two dimensions is not enough.[18] It is equally important to have a nuanced understanding of the ways in which AIDS interacts with poverty and income inequality, education, gender and other key structural drivers as reflected in the MDGs. Examining these relationships in closer detail begins to reveal overlapping vulnerabilities that can, in turn, uncover new opportunities for maximising progress across multiple MDGs. Growing evidence from the scientific literature points to the myriad ways in which AIDS interacts with the other MDGs. Although the pathways are dynamic and context-dependent, what is clear is that the interplay occurs in both directions.

#### A. Understanding the impact of AIDS on the MDGs

It is now evident that, particularly in those countries most affected by the epidemic, failure to address HIV will be a major obstacle in attaining other MDG targets. The impact of AIDS on MDGs 1 - 5 (poverty, education, gender equality, child mortality and maternal health) has been particularly well described (Box 1, Appendix). AIDS has been shown to exacerbate poverty, unemployment, hunger and food insecurity. The education system itself is weakened due to AIDS, when educators are impacted by high infection rates. The educational attainment of learners is compromised when children and families are impacted by AIDS. Recent studies show that AIDS can seriously curtail progress in improving maternal and child health, particularly in high prevalence countries. A gender component cuts across all of these impacts. Not only are women and girls more likely to be infected with HIV in sub-Saharan Africa, they also tend to disproportionately bear the burdens of its impact, especially in terms of poverty, access to livelihood opportunities and education.

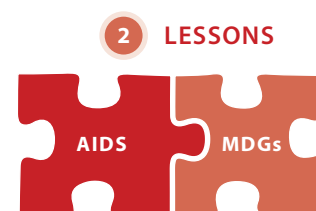
## B. Understanding the impact of the MDGs on AIDS

In examining the intersection between AIDS and the MDGs from the opposite direction, three MDGs are particularly relevant to the AIDS pandemic and have, in different contexts, been identified as key structural factors that increase HIV risk, particularly for women and girls. (Box 2, Appendix) These are MDG 1 (Poverty), 2 (Education) and 3 (Gender equality). Poverty and food insecurity can lead to coping behaviours, such as selling assets, removing children from school, migration, and transactional sex - thus increasing vulnerability to HIV. Conversely, educational attainment is correlated with delayed sexual debut and reduced sexual risk behaviours, and empowering women and girls enables them to take steps to reduce their risk of acquiring HIV. Finally, MDG 8 (global partnerships for development) continues to play an important role in shaping the effectiveness of the AIDS response, particularly in relation to the adequacy of development assistance and access to essential drugs and technology. Viewed from this perspective, making significant headway on HIV, particularly in relation to prevention, will require more commitment to tackling these AIDS and MDGs interactions.

Many governments, particularly in Africa, are drawing attention to how AIDS and the other MDGs impact on one another. This is clearly reflected in a number of the MDG Country Reports prepared by national governments for the 2010 MDG Summit (Figure 2, next page).

### Pillar 2. Documenting and exchanging lessons across MDGs

Understanding the linkages between AIDS and other MDGs is an important first step. But the AIDS and MDGs approach is more than this. Another critical step involves examining and sharing emerging lessons across the MDGs. Are there important lessons from the HIV field that could accelerate progress in other MDG areas – and vice versa? One of the overarching lessons from the HIV field is that biomedical and behavioural interventions work best when underpinned by rights-based and structural approaches – a strategic ‘combination prevention’ approach – that could promise accelerated action on other MDGs (Case Study 1, see page 13).[20]



**FIGURE 2: THE IMPACT OF AIDS ON MDGs AND VICE VERSA, AS REFLECTED IN MDG COUNTRY REPORTS (2008-2010)**



## CASE STUDY 1: SHARING LESSONS AND EXPERIENCE FROM AIDS FOR OTHER MDGS

**1) Addressing gender inequality:** The last decade has witnessed unprecedented attention to gender-related HIV vulnerability and, although much remains to be achieved, the global AIDS response has undoubtedly contributed to sharpening and advancing gender analysis and action. Some have argued that the AIDS response has already catalyzed action on gender in other fields – from food security, to education, to economic empowerment.[18] Explicitly linking gender inequality and gender-based violence to a tangible and devastating health outcome has begun to galvanize powerful intervention strategies, research evidence, financial resources and political commitment. This has resulted in benefits and lessons that could be applied to other MDG areas. For example, within the AIDS response, promoting gender equality has become a central feature of many global-level policy commitments. In addition, major donors and national governments have declared their commitment to address gender and HIV together in order to strengthen programming and accelerate progress.[18] The multiplier effects of addressing gender inequality highlight how investments in this area may prove to be a particularly cost-effective strategy across a range of health and development outcomes.



**2) The critical role of social capital and human rights-based approaches:** Human rights are at the core of sustainable development and the MDGs. The HIV response has been particularly successful at using rights-based approaches to empower and involve marginalized communities and to challenge social exclusion, approaches that carry important lessons for other MDGs.[21] Experience from a broad range of settings suggests that social capital,<sup>3</sup> can strengthen AIDS responses across a broad range of settings.[22] For example, in Uganda, some have suggested that effective social mobilization, including efforts by women's groups, critically underpinned the dramatic reductions in HIV prevalence from 30% to less than 10% between 1990 and 2005. These reductions largely preceded widespread implementation of conventional prevention measures, such as condom distribution, voluntary counselling and testing services, and the treatment of sexually transmitted infections (STIs).[22] Similarly, in India, strengthening social capital through the collective organisation of sex workers resulted in lower rates of STIs and increased economic empowerment for these workers as well as increased access to education for their children.[23] Recent research has highlighted that where there are non-discriminatory laws and regulations for men who have sex with men, prevention services reach them more easily. Conversely, where existing laws criminalize marginalized populations, AIDS responses are weakened.[24]). These experiences point to important lessons for understanding how strengthening social capital and promoting human rights-based approaches can make a critical contribution across a range of MDG areas.

**3) Expanding equitable access to technology and stimulating appropriate research and development:** The striking global inequity in access to antiretroviral therapy has spurred unprecedented attention to issues of relevance to many MDGs. In the decade-long struggle to lower the price of antiretroviral medicines in developing countries, the efforts of civil society, the use of Trade-Related Aspects of Intellectual Property Rights (TRIPS) flexibilities, such as compulsory licensing and generic competition, have worked together to reduce the cost of triple-drug therapy from over USD 10,000 per person per year to under USD 100 per person per year.[25] Whereas at USD 10,000, access to life-saving treatment was beyond the reach of the vast majority of those in low- and middle-income countries, at a few hundred dollars a year, procurement with funds from the Global Fund, PEPFAR and others became possible. The HIV field has generated valuable lessons on how TRIPS flexibilities and other mechanisms such as pooled procurement and innovative financing mechanisms can be leveraged to expand access to life saving technology. Drawing from these lessons can expand our understanding of how knowledge should be generated, owned and harnessed to support the kind of pro-poor development that is central to accelerating greater progress across multiple MDGs.

3. Social capital has been defined as the "features of social organization, such as trust, norms and networks that can improve the efficiency of society by facilitating coordinated action." (Putnam et al. 1993)

## ISSUE ANALYSIS

*“Like climate change, AIDS is a long-wave event.”*

Similarly, there are important lessons from other MDG areas that could benefit the HIV field. One example relates to the environment (MDG 7). There is growing concern about the potential impacts of climate change on health, such as the effects of global warming on existing and emerging infectious diseases. [26] Other important lessons from the environmental movement have specific implications for HIV. Two in particular stand out:

1. First, climate change research and advocacy have, by their nature, been *forward-looking* - attempting to predict and prevent future impacts. In contrast, AIDS research and advocacy has tended to be crisis-oriented. Only more recently have AIDS scholars begun to recognize the “long wave” nature of the epidemic, in which current infection rates will lead to long-term illness and social and economic impacts that span generations.[27]
2. Second, while the HIV field has benefited from increasing private sector investment in the AIDS response, and public-private partnerships for research and service delivery have been promoted, greater scope remains to encourage the business sector to address how their core activities may mitigate or drive vulnerability to HIV infection. Again, there may be important lessons to learn from the environmental field (Case Study 2).

### CASE STUDY 2. SHARING LESSONS AND EXPERIENCE FROM MDG 7 FOR AIDS: ENVIRONMENTAL IMPACT ASSESSMENTS

In sub-Saharan Africa, many studies have drawn strong correlations between the execution of capital projects, such as mining and road construction, with the spread of HIV among workers and the surrounding communities.[28] While Environmental Impact Assessments (EIAs) are designed to assess and limit the environmental impact of such projects, the potential of such processes for addressing HIV has not been fully explored. Building on experience from the environmental field, such projects could be viewed with an HIV lens in order to determine whether they may inadvertently increase population risk of infection, and if so, whether deliberate measures can be taken to reduce this risk. Just as governments currently require development projects to include an EIA, such projects could also be required to pass an AIDS impact assessment. Relevant criteria might include:

- the inclusion of strategies to reduce separation of migrant workers from their families;
- industry standards that provide alternatives to congregate, single-sex dwellings at work sites;
- transportation alternatives to long distance truck routes;
- inclusion of workplace AIDS policies and policies promoting gender equity;
- programmes that provide educational or economic alternatives to sex work for women living in communities surrounding high-risk areas.

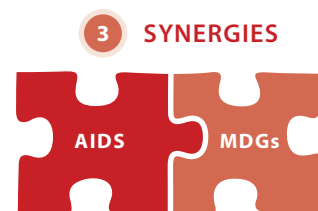
As with EIAs, the potential for harmful consequences could be assessed and regulated during and after the completion of such capital projects. Conversely, good practices could be encouraged through preferential consideration for contracts, as well as tax and other financial incentives that encourage programmes to demonstrate that HIV-related considerations have been taken into account.[29] In Eastern and Southern Africa, UNDP, in partnership with the Southern African Development Community (SADC), is currently testing such an approach.



### Pillar 3. Going beyond business as usual: creating cross-MDG synergy

Finally, applying an AIDS and MDGs approach is about testing and promoting promising strategies where simultaneously addressing AIDS together with other MDGs could be more effective (and cost-effective) than tackling them in isolation. Two recent programmes illustrate how efforts to address HIV have benefited from leveraging cross-sectoral partnerships and approaches. (Case Studies 3 and 4, next page) By using microfinance or conditional cash transfers as an entry point, these programmes have proven that it is possible to tackle poverty, gender inequality and education alongside HIV – both as important MDG targets in their own right and as an opportunity to strengthen HIV responses. To date, few such cross-MDG interventions have been well documented or evaluated, highlighting the need for further innovation in this area.

Research studies such as the two described on the next page are important for testing theories and designing innovative delivery models for addressing multiple MDGs. Furthermore, they suggest causal pathways and provide evidence for how programmes such as microfinance or cash transfers might provide a strategic entry point for influencing a range of health and development outcomes. *More importantly from a policy perspective, such studies are useful for drawing out broader lessons, and providing a metaphor or “proof of concept” for what might be possible in promoting such strategies on a wider scale.* Individual, localized interventions in and of themselves, are unlikely to have significant impacts on a national or regional level, and simply scaling-up individual programmatic responses is not the only goal. Rather, the challenge to governments and policy makers is to begin using the lessons from programmatic experiences to generate effective, cross-MDG responses that are relevant to their own contexts.



### CASE STUDY 3: CREATING CROSS-MDG SYNERGY: THE IMAGE PROGRAMME IN SOUTH AFRICA

#### *CAN MICROFINANCE EMPOWER WOMEN?*

Microfinance is a development strategy that provides credit and savings services for income generating projects to low-income populations, particularly rural women. While some studies have suggested that microfinance can empower women and reduce the risk of intimate partner violence [30-32], others have noted that providing loans to women can potentially exacerbate this risk by challenging established gender norms, and provoking conflict within the household.[33-36] In this light, some have questioned whether additional programme inputs that explicitly address community gender norms could be important for catalyzing broader empowerment benefits, while potentially diminishing the risk of gender-related conflict.[30, 36-39]



#### *IMAGE PROGRAMME: A CROSS-MDG STRATEGY THAT ADDRESSES POVERTY, GENDER EQUALITY AND HIV RISK*

The IMAGE Programme in South Africa set out to address this question by combining group-based microfinance with a Gender and HIV training curriculum, ultimately demonstrating improvements in three MDG areas [40]:

- **Poverty:** increased household expenditure, assets and membership in savings groups;
- **Gender equality:** a 50% reduction in intimate partner violence and improvements in nine measures of women's empowerment, including self-confidence and autonomy in decision-making;
- **HIV risk:** among young women participants, increased condom use, HIV testing and communication about HIV with partners.

#### *THE IMAGE APPROACH*

Loans targeted the poorest women in rural villages and were used to support a range of small businesses. During fortnightly loan repayment meetings, IMAGE trainers led microfinance clients through a participatory education programme with two phases, delivered over one year. The first phase consisted of ten one-hour training sessions, covering topics such as gender roles, cultural beliefs, power relations, communication, intimate partner violence and HIV. In the second phase, the loan centres lead efforts to mobilize the broader community to address priority issues including HIV and violence.

#### *EVIDENCE OF SYNERGY*

The programme was evaluated as a randomized trial among eight villages. Combining a poverty alleviation strategy with a gender-focused HIV initiative allowed these different elements to interact in a synergistic way. By building on an established microfinance programme, IMAGE was able to reach the poorest women in communities – a vulnerable group often excluded from conventional HIV outreach through health services or the media. Moreover, because the programme responded to women's basic economic needs, the IMAGE trainers had sustained interactions with this peer group every two weeks for more than a year. This is a degree of contact rarely afforded to most stand-alone health interventions. [41] Research has demonstrated further evidence of this synergy across MDGs. When microfinance alone was compared to IMAGE, although both interventions had similar impacts on poverty, only the combined approach (microfinance plus gender/HIV intervention) demonstrated the broader health and development impacts.[42] Finally, by using a delivery model (microfinance) that already recovered operational costs through interest on loans, the IMAGE programme has been able to scale up at minimal additional cost, reaching over 12,000 women in South Africa.

### CASE STUDY 4: CREATING CROSS-MDG SYNERGY: THE ZOMBA CONDITIONAL CASH TRANSFER PROGRAMME IN MALAWI

#### *WHAT ARE CONDITIONAL CASH TRANSFER PROGRAMMES?*

Conditional Cash Transfer (CCT) programmes have been widely used to provide cash to poor households in exchange for active participation in educational and health care services. In 2007, 29 developing countries had some form of CCT programme in place. While growing evidence suggests that even small financial incentives can influence uptake of services and health behaviours, to date this approach has not been commonly considered in HIV prevention.[43]



#### *THE ZOMBA CCT REDUCED GIRLS' HIV RISK AND IMPROVED SCHOOL ATTENDANCE*

A recent World Bank study in Zomba, Malawi, that linked cash transfers to girls' school attendance found a decrease in girls' risk of HIV and other STIs (60% reduction after 18 months among girls receiving cash transfers). In addition, there was evidence that participants were three to four times more likely to be in school at the end of the school year and more likely to delay marriage and pregnancy.[44] The researchers suggest that girls who received payments not only had less sex, but when they did, they tended to choose younger, safer partners. Moreover, the cash transfers may have led to reductions in transactional sex.[45]

#### *HOW WAS THE ZOMBA CCT DESIGNED?*

The Zomba CCT study randomly enrolled 3,796 adolescent girls and young women between the ages of 13 and 22 from Zomba, a district in Malawi with high HIV rates and school dropout rates among adolescent girls. The only condition for receiving cash payments every month was that the girls enrolled in the programme had to attend school regularly. As part of the program, their parents received cash payments as well. The girls' school attendance was checked every month and payment for the following month was withheld for any student whose attendance rate was below 75% in the previous month. Although the cash payments were made purely on the basis of school attendance, the money also made the girls less vulnerable to contracting HIV and other STIs.



# POLICY OPTIONS AND ACTIONS

## LOOKING FORWARD: 2015 AND BEYOND

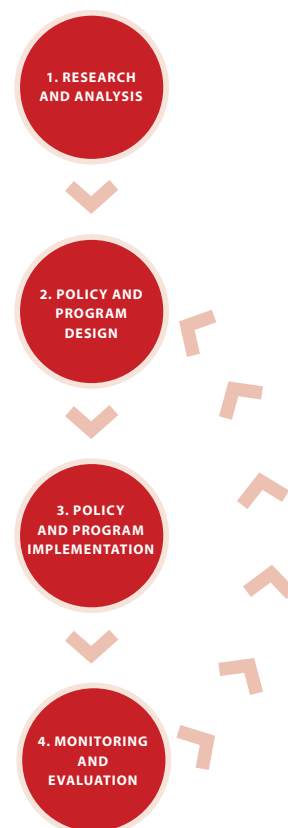
The following section concludes by considering some of the broader policy-level implications for AIDS and MDGs, and how a variety of development partners, including governments, the UN system, donors, civil society, and researchers, can begin to take this agenda forward. Entry points exist along the entire policy and programme lifecycle (Figure 3).

### 1. RESEARCH AND ANALYSIS

**Map the HIV epidemic in relation to the broader MDG and development context.** This paper has demonstrated the importance of examining structural factors that block progress on multiple MDGs to construct a picture of the HIV epidemic that is tied to an understanding of the current status of other MDGs. As the MDG country reports indicate, many governments already recognize critical linkages between AIDS and other MDGs at the macro level, however this has not yet trickled down to shape national AIDS responses, which remain primarily health-sector focused. Recent work by groups such as the aids2031 initiative<sup>4</sup> is making important headway in this area, and has begun to map out a stepwise methodology for programme managers to pursue at the national level to facilitate this kind of analysis.[18]

### 2. POLICY AND PROGRAM DESIGN

**Explore a range of cross-MDG strategies and support the scaling up of promising intervention models.** Such mapping may reveal opportunities where existing efforts to address other MDGs might benefit from applying an HIV lens. For example, cash transfer programmes might be structured to maximize benefits for girls education while reducing HIV risk, and delaying pregnancy and marriage. Where promising cross-MDG interventions have been developed, they should be expanded and replicated as appropriate. To date, the kinds of cross-sectoral collaborations described in this paper remain exceptions. Technical support and financial resources are required to spark further innovation in this area.[29] Such support should also consider what kind of capacity-building might be required for programme implementers themselves, and what kind of institutional structures need to be developed in order to support and manage expanded activities and mandates. With its mandate and role in the UN system, UNDP may be well positioned to support countries in identifying and applying these solutions.



*Figure 3. Integrating an AIDS and MDGs Approach into the policy and programme lifecycle*

4. The aids2031 initiative was established in 2008 to consider what has been learned about the AIDS response in the previous three decades and to make recommendations for a long-term response that could change the face of the pandemic by 2031. The initiative convened nine multi-disciplinary working groups to question conventional wisdom, stimulate new research and spark public debate around: modeling the epidemic; structural determinants (or 'social drivers'); the impact of new science and technology; programmatic responses; financing the response; communication, and the future of leadership.

**Ensure that countries' policy environments support and sustain the impact of cross-MDG programmes.** There are clearly limitations to what individual intervention programmes can achieve. Often, the impact of scaling-up or replicating locally successful models is constrained by a lack of realistic engagement with broader policies and structures that can curtail or expand their scope. Therefore, in order to be effective, intervention programmes need to be supported by country-level policies that carry the potential for far more sustained and systemic change (e.g., on gender equality) than can be achieved through individual programmes, acting in isolation. Lessons from the HIV field have clearly identified the importance of creating an enabling policy environment, particularly in relation to gender, human rights, intellectual property and innovation [18] – lessons that can be expanded to accelerate greater progress in other MDG areas. This commitment to addressing longer-term, structural development constraints and investing in enablers such as effective policies and institutions is a pillar of UNDP's MDG Breakthrough Strategy.<sup>5</sup> [46]

### 3. POLICY AND PROGRAM IMPLEMENTATION

**Generate AIDS and MDGs partnerships by reaching out across sectors to engage a broader range of health and development actors.** Although there have been long-standing calls to address the socio-economic determinants of health, actually tackling these underlying determinants has lagged behind. Bringing together a range of expertise extending beyond the health sector can raise significant challenges for creating effective synergy. These range from logistical barriers such as compartmentalized institutional structures and disease-focused funding mechanisms, to less tangible factors relating to specialization, training, competition, values, and communication amongst diverse disciplines. These barriers will need to be understood and addressed in a direct, strategic and evidence-informed ways so that AIDS and MDG experience can broaden the scope of HIV and MDG interventions to include new collaborations across multiple sectors and disciplines. We are now poised at an opportune moment in which we can develop a more robust approach to multi-sectoralism and to integrate HIV efforts with broader health and development approaches.

### 4. MONITORING AND EVALUATION

**Build best practice models by evaluating AIDS and MDG strategies against realistic timeframes.** There is a need for further research to guide programme and policy development across a range of settings. In relation to evaluating interventions that address structural drivers of HIV, it is likely that effecting meaningful and measureable shifts in economic well being, education, or gender equality will require longer timeframes than those afforded to more conventional technical or biomedical approaches. Thus, it will be important to link the application of cross-sectoral approaches to robust budget lines that will support substantial, long-term action and project cycles.[18] Through collaboration with research partners, UNDP's support to existing development initiatives in the fields of gender, energy, water and sanitation, education, health and sustainable agriculture may provide a natural laboratory for building and testing a broader AIDS and MDGs approach.

The steps described above, provide multiple opportunities and strategic entry points for a range of health and development actors, including governments, civil society, researchers, and the UNAIDS family, including UNDP (Table 1, next page).

5. The MDG Breakthrough Strategy (2010) is a key strategic document for UNDP. It describes what UNDP will do to support countries to achieve the MDGs by 2015 and to sustain progress already achieved in light of global economic, financial and food crises.

**TABLE 1: OPPORTUNITIES FOR STRENGTHENING AN AIDS AND MDGs APPROACH**

KEY ACTORS	OPPORTUNITIES
<b>Governments</b>	<ul style="list-style-type: none"> <li>• Ensure that national development plans, including PRSPs and NDPs address HIV through key sectors, as appropriate to the epidemic context</li> <li>• Ensure that National AIDS Plans include attention to key structural drivers and their intersections with the MDGs</li> <li>• Ensure that Ministries of Finance and Planning include appropriate funding to support action on HIV through key non-health sectors</li> <li>• Ensure that health sector plans address structural drivers and socio-economic determinants of poor health</li> <li>• Promote cross-sectoral development planning and action at national and sub-national levels to accelerate MDG achievement</li> <li>• Support integrated service delivery</li> </ul>
<b>Civil society</b>	<ul style="list-style-type: none"> <li>• Strengthen alliances between AIDS civil society organisations and those working in other MDG areas, including poverty, education, gender equality and the environment</li> <li>• Identify strategies and initiatives that successfully tackle multiple MDGs at once</li> <li>• Advocate for human rights-based approaches and involvement of marginalized populations in MDG initiatives</li> <li>• Advocate for civil society engagement in MDG planning and monitoring</li> </ul>
<b>Researchers</b>	<ul style="list-style-type: none"> <li>• Begin documenting approaches and lessons that may be transferred and adapted between AIDS and other MDGs</li> <li>• Develop and encourage greater cross-disciplinary research (e.g., tracking key HIV-related behavioural and biological markers within evaluations of development interventions, such as food security programmes, education initiatives, social protection programmes)</li> <li>• Work with AIDS and development partners to evaluate AIDS and MDG approaches</li> <li>• Document the value-added and cost-effectiveness of interventions that impact several MDGs simultaneously</li> <li>• Document current political, institutional and other barriers to new partnerships and maximizing synergies in order to create opportunities and incentives for greater cross-sectoral and cross-disciplinary collaboration (e.g., drawing lessons from the history of integrating STIs/Family Planning and/or SRH/HIV)</li> </ul>
<b>Donors</b>	<ul style="list-style-type: none"> <li>• Create funding structures that transcend traditional silos and encourage greater cross-disciplinary collaboration</li> <li>• Promote cross-MDG innovation funds that allow space for developing and testing new approaches with new partners</li> <li>• Provide funding over longer timeframes to support evaluation of cross-MDG interventions, including structural approaches to HIV</li> <li>• Include incentives for monitoring and evaluating multiple MDG outcomes, including HIV, as part of funding dedicated to structural approaches</li> </ul>
<b>UNAIDS and UN agencies</b>	<ul style="list-style-type: none"> <li>• Support the incorporation of socio-economic vulnerability mapping into traditional HIV epidemiological mapping</li> <li>• Continue to advocate for HIV as integral to MDG achievement and vice versa, compiling and sharing best practice models with governments and other development partners</li> <li>• Utilize the UNAIDS Outcome Framework to ensure that UNAIDS priority areas are integrated into other MDG targets (poverty, education, gender, child health, maternal health, TB and malaria, environment, global partnership)</li> <li>• Ensure that the technical strengths and strategic advantage of UN agencies are coordinated to enhance synergies between AIDS and MDGs</li> <li>• Ensure that UCC's role in the HIV-related aspects of the MDG Acceleration Framework (MAF) roll-out give adequate attention to the AIDS and MDGs approach</li> <li>• Support scaling up of successful cross-MDG pilots and initiatives</li> <li>• Promote and fund cross-thematic approaches and programmes within and across agencies</li> <li>• Facilitate cross-constituency sharing of experiences and lessons, drawing from work across MDGs</li> </ul>
<b>UNDP</b>	<ul style="list-style-type: none"> <li>• Leverage its strategic focus on human rights and development approaches to HIV (including mainstreaming AIDS in development and MDG planning, governance of AIDS responses, gender, sexual diversity and trade/intellectual property) to develop and scale up cross-MDG approaches</li> <li>• Ensure that CPAPs reflect UNDP's mandate on HIV and incorporate structural and cross-MDG approaches, as reflected in UNDP's recently launched MDG Breakthrough Strategy.<sup>[46]</sup> Facilitate the convening of the UN system at the country-level to support structural and cross-MDG approaches, especially as part of the roll-out of the MAF.</li> <li>• Promote and contribute to greater mapping of socio-economic vulnerabilities to traditional epidemiological vulnerability maps to enhance the 'know your epidemic/know your response' framework.</li> <li>• Build cross-sectoral collaborations through UNDPs existing work with a broad range of HIV and development civil society organisations.</li> <li>• Provide support to governments in the design and evaluation of social protection programmes to ensure that beneficial HIV impacts will be maximised.</li> </ul>

# CONCLUSION

Ten years have passed since world leaders gathered at the United Nations to sign the Millennium Declaration and express their commitment to achieving the Millennium Development Goals. Since that time, important shifts in the AIDS and development landscape have unfolded, shifts that have raised new challenges and opened up opportunities to take stock of where progress has been made and understand where a change in course may be needed. As this paper has described, because an AIDS and MDGs approach explicitly positions AIDS within the broader human development agenda, the approach provides a critical platform for governments, UN agencies, and other partners to galvanize resources, political will, and momentum behind a broader, structural approach to addressing HIV. Moreover, by pointing to important cross-MDG lessons and strategic investments that can engage a range of development partners, there is great potential for generating synergistic impacts that extend beyond HIV to benefit other MDG areas. Now is the time for the international community to revitalize the push toward the world that was envisioned for 2015: one that recognizes that health and human development are fundamentally linked and achievable for all.

## BOX 1. THE IMPACTS OF AIDS ON MDGs 1-5



AIDS  
↓  
Poverty

- **AIDS can worsen poverty** [47-51]
  - In Botswana, poverty rates are 0.5% higher per year due to AIDS.[52]
  - A Zambian study notes that a “striking feature of the economic impact of AIDS... is the rapid transition from relative wealth to relative poverty”.[50]
- **AIDS can increase unemployment**
  - A study in Indonesia showed that AIDS-affected households have higher unemployment and 55% less disposable income.[53]
  - AIDS can increase unemployment in a variety of ways: stigmatization and discrimination in the workplace, absenteeism due to ill health, caring for those who are unwell, or attending funerals.
- **AIDS can exacerbate hunger and food insecurity**
  - Poor health directly reduces agricultural productivity.
  - Households affected by AIDS divert time, income and assets toward caring for those who are sick.
- **These impacts are compounded for women, girls and the poor**
  - AIDS widows and orphans are often disinherited.
  - In India, the financial burden of HIV on affected households represents 82% of income in the poorest quintile as compared to roughly 20% in the richest.[54]
  - Even when drugs are free, poor families may still be unable to afford food or absorb the travel costs for care.[55]



AIDS  
↓  
Education

- **Teachers have been impacted by AIDS**
  - HIV prevalence rates among teachers in South Africa have been estimated to be 13%; in Botswana, this rate was 35–40%.[56-57]
  - The death of a teacher is often preceded by six months of relative disability, contributing to absenteeism and poorer education delivery.[57-58]
- **AIDS-affected children, including orphans, experience lower rates of school attendance and may perform more poorly**
  - Stigma and discrimination can keep children out of school.
  - Orphans have been shown to attend school less, and poor orphans perform more poorly in school.[59-60]
- **Girls may be most affected**
  - Girls may be pulled out of school to care for ill family members or because their families can no longer afford school fees.[61]
  - One study among AIDS-affected households in Indonesia found that girls were twice as likely to drop out of school as boys.[53]



AIDS  
↓  
Gender  
Equality

- **AIDS can disproportionately affect women and girls, severely curtailing their opportunities for social and economic advancement**
  - In sub-Saharan Africa, 60% of new infections are among women and this gender disparity is more pronounced among young women and girls.[4]
  - In most parts of the world, women and girls bear the burden of caring for those infected and affected by AIDS.



AIDS  
↓  
Child  
Health

- **AIDS accounts for a significant share of total under-five mortality**
  - AIDS accounts for 2% of child deaths globally.[62]
  - AIDS accounts for 4% in sub-Saharan Africa.[62]
- **In some countries, AIDS is a major cause of under-five mortality**
  - AIDS causes nearly 50% of child deaths in Swaziland and South Africa.[62]
- **Considering indirect mechanisms, the impact of AIDS on under-five mortality is likely even higher**
  - Malnutrition, which is heightened among AIDS-affected households, is an underlying cause of 33% of all under-five mortality worldwide.[62]
  - Maternal orphans, even after controlling for the HIV status of the mother, experience a mortality rate that is 3.3 times higher than average, in part because of higher rates of malnutrition.[63]



AIDS  
↓  
Maternal  
Health

- **Maternal mortality has been an intractable global health and development challenge**
  - Maternal mortality has declined slowly: from 320 in 1990 to 251 in 2008.[64]
  - This represents a decline of 22%, which falls far short of the MDG 5 target of a 75% decline by 2015.[64]
- **AIDS is a major driver of maternal mortality, especially in sub-Saharan Africa**
  - Globally, AIDS accounts for 18% of maternal mortality globally.[64]
  - In some countries in sub-Saharan Africa, prior trends that indicated improvements in maternal mortality have actually reversed, partly due to the impact of HIV. There has been an alarming net increase in maternal mortality since 1990.[64]

## BOX 2. THE IMPACTS OF THE MDGs ON AIDS



**Poverty**  
↓  
**AIDS**

- **The relationship between poverty, economic inequalities and HIV risk is complex [65-66]:**
- **Infection rates are highest in the poorest regions of the world.**
  - Globally, 90% of infections are in low- and middle-income countries. Two-thirds of those living with AIDS are in sub-Saharan Africa.[4]
- **Within poor regions, relatively wealthier countries may have higher levels of HIV.**
  - Despite relative high GDPs, Swaziland, South Africa and Botswana have some of the highest HIV prevalence rates in the world.[67-69]
- **Patterns have been changing over time.**
  - While transmission in many poor countries was initially concentrated among more affluent individuals [70-72], emerging data suggest this pattern may be shifting, with higher rates of infection borne by socially disadvantaged groups, particularly young women.[73-78]
- **There are strong associations between economic inequality and HIV.**
  - Among developing countries, there is a significant correlation between adult urban HIV prevalence and the GINI coefficient, a measure of a country's wealth gap between the rich and poor [51, 65, 79]. Emerging evidence highlights the role of social and economic transition in accelerating HIV transmission.[69, 72, 80]
- **Economic factors operate through a number of pathways to influence sexual decision making.**
  - Economic and power imbalances affect access to material resources; shape peer networks and social capital; influence patterns of school attendance; and condition a woman's risk of violence and ability to leave risky relationships [68]. Each of these, separately and together, creates overlapping vulnerabilities that shape social and sexual networks to influence HIV risk.[68, 81-82]



**Education**  
↓  
**AIDS**

- **Early in the epidemic, higher levels of HIV were found among the better educated. This was particularly the case in sub-Saharan Africa, where education was linked to affluence, mobility and higher levels of sexual risk behavior.[70] However, this pattern seems to be changing.**
- **Education is strongly HIV protective:**
  - A recent systematic review suggests substantially lower HIV risk among better educated populations in Africa.[83] In Africa, recent estimates suggest that each additional year of education leads to an approximately 7% reduction in the likelihood of acquiring infection.[84]
- **The protective effects of education operate through multiple mechanisms, and may be particularly important for girls.[70, 78]**
  - Children in school have safer social and sexual networks than out of school youth.[76, 85] In South Africa, young women who did not complete high school were almost four times more likely to be HIV-infected compared to those who completed high school.[86] Better educated women are more likely than their less educated peers to delay sex, marriage and childbearing, tend to use condoms more often, have fewer children and healthier babies, and enjoy better earning potential.[87]
- **Strong education programmes can have an impact on critical features of the epidemic**
  - Exemplary programmes have been shown to contribute to safer sexual behaviour
  - HIV education programmes in schools can be particularly effective in impacting students' knowledge about HIV and attitudes towards people living with HIV, thus reducing stigma and potentially encouraging access to HIV services
  - Life skills programmes can be complex to properly design, implement and evaluate, and more work is needed to strengthen such programmes and education systems, in general. [57]



**Gender Equality**  
↓  
**AIDS**

- **Gender inequalities combined with economic inequalities expose women to a higher risk of HIV**
  - Numerous studies have documented the multiple, dynamic pathways by which gender inequalities, as reinforced through laws, policies and social norms, drive overlapping HIV-related risk behaviours, including: intergenerational sex, transactional sex, coerced sex, violence against women, inability to negotiate sex and safer sex practices.[29]
  - A study in Zambia found that frequent droughts and limited income opportunities following the post-economic liberalization and closure of companies, were identified as the 'push' factors for women increasingly resorting to transactional sex.[88]
  - A Cape Town study found that girls from low-income households became sexually active earlier than average, and were more likely to have multiple partnerships particularly after a recent economic shock, such as a death in the house or job loss.[89]
  - In Botswana and Swaziland, food insufficiency among women was significantly associated with inconsistent condom use with a non-primary partner, exchange of sex for resources, intergenerational sexual relationships, and lack of control in sexual relationships. For men, food insufficiency only resulted in a 14% increase in the odds of reporting unprotected sex, and was not associated with other risky sexual behaviours.[90]

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