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Social health insurance

Social security and HIV/AIDS

*The experience of the National Social
Security Fund*

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"If, by 2025, millions of African people are still becoming infected with HIV each year, it will not be because there was no choice. It will not be because there is no understanding of the consequences of the decisions and actions being taken now, in the early years of the century. It is not inevitable, it will be because the lessons of the first 20 years of the epidemic were not learned, or were not applied effectively. It will be because, collectively, there was insufficient political will to change behaviour (at all levels, from the institution, to the community, to the individual) and halt the forces driving the AIDS epidemic in Africa. What we do today will change the future."¹

Introduction

At the end of 2004, UNAIDS/WHO² estimated that globally a total of 39.4 million people were living with HIV. Of these, 37.2 million were adults - 47 per cent women while 2.2 per cent were children under 15 years. At the same time, 4.9 million people got infected with HIV while 3.1 million died. For Sub-Saharan Africa, the statistics represent a terrible picture. Whereas the global prevalence rate as estimated by UNAIDS at the end of 2003 was 1 per cent and less than 1 per cent elsewhere in the world, it was a whopping 7.6 per cent for Sub-Saharan Africa! The region still exhibits the highest prevalence rates ever recorded with Swaziland, Botswana, Lesotho, Zimbabwe, South Africa and Namibia estimated at 38, 37, 29, 25, 22 and 21 per cent respectively, to mention but a few.

Sub-Saharan Africa has just over 10 per cent of the world's population, but is home to 25.4 million (65 per cent) of all people living with HIV/AIDS in the world. A total of 3.1 million (63 per cent) estimated new HIV infections took place in the region while of the 3.1 million AIDS deaths, 2.1 million (74 per cent) occurred in Sub-Saharan Africa. At the end of 2004,

¹ UNAID (2005) - AIDS in Africa: Three scenarios to 2025.

² UNAIDS/WHO 2005 - AIDS epidemic update 2004, Geneva, Switzerland.

the epidemic has left over 15 million children orphaned and sadly still, 81 per cent of these live in Africa.

Young women (aged 15-24) are bearing the brunt of new infections in sub-Saharan Africa. Recent population-based studies suggest that there are on average 36 young women living with HIV, for every 10 young men.

Southern Africa remains the worst affected sub-region in the world with South Africa having the highest number of people living with HIV in the world. An estimated 5.3 million people were living with HIV end 2003 in South Africa - 2.9 million of them being women. Unfortunately, there is no sign yet of a decline in the epidemic.

Life expectancy at birth has dropped below 40 years in nine African countries: Botswana, Central African Republic, Lesotho, Malawi, Mozambique, Rwanda, Swaziland, Zambia and Zimbabwe. All are severely affected by AIDS. In Zimbabwe, life expectancy at birth was 34 years in 2003, compared with 52 years in 1990.

Some countries in East Africa, such as Ethiopia, Kenya and Uganda, show signs of declines in HIV infection levels. The steepest drop has been in Uganda, where national prevalence fell from 13 per cent in the early 1990s to 4.1 per cent by end 2003. However, it is much too early to claim that these recent declines herald a definitive reversal in these countries' epidemics and, furthermore, the need for treatment, care and support will continue to increase for years to come.

Although varying in scale and intensity, the epidemics in West Africa appear to have stabilized in most countries. Overall, HIV prevalence is lowest in the Sahel countries and highest in Burkina Faso, Côte d'Ivoire and Nigeria, the latter having the third largest number of people living with HIV in the world (after South Africa and India).

Nigeria's 2003 HIV sentinel survey put national HIV prevalence at 5 per cent, a rise from the 1.8 per cent found in 1991, but roughly level with the 5.4 per cent recorded in 1999.

Côte d'Ivoire has continued to report the highest level of HIV prevalence in West Africa since the beginning of the epidemic, although prevalence in the capital Abidjan in 2002 was the lowest it had been in five years, at 6.4 per cent compared with 13 per cent in 1999. National adult HIV prevalence in Togo has stayed roughly steady at around 4 per cent. In the two countries flanking it, Benin and Ghana, HIV prevalence is in the 2 to 4 per cent range with little change noted over time.

Serious epidemics are underway in Central Africa, with Cameroon and the Central African Republic worst affected. In the Congo, meanwhile, national adult prevalence has edged below 5 per cent with new estimates putting it at 4.2 per cent with southern parts of the country remaining the worst affected.

The socio-economic impact of HIV/AIDS

HIV/AIDS and the family

HIV/AIDS not only inflicts unprecedented suffering to the individual and their family, but also poses a serious challenge for development. Behind the raw numbers of number of people infected, prevalence rates and death tolls is a reality that sick people cannot work and therefore cannot earn a living. Consequently, they cannot support their families, and children

may have to drop out of school to take care of the sick and work to support the family. The death of parents re-enforces the new role of children (and if lucky, grand parents) as household heads if they indeed survive mother-to-child HIV transmission. For Sub-Saharan Africa, poor as it is and its already poor social service and infrastructure, this has serious implications for economic development. In the early 1990s when AIDS reached its peak in Uganda, families suffered famine as people spent more time at funerals than at their farms. Culture had to evolve to avert a food crisis!

HIV/AIDS and the economy

The levels of absenteeism following sickness, and the associated medical costs and productivity losses to the business world are enormous. A joint UN programme on HIV/AIDS³ report quotes the gross domestic product (GDP) as estimated to drop by an average of 2.6 percentage points in countries with prevalence rates over 20 per cent. Governments and firms are directing funds that would otherwise be invested in productive sectors at fighting the epidemic.

HIV/AIDS and social security

HIV/AIDS has serious implications for social security. Globally, over half the world's population is excluded from social security. In Sub-Saharan Africa, social security coverage is not more than 10 per cent and restricted to the formal sector. If you consider the fact that unemployment rates are quite high, one can only imagine the magnitude of the problem. This implies that the impact of HIV/AIDS, in addition to other contingencies, is not being mitigated with formal social risk management framework i.e. through the labour market or social and health insurance. The main option available to 90 per cent of the population in Sub-Saharan Africa and other developing countries is the family. Yet the impact AIDS has on the family's ability to manage risks is enormous thus triggering a cycle of deprivation, further disease and poverty. This calls into question the current role and coverage of social security.

AIDS affects the most economically active age group (15 - 49) who are potentially members of social security schemes. It effectively reduces the number of people in employment and therefore may reduce the number of contributors depending on the magnitude of epidemic and unemployment rate. In developing economies, high unemployment rates may substitute this effect. However because of the sudden increase in short-term benefits, the amount of funds available for investment will dwindle and reduce the total revenue of the scheme.

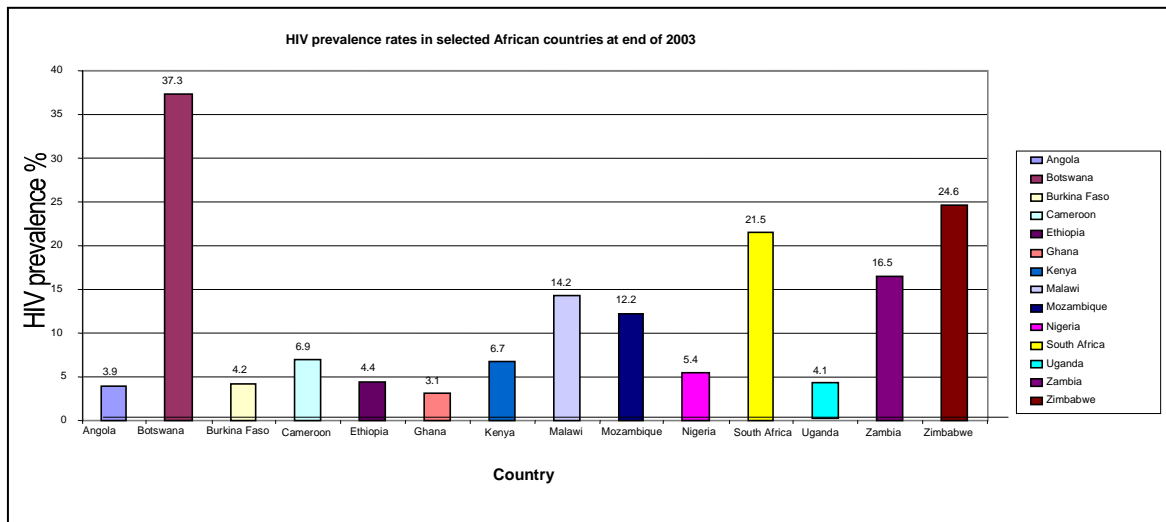
On the expenditure side of social security schemes, AIDS reduces the number of old age pensions in the long-term while increasing the number of invalidity claims/pensions in the short-term. AIDS also increases the number of survivors' claims/pensions in the short-term. For schemes administering funeral grants expenditure would have to increase to cater for AIDS-related deaths. However, duration of both invalidity and survivors' pensions should reduce until the use/availability of antiretroviral drugs (ARVs) improves. The effect is more profound in schemes offering health care benefits because AIDS directly affects health. The cost of frequent treatment of sick members to the health insurance schemes is huge but with declining costs of ARVs and availability of cheaper generic versions, the cost is reducing gradually.

³ UNAIDS 2003 - "Accelerating action against AIDS in Africa", Geneva, Switzerland.

Sizing up the HIV/AIDS problem in Sub-Saharan Africa

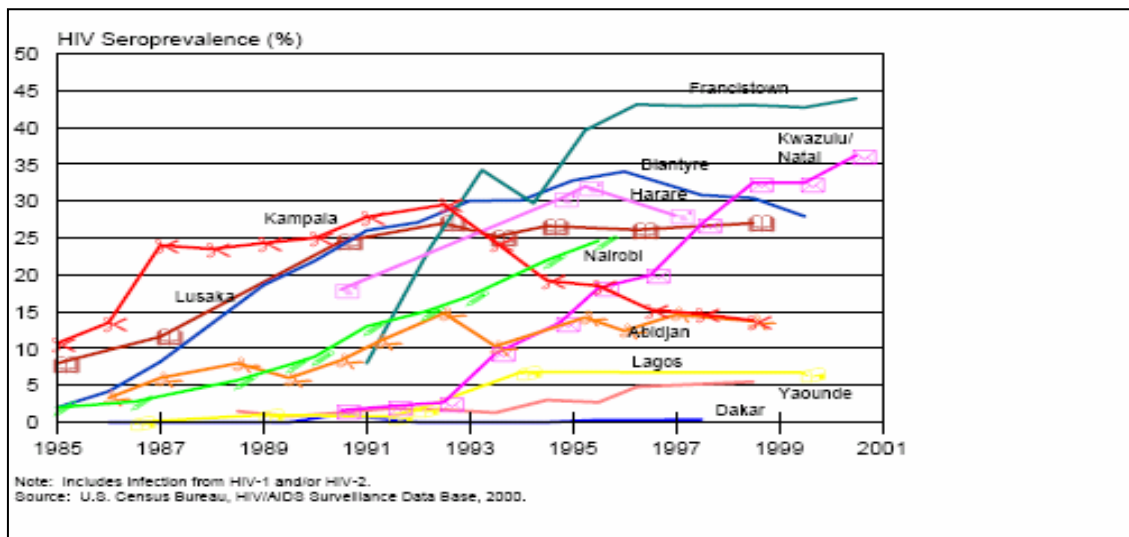
HIV/AIDS is Africa's greatest challenge in the twenty-first century. Sub-Saharan Africa is home to 65 per cent of all people living with HIV/AIDS, 74 per cent of all AIDS deaths and 81 per cent of AIDS orphans as estimated at the end of 2004. In southern Africa, it threatens to wipe out entire populations. UNAIDS⁴ cautions that there are no clear signs of a decline in the epidemics. Charts 1 and 2 show the trends in HIV prevalence in selected African countries at the end of 2003.

Chart 1. *HIV prevalence in selected African countries*



Source: UNAIDS/WHO - AIDS epidemic update 2004.

Chart 2. *HIV seroprevalence for pregnant women in selected urban areas in Africa*

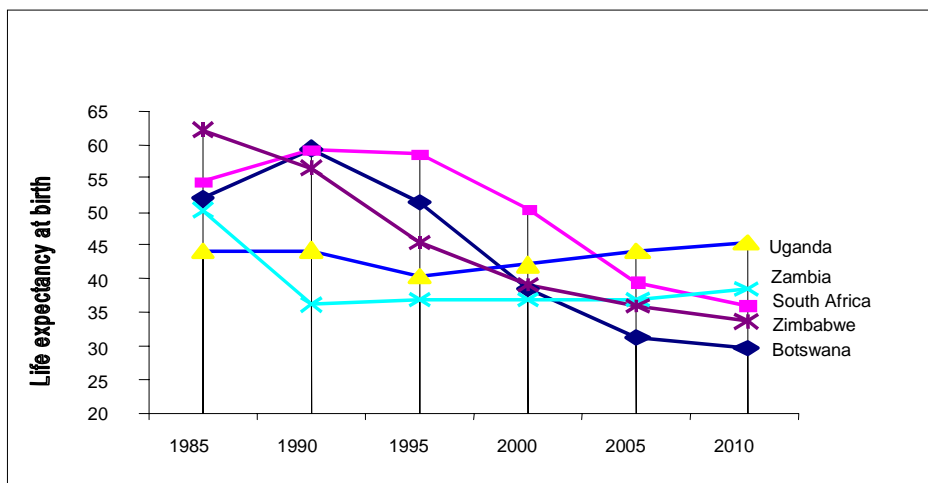


Source: United States Census Bureau.

⁴ UNAIDS 2003 - "Accelerating action against AIDS in Africa", Geneva, Switzerland.

AIDS has had a negative impact on longevity in Africa. Life expectancy in southern Africa, which rose from 44 years in the early 1950s to 59 years in the early 1990s, is set to drop to 45 years between 2005 and 2010 due to AIDS.⁵ Chart 3 below highlights the trends in life expectancy in selected African countries. It also illustrates that Uganda's successful HIV/AIDS response is beginning to pay-off on its life expectancy outlook.

Chart 3. *Life expectancy in selected African countries (1985 - 2010)*



Source: United States Census Bureau, May 2002.

The impact of HIV/AIDS on social and health services as well as food security is well documented. UNAIDS⁶ writes:

"In the hardest hit African countries, already fragile health systems are being robbed of skilled staff. In South Africa, an estimated 17 per cent of primary health-care workers are infected with HIV."

It is estimated that 6.5 million people faced severe food shortage in 2003. In the same report, Food and Agriculture (FAO) estimates that some 7 million African agricultural workers died from AIDS between 1985 and 2000 and another 16 million may die in the next 20 years unless effective response is implemented.

There is some good news though. There are cases of successful HIV/AIDS responses that offer useful experience and expertise within the region. The epidemic can be reversed. Uganda is one of them.

⁵ Plamondon *et al.* 2001. "AIDS Managing the financial consequences of a pandemic in a developing country context", ILO-FACTS, Geneva, Switzerland.

⁶ UNAIDS. 2003. "Accelerating action against AIDS in Africa", Geneva, Switzerland

HIV/AIDS in Uganda

Box1. *Uganda at a glance*

- Population - 24.4million in 2002 (estimated at 26.8 in June 2005).
- Per capita income in 2004 was about USD260.
- Life expectancy at birth is low: 43 years in 2002, compared to 47 years in 1990. It could have been ~55 years without AIDS.
- HIV/AIDS adult prevalence declined significantly over the last decade from about 18 per cent in the early 1990s to 4.1 per cent in 2003.
- Approximately over 1 million people have died of AIDS since its onset.
- Real GDP growth since 1995 averaged 6.7 per cent and was 5.9 per cent in 2004, with a projected growth rate of 5.4 per cent in 2005.
- Inflation decreased from over 33 per cent in 1990 to an average 3.5 per cent since 2000, lately showing however an increase to 5.9 in 2004 (estimated to be 5.9 in 2005).

The history of HIV/AIDS in Uganda

AIDS began to spread in Uganda on the shores of Lake Victoria in the late 1970s until the first AIDS case in Uganda was identified in 1982. By 1986 it had degenerated into a scourge and due to its physically wasting characteristics people christened it "SLIM". As the phrase might suggest, AIDS patients were exposed to a lot of stigma with patients sometimes left to die (even by relatives) without any care. The poor state of health services and infrastructure made the situation worse.

However, in 1986 the Uganda government acknowledged the problem and raised the alarm nationwide and Uganda's Health Minister announced to the World Health Assembly that there was HIV in Uganda. In the same year, the first AIDS control programme in Uganda was established. It focused on providing safe blood products, and educating people about risks. In 1987 a community-based organization, "The AIDS Support Organization" (TASO) was formed by volunteers who had been personally affected by HIV/AIDS to care for people living with HIV/AIDS.

In 1988, the first national survey to assess the extent of the epidemic was conducted and found the average prevalence in the population to be 9 per cent. A prominent Sweden-based Ugandan musician Philly Bongoley Lutaaya (RIP) publicly declared that he had AIDS and spearheaded information campaigns around the country.

In 1990 an AIDS information centre was established to provide voluntary testing and counselling. By 1992, the government had adopted a multi-sectoral approach to addressing the epidemic and coordinating the response to it. In 1994 various governmental departments - for example, agriculture, internal affairs, justice, etc. - established individual AIDS control programme units. The government borrowed USD50 million from the World Bank to fight the epidemic, with the Ugandan government and other donors making this up to a total of USD75 million to set up the Sexually Transmitted Infections Project.

In 1991, prevalence among pregnant women aged 15 - 24 peaked in this year at 21 per cent. In 1995, Uganda announced that it had observed declining trends in HIV prevalence. By 1998, prevalence among pregnant women had fallen to 9.7 per cent.

In 1997, Ugandans participated in a study of using antiretroviral drugs to prevent mother-to-child transmission of HIV. In 1998, the Drug Access Initiative was established to lobby for reduced prices for antiretroviral (ARV) medication which can improve the health of an infected person, and the establishment of the infrastructure necessary to allow these drugs to be generally accessible.

Since 2000, the government began to mainstream HIV/AIDS issues in Uganda's Poverty Eradication Action Plan.

Uganda has been hailed as a success story in Sub-Saharan Africa in the fight of the HIV/AIDS epidemic. Uganda's policies are credited with having brought the prevalence rate down from 18 per cent in the early 1990s to 5 per cent in 2001. At the end of 2003, UNAIDS reported that only 4.1 per cent of adults had the virus. The recipe was in implementing a well-timed and successful public awareness campaign with three main pillars namely: information, education and communication.

ABC approach

Uganda's response to HIV/AIDS is commonly referred to as ABC approach (Abstain, Be faithful or use a Condom). 98 per cent of HIV infection in Uganda is caused by heterosexual activity and the ABC approach was designed to accommodate this. The campaign was designed to increase awareness of the risk of HIV/AIDS, influence behaviour and reduce HIV infection. The campaign involves peer education in post primary and tertiary institutions, condom promotion and establishment of networks of people living with HIV/AIDS. In addition, the government beefed up laboratory and blood transfusion services, established voluntary counselling and testing (VCT) service centres across the country and launched an STD (Sexually Transmitted Diseases) management campaign. The population was encouraged to support and care for people living with HIV/AIDS and to stop stigmatizing AIDS patients because HIV/AIDS has no boundaries.

As a result of mainly behavioural change i.e. less partners, abstinence and use of condoms, national HIV prevalence which had peaked as high as 18 per cent in the early 1990s has been brought down to 4.1 per cent in 2003 (see Chart 1 and Table 2). This does not mean however that the battle is won. The sheer number of people and families affected and what this implies for their standard of living is still a huge challenge. With 530,000 people living with HIV and 940,000 orphans, the battle is still on.

Chart 4. *Median HIV prevalence among antenatal clinic attendees in major urban areas in Uganda (1986 - 2000)*

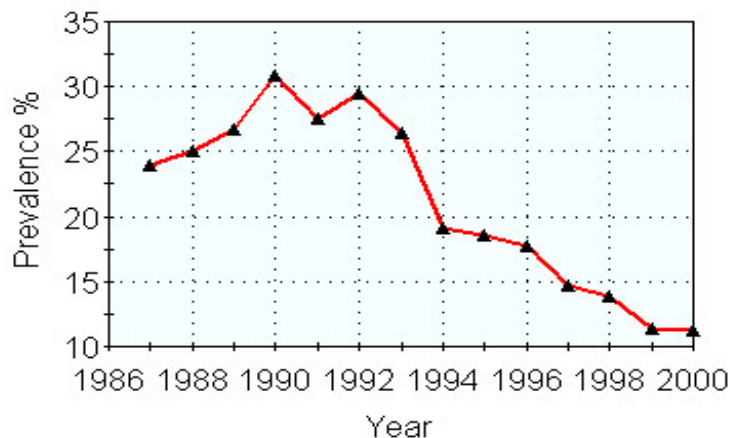


Table 1. Uganda's HIV/AIDS Statistics (end 2003)

	2003	2001
Median adult prevalence	4.1	5.1
Adults and children	530,000	620,000
Adults (15-49)	450,000	520,000
Children (0-14)	84,000	97,000
Women	270,000	310,000
Deaths	78,000	94,000
Orphans living (0-17)	940,000	910,000

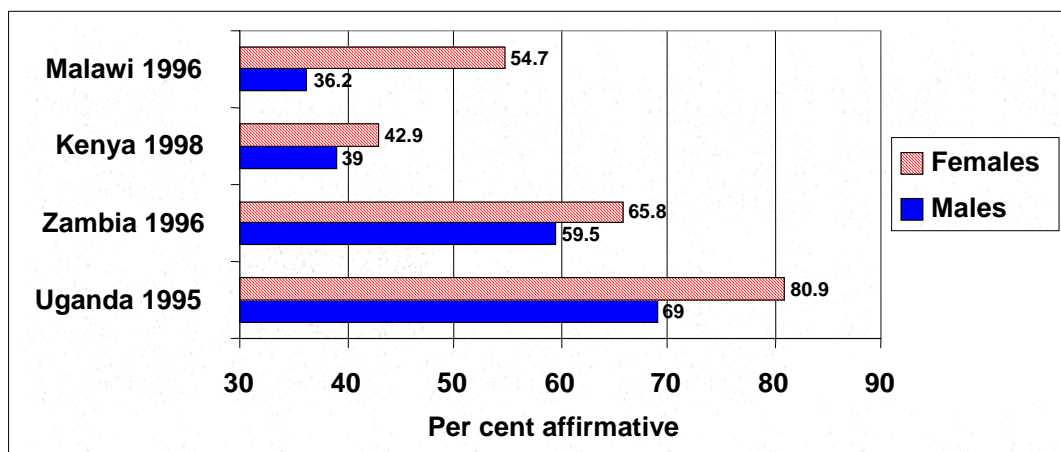
Source: UNAIDS/WHO. 2004. Report on the global AIDS epidemic.

Factors for the success of Uganda's ABC approach.

There are a number of reasons why the ABC approach was successful:

- Leadership and political openness from top to bottom**
 Right from 1986, President Yoweri Museveni did not mince any words about the severity of the HIV/AIDS problem. Museveni rapidly overcame denial and frequently spoke out on AIDS. He also ensured that other ministers also spoke out. He gave churches and NGOs freedom to act and encouraged AIDS research. Speaking at a BBC interview in August 2002, Museveni said: "When I had a chance, I would shout at them (the people)." I used to say, you are going to die if you don't stop this. You are going to die!"
- Multi-sectoral approach**
 The battle against HIV/AIDS was fought across the board. Ministers, civil servants, religious and community leaders provided further leadership at every tier of their respective constituency.
- Quality of communication**
 Awareness messages were locally designed, simple and consistent reinforced by cultural proverbs. They therefore effectively appealed to the local population.
- Community action**
 Everybody in the community took the role of their brother's keeper. By overcoming denial and discrimination, fostering openness and engaging families and communities, Uganda created a context for open discussion about AIDS. To a far greater degree than elsewhere, Ugandans learned about AIDS through social communication networks of families and friends. This is consistent with social diffusion theory, which asserts that we change behaviour because of the advice of close, trusted friends and peers, not impersonal experts. HIV/AIDS was not professionalized. The chart below illustrates this point.

Chart 5. *Percentage of people who received AIDS information from personal networks (friends/relatives) in selected African countries*



- Availability and access to information and prevention options**
 The promotion and availability of condoms certainly had an impact on risky behaviour. In Uganda, condoms can be purchased at the nearest kiosk and people are encouraged to purchase them without shame. Easy access to preventive options when other options e.g. abstinence have failed averts the risk that a person would expose themselves to HIV infection.

A brief on social security in Uganda.

The National Social Security Fund

The National Social Security Fund (NSSF) is a provident fund established by Act of Parliament in 1967. The act was repealed in 1985 giving NSSF the status of an autonomous body corporate managed by a tripartite board of directors and a managing director.

The scheme covers the formal sector except government employees (public service, teachers, military, police, prisons, local authorities) and provides old age, invalidity, and survivors' benefits.

The contributions (a percentage of gross wages) to the scheme are shared between employees and employers as follows: 5 per cent employee and 10 per cent employer.

Following an International Labour Office (ILO) and United Nations Development Programme (UNDP) project in 1994, there were plans to transform to a pension scheme but they have never materialized. Currently the social security sector is being reformed mainly to improve regulation and create some competition.

The NSSF which has always been under the Ministry of Gender, Labour and Social Development is now supervised by the Central Bank (Bank of Uganda) under the Ministry of Finance since September 2004.

As at December 2004, NSSF had 120,846 active members contributing monthly and has 433,133 total contributors (excluding those who have qualified for benefits and have been

paid). The NSSF collects UGX⁷8 billion monthly, and had its net-worth valued at UGX456 billion as at 31 December 2004.

The scheme has paid benefits (lump sum) to over 170,000 members. In 2004, NSSF paid UGX15.4 billion to 9,448 members. 26 per cent of the benefits paid were to survivors and invalidity claimants.

The government's pay-as-you-go pension scheme

The Government of Uganda runs a pay-as-you-go (PAYG) scheme under the Pension Act, Cap 286 and the Armed Forces Pension Act, Cap 295 for its public service employees - civil servants, teachers, medical workers and the military, police, prison forces.

Under the scheme, a pension is paid for a period of 15 years to anyone who qualifies as a retired person i.e. after 10 years service and aged 45 and above. The scheme pays commuted pension gratuity at normal retirement age (60 years).

The scheme also caters for early retirement on medical grounds (certified by government medical board) regardless of age as long as the employee has worked for 10 years. AIDS cases would be catered for under this arrangement.

Upon death, a death gratuity (lump sum) is paid and the survivor receives survivor benefit if the deceased qualifies for retirement. Unfortunately, statistics on the impact of HIV on this scheme are not available.

The impact of HIV/AIDS on the NSSF scheme

Invalidity and survivors benefits

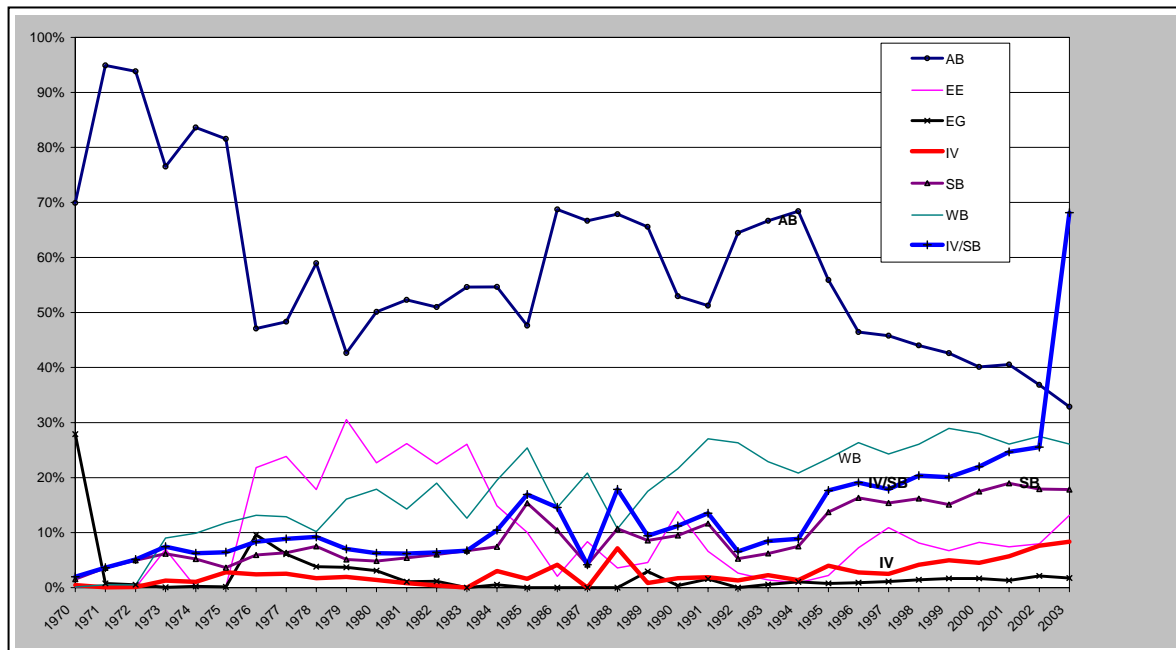
The impact of HIV/AIDS on the NSSF can be observed by taking a look at where it immediately impacts - invalidity and survivors.

NSSF pays invalidity benefits to any member who has been partially or totally incapacitated in such a way as not to be able to earn a reasonable livelihood. Claimants are subject to medical tests to confirm this.

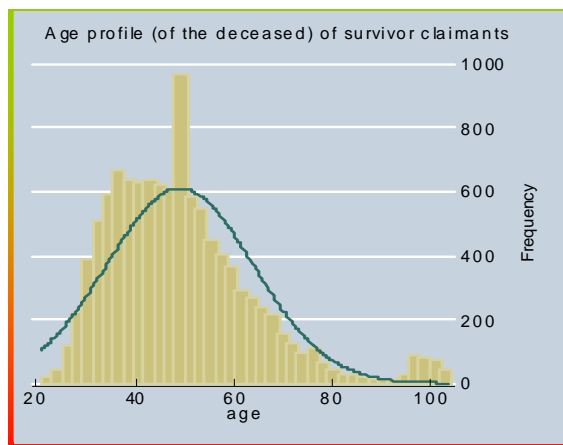
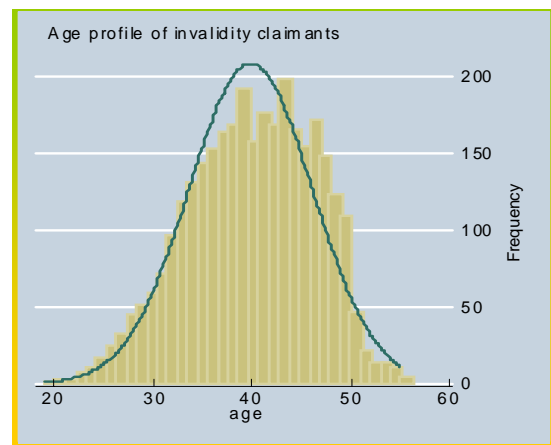
A survivor's benefit is paid to deceased members' survivors.

Chart 6 illustrates the falling relative share of age benefits (AB) during the mid 1990s as compared to invalidity benefits (IV), survivors benefits (SB) or invalidity and survivors benefits combined (IV/SB).

⁷ UGX = Uganda Shilling. USD1.00 =UGX1,750.

Chart 6. *Relative shares of different benefit claims paid by NSSF (1970-2003)*

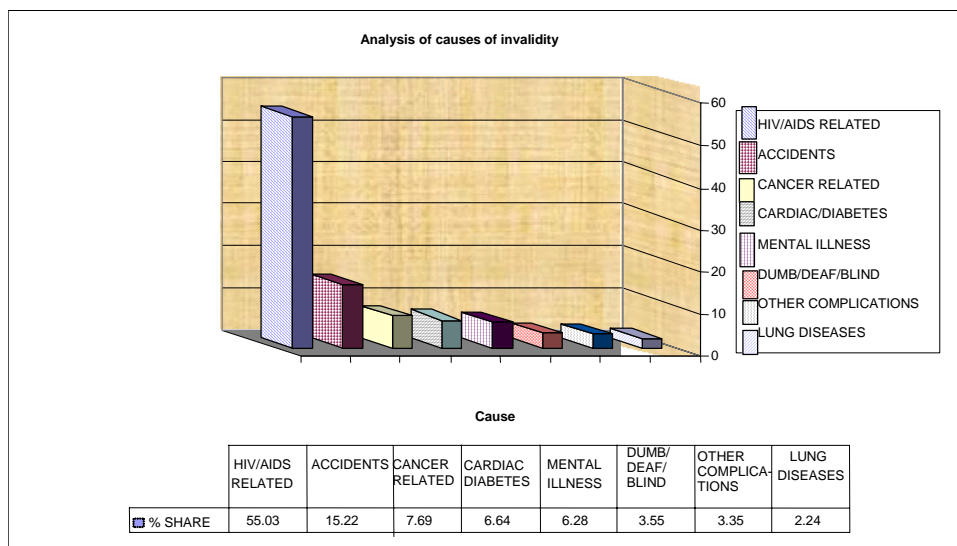
To trace the possible effects of HIV/AIDS on this trend, we analyzed invalidity claims between 1990 and 2004 for cause of invalidity. It was not possible to analyze the cause of death among survivors' benefits because claimants are not required to state the cause of death when they submit claim forms. What NSSF does is to confirm death. However, HIV/AIDS was number one of the top killers diseases in Uganda during the 1990 and it would be safe to assume that a big chunk (for lack of official morbidity statistics) of the deaths (especially considering the age profile of the deceased among survivor claims in chart 7) were due to AIDS. Over 50 per cent of the deceased were below age 47 and even then this could be because claimants did not have information or delayed to submit claims. Any claims above age 55 should have been claimed as either withdrawal (at 50) or old age (at 55); but they still appear in survivors claims.

Chart 7. *Age profile of survivor claims***Chart 8.** *Age profile of invalidity claimant*

The impact of HIV/AIDS on invalidity benefits

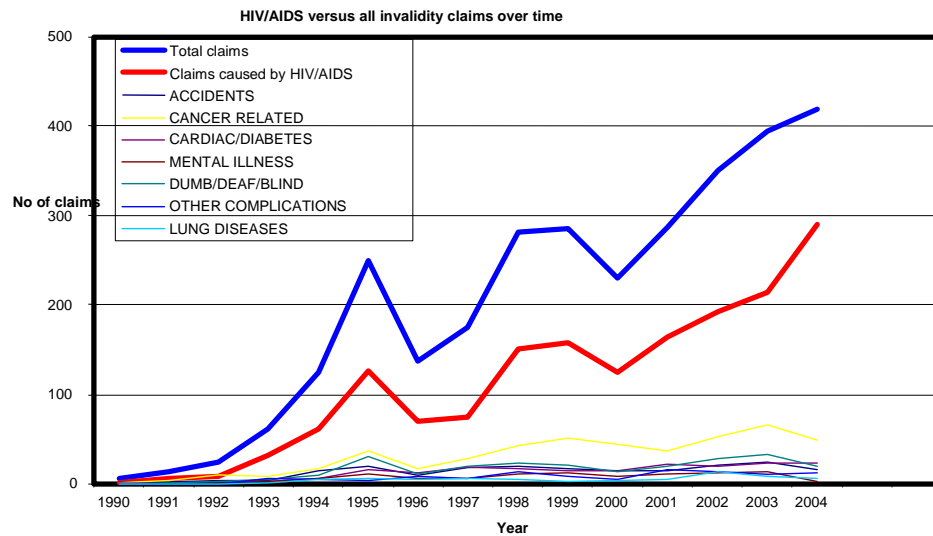
Analysis of NSSF invalidity claims, as chart 9 shows, revealed that 55 per cent of all claims were on account of AIDS-related invalidity. The mean age of claiming invalidity is 39.8, with 50 per cent of cases below 40 years which reinforces the fact that AIDS affects a quite young age group. The codes in Box 2 below explain the groups of diseases/causes of invalidity as used in the analysis.

Chart 9. *Causes of invalidity among NSSF invalidity benefit claimants (1990-2004)*



Box 2. *Explanations of codes of causes of invalidity*

1. HIV/AIDS related: TB, recurrent malaria, and meningitis.
2. Cardiac/diabetes: High blood pressure, stroke, cardiac and heart problems and diabetes.
3. Accidents: Bone fractures, dislocations, amputations, paralysis, burns.
4. Mental illnesses: Psychiatric and psychological disorders, epilepsy.
5. Other medical complications: liver, lung, kidney, gynaecological problems, goitre, sickle cells.
6. Cancer and related illnesses, leukaemia, leprosy, tumours, gout, elephantiasis.
7. Deafness, dumbness, blindness.
8. Lung-related diseases: Asthma, bronchitis.

Chart 10. Comparison of causes of invalidity (1990-2004)

The impact of HIV/AIDS on the NSSF scheme over time can be illustrated in charts 10 and 11. While the impact of all other causes is stable, it is clear from the shape of the graphs that HIV/AIDS has been driving invalidity claims since the mid 1990. The share of HIV/AIDS as a cause of invalidity has been steadily growing and so has the share of invalidity among other benefits.

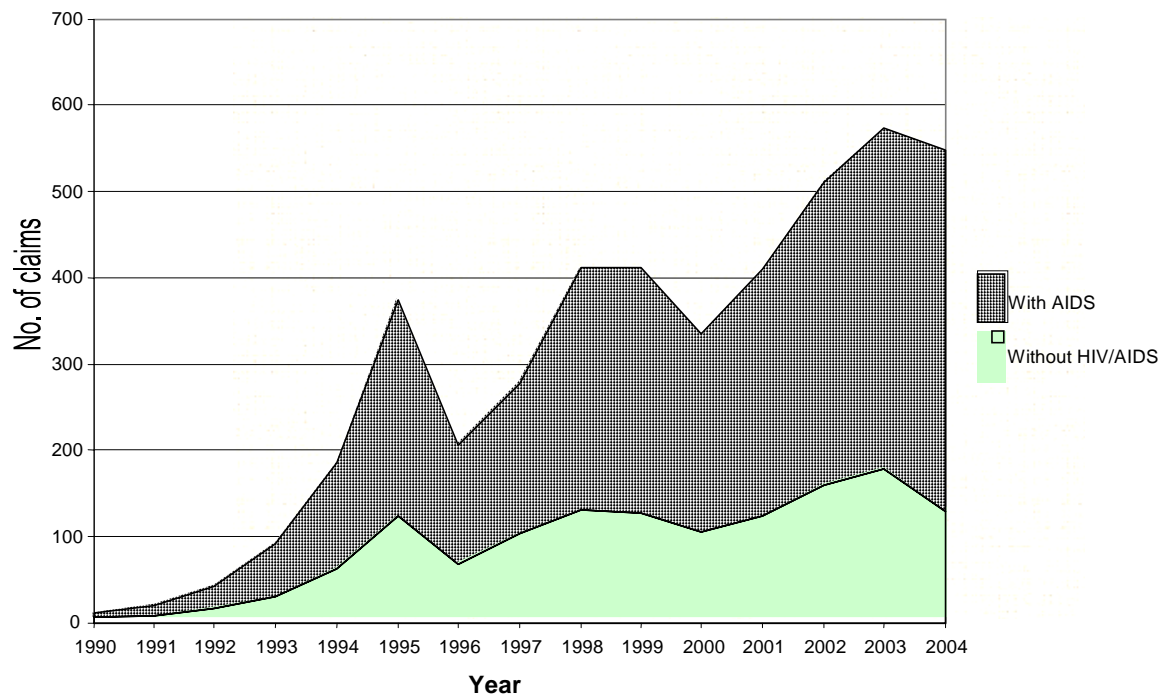
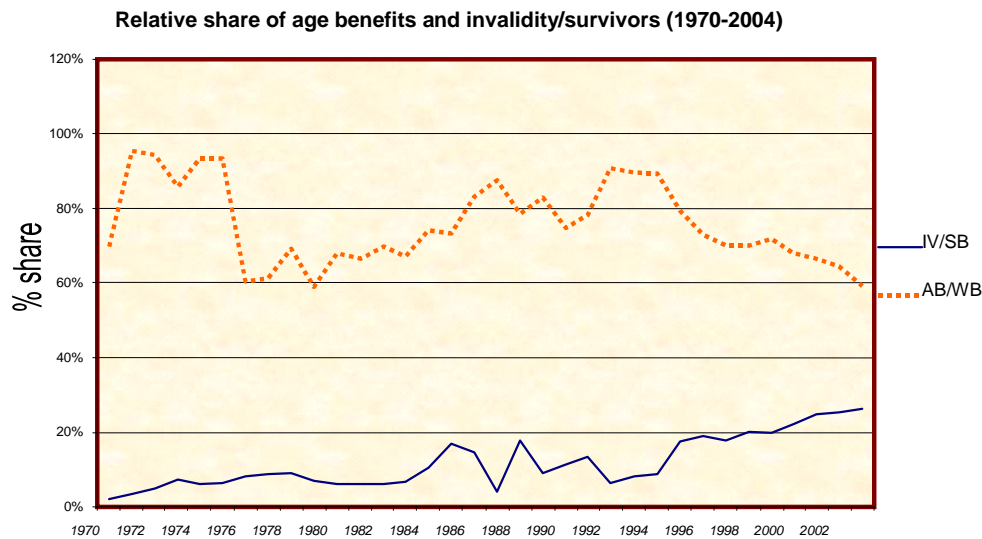
Chart 11. The contribution of HIV/AIDS in invalidity claims

Chart 12 reinforces this point. Whereas we would expect the NSSF scheme to be maturing and therefore paying more age benefits (and it is, judging from the relative share of old age

in total benefits), the share of old age benefits has been steadily falling since the mid 1990s while invalidity and survivors combined show a rise in the share.

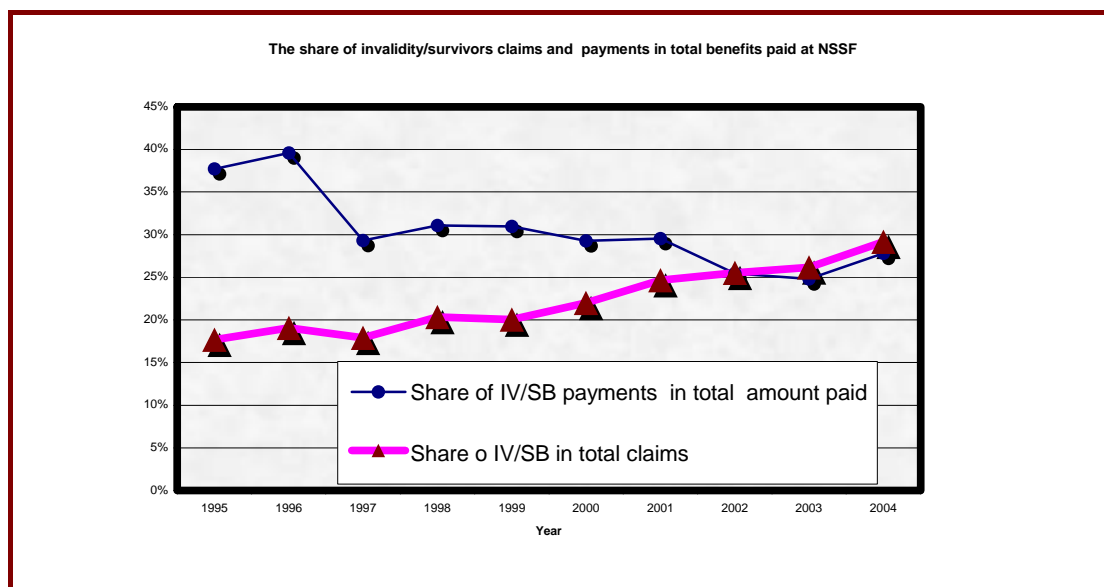
Chart 12. *Relative share of age benefits and invalidity and survivors' benefits (1970-2004)*



The impact on the scheme's finances

The impact is not limited to the number of claims alone. The share of payments (amounts of money) for invalidity and survivors is sizeable. The NSSF has been spending between 25 and 40 per cent of total claims payments on invalidity and survivors' claims (see Chart 13). In 2004, the NSSF spent UGX15.4 billion in benefit payments and 26 per cent of this went to pay survivors and invalidity. If we assume that 50 per cent of this was due to AIDS, and that the trend will continue, NSSF will continue to spend USD1.2 million that could have been invested to generate more revenue for the scheme.

Chart 13. *The share of invalidity and survivors in total claims*



NSSF's response

NSSF has not participated in any direct HIV/AIDS prevention activities to date but is planning on co-sponsoring AIDS awareness campaigns e.g. having AIDS messages on information packs and advertising materials, calendars, organizers, T-shirts. Over the years the scheme has relied on the national ABC response but NSSF now spends over UGX179 million annually on comprehensive medical insurance for its staff including ARV treatment.

Conclusion

The impact of HIV/AIDS on social security schemes is clear. HIV/AIDS has increased the incidence of invalidity and survivors' claims. The money paid to these beneficiaries could have been used to provide quality retirement for the member.

It is well known that HIV is a preventable disease and people with HIV/AIDS can live happy fruitful lives. Enough knowledge and experience is available showing how the epidemic can be contained. Countries need to take advantage of this and use best practice in this area. It is known that certain behaviour creates, enhances and perpetuates risk of HIV infection for example unprotected sex, multiple unprotected sexual relationships, lack of adherence to infection control guidelines in health centres, blood transfusions, and unsterilized injections. These behaviours arise out of lack of information, inability to negotiate safer sex, lack of access to condoms or thinking that HIV/AIDS affects people in different strata. In the absence of neither cure nor vaccine for HIV/AIDS and knowledge that HIV/AIDS is preventable, social security schemes like everybody else must participate in programmes that empower people to reduce risk and cope with the HIV/AIDS epidemic by persuading people to change their behaviour thus enabling them to engage in safer practices: It is also known that with adequate care people living with HIV/AIDS can live a normal and productive life. Social security schemes ought to provide friendly working environments for people living with HIV/AIDS among their employees as well as re-align their benefit packages to counter the challenge posed by the HIV/AIDS epidemic.

Social security schemes can intervene on two main fronts:

1. Prevention of HIV infection activities:

- Information is key to the fight against HIV/AIDS. Schemes can set aside budgets to participate in HIV/AIDS awareness to improve HIV/AIDS competence among their target population through co-sponsoring information and communication campaigns.
- Implement and promote work place HIV/AIDS policy and fight stigma.

2. Providing care to people living with HIV/AIDS

- Schemes need to adjust benefits and administrative arrangements to address needs of sick members for instance by providing "invalidity" benefits earlier so members can access ARV treatment.
- Some eligibility and qualifying conditions on invalidity may be relaxed or waived to give sick members faster access.
- For schemes that offer funeral benefits it might be possible to pre-pay or convert these benefits to meet medical expenses.

- With the falling costs of ARVs, schemes should aim to promote health insurance. Schemes have the advantage of negotiating better packages and premiums for their members.

NSSF spent an estimated USD1.2 million on invalidity and survivors due to AIDS in 2004. Of course, it is possible to use this USD1.2 million to provide medical care for the AIDS patients. And we are talking about 1,000 souls. This is the challenge of HIV/AIDS for social security schemes.