

MDGs and HIV/AIDS

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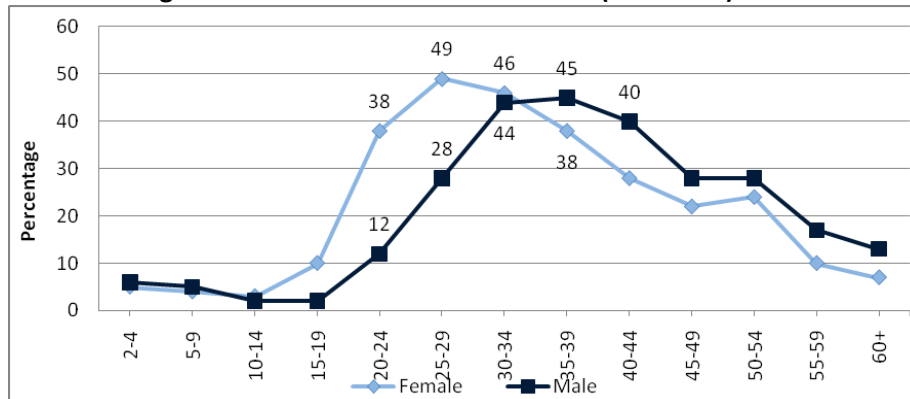
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The countdown to 2015 has begun. The next four years will be crucial. Although much work remains to be done, much has already been accomplished. When the MDGs were first formulated there was a clear idea of the challenges the AIDS epidemic could pose. Bizarrely this was not properly considered. The UNGASS meeting which took place in 2001 recognised the importance of AIDS. The MDGs should have recognised that the mortality and morbidity associated with the disease would mean that, in some settings, it was unlikely that some of the MDGs would be met.

In 2011 we have the chance to assess the situation and make some recommendations as to what needs to be done. There are three key points that need to be made by way of introduction:

- People infected with HIV will, some years after the infection, experience periods of ill-health that will increase in frequency, intensity and duration. In the absence of lifetime treatment they will die. The illness, morbidity, and death, mortality, result in the impact on the MDGs. The majority of those infected are young or middle aged adults (see Figure 1 for HIV prevalence in Swaziland). These are people who do not generally fall ill or make demands on the health service (except in the case of deliveries), thus AIDS morbidity and mortality may be seen as excess, over and above what is expected normally.

Figure 1. HIV Prevalence in Swaziland (DHS 2007)



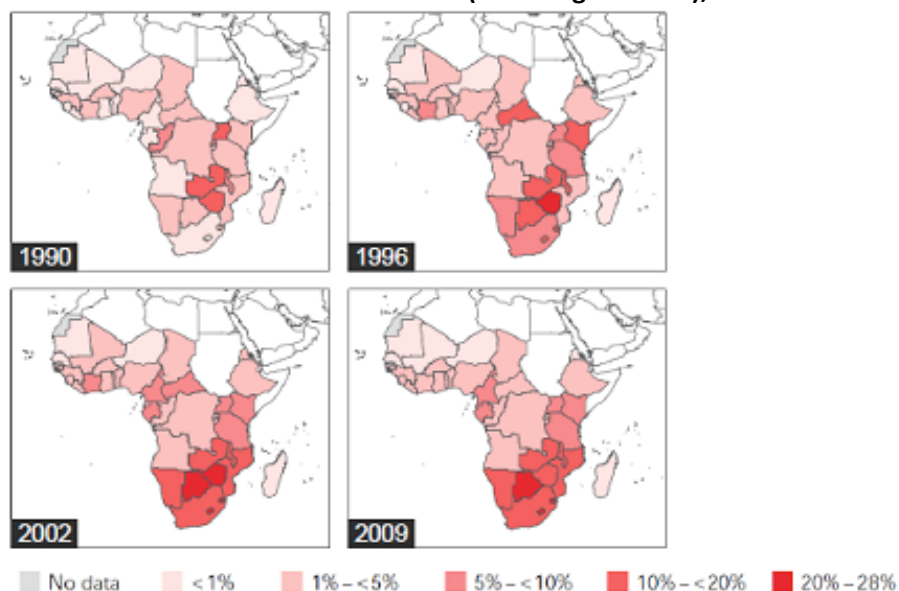
- In most of Sub-Saharan Africa (SSA), infections are sexually transmitted and there are more women affected, at younger ages, than men. Women who are HIV positive and give birth have about a 30% chance of passing the infection to their infants. If a child is infected, then he/she will fail to thrive and in the absence of treatment is very likely to die. There are interventions to prevent this vertical transmission.

- The epidemic is highly variable across SSA and should not be seen as homogenous. The prevalence is illustrated in the second figure. This means that its consequences are not uniformly catastrophic for the MDGs. The ideas of AIDS exceptionalism have been extensively explored in a number of articles.
- Hyper-endemic countries include Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe (See Table 1). Here AIDS must be seen as exceptional because of the numbers infected, the consequent levels of mortality and morbidity, and its demographic and social impacts. AIDS is changing the structure of societies; preventing development gains; and undermining efforts to meet the Millennium Development Goals. It will have an impact on the MDGs in all countries where prevalence is above 2-3% of adults, but it will be commensurately smaller. However in all resource poor countries AIDS is exceptional because of the cost and burden of providing treatment. Despite this, in 2006, at the General Assembly High-Level Meeting on HIV/AIDS, United Nations Member States agreed to work towards a goal of 'universal access to comprehensive prevention programmes, treatment, care and support' by 2010. (UNAIDS & WHO 2009).

Table 1. Estimated adult prevalence (%) for selected countries in 2009	
Botswana	24.8
Lesotho	23.6
Malawi	11.0
Mozambique	11.5
Namibia	13.1
South Africa	17.8
Swaziland	25.9
Zambia	13.5
Zimbabwe	14.3

Source: Adapted from UNAIDS 2010 Prevalence Map

Figure 2. HIV Prevalence in Sub-Saharan Africa (adults aged 15-49), from 1990-2009



Source: UNAIDS 2010 Prevalence Map

Where we stand

As detailed in the latest UNAIDS Report on the Global AIDS Epidemic, there have been some successes on the HIV/AIDS front: the number of new HIV infections has fallen from a peak of 3.5 million in 1996 to 2.7 million in 2008. Deaths from AIDS-related illnesses have also dropped from 2.2 million in 2004 to 2

million in 2008. Countries like Botswana have achieved progress in rolling out free access to treatment and have succeeded in raising the life expectancy of their citizens.

Despite such achievements, we cannot fool ourselves into believing that we have achieved many quick wins. MDG 1 - whose aim is to reduce those suffering from poverty and hunger by half by 2015 – is often cited as an example of remarkable progress, signalling that hundreds of millions of people have been lifted out of poverty. As Helen Clark recently underscored in a speech at the LSE, if we took China out of the equation, the number of people living in extreme poverty actually increased by approximately 36 million between 1990 and 2005,. This means that we cannot hide behind averages. Nor should we treat the MDGs as goals in and of themselves – they are a means to an end: real development on the ground and not just on paper.

Before identifying the challenges facing the achievement of the MDGs, we need a clear idea of where we stand and how much progress has really been made. By focusing on those MDGs that relate most closely to HIV/AIDS and after briefly assessing the extent to which the epidemic impacts other targets, we will be able to make some recommendations for moving forward as we approach 2015.

Table 2. Selected HIV and AIDS statistics for Sub-Saharan Africa				
	Adults and children living with HIV	Adults and children newly infected with HIV	% Adult prevalence (15-49 years)	AIDS-related deaths among adults and children
2009	22.5 m	1.8 m	5.0 m	1.3 m
2001	20.3 m	2.2 m	5.9 m	1.4 m

Source: Adapted from UNAIDS 2010 Prevalence Map

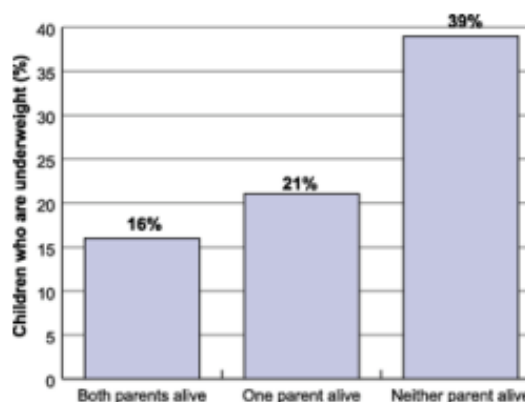
HIV/AIDS and the Millennium Development Goals:

MDG 1 (Eradicating extreme poverty and hunger)

Evidence suggests that AIDS may lower GDP growth by up to 1.5% per year. An analysis of 80 developing countries predicts that a ‘typical’ African country with 20% HIV prevalence grows 2.6% less, on

average, each year than it would if it was not afflicted by HIV/AIDS (Hecht et al 2006). A plethora of studies show that poverty is higher among households affected by HIV/AIDS than among unaffected households; these studies also document how declining family incomes lead parents to forgo long-term investments in favour of immediate consumption. With regards to extreme hunger, there is a growing body of evidence linking child nutrition, food security and HIV/AIDS. One study surveying 44 countries in Sub-Saharan Africa suggests that HIV prevalence was

Figure 3. Underweight Prevalence among Children Under Four in Lesotho



significantly negatively correlated with increasing calories and protein consumption. By increasing parental mortality and thus contributing to the number of OVCs (which are less likely to receive adequate nutrition compared to non-orphans), HIV/AIDS exacerbates the problem of malnutrition in high-prevalence countries. Infected people need more nourishment but are less able to access it.

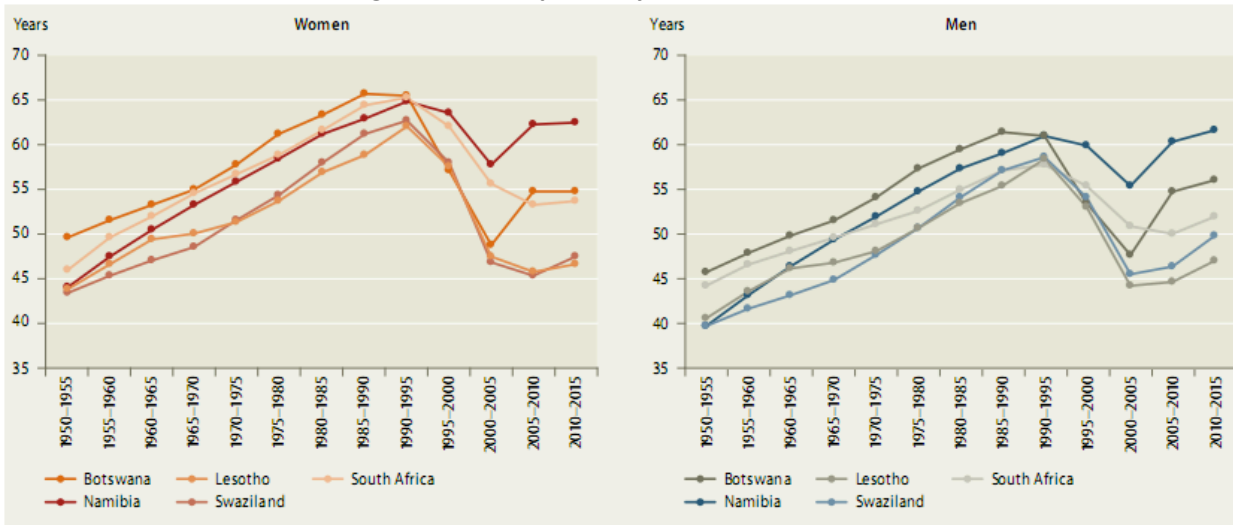
MDG 2 (Achieving universal primary education)

HIV/AIDS has a strong negative impact on the education sector. Sub-Saharan Africa is off track for meeting the target for both boys and girls to complete their primary school education by 2015 (Fourie and Schoeman 2010) but many successes have been recorded elsewhere. On the demand side, HIV affects the number of student enrolments and increases their absenteeism. The change in numbers gradually works its way up the educational system and has widespread affects well beyond the education sector. Attendance among orphans may be lower than among other children. The negative effects of HIV on education are felt particularly by females, who may be unable to attend school in order to care for sick family members or for lack of funds. The supply of education is also severely affected. Educational staff at all levels experience similar increased levels of illness and death as the general population. This decreases educational quality and poses challenges in replacing teachers who pass away.

MDG 3 (Promote gender equality and empower women)

It is a documented reality that 60% of infections in Sub-Saharan Africa occur in women, especially younger women and girls (UNAIDS 2009). The epidemic impacts women’s economic and social opportunities and hinders their role as caretakers; this in turn has a detrimental impact on the well-being of the family as a whole. Conversely, gender inequality and gender-based violence certainly exacerbate those conditions in which the spread of HIV proliferates and increases individuals’ risk of contracting the epidemic. High levels of illiteracy and limited financial independence aggravate women’s situation, particularly for those living in poor rural areas of Sub-Saharan Africa. HIV/AIDS also places a high burden on grandmothers. Many have to care for and take in their grandchildren, shouldering both a financial and social burden (Fourie and Schoeman 2010).

Figure 4. Life Expectancy in Southern Africa



Source: UNDESA The World's Women 2010 report

MDG 4 (Reduce child mortality)

Several high-prevalence countries in Sub-Saharan Africa are off track in meeting MDG 3, but the negative impact of HIV/AIDS on child mortality is particularly relevant and acute in high-prevalence areas. According to one study, by 2015 up to 90% of under-5 deaths in Botswana will be directly or indirectly caused by HIV/AIDS (Hecht et al 2006). A number of studies have shown that children born to mothers with HIV are approximately three

Figure 5. Child Mortality in High HIV Prevalence Countries of Sub-Saharan Africa

times more likely to die than children born to mothers not infected by HIV. Moreover, paediatric ARV formulations are few and their availability is poor. One study reveals that in 5 countries with adult HIV prevalence rates above 10% (Zambia, South Africa, Zimbabwe, Botswana and Swaziland), under-5 mortality not only failed to decline between 1990 and 2003 but actually increased (Millennium Indicators Database). Figure 5 represents trends for these countries, showing increasing or stagnating figures.

MDG 5 (Improve maternal health)

It is estimated that AIDS is responsible for 18% of maternal deaths globally. MDG 5, which seeks to reduce the maternal mortality ratio by three quarters, has seen the least progress out of all MDGs. The number of maternal deaths per 100,000 live births has in fact declined at a rate of 22%, much more slowly than necessary to meet the 75% reduction target by 2015. As

illustrated in Figure 4, it is difficult to establish the precise relationship between maternal mortality and HIV. In Botswana, which has a high prevalence rate, mortality decreased sharply between 1990 and 1995. Zimbabwe, with a lower HIV prevalence rate experienced a significant increase in MMR per 100,000 live births. Because certain Sub-Saharan African countries have even witnessed a net increase in maternal mortality since 1990, we are witnessing a reversal of past gains (Hogan et al 2010). In high prevalence countries like South Africa, HIV/AIDS is the leading cause in obstetrics' maternal deaths (Alban and Anderson 2007). Miscarriages, anaemia, postpartum haemorrhages and puerperal sepsis are all complications to which women with suppressed immune systems have a higher risk of being exposed. Studies in Zimbabwe and Malawi suggest that the risk of pregnancy-related death is eight to nine times higher in women who are HIV positive than in others (Hecht et al 2006).

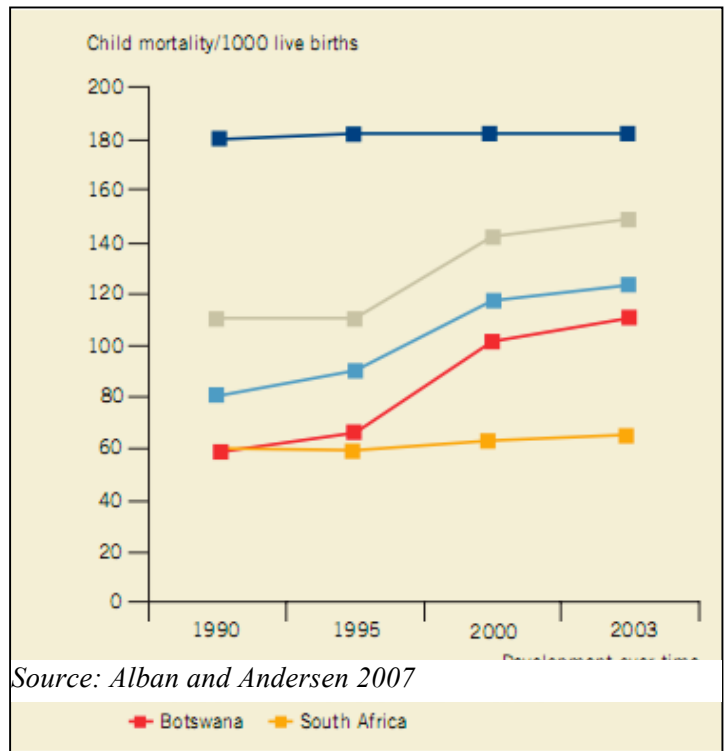
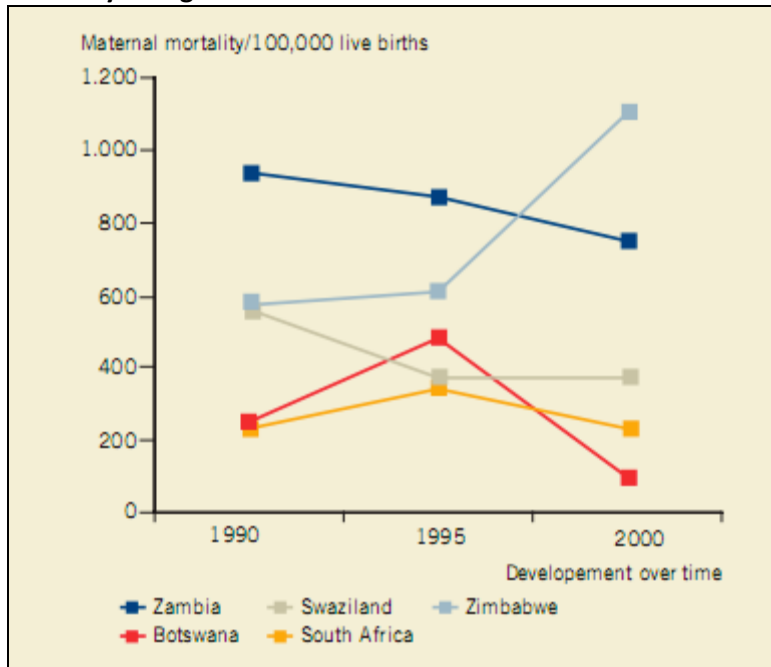


Figure 6. Maternal Mortality in High HIV Prevalence Countries of Sub-Saharan Africa

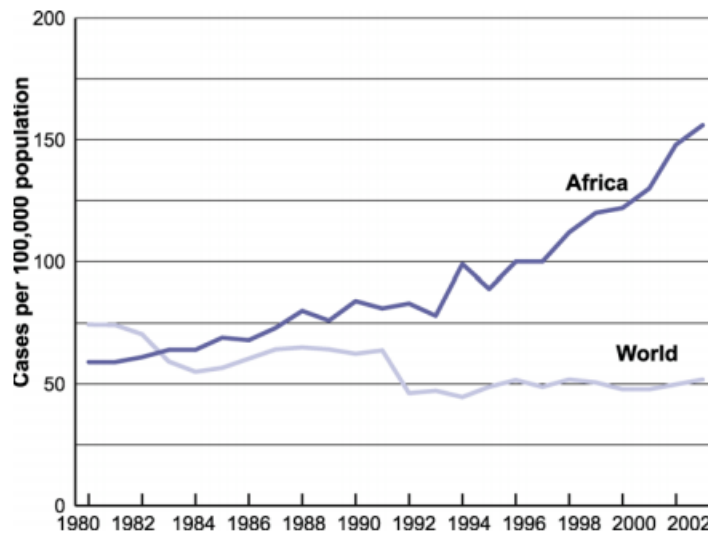


Source: Alban and Andersen 2007

MDG 6 (Combat HIV/AIDS, malaria and other diseases)

The interaction between AIDS and TB is well documented. The risk of acquiring TB doubles soon after HIV infection and increases during subsequent years. While 9% of TB cases are related to HIV/AIDS at the global level, in the WHO African region alone, the impact of HIV/AIDS is estimated at 31% (Alban and Andersen 2007). The most evident effect of HIV on malaria is related to pregnant women. More generally, recent studies suggest that HIV-induced immunodeficiency may decrease the immune response against malarial infection; the risk of contracting parasites and illness has been inversely correlated to CD4 cell counts (Hecht et al 2006).

Figure 7. Tuberculosis Case Notification Rates



Source: Hecht et al 2006

MDG 8 (Develop a global partnership for development)

Although to different degrees, many developing countries rely on official development assistance (ODA) to meet the health needs of their population. The (much-needed) attention and financial resources that have been committed to HIV/AIDS in the past decade have created both enormous opportunities and a wide range of problems, including those of sustainability and duplication of efforts among others. The

recent financial and economic crises (which led to debt crises, rising deficits and subsequent budget cuts), have rendered aid flows more unpredictable. Funding for HIV/AIDS in the coming years is likely to remain constant or decline, potentially jeopardizing the recent successful roll-out of HIV treatment along with many other HIV-related activities.

10 Key Challenges Facing the Achievement of the MDGs

What are the 10 key challenges we are facing in the run up to 2015, with respect to halting HIV and meeting the MDGs?

1. The number of new HIV infections in the world still outpaces the scale up of treatment, so the amount of attention and resources being devoted to prevention is still lagging.
2. In generalised epidemics, interventions continue to pay too little attention to most-at-risk-populations. Such interventions therefore fail to be cost-effective and to achieve the desired results.
3. Better technologies are needed for the prevention, diagnosis and treatment of HIV/AIDS. To date, vaccines and microbicides offer our best chance of controlling the epidemic so more attention needs to be focused on these.
4. ARVs have succeeded in keeping people alive for longer but still do not constitute a viable solution to the HIV/AIDS problem around the world. Their high cost creates a real problem of sustainability and still does not offer a silver bullet.
5. Sub-Saharan Africa is starting from a low level of achievement. This eliminates the possibility of achieving quick wins by picking the 'lowest hanging fruit' and makes the road ahead even harder to pave.
6. Fatigue by developing country governments and by the international community may decrease enthusiasm and willingness to meet the MDGs.
7. Failure to achieve results and meet pre-determined targets in 2015 may jeopardize future attention and resources. Credibility and continued support must be backed by concrete and substantial achievements and efficient/effective use of resources. HIV 'exceptionalism' is particularly vulnerable in this scenario of uncertainty. As outlined earlier, resource instability may jeopardize HIV treatment continuity, particularly for those countries highly reliant on donor funding.
8. The food, fuel and financial crises have had a negative impact on the MDGs. Such crises have had ripple effects on poverty, unemployment, food security, etc. The negative impacts of these shocks to the international order will continue to be felt in the developing world for the foreseeable future.
9. The interconnectedness of the Millennium Development Goals constitutes both a challenge and an opportunity. Because HIV/AIDS targets in SSA will not be achieved, most of the other MDG targets will also not be achieved. Their interconnectedness, however, signifies that if we achieve gains in one area, other areas will also improve.

10. Natural disasters, whose frequency and intensity have increased in the recent past, have diverted attention away and reversed gains made with respect to some MDGs (increasing poverty, disrupting education, decreasing life expectancy, etc). Such disasters will continue to manifest themselves in the foreseeable future and we must therefore learn to incorporate them into our development planning and thinking.

10 Most Pressing Recommendations for Africa and the MDGs

1. Both developing and developed countries must recognise and internalise the interconnectedness of different MDGs. An analysis carried out by the University of Pretoria suggests that because HIV/AIDS targets in Sub-Saharan Africa will not be achieved, most of the other MDG targets will not be attained either (Fourie and Schoeman 2010). This signals that the Millennium Development Goals should not be tackled in isolation from one another. Making progress on MDG 6 will allow us to work towards meeting other MDGs and vice versa.
2. The international community must recognise and reward those countries in Sub-Saharan Africa that have actually achieved much with respect to the MDGs. Ghana has already met its target to decrease the proportion of undernourished people. Botswana, as mentioned above, has made impressive leaps forward in terms of providing anti-retroviral treatment to its citizens. These examples must be show-cased more widely in order to encourage other countries to follow suit and reap the full benefits of such progress.
3. There is an urgent need for leadership and recognition of the impact of the epidemic among African leadership. There is a need for realism including recognition of most at risk populations.
4. We must devise innovative financing mechanisms to ensure that reaching the goal of universal treatment is financially sustainable. One idea could be for high-prevalence countries endowed with natural resources, to ring-fence say, 10-15% of revenues from such resources to finance ARVs (or other health-related goals).
5. Greater South-South cooperation must be encouraged. As some members of the G20 gain prominence on the world stage and their economies grow, their geopolitical weight accrues relevance and opens up opportunities for great knowledge sharing, funds for development, cultural exchanges and greater ownership of the development process.
6. We must look to future data projections rather than adopt a reactive stance towards the epidemic. Only then will we be able to achieve MDG 6 and work our way towards other goals. At the same time, we must not forget the importance of social determinants as obstacles to MDGs; these cannot easily be changed using simple, one-time interventions so we must be creative.
7. Given the relative lack of progress on MDG 5 (maternal mortality), investments in this area need to be stepped up. Countries should capitalise on the renewed interest in gender as it relates to HIV/AIDS transmission (see UNAIDS Global Aids Epidemic report 2010), by focusing attention on emergency obstetrical care and skilled birth attendance. At the same time, they must look to those targets that have done relatively well (like MDG 2 on universal primary education) and learn what things have been done right in those sectors.
8. The international community must prioritise and focus on countries where prevalence is higher than 10% among the adult population. It must always remember that there are differentiated

impacts of the epidemic on the MDGs. What works in Swaziland will not work in Senegal. It must appreciate that the epidemic is worst in the lower-middle income countries.

9. The HIV/AIDS community must be more forward-thinking and look beyond its borders for ideas and challenges. For example, it must do more and be more creative when thinking about ways to make HIV/AIDS funding more sustainable in the long-run. The HIV/AIDS community must be part of the movement calling for change in the existing international governance structures and financial arrangements. We need to learn from our mistakes and fight for a more stable and fair society, as uncertainty and instability affects vulnerable groups the most.
10. We should sustain the momentum for the integration of HIV/AIDS into national programs. More research is needed to fill the knowledge gaps in this area, but progress has been made and should be continued in the near future.

Conclusion

We must make good use of these four years that remain and devise a concrete action plan that injects fuel into the MDG initiative. With such a short time left until 2015, developing countries, and in particular Sub-Saharan African ones must assume the driving seat and capitalise on the momentum created by the MDGs to achieve substantial strides ahead.

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