

HIV AND AIDS: A JUSTICE PERSPECTIVE

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AMECEA	Association of Member Episcopal Conferences of Eastern Africa
ART	Antiretroviral Therapy
ARV	Antiretroviral (Drug)
BESSIP	Basic Education Sub-Sector Investment Programme
BMJ	<i>British Medical Journal</i>
CAFOD	Catholic Fund for Overseas Development
CD4	Cluster Designation/Differentiation, level 4
DFID	Department for International Development
EU	European Union
GTZ	German Technical Cooperation
HEARD	HIV/AIDS Economic and Research Division
HIV	Human Immuno-Deficiency Virus
ICASA	International Conference on AIDS and STIs in Africa
IFI	international Financial Institution
ILO	International Labour Organisation
IMF	International Monetary Fund
IRIN	integrated Regional Information Networks
JCTR	Jesuit Centre for Theological Reflection
MSF	Médecins sans Frontières
NGO	Non-Governmental Organisation
OVC	Orphans and Vulnerable Children
PLWHA	Person/People Living with HIV or AIDS
PRSP	Poverty Reduction Strategy Paper
RPR	Rapid Plasma Reagin
RTE	Radio Television Eireann
STI	Sexually Transmitted Infection
TB	Tuberculosis
TRIPS	trade-Related Aspects of Intellectual Property Rights
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
US	United States of America
WFP	World Food Programme
WHO	World Health Organisation
WTO	World Trade Organisation

FOREWORD

The vision of the Jesuit Centre for Theological Reflection (JCTR) is simply but powerfully expressed as: “A society where faith promotes justice for all in all spheres of life, especially for the poor.”

Today justice for all in all spheres of life is, we believe, fundamentally threatened by the presence of the HIV/AIDS pandemic. And this is especially the case with the poor in our society.

Because of this belief, we consider it to be of the greatest importance to focus attention on HIV/AIDS in a very holistic fashion. This means a fashion that goes beyond narrow sectoral approaches that deal primarily with medical diagnosis and response or behavioural critique and change.

Without being unduly critical of the serious and often-times heroic work done in recent years by so many in relating to the prevention and treatment of HIV/AIDS, it is necessary to ask whether this work has been as effective as it could have been had a more holistic approach been taken. Has the medical establishment (and the donors and government ministries supportive of this group) been focusing excessively on biomedical and pharmaceutical responses? Has the church (and many allied civil society groups) been narrowly emphasising human behaviour practices and the efforts necessary to change that behaviour?

It is precisely these questions that Michael J. Kelly, S.J., raises in this report that the JCTR commissioned at the end of 2005. Kelly is widely known, nationally and internationally, for both his precision and his passion in addressing the issues surrounding the HIV/AIDS situation in Zambia and wider, especially in the developing world. After a distinguished career as an educationist at the University of Zambia, Kelly took up the serious challenge that is undermining any human development possibilities for Zambia and so many other countries, the deadly spread of HIV/AIDS throughout all sectors of society.

In this report, he suggests a more dynamic framework within which to look at the prevention and treatment of HIV/AIDS. He does this by linking justice concerns such as poverty, gender disparities and power structures, stigma and discrimination, and global socio-economic structures and practices.

Kelly raises many sharp questions to government, international donors, church leaders and members, medical professionals, NGOs, families and individuals. Not all will agree with his analysis and his answers. But we hope that the cogency of his arguments will stimulate some much-needed discussion and reevaluation of what we should be doing to more effectively and equitably be facing the HIV/AIDS pandemic.

As an Appendix to this study, the JCTR adds some recommendations for actions to be taken by many different stakeholders. We look forward to an exchange with readers of the study.

Jesuit Centre for Theological Reflection
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HIV and AIDS: A Justice Perspective

Executive Summary

In June 2005, the United Nations acknowledged that the world was losing the struggle against HIV and AIDS and that, despite certain advances, the epidemic remained out of control. This study sees the epidemic as oppressive and dehumanising in itself, with its continuation and spread being rooted in human structures and systems that are themselves oppressive. These constitute a network of domination, oppression and abuse that excludes millions of human beings from sharing in, building up and enjoying a more just and equal world—and the central point from which the strands of the network radiate is the AIDS epidemic.

Conceptual Framework

HIV/AIDS is conceptualised as being driven by four forces: poverty, gender disparities and power structures, stigma and discrimination, and exploitative global socio-economic structures and practices. The more these thrive, the more HIV and AIDS will flourish. Equally, the more HIV and AIDS prosper, the greater the likelihood that poverty, gender disparities and power structures, stigma and discrimination, and disruptive socio-economic structures and practices will flourish and ensure the continuation of the epidemic. These four driving forces manifest themselves in a world where there have been two dominant approaches to responding to AIDS. One approach sees the epidemic as a condition that calls for a biomedical and pharmaceutical response, the other as a condition resulting from human behaviour practices and hence requiring a response that focuses on changing that behaviour.

Both models are critiqued for their concentration on the immediate causes and effects of HIV/AIDS and their failure to deal with the underlying and structural causes of the epidemic. Although there is global agreement that prevention should be the mainstay of the response to the epidemic, the policy directions currently being espoused seem destined to a never-ending struggle with the immediate causes of the epidemic—sexual behaviour, mother-to-child transmission, blood supplies, and injecting drug use. But because initiatives do not directly or sufficiently concern themselves with issues of poverty, inequalities in society, gender disempowerment, or north-south relations, the epidemic is likely to maintain the upper hand and perpetuate its unjust outcomes.

A particular deficiency seen in the behaviour change approach is its unspoken assumption that different patterns of behaviour are real possibilities for an individual and its failure to address the social factors that shape behaviour.

A Just Sexuality

Because sexual activity is the principal route for HIV transmission, the study examines the extent to which injustice frequently occurs in sexual behaviour, with special attention to the extent to which women and girls may be the

victims of such injustice. Instances are enumerated that reveal the double injustice in much sexual behaviour, the act itself being a violation of the rights of a sexual partner, and the act carrying the further injustice of exposing the partner to the risk of HIV transmission.

For a “just sexuality” to prevail, justice must be respected in every type of sexual encounter. At the minimum, this implies the observance of two principles:

1. The no-harm principle that induces “people who move into intimate sexual contact with their occasional, varying, or semi-detached partners” to take “the necessary efficient measures so that pregnancy, HIV and other sexually transmitted diseases ... are prevented”.
2. The equality principle that attaches as much value to the other as to oneself. This principle requires that, at the very least, a person should never be forced, directly or indirectly, to have sexual contact or to violate an exclusive committed relationship with another.

Practical forms of injustice may occur in four sexuality-related areas: narrow understandings that identify sexuality with physical sexual activity; failure to respect, protect and fulfil the rights of young people to comprehensive sex education; a moralising approach that fails to take account of the personal or socio-economic circumstances that may influence or even dictate a person’s behaviour; and failing to affirm that individuals are morally bound to follow what their conscience tells them is correct, even against the requirement of ecclesiastical or other authorities.

The Treatment of AIDS

The treatment of AIDS requires good nutrition, proper medication for common illnesses and opportunistic infections, the availability and accessibility of antiretroviral drugs (ARVs), the medical and social infrastructure that can deliver and monitor treatment measures, and supportive, understanding human care.

It is difficult for people in resource-poor households to meet all these requirements. Structural adjustment programmes and economic instability have had negative impacts on the nutritional status of the poor and have compromised the ability of health services to respond to people’s needs. The burden of providing much of the personal and nursing care required by AIDS patients in their homes falls largely on women who themselves may already be over-burdened and some of whom may also be living with HIV or AIDS. A further negative outcome is that girls may be taken out of school to help provide care in the home or to take over household and child-care responsibilities that can no longer be discharged by mothers or older female relatives who are providing AIDS care. This jeopardises a girl’s future in two ways: her truncated education does not equip her for life in the modern world, and she is deprived of the full education that would equip her with some protection against HIV infection.

The only way in which HIV infection can be controlled once it has gained a foothold in the body is through a combination of antiretroviral drugs. These are very effective in restoring life and vitality, even to patients who were close to death. Once started, antiretroviral treatment must continue for the rest of an individual's life. Moreover, because of the way the virus can develop resistance to the drugs being used, the individual must be monitored on a regular basis to ensure that resistance has not developed or, if it has, to change to other drugs.

Zambia has one of Africa's largest HIV/AIDS treatment programmes, with antiretroviral treatment (ART) reaching about 30 percent of those estimated to be in need. But the treatment came late to Zambia, as to so many other developing countries—about six years after it had been developed. If the treatment had been made available earlier, millions of lives would have been saved. Globally, ART reaches less than one in five of those in need. The rest are left to die. The enduring injustice is that “the people who are dying from AIDS don't matter in this world”. The global movement that seeks to see every person who is in need having access to treatment by 2010 is one that accords well with humanitarian, justice and human rights perspectives.

From a justice and equity stance, numerous other benefits of ART should be noted. Because of the way this treatment improves physical well-being and makes it possible to resume productive work, it acts significantly against poverty. It helps households to remain productive and intact. It prevents children from being orphaned. It dispels many of the fears, myths and misconceptions that underlie stigma and discrimination. Moreover, because it reduces the pressure on health services the provision of universal ART, despite its high costs, can result in major national savings, as can be seen in the case of Brazil.

Notwithstanding its enormous benefits (and the moral and justice imperatives of extending it to every person in need), the treatment of AIDS bristles with still unanswered justice, equity, ethical and practical questions. One set of questions relates to the sustainability of provision and costs. Because persons who begin on a course of ARVs must continue to take the correct medication for rest of their lives, there should be some assurance that they will be able to continue to do so. Currently there is no such assurance, so that the lives of these persons quite literally depend on political and economic decisions that will almost certainly be made in the developed countries and that have not yet come to the foreground. Questions also arise when those on ART have to move to different drugs which are very much more costly and are not always available in the poorer countries.

A second set of questions concerns equity in access to ARVs. There is need for determined measures to ensure that the right to treatment of women, those in rural areas, and marginalized groups (such as commercial sex-workers or prisoners) is respected. There has also been unjust neglect of children. Although 660,000 children were in need of ART in 2005, only about five percent were able to receive it, largely because of the non-availability and/or non-affordability of child-friendly versions of the ARV drugs.

HIV/AIDS and Poverty

There is no simple equation between HIV/AIDS and a country's national wealth or poverty status. AIDS is not a disease of poor countries. Nevertheless, where wealth is concentrated in the hands of a few, the majority are so indigent that they cannot satisfy their basic needs, and society is fragmented and in a state of some disarray, the scene is ripe for HIV and AIDS to make significant inroads. This implies that social and economic measures that will bring about a more just distribution in the wealth of the world and within individual countries are by that very fact measures against HIV and AIDS. Likewise, measures that strengthen civil society, foster stable, predictable and transparent governance, and promote a sense of social confidence throughout society, are also measures against the epidemic.

If it cannot be said that HIV/AIDS is a disease of poor countries, neither can it be said that it is a disease of poor people. Nevertheless, there is a well-established connection between HIV/AIDS and poverty, with their economic and social circumstances putting the poor at higher risk of HIV infection, and accentuating their susceptibility and vulnerability to infection. The poor are very familiar with malnutrition, micronutrient deficiencies, malaria, tuberculosis, and infestation by bilharzia and other worms. Each one of these conditions depresses the immune system in such a way that an individual becomes more easily HIV infected (and equally, an infected individual who experiences any one of these conditions is a more potent transmitter of HIV). What it means to be poor also increases vulnerability. Under pressure to meet immediate needs, the poor must live for the present. They do not see that they have any future to protect and hence may fail to appreciate the need to protect themselves against the possibility of HIV infection.

HIV and AIDS also have the effect of making the poor poorer. This is due to the way the epidemic causes costs to rise, reduces incomes and resources, and necessitates the diversion of resources. The costs of goods and services increase as industry raises prices to offset the ways in which HIV and AIDS affect its operations. Incomes and resources decline as jobs are lost through sickness or death; farm production is reduced; loans cannot be repaid; households headed by the elderly or children produce less; and the volume of sales declines because customers do not have resources to spare for anything but the most essential purchases. In addition, in order to survive, many households may have to dispose of capital assets, among them productive assets such as animals, machinery or equipment, thereby imperilling their future productivity.

The epidemic is also bringing about a massive diversion of resources—money, time, human engagement, institutions and systems. While this is occurring at both international and national levels, the poor are more severely affected by the way the epidemic eats into their household and personal resources. These are diverted to the disease in the form of payments for medicines, tests, palliative care, cleaning, transport, funerals, periods of mourning. Catering for additional household members in response to the orphans challenge requires that in many households limited resources must

be spread more thinly over larger numbers. Where there is AIDS in the household, labour resources must go to AIDS care and away from productive work.

The cumulative effect of these various situations is that the poor become poorer. Poverty deepens and becomes more extensive. The state of the “wretched of the earth” becomes even more wretched and their susceptibility to HIV infection becomes even more accentuated. Perhaps the oppressive face of HIV and AIDS is seen most clearly in the way it thrives off poverty and reinforces poverty. For AIDS-stricken countries and AIDS-stricken households, “make poverty history” is more than a slogan. It is a cry from the hearts of oppressed people to be freed from the domination of the unjust and exploitative situations that bind them into poverty and tether them to HIV and AIDS.

Women, Gender Disparities and the AIDS Epidemic

On physiological grounds, the risk of HIV infection is greater for women and girls than for men and boys. In addition, women’s risks are increased by a wide array of social, cultural, economic and legal factors, all of which are embedded in extensive theoretical and practical gender inequalities. In particular, at the sexual level, unequal power-relations give women a subordinate position and make them submissive to men. Several established practices in society also have the twofold outcome of demeaning women and enhancing their risk of HIV infection. These include various forms of sexual violence in the home, community and workplace; indulgence towards men who take sexual liberties; and the practice of older married men of having a “girlfriend” on the side. Further, some customary practices, such as early marriage, widow inheritance, ritual cleansing, and dry sex, have the same double effect of treating women as chattels and making them more vulnerable to HIV infection.

The message that women are there to be at the service of men, in sexual and other ways, is transmitted from an early age through child-rearing practices that form girls to be non-assertive and to accept subordinate status in relation to men. The insistence at times of initiation and pre-marital “kitchen parties” that the prime responsibility of a woman is to please her husband at all costs reinforces the message of her inferior status. Effectively this leaves many women psychologically powerless to take steps to protect themselves against possible HIV infection from their husbands.

In African society, as in many other parts of the world, married women often face violence and abuse if they demand condom use or refuse sex from their husbands or long-term partners. While many women are vulnerable to HIV because they are single or without a partner, the disturbing fact is that even more of them are vulnerable to infection because they are married and remain faithful to a partner who does not reciprocate this trust.

Economic factors further accentuate women’s vulnerability to HIV infection. “A woman’s access to property usually hinges on her relationship to a man.

When the relationship ends, the woman stands a good chance of losing her home, land, livestock, household goods, money, vehicles, and other property. These violations have the intent and effect of perpetuating women's dependence on men and undercutting their social and economic status."

Compounding all these restrictions and limitations is the heavy HIV and AIDS burden that women must bear. The burden of care that they already carry is greatly increased by additional responsibilities in caring for sick family members and for orphans from their own or their husbands' extended families. Even if personally HIV infected, or ailing from some other illness, women must continue to manage a household, provide care, produce food and generate income. Access to ARVs is problematic for many women who feel disempowered by a culture that gives priority to the health needs of men. "On top of this, women are often daunted by the bureaucracy surrounding (the delivery of antiretroviral therapy). There are official documents to sign and many women cannot read or write, so they feel intimidated."

For the greater part, this stalking of women by HIV and AIDS arises from society's unjust allocation to them of an inferior status. Were it not for the unjust treatment and exploitation that women experience, the epidemic would not have its current worldwide grip. It would not have its current stranglehold on southern Africa. Fewer men would be infected. Far fewer women would be infected, and because this would reduce the incidence of parent-to-child transmission, fewer children would be infected.

Responding to the AIDS epidemic, in terms of prevention, treatment, and impact mitigation, will only succeed when robust, sustained and specific action is taken to reduce and ultimately eliminate the prejudice, discrimination and unjust treatment that women experience. Without a frontal attack on the injustice of gender inequality, the dominance of the epidemic will continue.

Gender equality is necessary in the light of what HIV and AIDS can do to women. But even more fundamentally it is necessary in its own right. AIDS or no AIDS, women and men are essentially equal. Making that equality a lived reality is a major challenge for every individual, community, institution and country.

Stigma and Discrimination

Stigma and discrimination are powerful forces that have the double effect of demeaning individuals infected or affected by HIV and AIDS, and making it more difficult to deal effectively with the disease.

Stigmatisation of a person living with HIV or AIDS means that they are discredited, branded as unworthy, reduced in value, or assume lesser worth in our eyes, and often also in their own eyes. What is not always recognised is that the irrational act of stigmatising also makes the stigmatiser lose value and become less worthy and less human—the stigmatiser responds to those living with HIV or AIDS as if they were of lesser value, and in doing so becomes of lesser value as a human being.

Stigma and discrimination manifest themselves in many settings—in the home, in the community, in the work situation, in health-care settings, and in education settings. What those who are stigmatised experience in every one of these settings represents a denial in practice of human rights. Perversely, the injustice that is brought about in these ways by HIV and AIDS also contributes to the continuation and proliferation of the disease. This is because stigma and discrimination create a culture of silence and denial where it is difficult to take the action necessary to fight HIV effectively.

The injustices that stigma and discrimination represent for people living with HIV or AIDS bring untold personal unhappiness into their lives. Very many of those who become infected with HIV can actually come to terms with their infection. But almost every one of them finds it much more difficult to live with stigma and discrimination. These challenge their sense of personal worth, dignity and what it means to be human. African philosophy recognises that “a person is a person through other persons”. By attacking the bonds that link people to one another, stigma and discrimination undermine the very humanity of infected individuals and make it impossible for some to continue living.

Global Economic Structures and Practices

The years during which globalization worked its way down into the lives of communities and individuals have seen an increase in poverty and inequity. The extent to which it can be said that globalization is directly responsible for the increased poverty of individuals and countries and for growing income inequalities is not clear. But globalization as practised has resulted in wealth, prosperity, influence and future promise for the few; poverty, exclusion, voicelessness, and stagnant hopelessness for the many. The emergence of such situations has considerably increased the susceptibility of countries, communities and individuals to HIV and AIDS, especially when it is recalled that poverty and inequity, working together, provide a fertile breeding ground for the continuation and spread of the epidemic. In this sense, it has to be acknowledged that global economic structures and practices have facilitated the continued domination of the AIDS epidemic and in some circumstances have made their own direct contribution to this dominance.

Notwithstanding increased worldwide concern about the AIDS epidemic, the broad global approach, especially as embodied in behaviour change policies, seems to be a combination of containment and what might be called “otherisation”: do not let the epidemic extend beyond the world’s current hotspots; confine it to the marginalized groups (commercial sex workers, men who have sex with men, injecting drug users, the poor in developing countries); make it somebody else’s problem, “out there”, elsewhere, belonging to “Them” but not to “Us”. Inevitably, of course, this institutionalises stigma and discrimination at the heart of global policy. In practice, it means denying HIV and AIDS as a global disease and ultimately as a global concern. But, a global society is too porous, too flexible, too changeable, too interconnected for this to work.

More specifically, the World Bank and the International Monetary Fund (IMF) have come in for stringent criticisms in recent years because of the adverse impacts of their structural adjustment policies on health and education systems. Critiques, ranging from sharp disparagement to carefully worded academic evaluations, link these policies to the spread of the AIDS epidemic. Thus, Stephen Lewis writes that “one of the critical reasons for Africa’s inability to respond adequately to the pandemic can be explained by user fees in health care ... and user fees in education”. The essential basis for the criticisms is the way both institutions gave first priority to economic stability, far ahead of every social need and human right, including the right to life and to good health.

Global trade structures are relevant to the AIDS epidemic on two grounds: first, trade structures have much to do with maintaining a country in or freeing it from poverty; and second, the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement has much to do with the availability and flow of antiretroviral drugs and other technologies for responding to HIV and AIDS.

HIV/AIDS prevention efforts need to be grounded in the broader struggle for social and economic rights for the poor. But international trade relations currently do not favour poor countries in Africa or elsewhere in the world. Instead they are heavily weighted in favour of the wealthier countries, while simultaneously creating barriers to the market access of goods from poorer countries. This unfair global process serves to maintain countries in their poverty and by that very fact to maintain the AIDS epidemic that ravages them. Much the same could be said about debt, with many countries spending as much or more on debt servicing than they do on their health services. The limits that the never-ending servicing of debts places on a country’s ability to pull itself out of poverty are also limits on its ability to respond to the AIDS epidemic.

The TRIPS Agreement covers all areas of technological innovation, transfer and dissemination. Its relevance to the AIDS epidemic is that the TRIPS Agreement covers access to the life-preserving antiretroviral drugs that have been developed by a small number of pharmaceutical giants in Europe and the United States. The Agreement also covers access to other important epidemic-related technologies, such as tests for the diagnosis of HIV in very young infants.

The World Trade Organization has acknowledged the public health problems coming from HIV/AIDS and other epidemics and encouraged member states to make full use of the flexibilities built into the TRIPS Agreement. But while there has been some progress, the consensus of practitioners is that, even with the most recent amendments of December 2005, the regulations still do not allow drugs, especially those that are being newly developed, to be made readily available at affordable prices. Little has been done to open the door to provide a legal way for poorer countries to develop, manufacture or import life-preserving drugs.

The Movement of People

Large-scale population movements contributed to the early explosive spread of HIV and AIDS. They continue to do so. It is estimated that some 150 million individuals are living permanently or for extended periods in a country other than their own. In addition there are the millions who migrate from rural to urban areas within their own countries, in addition to other internal migrants. Economic reasons are at the root of much migration, both internal and international. Usually, migrants are looking for work or better-paid work. There is also much involuntary migration. This includes refugees from situations of conflict or civil strife, and displacement due to conflict or natural disasters.

Factors such as much mobility, separation from protective customary norms, working in high risk situations, working in isolated situations, protracted border formalities, and transactional sex, increase the vulnerability of mobile populations to HIV. Because their concerns are with the more immediate challenges of physical survival and financial need, most individuals on the move regard HIV as a distant risk. But during their travels or at their destinations, many of them experience conditions that provide an optimal context for HIV transmission.

Numerous equity and justice concerns arise from the HIV vulnerability of mobile populations: the crying need to see an end to all forms of human trafficking; ensuring that all migrants have access to health, testing, care, treatment and support services, and that they are encouraged to make full use of these services; the protection of migrants with HIV or AIDS from discrimination and xenophobia when they are in another country; ensuring that infected migrants can continue to live where their access to ARVs commenced; establishing immigration regulations that do not block entry (or require deportation) on grounds of HIV infection; accelerating the issue of visas and goods documentation at borders, so as to reduce HIV-risk delays; establishing better living and working conditions for seasonal agricultural and fishery workers, domestic workers, and transient mine workers; developing local work opportunities so that there will be less migration on economic grounds.

Brain Drain

Many severely affected countries, especially the poorer ones, find that their ability to respond to HIV and AIDS is being hampered by the loss of their skilled health and other professionals to wealthy industrialized countries. Responding to the epidemic is further hampered by the considerable movement of health care professionals within countries (from rural to urban areas, from the public sector to private practice, and from primary health care to secondary and tertiary provision) and from poorer to wealthier developing countries (as from Zambia to Botswana).

This “brain drain” of health care workers from Africa is further crippling already fragile health care systems throughout the continent, as they struggle to provide ART to hundreds of thousands of people. An anomaly in this situation is the readiness of countries that support developing countries’ training

programmes to bleed away many of the best products of these programmes once training has been completed and some experience garnered.

A further anomaly is that the provision of ART within countries is exacerbating the shortage of personnel for other basic health care services. Externally funded HIV/AIDS programmes usually offer better salaries and conditions than ministries of health. These are attracting doctors, nurses, pharmacists and technical staff away from public-sector positions to work in these foreign-funded programmes. The result is a further weakening of already fragile health care systems.

Impacts on the Young

As the epidemic of HIV and AIDS continues to unfold, the world is becoming more keenly aware of the various ways it impacts on the young—children affected by HIV and AIDS (including orphans), and youth or young people under the age of 25. Orphans and vulnerable children (OVC) are of concern because of the way the epidemic robs them of what cements them to the past, undermines their present opportunities, and jeopardizes their future. Young people under the age of 25 are of concern because they are the AIDS generation—they have never known a world without HIV and AIDS; and because they are at the ages where they are most susceptible to HIV infection—young people, aged 15–24, account for about half of new adult HIV infections and 28 percent of the global total of adults living with HIV or AIDS.

The major justice issue relating to orphans and vulnerable children is failure at almost every level to build them into comprehensive responses to the epidemic. The Zambian Government has acknowledged that it is not giving sufficient priority to the problems of OVC, while poverty reduction strategy papers (PRSPs) do not manifest a strong commitment to the needs of orphans and other vulnerable children, with many of them not mentioning the issue at all.

While UNICEF and some prominent NGOs tend to lead the world in the campaign for more meaningful interventions on behalf of OVC, the response of the faith-based organizations at the grassroots level, where the challenge really occurs, has also been outstanding. A proliferation of faith-based community initiatives, led by a veritable army of religiously committed and motivated volunteers, is making a major contribution to the protection of Africa's orphaned generations. The religious leadership could do even more if it placed mobilizing action to care for orphans, vulnerable children and families affected by HIV/AIDS higher on their agendas, spoke about the issue more frequently at church services and on other suitable occasions, and maintained pressure on government and civil society never to overlook the needs of children.

However, the veritable avalanche of community responses to the OVC challenge should not mask the fact that so many families experience difficulty in coping. Underlying their apparent success is the selfless sharing strategy that frequently characterises those living in poverty—the poor helping the

destitute by sharing what they cannot afford. But this is hardly something that can be held up as a good model of coping.

Injustices against children may also be perpetrated when families are broken up on the death of a parent or when orphans or street children are “repatriated” from their town setting to a rural village. Enabling orphaned children to stay together as a sibling group is often of fundamental importance to their emotional and psychological well-being. Further, in addition to infringing their right to participate in decision-making affecting their future, the practice of repatriating children to the village from which the deceased parents are believed to have come frequently creates numerous social problems that result in much unhappiness both for the children and for those in the village where they are re-located. There is need for much greater adherence to the principle that in all that concerns children, the best interests of the child should be a primary consideration.

The relationship of HIV/AIDS to youth encompasses a wide range of issues, four of which have strong justice overtones. Although young people under the age of 25 comprise almost half of the world’s population, teenagers and young adults are not given sufficient voice.

1. Although the majority of young people know something about HIV and AIDS, teenagers and young people still do not have access to enough correct information.
2. Teenagers and young adults do not have sufficient access to youth-friendly health services and HIV testing facilities.
3. Many teenagers and young people lack economic security and prospects for employment, with about half those without jobs being aged 24 or less.

The non-availability of employment and work prospects for young people is a key missing ingredient in global strategies against HIV and AIDS. It is not merely that because young people have so little to do that they have more time for behaviours that may put them at risk of being infected with HIV. It is much more that they are deprived of opportunities for developing their human dignity and self-respect.

Impacts on the Elderly

In many developing countries the AIDS epidemic has increased the burden on older people in two ways. First, because of the deaths of their children they can no longer receive the financial and other support that their children would otherwise have provided for them; and second, in their frailty and very often in their poverty, they have to take on care responsibilities for orphaned children. Older people have always been involved, to some extent, in caring for the young. But because of AIDS, the extent of this care has greatly increased.

The burden of orphan care is falling more extensively on the weaker members of society—women who are old, very often poor, and not infrequently in poor health. A distinctive characteristic of the evolving household model is that

often there is no middle generation (women or men) but only the old and the young somehow supporting one another. The elderly caregivers are apprehensive about their ability to care for and rear the young, but feel under pressure to take on this responsibility because there is no one else who can do so. Because of age, the personal health status of elderly caregivers is often not good and it may be worsened by the stress, anxiety and burden of providing care. This fills many of them with an overwhelming sense of worry and concern.

Caring for these frail caregivers can test the commitment of a society to principles of justice and equity. Two questions arise:

1. How can these elderly carers be enabled to cope with the economic, caring and psychosocial demands placed on them?
2. Who will care for these elderly carers when they are no longer able to care for themselves or their dependants?

There is a strong case for the adoption of exceptional measures for the protection of elderly caregivers. In common with children affected by HIV and AIDS, they are a very vulnerable group. But, unlike orphans and vulnerable children, they are a much-neglected group. The United Nations has suggested the adoption of social protection measures to respond to the needs of this very vulnerable group, but so far few governments have taken any action (although the promise and the affordability shown by pilot cash transfer schemes might change this situation).

The Vulnerability of the Earth

HIV/AIDS affects systems directly and indirectly through sickness and death. This applies not merely to human systems, such as education or health, but also to the ecological systems on which humanity depends so intimately. The immediacy with which households experience the labour and financial impacts of AIDS impairs their ability to make sustainable use of natural resources. When time, energy and money must be spent to relieve the effects of AIDS sickness, and when there are fewer healthy individuals in a household who can put in a full day's work, concern for long-term ecological integrity is not a high priority. Because of this, there is more likelihood of exploitative relationships in which natural resources are over-used or poorly managed.

Reduced ability to transmit knowledge and skills and actual degradation of natural resources are the two principal channels through which this occurs. Rural populations are aware of the need to maintain a balanced relationship with the environment that sustains them. Centuries of experience have resulted in patterns of cropping, animal husbandry, fishing and general environmental management that yield good returns to the individual without wreaking harm on the environment. The knowledge and skills for maintaining this balanced relationship are passed from generation to generation, not in a formal way but through the informal learning of children from their parents and elders. HIV/AIDS has put this under threat. So many have died or are seriously ill in the generation with the knowledge and skills that they are no

longer able to transmit these to their children. The result is considerable risk of environmental degradation, as through over-fishing or fishing at the wrong time of year, failure to preserve certain tree species, or lack of attention to watercourses and where run-off is directed.

Through HIV and AIDS “our own flesh and blood, the earth, is dying”, but very few seem to care. Years must elapse before the damage that HIV does to the human body reveals itself in the sicknesses of AIDS. It could be the same with the earth. The present generation has the responsibility of finding innovative ways to ensure that the epidemic does not undermine the future of humans or their environment. This is a matter of justice to the present generation, to future generations, and to the earth on which we all depend for sustenance.

The Response of the Christian Churches to HIV and AIDS

There is need to acknowledge and proclaim the enormous contribution that the major faiths, and in particular the Christian Churches, continue to make to HIV prevention, care, support, treatment, and impact mitigation. Their activities in this area are firmly grounded in a strong human rights based approach that promotes a culture of life, respect for the sacredness of the individual, and the celebration of life. They also draw their inspiration from social teaching that advocates strongly for the transformation of economic, political and social structures that effectively exclude the poor and deny the equal personal role and dignity of women. In other words, church teaching consistently and effectively addresses some of the major driving forces of the AIDS epidemic. The immediate contact of the faith communities with people at the grassroots level, in their homes and elsewhere, further strengthens their ability to address the various concerns that arise from the epidemic.

With their closeness to the people and their long experience, the Churches in Zambia have come to recognize that it is neither effective nor sufficient to treat HIV as an object of intervention, in isolation from its social and economic contexts. While they recognize the behavioural and medical concerns that HIV and AIDS raise, they do not concur that it is sufficient to address the epidemic from outside by the technological interventions of a condom, a test kit or an antiretroviral drug. Instead, they see it as requiring a more holistic approach that addresses both economic and personal development. Hence, an increasing amount of church activity is being dedicated to social and economic development, while a major share of church concern has always been with personal development.

Because of this, in addition to their traditional health and education activities, the various church bodies in Zambia work for the improvement of agriculture, water and sanitation, improved livelihoods, acceptance of the equality between men and women, improved nutritional status for children and adults, and the development of infrastructure. Each of these activities relates significantly to developing an environment that is less conducive to HIV transmission. In the majority of cases, the churches undertake this work without recognizing explicitly that it contributes to the control of HIV and AIDS.

While much has been accomplished, there is room for even more—more forthright speaking on every possible occasion about the epidemic; absolute rejection of every utterance, pronouncement or practice that carries any connotation of stigma or discrimination; working even more resolutely at the major tasks of eliminating poverty and ending the subjugation of women; mobilizing their communities for a massive humane and practical response to the orphans challenge; and galvanizing their members into action for the reduction of HIV transmission, the promotion of a just sexuality, the provision of care and support for those infected or affected, and the mitigation of the impacts of the disease and epidemic.

The time of AIDS is a time of great perplexity. But it is also a time of great challenge and a time of great grace. The Church has the responsibility of discerning God in the current situation and of hearing what God is saying to it through the crisis of HIV and AIDS. It is also duty bound to help others experience God even in the circumstances of HIV and AIDS. In the final analysis, the responsibility of the Church is to live, speak and act as Christ would have done in this era of HIV and AIDS, to be Christ to those who are infected and affected, to bring Christ's message of hope and certain victory to suffering people and a suffering world.

Conclusion

This study has been animated by three considerations:

1. There is strong synergy between the AIDS epidemic and four basic root causes: poverty; gender disparities and power structures; stigma and discrimination; and exploitative global economic structures and practices.
2. Responding to HIV and AIDS is intimately connected with the practice of justice.
3. AIDS and justice issues are so intimately linked that action on behalf of justice will almost automatically be action against the epidemic.

Dismantling the unjust structures in which poverty, the low status of women, stigma and discrimination, and exploitative global economic practices, are embedded, and establishing just structures and practices in their place, will create a terrain in which the human immuno-deficiency virus can no longer flourish. Equally, action against the epidemic will be action on behalf of justice. As this report shows, the shape and extent of the AIDS epidemic is determined by various unjust forces, many of them outside the areas normally addressed by HIV and AIDS programmes. Addressing HIV and AIDS serves as an entry point and catalyst for addressing these broader injustices. Briefly, then, one can say that the more HIV/AIDS, the less justice—but the more justice, the less HIV/AIDS.

HIV and AIDS: A Justice Perspective

Chapter 1 Setting the Scene

Introduction

Almost twenty-five years have passed since the publication of the first report on what was to develop as the AIDS pandemic.¹ During those years HIV and AIDS have expanded at an accelerating rate in every continent and now affect every country in the world for which information is available. But at the same time, the first quarter century of HIV and AIDS has witnessed some notable achievements. In particular, effective treatments have been developed that can keep HIV under control, extend life and improve its quality. Further, prevention efforts have been attended by some success, though this is limited and occurs mostly within clearly defined groups. What is needed now is to make these benefits accessible to all who could profit from them.

But this is not happening. Instead, as the disease spread, the world toyed with approaches and strategies that have not succeeded in stemming its advance, in bringing care, support and treatment to the infected, or in mitigating the impacts of the epidemic on individuals, communities, structures and societies. As a result, millions have become infected, millions are sick and millions more have died. Many of these infections, illnesses and deaths could have been prevented. But the world did not take the necessary steps. "The bottom line is, the people who are dying from AIDS don't matter in this world." This sombre editorial comment from the *British Medical Journal*² highlights the central injustice of HIV and AIDS, that it leads to so many preventable illnesses and deaths, involving a huge toll of attendant suffering, development reversals, the further marginalization of the poor and weaker members of society, and an increase in inequalities at various levels. Moreover, this situation continues and not enough is being done at local, national or international levels to remedy it.

Because of the way they permeate almost every facet of life, HIV and AIDS are powerful factors that undermine the common right of people to their personal dignity and integral human development. Where prevalence rates are high, the epidemic prevents individuals, communities, and countries from doing more, becoming more, and being worth more. Instead it constrains them in a cycle where they can do less, know less, have less, and become less, something that is the direct opposite of Pope Paul VI's criterion for development.³

The AIDS epidemic is oppressive and dehumanising in itself. Moreover, as will be seen, its continuation and spread are rooted in and promoted by human structures and systems that are themselves oppressive:

- Stigma and discrimination
- Gender imbalances and power structures
- Economic imbalances
- Certain traditional/cultural perspectives and practices
- North-South relationships
- Globalization as practised
- Extensive movement of people in search of work
- Brain drain.

The interplay of these various situations constitutes a network of domination, oppression and abuse that excludes millions of human beings from sharing in, building up and enjoying a more just and equal world. And the central point from which the strands of the network radiate is the AIDS epidemic that keeps individuals in a state of captivity, grinds them down, constrains their freedom to enjoy their human rights, and deprives them of the benefits of health, well-being, family and community. The entire cluster runs contrary to human and religious understandings of justice with their emphasis on liberation from oppression.

The theologian, Lisa Sowle Cahill, has strongly expressed this link between AIDS and justice: "AIDS is a justice issue, not primarily a sex issue. ... Perhaps an even more basic issue than economic and gender relations in the countries most affected by AIDS is the justice of the interlocking local and global economic systems that disrupt traditional societies, displace economic and educational infrastructures, and cut off access to kinds of prevention and treatment of disease whose efficacy in Europe and North America is well established".⁴

Analytic Framework

Almost inevitably, social and economic inequalities occur in any society. The minimum rock bottom prerequisite for a just society is that these inequalities be managed in ways that ensure that the conditions of the less fortunate do not grow worse. But while this is necessary, it is far from being sufficient. A just society is one that seeks to lessen inequalities and improve the conditions of the less fortunate. Ideally, therefore, the just society would seek to manage the inequalities in ways that reduce them and are to the advantage of the less fortunate. This has been expressed in a positive way by Pope Benedict in his encyclical *Deus Caritas Est*: "the aim of a just social order is to guarantee to each person ... his share of the community's goods".⁵

But HIV and AIDS tend to accentuate the inequalities, making it difficult to achieve justice and a just society. Where AIDS prevails, inequalities increase. The less fortunate become ever more marginalized. The poor become poorer. Women are disempowered. The environment for the socialisation of children disintegrates. Old people, without resources or energy, are thrust back into parenting responsibilities for a young generation. The earth absorbs the havoc wreaked on her but in doing so becomes more degraded. These negative impacts on the weaker members of the human community arise because of

the epidemic. At the same time they feed into its continued growth and a worsening of the situation.

The AIDS epidemic can be conceptualised as being driven by four forces: poverty, gender disparities and power structures, stigma and discrimination, and exploitative global socio-economic structures and practices (Box 1). These forces likewise interact in growth-enhancing ways with the epidemic. The more they thrive, the more HIV and AIDS will flourish. The more HIV and AIDS prosper, the greater the likelihood that poverty, gender disparities and power structures, stigma and discrimination, and disruptive socio-economic structures and practices will flourish and ensure the

Box 1: AIDS and Justice. An Analytic Framework

The *framework for the current global response to HIV and AIDS* has three elements:

1. Narrowly conceived prevention policies and failed efforts
2. Excessive attention to sex
3. Inadequate and problematic care, support and treatment efforts

Operating within this framework, four *major forces drive the HIV and AIDS epidemic*:

1. Poverty
2. Gender disparities and power structures
3. Stigma and discrimination
4. Exploitative global socio-economic structures and practices

Driven by these forces *the epidemic has major negative impacts on*

1. The poor
2. Women
3. Children
4. The elderly
5. The earth

These negative impacts feed back into and reinforce the driving forces, thereby accentuating their potential to sustain the epidemic and make it worse

Justice issues arise in relation to

1. *The current global response framework*
2. *Each of the forces that drive the epidemic*
3. *Each of the parties impacted by the epidemic*

continuation of the epidemic (see Figure 2, below). These four driving forces, individually and in their interactions with each other, bespeak a wide range of injustices. Through their impact on the AIDS epidemic and the environment it has created for itself they highlight existing injustices or magnify their impacts; they also create new ones.

The driving forces for the AIDS epidemic do not, however, operate in a vacuum. They manifest themselves in a world that has set itself to addressing HIV and AIDS for almost a quarter of a century. Two major intersecting response models have emerged: the biomedical model, which sees HIV and AIDS as a medical condition that can be solved by a biomedical and pharmaceutical response; and the behavioural model, which sees the epidemic as something resulting from human behaviour practices and hence requiring a response that focuses on changing that behaviour. Both approaches are valid and must be taken into account. But, whether taken separately or together, their application focuses so strongly on the virus and the medical condition it causes that they deal with only part of the problem.

This narrow and almost exclusive focus on the virus has contributed in no small measure to global failure to respond adequately to the epidemic. Louis Pasteur, the father of the science of virology, once remarked, “the virus is nothing, the terrain is everything”.⁶ With their focus on the virus, the biomedical and behavioural models have paid insufficient attention to the terrain, the socio-economic environment within which the epidemic thrives. “Addressing effective HIV prevention is not simply finding good arguments for HIV prevention, but more importantly addressing the social problems that inhibit HIV prevention measures”.⁷ The current global response framework does not adequately address these social issues. Instead, “the epidemic and its response have been seen as addressable from outside, by technological interventions—a drug, a condom, a test kit”.⁸ By failing to give due recognition to HIV/AIDS as a development problem and not responding to it as such, confining the response to the biomedical and behavioural approaches contributes to the injustice of the epidemic, dealing with it in a patchy way, engaging in fire-fighting exercises, but never getting down to altering the conditions that will change the “terrain” and thereby disempower the virus.

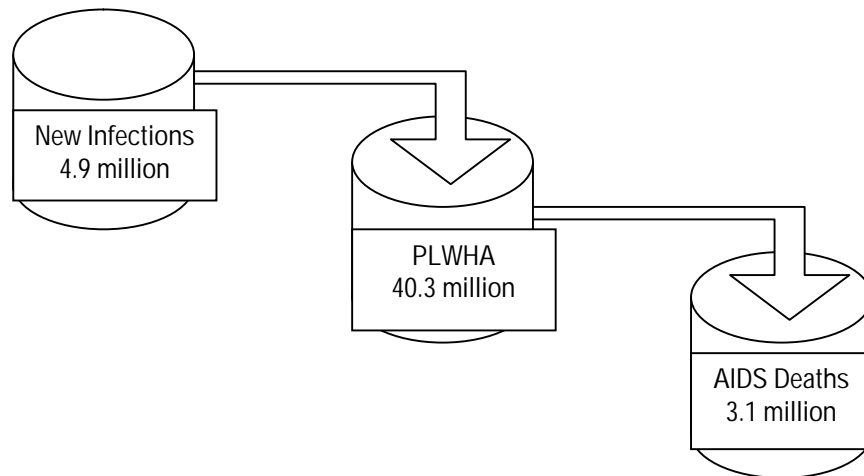
Chapter 2

Justice Aspects in the Current Response Framework

HIV Prevention

Globally, HIV infection continues to occur at an alarming rate. During 2005, an estimated 4,900,000 new infections occurred.⁹ This is the equivalent of more than nine every minute, or one every six or seven seconds. In Zambia, an estimated 75,000 new adult infections occur each year (more than eight every hour), with 40,000 of these being women. In every region of the world, the number of adults and children who become newly infected with HIV each year exceeds the number who die of AIDS—most recently, 4.9 million individuals became newly infected, while the disease led to an estimated 3.1 million deaths in 2005 (Figure 1). This means that the global pool of infected persons (persons living with HIV or AIDS, PLWHA) is growing steadily and quickly: at the end of 2005, it was estimated to stand at 40.3 million, compared with 37.5 million at the end of 2003. The growing size of the pool of infected persons is attributable both to new infections and to infected persons living longer

Figure 1: Global HIV/AIDS Dynamics, 2005



because of the increased availability of antiretroviral drugs (ARVs)—the scaling-up of this treatment is believed to have averted between 250,000 and 350,000 deaths in 2005.

The continued growth of the epidemic, which outstrips global and local efforts to contain it, underlines the importance of scaling up and intensifying HIV prevention efforts. The world has been guided in this respect by the stance adopted by the United Nations General Assembly when it considered HIV and AIDS in June 2001: “Prevention must be the mainstay of our response”. From a justice perspective this is surely as it should be. Reduction in the number of new infections is the most effective way of preventing the disease from consolidating or increasing its stranglehold on individuals, families, communities and societies. Understandings of justice, both Judeo-Christian (the liberation of the oppressed and action on behalf of the weaker members of society) and philosophical (the management of situations so that they are to

the greatest benefit of persons who are least advantaged), require such action.

As noted already, current dominant response models to the epidemic focus on HIV and AIDS as a medical and/or as a behavioural issue. A similar narrow perspective informs the entire set of programmatic actions that UNAIDS, in its most recent policy document, deems essential for HIV prevention, namely:

1. Prevent the sexual transmission of HIV.
2. Prevent mother-to child transmission of HIV.
3. Prevent the transmission of HIV through injecting drug use, including harm reduction measures.
4. Ensure the safety of the blood supply.
5. Prevent HIV transmission in healthcare settings.
6. Promote greater access to voluntary HIV counselling and testing while promoting principles of confidentiality and consent.
7. Integrate HIV prevention into AIDS treatment services.
8. Focus on HIV prevention among young people.
9. Provide HIV-related information and education to enable individuals to protect themselves from infection.
10. Confront and mitigate HIV-related stigma and discrimination.
11. Prepare for access and use of vaccines and microbicides.¹⁰

Focusing so exclusively in these ways on the virus yielded meagre returns in the past. There is reason to fear that maintaining this narrow perspective will prolong the years of global failure to respond adequately to the epidemic. It is almost universally acknowledged that AIDS presents a multi-dimensional development challenge that can only be solved by a multi-sectoral approach. There is little more than token commitment to such an approach in the UNAIDS policy document. The tragedy of this is that the policy direction espoused by the world's leading AIDS response agency will continue to be directed to a never-ending struggle with the immediate causes of the epidemic—sexual behaviour, mother-to-child transmission, blood supplies, and injecting drug use. But it will fail to address such underlying and structural causes as gender inequalities; poverty and inequalities in society; joblessness; legal systems; war and conflict; corruption; north-south relations; structural adjustment and externally imposed conditionalities; and ecological abuse. This being so, the epidemic is likely to maintain the upper hand, to continue to wreak havoc in families and communities, to drain countries of their personnel and financial resources, to retard and even further reverse development efforts, and to lead to unending misery for millions of men, women and children. It would be hard to imagine a greater injustice.

The Behavioural Approach to Prevention

The behavioural approach to prevention deals essentially with the modification of behaviour on the part of an individual. It addresses the obvious risks of sex and injecting drug use, and factors that increase individual

vulnerability (e.g., ignorance or peer pressure). It follows a logical pattern, as if individuals were in full control of their choices, HIV risk-reducing decisions were always based on reason, and every sex or injecting drug use activity was fully free and rational. Taking little account of non-western worldviews, the uniform context for the behaviour change approach is that of the homogenised, individual, scientifically medicalised, western cultural world.

The continued global increase in HIV infections demonstrates that this simplistic, straight-line approach does not bring the desired results. Neither is it an approach that commends itself to researchers and practitioners from Africa, Asia, Latin America and the Caribbean. As far back as the late 1990s, through a series of worldwide consultations and consultative workshops, UNAIDS promoted the development of a more adaptable framework for HIV and AIDS communications. The new framework, which was based more on social and environmental context than on individual behaviour, underscored the importance of government policy, socio-economic status, culture, gender relations, and spirituality, as virtually universal factors for HIV preventive health behaviour. Specifically, the new framework decried a number of assumptions:

- That individuals can or will exercise total control of their behaviour.
- That decisions about HIV prevention are based on rational volitional thinking, with little regard for the emotional involvement involved in sexual activity.
- That knowledge, attitudes and beliefs lead in a sequential linear fashion to behaviour and practice, despite the fact that sexual behaviour often precedes rational decisions based on knowledge of risks.
- That a simple strategy designed to trigger a once-in-a-lifetime behaviour (such as immunisation) would be equally adequate for changing and maintaining complex, life-long behaviours (such as more responsible sexual behaviour or consistent condom use).¹¹

Referring to the social context, the report made the important observation, “Seeking to influence behaviour alone is insufficient if the underlying social factors that shape behaviour remain unchallenged”.¹² This sentiment was re-echoed the following year by Cahill when she wrote, “A choice to engage in different sexual behaviour patterns—like sexual fidelity in marriage to an uninfected spouse and a healthy lifestyle—is only possible when one’s social circumstances offer those different patterns as real possibilities for oneself”.¹³

Unfortunately, these insights do not animate current behavioural approaches to HIV prevention. Instead, the rational, linear, individualistic approaches that have dogged the response to HIV transmission since the AIDS epidemic was first recognised in the early 1980s continue to prevail (and in June 2005 were yet again endorsed by the UNAIDS governing board¹⁴). It seems certain that the AIDS epidemic will continue to outstrip every effort to contain it for as long as the campaign does not vigorously address aspects in society that make it extremely difficult, if not impossible, for a large proportion of men and women to adopt responsible sexual behaviour. In Cahill’s words, different patterns of

responsible sexual behaviour must become real possibilities for a person. The deep underlying and structural factors of poverty, gender imbalances and power structures, an exploitative global economic system, and pervasive stigma and discrimination erode and in many instances eliminate this possibility. These are powerful fuelling forces for the epidemic, intimately connected with both HIV transmission and AIDS, creating the climate in which both can flourish and themselves being aggravated by their success in promoting the epidemic (Figure 2). Responding to each one of these is in itself a justice issue. Responding to them so as to facilitate more successful HIV prevention efforts is equally a matter of justice, calling for situations to be changed so that those who are vulnerable or at risk can make the free, responsible and fully human choices that will protect them against possible HIV infection. But regrettably, for the majority, this is a justice denied.

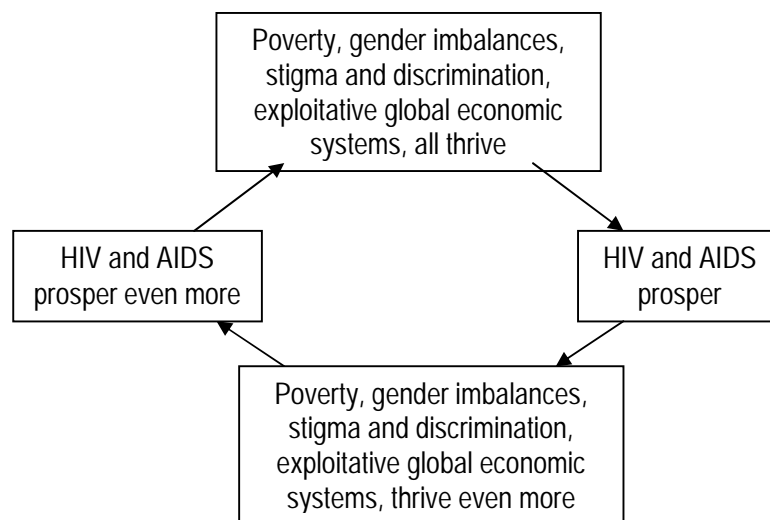


Figure 2: The Vicious HIV/AIDS and Negative Social Circumstances Cycle

A Just Sexuality

Cahill's words bear repeating: "AIDS is a justice issue, not primarily a sex issue".¹⁵ Because the commonest way for HIV transmission to occur is through sexual activity, global policy has focused very strongly on sexual behaviour and how to manage this in ways that will reduce the risk of HIV transmission. Some of the limitations of this narrow approach were dealt with in the previous section. But this is not to say that there is no room in the HIV/AIDS response for attention to sex and sexuality (or to drug-injecting behaviour in societies where this is a major route for HIV transmission). Sexual behaviour is so extensive in human life and so significant in a world with AIDS that failure to consider it would be irresponsible.

Only too often, sexual behaviour is also unjust behaviour. Any sexual activity that violates the rights and dignity of either of the partners, including the right to say 'no', is in itself an act of injustice. Moreover, a further injustice is committed against a sexual partner when a person who is or could be HIV

positive has sexual intercourse without advising the partner about HIV implications and taking measures to reduce the possibility of transmitting the virus. Instances occur in numerous situations:

- When a husband requires sex from his wife without allowing her any freedom of choice or considering (with her) how to reduce the risk of HIV transmission. This double injustice has resulted in proportionately more married women who remain faithful to their husbands becoming infected than unmarried women who may have more than one partner.
- When traditional practices expose women or girls to frequently unwanted and always unsafe sexual practices, as in ritual cleansing, dry sex, female genital mutilation, and early marriages.
- When sex occurs with violence, and in particular when there is rape.
- When sex is used in conflict situations as an instrument of subjugation, for population control, for the distribution of resources, or as an instrument of terror.
- When a woman must engage in survival sex in order to maintain herself or her household, or keep a roof over her head.
- When there is transactional sex, with a woman being implicitly or explicitly induced to exchange sex for cash or other benefits, as occurs in “sugar-daddy” and “preserving a good relationship with the boyfriend” cases.

These and similar occurrences reveal the extent to which injustice can occur in sexual behaviour (and the extent to which women and girls may be the victims of such injustice). They also reveal the double injustice in much sexual behaviour, the act itself being a violation of the rights of a sexual partner, and the act carrying the further injustice of exposing the partner to the risk of HIV transmission. Injustice can also occur in understandings and communications relating to sexuality and the interventions that reduce the risk of HIV transmission.

Roger Burggraeve, professor of moral theology at the Catholic University of Leuven, appears to have been the first to refer to a “just sexuality”.¹⁶ According to Burggraeve, justice must be respected in every type of sexual encounter. At the minimum, this implies the observance of two principles:

1. The no-harm principle that induces “people who move into intimate sexual contact with their occasional, varying, or semi-detached partners” to take “the necessary efficient measures so that pregnancy, HIV and other sexually transmitted diseases ... are prevented”.
2. The equality principle that attaches as much value to the other as to oneself. This principle requires that, at the very least, a person should never be forced, directly or indirectly, to have sexual contact or to violate an exclusive committed relationship with another.

With their attention to respect for human life and the dignity of both sexual partners, both principles are strongly embedded in a justice and human rights framework. They also embody practical recognition of responsibility between the partners themselves and towards society. The latter responsibility is

shown in the partners' concern that their sexual activity will not burden society with such undesirable consequences of their behaviour as an unwanted pregnancy or an additional instance of HIV infection. Practising this just sexuality is seen as an urgent moral duty—and hence as something binding—and not just as a neutral piece of advice. Prerequisite to it are correct information, assertiveness and other life skills, and the motivation to make use of the information and skills—which are also the features that sound sex education programmes set out to promote.

The Meaning of Sexuality: A number of errors and injustices commonly occur when sex is dealt with in the context of the AIDS epidemic. One is the near identification of sex and sexuality with the physical act of having sex. This misconception overlooks the fact that sexuality is an ever-present driving force within human beings that makes them want to go beyond their selfishness and to give and receive delight, whereas having sex is an activity confined by time and space. In its best sense, sexuality is the growth (and sometimes the expression) of a relationship between two people that has potential to promote mutual acceptance of each other as they actually are, with their specific qualities, vulnerabilities, imperfections, characteristics and opportunities.¹⁷

Sexuality is integral to our being human persons. “We are human beings through our being bodily sexual beings”.¹⁸ Much wider than physical, bodily relationships, sexuality encompasses the “spiritual, emotional, physical, psychological, social and cultural aspects of relating to one another as embodied male and female persons”.¹⁹

Having sex, on the other hand, refers to the very particularised, physical, short-lived bodily encounter with another in a union that is often referred to as ‘making love’. This could also be called genitality, the physical, genital dimension of sexuality. It is a part of sexuality, and an important part, but still only one part. When making love is not possible or is not appropriate, all the other aspects of sexuality remain—love, joy, goodness, kindness, affection, sharing, family, and community.

Introducing people to this more extensive, liberating understanding of sexuality—and all that it implies—would very likely be just as successful in helping them live safe lives in a world with AIDS as would instruction on techniques and technologies for avoiding HIV risk.

Sex Education: But young people must also learn about such techniques and technologies, and this is where a second injustice manifests itself in the area of sex and AIDS. Young people have a right to know about sex, sexual practices, HIV-related sexual risks, reducing risk-taking behaviour, and how to protect themselves against HIV infection.²⁰ This means that they have a right to good sex education. They also have a right to be able to adopt such measures as will offer them increased protection against possible infection. It is a violation of their rights, and therefore unjust, to deny them the necessary knowledge and access to the services they require.

This is something that does not sit lightly with some adults. Many feel uneasy and uncomfortable at the thought of sex being discussed openly with the young. In addition, many also make the mistake of thinking that teaching about sex leads to more promiscuous behaviour on the part of young people. There is no evidence, however, that sex education increases sexual activity, leads to promiscuous behaviour, or increases the risk of HIV infection. In fact the evidence is in the other direction: careful investigations, in Africa and elsewhere, have found that properly conducted sex education contributes to delay in the onset of sexual activity, increased recourse to abstinence, reduction in the number of sexual partners, and a lessening of the incidence of sexually transmitted infections (STIs) and unwanted pregnancies.²¹

But just as there is a violation of rights in withholding information or not facilitating access to supplies and services, it is likewise unethical to present information in a sexually provocative way or to promote condoms indiscriminately without regard to the need for education on their responsible use and on possible alternatives. The public—and many of those being targeted by some of the billboards and media programmes—may perceive information campaigns as conveying one message: ‘it’s all right to have sex as long as you do it safely’. As occurred in Zambia in 2001, media advertisements have had to be withdrawn because they were open to this interpretation.

When practice does not live up to ideals: A third injustice in the field of sex and AIDS lies in the moralistic approach that condemns whatever does not conform to the highest ideals. This fails to take account of the personal or socio-economic circumstances that may influence or even dictate a person’s behaviour. It does not allow for the fact that a person may not have total freedom to govern his or her own life or the circumstances relating to sexual activity, as is the case of the multitude of women who have no say, inside or outside of marriage, in when or how sex will take place.

A prevention model proposed by CAFOD recognizes an extensive continuum of risk-reducing measures that an individual could choose.²² Towards the lower or no risk end of the continuum, measures such as abstinence or condom use provide sure or very considerable protection against HIV infection; towards the increased risk end, measures such as a reduction in the instances of casual sex entail more limited risk reduction. It is necessary to recognize the possibility that circumstances may be such that the individual is not free to choose the best option, but only one that is safer, even if this falls short of the moral ideal (and of the no-risk ideal for HIV prevention). Moral guidance should, however, encourage the individual to move to progressively safer options, even if these still do not match up to the highest moral ideal.

The supremacy of conscience: Injustice also prevails when teaching from any source makes people uneasy about following what their conscience tells them is correct. Morally responsible persons form their consciences during their years of growth, through the circumstances of their lives, by internalizing moral messages, and through unstructured personal reflection. For them, conscience is an inner authority that must prevail above all else. A human

being must always obey the certain judgement of conscience.²³ Acting against it would be to do wrong. “Deep within his conscience man discovers a law which he has not laid upon himself but which he must obey. Its voice, ever calling him to love and to do what is right and to avoid evil, sounds in his heart at the right moment. ... His conscience is man’s most secret core and his sanctuary. There he is alone with God whose voice echoes in his depths”.²⁴

It is significant that Pope Benedict XVI, while he was still known as Cardinal Ratzinger, wrote that “over the pope as the expression of the binding claim of ecclesiastical authority, there still stands one’s conscience, which must be obeyed before all else, even if necessary against the requirement of ecclesiastical authority”.²⁵ Reassurance on this matter would ease the stress of many, especially women (including those who must use survival sex for the support of their households), in the steps they must take to keep themselves free of HIV infection.

The Treatment of AIDS

Many see AIDS treatment as being synonymous with antiretroviral therapy (ART). However, comprehensive AIDS treatment encompasses much more than ART, since it requires:

1. Good nutrition and a balanced diet, with a plentiful supply of key micronutrients.
2. The availability and accessibility of common medicines as well as those for opportunistic illnesses.
3. The availability and accessibility of antiretroviral drugs.
4. The medical and social infrastructures that can deliver and monitor treatment measures.
5. Supportive, understanding human care.

Meeting each one of these requirements is important, though in resource-poor settings it may be difficult to do so. UNAIDS has stressed that “a good diet that provides the full range of essential micronutrients is important to the health of people infected with HIV and can help bolster the immune system, boost energy levels and maintain body weight and well-being. For people on antiretroviral therapy, good nutrition and clean water help treatment work more effectively.”²⁶ A similar point has been made by the World Food Programme: “ARVs alone will not put an end to the scourge of HIV/AIDS. There is still an urgent need for an integrated approach for all those who are HIV positive. Food must be part of it.”²⁷

Low-income households often find it difficult to comply with this requirement. They may be so hard-pressed in ensuring that there is enough basic food for everyone that they remain with few resources to provide the usually more costly diet needed by a person with AIDS. Food insecurity, due to the impact of the disease on a household’s productive activities, or resulting from the shock therapy experienced by many countries that were pressurized into adopting IMF-dictated structural adjustment programmes, or because of drought conditions, combine to make it even more difficult for many of those

who live in poverty to ensure a balanced, nutritious diet for a person living with HIV or AIDS.

Because of their impaired immune systems, persons with HIV or AIDS need to protect themselves against all other forms of illness, both those experienced by non-infected members of the community and those that in the absence of HIV they normally would not experience (opportunistic illnesses²⁸). However, health care services have not yet recovered from the setbacks they suffered during the 1980s and 1990s in response to structural adjustment programmes. The legacy of these programmes and the drain that debt servicing imposes on national resources have resulted in inadequately stocked pharmacies, poorly staffed and maintained clinics and hospitals, and insufficient laboratory and technical facilities. Medicines for common illnesses are not always available or may have to be purchased at prices that poor households cannot afford. Medications for some of the conditions that a person with AIDS may experience (such as fungal infections in the mouth) may be costly and are not always covered by schemes that give free access to ARVs (though it should be noted that these conditions generally do not occur in a person who is on an ARV regimen). Thus, a study in Senegal found that when the costs of drugs for opportunistic infections, laboratory tests, consultations and hospitalisation fees were included, patients on ART paid an additional US \$130 a year, a significant amount for a person from a low-income household.²⁹

Supportive and understanding human care, whether in a hospital, hospice or home setting, is crucial for a person living with AIDS. In addition to what medical science can provide, the individual needs emotional, psychological and spiritual support. Frequently also, nursing care will be needed. The burden of providing much of this personal care falls largely on women who themselves may already be over-burdened and some of whom may also be living with HIV or AIDS. The disproportionate burden that AIDS care imposes on women aggravates the disadvantage women experience in relation to health care in general and AIDS treatment in particular (Box 2). A further outcome is that girls may be taken out of school to help provide care in the home or to take over household and child-care responsibilities that can no longer be discharged by mothers or older female relatives who are providing AIDS care. This jeopardises a girl's future in two ways: her truncated education does not equip her for life in the modern world, and she is deprived of the full education that would equip her with some protection against HIV infection.

Antiretroviral Treatment

To date, no cure has been found for HIV since, as yet, there is no known way of completely eliminating the virus from the body. It was not until the mid-1990s that the use of a number of antiretroviral (ARV) drugs in combination was found to have lasting impact in controlling and holding at a low level the amount of HIV in the body (the viral load). But once it has entered the body the virus remains there and if drug treatment stops (or the virus develops

Box 2: Why should women always be the ones who sacrifice?

In Petauke, a small rural town in eastern Zambia, of the 40 people who are receiving ARVs, only three are women. Dr Muchango Siwale, who works at the local hospital, is perplexed. Although fewer women than men come into his surgery, "a lot more than three should be on treatment."

While it is generally difficult for rural people to access decent and timely health care, it is doubly difficult for women, who are more often poor, voiceless and subject to customs that expect them to sacrifice for their families.

The problem, says Siwale, is that women traditionally try to ignore their health needs. "Women do not know their own value. They are real beasts of burden. They get sick but, as long as they are able to pick up a hoe and till the land, they carry on till they drop dead."

His assistant, nurse Alyce Banda, also blamed the expectations heaped on women if they are to be considered "good" wives. "When last did elders or even neighbours sit a man down and tell him to take his wife to the clinic because she does not look well? And yet women are chastised by society if they do not take their husbands to the clinic for the slightest ailment. They are accused of trying to kill him."

Banda, a midwife, said in her 10 years at the clinic she had seen women bringing their husbands on wheelbarrows, bicycles and even on their backs, like babies. But she has yet to see a man even offer the support of his arm and bring his wife for treatment.

A group of women attending antenatal classes in Petauke frankly explained that if they were HIV-positive, their husbands would be unwilling to spend money on lifelong ARV treatment for them. They would rather divorce a wife considered too "expensive".³⁰

resistance to the drugs being used) it can quickly resume its onslaught on the body's defence mechanisms. However, the combination drugs are very effective in restoring life and vitality to patients who were close to death. Because of the quick way they do so, they are sometimes referred to as the "Lazarus drugs".

It took several years before the benefits of antiretroviral therapy (ART) became available to the general public in developing countries. There were

three reasons for the delay: the high prices charged by drug manufacturing companies; gross inadequacy of international funds for the purpose; and concerns about country ability to deliver the treatment. Strenuous efforts by civil society played a major role in having the drug companies reduce their prices. Following the 2001 UNGASS (United Nations General Assembly Special Session on HIV and AIDS), international funding for addressing HIV and AIDS increased very considerably. Because the countries assembled for this meeting pledged themselves “to provide progressively and in a sustainable manner the highest attainable standard of treatment for HIV/AIDS, including the prevention and treatment of opportunistic infections, and effective use of quality-controlled antiretroviral therapy,”³¹ a powerful drive for ARV treatment surged across the world, with elaborate programmes being developed to counter apprehensions about country capacity to deliver.

Responding to the imperative of treatment, WHO committed itself in July 2002 to get three million people on to ARV treatment by the end of 2005 (the Three by Five initiative). The target has not been reached, but the achievements of the initiative are significant: about a million people in developing countries are now on ART (Table 1), more than a quarter million deaths were averted in 2005, and even in resource poor settings treatment is being extended to large numbers. In the words of Stephen Lewis (the United Nations Secretary-General’s Special Ambassador for HIV and AIDS in Africa), the initiative “has unleashed an irreversible momentum for treatment ... (and) has ushered the phrase ‘universal treatment’ into the language of the pandemic, meaning that we’re now all fixated on getting everyone who needs treatment, into treatment, as fast as possible.”³² A dynamic global movement has now evolved out of the Three by Five initiative, the target being to achieve as close as possible to universal access to treatment by 2010. Designated as “universal access”, the movement seeks not merely to scale up access to treatment for AIDS, but also to ensure that every individual in need will have access to HIV prevention, treatment, care and support.³³

Table 1: ART Coverage in Low and Middle-Income Countries, June 2005

Geographical Region	Number of people receiving ARVs	Estimated need	Coverage
Sub-Saharan Africa	500,000	4,700,000	11%
Latin America & the Caribbean	290,000	465,000	62%
East, South and South-East Asia	155,000	1,100,000	14%
Europe and Central Asia	20,000	160,000	13%
North Africa and the Middle East	4,000	75,000	5%
Total	970,000	6,500,000	15%

Source: WHO Website, January 2006

Zambia is credited with having one of Africa's largest HIV/AIDS treatment programmes. Though access to ART is still limited, outreach to those in need is increasing rapidly. As of November 2005, 43,771 persons were receiving ART, or 29 percent of those estimated to be in need.³⁴ In June 2005, the Minister of Health announced that, in view of the overwhelming poverty levels and the high cost of accessing treatment, ART would be provided free in all public health facilities. "Free services in this context include all aspects of ART, including ARVs, laboratory services and tests, that is, full blood count, liver function test, total lymphocyte count, CD4 cell count, RPR (rapid plasma reagin), sputum examination, haemoglobin and any other related services."³⁵ However, with 153,000 people in need of ART as of June 2005, Zambia is among the 20 countries identified by the World Health Organization (WHO) as having the highest unmet need for ART. Moreover, in addition to those already identified, projections are that each year a further 85,000 persons in Zambia living with HIV will become eligible for ART.³⁶

Justice, Equity and Ethical Issues in ART

Several years passed between the introduction of multiple drug ART in 1996 and the widespread efforts of the Three by Five initiative in 2003 - 2005 to make it accessible and available to those most in need of it. And even still, coverage remains very inadequate. As Table 1 shows, only about 15 percent of the estimated need is being met in developing countries. This is a manifestation of injustice on a global scale. Were it not for the self-interest of pharmaceutical companies, the World Trade Organization's (WTO's) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), the inadequacy of financial and other resources, and the absence of any sense of international or national urgency to save people's lives, millions who died could have lived. The BMJ observation, cited in the introduction to this study, sums it up succinctly: "The bottom line is, the people who are dying from AIDS don't matter in this world" — largely, one suspects, because they are poor and voiceless, the "wretched of the earth". From another perspective the situation was saliently captured by Nelson Mandela in 2003 when he said that "the most striking inequity is our failure to provide the lifesaving treatment to the millions of people who need it most ... If we discard the people who are dying from AIDS, then we can no longer call ourselves decent people".³⁷

The major challenge that the availability of ART poses to justice and equity is to ensure that this treatment reaches every man, woman and child who is in need of it. Nothing less can satisfy real human sensitivity and the Christian conscience. Nothing less can satisfy the human conscience. From this perspective, the current Universal Access movement is clearly based on impregnable humanitarian, justice and human rights grounds.

From a justice and equity stance it should also be noted that in addition to protecting an individual's right to health and life, ART brings numerous other benefits. Because of the way it improves physical well-being and makes it possible to resume productive work, it acts significantly against poverty. It helps households to remain productive and intact. It prevents children from being orphaned. It dispels many of the fears, myths and misconceptions that

underlie stigma and discrimination. Moreover, because it reduces the pressure on health services the provision of universal ART, despite its high costs, can result in major national savings. WHO data from Brazil indicate that the costs associated with providing universal access to ART from 1996 to 2002 amounted to US \$1.8 billion, but the savings in hospital and ambulatory care services reached \$2.2 billion.³⁸

There is every justification, therefore, on moral, social and economic grounds, to work determinedly for universal, free access to ART. This is a Christian and human responsibility. At the same time, however, it has to be recognised that ART provision bristles with still unanswered justice, equity, ethical and practical questions. Two of these are examined here: sustainability of provision and costs, and equity in access.

ART: Sustainability of Provision and Costs

ART does not cure HIV. Infected persons who begin on a course of ARVs must continue to take the correct medicines for the rest of their lives. But because of the way the virus reproduces itself in the body (and sometimes because the individual does not adhere faithfully to the prescribed treatment), the virus can become resistant to the first set of drugs that are prescribed (first-line treatment). The possibility of this is one of the reasons why a person on ART must receive regular check-ups from a skilled and knowledgeable physician. If resistance develops, the doctor should prescribe another combination of drugs (second-line treatment). Experience in South Africa has shown that seventeen percent of patients who have been on treatment for four years need to move to second-line treatment.³⁹

Several sustainability and costs issues arise. First, what assurance is there that treatment will remain available for the lifetime of a patient? Second, will second-line treatment (and subsequently even further combinations of newer drugs) be available when needed? Third, how much is universal access to ART likely to cost, and is the world community prepared to meet this cost over a period that could run into decades?

The international support that makes ART access possible is generally phrased in terms of short time-periods. But when considering AIDS treatment the short-term perspective is too limited. The majority of those on treatment are young or middle-aged adults who would hope that ART would help them to live for several more years. But there are no open-ended financial commitments to providing ART for a decade, and maybe even several decades, into the future. Because of this, the lives of those who have commenced treatment remain at the whim of political and financial decision-makers, most of them geographically remote, few of whom have yet even begun to consider this question. This does not seem to be ethically correct. Justice requires that a world awash with resources makes the firm, irrevocable, long-term financial commitments—and honours those commitments—that will ensure the availability of life-preserving ARVs for as long as they are needed, even if this need extends for several decades.⁴⁰

On the availability and affordability of second-line treatment, Mediciens sans Frontieres (MSF) projects in South Africa are already experiencing problems that may become more frequent elsewhere in Africa and the developing world. At the Abuja ICASA (December 2005), the organization reported that urgently needed newer AIDS drugs and formulations of existing drugs are not available because brand name companies are choosing not to sell them and there are no generic versions. MSF also reported that while they paid US \$194 per patient per year for standard first-line therapy, second-line treatment costs \$1,661 per patient per year. A similar situation has been reported from Thailand, where the price of first-line drugs is \$24 per month, but for second-line treatment this rises to \$239 per month.⁴¹

In December 2005, the WTO made amendments to the TRIPS agreement, but the consensus of practitioners is that the amendments are based on mechanisms that have not worked in the past, that they will make it very cumbersome for countries to be able to import generic drugs (and that will allow them to do so only on a country-by-country and drug-by-drug basis), and that newer medicines will continue to be priced beyond the reach of the poor.⁴² In 1990, Pope John Paul II stated that “indifference on the part of public authorities, condemnatory or discriminatory practices toward those affected by the virus, or self-interested rivalries in the search for a medical answer, should be considered forms of collaboration with this terrible evil which has come upon humanity”.⁴³ It is legitimate to ask whether international trade regulations that obstruct the ready availability of affordable life-preserving drugs to people who are in need of them may not also be a form of collaboration with the evil of HIV and AIDS.

It is remarkable that little consideration has been given to the potential costs of making access to ART available to every person whose HIV condition progresses to the stage where ART is needed. Currently about 40 million persons are infected with HIV. If each of these were on treatment by 2010, drug costs alone would be of the order of US \$8 billion per year at the present prices for first-line treatment (and \$64 billion at the prices for second-line treatment). To this must be added the costs of health care staff, laboratory services, and the costs of treatment for opportunistic infections. These can amount to three to four times the price of the drugs. Thus at the most conservative prices, in the not too distant future treatment alone may cost upwards of \$25 billion a year. Clearly, this would be an enormous increase on what has been spent in recent years on all aspects of the epidemic—\$4.7 billion in 2003 and \$6.1 billion in 2004. UNAIDS estimates that \$15 billion will be needed in 2006, \$18 billion in 2007 and \$22 billion in 2008 for prevention, treatment and care of AIDS worldwide.⁴⁴ With treatment accounting for only about one fifth of this entire amount, the projections fall very far short of what the cost of universal treatment seems likely to be.

While all of these figures seem to be gigantic, they are ‘reasonable’ in the context of other global expenditures. In 2004, military spending worldwide was \$1,035 billion.⁴⁵ In 2003, the United States spent approximately \$400 billion on new vehicles.⁴⁶ Does the world have the moral fibre to commit to the preservation of life about five percent of what it dedicates each year to the

military industry and the potential destruction of lives? Would it be feasible for the United Nations to propose a tax of this size on military spending, so that there will be enough resources to get every person onto ART and to keep them on treatment for the rest of their lives? Or is it still the bottom line that the people who are dying from AIDS don't matter in this world?

Equity in Access to ARVs

Although AIDS treatment, care and support may be available in principle, access is not always possible for some groups and may be denied to others. In many societies, cultural attitudes may give priority to the health needs of men over those of women (see Box 2 above). User fees are also likely to be more of an access block for women than for men. “ The experience in several African countries shows that when treatment is free, more women and children access it. When there is co-payment, however small, men are the majority of patients. On average, in free ART programmes, 60 percent of the patients are women, 10 percent are children, and 30 percent men. When co-payment is involved, 60 percent are men and 40 percent women”.⁴⁷ When Zambia abolished all user fees in 2005, the uptake of ART on the part of women greatly increased.

WHO figures “indicate that women and men are about equally represented in treatment populations in most countries”, though in Namibia more women are benefiting.⁴⁸ In sub-Saharan Africa, nearly 6 out of 10 adults on treatment are women.⁴⁹ This represents quite an equitable distribution in a region where 57 percent of the adults who are living with HIV are women. It should be noted, however, that WHO does not have gender-disaggregated data for all countries. Moreover, in some of the countries for which such data is available, the proportion of women on treatment is lower than the proportion of women who are HIV infected. This was the case in 2004 in Kenya, Uganda, Zambia and India, but it is not known whether this gender gap has closed or widened since then. In Zambia, 57 percent of adults who are HIV positive are women, while women constitute about 53 percent of those on ART.

Ensuring access for those in remote areas continues to pose problems. Because urban locations tend to be better resourced in terms of medical and technical staff and infrastructure, treatment programmes have tended to be concentrated in these areas, leaving those in rural areas at considerable disadvantage (Box 3). A major equity issue in the expansion of ART is to ensure a speedy response to the needs of rural populations. If it is to be adequate, a response designed for rural people should either cover what the individual has to pay in order to travel to a distant health centre or should support home-based care and community groups who would get the necessary medicines to individuals (and—possibly—be active in ensuring the various aspects of patient compliance). Something similar needs to be put in place for the poor. ART and the related services may be free, but paying for transport so that they can access them may be something that the poor could not afford on a regular basis.

Box 3: ARV rollout not reaching Provinces

In the remote district of Zambezi, near the Zambian border with Angola, getting hold of anti-AIDS drugs is a major struggle for those living with the virus. HIV-positive Zambians in need of treatment have to travel more than 500 km on potholed roads once a month to receive the life-prolonging medication at a health facility in Solwezi. The provincial capital is the only centre providing antiretrovirals (ARVs) in this impoverished region.

Melody Sachikoka discovered she was HIV-positive about three years ago, but does not have the 300,000 Kwacha (US \$65) it costs for a round-trip to Solwezi for a CD4 count test (which measures the strength of the immune system) - a requirement before treatment can begin. Getting to the provincial capital is not only expensive, but also extremely uncomfortable; public transport is erratic, and the greater part of the journey is made on rutted dirt roads in vehicles that have seen better days.

"Most of our members can't even raise K50,000 (US \$11) per month ... they have been dying before receiving treatment," said Alex Kalukangu, secretary of the Zambezi branch of the Network of Zambian People Living with HIV/AIDS (NZP+). According to Kalukangu, statements by government officials in the media congratulating themselves on the widespread availability of treatment in Zambia were giving people in inaccessible areas "false hope". "It is saddening to hear ministers or anti-AIDS activists saying we have so many ARVs, but people here are dying ... they should not just be speaking in Lusaka to please donors - we need ARVs here," he stressed.⁵⁰

Justice and equity also demand that ART should be available to marginalized groups such as commercial sex-workers, prisoners, refugees and migrant groups. It is particularly important that members of these groups should be able to continue with treatment that was started in another location. The need for this caution arises especially with prisoners, whether on being committed to prison (to ensure that when in prison they can continue with treatment commenced beforehand) or on release (to ensure that they can continue with treatment to which they had access when in prison).

Children and Access to ART: A final major ART equity concern relates to what amounts to the exclusion in practice of children from treatment. An estimated 2.3 million children under the age of fifteen are living with HIV; the majority of these are in developing countries. Most of these are very young children who are HIV positive because of parent-to-child transmission.⁵¹ Because of the immaturity of a child's immune system, HIV progresses to AIDS more rapidly in children than in adults. This leads to a very large proportion of the children

living with HIV/AIDS being in need of treatment—estimates from WHO are that 660,000 children needed access to ART in 2005.⁵² But there is very little prospect that they will receive the necessary treatment. The result is that about half of the children who are HIV positive from birth die before their second birthday.

The foremost reason for this unjust neglect of children is the absence of affordable child-friendly versions of the ARV drugs. Infant medication is given in either syrup or tablet form. The syrup is bitter and foul-tasting, with the result that often the infant spits it out; in addition it is expensive and generally needs refrigeration, so that on both counts it exceeds the resources available to the majority of caregivers in resource-poor settings. Tablets suitable for infants and small children either have not been developed or are enormously expensive. Because of this, health workers in poorer communities must take tablets or capsules meant for adults, crush them, and judge what might be the right dosage for a particular child's height and weight; this may lead either to overdosing, with adverse side-effects, or to under-dosing, which can gradually build up resistance to the drug. Regardless of the outcome, this is little more than a hit-or-miss procedure that, understandably, health workers and caregivers are reluctant to adopt.

Because nine out of ten children born with HIV live in Africa, the pharmaceutical companies do not see that much profit would come from researching and developing HIV/AIDS tests and medicines for children. As a result, millions of children become ill and die. Seven years of adult illnesses and deaths passed before there were major moves to extend ART to those who needed it in the developing countries. Further major moves are now needed to extend this therapy to children and to put an end to needless child deaths—and to the sound of sobbing and loud lamenting as parents weep for their children because they are no more (cf. Jeremiah, 31: 15).

Chapter 3

Justice and the Forces Driving the AIDS Epidemic

Poverty: HIV/AIDS and Poor Countries

HIV and AIDS is not a disease of poor countries. Although the United States is very wealthy, it is the country where HIV and AIDS were first detected, and even today is home to more than a million infected persons. Botswana, one of the wealthiest countries in Africa, has the second highest HIV prevalence rate in the world. There are more people living with HIV and AIDS in South Africa, which accounts for about 39 percent of the gross domestic product of sub-Saharan Africa, than in any other country in the world. On the other hand, though Comoros is one of the poorest countries in the world, it also has one of the world's lowest HIV infection rates. Clearly, there is no simple equation between HIV/AIDS and a country's national wealth or poverty status.

It has, however, been hypothesised⁵³ that the extent of HIV in a country bears some relationship to the interaction between a country's level of wealth, with particular attention to the way in which this is distributed, and the operation of those features of social organisation (trust, norms, networks; sense of social confidence; efficient economic management, regulation and legal frameworks; the ability to act collectively) that enable a society to function. According to this paradigm, an extensive AIDS epidemic is more likely to occur in countries that are deficient in the operation of these social features, especially if there is much inequality in the distribution of national wealth. One reason is that the lack of social cohesion and the inequalities in the distribution of wealth contribute to rapid changes in lifestyles and patterns of sexual mixing that in turn lead to risky sexual behaviour. A similar viewpoint guided the team that developed scenarios for AIDS in Africa up to 2025: "Societies will find prevention and care more difficult where: unity is eroding; there are high levels of inequality; or factionalism or ethnic and religious tensions predominate and lead to violence."⁵⁴

It has to be noted that "growth alone is not a panacea (for HIV and AIDS). Economic and social development with social justice is also necessary. This means addressing issues of equality, human rights and the construction of 'civil society'."⁵⁵ There is need for further investigations in this area, but enough is known to be able to say with some assurance that where wealth is concentrated in the hands of a few, the majority are so indigent that they cannot satisfy their basic needs, and society is fragmented and in a state of some disarray, the scene is ripe for HIV and AIDS to make significant inroads. This is the situation in many parts of the world and the experience of the past quarter century has shown the vulnerability of an unequal world society to the onslaught of the epidemic. It is also the situation within many of the severely affected countries.

The implication of this is that social and economic measures that will bring about a more just distribution in the wealth of the world and within individual countries are by that very fact measures against HIV and AIDS. Likewise, measures that strengthen civil society, foster stable, predictable and

transparent governance, and promote a sense of social confidence throughout society, are also measures against the epidemic. The point was well brought out in the 2005 Scenarios Report:

(T)he shape and extent of the AIDS epidemic is determined by a range of powerful forces outside of the areas in which HIV and AIDS programmes normally respond. Addressing HIV and AIDS may act as a catalyst for addressing these broader socio-economic and political dynamics. Equally, addressing HIV and AIDS effectively requires a consideration of these deeper forces.⁵⁶

There is need for more appreciation of this as well as for the action that such appreciation might prompt.

Poverty: HIV/AIDS and Poor People

If it cannot be said that HIV/AIDS is a disease of poor countries, neither can it be said that it is a disease of poor people. The first two decades of the epidemic saw many wealthy people succumbing to AIDS-related sicknesses and death. Even today, HIV and AIDS occur quite extensively among those who are better off, but for many of these the effects are camouflaged by the ability, arising from their wealth status, to access medical care for opportunistic infections and life-preserving antiretroviral drugs (Box 4).

Box 4: To live depends on being able to pay for life

I am an African. I am living with AIDS. I therefore count as one among the forbidding statistics of AIDS in Africa. I form part of nearly five million South Africans who have the virus. I speak also of the dread effects of AIDS with direct experience. ... My presence here embodies the injustices of AIDS in Africa because, on a continent in which 290 million Africans survive on less than one U.S. dollar a day, I can afford monthly medication costs of about U.S.\$400 per month. Amid the poverty of Africa, I stand before you because I am able to purchase health and vigour. I am here because I can afford to pay for life itself.⁵⁷

Nevertheless, there is a well-established connection between HIV/AIDS and poverty. This has long been acknowledged, but for the greater part only in general terms, without serious efforts to unpack the notion of poverty so as to clarify why there should be such a connection. For this reason it will be helpful to examine the relationship between HIV/AIDS and poverty along a number of different dimensions:

- The poor are at higher risk of HIV infection.
- On health and socio-economic grounds, the poor are more susceptible to HIV infection.
- Poverty increases the vulnerability of the poor to HIV infection.
- HIV and AIDS make the poor poorer.

In a society with a generalised AIDS epidemic, their circumstances put the poor at higher risk of HIV infection than the non-poor. Since time is their greatest economic asset, those who are poor may not be able to afford either the cash or opportunity costs of medical treatment. Hence they may carry untreated sexually transmitted infections (STIs) and other conditions that increase the likelihood of HIV infection. Their limited access to health care is frequently aggravated by the non-availability of health services where they live or the non-availability of the necessary drugs within those services. Because of their poverty, and as a survival strategy, poor women and children may have to trade sex for income, with all the attendant risks of becoming infected with HIV. In a situation where only a small minority have gone for HIV testing, those living in poverty seldom know their own HIV status or that of their sexual partners. Even in a highly subsidised social marketing situation, the poor are less likely to be able to afford condoms, and because of their living conditions they are also less likely to be able to store them properly, use them consistently, or apply them correctly. One other factor that puts the poor, especially poor women and girls, at higher risk of HIV infection is the provision of care to AIDS patients in the home, without the protection of the gloves or disinfectants that they cannot afford to buy.

The poor are more susceptible to HIV infection on health grounds. They are all too familiar with malnutrition, micronutrient deficiencies, malaria, TB, and infestation by bilharzia and other worms. Each one of these conditions depresses the immune system in such a way that in the event of a contact an individual becomes more easily HIV infected (and equally, an infected individual who experiences any one of these conditions is a more potent transmitter of HIV).⁵⁸ Improving the general health and nutrition status of the poor, reducing the incidence of malaria (for instance, by spraying areas that are breeding sites for malarial mosquitoes or through the use of treated bed-nets), and reducing worm infestation (through public health schemes operated through schools, communities and even churches) would be salient moves in reducing the susceptibility of the poor to HIV infection (and decreasing the potency of already infected individuals to transmit the disease).

On social grounds, the poor, and especially poor women, frequently have a lower educational status, and thus have had limited access to what is acknowledged to be a social vaccine against the disease.⁵⁹ As a result, they tend to have less knowledge about the disease, how to protect themselves, the advantages of testing, and the medical services that are available. Socially also, the poor are often forced to leave their own areas and their own country in search of work. This increases the infection risks not only of those who move but also, on the return of spouses and partners, of those who remain behind. The overcrowded unsanitary conditions in which so many of the poor live also contribute to their vulnerability. Overcrowding can facilitate sexual interaction and activity, while lack of access to water can result in poor personal hygiene, a factor that increases the possibility of ulcerative STIs and thereby the risk of HIV infection.

Box 5: What is true of youth is equally true of the poor

Regarding youth life styles, nearly 70 percent of youth (16–20 years old) are out of school, 70–75 percent are unemployed, 80 percent live in high density compounds and are poor, and there is virtually no “healthy” recreation or entertainment available. Youth live for the moment. They experiment, explore, and seek immediate gratification. They want to make money now, and for girls sex is a means for making money. Boys want girls to flock around them, to look appealing to girls, and they want sex..... Regarding the aspirations of youth in Zambia, many say they have nothing to look forward to and no hope for the future. Education is no guarantee of a good job, money, or a secure future. Youth in Zambia do not feel at risk for HIV infection. Unplanned pregnancies are much more worrisome to girls than STDs or HIV, claiming that they could not live with the embarrassment of becoming pregnant, but if they had an STD or HIV no one would know. By and large, youth view STDs as treatable, but, without a positive attitude towards the future, they don't worry about the lack of treatability of HIV.⁶⁰

What it means to be poor also increases vulnerability. Poor people have few choices regarding their place and type of work, where they will live, their neighbours, what they will spend their money on, what they will eat, how they will dress, and how they will recreate themselves. Under pressure to meet immediate needs, they live for the present. They do not see that they have any future to protect and hence fail to appreciate the need to protect themselves against the possibility of HIV infection. To many, the prospect of AIDS sickness in eight or ten years' time is something very remote and unreal. What a Zambian delegate said about youth, at the Durban AIDS Conference in June 2000, could equally be said about the poor (Box 5).

Impacts on the Poor

Because of HIV and AIDS the poor become poorer. This is due to the way the epidemic causes costs to rise, reduces incomes and resources, and necessitates the diversion of resources. The costs of goods and services increase as industry raises prices to offset the ways in which HIV and AIDS affect its operations (such as through reduced productivity, increased medical costs, high funeral expenses, higher insurance costs, and the cost of in-house HIV and AIDS education programmes). Incomes and resources decline as jobs are lost through sickness or death; farm production is reduced; loans cannot be repaid; households headed by the elderly or children produce less; and the volume of sales declines because customers do not have resources to spare for anything but the most essential purchases. In addition, in order to survive many households may have to dispose of capital assets, among them productive assets such as animals, machinery or equipment, thereby imperilling their future productivity.

The epidemic is also bringing about a massive diversion of resources—money, time, human engagement, institutions and systems. At the international level there are the billions of dollars being spent each year on care and treatment, on prevention efforts, and on research. This is in addition to the vast AIDS industry of policy formulation, administration, management, monitoring and evaluation, conferences and travel that the disease has occasioned. In an AIDS-free world these resources might somehow have been used for other more productive undertakings. The situation is mirrored at national levels where responding to the epidemic imposes increasing demands on medical, human, agency and NGO resources. The increased occupancy of hospital beds by those with AIDS results in declining possibilities for the poor to gain access to necessary hospital care. Household and personal resources are likewise being diverted to the disease in the form of payments for medicines, tests, palliative care, cleaning, transport, funerals, mourning. Catering for additional household members in response to the orphans challenge requires that in many households limited resources must be spread more thinly over larger numbers. Where there is AIDS in the household, labour resources must go to AIDS care and away from productive work.

The cumulative effect of these various situations is that the poor become poorer. Poverty deepens and becomes more extensive. The state of the “wretched of the earth” becomes even more wretched and their susceptibility to HIV infection becomes even more accentuated. Perhaps the oppressive face of HIV and AIDS is seen most clearly in the way it thrives off poverty and reinforces poverty. For AIDS-stricken countries and AIDS-stricken households, “make poverty history” is more than a slogan. It is a cry from the hearts of oppressed people to be freed from the domination of the unjust and exploitative situations that bind them into poverty and tether them to HIV and AIDS. And as they cry, they wait to hear the re-assuring word: “I have seen the miserable state of my people. ... I have heard their appeal to be free of their slave-drivers. ...I mean to deliver them” (Exodus, 3: 7-9).

Women, Gender Disparities and the AIDS Epidemic

The Situation

The impact of the AIDS epidemic on women and girls is acute. Out of 23 million infected adults in sub-Saharan Africa, 57 percent are women. Women are becoming infected with HIV at an earlier age than men, and in consequence experience AIDS-related illness and possible death at younger ages than men. In several southern African countries, more than three-quarters of all young people living with HIV are women, while in sub-Saharan Africa overall, young women between 15 and 24 years old are at least three times more likely to be HIV-infected than young men.⁶¹ While consensual sex is certainly part of this picture, sexual violence and other forms of injustice against women contribute directly to this disparity in infection and subsequent mortality.

In addition to the coercion—physical, psychological or economic—that figures importantly in the sexual experiences of women and girls, several other factors contribute to the increasing feminization of the AIDS epidemic. The extensive and fragile tissues in the sexual areas of the female body, and their greater exposure to large volumes of high risk body fluids, makes women more vulnerable to HIV infection than men. The vulnerability of a teenage girl is further aggravated by the ease with which her immature genital tract can be lacerated and become infected.

But apart from these biological factors, the risk of HIV infection for women and girls is compounded by a wide array of social, cultural, economic and legal factors, all of which are embedded in extensive theoretical and practical gender inequalities. The gendered aspects of almost every one of these factors implies denial in practice of the first article of the Universal Declaration of Human Rights, “all human beings are born free and equal in dignity and rights”. They express the subordination of women in their relationships with men. They degrade women. Instead of making women’s essential equality with men a lived reality, they deny this by proclaiming that in the practical situations of life women are inferior to men. And as they do so, they heighten women’s risk of becoming infected with HIV.

At the sexual level, unequal power-relations give women a subordinate position and make them submissive to men. For the greater part, women are weakly placed to determine the circumstances of their sexual lives, to control when, with whom, and under what conditions they have sex. Double standards for sexual behaviour prevail for women and men throughout society, both traditional and modern. Men are expected to be knowledgeable and experienced in sexual matters, whereas women are expected to be somewhat naïve—if they show knowledge or interest in sexual areas they may be regarded as immoral or promiscuous.

Several established practices in society also have this twofold outcome of demeaning women and enhancing their risk of HIV infection. These include various forms of sexual violence in the home, community and workplace; indulgence towards men who take sexual liberties; and the practice of older married men of having a “girlfriend” on the side. Further, some customary practices, such as early marriage, widow inheritance (see Box 7 below), ritual cleansing, and dry sex, have the same double effect of treating women as chattels and making them more vulnerable to HIV infection.

The message that women are there to be at the service of men, in sexual and other ways, is transmitted from an early age through child-rearing practices that form girls to be non-assertive and to accept subordinate status in relation to men (Box 6). The insistence at times of initiation and pre-marital “kitchen parties” that the prime responsibility of a woman is to please her husband at all costs reinforces the message of her inferior status. Effectively this leaves many women psychologically powerless to take steps to protect themselves against possible HIV infection from their husbands.

Box 6: Is it acceptable to be beaten by one's husband?

About 80% of Zambian wives find it acceptable to be beaten by their husbands "as a form of chastisement", according to the latest Zambia Demographic Health Survey.

Out of 5,029 women interviewed countrywide, 79% said they should be beaten if they went out without their husband's permission. Sixty-one percent said a beating was acceptable if they denied their husbands sex, while 45% said a beating was in order if they cooked 'bad' food.

Compounding the abuse was the culture of silence around domestic violence. "This is an aberration—and women are making an abnormality normal," said National Aids Council director, Dr Alex Simwanza, when he recently met traditional leaders to urge their support in fighting gender-based violence.

"Zambian wives are living in a sorry state. As far as they are concerned they can be beaten for almost anything. This is a frightening phenomenon," he noted.

Simwanza said most of the women who took part in the survey did not believe they had sexual or reproductive rights. Quoting the survey, he said 88% of women felt their husbands could have sex with them just after giving birth, while 67% said they would have sex even though they did not want it.

Simwanza blamed the submissive attitude uncovered in the poll on what is taught to girls during puberty rites.⁶²

In African society, as in many other parts of the world, married women often face violence and abuse if they demand condom use or refuse sex from their husbands or long-term partners. While many women are vulnerable to HIV because they are single or without a partner, the disturbing fact is that even more of them are vulnerable to infection because they are married and remain faithful to a partner who does not reciprocate this trust. Thus, among sexually active girls aged 15–19 years in Kisumu (Kenya) and Ndola, HIV-infection levels have been found to be 10 percent higher for married girls than for their sexually active unmarried age-mates.⁶³ The adverse situation for women is aggravated by the fact that, with few exceptions across Africa, marital rape is not recognized as a crime, and domestic violence is seen as a right of married men.⁶⁴

Economic factors further accentuate women's vulnerability to HIV infection. They have limited access to capital or credit. Some societies do not allow women to own land. Because they receive inadequate financial support from their spouses, many women must apply their own ingenuity and resources to

maintaining their household. All too frequently the sale of sex becomes the only way to meet household survival needs. Although the law may offer them nominal protection, many widows experience considerable violations of their property and inheritance rights (Box 7). Relatives may “grab” the property of their late husband, evict them from their homes, strip them of their possessions, or force them to engage in risky sexual practices if they are to keep their property. Human Rights Watch has aptly summarised the situation that exists in many countries: “A woman’s access to property usually hinges on her relationship to a man. When the relationship ends, the woman stands a good chance of losing her home, land, livestock, household goods, money, vehicles, and other property. These violations have the intent and effect of perpetuating women’s dependence on men and undercutting their social and economic status.”⁶⁵

Box 7: I was thrown out of my home when my husband died because I had only given birth to girls

When my husband died, his relatives came and took everything. They told me to take my clothes in a paper bag and leave. I left, because if I had resisted they would have beaten me. The relatives identified someone to inherit me. It was a cousin of my husband. They told me, ‘Now you are of less value, so we’ll give you to anyone available to inherit you.’ I didn’t say anything. I just left and went to my parents’ home. . . . This is customary. If I had married the cousin, I could have lived where I was. I decided not to because he was polygamous, he had five other wives. . . . I know if a woman is inherited, she is normally mistreated by the one who inherits her. If I had sons instead of daughters, they would have apportioned land to me. . . . When they told me to leave, they said there was no way they could recognize my daughters since they’ll marry and leave the homestead. They said I shouldn’t have given birth at all. . . . My in-laws took everything: mattresses, blankets, utensils. They chased me away like a dog. I was voiceless.⁶⁶

As well as failing to protect the property and inheritance rights of women and children, justice systems may also be weak in responding to cases of sexual abuse. Regrettably, the attitude of the legal and law enforcement agencies in cases of alleged rape frequently reflects the way of thinking of a male-dominated society. “The courts often do not take (the) case seriously and, in the case of an older girl with a complaint of sexual abuse, the case may hinge on whether or not the judge believes she ‘asked for it’.”⁶⁷ The poor protection offered by the courts increases the reluctance of families to seek justice for crimes of sexual abuse against women and children. The light sentences that courts frequently hand down also proclaim the very degrading message that these are not regarded as serious offences and that officially the state takes them quite lightly.

Compounding all these restrictions and limitations is the heavy HIV and AIDS burden that women must bear. The burden of care that they already carry is greatly increased by additional responsibilities in caring for sick family members and for orphans from their own or their husbands' extended families. Even if personally HIV infected, or ailing from some other illness, women must continue to manage a household, provide care, produce food and generate income. Access to ARVs is problematic for many women who feel disempowered by a culture that gives priority to the health needs of men (see Box 3 above). "On top of this, women are often daunted by the bureaucracy surrounding (the delivery of antiretroviral therapy). There are official documents to sign and many women cannot read or write, so they feel intimidated."⁶⁸

Stephen Lewis and James Morris (of the World Food Programme) have powerfully summed up these various impacts of HIV and AIDS on women:

The HIV/AIDS pandemic is compounding the premature death of thousands of productive people—particularly women—across (southern Africa), and is wrecking the livelihoods of millions more while sowing the seeds of future famines. ...The incredible assault of HIV/AIDS on women in particular has no parallel in human history. Women are the pillars of the family and community—the mothers, the care-givers, the farmers. The pandemic is preying on them relentlessly, threatening them in a way that the world has never yet witnessed.⁶⁹

The Way Forward

For the greater part, this stalking of women by HIV and AIDS arises from society's unjust allocation to them of an inferior status. Were it not for the unjust treatment and exploitation that women experience, the epidemic would not have its current worldwide grip. It would not have its current stranglehold on southern Africa. Fewer men would be infected. Far fewer women would be infected, and because this would reduce the incidence of parent-to-child transmission, fewer children would be infected.

Response to the AIDS epidemic, in terms of prevention, treatment, and impact mitigation, will only succeed when robust, sustained and specific action is taken to reduce and ultimately eliminate the prejudice, discrimination and unjust treatment that women experience. Without a frontal attack on the injustice of gender inequality, the dominance of the epidemic will continue. The most recent policy document from UNAIDS on HIV prevention has recognized how crucial this is as an overarching principle: "All HIV prevention efforts/programmes must have as their fundamental basis the promotion, protection and respect of human rights including gender equality."⁷⁰ The document further identifies seven action areas to address women's vulnerability to HIV and affirms that action in each of these areas and towards the broader goal of gender equality is necessary to turn back the increasing feminization of the epidemic globally:

1. Preventing HIV infection among young women and girls, focusing on improved reproductive health care;
2. Reducing violence against women;
3. Protecting the property and inheritance rights of women and girls;
4. Ensuring equal access by women and girls to care and treatment;
5. Supporting improved community-based care with a special focus on women and girls;
6. Promoting access to existing prevention options including the female condom, and research into new prevention technologies such as microbicides;
7. Supporting ongoing efforts towards universal education for girls.⁷¹

The UNAIDS document acknowledges the need to move towards the broader goal of gender equality. This is necessary in the light of what HIV and AIDS can do to women. But even more fundamentally it is necessary in its own right. AIDS or no AIDS, women and men are essentially equal. Making that equality a lived reality is a major challenge for every individual, community, institution and country. The AIDS epidemic has highlighted the tragedies that gender inequality can bring in its wake. But it also points to the need for wholesale transformation of the social, economic, legal and political structures of society that will see an end to practices and attitudes that offend against the dignity of women and men alike. Here, as in the sphere of poverty, the epidemic acts as a catalyst, calling on people and institutions across the world to create a more just society, characterised in practice as well as in theory by respect for the basic principle that “all human beings are born free and equal in dignity and rights”.

Stigma and Discrimination

Stigma and discrimination are powerful forces that have the double effect of demeaning individuals infected or affected by HIV and AIDS, and making it more difficult to deal effectively with the disease.

Stigma is a process that goes on inside us,⁷² through which we attach a negative social label of disgrace, shame, prejudice or rejection to a person because that person is different from us in some way that makes us uncomfortable or that we regard as undesirable or disturbing. It involves separating “us” from “them” and suggests that somehow “they” are of lesser status or are less worthy of respect. Stigmatisation of a person living with HIV or AIDS means that they are discredited, branded as unworthy, reduced in value, or assume lesser worth in our eyes, and often also in their own eyes. What is not always recognised is that the irrational act of stigmatising also makes the stigmatiser lose value and become less worthy and less human—the stigmatiser responds to those living with HIV or AIDS as if they were of lesser value, and in doing so becomes of lesser value as a human being.

Discrimination occurs when a person is treated differently because of belonging to, or being perceived to belong to, a different group. The difference can be based on age (e.g., children), race, religion, nationality, gender, socio-

economic status, occupation, politics, health status, educational level, size, clothing or any other defining characteristic. If the different treatment is in the person's best interests and is in accordance with accepted international law and human rights requirements, the discrimination is positive. If the different treatment that the person receives is unfair or unjust in comparison to the treatment that others receive, the discrimination is negative. In the context of HIV and AIDS the concern is with negative discrimination. At some point, this always involves some external manifestation of stigma and a violation of human rights.

HIV and AIDS discrimination manifests itself in many settings, some of which are instanced here:

- *In the home:* sharing of bedrooms, bathrooms, bed clothing, eating utensils, cooking responsibilities, etc. may cease. The person may be judged or blamed for bringing HIV or AIDS into the household. The person may be isolated.
- *In the community:* there may be segregation in schools and health settings. The infected person may experience mocking, avoidance, cutting looks, gossip, or offensive curiosity. Without any question of consent, a person's HIV status may be openly revealed and talked about. By imposing a huge increase in rent, a landlord may drive an infected person from rented accommodation. It may be made clear that an infected person is not welcome at social or community gatherings. Parents may not allow their children to play or mingle with children from a household where there is AIDS.
- *In the work situation:* employment may be refused or terminated. An employer may fail to make any reasonable accommodation for the special needs of an infected employee. An infected worker may experience unfriendly or uneasy attitudes on the part of fellow-workers. An infected worker may be denied membership of a medical aid scheme. Banks may refuse loans. The numbers buying at a market stall may fall off sharply if it becomes known that the owner is HIV-infected.
- *In health-care setting:* medicines may be denied because "they would be wasted on a person who will not get better". A person may be tested for HIV without giving informed consent or may be informed of their HIV status without being counselled. Health care personnel may adopt censorious judgemental attitudes to an infected individual.
- *In education settings:* students from families where there is AIDS may be victimised at school. Fellow-students may mock an orphaned colleague because a parent died of "that" disease. Children with AIDS may be denied access to school (as occurred with children from the Nyumbani Orphanage in Nairobi, until Kenya's High Court made a ruling in January 2004 that schools could not deny access to children on the grounds of their HIV or AIDS status). Entry to another country for higher studies may be denied on the basis of HIV status.

It is clear that every one of these situations represents a denial in practice of human rights. Each one of these discriminatory acts is unjust. Perversely, the

injustice that is brought about in these ways by HIV and AIDS also contributes to the continuation and proliferation of the disease. This is because stigma and discrimination create a culture of silence and denial where it is difficult to take the action necessary to fight HIV effectively. They create a climate that discourages individuals from coming forward for testing, and from seeking information on how to protect themselves and others. People living with HIV may choose not to access health care, prevention and education services for fear of being stigmatised by health care and service providers or by community members who learn almost inevitably about the person's condition. In these and other ways, stigma and discrimination pose a major threat to the success of HIV prevention and care. The United Nations has acknowledged this in a recent report: "HIV stigma and the resulting actual or feared discrimination have proven to be perhaps the most difficult obstacles to effective HIV prevention. Stigma and discrimination simultaneously reduce the effectiveness of efforts to control the global epidemic and create an ideal climate for its further growth."⁷³

The injustices that stigma and discrimination represent for people living with HIV or AIDS bring untold personal unhappiness into their lives. Very many of those who become infected with HIV can actually come to terms with their infection. The possibility of treatment, positive living, and alternative therapies reassure them that they can live with HIV or AIDS. But almost every one of

Box 8: What medicine can you give us to combat stigma?

At a conference on stigma and discrimination, held near Pretoria in October 2005, a young Namibian woman, Victoria Bam⁷⁴, recounted her experiences. She said that she had been very happily married to a husband whom she greatly loved and that they had two beautiful children. One of the children fell sick, was diagnosed as having AIDS, and eventually died when still very young. Victoria and her husband went for an HIV test and both were found to be HIV-positive.

Because of the death of their child, their HIV-status became common knowledge in the community and they experienced much hostility and stigma. This became so intense that Victoria's husband, unable to stand it any longer, took his life. Having lost one of her children and her husband, Victoria (who is now taking life-supporting antiretrovirals) challenged her audience by asking: "With ARVs we can cope with AIDS, but what medicine can you give us to combat stigma and discrimination?"

The world is still waiting for an answer.

them finds it much more difficult to live with stigma and discrimination. These challenge their sense of personal worth, dignity and what it means to be human. African philosophy recognises that “a person is a person through other persons”. By attacking the bonds that link people to one another, stigma and discrimination undermine the very humanity of infected individuals and make it impossible for some to continue living (Box 8). Perhaps nothing highlights so effectively and so tragically as this the injustice of HIV-related stigma.

Global Economic Structures and Practices

As with health and well-being, HIV/AIDS is not just an individual concern; it is a global issue. In many respects, the AIDS epidemic is a product of globalization. Its explosive spread became possible because of growing world interconnectedness through rapid transportation, international trade routes, and large scale population movements. Its global grip was further strengthened by the deepening poverty resulting from the supremacy of the profit motive as the central ethic in the practice of globalization. Because of the way they transcend boundaries and previous public health conceptions, HIV and AIDS are a “problem that is not handled easily by the mechanisms and methods of the nation state”.⁷⁵ As a result, they have claimed extensive international attention, notwithstanding the fact that the main transmission route for infection through the very private but globally necessary activity of sexual intercourse makes it difficult to ensure global surveillance, let alone control. Globally, the epidemic has security, economic, demographic and humanitarian implications that are placing it on a par with concerns about global warming or ozone layer depletion—and with as little global success.

In its best sense, globalization looks to a brave new world achieved through a greater sense of interdependence, commitment to shared universal values, solidarity among peoples, and new awareness that every individual is part of a global community that exists to serve the best interests of all. In line with this perspective, recent years have seen significant positive developments in the global community’s response to HIV and AIDS. These have manifested themselves in:

- more widespread global concern;
- new monitoring and funding mechanisms, forms of collaboration and interest on the part of the United Nations and the international community;
- greater international advocacy;
- increased political leadership;
- substantial increases in global funding;
- extensive international interest in lowering drug prices so that treatment becomes more readily available and accessible;
- considerable research focused on new technologies, such as the development of vaccines and microbicides⁷⁶.

The other side of this coin is that the years during which globalization worked its way down into the lives of communities and individuals have seen an

increase in poverty and inequity. The Fair Globalization Report⁷⁷ notes that during the past 10–15 years:

- The number living in absolute poverty increased in sub-Saharan Africa, Europe, Central Asia, and Latin America and the Caribbean.
- The poor, those without assets, the illiterate and unskilled workers have lost out.
- There has been an increase in income inequality in the great majority of non-industrialised countries.
- The social cost of globalization has fallen disproportionately on women

The extent to which it can be said that globalization is directly responsible for the increased poverty of individuals and countries, for growing income inequalities, and for the fracturing of the relationships and continuities that underpin social cohesion is not clear. But it has to be acknowledged that globalization as practised has resulted in wealth, prosperity, influence and future promise for the few; poverty, exclusion, voicelessness, and stagnant hopelessness for the many. The emergence of such situations has considerably increased the susceptibility of countries, communities and individuals to HIV and AIDS, especially when it is recalled that poverty and inequity, working together, provide a fertile breeding ground for the continuation and spread of the epidemic. In this sense, it has to be acknowledged that global economic structures and practices have facilitated the continued domination of the AIDS epidemic and in some circumstances have made their own direct contribution to this dominance.

Notwithstanding increased worldwide concern about the AIDS epidemic, the broad global approach, especially as embodied in behaviour change policies, seems to be a combination of containment and what might be called “otherisation”: do not let the epidemic extend beyond the world’s current hotspots; confine it to the marginalized groups (commercial sex workers, men who have sex with men, injecting drug users, the poor in developing countries); make it somebody else’s problem, “out there”, elsewhere, belonging to “Them” but not to “Us”. In the process, subtly blame human beings, countries, regions, and even continents, for bringing the disease on themselves. Stereotype them for their liberal sexual or drug-injecting lifestyles, and place the onus for changing behaviour on them (instead of on the systems that take away the freedom needed for any other form of behaviour). Inevitably, of course, this institutionalises stigma and discrimination at the heart of global policy. In practice, it means denying HIV and AIDS as a global disease and ultimately as a global concern.

But, a global society is too porous, too flexible, too changeable, too interconnected for this to work.⁷⁸

In addition to these generalised implications of globalization as practised for increasing poverty and inequality, global structures and practices have contributed to failure to respond appropriately to HIV and AIDS, and even to their entrenchment and spread, in a number of particular areas. Three of these that have specific justice dimensions merit special consideration: the

responsibility of the Bretton Woods institutions, the impacts of WTO trade arrangements, and the movement of people.

The Role of the International Monetary Fund and the World Bank

The International Finance Institutions (IFIs), specifically the World Bank and the International Monetary Fund (IMF), have come in for stringent criticisms in recent years because of the adverse impacts of their structural adjustment policies on health and education systems. Critiques, ranging from sharp disparagement to carefully worded academic evaluations, link these policies to the spread of the AIDS epidemic.

Stephen Lewis, the United Nations Secretary-General's Special Envoy for HIV and AIDS in Africa, says frankly: "The result of the IFIs' destructive power over Africa was to compromise the social sectors, particularly the health and education sectors to this day. ...One of the critical reasons for Africa's inability to respond adequately to the pandemic can be explained by user fees in health care ... and user fees in education".⁷⁹

A more cautious analysis from University College London, concludes: "Certain components of adjustment reforms, such as currency devaluation and trade liberalization, may produce mixed effects on the vulnerability of women and children to HIV/AIDS. Other reforms, such as financial liberalization, removal of food subsidies, and introduction of user fees for healthcare and education have a negative impact on the spread of the epidemic among poor women and children."⁸⁰

International civil society has also expressed its misgivings about the role of the World Bank and the IMF, and has taken the IMF to task for insisting that keeping inflation low is more important than increasing public spending to fight HIV/AIDS:

Despite the fact that the global community stands ready to significantly scale-up levels of foreign aid to help poorer countries finance greater public spending to fight HIV/AIDS, many countries may be deterred from doing so due to either direct or indirect pressure from the IMF. The IMF fears that increased public spending will lead to higher rates of inflation, but there is an open question in the economics profession about how high is too high, and what is an appropriate level of inflation. Despite this being an open question among economists, the IMF has taken an extremist position that lacks adequate justification. Such a position seriously undermines the best efforts of the global community to meaningfully address the HIV/AIDS epidemic and other health issues such as tuberculosis (TB) and malaria.⁸¹

None of the critiques suggest that the IFI structural adjustment policies caused the AIDS epidemic, but they manifest the mounting belief that these policies have contributed significantly to consolidating the epidemic's foothold in African countries. Neither is there any suggestion of malice on the part of the IFIs, though there is much reference to unintended consequences,

unforeseen outcomes, and inadvertent facilitation of conditions that increased the vulnerability of women and children to HIV/AIDS—expressions that are all too familiar to those concerned with the impact of structural adjustment programmes on poverty.

Box 9: The reluctance of the World Bank to make a special case for HIV/AIDS

In 1998, the Bank and the donor community (or cooperating partners) worked with the Zambian Ministry of Education in developing the Basic Education Sub-Sector Investment Programme (BESSIP) for the expansion and improvement of primary education. Before the programme was formally endorsed, the Zambian authorities proposed that, because of the extent of HIV/AIDS, BESSIP should embody a special component that would address the epidemic in the primary school sector (principally teacher shortages, pupil participation, and orphans). The World Bank did not accept the proposal, stating that the issues were adequately addressed elsewhere in BESSIP. Not fully satisfied, the Zambian authorities submitted a document on the matter to UNICEF which, in turn, brought it to higher levels in the Bank. Some months later, in a major change of direction, the Bank proposed that where possible all Bank projects in severely affected countries should be “retrofitted” with HIV/AIDS components—and shortly afterwards HIV/AIDS became a special component of BESSIP.

Although the World Bank pioneered some of the early research work on HIV/AIDS in Africa, it came only slowly to understand the need to mainstream the epidemic into all its activities (Box 9). Even when it had established a high-level multisectoral AIDS Campaign Team for Africa and was guided by a refreshingly new strategic plan, the Bank continued to think that it should respond to AIDS in Africa through loans. It was quite taken aback at the hostility to this proposal shown at the African Development Forum in Addis Ababa in 2000.⁸² It was not until 2002 that, bowing to the pressure, it finally conceded that new funds for fighting AIDS in Africa would come as grants and not as loans or additional debt.

Stephen Lewis has commented on the way “the cerebral aristocrats of the IFIs plough ahead as if financial architecture mattered far more than human vulnerability”.⁸³ He has also warned that

structural adjustment is not dead'; it's just morphed into other forms. The imposition of conditionality is still alive and well, fashioned now more often by the IMF as it continues to impose macroeconomic frameworks on impoverished African countries. ... (T)he IMF simply doesn't understand the combined ravages of HIV/AIDS and poverty;

simply fails to understand that you can't deny hiring health professionals, in the face of an apocalypse, just because you adhere religiously to some rabid economic dialectic which says that no matter how grievous the circumstances, you can't breach the macroeconomic environment. I saw it in Zambia. I saw it in Malawi, and in each case the governments were frantic, but the IMF wouldn't budge.⁸⁴

The reason for introducing so many lengthy quotations is to underline two fundamental justice-related anomalies that beset these two major institutions in today's world. The concern here is with these anomalies in the field of HIV and AIDS. But they also manifest themselves in other fields—poverty, debt reduction, protection of the environment, trade regulations, and others. One is the way economic stability is accorded first priority, far ahead of every social need and human right, including the right to life and to good health. The other is the lack of accountability of the IFIs to the people of the world for their policies and programmes. Is it possible that addressing the AIDS epidemic might help to change these situations? Could the IFIs learn some lessons from the Global Fund to Fight AIDS, TB and Malaria and its requirement to have NGO and grassroots representation on its board? The World Bank and the IMF would in all likelihood serve the people of the world better and more humanely if they could be more accommodating to popular participation, promote democratic involvement, and maintain manifestly transparent structures.

The Regulation of Trade

There are two reasons why global structures of trade are relevant to the AIDS epidemic: first, trade structures have much to do with maintaining a country in or freeing it from poverty; and second, the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement has much to do with the availability and flow of antiretroviral drugs and other technologies for responding to HIV and AIDS.

HIV/AIDS prevention efforts need to be grounded in the broader struggle for social and economic rights for the poor.⁸⁵ The UNAIDS Scenarios project touched on a similar point in its statement that “the nature of Africa's economy—which includes the livelihoods of rural areas, informal trading and manufacturing, modern commodity exports, a small manufacturing base, and dependence on external assistance—has been one of the strongest drivers of the AIDS epidemic”.⁸⁶

But international trade relations currently do not favour poor countries in Africa or elsewhere in the world. Instead they are heavily weighted in favour of the wealthier countries, while simultaneously creating barriers to the market access of goods from poorer countries. This creates a massive imbalance, against the interests of poorer countries (and therefore indirectly on behalf of the maintenance and proliferation of HIV and AIDS). The fact that a one percent increase in trade would benefit Africa more than a fivefold rise in aid and debt relief⁸⁷ demonstrates the potential of fairer trade regulations to help

Africa lift itself out of poverty (and to confront HIV/AIDS more vigorously as it does so).

The World Trade Organization (WTO) launched a round of trade talks in Doha (Qatar) in November 2001, with a view, among other things, to bringing more equity into the world trading arrangements and regulations. A specific issue for consideration was the agricultural subsidies provided by the European Union and the United States to their farmers (a subsidy of US \$2 per day is paid for every cow in the European Union), given that access to international markets is denied to farmers from developing countries that subsidise agriculture and farm produce. The Doha talks, and succeeding efforts to bring them to a conclusion, made little progress. The most recent efforts, in Hong Kong in December 2005, once again registered a virtual stalemate. The Hong Kong round took no meaningful steps to dismantle the subsidy package that enables EU and US farmers to flood the world market with goods at a price that unsubsidised African farmers cannot hope to match. The world scales continue to be loaded against agriculture being a profitable export for African and other poor countries.

The former UN Human Rights Commissioner, Mary Robinson, spoke of an earlier round of trade talks (in Cancun, Mexico) as not being a “transparent and fair process, but rather a process where the stronger more influential countries have an inside track and exert that influence”.⁸⁸ This unfair global process serves to maintain countries in their poverty and by that very fact to maintain the AIDS epidemic that ravages them. Much the same could be said about debt, with many countries spending as much or more on debt servicing than they do on their health services. The limits that the never-ending servicing of debts places on a country’s ability to pull itself out of poverty are also limits on its ability to respond to the AIDS epidemic.

The second AIDS-related aspect of global trade regulations concerns the TRIPS Agreement.⁸⁹ This Agreement endeavours to promote a balance between private incentives for innovation and the public interest of maximising access to new products. The Agreement covers all areas of technological innovation, transfer and dissemination. Its relevance to the AIDS epidemic is that the TRIPS Agreement covers access to the life-preserving antiretroviral drugs that have been developed by a small number of pharmaceutical giants in Europe and the United States. The Agreement also covers access to other important epidemic-related technologies, such as tests for the diagnosis of HIV in very young infants.

At the Doha meeting in November 2001, the WTO acknowledged the public health problems coming from HIV/AIDS and other epidemics and encouraged member states to make full use of the flexibilities built into the TRIPS Agreement. One of these is known as compulsory licensing where, in cases of declared emergency, a country could manufacture a patented drug without the permission of the patent holder, in return for an agreed royalty (Box 10). Subsequent rounds of trade talks have sought to clarify these flexibilities and how they could be applied, but the question remains whether the TRIPS provisions can be brought speedily and effectively into practice where they

are most urgently needed. While there has been some progress, the consensus of practitioners is that, even with the most recent amendments (those of December 2005), the regulations still do not allow drugs, especially those that are being newly developed, to be made readily available at affordable prices.⁹⁰ Little has been done to open the door to provide a legal way for poorer countries to develop, manufacture or import life-preserving drugs.

Box 10: Compulsory Licensing in Zambia⁹¹

In September 2004, the Zambian Ministry of Trade, Commerce and Industry issued a compulsory license, in favour of a local company (Pharco), to manufacture under the name “normavir” a triple compound of the antiretroviral drugs lamivudine, stavudine and nevirapine. The compulsory license, which was issued in the light of the conditions of national emergency and extreme urgency created by the HIV/AIDS pandemic, provided for the payment to the patent owners of royalties not exceeding 2.5 percent of the turnover on normavir each financial year.

The Director of the United States organization, Consumer Project on Technology, has commented that “the two page Zambia license should serve as a model for other developing countries facing an AIDS crisis”.

A TRIPS-related development that has occasioned much concern is the law that India passed in March 2005, prohibiting the domestic production of low-cost, generic versions of patented medicines, including antiretroviral drugs. The purpose of the law was to bring India into line with the TRIPS Agreement on patents and the move was said to be necessary for the promotion of further drug research and development in the country and for attracting foreign investors. It should be noted in passing how India felt obliged to respond to pressures from the pharmaceutical industry, which tends to be the most profitable in the world. Since India is a major provider of high-quality, inexpensive generic AIDS drugs to Africa and the rest of the developing world, the eventual impact of the new law may be very much higher prices that could lead to the choking off of supplies. It will be some years before the new Indian procedures in registering patents will begin to have an effect on prices, but the concerns are that when that time comes the price of Indian-produced drugs may be out of reach for millions living with AIDS in Africa and elsewhere. This development puts the sustainability of many ART programmes at risk. It also puts the lives of those who are on ARVs at the literal mercy of business and pharmaceutical interests elsewhere in the world. In an almost obscene way, these interests seem to assume the role of arbiter of life and death, “offering life or death, blessing or curse. Choose life, then, so that you and your descendants may live” (Deuteronomy, 30: 19)—but people can only choose life if they can afford to pay (see Box 4 above).

The Movement of People

Large-scale population movements contributed to the early explosive spread of HIV and AIDS. They continue to do so. It is estimated that some 150 million individuals are living permanently or for extended periods in a country other than their own.⁹² In addition there are the millions who migrate from rural to urban areas within their own countries, in addition to other internal migrants. Economic reasons are at the root of much migration, both internal and international. Usually, migrants are looking for work or better-paid work (though sometimes they may also be seeking more favourable living circumstances, such as better access for their dependents to health care and education, or greater proximity to family). There is also much involuntary migration. This includes refugees from situations of conflict or civil strife, and displacement due to conflict or natural disasters. In addition, there are the estimated one to two million victims of human trafficking, mostly women and children, who are coerced each year into prostitution or forced labour.

Mobile populations include military personnel (including peace-keeping forces), truckers and other transport workers (in airline, railway and bus companies), mine workers, construction workers (for roads and major infrastructure), agricultural farm and plantation workers (mostly seasonal), informal traders, domestic workers, refugees, and persons displaced within a country because of conflict or an emergency arising from a natural disaster.

Several factors increase the vulnerability of mobile populations to HIV:

- work involving mobility, in particular the obligation to travel regularly and live away from a spouse;
- separation from socio-cultural norms that regulate behaviour in stable communities;
- work in isolated environments where recreational facilities are limited and access to commercial sex workers is easy;
- greater tendency to resort to drugs and alcohol;
- limited access to health facilities, including treatment for sexually transmitted infections (STIs), and HIV/AIDS prevention and care programmes;
- types of accommodation, such as single-sex, overcrowded living quarters or having to sleep in trucks;
- stressful and dangerous working conditions, with high risk of physical injury (such as in a mine or when on military operations);
- protracted border formalities (increasing the possibility of high risk sexual behaviour);
- workplaces dominated by men;
- transactional sex, sexual abuse and sexual violence;
- a sense of anonymity which allows for more sexual freedom;
- xenophobia (frequently experienced by non-national migrant informal traders) and discrimination;
- lack of legal rights and legal protection (experienced particularly by seasonal agricultural workers, informal traders and domestic workers).⁹³

Because their concerns are with the more immediate challenges of physical survival and financial need, most individuals on the move regard HIV as a distant risk. But during their travels or at their destinations, many of them experience conditions that provide an optimal context for HIV transmission—the context where men have money, have few recreational options, are away from families, and are amid low-income communities where women’s limited access to education, employment, credit or income can facilitate resort to commercial or transactional sex.

Numerous equity and justice concerns arise from the HIV vulnerability of mobile populations: the crying need to see an end to all forms of human trafficking; ensuring that all migrants have access to health, testing, care, treatment and support services, and that they are encouraged to make full use of these services; the protection of migrants with HIV or AIDS from discrimination and xenophobia when they are in another country; ensuring that infected migrants can continue to live where their access to ARVs commenced; establishing immigration regulations that do not block entry (or require deportation) on grounds of HIV infection; accelerating the issue of visas and goods documentation at borders, so as to reduce HIV-risk delays; establishing better living and working conditions for seasonal agricultural and fishery workers, domestic workers, and transient mine workers; developing local work opportunities so that there will be less migration on economic grounds.

Brain Drain

The movement of people complicates the response to HIV and AIDS in another salient way. Many severely affected countries, especially the poorer ones, find that their ability to respond to HIV and AIDS is being hampered by the loss of their skilled health and other professionals to wealthy industrialized countries. Thousands of these professionals are working in clinics and hospitals in Britain, the United States and Canada, largely because their home countries are not able either to pay them an adequate salary or to provide satisfactory working conditions. In addition to this loss, responding to the epidemic is further hampered by the considerable movement of health care professionals within countries (from rural to urban areas, from the public sector to private practice, and from primary health care to secondary and tertiary provision) and from poorer to wealthier developing countries (as from Zambia to Botswana).

This “brain drain” of health care workers from Africa is further crippling already fragile health care infrastructures throughout the continent, as they struggle to provide ART to hundreds of thousands of people. Zambia, for instance, has only seven physicians per 100,000 population, compared with the WHO minimum recommended requirement of twenty-two, while Malawi has fewer than three per 100,000. A measure of the impact of the brain drain is that Zambia’s public sector has retained only 50 of the 600 physicians trained in the country between 1978 and 1999. Zimbabwe’s story is equally disturbing: during the 1990s, 1,200 doctors were trained in Zimbabwe, but only 360 of these were still practicing in the country in 2001.⁹⁴ Education ministries report

similar losses with an outflow of teachers to countries or education systems that can offer them better salaries and conditions of service.

An anomaly in this situation is the readiness of countries that support developing countries' training programmes to bleed away many of the best products of these programmes once training has been completed and some experience garnered. But there does not seem to be any clear-cut solution to the whole issue of "brain drain". The era of globalization would hardly countenance restrictions on the free movement of qualified personnel from one country to another. Reimbursing countries for the loss of locally trained professionals has also been mooted, but valuable as such reimbursements might be, they would not compensate for the reduced ability to provide medical, teaching, social and other services, especially where there is much HIV/AIDS. Manifestly, the wealthier countries should respond to their own need for more health and education personnel by training more people domestically rather than by recruiting them from developing countries. Doing so would probably involve extensive shifts in resources to ensure conditions that would attract and retain trainees. Major improvements in salaries and conditions of service for health care workers and other providers of social services in developing countries might help to stem some of the movement to more developed countries, but there does not seem to be any great sense of urgency about the need for such a step.

A further anomaly is that the provision of ART within countries is exacerbating the shortage of personnel for other basic health care services. Externally funded HIV/AIDS programmes usually offer better salaries and conditions than ministries of health. These are attracting doctors, nurses, pharmacists and technical staff away from public-sector positions to work in these foreign-funded programmes. The result is a further weakening of already fragile health care systems.

Some experts believe that what is happening with personnel merely manifests the situation across the entire HIV and AIDS spectrum. They are concerned that attention to the epidemic may be overshadowing or even crowding out attention to other illnesses, such as respiratory infections. The UNAIDS Scenarios report noted the danger of isolationism in which HIV is treated as the object of interventions, in isolation from its social and economic context.⁹⁵ A more productive approach is to recognize that AIDS is indeed an exceptional disease that requires exceptional measures, but to locate the disease and the responses within the framework of the crisis of underdevelopment. But globalization as practised seems to be almost too brash to give priority to solving such a crisis.

Chapter 4

Impacts of the AIDS Epidemic

The Impacts on Peoples and Societies

In every severely affected country, HIV and AIDS have wide-ranging negative effects. These include:

- The reversal of decades of health, economic and social progress.
- Reduced life expectancy.
- Slower economic growth.
- Deepened and more extensive poverty.
- Enhanced gender inequities as women and girls are affected more than men and boys.
- Chronic food insecurity.
- A growing human capacity crisis.

Through these adverse impacts, the epidemic deprives people of the capacity to develop their full potential and lead productive, creative lives that accord with their values, needs and interests. It thereby reduces their potential to lead long and healthy lives, to increase their store of knowledge and understanding, to have access to the resources needed to maintain a decent standard of living, and to be able to participate in the life of the community. In doing so, the epidemic undercuts every prospect for human development and restricts human freedoms by reducing the capabilities and opportunities for individuals to lead a life they have reason to value.

In this situation, the poor, women, children, the young, the elderly, and the earth itself emerge as the principal losers.¹

The Young and the Old

As the epidemic of HIV and AIDS continues to unfold, the world is becoming more keenly aware of the various ways it impacts on the young. This term refers to two categories of young people, children affected by HIV and AIDS (including orphans) and youth or young people under the age of 25. Orphans and vulnerable children are of concern because of the way the epidemic robs them of what cements them to the past, undermines their present opportunities, and jeopardizes their future. Young people under the age of 25 are of concern because they are the AIDS generation—they have never known a world without HIV and AIDS; and because they are at the ages where they are most susceptible to HIV infection—young people, aged 15–24, account for about half of new adult HIV infections and 28 percent of the global total of adults living with HIV or AIDS.⁹⁶

¹ The following sections will consider the impacts of the epidemic on the young, the elderly and the earth. The impacts on the poor have already been considered above in the section on Poverty: HIV/AIDS and Poor People, and the impacts on women in the section above on Women, Gender Disparities and the AIDS Epidemic.

Less attention is paid to those at the other end of the age spectrum, old people who frequently have to bear the brunt of orphan care. This situation is changing through the work of HelpAge International, a global network of not-for-profit organizations that works to achieve lasting improvements in the quality of the lives of disadvantaged old people, though as yet the elderly receive neither the attention nor the action that their situation calls for.

Orphans and Vulnerable Children

In 2003/2004, Zambia conducted its second situation analysis of orphans and vulnerable children. By 2002, over 15 percent of children under the age of 15 had lost one or both parents (amounting to more than 710,000 children). The number of orphaned children is growing and it is believed that by 2004, 19 percent of the children under the age of 18 (about 1,100,000 children) had been orphaned. As they grow older, greater proportions of children are orphaned. In 2002, 12 percent of 5-year-old children had already been orphaned, but for the 14-year-olds of that year, 31 percent of urban children and 27 percent of rural children had lost one or both of their parents.⁹⁷

The major justice issue relating to these and other orphans and vulnerable children is failure at almost every level to build them into comprehensive responses to the epidemic. In the graphic words of Archbishop Desmond Tutu, “the daily consequences of the global pandemic on millions of children that live with dying parents or have been orphaned *lie under the radar* of most governments and agencies. The unfolding tragedy is barely visible.”⁹⁸

Zambia’s situation analysis appears in an official government report that makes the frank acknowledgement:

Government is not giving sufficient priority to the problems of OVC. Inadequate funding to key ministries reduces the provision of effective services to OVC. Inadequate coordination reduces the quality of policy decisions that affect OVC. Inadequate services are devoted to protecting children, and to fulfilling the legal responsibility of care incumbent on Governments. Inadequate legislation means that Zambia’s children do not enjoy the rights provided in the Convention on the Rights of the Child and are not assured of protection.⁹⁹

In the same vein, a 2004 review of poverty reduction strategy papers (PRSPs) in 19 African countries found that they did not manifest a strong commitment to the needs of orphans and other vulnerable children, with only about one-third of them mentioning the issue at all.¹⁰⁰ Zambia’s PRSP is among this minority, with improving the quality of life for OVCs appearing as a first priority activity in the section that deals with HIV/AIDS as a cross-cutting issue. Globally, however, about 40 percent of the countries with a generalized AIDS epidemic do not have any national policy in place to provide essential support to children orphaned or made vulnerable by HIV/AIDS.¹⁰¹

UNICEF has highlighted some of the global outcomes of this neglect of children:

- Every day, there are nearly 1,800 new HIV infections in children under 15, mostly from mother-to-child transmission.
- Every day, about 1,400 children under 15 die of AIDS-related illnesses—one every minute.
- After almost a quarter century of experience of the epidemic, less than 10 percent of the children who have been orphaned or made vulnerable by AIDS receive public support or services.¹⁰²

Notwithstanding these horrendous statistics, the needs of children tend to be overlooked in HIV prevention and treatment strategies, policy formulation, and budgetary allocations. The extent and growth of the OVC AIDS crisis poses a major moral challenge for governments, civil society, the churches, and every concerned individual. Each one needs to take action and avoid being a member of the group castigated by Isaiah: “Your princes are rebels, accomplices of thieves. All of them greedy for presents and eager for bribes, they show no justice to the orphan, and the widow’s cause never reaches them” (Isaiah 1: 23).¹⁰³

There can be little doubt that UNICEF and some prominent NGOs (such as ActionAid, Oxfam, Save the Children, and the International HIV/AIDS Alliance) are leading the world in the campaign for action that takes specific account of the impact of AIDS on children. The high moral ground is theirs. The response of the faith-based organizations at the grassroots level, where the challenge really occurs, has also been outstanding. Because these activities are small-scale, dispersed and not well documented, they do not receive the recognition they deserve. Nevertheless, it is reassuring to note that research bears out that in almost all of the severely affected countries, the most effective and comprehensive responses on behalf of children are in fact coming from the faith-based communities (or from community organizations that have been stimulated by parent religious bodies).¹⁰⁴

These community responses to children affected by AIDS have been characterized as rising from a trickle during the 1990s to a veritable flood in more recent years.¹⁰⁵ Though many of the responses are small, supporting fewer than a hundred children, their cumulative impact is very considerable. This proliferation of faith-based community initiatives, led by a veritable army of religiously committed and motivated volunteers, makes a major contribution to the protection of Africa’s orphaned generations. This work certainly deserves encouragement and support, but the religious leadership could do even more if it placed mobilising action to care for orphans, vulnerable children and families affected by HIV/AIDS higher on their agendas, spoke about the issue more frequently at church services and on other suitable occasions, and maintained pressure on government and civil society never to overlook the needs of children.

A further justice aspect arising from the challenge of orphans and vulnerable children is what has been called the “myth of coping”.¹⁰⁶ Although there has been some increase in the number of street children and in child-headed households (there may be over 20,000 child-headed households in Zambia¹⁰⁷), the numbers in either category are very much smaller than the

known number of orphans. Hence it is presumed that families and communities are managing the crisis and somehow are coping. Superficially this may be so. Families, and especially women, respond to orphans with unprecedented heroism and generosity. But AIDS brings with it the problems of deepening poverty and of having to make do with less. The fact is that under these pressures many households affected by HIV/AIDS only seem to cope, and several cannot manage at all. On the contrary, they break up and their members—orphans, widows and the elderly—join other households. Underlying the apparent success of family coping is the selfless sharing strategy that frequently characterises those living in poverty—the poor helping the destitute by sharing what they cannot afford. But this is hardly something that can be held up as a good model of coping.

Beguiled by the notion that families and communities are coping, governments and agencies wash their hands of responsibility, or at best provide little more than partial and piecemeal relief. They assuage their conscience by applying “a bandage to the wounds of national or global inequality when what has been required for a very long time is extensive and expensive surgery”.¹⁰⁸

Injustices of another kind are perpetrated when families are broken up on the death of a parent or when orphans or street children are “repatriated” from their town setting to a rural village. When there is a parental death, relatives may decide to “share out” the surviving children among themselves, thereby reducing the economic burden on any one of them. But this is often a source of great emotional distress to children who have become attached in a special way to their siblings, particularly if they have shared together the trauma of supporting the deceased parent through a long drawn out and harrowing illness. Having lost a parent, they are now being asked to surrender their connectedness with their siblings and to embark on life in a new and sometimes strange family. To increase their distress, and in violation of their right to be heard and have their views taken into account¹⁰⁹, they may not be consulted, but merely find that they have been allocated to the family of a particular relative. While relatives generally act in good faith, they should be helped to see how important it may be for children that they stay together as a family, even in a child-headed household, and how sensitive they should be to the child’s needs and rights at a time of great emotional turbulence.

A strategy that relatives sometimes adopt when deciding on the future of an orphaned child, and that governments may tend to impose on street-children, is one of forced repatriation to the village from which the child’s parents are believed to have come. Reports from rural areas suggest that the practice of sending urban orphans to live with their rural relatives may be on the increase. In addition to the injustices of sibling dispersion and non-consultation raised in the previous paragraph, a host of problems can beset this practice. Children from urban areas have little knowledge or practical skills for rural living. They may not speak the local language. Their difficulties in adjusting to life in a rural area are compounded by the difficulties of their rural relatives in adjusting to their urban ways and expectations. Unless the child is very young, the experiences of family, school, community and

organization of daily living are so different that successful acculturation is very problematic for both the newly arriving child and the receiving family.

When the “back to the village” strategy is adopted, it may often be the case that the driving consideration for the relatives or the government agency will be to solve the problem by hiding it or moving it elsewhere so that it becomes less visible. Apart from the fact that relocating a problem does not solve it, such a move violates yet another child rights principle, that of the best interests of the child: “In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration”.¹¹⁰

Box 11: Child-care for a parent with AIDS

Children who care for adults may experience a world gone seriously awry. A young girl of eight or nine may be used to caring for younger siblings; she is unprepared to care for her mother, father, or both of them. ... Coping with a parent who is weak and requires food to be cooked or water to be brought is one thing. Coping with a parent’s severe diarrhoea, declining mental function and mood changes is quite another.¹¹¹

In concluding this section on children affected by HIV and AIDS, it bears re-stating that their first need is for love and human security. No price can be set on the essentials of parental love and affection that so many of them have lost. Moreover, becoming an orphan through the AIDS-related death of a parent is a long-drawn out and distressing experience. Children experience tremendous emotional anguish in watching a parent die in pitiless suffering and possibly humiliating circumstances (Box 11). Shattered by their experiences and drained by their loss, they look to the world to help them meet their basic human needs for economic security, food and adequate nutrition, health care, education, shelter, and the emotional health that will sustain them in their orphan status. It is remarkable and quite unacceptable that to date the world has not seen fit to respond to their needs in a coordinated and comprehensive way. The world stands condemned by its failure to do so.

Teenagers and Young Adults

In June 2001, the United Nations General Assembly Special Session on HIV/AIDS committed the world to time-bound action on behalf of young people in a number of areas. Two of the statements in its *Declaration of Commitment* are particularly relevant:

§47 By 2003, establish time-bound national targets to achieve the internationally agreed global prevention goal to reduce by 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25 per cent and by 25 per cent globally by 2010.

§53 By 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection; in full partnership with youth, parents, families, educators and health-care providers.

The evidence suggests that where comprehensive and long-term prevention programmes (of the traditional behaviour change and biomedical patterns) were adopted there was some element of success in reducing HIV prevalence among young women. On the other hand, less intensive and isolated efforts were in fact accompanied by rising prevalence rates.¹¹² Changing the pattern of the infection among teenagers and young adults is the greatest single challenge that the epidemic poses. An AIDS-free future can only be achieved through an AIDS-free youth. Success with the young is success against the epidemic. Failure with the young gives the upper hand to the epidemic.

The range of issues that relate to the AIDS pandemic and youth is so wide that they could not all be discussed here.¹¹³ However, there seem to be four missing elements that encapsulate the justice aspects in this relationship between young people and HIV/AIDS.

Teenagers and young adults are not given sufficient voice: Today's youth generation is the largest in history. Young people under the age of 25 comprise almost half the world's population, while in Africa over half the population is estimated to be under the age of 18. Although international treaties protect young people's right to be heard and have their views taken seriously (see footnote 109), young people themselves report that they are not included as equal partners in HIV and AIDS programmes and services and that in particular young people living with HIV or AIDS are excluded from such partnerships.¹¹⁴ Most often, they are treated as beneficiaries of information and services, but are not recognized as necessary, knowledgeable, and effective agents of change. Adults take decisions on their behalf and quite often design and implement programmes for them that are neither suitable nor effective. This is not as it should be. As young people, they have a right to be heard. As individuals constituting the group that is especially susceptible to the possibility of HIV infection, they should participate actively in the formulation of policies and plans and the development of programmes aimed at blocking HIV transmission. Denying a sufficient voice to youth can be classed as yet another form of collaboration with the evil of HIV and AIDS.

Teenagers and young people do not have access to enough correct information: Although the majority of young people know something about HIV and AIDS, many do not have correct information on how HIV is

transmitted and how to protect themselves against the virus. UNICEF reports that “in none of the 34 countries in Sub-Saharan Africa with recent surveys were more than half of young women aged 15–24 aware of critical prevention and transmission methods.”¹¹⁵ Cultural conservatism, which resists discussion of sex with the young or in educational settings, and the misconception that HIV and AIDS education promotes sexual promiscuity, are major obstacles that prevent young people from accessing accurate information. The adult world often treats young people very unfairly—if they ask for information, they are chastised for raising issues to do with sex; if they behave inappropriately, they are chastised for “not knowing better”. Boys that “do speak, especially to adults, are often ignored or told to ‘act like a man’, without being told what it is to be a man.”¹¹⁶ Young people generally look to the adult world for two things: the support, encouragement and affirmation of trusted adults to help them through a time of uncertainty and growth; and an adult honesty and integrity that can accept fresh insights and does not routinely condemn out of hand everything that appears new.

Teenagers and young adults do not have access to youth-friendly health services and HIV testing facilities: Young people need adequately resourced health services to which they can present themselves at times and in a manner that they do not perceive as constituting a threat. The services provided, the personnel providing them, and the circumstances under which provision is made should be highly professional, non-judgemental, understanding, and supportive of every young person who may present for attention. These services should provide information and services (such as condoms) relating to HIV/AIDS, other STIs and illnesses, and pregnancies, and offer counselling and support on relationships, rape, substance abuse, and other issues of concern to young people. Young people also need widely available voluntary testing and counselling services, with great attention to the need for counselling that will provide emotional support to an anxious young person, and for absolute confidentiality, not merely in regard to the test results but also in the circumstances and set-up of the testing facilities. More readily available HIV testing and counselling facilities would enable adolescents and young people who test positive to get more timely care, support and treatment and would strengthen the determination of those who test negative to remain so. The importance of health and HIV testing services being youth-friendly cannot be too strongly emphasised. Judgemental and discouraging attitudes on the part of the service providers would defeat the whole purpose of centres for this purpose by deterring young people from seeking the information, services and treatment they require.

Many teenagers and young people lack economic security and prospects for employment: According to ILO, almost half of those without jobs are aged 24 or less.¹¹⁷ This has an immediate bearing on the risk of HIV infection. Where job opportunities and prospects for sustainable livelihoods exist, young people feel they have a future to look forward to and protect. But where they have nothing to look forward to and little hope for the future, there is little incentive for them to take steps to safeguard themselves against HIV infection. The immediate conditions of daily life are so adverse that they outweigh concerns

about contracting HIV/AIDS (see Box 5 above). This may be why it is now emerging that HIV infection among the employed tends to be lower than among the unemployed. The deep underlying reason for this almost certainly lies in the fact that it is through employment and work that one achieves fulfilment as a human being and in a sense becomes 'more a human being'.¹¹⁸ The non-availability of employment and work prospects for young people is a key missing ingredient in global strategies against HIV and AIDS. It is not merely that because they have so little to do that they have more time for behaviours that may put them at risk of being infected with HIV. It is much more that they are deprived of opportunities for developing their human dignity and self-respect.

The Elderly

In many developing countries the AIDS epidemic has increased the burden on older people in two ways. First, because of the deaths of their children they can no longer receive the financial and other support that their children would otherwise have provided for them; and second, in their frailty and very often in their poverty, they have to take on care responsibilities for orphaned children. Older people have always been involved, to some extent, in caring for the young. But because of AIDS, the extent of this care has greatly increased. In 1992, grandparents were caring for 20 percent of Zambia's orphans; by 2002 they were caring for 33 percent of a greatly increased number.¹¹⁹ The situation is even more accentuated in other countries. In South Africa and Uganda 40 percent of orphaned children live with their grandparents and in Zimbabwe over half.¹²⁰ Where there are no grandparents, or they are not able to assume the responsibility, other old people step into the breach: a programme in Tete Province, Mozambique, identified 774 older people caring for a total of 2,187 orphans, most of them under the age of 10, in five villages.¹²¹ Of 685 care-givers interviewed in a Zimbabwe study, 73 percent were over 60 and 74 percent were female.¹²²

Box 12: The challenge facing the elderly

65-year-old man, Zimbabwe, the main care-giver of three school-aged children: Looking after orphans is like starting life all over again, because I have to work on the farm, clean the house, feed the children, and buy school uniforms. I thought I would no longer do these things again. I am not sure if I have the energy to cope.¹²³

76-year old man, Zambia: In the good old days, when there were deaths of parents, it was easy to incorporate one or two orphans. But when you have nine, what can an old man like me do?¹²⁴

62-year old woman, Bulawayo, Zimbabwe: I am so afraid of what the future has in store for these orphans. If I were to die and leave them, there would be no one to look after them.¹²⁵

Clearly, the burden of orphan care is falling more extensively on the weaker members of society—women who are old, very often poor, and not infrequently in poor health. A distinctive characteristic of the evolving household model is that often there is no middle generation (women or men) but only the old and the young somehow supporting one another. The elderly caregivers are apprehensive about their ability to care for and rear the young, but feel under pressure to take on this responsibility because there is no one else who can do so (Box 12).

Because of age, the personal health status of elderly caregivers is often not good and it may be worsened by the stress, anxiety and burden of providing care. This fills many of them with an overwhelming sense of worry and concern. Their age, the distances involved and their economic circumstances reduce the access of many to health and social services. They feel too old to start self-help or income generating projects, and they do not feel themselves able to undertake agricultural activities on the scale needed to feed the household. Many also experience difficulty in adopting a new parenting role that necessitates their relationship with their grandchildren becoming more authoritative and directive.

Caring for these frail carers can test the commitment of a society to principles of justice and equity. Two questions arise:

1. How can these elderly carers be enabled to cope with the economic, caring and psychosocial demands placed on them?
2. Who will care for these elderly carers when they are no longer able to care for themselves or their dependants?

There is a strong case for the adoption of exceptional measures for the protection of elderly caregivers. In common with children affected by HIV and AIDS, they are a very vulnerable group. But, unlike orphans and vulnerable children, they are a much-neglected group. The United Nations Declaration of Commitment has committed governments to review the social and economic impact of HIV/AIDS on women and the elderly, particularly in their role as caregivers, and has suggested the adoption of necessary social protection actions.¹²⁶ Few countries, however, appear to be considering this issue. It is not something that ranks high on the priorities of governments. Possibly it is overshadowed by the magnitude of the orphan challenge. But if the vulnerability of elderly caregivers is not addressed, who will be left to attend to the needs of the orphaned generations in Africa and elsewhere?

Fortunately, this situation now appears to be changing. UNICEF, DFID (UK Department for International Development), GTZ (German Technical Cooperation), and other agencies are promoting national social welfare programmes that ensure regular and predictable transfers of cash or food to poor households, particularly those headed by older people or women caring for children (Box 13). The evidence suggests that these social transfers have a role in empowering the poorest households, promoting gender equity, and helping individuals tackle risk and vulnerability. They are an important

mechanism, therefore, not only for helping the elderly, but also for making progress towards the achievement of the poverty and inequality Millennium Development Goals.

Box 13: The Kalomo cash transfer pilot scheme

The Kalomo programme provides a small transfer of US\$0.50 a day to the poorest 10% of households in the Kalomo district of Zambia, some 1000 in total. Households with children receive US\$0.17 more. Over 50% of the beneficiary households are headed either by old people or by children, and 57% of the beneficiaries are children.

Although at an early stage, the programme is already demonstrating similar impacts to other cash transfer programmes. Households report improved nutrition, with an increase in the number of meals and amount of food they consume each day. Fewer people are dying, the health status of beneficiaries has improved, and overall absenteeism from school has declined by 16%.

People have invested, on average, almost 30% of the cash they have received by purchasing, for example, goats for breeding, oxen to help with ploughing, and seed for planting. Others have paid neighbours to plough their gardens.¹²⁷

The Vulnerability of the Earth

Natural resources sustain the life of every species on earth. Human history presents a long conflicting story of prudent concern on the one hand for the sustainable care and management of these resources and, on the other hand, their pillaging through exploitative and destructive undertakings. When circumstances change, especially when they change rapidly, human endeavour may find itself drifting from long-term conservationist activities to those that are short-term, utilitarian and potentially destructive. The AIDS epidemic constitutes such a shock situation and has the potential to result in considerable ecological deterioration and degradation. Very little consideration has been given to this potential threat of HIV and AIDS to the environment, but that very fact may in itself be one of its greatest threats.¹²⁸

HIV/AIDS affects systems directly and indirectly through sickness and death. This applies not merely to human systems, such as education or health, but also to the ecological systems on which humanity depends so intimately. The immediacy with which households experience the labour and financial impacts of AIDS impairs their ability to make sustainable use of natural resources. When time, energy and money must be spent to relieve the effects of AIDS sickness, and when there are fewer healthy individuals in a household who

can put in a full day's work, concern for long-term ecological integrity is not a high priority. Because of this, there is more likelihood of exploitative relationships in which natural resources are over-used or poorly managed.

Reduced ability to transmit knowledge and skills and actual degradation of natural resources are the two principal channels through which this occurs. Rural populations are aware of the need to maintain a balanced relationship with the environment that sustains them. Centuries of experience have resulted in patterns of cropping, animal husbandry, fishing and general environmental management that yield good returns to the individual without wreaking harm on the environment. The knowledge and skills for maintaining this balanced relationship are passed from generation to generation, not in a formal way but through the informal learning of children from their parents and elders. HIV/AIDS has put this under threat. So many have died or are seriously ill in the generation with the knowledge and skills that they are no longer able to transmit these to their children. The result is considerable risk of environmental degradation, as through over-fishing or fishing at the wrong time of year, failure to preserve certain tree species, or lack of attention to watercourses and where run-off is directed.

Specific aspects of the day-to-day response of households to HIV and AIDS can result in actual degradation of natural resources. AIDS-related sicknesses in a household can lead to:

- Increased dependence on wild plants for food (leading to reduced supplies for other animal species and ultimately to the possible extinction of some species).
- Increased harvesting of plant material for use as herbal remedies, a strategy that has already led to the extinction of a number of species.
- Contamination of water sources through the disposal of human waste near to where people live and get their water.
- Environmental degradation through the indiscriminate disposal of non-bio-degradable items.
- Increased pressure on water and fuel resources, to cater for the washing of soiled clothing and bedding.
- Decline in the productive capacity of soils in the vicinity of an affected homestead, because of over-intensive use arising from age or sickness-related inability to cultivate more remote fields or from failure to transfer skills and knowledge.
- Uncontrolled cattle grazing, because labour to herd them cannot be mobilised, leading to degradation of grazing grounds and pollution of sources of water for human consumption.
- Lack of labour for the maintenance of contour ridges and for similar environmental management activities.
- Increased use of wildlife for food, and hence the potential extermination of animal, insect and bird species.

The environment may also suffer because of AIDS-related deaths:

- Trees are cut down to provide wood for coffins. The Kenyan environmentalist and Nobel Laureate, Professor Wangari Maathai, once observed laconically, “converting trees into coffins is not very good for the living”.
- The increased number of burial sites near to homes in rural areas puts water sources at risk of being contaminated when human remains decompose (there is no risk, however, of the water being contaminated with HIV since the virus cannot survive long enough for this to happen).
- The pressure for more burial sites in urban areas leads to the extension of cemeteries or the development of new ones, sometimes in an unplanned, haphazard way, and with little consideration for the environmental implications.
- In both rural and urban areas, decades must pass before land where people have been buried can be used for agricultural, housing, infrastructure or other legitimate development purposes.

But while AIDS poses potential threats for the environment, it is also true that a degraded environment can increase susceptibility to HIV. This occurs particularly in the case of selenium deficiency. Individuals who are deficient in this element are easily infected by HIV, which quickly progresses to AIDS.¹²⁹ They are also more susceptible to other diseases, such as hepatitis, Kaposi's sarcoma, and other forms of cancer. The availability of selenium in the food chain has been reduced by increasingly acid rainfall which, in its turn, results from the increased consumption of fossil fuels (coal, oil and natural gas). Through this sequence of events, the damage that the consumption-oriented industrialized world does to the environment is already having a negative impact on the lives of people, especially those without the resources to compensate for what should be integral to their normal diet.

These issues are raised in this report because through HIV and AIDS “our own flesh and blood, the earth, is dying”¹³⁰, but very few seem to care. Years must elapse before the damage that HIV does to the human body reveals itself in the sicknesses of AIDS. During those years, the body's immune system becomes progressively weaker until eventually it is unable to offer protection against common ailments and exposes the body to impairment by ailments that are less common. This situation was developing among thousands of people in the 1970s. They were already infected with HIV, but the world knew nothing about their condition until the bombshell of AIDS exploded in the 1980s. Could our earth be going through a similar process? What convulsions will it experience in millennia to come because of the insidious inroads of HIV and AIDS today? This generation cannot tell. But this generation has the responsibility to find innovative ways to ensure that the epidemic does not undermine the future of humans or their environment. This is surely a matter of justice to the present generation, to future generations, and to the earth on which we all depend for sustenance.

Food Security

Finally, some mention must be made of the way the AIDS epidemic undermines food security whereas, on the other hand, adequate food and good nutrition can reduce susceptibility to HIV infection, reduce the potency of an infected person to transmit the infection, slow down progress from HIV to AIDS, and provide support and reinforcement for the virus-controlling work of ARVs.¹³¹ An abused environment is already compromised in its ability to produce food in the quantity and variety needed to maintain good health. But HIV and AIDS greatly exacerbate this situation.

In agricultural households AIDS reduces food security in a wide variety of ways. The illness or death of an adult household member generally results in less intensive crop, soil and animal husbandry efforts. Remote fields may be left fallow, soil conservation measures abandoned, and animals uncared for. There may be a switch from labour-intensive crops (such as cereals and oilseeds) to less demanding and often less nutritious ones (such as cassava). The timing of essential farming operations may not be well organized. Livestock and other farm assets may be sold to meet medical and care expenses or be used up for funeral costs. Because labour is no longer so freely available, care for food stocks between harvests may be impaired, with negative consequences for both food security and the availability of seed for sowing in the next agricultural season. A further consequence is that children can no longer learn to farm because their parents are no longer alive, or are too sick, to teach them. The plight of agricultural households is also aggravated by the breakdown in agricultural support services as extension staff fall ill and die.

The outcomes are predictable: less food, increased malnutrition, less food security, and increased vulnerability to HIV/AIDS.

In a remarkable statement to the United Nations Security Council in April 2003, the World Food Programme (WFP) highlighted many of these problems and called for a series of remedial actions that would require no more than modest investments. The statement concluded, however, by calling for one further action—a major investment in Africa's children:

The long-term future of Africa will depend greatly on a well-nourished, educated and skilled workforce. WFP would like to work in partnership with NEPAD to get all primary school-aged African children to attend school through support for school feeding activities. ... The impacts in terms of nutrition, health, and education—especially for girls—are tremendous: enrolment rates, performance scores and access to secondary schooling soar while girl-child marriages and early pregnancies decrease. For me, the concept of empowerment of women could not be more tangible. School feeding is the single best vehicle to address the Millennium Development Goal to cut poverty and hunger by half.¹³²

This statement bears out the inter-relatedness of issues surrounding HIV and AIDS: the disease or sickness of HIV and/or AIDS; the epidemic; food

security; children's education; the empowerment of girls and women; support from the industrialized world. It also underlines the interconnectedness of the Millennium Development Goals and the way in which success in meeting the goal of combating HIV/AIDS can promote and be promoted by success in meeting other goals.

Chapter 5

The Response of the Christian Churches to HIV and AIDS

It is appropriate before concluding to say something about the role of the Christian Churches, especially the Catholic Church, in the response to HIV and AIDS. The basic principles that are the mainspring of the church response are similar to those that guide the response of the Churches to every major national or social issue. While HIV and AIDS are exceptional in the extent of the losses they bring to individuals, the community and the country, the fact that they are rooted in under-development, poverty, inequality and a broad range of injustices means that the Christian response must be based on principles that will be effective not only in responding to the AIDS epidemic but also to the parallel “epidemics” of other situations such as malaria and tuberculosis, hunger, debilitated health status, inadequate health and education facilities, the subjugation of women, the marginalisation of those living in rural areas and urban shanty townships, the voicelessness of the majority, the widening gap between the rich and poor, and the sub-human poverty in which the majority survive.

While the Churches in Zambia have not formally elaborated any joint statement of the underlying religious principles that guide their response to HIV and AIDS, it is likely that they would agree on the fundamental importance of the following:

- The sacredness of the person as made in the image and likeness of God, making each one intrinsically worthy of dignity and respect.
- The sanctity of each individual human life, from the moment of conception until death.
- Conscience as each individual’s most secret core and sanctuary that enables faith to issue in responsible personal choice.
- Overriding concern for solidarity, compassion and effective response in relation to those who experience sickness, loss, catastrophe, deprivation, unfair treatment, or any form of discrimination.
- Recognition that the earth and its goods belong by right to all, are there to be shared fairly by all, and must be protected for the current and future use of all.

Principles such as these can have enormous motivating power in stimulating responses at every level to HIV and AIDS. This is precisely what has been experienced in Zambia and other countries in sub-Saharan Africa, where there is much overlap between the church and secular response and considerable integration between faith-based and community-based programmes. Equally, each of the principles that have been enumerated has a social and justice dimension. They speak to liberation from oppression and the elimination of inequities.

The Church Contribution to the Struggle with HIV and AIDS

In this light, the enormous contribution that the Christian Churches have made to HIV prevention, care, support, treatment and impact mitigation must be acknowledged and proclaimed. The Churches have made this contribution through:

- Their strong human rights based approach that promotes a culture of life, respect for the sacredness of the individual, and the celebration of life.
- The enormous efforts that they pour into care for the infected and impact mitigation for the affected—religious bodies provide between a quarter and a half of all the AIDS care in the world. Care, support and treatment are integral to prevention, creating a more effective environment for it.
- Christian social teaching that advocates strongly for the transformation of economic, political and social structures that effectively exclude the poor and deny the equal personal role and dignity of women. In other words, fundamental church teaching consistently and effectively addresses some of the major driving forces of the AIDS epidemic.
- The concern of religious organizations to promote a strong sense of community and social cohesion among their members—the degree of such cohesion has been identified as being a key factor determining the speed with which HIV infection spreads and the numbers who become infected.¹³³
- The immediate contact that religious personnel maintain with people at the grassroots level. They deal with them directly, in their homes and elsewhere, without recourse to other intermediary functionaries. UNAIDS has stressed how grassroots and community mobilization is the core strategy on which success against HIV/AIDS builds.¹³⁴
- The high moral standards promoted by the Churches. The Catholic Church is resolute in proposing high ideals for its members and in requiring sexual abstinence outside marriage, the only completely certain way of avoiding the sexual transmission of HIV. It is equally resolute in requiring fidelity within marriage, which—apart from the case of a discordant couple—is the only completely sure way of not becoming HIV infected when practising sex. In maintaining these ideals, the Church is adopting a prophetic stance against the debasing of the body and the commodification of women and girls, and in favour of the institution of the family.

The Church Approach to HIV and AIDS

With their closeness to the people and their long experience, the Churches in Zambia have come to recognize that it is neither effective nor sufficient to treat HIV as an object of intervention, in isolation from its social and economic contexts.¹³⁵ While they recognize the behavioural and medical concerns that HIV and AIDS raise, they do not concur that it is sufficient to address the epidemic from outside by the technological interventions of a condom, a test kit or an antiretroviral drug.¹³⁶ Instead, they see it as requiring a more holistic approach that addresses both economic and personal development. Hence,

an increasing amount of church activity is being dedicated to social and economic development, while a major share of church concern has always been with personal development.

The result is that, in addition to their traditional health and education activities, the various church bodies in Zambia work for the improvement of agriculture, water and sanitation, improved livelihoods, acceptance of the equality between men and women, improved nutritional status for children and adults, and the development of infrastructure. Each of these activities relates significantly to developing an environment that is less conducive to HIV transmission. In the majority of cases, the churches undertake this work without recognizing explicitly that it contributes to the control of HIV and AIDS. In some cases, however, early responses to the epidemic revealed the need for greater attention to development concerns. Thus, the Salvation Army, at Chikankata Hospital in the Southern Province, initially concentrated on in-patient hospital care for AIDS patients. From there it moved to home-based care and subsequently to an integrated approach that stresses holistic care, which aims to meet the physical, social, spiritual, economic and psychological needs of both the individual and the community.¹³⁷

From time immemorial, Christian teaching has promoted abstinence outside of marriage and fidelity to a single partner within marriage as the norms for a practicing Christian. These ideals have always featured in Christian education and formation programmes whether targeted at young people or at adult members of congregations. While it is frankly acknowledged that not everybody lives up to what is expected, it is also recognized that the absence of high expectations would signify defeatism in regard to central principles of behaviour based on the full acceptance of the Christian gospel message. In addition, the Christian ethic has consistently been opposed to the liberalization and commercialisation of sex. Its principles of the sacredness of the human person and the inherent equality of men and women prohibit treating sex as a commodity for sale or as an advertising ploy to enhance the sale of other commodities. In this respect, Church teaching is strongly opposed to every portrayal that degrades women or casts them in a humiliating light.

In the climate of HIV and AIDS, the Christian ethic has continued to promote the same principles of abstinence and fidelity as the surest way of bringing under control the sexual transmission of HIV. These high ideals are placed before church members and others as being both worthy and possible of attainment. They are integral to the ethical foundation on which the churches build their teaching. They are promoted on occasions of formal church gatherings and through the churches' preaching ministry. They are fostered through various church organizations, some of which, such as Youth Alive Zambia, have been established for the express purpose of promoting among young people the values of abstinence and self-control before marriage and fidelity within marriage. The ultimate purpose of this formation is to help church members develop a responsible and fulfilling sexuality that will sustain a healthy and stable family life. At the same time, these behaviours protect against HIV infection.

Challenges for the Church Arising from HIV and AIDS

Following in the footsteps of its Founder, the Church exercises a ministry of service, teaching and speaking with a prophetic voice. It has always been called to this, but the challenge is more pressing and more complex in an era when the domination of HIV and AIDS has brought so much suffering, confusion and sense of hopelessness.

As *servant*, the Church must face the challenges of stigma and discrimination that poison human relationships, bring enormous personal pain to those who experience these, and make it very difficult to bring the disease out into the open so that it can be both checked and treated. The Church must also ensure that it incorporates people living with HIV and/or AIDS into its life and practices, establishing solidarity with them, making them welcome as integral and valuable members of the community, and making it possible for them to participate in real and meaningful ways in church and community life. A further challenge faced by the Church is that of orphaned and vulnerable children. Their numbers are so large that there is danger that a disaffected generation may grow up within badly affected communities. But as noted already, the Church has always worked hard for children. The challenge today is to do more, to do it in cooperation with others, and to energise communities and families so that they can make their essential contribution to responding to the orphans' challenge.

As *teacher*, the Church is challenged to deal more openly and positively with sexuality, not seeing this as something undesirable or even wrong, but developing a theology that acknowledges the goodness of sexuality and recognizes its role in human development and happiness. This also calls for a more developed morality that is no longer excessively concerned with rules and prescriptions but seeks to build up an understanding of the human conscience as the bulwark of moral understanding and behaviour and that liberates individuals to exercise personal responsibility in their lives. Integral to such developments would be a deeper exploration of the meaning and practice of a just sexuality.

As *prophet*, the Church is challenged to show itself as a leader in the struggle with the epidemic. This means it must bring its wisdom, resources, and advocacy to bear on all aspects—prevention, care, support, treatment, orphan care, stigma, human rights abuses, female disempowerment, poverty, exploitative socio-economic structures and practices, and the mitigation of negative impacts. The Church's leadership role would be enhanced if it acknowledged publicly that its own members (religious personnel, ministers and lay persons) have AIDS so that it could be seen to be speaking and leading from a position of strength, internal knowledge and understanding, arising from an awareness of its own infection.

There is the further challenge of raising awareness, speaking compassionately and fearlessly about the epidemic at church gatherings and services, raising the issue at educational, medical, social service and other meetings in which the Church often participates. Finally, there is the challenge

of overcoming inertia. The Church does much, but it has the potential to do more. It needs to be seen to be in the forefront, speaking, acting, leading, guiding. It needs to stimulate communities, civil society, the private sector, and the government. It needs also to stimulate itself. Dealing with HIV and AIDS is urgent. People are becoming infected. Millions are dying. The Church cannot afford to be sluggish in responding to such a situation.

Looking to the Future

It is excellent that so much has been accomplished. But there is room for even more. From the perspective of justice and of a more effective response to the challenge of HIV and AIDS, it would be desirable if the Church would:

- Speak out loud and clear on every possible occasion about the epidemic, overcoming silence or denial in its own personnel, in its members and in its teaching.
- Adamantly and repeatedly reject every utterance, pronouncement or practice that carries any connotation of stigma or discrimination.
- Pour its enormous human and organizational resources even more resolutely into the major tasks of eliminating poverty and ending the subjugation of women (recognizing the sea-change the latter will mean for many of its internal structures and practices).
- Recognize the dimensions of the orphans challenge and mobilize its communities for a massive response to it in humane and practical ways.
- Galvanize its members into action for the reduction of HIV transmission, the promotion of a just sexuality, the provision of care and support for those infected or affected, and the mitigation of the impacts of the disease and epidemic.
- Work in cooperation and harmony with every Christian denomination and with those of other faiths, the representatives of local cultures, civic personnel, and local, national and international leaders.
- Maintain a multidimensional response to HIV/AIDS at the top of its agenda and as an integral element in its seminary and other training programmes.
- Acknowledge more openly and humbly that, in addition to HIV infected lay-members, many religious leaders and dedicated religious personnel are HIV positive, so that in truth the Church, the body of Christ, truly has AIDS.

The time of AIDS is a time of great perplexity. But it is also a time of great challenge and a time of great grace. God is close at this time, probably closer than at other periods in history, just as he was close in an especial way when Jesus suffered an appalling death on the Cross. The Church has the responsibility of discerning God in the current situation and of hearing what God is saying to it through the crisis of HIV and AIDS.¹³⁸ It is also duty bound to help others experience God even in the circumstances of HIV and AIDS. In the final analysis, the responsibility of the Church is to live, speak and act as Christ would have done in this era of HIV and AIDS, to be Christ to those who are infected and affected, to bring Christ's message of hope and certain victory to suffering people and a suffering world.

Chapter 6

Conclusion: A Justice Perspective

This report has endeavoured to take a fresh look at HIV and AIDS, largely through the lens of justice and human rights. It has highlighted a number of AIDS-related areas where a justice perspective extends understanding and demands action. While it has presented a considerable amount of detail in a number of areas, it has been animated throughout by three considerations.

First, the thesis of the report is that there is strong synergy between the AIDS epidemic and four basic root causes:

- Poverty;
- Gender disparities and power structures;
- Stigma and discrimination; and
- Exploitative global economic structures and practices.

In many respects, these form the roots of the epidemic. So long as they remain in their present healthy condition, the epidemic will continue to thrive. The success of HIV/AIDS in flourishing and extending its grip during the past twenty-five years is testimony to global failure to address these underlying and structural causes.

Second, responding to HIV and AIDS is intimately connected with the practice of justice. The continued dominance of the epidemic is testimony to failure to take account of the numerous justice and human rights strands with which the epidemic is intertwined. In the long term, success in responding to the epidemic can only come through an approach based on values—the values of justice, human rights and human dignity.¹³⁹ The Universal Declaration of Human Rights opens by recognizing “the inherent dignity and the equal and inalienable rights of all members of the human family” as the foundation of freedom, justice and peace in the world. The practical recognition of this inalienable dignity is likewise the foundation of freedom from the evil that HIV/AIDS constitutes.

The AMECEA (Association of Member Episcopal Conferences of Eastern Africa) Bishops have also appealed to this inherent human dignity as the sacrosanct wellspring that must give rise to action on behalf of justice in the realm of HIV and AIDS: “all persons carry with them a dignity that is not diminished by suffering or sickness. Therefore, all facets of justice—be they social, cultural, political, legal or economic— must also, without discrimination, apply to all people who are affected or infected with HIV/AIDS.”¹⁴⁰ Since HIV and AIDS affect every person who lives in today’s AIDS-infected world, the Bishops’ message encompasses every individual and everything that relates to the epidemic. A justice and human rights based approach forms the most coherent basis for responding to the epidemic and, possibly of greater importance, getting ahead of it.

Third, AIDS and justice issues are so intimately linked that action on behalf of justice will almost automatically be action against the epidemic. Dismantling the unjust structures in which poverty, the low status of women, stigma and discrimination, and exploitative global economic practices, are embedded, and establishing just structures and practices in their place, will create a terrain in which the human immuno-deficiency virus can no longer flourish. Equally, action against the epidemic will be action on behalf of justice. As has been seen throughout this report, the shape and extent of the AIDS epidemic is determined by various unjust forces, many of them outside the areas normally addressed by HIV and AIDS programmes. Addressing HIV and AIDS serves as an entry point and catalyst for addressing these broader injustices. Briefly, then, one can say that the more HIV/AIDS, the less justice, and the more justice, the less HIV/AIDS.

This viewpoint provides guidance for those whose work is in areas not directly related to the epidemic but who want to make a difference for the better. So many say, “we would like to do something, but we don’t know what to do”. A legitimate answer is “do better and do more of what you are already doing to see an end to poverty, to make women’s equality a lived reality, to help disadvantaged children get a sound basic education, to reduce stigma and discrimination, to raise awareness of the injustices in today’s world and to stimulate action to address them. Do these things and you are working against HIV and AIDS.” Putting it in other terms: “work for the achievement of each of the Millennium Development Goals, and then you will certainly be taking action against the epidemic—not merely by addressing the goal of combating HIV, tuberculosis and malaria, but also by addressing the goals of poverty reduction, more extensive female empowerment, more universal education, improved maternal and child health, and assured environmental sustainability.” HIV and AIDS have woven the basic needs of individuals into a seamless whole. Addressing any one of these needs is addressing the epidemic; addressing the epidemic is addressing the factors that obstruct realization of basic human needs.

Finally, it should be noted that this long-term, justice and rights-based approach to dealing with the AIDS epidemic must go hand-in-hand with more immediate prevention, treatment and impact mitigation measures. If the long view had been adopted when the epidemic first “broke” in 1981, the situation would never have deteriorated to what it has become today. Lives would have been saved. Sickesses would have been averted. The crisis would not be as we know it now. But the crisis is with us and must be dealt with in the immediate as well as in the long term. But the short-term approach can also be transformed by the justice perspective. This would save it from being little more than a fire-fighting approach that currently deals—not very effectively and essentially too late—with little more than the superficial drivers of the epidemic: sexual behaviour, infected blood, mother-to-child transmission, and injecting drug use. Integrating the long-term and short-term approaches into a single rights and justice based approach is likely to bring sustainable immediate results and to usher in a world that has begun to free itself from HIV and AIDS.

End-Notes

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- ¹ *Morbidity and Mortality Weekly Report*, June 5, 1981. Centers for Disease Control and Prevention's National Center for HIV, STD and TB Prevention.
- ² *British Medical Journal* 2002; 324:181-182 (26 January)
- ³ Encyclical Letter, *Populorum Progressio*, §6.
- ⁴ "AIDS, Justice, and the Common Good" in *Catholic Ethicists on HIV/AIDS Prevention*, edited by James F. Keenan and others, New York: Continuum Press, 2000, pp. 282, 284.
- ⁵ Encyclical Letter, *Deus Caritas Est*, January 2006, § 26.
- ⁶ Quoted in *AIDS and the Ecology of Poverty*, Eileen Stillwaggon. New York: Oxford University Press, 2006.
- ⁷ "About this Book", James F. Keenan. In *Catholic Ethicists on HIV/AIDS Prevention*, edited by James F. Keenan and others, New York: Continuum Press, 2000, p. 14.
- ⁸ "Towards an Ethical Response to the HIV Epidemic", Elizabeth Reid. In *African Network on Ethics, Law and HIV. Proceedings of the Intercountry Consultation*, Dakar, Senegal, 27th June – 1st July, 1994, p. 4.
- ⁹ Unless otherwise stated, the global figures quoted in this section come from the UNAIDS report, *AIDS Epidemic Update, December 2005*. Geneva: UNAIDS.
- ¹⁰ *Intensifying HIV Prevention. UNAIDS Policy Position Paper*. Geneva: UNAIDS, August 2005, p. 22.
- ¹¹ *Communications Framework for HIV/AIDS. A New Direction*. A UNAIDS/Penn State Project. Geneva: UNAIDS, 1999, pp. 23-24.
- ¹² *Ibid.*, p. 21.
- ¹³ "AIDS, Justice, and the Common Good" in *Catholic Ethicists on HIV/AIDS Prevention*, edited by James F. Keenan and others, New York: Continuum Press, 2000, p. 282.
- ¹⁴ The UNAIDS policy endorsed in June 2005 did, however, place strong emphasis on the achievement of greater gender equality.
- ¹⁵ *Ibid.*, p. 282.
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- ²⁷ *War against AIDS must start with Poverty*. James T. Morris, Executive Director, World Food Programme, Message for World AIDS Day, 1st December 2005
- ²⁸ Opportunistic illnesses are "illnesses caused by various organisms, some of which usually do not cause disease in persons with healthy immune systems. Persons with advanced HIV

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- infection may suffer opportunistic infections of the lungs, brain, eyes and other organs" (*AIDS in Africa: Three Scenarios to 2025*, UNAIDS 2005, p. 213).
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- ⁹⁰ A very cumbersome procedure has been established that requires Country A to notify the WTO of its exact import needs for a generic product, and of its intent to issue a compulsory license in order to import it. Only after that could Country B also issue a compulsory license to authorize the generic manufacture of the medicine for export. The amended regulations do not allow for the procurement of medicines through international tendering, which is the most common and efficient way of purchasing drugs. *Medicins sans Frontieres*: www.doctorswithoutborders.org/pr/2005/12-06-2005_1.htm.
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APPENDIX

SOME RECOMMENDATIONS FROM JCTR FOR ACTIONS RESPONDING TO

HIV AND AIDS: A JUSTICE PERSPECTIVE

Building upon the analysis of Michael J. Kelly's study, we at the Jesuit Centre for Theological Reflection offer some specific recommendations for actions that can be taken in response to the challenges that he raises. These actions are in line with our commitment to advocacy for greater social justice for all in our society, especially for the poor.

Government

- should pay greater attention to the socio-economic environment within which HIV/AIDS is contracted – e.g., poverty conditions, education opportunities, general health care, employment possibilities, etc.
- should define development as people-oriented and not simply in terms of economic growth or wealth creation
- should promote greater justice for women by attacking economic, social and cultural structures that continue to disempower women
- should take more seriously meeting the challenge of the growing population of OVCs with programmes of protection, care, education and health

International Donors

- should critically examine and reject the enforced economic reforms that have caused considerable social suffering among the majority of the people in a country like Zambia
- should promote reform of inequitable trade arrangements that promote poverty in developing countries (e.g., agricultural subsidies) or restrict availability of inexpensive drugs (e.g., WTO regulations)
- should provide support for interventions beyond medical and behavioural aspects, such as increasing educational opportunities for all, especially for the girl child

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- should encourage and support governments to embark on “quick impact” initiatives such as feeding programmes in schools to enhance educational attainment and promote good nutrition.

Church

- should keep up its strong voice for greater social justice in all aspects of life and add strength to that voice by its own clear witness to justice
- should sharply condemn and root out any stigma or discrimination relating to persons living with HIV/AIDS
- should look at its moral teaching in a more holistic fashion, getting out of a narrow focus on the “condom debate” into a wider discussion of “just and responsible sexuality”
- should pay special attention to the issues of justice for women, both in the church and in the wider society, in order to strengthen family life that is supportive of responsible citizenship in a world challenged by HIV/AIDS
- should provide greater access for youth to educational opportunities for development of the whole person, for life skills and moral training, for participation in decision-making and for general ability to relate maturely to life’s challenges

Medical Professionals and Institutions

- should address wider health issues relating to HIV/AIDS than only the provision of ART
- should lobby government and donors for greatly improved general health care for all citizens, regardless of financial status
- should lobby for improved working conditions for medical personnel that would assure adequate health care delivery and lessen the impact of the “brain drain”

NGOs

- should effectively raise the justice issues, especially those relating to the empowerment of women and of youth and the care of elderly
- should challenge any traditional and cultural practices that contribute to an environment in which HIV/AIDS is spread
- should pay greater attention to ecological issues that are closely related to HIV/AIDS

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- should use the JCTR *Basic Needs Basket* as an advocacy tool to promote greater food security and household justice – e.g., responsible budgeting

Families

- should encourage a culture of sexual responsibility that is truly just
- should teach the values of self-sufficiency, hard work and community care

These are only a sampling of the kind of recommendations that we feel come out of Kelly's study. Central to all of them is the conviction that the HIV/AIDS pandemic will only be effectively and equitably addressed by responding to the three considerations that Kelly has argued form the basis of his study:

1. There is strong synergy between the AIDS epidemic and four basic root causes: poverty; gender disparities and power structures; stigma and discrimination; and exploitative global economic structures and practices.
2. Responding to HIV and AIDS is intimately connected with the practice of justice.
3. AIDS and justice issues are so intimately linked that action on behalf of justice will almost automatically be action against the epidemic.

The basis for our JCTR recommendations can be found in the concluding remarks of the *Executive Summary* of this study:

Dismantling the unjust structures in which poverty, the low status of women, stigma and discrimination, and exploitative global economic practices, are embedded, and establishing just structures and practices in their place, will create a terrain in which the human immuno-deficiency virus can no longer flourish. Equally, action against the epidemic will be action on behalf of justice. As this report shows, the shape and extent of the AIDS epidemic is determined by various unjust forces, many of them outside the areas normally addressed by HIV and AIDS programmes. Addressing HIV and AIDS serves as an entry point and catalyst for addressing these broader injustices. Briefly, then, one can say that the more HIV/AIDS, the less justice—but the more justice, the less HIV/AIDS.

We at JCTR invite others to join us in responding to HIV/AIDS with this justice perspective.