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THE HIV EPIDEMIC AND SUSTAINABLE HUMAN DEVELOPMENT

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I intend to explore two different aspects of the topic for this component of the Session. Inevitably the treatment will be broad-brush and it is not my intention to do other than to set-out some of the relevant relationships, and then to attempt to draw some useful conclusions.

The two questions I want to try and address are :

WHAT IS SUSTAINABLE HUMAN DEVELOPMENT? and

WHAT IS THE RELATIONSHIP BETWEEN THE HIV EPIDEMIC AND SUSTAINABLE HUMAN DEVELOPMENT [SHD]?

A. WHAT IS SUSTAINABLE HUMAN DEVELOPMENT?

There is no agreement among development practitioners as to what SHD is or is not - indeed whether this represents something new, as UNDP seems to

believe, or is simply a reformulation of development objectives which have long been at the core of development policy. This is not to argue that the concept has no value - this is not my position at all - but rather to suggest that SHD, whatever its rhetorical significance, may in fact contain little which is new, and may in practice offer little OPERATIONAL guidance to those who have responsibility for policy and programme development.

There is a long history of debate on development going back at least to the discussions relating to Soviet industrialisation in the 1920s. While it may not be necessary to go back that far it is worth reviewing thinking about development since 1945 - which is roughly speaking when economists and other social and natural scientists began extensively to theorise about development. The core questions have always been why some countries were rich and others poor, and how to change socio-economic, cultural and political conditions so that a larger % of the world's population had the real and supposed benefits of development. What was central to such theorising was the assumption that development, which was tacitly assumed as amounting to the values and material benefits common to the rich countries (but not available to ALL who lived in such countries), was what poor countries who lacked these things needed to acquire through development. It was self-evident, so it was argued, that poor countries would be better-off with more material possessions than without, and that these were attainable if only they would adopt the values and the institutions which had led to general abundance in the rich countries.

So development was both a set of targets and a process. Implicit in the process was the assumption that there existed models or routes towards development such that countries who followed these would in time achieve its fruits. Of course the emphasis on different elements of the development model changed over time, and different theorists and practitioners emphasised different factors as being central to the process. Some argued that raising investment rates was the way forward (seeing capital formation as central to the process - building on the research of economists like Kuznets and on the theories of Harrod and Domar - sometimes enshrined in both theory and practice as by Mahalanobis in India, as also in many centrally planned economies). Others emphasised the role of human factors in the development process - so that education and skill creation were seen as crucial for development. Yet others focussed on institutional and cultural elements which were said to hinder development. And yet others argued in favour of market processes - and especially those processes associated with opening countries to the benefits of trade, international investment and the international transfer of technology - usually based on a belief in trade and mobility of capital/technology as the engine of growth and transformation. With capital mobility the mechanism for both technology and management transfer so that production was relocated worldwide in accordance with dynamic changes in comparative advantage.

Central to most of these models of development are different conceptions of the

role of the State - to a degree it seemed possible to pick and choose, as is manifest in the recent rethinking on this issue by the World Bank. It is instructive to observe how the Bank has see-sawed in its perceptions of the role of the State in the development process. Until the late 1970s the Bank lent extensively to governments in the developing world for all kinds of infrastructure projects - from roads, to water to agriculture - reflecting its beliefs at the time that the State could be an instrument of development. But at the time of the introduction of SAPs (the 1980s) the Bank shifted to a belief in the minimalist State and pursued policies and programmes to achieve this in many countries. Yet overnight in the World Development Report 1997, *The State in a Changing World*, the Bank proved capable of completely reversing its position so that the State is again resurrected as an essential instrument of development. Such is the power of theory unrelated to historical experience of development.

The lessons of history on the essential role of the State as critical for providing essential structures that the market cannot efficiently supply are only too clear for those that have eyes to see. Who else but the State can ensure the general health of the population, provide the requisite skills and education, build and maintain a communications and transport infrastructure, establish and fairly implement a framework of laws, and support those elements of social capital essential for a free society? Who else but the State has responsibility for setting the macroeconomic framework within which micro decisions need to be taken? Indeed it is the failures of the State in determining parameter conditions relating to the exchange rate, taxation structures and the rate of inflation which have generated such large scale misallocation of resources in many poor countries. But if the State does not perform these roles efficiently and realistically then who will? Ultimately it is the State which has the responsibility of ensuring that the outcomes of development reflect widely held social objectives, and that the benefits of development are equitably distributed.

In the past 50 years or so during which development has been consciously pursued as an objective by all poor countries the means by which it is to be achieved have changed with intellectual fashion and to a lesser degree with experience. What was rarely if ever challenged in debates about development and what remained more or less implicit in development policy and programming, were the assumed targets of development. DEVELOPMENT WAS SEEN INTRINSICALLY AS A GOOD THING. What the discussion about SHD has done is to raise fundamental questions both about process and to a lesser degree about the purposes of development.

On what grounds would it be possible to argue that development was in fact questionable both in terms of HOW it is achieved and also in terms of WHAT it is that development is supposed to achieve?

What has become apparent is that development as represented by the experience of the rich countries is a mixed blessing - that development while it

may make it possible to provide for the material needs of most people in rich countries does not do so for all; that development seems to be associated with destruction of social capital in many countries - with losses of core values such as trust and community - and the enhancement of other values such as anomie and forms of social, economic and political exclusion. Even more central is the fact that market processes which have increasingly come to dominate the form of development in the rich countries cannot, and does not, address EXTERNALITIES. These are in part social (a widening of the gap between rich and poor in almost all dimensions - and not just in income terms) and in part environmental (factors such as global warming that are internal to the market processes of economic growth and which are already undermining sustainable development in both rich and poor countries).

Furthermore, there are no ways that market systems can create outcomes that are gendered, other than those which continue to leave women discriminated against in labour and credit markets and in access to political and economic decision making - this in spite of the rhetoric of many decades about the need to rectify the situation. Here the gap between supposed public intent and outcomes is even wider in developing countries than in rich ones, with consequences for the HIV epidemic which are evident for all to see.

WHAT CAN BE CONCLUDED FROM THE FOREGOING ?

1. That development as represented by the experience of the rich countries creates many problems. Foremost amongst these are an intensification of social and economic inequality in many countries in terms of class and gender, often associated with pressures towards a diminished role for the State and a reduced role for other social institutions which may in the past have ameliorated the excesses of market processes. A gradual realisation that social cohesion in many countries and regions is threatened by policies and processes which have given priority to economic growth over other desirable policy objectives. And evidence that the pursuit of private interest, often driven by greed, is far from Pareto efficient - that there are in fact losers and gainers from economic growth and that the welfare losses of the former may exceed those of the latter. Amongst the losers are future generations who will have to deal with environmental costs and other externalities which will reduce future world welfare for all. Amongst the losers almost everywhere are women who are generally denied access to opportunity and power, both economic and political, with the inevitable result that they are both exploited and denied the opportunity to play a full role in society.

2. That the pursuit of development has to concern itself both with the objectives of development and the processes for achieving these. SHD has the benefit of focusing attention on the purposes of development - that the objective of development is to increase human welfare in all of its dimensions and NOT

simply those that are economic. It is, therefore, closer to philosophical concepts of what constitutes a "good life" in which it is possible for all citizens to be free of material deprivation so that they are able to actively participate in national and community processes through the exercise of their social and political rights. The denial in many countries of these rights to women is indeed perhaps the greatest challenge facing far too many countries.

3. That the achievement of SHD requires processes which are themselves inclusive and participatory if in fact the outcomes are genuinely to represent what people want rather than what elites prefer. At the centre of such processes are principles of social, political and economic inclusion which are based both on rights and responsibilities. Only if the human factor is seen as central to the processes of development will its targets represent what men and women want and thus be realisable.

4. Useful though SHD is as a concept which helps to redefine the objectives and processes of development it is less clear about operational issues. Even given agreement on objectives, and commitment to inclusive processes, it is far from clear how to create political and economic conditions in all countries in which the general welfare will prevail where this conflicts with sectional interest. Ultimately SHD may fail not in its espousal of social objectives and a concern for sustainability, but rather in the naivety of its political assumptions - a belief that powerful economic and political groups will act contrary to self-and class-interests. Central to these concerns about power relationships are those relating to men and women, which is ultimately about the willingness of men to give up power in favour of women.

It can be concluded that,

- the involvement of an educated and empowered population is critical for setting the agenda of development;
- an empowered population is central to processes for achieving the development agenda so as to ensure equitable and sustainable outcomes;
- human welfare must be the sole objective of development; and
- what is unclear is how one moves from what is - the present - to where one wants to be.

B. WHAT IS THE RELATIONSHIP BETWEEN THE HIV EPIDEMIC AND SHD?

This is a complex matter and the following represents a drastic simplification of what are little understood issues. It should be remembered that what we have is a bi-directional relationship; thus -

THE HIV EPIDEMIC HAS EFFECTS ON SUSTAINABLE HUMAN DEVELOPMENT and

SUSTAINABLE HUMAN DEVELOPMENT HAS EFFECTS ON THE HIV EPIDEMIC

In what follows, I have selected only some aspects of the problem - those which seem to me to have the greatest policy and programme relevance. In no sense is this paper intended to be a complete analytical or empirical discussion - indeed I have been deliberately selective both in respect of the issues raised and in the marshalling of evidence in support of conclusions presented below.

1. POVERTY, INEQUALITY AND GENDER

There would be general agreement that the primary objective of SHD is to eradicate poverty for unless this is achieved there can be no way in which citizens can lead a full and productive life - able to support their children and to engage in those political, economic and social activities which are the hallmarks of a democratic society. In a region such as Asia and the Pacific this is a huge task - with perhaps 70% of those living in absolute poverty worldwide. Poverty on this scale is simply not going to be eradicated in the foreseeable future nor is the accompanying income and asset inequality. For many countries in the region have not only large numbers of men, women and children in deep poverty, but they also experience the consequences of observing the life-styles, and often being exploited by, those who are rich. Obviously there are differences in the incidence of poverty and inequality between countries and within countries, but the essential defining element of the Region as a whole is the size of the poverty problem and the consequent scale of the policy and programme problem in attempting to reduce it.

How does the HIV epidemic relate to this state of affairs and what are the implications of Poverty and Inequality for the achievement of SHD? Poverty and HIV transmission are obviously related but this is in no sense a simplistic relationship. The poor worldwide probably account for most of those who are infected and affected by HIV, but there are many of the non-poor who are also infected and affected. So it cannot be simply poverty which determines those behaviours which lead to HIV infection, for those who are not poor (the well off and the rich, the educated and the healthy) are also often infected with the virus in all countries - including the Asia and Pacific Region. It follows that the absence of income constraints and having knowledge of the risks of acquiring HIV can still lead to behaviours which lead to infection - those associated, for example, with young men taking the plane from Kuala Lumpur for Bangkok on a Friday evening for sexual entertainment.

So HIV infection is not confined to the poor, and the rich and better educated

are also becoming infected, with important consequences for SHD since these groups possess precisely the skills, education, training and experience so critical for achieving SHD. They account for much of the accumulated investment in human resources in the Region, and if SHD is right in its assertion that the human factor is THE important input in its achievement then their growing infection with HIV threatens what is going to be feasible. This seems to me to be one of the key important conclusions:

- SHD as a target is threatened because a key input in the process of development- the educated, the experienced, the skilled are also becoming infected with HIV so reducing the human resources critical for development in the region. It will also reduce the capacity of this class to save - and savings are necessary for capital investment in agriculture and industry. The capacity of this class to save and invest, and to manage enterprises and public services is critical to achieving SHD.

What of the poor who are absolutely the largest group in the Region as they are also the supposed beneficiaries of SHD? The poor are not only income and asset poor they also lack those characteristics of education and good health so important for a modernising economy and society. Within the poor it is often women and women-headed households who are the poorest of the poor - often deprived of reasonable access to education, housing, health services and lacking anything that could be described as a "sustainable livelihood". It is scarcely surprising that in these circumstances the poor adopt survival strategies which expose increasing numbers to HIV. This seems to be true for women, and especially young women, who as noted above are everywhere subjected to social, economic and political discrimination, and often exploitation. It is scarcely surprising that the group experiencing the fastest rate of growth of HIV infection worldwide is women, with in many countries rates of infection in young women under the age of 20 some 5 to 6 times those of young men. The typical age and gender distribution in most countries, including Thailand as a good example, is for young women to outnumber men amongst those infected at earlier ages (so that women lose more years of life as a result of earlier infection and through their generally reduced access to treatment in almost all countries).

The behaviours which expose the poor to HIV infection also constrains their ability to cope with infection - their lack of assets/savings, the vulnerability and uncertainty of their sources of income, their lack of access to knowledge about infection processes including understanding of opportunistic illnesses, and their general lack of access to health and other support services. Access to even the least costly of drugs and to inexpensive material supplies for the care of the sick is denied to the poor in most places with important consequences for HIV progression rates. Those infected with HIV unnecessarily die from opportunistic infections which can be relatively cheaply treated with inexpensive drugs, and thus lose years of potentially productive life during which they could have

supported both themselves and their families. Again the evidence is that for the poor, as for the rich but with more disastrous consequences for the poor, the experience of HIV infection deepens personal and family poverty and is often associated with forms of social and economic discrimination and isolation.

Three important conclusions follow from the foregoing:

- The HIV epidemic has its roots in the widespread poverty present in the region, although poverty is not the only factor driving the epidemic. But addressing through appropriate policies and programmes (SHD) the causes of poverty there is a chance that behaviours can be modified so as to reduce future HIV transmission.
- Since HIV infection and its costs are closely correlated with gender factors it follows that addressing sources of gender inequality through SHD holds out a possibility of reducing future HIV transmission and thus the costs of the epidemic. Gender inequity is a central objective of SHD and reducing this will make it easier to address the underlying causes of transmission. Improving access to sustainable livelihoods and to better social services will mitigate the impact of the epidemic on those affected.
- Sadly the HIV epidemic intensifies poverty and deprivation and increases social exclusion both for those infected and those affected. As such the epidemic makes the achievement of SHD that much more unlikely given that poverty in the region is already a major problem and the epidemic has the capacity to increase its level and incidence. The HIV epidemic makes the task of SHD greater than it would otherwise have been in the absence of HIV, and simultaneously reduces the human resource capacity in the region for undertaking those activities essential to poverty and gender focused programmes.

2. MEASURING THE IMPACT OF THE EPIDEMIC ON SHD - THE UNDP HUMAN DEVELOPMENT INDEX

The HDI of UNDP is widely used as an aggregate measure of progress with human development and is a useful proxy for assessing the performance of countries. It has some disadvantages as do all weighted indexes. In the usual form the HDI is an index which combines life expectancy, a measure of educational attainment and GDP per capita - all clearly important indicators of human development. There are obviously problems with the measurement of the different components of the index where there is a great deal of country variance in the coverage and quality of the basic data. There are other problems such as the absence of distribution indicators, most obviously in the use of GDP per capita which provides a poor indicator of the distribution of income (and no direct indication of the inequality of wealth which may be increasing). There are also major problems with setting the weights for such a index where there is an element of arbitrariness in their selection.

Nevertheless in spite of all of the caveats the HDI is probably the best general indicator we have of human development. Clearly no-one believes that SHD is achievable without rising per capita GDP - economic growth is a necessary if not sufficient requirement for reducing poverty and improving the standard of living. But unfortunately for a number of reasons the HIV epidemic is likely to reduce average rates of increase in GDP (in economic growth). This will happen through the effects of losses of human resources due to morbidity and death; to reduced national savings as resources are diverted away from productive uses and into consumption (especially rising expenditure on health and other social expenditure), and through losses of social capital (as society experiences the effects of changes in values and losses in the efficiency of institutions affected by the epidemic). The evidence from high prevalence countries in Africa who are experiencing more mature epidemics is that growth rates of GDP may be reduced by 0.5 to 1.0 % per annum due to the epidemic. These losses may be much larger where the skilled, highly educated and experienced form a significant proportion of those infected with HIV, and when account is taken of the general effects of the epidemic on the efficient functioning of the economy.

- So the evidence is that rates of GDP growth are adversely affected by the HIV epidemic and that these losses can be very significant over time depending on the structure of economies, on the distribution of the infection in the population and its incidence, and on the aggregate effects of the losses of human resources on the efficiency of the production system - in both the formal and informal sectors.

It is unclear what the effects of the HIV epidemic will be on educational attainment which accounts for one-third of the HDI. What seems to be happening in many countries is that enrollment in formal education is reduced as households respond to the pressure on resources by withdrawing children from school. There is a clear gender bias to the response of many parents when making choices: girls are much more often taken out of school when family coping mechanisms are placed under pressure by the epidemic. There are many reasons for this gender bias - in part it is income related, where attendance at school has direct costs (fees and uniforms etc.) and in part it is opportunity costs (the labour of children - especially girls - becomes more valuable to the family as incomes are even more constrained by the epidemic, including also the diversion of women to caring roles, and/or the additional burdens on the household caused by greater expenditure on health, transport, etc., directly related to illness in the family).

Whatever the explanation it seems that one consequence of the epidemic will be a reduction in educational achievement, especially of girls and young women, which will impede the achievement of one of the main goals of SHD. That is the achievement of greater gender equality as both an end in itself and as a means for achieving higher living standards for all. Unfortunately the HIV

epidemic has the potential for increasing gender inequality in many ways, not least in reducing the access of girls to education and also to better health where education is an important factor in understanding how to live a more healthy life.

- It follows that educational attainment which is already gender biased in the region will become more so as a result of the HIV epidemic rather than less. This will make it even more difficult to achieve greater gender equality for women in spite of this being a core objective of SHD.

Finally there is the effect on the HDI of changes in life expectancy directly and indirectly attributable to the HIV epidemic. Here the evidence is only too clear; the epidemic has the capacity to drastically increase adult mortality rates - raising these by factors of 5 or 6 times what they would be without AIDS. Since the epidemic is concentrated on the working age groups of 15-45 where mortality would generally be low the effects of HIV (and TB) are disastrous - these groups would otherwise tend to have low mortality rates. To give an example from Africa where the epidemic is more advanced; in Tanzania HIV and AIDS are now the largest causes of death for both men and women in the age group 15-59.

Figures 1 and 2 present data on life expectancy for a selected number of countries in sub-Saharan Africa where the epidemic is more mature than it is in the Asia and Pacific region. The projections for the year 2010 should be seen more as scenario predictions given the difficulties in estimating the likely trends in HIV over a period as long as 15 years. What is apparent is that the effects on life expectancy of the epidemic are already apparent in many countries in Africa, with highly significant falls in LE in many countries in the region. Thus in Zambia the Without AIDS LE in 1996 would have been approximately 60 years, whereas the With AIDS LE in 1996 is estimated to be about 35 years. The projected data on LE for 2010 represents an even more serious situation, with further declines in many countries in the Africa region. In some countries the situation is no less than disastrous. In Zimbabwe, to take one example, LE is predicted to be almost 70 years in the Without AIDS scenario, but declines to about 32 years in the With AIDS case.

The effects of HIV/AIDS on life expectancy are already apparent. Similar effects must already be underway in those countries in Asia and the Pacific with highest prevalence and most mature epidemics (such as Thailand and Myanmar).

- The effects on life expectancy of the HIV epidemic are potentially disastrous as the epidemic intensifies in the Asia and Pacific region and adult mortality rates increase. It is possible that life expectancy may over the next 25 years be reduced very significantly with enormous consequences on the potential for achieving SHD. A central objective of

SHD is to increase life expectancy through improvements in the standard of living of the population, but the HIV epidemic has the potential for drastic reductions in this crucial indicator of human development.

It is possible to make calculations of the effect of the HIV epidemic on the HDI so as to assess the effect of the epidemic on human development - to measure the impact of the HIV epidemic on SHD. It is rather easier to assess the effects of changes in life expectancy on the HDI than the other two components of the index. Doing this can demonstrate how significant the effects of the epidemic will be on sustainable development in the region; and the evidence is that these can build-up to very significant effects indeed.

3. INCLUSIVE AND EXCLUSIVE PROCESSES

One of the objectives of SHD is to bring about a wider participation of civil society in the processes of decision making. Or, to put it differently, SHD aims to strengthen social capital through activities which build capacity in institutions and through changes in values that support wider participation by all groups in social decision making. Central to achieving this are policies for greater democracy, more open and accountable systems of governance, and increased authority for those who have responsibility for ensuring that human and legal rights are observed by all. Of course the gap between aim and actuality is presently huge, and many countries in the Asia Region are a long way from achieving the ideal in these respects. Indeed there is continuing dispute in some countries as to whether there are natural and intrinsic rights, with some leaders arguing that there is no such thing. Whether or not there is something that can be described as natural rights which are common to all is not central to our present concerns, important though it undoubtedly is to socio-economic progress in the Region.

What is central to our present concerns is whether the HIV epidemic has created conditions which have moved countries closer to the ideals of SHD or the opposite. The evidence here is, however, very mixed. In many countries in the Region the HIV epidemic continues to be seen as a health problem and responsibility resides still with Ministries of Health. It follows that the epidemic has continued in many places to be viewed as part of the normal response to infectious diseases - to be addressed within the traditional framework of laws and regulations, and utilising traditional health approaches. Indeed in many countries the initial response to the epidemic has been often to seek out ways of applying the law as if using the law as a threat was an appropriate response. Central to this approach is a conceptualisation of the epidemic which sees the problem as one of "core groups" who engage in anti-social and reprehensible behaviours. The aim of policy is to identify these "core groups" and to implement policies and programmes that will change their behaviour.

Essentially the approach has been, and in many countries continues to be, one which is the opposite of inclusive - it defines a problem and then seeks to impose a solution.

The problem is perceived as being not the virus but people, and the processes followed are in most countries those traditional to public health programmes. Of course this is not true everywhere in the Region, and Australia is a remarkable example of how to develop a new consensus within society of what the problems are, how to build social capital, and how to develop policies and programmes which are genuinely participative and inclusive. Moreover such policy and programme development can, and should, involve those infected and affected by the HIV epidemic. To achieve these desirable objectives - of inclusion and participation - requires the development of an enabling framework of laws which are supportive of an effective response to the epidemic. It means establishing a set of principles of action for programme activities which ensure that these are based on collaborative processes and are not simply implemented and imposed by Government.

Paradoxically the HIV epidemic has the capacity to make the processes which are considered essential to the achievement of SHD more rather than less achievable. For while the initial response to the epidemic in most countries is, and continues to be, one which is inappropriate (to put it mildly) to what is required for an effective response, there has been in time in some countries a realisation that things have to be done differently. In a real sense the epidemic poses problems which cut across class and interest group identity. It threatens social and economic development, and may yet undermine political stability. Thus in an increasing number of countries, and also at a regional level, there now exist NGOs and networks of PLWHA, legal and ethical and human rights networks, and support groups for those affected - admittedly still too few but it is a start. Some Governments have come to a realisation that they have to broaden their response to the epidemic and this has to involve the rest of civil society - along the way understanding that strengthening the capacity of NGOs and CBOs and involving these in policy and programme development is the only way forward. There still remains a big distance to travel, but the road ahead has begun to look much clearer than it was even 5 years ago.

While policy and programme responses in the region have initially represented a retreat from the inclusive principles of SHD, in some countries there is now a gradual realisation that an effective response requires the active participation of civil society. Paradoxically the HIV epidemic has created a need and an opportunity for innovative approaches to governance which make the processes needed for SHD more attainable rather than less so. But there remains a large gap between those countries that have responded effectively through building social capital and those that have yet to do so.

CONCLUSIONS

It seems unnecessary to recap the specific conclusions of this paper since these have been identified as the discussion proceeded. What is being asserted is that SHD, which is a weighted set of objectives which are social, economic and political, is unlikely to be achievable in many countries with high levels of HIV and AIDS. Even in the best of conditions to seek to eradicate poverty within a foreseeable future is improbable, in part because of the scale of the task and in part because the enabling conditions for its achievement are rarely present in many countries. Some of the objectives of SHD require collaborative action between countries with widely divergent interests and are unlikely to be attainable.

But the core proposition, based on the empirical evidence of the effects of the HIV epidemic on many countries in sub-Saharan Africa, is that the losses of human resources and the erosion of social capital will seriously impede the achievement of SHD. Indeed in countries with high levels of HIV prevalence it is impossible to see how it could be feasible to achieve SHD given the scale of the socio-economic consequences of the epidemic. On the other hand, in low HIV prevalence countries, many of which are in Asia and the Pacific region, this is precisely the time when efforts to achieve SHD need to be intensified. For the structural causes of the epidemic, such as poverty and gender inequity, together with structures of governance which are unrelated to what is needed for an appropriate response to the epidemic, are what SHD is intended to redress. Setting in process those activities essential to the achievement of SHD will simultaneously put in place those conditions which will slow HIV transmission, and also strengthen the capacity of social and economic systems to cope with the impact of the epidemic.

Endnotes

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BIOGRAPHICAL NOTE

Desmond Cohen is an economist with university teaching experience in Africa, Canada, the UK and the USA. Formerly he was a Governor and Associate Fellow at the Institute of Development Studies, University of Sussex in the United Kingdom and until 1990, he was Dean of the School of Social Sciences.

He has both research and applied macro-economic policy experience in a number of African and Asian countries. Previously he was an adviser to the British Treasury on international financial policy. In 1997-98 he was Director of the HIV and Development Programme (UNDP), and currently he is Senior Adviser on HIV and Development.