FOIA Number: 2007-1550-F

FOIA MARKER

This is not a textual record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

Collection/Record Group: Clinton Presidential Records

Subgroup/Office of Origin: National AIDS Policy Office

Series/Staff Member:

Subseries:

OA/ID Number: 21075

FolderID:

Folder Title:
Background for Report [3]

Stack:	Row:	Section:	Shelf:	Position:
S	67	1	3	3

Prepared by John Stover, Policy PROJECT.

The Economic Impact of AIDS

AIDS has the potential to create severe economic impacts in many African countries. It is different from most other diseases because it strikes people in the most productive age groups and is essentially 100 percent fatal. The effects will vary according to the severity of the AIDS epidemic and the structure of the national economies. The two major economic effects are a reduction in the labor supply and increased costs:

Labor Supply

- The loss of young adults in their most productive years will affect overall economic output
- If AIDS is more prevalent among the economic elite, then the impact may be much larger than the absolute number of AIDS deaths indicates

Costs

- The direct costs of AIDS include expenditures for medical care, drugs, and funeral expenses
- Indirect costs include lost time due to illness, recruitment and training costs to replace workers, and care of orphans
- If costs are financed out of savings, then the reduction in investment could lead to a significant reduction in economic growth

A World Bank study of the economic impacts of AIDS in Africa concluded that the macroeconomic impacts of AIDS could be significant.[1] Yet there is still time to mitigate the economic impact of AIDS; over half of Africa's population live in countries where the epidemic is "concentrated," that is, where HIV infection is concentrated in groups with risky behavior and is not yet widespread in the general population.[2]

The economic effects of AIDS will be felt first by individuals and their families, then ripple outwards to firms and businesses and the macro-economy. This paper will consider each of these levels in turn and provide examples from various African countries to illustrate these impacts.

Economic Impact of AIDS on Households

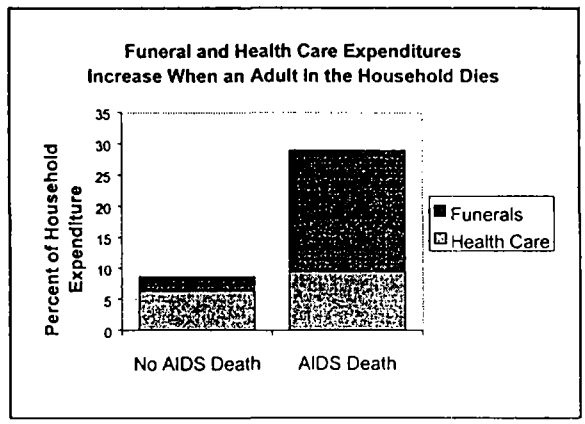
The household impacts begin as soon as a member of the household starts to suffer from HIV-related illnesses:

- Loss of income of the patient (who is frequently the main breadwinner)
- Household expenditures for medical expenses may increase substantially
- Other members of the household, usually daughters and wives, may miss school or work less in order to care for the sick person
- Death results in: a permanent loss of income, from less labor on the farm or from lower remittances; funeral and mourning costs; and the removal of

children from school in order to save on educational expenses and increase household labor, resulting in a severe loss of future earning potential.

Studies in Tanzania, Coté d'Ivoire, Uganda, and Ethiopia have documented the tremendous burden of loss of income, large health care expenditures, and consumption of savings to pay for funeral and mourning costs:

- In **Tanzania**, a study of adult mortality found that, 8 percent of total household expenditure went to medical care and funerals in households that had an adult death in the preceding 12 months. In households with no adult death the figure was only 0.8 percent. In addition to increased expenditures, many households experienced a reduction in remittances if the adult member worked outside the home. In partial compensation for these financial setbacks, many households were forced to remove children from school in order to reduce education-related expenditures and have the children help with household chores.[3]



Graph does not reflect text.

- In **Cote d'Ivoire**, households with an HIV/AIDS patient spent twice as much on medical expenses as other households. Furthermore, 80 percent of the expenditures went to the AIDS patient, rather than to other household members who are ill. When the person with AIDS died or moved away, average consumption fell by as much as 44 percent during the following year.[4]

- In **Uganda**, the economic impact of HIV-related deaths was stronger than other types of death, as households lost much of their savings in order to pay health care and funeral expenditures. Asset ownership declined when the death of an HIV+ member occured, but remained stable when the death was of an HIV- member.[5]

- In **Ethiopia**, a study of 25 AIDS-afflicted rural families found that the average cost of treatment, funeral and mourning expenses amounted to several times the average household income.[6]

Economic Impact of AIDS on Agriculture

Agriculture is the largest sector in most African economies accounting for a large portion of production and a majority of employment. Studies done in Tanzania and other countries have shown that AIDS will have adverse effects on agriculture, including loss of labor supply and remittance income. The loss of a few workers at the crucial periods of planting and harvesting can significantly reduce the size of the harvest. In countries

where food security has been a continuous issue because of drought, any declines in household production can have serious consequences. Additionally, a loss of agricultural labor is likely to cause farmers to switch to less-labor-intensive crops. In many cases this may mean switching from export crops to food crops.[7] Thus, AIDS could affect the production of cash crops as well as food crops.

- A study done by the **Zimbabwe** Farmers Union (ZFU) showed that the death of a breadwinner due to AIDS will cut the production of maize in small scale farming and communal areas by 61 percent. Similar results were obtained for other crops (see table at right). The fall in output results from losses of labor and remittances and the need to spend scarce resources on medical expenses.

Reduction in Production Due to AIDS Deaths in Zimbabwe

Crops	Reduction in Output
Maize	61%
Cotton	47%
Vegetables	49%
Groundnuts	37%
Cattle Owned	29%

- In **Ethiopia**, the male head of the household is responsible for special tasks, such as oxen cultivation, harvesting, threshing and farm management. One study found that the effect of an AIDS death varied by region: it would have the most severe effect on harvesting teff in Nazareth, on digging holes for transplanting enset plants in Atat, on ploughing millet fields in Baherdar, and on picking coffee in Yirgalem. Women are generally responsible for other tasks: leveling, weeding, harvesting minor crops, transporting produce, and household duties. The death of the wife to AIDS can make it difficult for other household members to carry out these tasks, in addition to caring for children. The death of a family member because of AIDS also leads to a reduction in savings and investment. The stock of food grain can be depleted to provide food for mourners and the other expenses were met most often by selling livestock. Such loss of productive assets only makes it harder to survive in the future.[8]

- **In Kagabiro village, Tanzania, when a household contained an AIDS patient, the household labor supply was severely affected: on average, 29% of household labor was spent on AIDS-related matters, including care of the patient and funeral duties. If two people were devoted to nursing duties, as occurred in 66% of the cases, the total labor loss was 43%, on average.**[9]

- In **Malawi**, 10% of GDP comes from estate agriculture. A recent study evaluated the costs of HIV/AIDS on a tea estate there (see table at right). The study found that the costs are determined by the levels of both employee benefits and of skilled labor necessary for production. It predicted that, in the longer term,

Cost of HIV/AIDS on a Tea Estate in Malawi

Description	Total Cost (£)	Related to HIV (%)	Cost of HIV (£)
Provision of medical services	22,275	25	5,569
Funeral costs	928	75	696
Death in service benefits	4,691	100	4,691
Absence	14,875	25	3,719
Total	42,769		14,675

the negative impact on the supply of skilled labor will be the strongest effect of HIV/AIDS.[10] It will become increasingly difficult to recruit skilled people, even at the national level.

- Data collected in **Uganda** indicate that agricultural tasks were frequently disrupted when women needed to care for household members ill with AIDS-related conditions.[11]

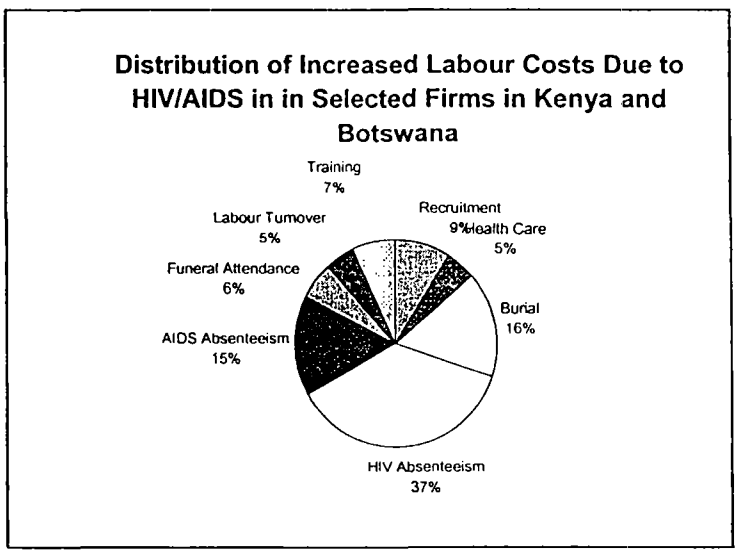
Economic Impact of AIDS on Firms

AIDS may have a significant impact on some firms. AIDS-related illnesses and deaths to employees affect a firm by both increasing expenditures and reducing revenues. Expenditures are increased for health care costs, burial fees and training and recruitment of replacement employees. Revenues may be decreased because of absenteeism due to illness or attendance at funerals and time spent on training. Labor turnover can lead to a less experienced labor force that is less productive.

Factors Leading to Increased Expenditure	Factors Leading to Decreased Revenue
Health care costs	Absenteeism due to illness
Burial fees	Time off to attend funerals
Training and recruitment	Time spent on training
	Labor turnover

The actual distribution of these costs has been calculated as part of various USAID-funded AIDSCAP studies of the private sector impact of AIDS:

- One study examining several firms in **Botswana** and **Kenya** showed that the most significant factors in increased labor costs were absenteeism due to HIV or AIDS and increased burial costs as shown in the figure to the right.[12]



- Another study in **Zimbabwe** found that the major expense was health care costs. The transport company in this study has a large staff of 11,500 workers. Since the company offers significant health benefits to its employees, the cost of AIDS is even higher than for other companies that do not provide such benefits. The study estimated that there are currently more than 3,400 workers who are infected with HIV and 64 who died from AIDS in 1996. The total costs of AIDS to the company in 1996 were estimated at Z$39 million, equal to about 20 percent of the company's profits. More than half of

this amount resulted from increased health care costs. By 2005 the cost of AIDS to the company could reach Z$108 million. There may be indirect costs as well. The report speculates that HIV/AIDS will worsen employee morale and create greater labor-management tensions and cause a labor shortage among skilled positions.[13]

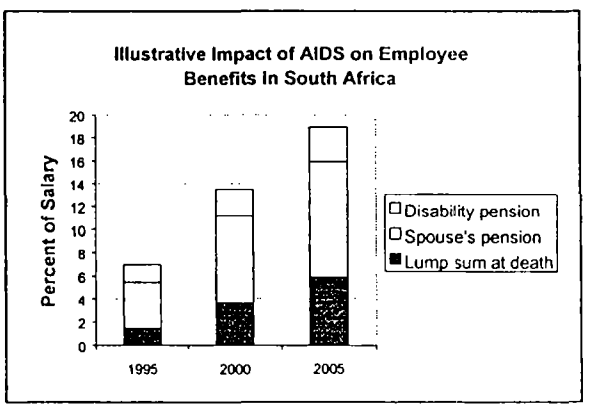
Various studies have also examined the total annual cost of AIDS to different companies, as well as the annual cost of AIDS per employee.[14] These studies found that the annual cost of AIDS per employee varied from US$17 to US$300, as shown in the table below:

Company Name	Total Annual Cost of AIDS	Annual Cost of AIDS per Employee
Botswana Diamond Valuing	US$ 125,941	US$ 237
Botswana Meat Commission	US$ 370,200	US$ 268
Cote d'Ivoire food processing firm	US$ 33,207	US$ 120
Cote d'Ivoire textile firm	US$ 32,667	US$ 29
Cote d'Ivoire packaging firm	US$ 10,398	US$ 125
Kenyan automobile firm	US$ 21,312	US$ 17
Kenyan transport firm	US$ 61,132	US$ 28
Muhoroni Sugar, Kenya	US$ 58,303	US$ 49
Kenyan lumber firm	US$ 40,630	US$ 25
Uganda Railway Corporation	US$ 77,000	US$ 300

Increased labor costs can reduce the profits necessary for expansion. This impact on profits can be considerable:

- The Indeni Petroleum Refinery in **Zambia** spent ~~US$26,400~~ on AIDS-related costs in 1994, more than its declared profits of ~~US$25,514~~ in that year.[15]

- A study in **South Africa** ~~examined the expected impact of AIDS on employee benefits, and thus on corporate profits. It~~ found that at current levels of benefits per employee, the total costs of benefits would rise from 7 percent of salaries in 1995 to 19 percent by 2005. ~~Since these additional costs will have to be paid at the same time that productivity is declining,~~ due to AIDS, ~~the net impact on profits could be significant.~~[16]



Finally, other costs associated with AIDS that firms face include:

- The **Uganda** Railway Corporation has been hard hit by AIDS among it employees, experiencing a labor turnover rate of 15 percent per year in recent years.[17]

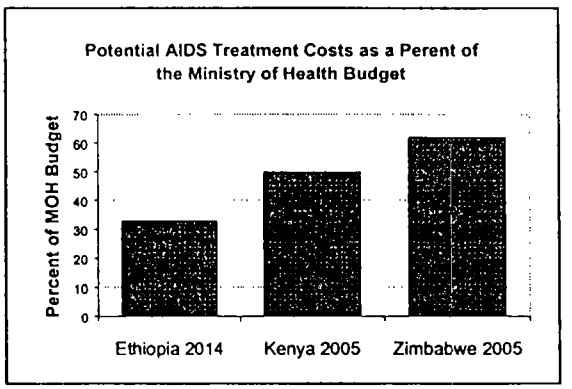
- Medical aid companies in **Zimbabwe** have estimated that meeting all the claims of just one percent of HIV-infected members could result in a 31 percent increase in insurance rates. Most of this increase would have to be paid by employers.[18]

For some smaller firms the loss of one or more key employees could be catastrophic, leading to the collapse of the firm. In others, the impact may be small. Firms in some key sectors, such as transportation and mining, are likely to suffer larger impacts than firms in other sectors. In poorly managed situations the HIV-related costs to companies can be high. However, with proactive management these costs can be mitigated through effective prevention and management strategies.

Impacts on Other Economic Sectors

AIDS will also have significant effects in other key sectors. Among them are health, transport, mining, education and water, govt civil servants and the military. (have more access to cash)

- **Health.** AIDS will affect the health sector for two reasons: (1) it will increase the number of people seeking services and (2) health care for AIDS patients is more expensive than for most other conditions. The number of AIDS patients seeking care is already overwhelming health care systems. In many hospitals in Africa, half of hospital beds are now occupied by AIDS patients. AIDS is also an expensive disease. The graph shows projected expenditure on AIDS as a percentage of public health spending for three African countries.[19] On average, treating an AIDS patient for one year is about as expensive as educating ten primary school students for one year. Governments will face trade-offs along at least three dimensions: treating AIDS versus preventing HIV infection; treating AIDS versus treating other illnesses; and spending for health versus spending for other objectives. Maintaining a healthy population is an important goal in its own right and is crucial to the development of a productive workforce essential for economic development.



- **Transport.** The transport sector is especially vulnerable to AIDS and important to AIDS prevention. Building and maintaining transport infrastructure often involves sending teams of men away from their families for extended periods of time, increasing the likelihood of multiple sexual partners. The people who operate transport services (truck drivers, train crews, sailors) spend many days and nights away from their families. A survey of bus and truck drivers in Cameroon found that they spent an average of 14 days away from home on each trip and that 68 percent had sex during the most recent trip and 25 percent had sex every night they were away.[20] Most transport managers are highly trained professionals who are hard to

replace if they die. Governments face the dilemma of improving transport as an essential element of national development while protecting the health of the workers and their families.

- **Mining.** The mining sector is a key source of foreign exchange for many countries. Most mining is conducted at sites far from population centers forcing workers to live apart from their families for extended periods of time. They often resort to commercial sex. Many become infected with HIV and spread that infection to their spouses and communities when they return home. Highly trained mining engineers can be very difficult to replace. As a result, a severe AIDS epidemic can seriously threaten mine production.

- **Education.** AIDS affects the education sector in at least three ways: the supply of experienced teachers will be reduced by AIDS-related illness and death; children may be kept out of school if they are needed at home to care for sick family members or to work in the fields; and children may drop out of school if their families can not afford school fees due to reduced household income as a result of an AIDS death. Another problem is that teenage children are especially susceptible to HIV infection. Therefore, the education system also faces a special challenge to educate students about AIDS and equip them to protect themselves.

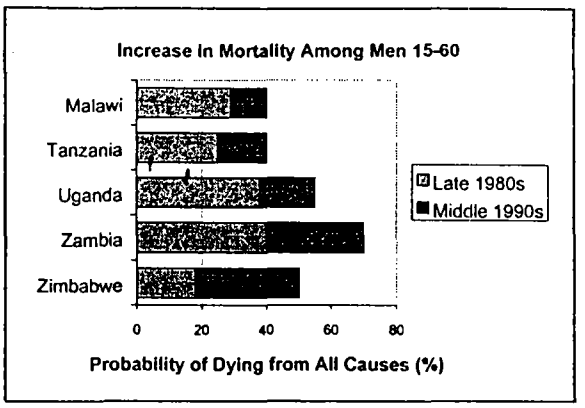
- **Water.** Developing water resources in arid areas and controlling excess water during rainy periods requires highly skilled water engineers and constant maintenance of wells, dams, embankments, etc. The loss of even a small number of highly trained engineers can place entire water systems and significant investment at risk. These engineers may be especially susceptible to HIV because of the need to spend many nights away from their families.

Macroeconomic Impact of AIDS

The macroeconomic impact of AIDS is difficult to assess. Most studies have found that estimates of the macroeconomic impacts are sensitive to assumptions about how AIDS affects savings and investment rates and whether AIDS affects the best-educated employees more than others. Few studies have been able to incorporate the impacts at the household and firm level in macroeconomic projections. Some studies have found that the impacts may be small, especially if there is a plentiful supply of excess labor and worker benefits are small. Other studies have found significant macroeconomic impacts. Studies in Tanzania, Cameroon, Zambia, Swaziland, Kenya and other sub-Saharan African countries have found that the rate of economic growth could be reduced by as much as 25 percent over a 20-year period.

There are several mechanisms by which AIDS affects macroeconomic performance.

- AIDS deaths lead directly to a reduction in the number of workers available. These deaths occur to workers in their most productive years. As younger, less experienced workers replace these experienced workers, worker productivity is reduced. The graph to the right illustrates the magnitude of the problem in five African countries.[21] It shows the increase in mortality among men of working age from the late 1980s to the mid-1990s. Most, if not all, of this increase is due to AIDS.



- A shortage of workers leads to higher wages, which leads to higher domestic production costs. Higher production costs lead to a loss of international competitiveness which can cause foreign exchange shortages.

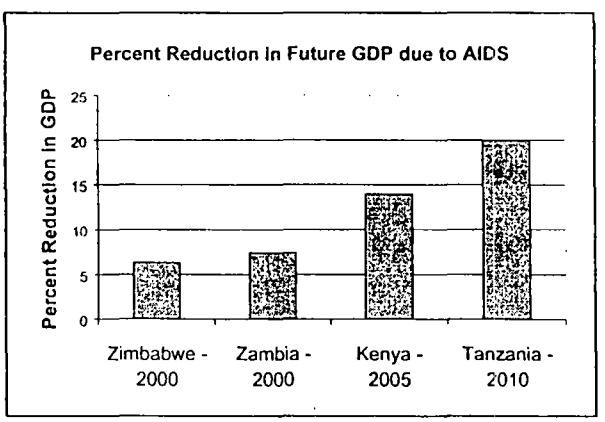
- Lower government revenues and reduced private savings (because of greater health care expenditures and a loss of worker income) can cause a significant drop in savings and capital accumulation. This leads to slower employment creation in the formal sector, which is particularly capital intensive.

- Reduced worker productivity and investment leads to fewer jobs in the formal sector. As a result some workers will be pushed from high paying jobs in the formal sector to lower paying jobs in the informal sector.

- The overall impact of AIDS on the macro-economy is small at first but increases significantly over time.

Several studies have found that these effects could be large in some African countries.

- A World Bank study examined the macroeconomic impact of AIDS in 30 sub-Saharan African countries.[22] This study concluded that the net effect is likely to be a reduction of the annual growth rate of GDP of 0.8 to 1.4 percentage points per year and a 0.3 percentage point reduction in the annual growth rate of GDP per capita.



Very important

- A simulation model of the economy of **Cameroon** concluded that the annual growth rate of GDP could have been reduced by as much as 2 percentage points during the 1987-1991 period because of AIDS.[23]

- A study of the macroeconomic impacts of AIDS in **Zambia** found that by 2000 the GDP would be 5 to 10 percent lower because of AIDS than it would be if there were no AIDS affecting the population. The authors concluded, *"...without unprecedented infusions of free foreign aid to mitigate the effects of AIDS, the economy of Zambia will suffer considerable damage."*[24]

- An assessment of the macroeconomic impacts of AIDS in **Tanzania** by the Government of Tanzania, the World Bank and the World Health Organization in 1991 found that total GDP will be 15 to 25 percent smaller in 2010 because of the impact of AIDS.[25]

- A study of the impact of AIDS on the economy of **Kenya** projected that GDP will be 14 percent lower in 2005 than it would have been without AIDS. GDP per capita will be 10 percent less in 2005.[26]

- Effects on savings in country. investment.
- Effects on private sector

What Can Be Done?

AIDS has the potential to cause severe deterioration in the economic conditions of many countries. However, this is not inevitable. There is much that can be done now to keep the epidemic from getting worse and to mitigate the negative effects. Among the responses that are necessary are:

- Plan for AIDS in all development sectors.

- **Prevent new infections.** The most effective response will be to support programs to reduce the number of new infections in the future. After more than a decade of research and pilot programs, we now know how to prevent most new infections. An effective national response should include information, education and communications; voluntary counseling and testing; condom promotion and availability; expanded and improved services to prevent and treat sexually transmitted diseases; and efforts to protect human rights and reduce stigma and discrimination. Governments, NGOs and the commercial sector, working together in a multi-sectoral effort can make a difference. Workplace-based programs can prevent new infections among experienced workers.

- **Design major development projects appropriately.** Some major development activities may inadvertently facilitate the spread of HIV. Major construction projects often require large numbers of male workers to live apart from their families for extended periods of time, leading to increased opportunities for commercial sex. A World Bank-funded pipeline construction project in Cameroon was redesigned to avoid this problem by creating special villages where workers could live with their families. Special prevention programs can be put in place from the very beginning in

projects such as mines or new ports where commercial sex might be expected to flourish.

- **Programs to address specific problems.** Special programs can mitigate the impact of AIDS by addressing some of the most severe problems. Reduced school fees can help children from poor families and AIDS orphans stay in school longer and avoid deterioration in the education level of the workforce. Tax benefits or other incentives for training can encourage firms to maintain worker productivity in spite of the loss of experienced workers.

- **Mitigate the effects of AIDS on poverty.** The impacts of AIDS on households can be reduced to some extent by publicly funded programs to address the most severe problems. Such programs have included home care for people with HIV/AIDS, support for the basic needs of the households coping with AIDS, foster care for AIDS orphans, food programs for children and support for educational expenses. Such programs can help families and particularly children survive some of the consequences of an adult AIDS death that occur when families are poor or become poor as a result of the costs of AIDS. The costs of these programs can vary widely.[27]

Annual Costs of Programmes to Mitigate the Household Impacts of AIDS, Kagera, Tanzania, 1992

Type of Programme	Annual Cost (US$)
Home care for people with AIDS	$227 per patient
Orphanage care	$1,063 per child
Foster care	$185 per child
Feeding post	$69 per child
Basic needs support	$47 per household
Educational support	$13 per child

A strong political commitment to the fight against AIDS is crucial. Countries that have shown the most success, such as Uganda, Thailand and Senegal, all have strong support from the top political leaders. This support is critical for several reasons. First, it sets the stage for an open approach to AIDS that helps to reduce the stigma and discrimination that often hamper prevention efforts. Second, it facilitates a multi-sectoral approach by making it clear that the fight against AIDS is a national priority. Third, it signals to individuals and community organizations involved in the AIDS programs that their efforts are appreciated and valued. Finally, it ensures that the program will receive an appropriate share of national and international donor resources to fund important programs.

Perhaps the most important role for the government in the fight against AIDS is to ensure an open and supportive environment for effective programs. Governments need to make AIDS a national priority, not a problem to be avoided. By stimulating and supporting a broad multi-sectoral approach that includes all segments of society, governments can create the conditions in which prevention, care and mitigation programs can succeed and protect the country's future development prospects.

[1] Over, M. 1992. The Macroeconomic Impact of AIDS in Sub-Saharan Africa. AFTPN Technical Working Paper 3. World Bank, Africa Technical Department, Population, Health, and Nutrition Division, Washington, DC.

[2] Ainsworth, M and M Over. 1998. AIDS and Development: The Role of Government. AIDS; 12(5): 12-13. IAS Newsletter No. 9.

[3] Mead Over, Martha Ainsworth, et al. 1996. Coping with AIDS: The Economic Impact of Adult Mortality from AIDS and Other Causes on Households in Kagera, Tanzania.

[4] Bechu, N. 1998. The impact of AIDS on the economy of families in Cote d'Ivoire: Changes in consumption among AIDS-affected households. In M Ainsworth, L Fransen, and M Over, eds., Confronting AIDS: Evidence from the developing world: Selected background papers for the World Bank Policy Research Report. European Commission: United Kingdom; and AIDS Analysis Africa; 8(1): 2-3

[5] Menon, R, MJ Wawer, JK Konde-Lule, NK Sewankambo, and C Li. 1998. The economic impact of adult mortality on households in Rakai district, Uganda. In M Ainsworth, L Fransen, and M Over, eds., Confronting AIDS: Evidence from the developing world: Selected background papers for the World Bank Policy Research Report. European Commission: United Kingdom

[6] Demeke, M. 1993. The Potential Impact of HIV/AIDS on the Rural Sector of Ethiopia. Unpublished manuscript, January 1993.

[7] Ilinigumugabo, A. 1996. The economic consequences of AIDS in Africa. African Journal of Fertility, Sexuality and Reproductive Health; 1(2):153-61.

[8] Demeke, M. 1993. The Potential Impact of HIV/AIDS on the Rural Sector of Ethiopia. Unpublished manuscript, January 1993.

[9] Tibaijuka, AK. 1997. AIDS and Economic Welfare in Peasant Agriculture: Case Studies from Kagabiro Village, Kagera Region, Tanzania. World Development; 25(6):963-975.

[10] Jones, C. 1997. What HIV cost a tea estate in Malawi. AIDS Analysis Africa; 7(3): 5-7.

[11] Taylor, L, J Seeley, E Kajura. 1996. Informal care for illness in rural southwest Uganda: the central role that women play. Health Transition Review; 6(1):49-56.

[12] Roberts, Matthew and Bill Rau, African Workplace Profiles: Private Sector AIDS Policy, AIDSCAP, Arlington, VA, USA.

[13] : Roberts, Matthew and Bill Rau, African Workplace Profiles: Private Sector AIDS Policy, AIDSCAP, Arlington, VA, USA

[14] Roberts, Matthew and Bill Rau, African Workplace Profiles: Private Sector AIDS Policy, AIDSCAP, Arlington, VA, USA.; Aventin, L and P Huard. 1997. HIV/AIDS and manufacturing in Abidjan. *AIDS Analysis Africa*, Vol 7(3): June 1997.; Ainsworth, Martha, "The Impact of HIV/AIDS on African Development", presented at the African Development Bank HIV/AIDS and Development in Africa Symposium, May 11, 1993.

[15] Southern African Economist, 1997. "AIDS toll on regional economies," April 15-May 15, 1997.

[16] Southern African Economist, 1997. "AIDS toll on regional economies," April 15-May 15, 1997.

[17] Ainsworth, Martha, "The Impact of HIV/AIDS on African Development", presented at the African Development Bank HIV/AIDS and Development in Africa Symposium, May 11, 1993.

[18] Southern African Economist, 1997. "AIDS toll on regional economies," April 15-May 15, 1997.

[19] Ministry of Health, 1998. *AIDS in Ethiopia, Second Edition*, Addis Ababa: Epidemiology and AIDS Department, 1998.; NASCOP, 1998. *AIDS in Kenya, Fourth Edition*. Nairobi: National AIDS and STDs Control Programme, 1998.; Ministry of Health and Child Welfare, 1998. *HIV/AIDS in Zimbabwe*. Harare: National AIDS Coordination Programme, 1998.

[20] *AIDS Analysis Africa*, Vol. 4 (5), September/October 1994.

[21] UNAIDS, 1998. *Report on the global HIV/AIDS epidemic, June 1998*. Geneva: UNAIDS, WHO,. 1998.

[22] Over, Mead, 1992. "The Macroeconomic impact of AIDS in Sub-Saharan Africa," The World Bank, Technical Working Paper No. 3., 1992.

[23] Kambou, Gerard, Shantayanan Deverajan and Mead Over. 1992. "The Economic Impact of AIDS in an African Country: Simulations with a Computable General Equilibrium Model of Cameroon", *Journal of African Economies*, Volume 1, Number 1.

[24] Forgy, Larry. 1993. "Mitigating AIDS: The Economic Impacts of AIDS inZambia and Measures to Counter Them," REDSO/ESA, February 1993.

[25] Cuddington, JT, 1992. Modelling the Macroeconomic Effects of AIDS, with an Application to Tanzania, *World Bank Economic Review*, 7(2):172-189.

[26] Hancock, John; David Nalo; Monica Aoko; Roselyn Mutemi; Steven Forsythe, 1996. "The Macroeconomic Impacts of AIDS," *AIDS in Kenya*, FHI: Washington, DC, 1996.
[27] World Bank, 1997. *Confronting AIDS: Public Priorities in a Global Epidemic*. New York: Oxford University Press.

NSC drinks just before Cologne

USAID

Working Paper:

Accelerating the Implementation of HIV/AIDS Prevention and Mitigation Programs in Africa

Draft in Progress
March 1999

USAID Bureau for Africa
Office of Sustainable Development
Division of Human Resource Development

USAID Global Bureau
Center for Population, Health, and Nutrition
HIV/AIDS Division

Accelerating the Implementation of HIV/AIDS Prevention and Mitigation Programs in Africa

EXECUTIVE SUMMARY

This paper[1] summarizes the lessons learned and experiences of USAID operations, and perspective on newer issues, regarding the implementation of HIV/AIDS programs in Africa. The problem in most African countries in dealing with the disease is not what to do, as there are proven packages of interventions, but how to provide them on a large enough scale and in a concerted manner to make a difference. The attached paper and appendix contain approaches for scaling up interventions and ensuring an expanded response to HIV/AIDS. The appendix also focuses on suggestions specific to the World Bank and donors. The paper is largely based on feedback from USAID's country missions, particularly in East and Southern Africa.

The purpose of this paper is:

- To share experiences and lessons learned based on USAID's work in the field over the past 15 years, regarding constraints to expanding and improving HIV/AIDS prevention and mitigation program implementation. It is this area of implementation where USAID can be most helpful, by assisting to focus attention, energy and resources on real on-the-ground obstacles facing countries and programs.

- To identify new issues in developing a bolder response commensurate with the seriousness of the expanding HIV/AIDS pandemic in the region.

The information contained in the paper may not be new, but it may underscore some of the priorities that have emerged in the process of program implementation thus far. There is widespread agreement among those involved in program implementation that high level *commitment, increased local capacity to implement HIV/AIDS prevention and control programs on a national scale, and stronger coordination among donors and other agencies for concerted actions* are essential for a successful initiative. Yet their realization still eludes most countries.

---

[1] This is an evolving paper. The United States Agency for International Development (USAID) developed this paper initially to share lessons learned from USAID HIV/AIDS programming with the UNAIDS program and the World Bank as they developed new initiatives for Africa.
Please forward your comments and suggestions to Dr. Ishrat Z. Husain, Senior Technical Advisor for HIV/AIDS, USAID Bureau for Africa at ihusain@afr-sd.org or by mail to 1325 G Street, NW, Suite 400, Washington, DC 20005, USA

The suggestions for improving implementation include:

- Bilateral and multilateral donors work together in a strong coalition, both centrally and at the country level, over the next five to ten years.

- Concerted actions, applying all possible interventions in one area, be taken to ensure synergy and maximum impact. Fragmented actions are responsible for wasted efforts.

- Donors providing substantial funding enhance their capacity in the field to provide necessary technical and administrative support to the local agencies in a timely manner.

- Local agencies and donors together develop an operational strategy to generate and strengthen commitment to the prevention and mitigation of HIV/AIDS at all levels.

- Together, country HIV/AIDS programs and donor coalitions ensure that increased funding and technical assistance are in place to enable implementation of proven packages of interventions by public and private sector partners on a national basis. These include access to condoms, STD drugs, information, testing and counseling; community and home based care and support, including care of orphans.

- Special emphasis in both prevention and mitigation is given to women and youth. This should include measures to reduce poverty.

- Governments, with the support of donors, not only strengthen the capacity of the public sector, but also fully utilize the available capacity in the private sector and non-governmental organizations.

- Governments and donors put all their efforts into mobilizing communities and all relevant sectors in the program through the formation of village and district AIDS committees.

- In-country policy dialogue at the highest levels includes specific actions that will improve and expand program implementation, as identified through in-country formative research and feedback from implementers and clients.

- Programs address the interactions between prevention and care, and involve infected and affected individuals and communities.

- Actions are designed and based on the voices and wisdom of local people and communities.

- Donors together establish fund for massive training of managers, professionals, community leaders, youth and others involved in the program.

- Commodities are procured and made available in a timely fashion. Management and technical assistance is provided to ensure that countries meet donor requirements.

INTRODUCTION

Africa is sitting on the brink of disaster given the current and potential rate of HIV infection. Countries with high and rising infection rates among youth will face the loss of at least one if not two generations, in the future. The gravity of the situation dictates actions as if in a war setting. This includes strong commitment at the highest levels to stem the tide of the epidemic as well as measures to reduce the stigma associated with the disease. Speedy program implementation will require involving communities by forming community, villager and district AIDS committees at an accelerated pace, establishing a rapid or emergency response team for resolving implementation problems, and utilizing all possible resources to deal with the epidemic, including the military. This disease is both a health and development problem. It is not enough to treat it as only a health issue as it amounts to treating the symptoms and not the causes of the disease. In this context, a renewed effort has to be made to make different sectors work together. Intensive efforts will mean an unconventional mobilization of all sectors of society and the economy in the fight against the disease.

ADDRESSING THE IMPLEMENTATION PROBLEMS

The experiences with the implementation of HIV/AIDS programs in a number of countries in Africa indicate the following basic requirements for its success:

Commitment on the part of policy makers, implementers, civic society and donor agencies to prevent the disease and mitigate its impact in a defined period. Reducing the stigma associated with the disease often is the most important element in generating and monitoring country commitment. Commitment is critical for mobilizing financial and human resources that are grossly inadequate to implement most programs. It is important for stimulating behavior change and for creating a supportive environment. A comprehensive and well-coordinated operational strategy for systematically generating and sustaining commitment can be developed and applied on the basis of experiences thus far.

Capacity to plan, manage and provide a set of interventions proven to be effective on a smaller scale on a country-wide basis. The scaling up of these interventions, experience shows, will be possible only by tapping the organizations, agencies and sectors that have not yet been fully utilized for implementing key components of HIV/AIDS programs. These include private sector, non-governmental organizations, non-health sectors and non-formal community and youth groups.

Coordination among the donors and agencies involved in implementation to make best use of resources for meeting the priority needs. Resource shortages are exacerbated by economic decline and underscore the importance of and need for coordinated actions. A consortium of both bilateral and multilateral donors for HIV/AIDS at the country level may be an effective mechanism for such coordination. Similarly, coalitions of NGOs and of other implementers

could also be formed to help coordinate actions. They may need financial and technical support of donors for making these coalitions work.

Furthermore, the programs are being implemented in a fragmented manner. For example, social marketing is carried out in one area and community mobilization in another area. **Concerted** application of interventions will provide the necessary synergy and better results for given resources.

The following sections elaborate on the above points.

Strengthening Country Commitment

USAID field missions have consistently reported that the existing level of country commitment, with the exceptions of Uganda and Senegal, does not match the seriousness of the situation. Commitment is singularly important to mount the type of effort that is required at this stage. While the political will at the highest level is critical, commitment at all levels and by all agencies is important. These include governmental and non-governmental agencies responsible for different sectors, opinion leaders, community leaders, business and labor leaders, parliamentarians, religious leaders, and youth and women groups. In addition, the commitment must be sustained so that it continues until the disease is well under control.

Despite the importance of commitment, there are few operational strategies in any country to systematically generate it. Experience has shown that dedicated individuals and agencies can and do generate commitment. For example, non-governmental organizations influenced the thinking of policymakers, as well as policies in South Africa and Kenya. Peers among policy makers and politicians in regional and sub-regional settings have influenced each other's thinking, as in the case of the South African Development Community. Adequate experiences within the country and among countries and donors exist to develop an operational strategy to strengthen commitment at all levels. USAID can possibly take a lead in organizing sharing of experiences at country and sub-regional levels as a first step in the development of this operational strategy.

A major impediment to commitment to fight HIV/AIDS, as observed by Missions and other partners in the field, is the stigma associated with the disease. Concerted actions to reduce stigma (see next section) have to be an important element of the operational strategy to generate commitment. In addition, the processes and elements of generating commitment that can be a part of an operational strategy are:

- **Support to Local Advocacy Groups**

Providing information, technical support and resources to local groups and organizations has been effective in building constituencies, influencing policies, developing regulatory mechanisms, as well as in promoting and monitoring implementation. These processes work as they foster local ownership, engage groups that know the internal processes and dynamics of target audiences and are able to expand visible national constituencies. They can organize rallies

and marches and mobilize grass-root support. USAID/Kenya consistently supported the Kenya AIDS NGO Consortium and MAP International with resources and technical assistance to promote policy change. Both organizations have been acknowledged, inside and outside the country, and for their role of sensitizing political and religious policy makers and achieving significant policy openings. In South Africa, coalition building through NACOSA (a coalition of NGOs, unions, community groups and political parties) resulted in a draft strategy for kick-starting the new government's national HIV/AIDS preventive efforts. The strategy with few modifications became the national policy. More recently, USAID-supported advocacy training is helping provincial and national leaders mobilize interest and action in HIV/AIDS efforts. The tools that USAID made available to these leaders include repackaged advocacy materials that summarize the best evidence available and make specific action recommendations for selected audiences (e.g. *An Introduction to Advocacy* produced by SARA project).

- **Policy Dialogue Between the Country Officials and Donors**

Given the seriousness of the HIV/AIDS situation, a strong and sustained commitment is needed from the top leaders of the country. It has been USAID experience that ambassadors, UN agency representatives, and other high level officials can be effective in continuously communicating the need for national governments and civil society to address HIV/AIDS. Further, where the dialogue is confined to the Ministry of Health it is less effective than when all relevant ministries (Finance, Labor, Education and others) are drawn into the discussion. Analyses contained in USAID's AIDS Impact Model, and the World Bank's economic reports showing the devastating impact of AIDS have been used to sensitize country leadership. While these have generated temporary increases in attention at the policy level, too often they fail to translate into actions on budgets and program implementation. The reasons for this failure need to be reviewed. However, USAID's experience shows that additional measures that could make this dialogue more fruitful are:

- ✓ Agreement with country officials on specific actions towards accelerated implementation of key program components with definite monitoring indicators.

- ✓ Consistent and regular high level dialogues using surveillance data to review progress at frequent intervals.

- ✓ Policy dialogue based on consultation with other donors and implementers and highlighting the disastrous implications of inaction for the country and different sectors. In addition, senior donor representatives working with various sectors should actively work with their counterparts to determine actions to be taken through sectoral programs.

- **Establishment of Surveillance System**

Local capability for systematic surveillance, impact analyses and monitoring/evaluating program progress is a necessary complement to the above efforts. Policy makers and donors need to know

how effectively and at what pace policies are being implemented. For appropriate decision making about the use of limited resources, information on the effectiveness of interventions and their costs is essential. These data can be the most effective tool for policy analysis.

Surveillance efforts are *ad hoc* at present. The USAID mission in Kenya recently organized an Africa-wide workshop on monitoring and evaluation. A manual is under preparation and USAID would like to suggest a common approach among the countries and donors in this respect. USAID is also working to improve surveillance frameworks and evaluation methods as part of its MEASURE project and has also worked with CDC. In addition, it is in the process of undertaking a sub-regional initiative in Southern Africa to help standardize the system among countries.

There are a growing number of tools for these forms of surveillance (or monitoring) which can be applied. An example is the policy implementation-monitoring tool that the Commonwealth Regional Health Community Secretariat (CRHCS) has developed for its member states in East and Southern Africa.

- **Reducing the Stigma Associated With the Disease**

Our missions have reported that the stigma associated with HIV/AIDS has hindered both individual and collective prevention and mitigation responses. Fear of rejection, discrimination and exploitation have kept many people from being tested or, if HIV positive, from discussing the implications of their infection with their families and/or communities. USAID and other donor programs have begun to break down some of the barriers by:

- **Engaging Religious Leaders**

Statements by religious leaders that provide correct information about the disease and promote behavior change are considered effective in preventing the disease. For example, a study in Uganda reported that people who were exposed to a trained religious leader or trained community worker were more likely to have correct AIDS information, less likely to report extra-marital partners and/or multiple partners and more likely to use condoms. The religious leaders in Uganda also showed continued commitment to deal with the problem even after funding of their work expired. Training, information exchange, and study tours for religious leaders were also effective in desensitizing controversial family planning programs in the seventies.

- **Voluntary Testing and Counseling**

In Africa, where men are reluctant to use condoms with their wives, the message to use condoms does not have an impact unless people know their HIV status. Well over 95% of people in Africa do not know their sero-status. Large proportions of those who are infected do not take precautionary measures. Paradoxically, a substantial proportion of those not infected believe that they are and engage in risky behaviors. Another very important issue involves couples where one

partner is infected and the other not, but where neither knows their sero-status and present potential risk to each other.

To counter this lack of perceived personal risk USAID is now using what is called a "second generation" of behavior change tools. These include social mobilization, skill building, intensive interpersonal counseling, and increasingly the addition of HIV testing. The knowledge of sero status helps in direct preventive measures such as transmission to partners as well as from mother to child. In addition, large scale testing and counseling itself leads to more open discussion and reduction of stigma. For example, the diffusion effect of testing and counseling of close to 400,000 persons has significantly contributed to the prevention successes in Uganda. Similar success is reported from Tanzania where HIV testing and counseling resulted in behavior changes of individuals and couples. Obviously, voluntary testing and counseling needs rapid expansion beyond the currently limited scale.

- **HIV/AIDS Information Centers**

Adequate information on HIV/AIDS is not available even in many urban areas. The HIV/AIDS information centers have made a difference in selected urban areas of Uganda. They are now being expanded to other parts of the country. Still even in Uganda the services are not able to meet the demand. Establishment of these centers should be a high priority in an effort to reduce stigma.

- **Attention to Special Problem of Stigma for Women, Youth, and Orphans**

HIV/AIDS presents a number of issues specific to women, their role in society, as well as relationships to men. In Africa, the state of women is a disenfranchised one as concerns their relative risk for HIV. In addition to their increased risk for transmission, they are at great risk for increased poverty given their lack of inheritance rights and overall social standing. As such, special emphasis is needed to address the issues facing women including the implications of the stigma associated with the disease. Women at the brink in economic terms in several countries have strongly expressed the intense desire and readiness to undertake economic activities to improve their status. Organizations like Foundation for International Community Assistance (FINCA) have responds to these demands and have successfully provided seed money and training in a few countries on a limited scale. These activities have a much larger demand. They have potential to prepare women to deal with the stigma.

The focus of economic activities should be young men and women who are unemployed and do not have access to information and counseling. They are especially vulnerable and do not seek information due to fear of stigma. They are frustrated and angry. The private sector-both commercial and industrial can help train the youth in information technology and other areas of high demand for the mutual benefit. The multi-nationals may consider establishing a special fund for youth training. USAID has prepared briefing material for private businesses. A cadre of youth can be trained to provide information and advice on HIV/AIDS to communities. Few micro-enterprises, at present, cater to youth. USAID has a special project to analyze the problem of

youth called FOCUS. It also proposes to encourage expansion of micro-enterprises for youth and make of HIV/AIDS education as part of the training.

Ten million dollars has been obligated by the United States government for the care of orphans, of which 7 million dollars has already been allocated to several African countries. Additional funds have been made available by USAID through displaced children and orphans fund (DCOF). DCOF has thus far supported a number of community level activities for the care of orphans and displaced children. These activities have been useful not only for the care of orphans but also help reduce the stigma by involving communities and their leaders. (See next section on community involvement)

- **Expanding the Environment in Which Prevention Information is Disseminated**

HIV/AIDS prevention messages, in USAID's experience, have greater receptivity by:

- ♦ Conveying preventive messages by all sectors of the economy: HIV/AIDS has an impact on all sectors therefore prevention messages have to be part of their services.

- ♦ Integrating Health, Family Planning and HIV/ AIDS education: Health education systems have to be strengthened on an urgent basis in order to provide adequate health related education.

- ♦ Combining Mitigation and Prevention: The infected person particularly at the community level can effectively convey important preventive messages.

- ♦ Strengthening the Capacity of the Media to Cover HIV/AIDS: Saturation of the HIV/AIDS topic by the media particularly with the objective to convey correct information and facilitate open discussion contributes a great deal to reducing the stigma. The training of the media officials and writers has been instrumental in extending the coverage in a few countries.

- ♦ Using the Private Sector to Convey Messages: Private sector companies such as Coca-Cola and beer marketers have the capacity to reach the remote areas. These organizations can be utilized to convey HIV/AIDS messages.

- **Identifying and Supporting Champions**

Individuals who are well respected and admired by the public such as noted celebrities, sports figures, film actors, and others could make a difference by speaking out and championing the cause of fighting the disease. Infected individuals are even more compelling.

The ability of infected and affected individuals to speak out is directly related to their feeling safe to do so. As such, regulations, laws, public leaders statements, and other steps to protect those infected is vital to encouraging their disclosure.

Expanding the Local Capacity for HIV/AIDS Prevention and Mitigation

In USAID experience mobilizing the power of the people or the communities is the most potent and expedient means of expanding implementation capacity. It is equally important to utilize the under-utilized capacity of the private sector (see next section), non-governmental organizations, local research institutions, informal community groups and the military. Strengthening the capacity of governmental agencies for implementing HIV/AIDS efforts is an imperative particularly through providing management training and adequate budget. In general, there are shortages of technical and professional leaders in governmental and other sectors.

The National AIDS control programs have been criticized since the mid-1980s as managerially weak and without bureaucratic influence. NGOs often have been criticized as lacking in-depth technical skills. Community groups often do not have adequate managerial or technical support due to weak local government structures and limited capacity of NGOs to undertake strong prevention and mitigation efforts.

- **Formation of District and Village AIDS Committees**

The only way HIV/AIDS prevention and mitigation efforts can be sustained on a long haul is through the involvement and ownership of the communities. A number of examples of successful pilot efforts exist but they have not been scaled up for different reasons. One of the reasons being that these pilot program have been funded by donors who have not disseminated the results or mobilized support for scaling up.

The usefulness of community involvement is exemplified by a project in Malawi called Community-based Options for Protection and Empowerment (COPE). COPE, funded by USAID, is implemented through Save the Children Federation. It is a systematic approach to mobilize the community-based responses to the care of orphans and other people affected by HIV/AIDS. It works through the multi-level and multi-sectoral structure established by the Government and UNICEF for prevention of HIV/AIDS and mitigation of its impact. The multi-level structure comprises district, community and village HIV/AIDS committees. The multi-sectors included governmental and non-governmental organizations, religious groups, the business community and other relevant community members. Working with the individual community members COPE strengthened their capacity to implement activities that assisted families in home-based care and trained youth and other high-risk groups in HIV prevention. It also assisted families and community members in mobilizing internal and external resources to sustain the activities. COPE is in the process of linking with other programs like LIFE (Local Income and Food Enhancement) and FINCA where members of the Community AIDS Committee (CAC) will be eligible for loans to start income generating activities.

An interesting feature of this experience is that CACs are putting pressure on District level Committees to work inter-sectorally to provide comprehensive support. Also COPE is advocating for and influencing national policies on behalf of HIV/AIDS affected families and children.

Similar successes in community efforts have been achieves in selected communities of Zambia and Uganda through USAID supported projects. There are examples of successful projects funded by other donors or communities themselves in other countries notably in Zimbabwe.

- **Strengthening the NGOs for Community Outreach**

The most effective prevention and mitigation efforts at the community level are being carried out through the NGOs as mentioned above. Further, groups like TASO in Uganda illustrate other possible approaches. These types of NGOs deserve support for expanding their capacity and creating a network of them in Africa. In addition, all NGOs with outreach capability, irrespective of whether their primary function is health, should be trained to deal with HIV/AIDS. In Zimbabwe, over sixty NGOs came forward to request capacity building for dealing with HIV/AIDS. Effective program implementation in Africa will be contingent upon strengthening the capacity of NGOs, coordination of activities among them, as well as building partnerships between them and government.

- **Establishing Mechanisms for Multi-Sectoral Program Implementation**

Donors, such as the World Bank and USAID, with broader development agendas have the capacity and legitimacy to help different sectors in assessing the impact of HIV/AIDS on the respective sector and in defining the measures that can be included in the activities of that particular sector. Collaboration between agencies in developing a protocol in this respect may help in making the multi-sectoral approach work.

Further, income-generating activities for the youth, an extremely important element in HIV prevention, require a mechanism for different sectors to work together. It exists in the form of Ministries for Youth, etc., but by and large they are non-functional due to the difficulty in obtaining the collaboration of other ministries. USAID has launched a skill development project for youth in Mali. The project is in the process of carrying out a study and testing mechanisms for different sectors to work together. Similar efforts are underway in other countries. These experiences need to be reviewed and discussed with the government and among donors.

It may also be useful to review what factors determine the collaboration among different sectors at the community level. USAID has successful experiences in this collaboration in the context of community care of orphans and sick in Zambia, Malawi and Uganda.

- **Supporting the Local Institutions for Analytical Work and Generating New Ideas**

Local research institutional capacity in most countries need rapid expansion through training and partnership with outside institutions to undertake analytical work in priority areas. These include assessments of the impact of AIDS, analyses of surveillance data and development of the understanding of determinants of risky behavior. In addition, these institutions can provide new ideas for improving program implementation by conducting focus group discussions. Supporting

ideas coming from the respective affected populations may be the most valuable contribution of donors.

- **Targeting and Prioritizing**

In view of the limited national implementation capacity, priority actions and of groups for priority support is critical for making an impact. Among the priority groups for providing services are the young, women, orphans, vulnerable populations (e.g., certain industrial workers such as transport and mining, etc), and those already infected. Transparent policies are needed to determine which services should be available and to whom, and how to provide them.

- **Mobilizing Military Personnel**

USAID supported a Geneva based organization called Civil-Military Alliance to Combat HIV and AIDS. The idea is that countries have mobilized the military in the past to help in natural disasters. HIV/AIDS could be treated as a disaster in the making and it might be useful to think of similar actions. These could include using military personnel on a rotation basis to deliver government commodities and services. This involvement could have a double advantage of educating military personnel where the rate of infection is quite high and improving the availability of services to people.

- **Massive Training Program**

African countries as it is have been suffering from shortage of trained personnel. The situation is exacerbated by the high death rate among the educated and trained due to AIDS. Thus the immense requirements for training and retraining of all types of workers.

A large part of the success of population programs can be attached to generous donor, university and private foundation resources made available for training. A similar, or even larger, effort is needed for HIV/AIDS. Assessments of training needs of different implementing agencies are required. Training should be on the job to the extent feasible. In this respect the capacity of the local institutions to provide quality-training need to be expanded perhaps through collaboration with outside institutions. Donors could create a large fund dedicated to training and orientation of personnel from key agencies and of the community leaders and change agents.

- **Improving Commodity Procurement and Distribution**

Inadequate availability of condoms, STD drugs and testing agents for nationwide programs is the most serious problem. It is both a problem of lack of resources and of administration bottlenecks when resources are available. For example, in Kenya donor funding has been available and yet the shortages of commodities have seriously hampered program implementation. In many countries, STD drugs and condoms arrive late (sometimes three years after the donor funding is made available). In addition to general shortages of commodities other problems noted by our Missions include:

- Drugs and equipment that are needed together for a program arrive at different times.
- Oversupply of commodities, in some cases disrupts donor-funded social marketing programs.
- Quality problems resulting from procurement based on low cost only.
- Payment delays lead to non-participation by suppliers.
- Commodities provided are not on the approved essential drug list.
- Commodities "brands" provided is not known or acceptable to consumers.

Details of problems reported by our missions appear in the appendix. USAID has launched a program to improve public sector logistic systems, called the Regional Logistics Initiative (RLI). It was found to be useful by the Kenyan government and has now been implemented on a regional basis. In Zambia, the government is using RLI to ensure that it obtains commodities under the World Bank health program. USAID intends to brief the World Bank on this initiative.

- **Greater Involvement of the Private Sector**

Private industrial, commercial, and service sectors have tremendous stakes in preventing the disease. Evidence has surfaced, as is now being reported in the press (e.g., *New York Times*), that banks, insurance companies and mining companies in certain countries are hiring extra employees, at added cost to doing business, to protect productivity as employees fall sick.

In an USAID-assisted project in Tanzania, a national trade union was able to persuade businesses not only to host HIV/AIDS programs at the work place but to contribute to the cost of running those programs. In Kenya, another USAID-supported project with a small number of large businesses stimulated demand from other companies for preventive services with the understanding that the companies will pay for services. In South Africa, USAID assistance to the national trade union federations has led to the development of a common HIV/AIDS policy, which will now be implemented. Similarly, work with a mining company to prevent STDs and implement HIV/AIDS has led to requests for replication across other mining companies. Moreover, it has been USAID's experience that in some sectors, such as business and labor, only peers can influence their actions to undertake more HIV/AIDS efforts.

Apart from the involvement of large businesses in preventing the disease, the non-profit private sector has shown its potential in social marketing of commodities and behavior change. USAID has seen that social marketing not only provides important commodities to consumers at reasonable prices, but also stimulates the growth of commercial marketing for condoms. Working with the private sector affords an important additional benefit for HIV/AIDS prevention: it is an effective way of working with men.

Thus, countries and donors should strengthen the programs by:

- greater involvement of the industrial and commercial sectors in HIV/AIDS prevention.

- contracting nation-wide expansion of the social marketing and behavior change programs including health education out to the private sector.

- using the private sector for organizing skill development and income generating activities for the youth.

As a first step, countries and donors should organize a meeting of representatives of local businesses and their foreign counterparts to discuss their involvement on a large scale, determine their interest and capacity.

Expanding Field Capacity of Donors to Coordinate, Monitor and Facilitate Implementation

As the World Bank and UNAIDS are in the process of strengthening their capacity to deal with the problem of HIV/AIDS in Africa it is important for them to undertake similar strengthening in the field by assigning administrative and technical resident staff in the field.

Large donors like the World Bank can help accelerate implementation by having staff on the ground to provide both administrative and technical support to implementing agencies. For example, the procurement of condoms and STI drugs in Kenya would not have experienced delays of two years if there were adequate Bank staff in the field to help in trouble shooting and training the locals in procurement and disbursements. The World Bank is addressing these problems as part of its decentralization process and is assigning staff to the field.

Programs work best when strong National AIDS Control bodies or other designated government offices provide leadership in coordinating donor assistance and program implementation. Notwithstanding the coordination by government, donors could organize to exchange information, experiences, and ideas among themselves. It will also ensure coordinated policy dialogue with the government and that all-important aspects of the program are funded and technical assistance provided. Therefore, it is useful to consider formation of a donor consortium in all countries with the purpose of jointly programming and monitoring and carrying out policy dialogue in a more systematic way. The consortium should include multi-lateral as well as bi-lateral donors.

ACTIONS FOR ACCELERATING PROGRAM IMPLEMENTATION

The following actions by countries and donors have the potential to contribute to improving and accelerating implementation:

- **Establish a rapid or emergency response team**

  Such a team suited for severely effected countries should include the most influential and dynamic persons from the public, governmental and non-governmental organizations, and private sector. Possible functions of the team could include identifying the bottlenecks to implementation and then following up with respective agencies in a collegial and cooperative manner. Another responsibility could include monitoring the impact of the epidemic on various sectors and identifying strategies to intervene and cope.

- **Form donor consortia in selected countries to help accelerated implementation:**

  The consortia should ensure countrywide availability of condoms and STI drugs, voluntary counseling and testing, dissemination of information on prevention, stigma reduction, social mobilization, multi-sectoral planning and program implementation, and strengthening mitigation efforts. Special attention needs to be paid to the procurement and availability of commodities.

- **Establish a training fund jointly funded by the donors:**

  To rapidly train and orient different categories of workers including advocacy groups, managerial and professional workers of relevant agencies, community level leaders and others generous amount of resources are needed, therefore a massive training fund has to be created.

- **Develop operational strategies to implement advocacy efforts:**

  Countries and donors organize sharing of experiences with local advocacy groups on strengthening of commitment at different levels to implement HIV/AIDS prevention and mitigation. This will allow for developing an operational strategy to systematically generate commitment.

- **Stimulate private sector interest:**

  As a first step a meeting of private sector groups should be organized to discuss the ways of enlarging their role in the program. This should include in- country businesses and interested multi-nationals.

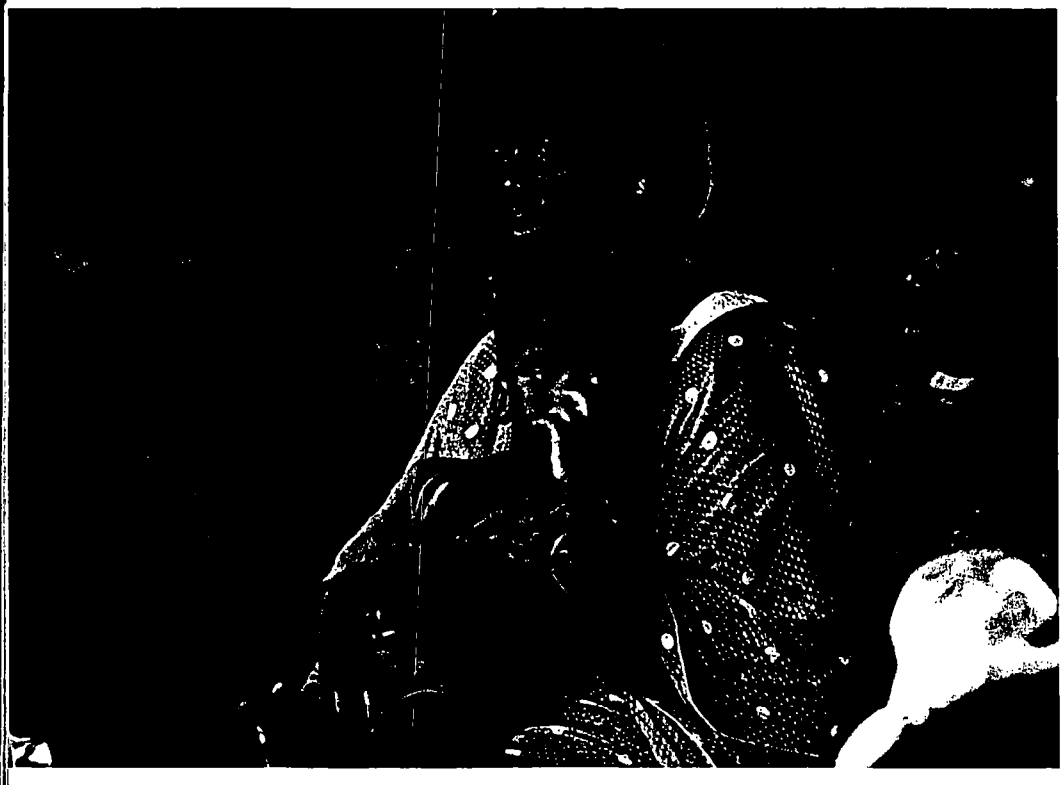
- **Intensify efforts to make multi-sectoral programs work:**

  The multi-sectoral work is particularly important in the context of implementing youth, women, and orphan-related policies and conveying HIV/AIDS prevention messages. Particular attention needs to be focused on the link between HIV/AIDS and poverty, including the development of income generating activities for those most vulnerable.

- **Formulate a well defined agenda for analytical work:**

  Analytical work will yield immediate results by providing new ideas from the people themselves on how to implement the program effectively, by giving new insights into the determinants of risky behavior and by continuously analyzing progress through surveillance data.

Defining the challenge of Africa



The following remarks are abstracted from Hoosen Coovadia's keynote address at IAPAC's First International Conference on Healthcare Resource Allocation for HIV/AIDS and Other Life-Threatening Illnesses, November 10-11, 1997, in Washington, DC. Readers are invited to review the full text and references on the IAPAC Web site (www.iapac.org). These remarks are as timeless as the truth that underscores them and provide a blueprint for evaluating Bristol-Myers Squibb's Secure the Future.

Hoosen Coovadia, MD

I have come here, not as a supplicant from the Third World with cupped palms asking for more, nor from Conrad's "heart of darkness" seeking light, but as a colleague, admirer, and—I hope—a friend, to the uniquely vigorous academic institutions of American society. I am here to turn the hard light of scrutiny onto what we ourselves in the poorer countries of this world should be doing but have failed to do, inasmuch as I wish to remind the industrialized world of its responsibilities for the control of the HIV/AIDS epidemics.

My task is to say that despite the fact that the most recent figures reveal declining numbers of AIDS cases in the US and Western Europe, we remain inextricably bound each to the other in a global society where diseases know no walls and we are all threatened if a single one of us is in danger. Jonathan Mann rightly observed that "the epidemic cannot be stopped in one country until it is stopped in all!"

The dialogue between North and South on HIV/AIDS bears an exact likeness to the broader discussions on the global economy, world trade, the role of the UN Security Council, and a host of similar large scale issues. The idea of dialogue between the rich and poor nations flows mostly, though not exclusively, in one main direction—from the former to the latter. This generates a culture of medicine in which the language of discourse is dominantly the language of the industrialized countries. This is true whether the discussion is on health research, health services, health economics or health education. It is cruelly true for HIV/AIDS where the overwhelming burden of disease is borne by Africa, Asia, and Latin America.

This meeting is taking place at a critical point when new combination therapies are threatening to deepen the divisions among people with HIV in the world: those with access to triple therapy and those without. I fear the language of HIV will shift to a preoccupation with the drug management of a chronic disease (such as TB, diabetes) rather than an emphasis on prevention and vaccination; will move to discussions on what is good for a few rather than what can be of benefit to millions.

A challenge to the world community on the pandemic of HIV/AIDS is to change the language of discourse, so that the problems of the majority with this dreadful disease, who happen to live in developing countries, assume a primacy they do not have at present. From HIV/AIDS we will have to begin to transform the culture of medicine for other diseases so that global priorities carry the stamp of universal agreement.

This culture of medicine has deep philosophical roots and changing it will be an enormous undertaking. Your history and traditions have created a profound respect for the individual, a healthy skepticism of government and a lesser consideration for the rights of collectives. We, on the other hand, through circumstance and inclination, have emphasized context and therefore sought to protect the rights of communities to a greater extent than the rights of the individual. We are motivated by Bentham's principle of the greatest good for the largest number. When this conviction comes together with our appreciation of some fundamental social reasons for the accelerated spread of HIV/AIDS in

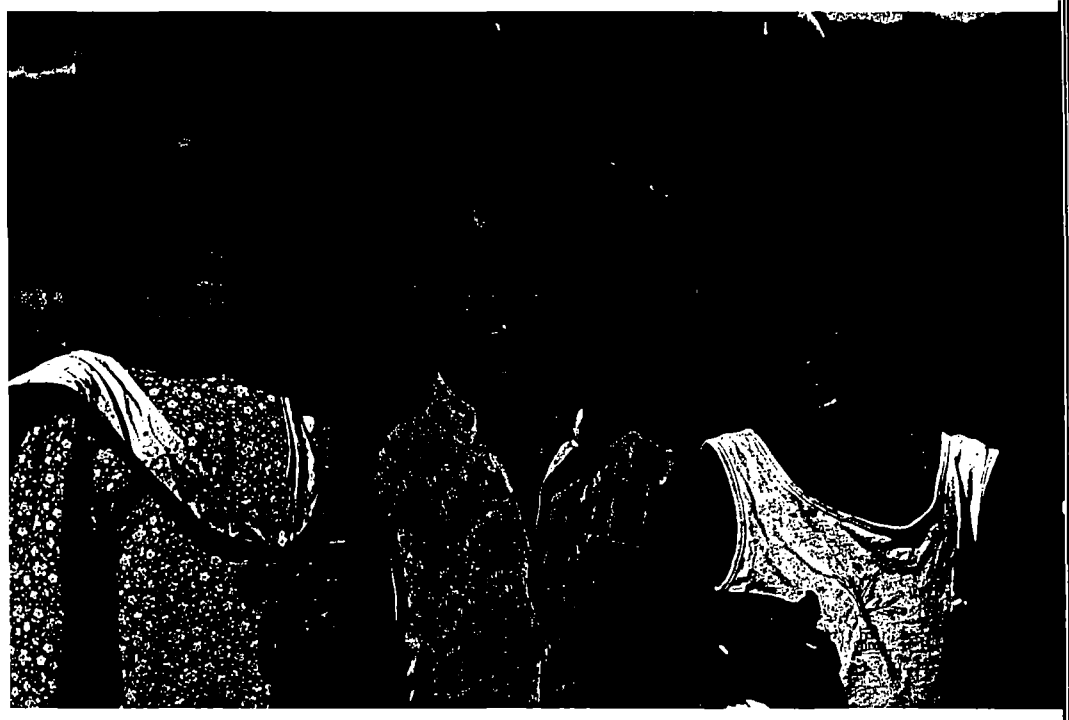
the Third World, we are keen to address these social factors as a priority.

The demographic and economic impact of HIV/AIDS, the inferior social status of women, the escalating unemployment and the social disruption in sub-Saharan Africa which has led to an increase in commercial sex workers, huge migrations of people within and across national boundaries, rapid and chaotic urbanization, a change in cultural values, a rise in STDs and drugs, and a fall in provision of health services, all demand more than a medical response. D'Cruz-Grote speaks of "Supportive Social and Economic Environments" which are critical for establishing a receptive milieu in which other interventions may succeed.

The economic environment in which drug purchases and sales occur require attention. A more flexible approach in developing countries by pharmaceutical companies, in which the US has such a large interest, can make a sizeable impact on HIV/AIDS. The increasing dominance of [pharmaceutical companies] in South Africa has narrowed options for access to healthcare by those who need it and has diminished the role government can play in promoting health for all its citizens.

This is a challenge that has been taken up by UNICEF and other international agencies for vaccines and can be supported and extended for HIV/AIDS through our joint efforts. I have heard that some moves, initiated by [pharmaceutical companies] producing antiretrovirals, are already under way in South Africa to address this issue. Therefore, the challenge and the task to combat the social and economic foundations of HIV/AIDS are nothing less than an undiminished quest for the "development" of resource-poor countries. By "development" I mean a process of social change which advances and improves the quality of life.

At the center of this transformation is an increasing liberation of the individual and community from a range of constraints, an enhancing of the freedom of choice between different options, and a strengthening of the capacity for self-reliance, self-sufficiency and full participation in social processes. It is heightened access to employment, income, wages, education, healthcare, and social security. Theodore Schultz, the Nobel prize-winning economist, has summed this appropriately when he comments that, "The wealth of nations



has come to be predominantly the acquired abilities of people—their education, experience, skills, and health. The future productivity of the economy will be determined by the abilities of human beings."

Therefore, throwing money or drugs alone at HIV/AIDS will not halt the epidemic. Global measures to reduce social and economic deprivation will make a major contribution. To illustrate this, the recent experience in Côte d'Ivoire in using ZDV to reduce mother-to-infant (MTI) transmission of HIV revealed unexpected barriers to success. The extremely wide range of factors contributing to the AIDS epidemics require a broad comprehensive set of interventions—in all countries but especially in developing countries. This view should shape the culture of medicine for the years ahead. This approach accords with the nature of HIV in Africa and elsewhere; three concurrent epidemics are unfolding:

- Invisible HIV (asymptomatic)
- Visible HIV (symptomatic)
- Mortality

Accordingly, our interventions should encompass a continuum from prevention to care to development.

It is no use telling the people in Africa that AIDS is another plague like other plagues of smallpox, measles, and Black Death, which have appeared as darkened shadows on the landscape of human history. It is no use reminding Africans that these shadows have lengthened but have then finally disappeared. This AIDS epidemic is immediate and terrible and relentless, and therefore it is pointless to anticipate under such circumstances a "victory of memory over forgetting." Like no other, this disease violates the most intimate privacies of man and woman, and pierces the secret life of communities. Given the intensely personal and often furtive nature of this infection, access to individuals and groups of people is critical. Access for prevention, access for detection, access for care and for support.

What shall we do when we reach the people? We know of interventions that work—aggressive treatment of STDs, condom distribution, needle exchange (where appropriate), and educational efforts and mass awareness campaigns. It is worth reiterating that one of the primary challenges to the world community is to promote and fund interventions which are aimed not only at individual behavior change but also at the social, economic, and structural determinants of HIV/AIDS. I have discussed this under the need for broad development initiatives.

Mass awareness campaigns in sub-Saharan Africa, Mexico, Thailand, and India have increased knowledge but behavior change has been disappointing. So the challenge to the world community is to uncover and support the most effective methods which can initiate, promote, and sustain healthy behaviors, especially sex behaviors, at population level among at-risk groups. I would like to dwell on one

particular pathway to encouraging changes in risky behavior which I believe is worth exploring. This pathway is the route through what we call civil service organizations or community-based organizations, more popularly NGOs (nongovernmental organizations).

South Africa has a rich heritage of many thousands of NGOs—a heritage of the years of anti-apartheid struggle. It was these NGOs which drove the apartheid government into retreat; the same NGOs which mobilized millions in their schools, unions, and in their homes; the same NGOs which ensured an authentic people's victory over the forces of racial oppression. We should support and consolidate these same forces against this different war against HIV/AIDS.

Throughout Africa these NGOs can ensure an access to communities that governments rarely achieve and their prospects of success are higher because of the confidence communities have in them. They are close to communities, have much local knowledge and experience, can be innovative and flexible in their responses and diverse in their programs.

There is wide acceptance of an enhanced role NGOs can assume, inter alia, in promoting healthy behaviors. A key operational style of NGOs is the ability to establish and work through civil society networks. The participation of people in informal and formal networks, encouraging positive social norms and building high levels of trust, can raise family values and enhance social cohesion, can build what has been termed "social capital."

We are familiar with financial capital, property capital, and political capital; all these are important surrogate markers of prosperity. However, for the many millions of poor who have to depend on the reserves of their own capabilities, "social capital" is particularly apposite to the prevention and care for HIV/AIDS. It is intuitively appealing but does it work? Some evidence suggests it might!

These NGOs should be the focus and catalyst for new partnerships between government, the private sector, and civil society. Indeed these partnerships should extend to global forums such as this, international organizations such as the UN, and national bodies. All these partnerships must be based on mutual respect and an affirmation of the sovereignty of local decisions.

What do the experiences of Africa tell us about healthcare resource challenges which have to be taken up seriously by the world community? I am grateful to Quarraisha Abdool-Karim who sits on the International AIDS Society for sharing the results of a paper by her and her co-authors in *AIDS*.

National AIDS programs have been established throughout sub-Saharan Africa, usually within ministries of health. This location of the programs has to be examined carefully as AIDS requires the cooperation of a wide range of nonhealth-related institutions. Participation of civil society and other ministries has been minimal. The principles of most of the programs are based on the Global Programme on AIDS of WHO and have emphasized prevention more than care and support. Recently there has been further progress in some countries: budgets for HIV/AIDS have tripled in South Africa, female condom use promoted in Zimbabwe, and STD treatment aggressively pursued in Tanzania and Senegal. Screening of blood and voluntary testing sites are becoming more widespread.

Impediments to these AIDS programs are considerable: political commitment often wavers (except for Senegal, Uganda, Côte d'Ivoire, and Zambia), broader development stagnates, and the capacity to respond to the epidemic is hobbled. For example, annual government expenditure on HIV/AIDS ranges from less than 1 percent to about 15 percent of total health expenditures, a pitiful US$0.30 is spent per capita (range $2.96-0.04) and only 12 percent of planned activities on HIV/AIDS were carried out in Tanzania.

In brief, Africa, which has about 13 million of the global total of 20 million HIV infections, has acknowledged the problem and responded—vigorously in only a tiny fraction of countries, slowly and feebly in most. Africa has to respond by scales of magnitude higher if the epidemic is to be controlled and the human development gains of the recent past protected. I cannot think of a more compelling challenge to the World Community than to participate in the protection of African health and the acceleration of African development, both of which are fundamental to the attainment of not only continental but international peace, democracy, and security.

As this millennium fades and a new thousand years begin, I anticipate that this conversation will continue without interruption between people from the hidden corners of the world, which are nearly always poor, and where HIV remains a catastrophe, between them and you. And in this conversation I would urge you to make sure that while you hear the eloquence of the powerful, you listen attentively to the subdued but insistent cries of the weak, and are not deaf to the barely audible sounds of the poor, the disabled, and the disorganized. Listen to these voices with your head and your heart, and let us change the world, so that those in daily danger of HIV and those already infected, can believe there is hope for avoidance and protection, there is hope for care and support, there is hope for a cure, but most of all, can say thank God someone cares. ■

Hoosen M. Coovadia, MD, is the head of the department of pediatrics and child health at the University of Natal; chair of the South African government's AIDS Advisory Group; and chair of the 13th International AIDS Conference in 2000.

HIV/AIDS FACTS and FIGURES:
04/21/99

Basic HIV/AIDS Statistics:
Since the beginning of the HIV/AIDS pandemic 47 million persons have become infected with HIV, the virus that causes AIDS (33.5 million in sub-Saharan Africa)

Of this total number:

- 33. 4 million are currently living with HIV (22.5 million in sub-Saharan Africa)
- 14 million have died (12 million in sub-Saharan Africa)
- 5.8 million new HIV infections occurred in 1999 (4 million in sub-Saharan Africa)

We estimate that by the year 2005, the cumulative total of persons infected by HIV will reach 100 million, with approximately 60% of these persons living (or have died) in sub-Saharan Africa.

U.S.G. Funding for the Response to the Global Pandemic (with specific funding information on sub-Saharan Africa and in South Africa) :

The U.S. Government response to the global pandemic began in 1986 and since then we have contributed $1.143 billion to the effort. Since the early 1990's, the U.S. has been the lead donor, contributing 25% of the budget for UNAIDS each year (In 1999 = $15 million) and 48% of overall development assistance devoted to HIV/AIDS prevention and control in the developing world. ($125 million in 1999) The U.S. contributes four times more than the next largest bilateral donor (Netherlands).

Since1986, USAID has expended in sub-Saharan Africa approximately $650 million dollars (50% of the total global expenditure) In 1999, total expenditure will be $74 million and an additional $ 7 million for Africa from the *Supplemental Fund for Children Affected by HIV.*

Since 1990, USAID South Africa has obligated approximately $28.5 million for HIV/AIDS programs. In 1999, planned obligations will be $1.5 million, plus an additional $1.4 million from the *Supplemental Fund for Children Affected by HIV/AIDS.*

HIV-AIDS Funding for FY 1999 and FY 2000

HIV/AIDS Component	FY 1999	FY2000 (still being finalized)
Total HIV/AIDS appropriation	**$125,000,000**	**$127,000,000 (requested)**
-Africa	-$56,000,000	-$55,100,000
-Latin America/Caribbean	-$13,000,000	-$13,200,000
-Asia/Near East	-$19,000,000	-$21,350,000
-Global	-$36,000,000 (50% -$18 million- of this sum is targeted at Africa)	-$35,750,000 (50%- $17 million -of this sum is targeted at Africa)
-Other Central Bureaus	-$1,000,000	-$1,600,000
Additional Funding for HIV/AIDS activities (not part of the HIV/AIDS appropriation)		
Eastern Europe/Newly Independent States*	**$1,750,000***	**$1,750,000***
Condom procurement*	**$21,145,833**	**$20,907,717**
Children Affected by HIV Supplemental Funding*	**$10,000,000***	NA
Africa	-$7,000,000	NA
Latin America/Caribbean	-$200,000	NA
Asia/Near East	-$1,800,000	NA
Global	-$1,000,000	NA

* These funds are not part of the HIV/AIDS appropriation FY request.

AIDS is a Global Emergency that beckons a more aggressive US reponse

- In the next decade, 40 million children will be orphaned AIDS, 95% of whom will live in sub-Saharan.
- AIDS is not just taking lives, it is threatening economies, political stability, and civil society.
- AIDS is wiping out decades of progress on a variety of development fronts, including per capita GNP, infant mortality, and life expectancy.
- Leadership and investment can help, and has helped, to turn the tide.
- As goes Africa, so will go India, Asia, and the new Soviet states, and by 2005, more than 100 million people worldwide will be HIV+.
- In the face of a ***300% increase in annual HIV incidence***, the US global AIDS budget has remained flat funded at approximately $125 million. Including the cost of inflation in this scenario, flat funded is actually equal to ***a 25% cut in real US funding***.

Children and Families Global AIDS Initiative

To being to keep pace, and perhaps to even gain ground, in the global war on AIDS, a $100 million new investment in FY2000 is required. This will enable the US, in partnership with host countries. to move forward with an aggressive four pronged approach:

(1). **Caring for Children Orphaned by AIDS/War**

(2). **Providing Home and Community Based Care**

(3). **Preventing the Further Spread of HIV**

(4). **Gear Up for War -- Capacity Development**

The Washington Post

AN INDEPENDENT NEWSPAPER

Kosovo and Sierra Leone

ONE OF THE bloodiest wars of the '90s may be winding down. We refer here not to Kosovo but to West Africa's Sierra Leone. Late in May, Africans, led by Nigeria and helped by President Clinton's envoy for the purpose, the Rev. Jesse Jackson, produced a cease-fire and power-sharing talks. You missed the news? It happened with hardly any of the acclaim that marked the breakthrough in Kosovo.

The war in Sierra Leone seemed endless, unendable, horrible and duplicative of other regional wars; it unfolded in a quarter little known to Americans. Perhaps for such reasons it received only episodic attention. But how then to explain the emergence of Kosovo as a major concern of American policy and a large topic in the news? For Kosovo's war also has seemed endless, unendable, horrible and duplicative, and it also unfolded in a remote quarter.

Jesse Jackson, for one, has been inquiring into this discrepancy. He notes that where the United States is sending $15 million to the West African organization that worked to end the Sierra Leone war, it has made a "down payment" of $13 billion for Kosovo. He does not say, as many in Africa do, that behind the gap lies a question of race. He does say that if American cameras brought home the pictures of Sierra Leone's misery, the American conscience would be touched and the disparities in American treatment of the two countries would narrow.

Over the decades American policy has found compelling national interest, and American media have found plenty of news, in convulsions in nonwhite countries. The American record in providing humanitarian aid to Africans is notable. Still, the traditional Eurocentric quality of American global engagement is plain and becomes even sharper when crisis flowers. Thus did the United States turn a decade's full attention on Bosnia and then Kosovo, even as successive upheavals in Somalia, Sudan, Rwanda, Zaire/Congo and Sierra Leone generally prompted a less ambitious and more selective approach.

The contrast can be explained by circumstances, but that is not good enough. A fair and sustainable policy must tap the energies and resources that ease rather than aggravate the lingering question of why the United States sometimes appears readier to help a distressed white country than a distressed black one.

HIV/AIDS epidemic around the world. The President also will announce that NIH will invest $164 million in FY1999, a $38 million increase over last year, in critical research projects aimed at reducing the number of AIDS orphans by preventing and treating HIV/AIDS internationally. These projects will include: a new prevention trials network to reduce adult and perinatal transmission of HIV/AIDS; new strategies to prevent and treat HIV infection in children; funding to train more foreign scientists to collaborate on this epidemic; research on the prevention and treatment of the opportunistic infections, such as tuberculosis, that commonly kill people with HIV/AIDS; and research on topical microbicides and other female-controlled barrier methods of HIV prevention.

$10 million in USAID emergency relief funding to provide support for AIDS orphans. USAID will make available $10 million in emergency funding to support community-based efforts for orphans in the countries most affected by this problem. These efforts will include training and support for foster families, initiatives to keep children in school, vocational training, and nutritional enhancements. In addition, USAID will take steps to help prevent the spread of HIV from mothers to children and to improve medical care for children already infected with HIV.

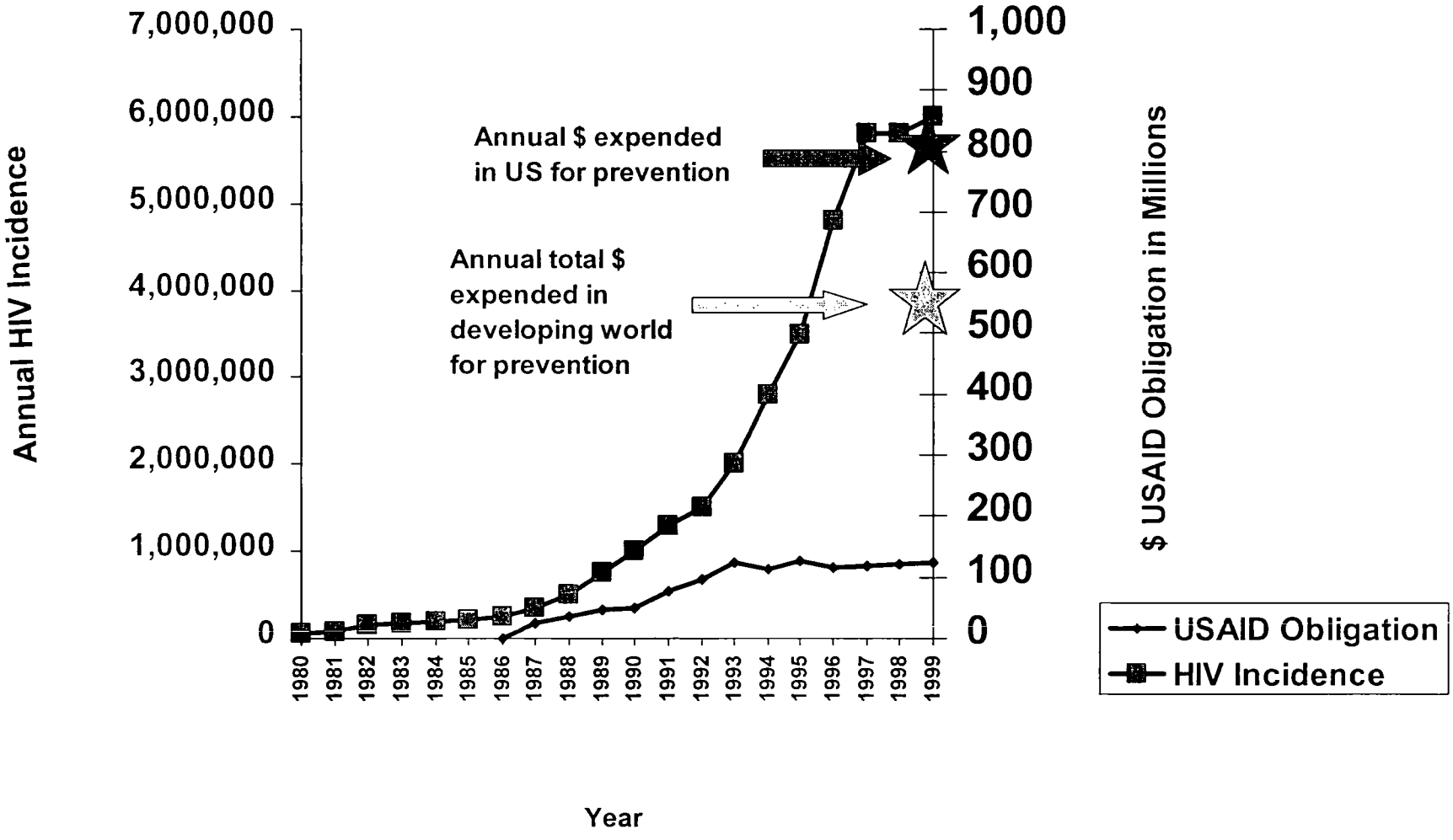
AIDS Policy Advisor Sandra Thurman to lead fact-finding delegation to raise awareness and make recommendations to address growing problem of AIDS orphans. President Clinton will ask Sandra Thurman, Director of the Office of National AIDS Policy, to lead a fact-finding delegation early next year to Sub-Saharan Africa, where 90 percent of AIDS orphans reside. The delegation will include representatives from key Congressional offices. Its goal will be to raise awareness of this emerging problem and to develop recommendations for action.

New steps to address the continued needs of those living with HIV/AIDS in the United States. While the problem of HIV/AIDS is particularly acute internationally, the President will underscore the impact of HIV/AIDS on families in this country as well. The President will highlight an announcement today by Vice President Gore of more than $200 million in funds this year for the Housing Opportunities for People With AIDS (HOPWA) program to prevent individuals affected by HIV/AIDS and their families from becoming homeless. The Vice President will announce these grants at a meeting with local community leaders who provide housing and other support services for people living with HIV/AIDS and with several individuals and families who have benefited from these services.

A solid record of achievement in HIV/AIDS. Today's announcements build on a deep and ongoing commitment by the Clinton Administration to respond to the AIDS crisis both in the United States and across the world. The Administration has fought for other critical investments in HIV/AIDS. This year alone, the President:

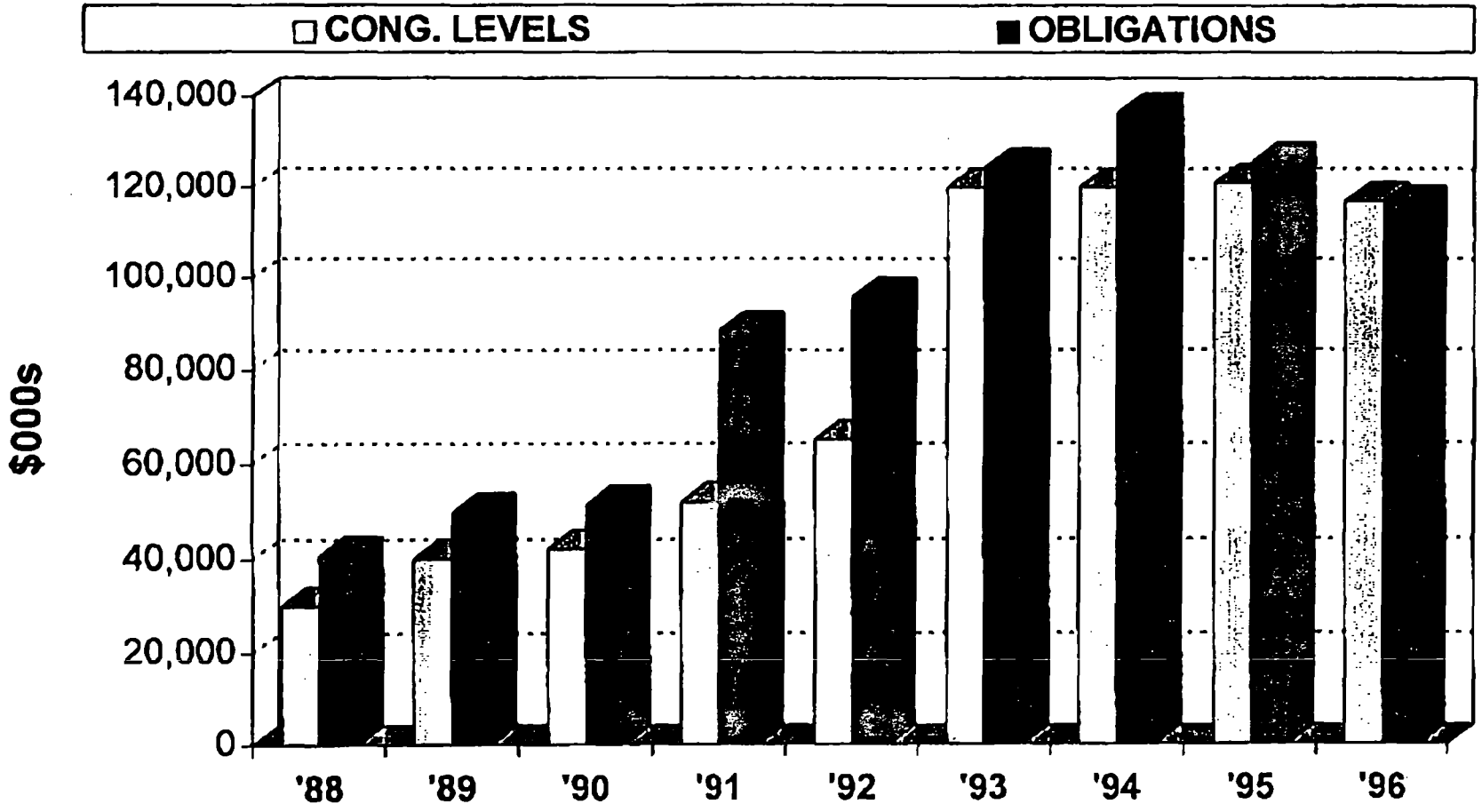
- Declared HIV/AIDS in racial and ethnic minority communities to be a severe and ongoing health care crisis and unveiled a new $156 million initiative to address this problem. This initiative included crisis response teams, enhanced prevention efforts, and assistance in accessing state-of-the-art therapies.

Annual HIV Incidence (# of new HIV infections/year) Compared to Annual USAID $ Obligation for HIV/AIDS Programs



USAID

Trends in USAID HIV/AIDS Funding
Obligations vs Congressional Levels (FY 88 - FY 96)



Source: USAID'S Report to Congress, CIHI Subject Files, and AC/SI System

HIID

Strategies for Combating The Health Crisis in Sub-Saharan Africa

Jonathon Simon[1]
Sydney Rosen[1]
Donald M. Thea[1]
Scott Gordon[2]
Paul S. Zeitz[3]

March 11, 1999

[1]Harvard Institute for International Development
[2]Harvard School of Public Health
[3]Johns Hopkins University School of Hygiene and Public Health

ABSTRACT

The health status of people living in sub-Saharan Africa has dramatically declined declined during the 1990's. Infectious diseases, maternal mortality and ineffective use of resources have been shown to negatively impact efforts to bolster economic development thereby reducing the resources available to improve health. This strategy briefing focuses on the most critical public health issues confronting African ministers and proposes a series of recommendations to address the problems. The recommendations are organized in accordance with the systemic nature of the crisis, and address the need to do the following: mobilize additional resources, use resources more efficiently and promote new approaches to public health financing and service delivery. The inter-sectoral nature of the public health crisis and its macroeconomic costs and micro-economic burdens on households, will require active and coordinated participation from all levels of government and international agencies. African governments are ideally positioned to begin the processes of reform and negotiations with international donors outlined in this briefing.

The Public Health Crisis in Sub-Saharan Africa

March 11, 1999

I. Public Health in Africa in the 1990s

1. Introduction

Public health in sub-Saharan Africa in the last years of the twentieth century is a disaster. If the 1970s and 1980s were known as the decades lost to cross-border conflict, economic stagnation, and social decline, historians will label the 1990s as the decade lost to epidemic, faltering health service delivery, and serious deterioration in all measures by which societies gauge their health. Life expectancy, child mortality, maternal mortality, and other key public health indicators have remained flat or deteriorated, some markedly, in the past ten years. Life expectancy at birth is the lowest in the world and has fallen by as much as two decades in some parts of the continent. An African child born today will, on average, live eleven fewer years than will a child born in a low-income country in Latin America or Asia. One out of seven African children dies before his or her fifth birthday and maternal mortality rates are among the highest in the world. Malaria, a disease once thought to be in retreat, now kills more than a million Africans each year. Access to quality health care has disintegrated in the face of crumbling infrastructure, a dearth of trained personnel, and a lack of essential drugs.

Looming over all these problems is the HIV/AIDS pandemic, now considered the worst infectious disease catastrophe since bubonic plague halved the population in the five years after it reached Europe in 1347. Although marching at a slower rate than plague, the AIDS epidemic is accelerating and will kill over 20 million Africans during the next decade. The effect HIV will have on African economic development and national security is staggering. AIDS is a public heath crisis the magnitude of which has not been imagined in modern times. Although some countries and regions have fared better than others, the overall picture of public health in sub-Saharan Africa as we enter the next century is dismal.

Over the last 15 years most of sub-Saharan Africa has experienced less economic progress than any other part of the world. The issue extends well beyond disappointing economic growth: between 1985 and 1996, twenty-one sub-Saharan countries *contracted* economically. The overall per capita economic growth rate, weighted by population, was estimated to be *negative* 0.6 percent per year (and a dismal negative 2 percent per year in the first half of the 1990s). Although a group of ten or so countries began to rebound in the mid-1990s and are now growing rapidly, driving up the region-wide per capita average GDP growth to 1.4 percent/year, a dozen others are still experiencing falling GDP/capita (Fischer et al. 1998). As a result of this decade and a half of economic faltering, nearly one half of the continent's population lives in abject poverty and can neither defend itself effectively against disease nor pay for treatment once infected. Poverty alleviation, driven by rapid, and equitable, economic growth that benefits the poor as well as the rich, is thus the goal for improved health.

The purpose of this briefing on the public health crisis in sub-Saharan Africa is to focus attention on the most critical public health issues confronting senior African economic policy makers and to identify near-term priorities for government action. We believe that improving public health is essential to enabling economic growth and development.

Health in Africa is in crisis and poses a threat to the political and economic initiatives that are at long last possible with the end of the Cold War. Failure to address the public health crisis commits too many people to an early death, abandons too many women and children to unnecessary illness, extracts too many able workers from the workforce, and risks too much social instability. Failure to act undermines the potential benefits of economies that are more open and embrace more participatory democratic systems, and it further widens the gap between African nations and the rest of the world in the new millenium. The crisis in public health in Africa is not a health-sector emergency—it is a national emergency. Although some of the recommendations made here are directed at the public health system and health professionals, *many can only be implemented through the concentrated efforts of national initiatives led by the senior economic managers and political leaders of African nations.*

2. A brief review of the decade

Although the list of the region's serious health concerns is long, four key issues—child mortality, maternal mortality, malaria, and HIV/AIDS—illustrate the disturbing story of public health in sub-Saharan Africa in the 1990s.

- Improvements in under-five mortality achieved through hard-fought battles in child and maternal health over the past several decades have slowed in most countries, leaving African children with the poorest survival to age five of children anywhere in the world. In seven countries, child mortality actually increased during the first five years of the decade. The most important killers of children in Africa are infectious diseases, alone or in combination with poor nutrition. Lower respiratory infections; malaria; measles; and diarrheal diseases, associated with poor water supply and sanitation, together account for 65 percent of under-five mortality, and nearly 40 percent of the total disease burden in sub-Saharan Africa (Murray and Lopez 1996). In high-income countries, these four diseases have been almost eliminated or are routinely treated, resulting in virtually no deaths. As a result, an African child is three times more likely to die before the age of five than an East Asian child, and twenty times more likely to die before five than a child in a high income country (Ibid).

- Maternal mortality rates in sub-Saharan are the highest in the world—fully three times the rates of developing countries as a whole. In 1990, one out of every sixteen African women died of maternal causes in Africa, compared with the 1990 rate in North America of one in 3,700 (WHO 1999). The disproportionately high maternal mortality seen in sub-Saharan Africa is not simply a consequence of the low income afflicting this region. Maternal mortality in Ivory Coast is 30 times higher than amongst Sri Lankan women with the same income level of approximately $700/year (World Bank, 1997a).

- Malaria, never brought under control even in the best of times, has re-emerged as a major killer in the region. Ninety percent of the world's burden of malaria is borne by sub-Saharan Africa. Current estimates put malaria-related deaths at 1.5-2.5 million per year, and the number of clinical cases at half a billion—nearly the equivalent of one clinical case per year for every African citizen. The economic costs of malaria to the region are staggering—$1.7 billion in 1995, according to one widely cited estimate—or 1 percent of the region's forcasted GDP for that year (Shepard et al. 1991). A tenth of all hospital admissions and 20-30 percent of clinic visits are due to malaria. For poor African households, the cost of malaria was estimated at 32 percent of annual household income in one country in 1992 (Ettling et al. 1994).

- The toll of the HIV/AIDS epidemic on sub-Saharan Africa is horrifying. More than two thirds of the world's HIV infections and AIDS cases are found in Africa, and the rate of increase there is higher than in any other region. More than 85 percent of the deaths due to AIDS worldwide have occurred in this region and a quarter of these are in children. In 1998 alone AIDS killed two million people and was responsible for 5,500 funerals each day (UNAIDS 1998). Life expectancy is dropping throughout the continent. In one heavily affected country it has fallen by 22 years to just 42 (World Bank 1997b). Especially alarming for Africa's economic future is the disproportionate impact on educated young adults who hold technical and managerial positions. In one study 34 percent of people with post-secondary education were HIV-positive, compared to just 18 percent of those with a primary education, and civil servants were more than three times more likely to be infected than farmers (World Bank 1997b). As current HIV infections gradually become full-blown AIDS cases, the impact on African productivity and economies further impair development and growth.

Taken together, the diseases (which do not include tuberculosis, a major killer in its own right) described above account for 45 percent of all mortality and 43 percent of the overall burden of disease in sub-Saharan Africa. What makes these figures particularly dramatic is the realization that in other part of the developing world, such as Latin America, these conditions account for just 15 percent of all mortality (Murray and Lopez 1996)—and people live an average of eighteen years longer (World Bank 1998). Africans, even in the poorest countries, do not need to die at such rates from such causes.

Heightening the impact of these diseases is the erosion of health systems and health infrastructure over the decade. The overall lack of resources, as well as the low priority given to health in national resource allocations, and in some cases, the fiscal discipline required by structural adjustment programs have drained the health sector of both physical and human resources. African governments spent about 2 percent of GDP on health services in 1996, slightly below the average for the developing world, but far below the 6 percent average of high-income countries (World Bank 1998). Per capita spending on public health in sub-Saharan Africa has increased by about 1 percent per year in the past decade, the lowest annual increase of any developing region (Gupta et al. 1998). Facilities and technology have deteriorated badly and often function without even the most basic supplies. The loss of the human capital stock has followed this decline as trained health personnel leave national health systems. The failure to use available resources efficiently, for a variety of reasons, has only worsened the problem. The

problems listed above do not affect every country in the same way or to the same extent. Though some may be doing better, overall the whole region is immersed in a public health crisis unlike any other region of the world.

3. Public health and economic development

The five issues described above are just selected pieces of the public health crisis. Hunger and malnutrition, national and domestic violence, alcohol and tobacco abuse, road accidents, air and water pollution, tuberculosis, among other conditions take a higher toll on sub-Saharan Africa than they do on most other parts of the world. The toll is not just physical and social—it is also economic. The public health crisis extracts macro-economic costs, imposes micro-economic burdens on households, and levies inter-sectoral costs and responsibilities.

Illness reduces the expected benefits of investments in human capital and reduces labor and entrepreneurial productivity. Country-specific studies estimate the economic burden of illness at 13-16% of per capita GDP (King and Wang, 1993). A recent study making cross-country comparisons of the effect of malaria (alone or as a marker of other tropical diseases) on macro-economic growth suggests that malaria reduces GDP growth by 1.3% per year after taking into account initial poverty, economic policy, tropical location, and life expectancy among other factors (Gallup and Sachs, 1998).

The fragile but significant economic improvements being seen in some sub-Saharan African countries due to recovery from armed conflicts , exploitation of recently discovered oil reserves and improved policies will in part be sustained by private capital inflows (Fischer, 1998). This is particularly true in the setting of declining official development assistance. Productivity of private capital in some sub-Saharan countries is adversely affected by inadequate physical infrastructure and an inadequate stock of human capital (Findlay, 1996). Widespread disease and poor health affecting the workforce will further impair Africa's diminished ability to attract private foreign capital compared with other developing countries (Bhattacharya, 1997).

Several studies on the total cost of disease to African households concluded that households spend an average of 6.4 percent of household income on illness (World Bank 1994). The share of per capita GDP lost to illness is even higher—an average of 15 percent. Adults typically lose as many as twenty-five days of productive time per year, either to their own illness or to caring for sick family members (Rosen and Vincent 1999).

One of the distinguishing features of public health management in sub-Saharan Africa is the extent to which health outcomes are determined by activities in other sectors. Nowhere else is the effect on public health of investments in infrastructure, environment, and agriculture as pronounced as it is in Africa. Perhaps the most compelling example of this is in the area of water supply and sanitation infrastructure. Two thirds of the rural population of sub-Saharan Africa lacks access to a safe and convenient water supply, and 81 percent lack even basic sanitation facilities. Because of the connection of these infrastructure services to infectious disease transmission, some 11 percent of all morbidity and mortality in the region are attributed to poor water supply and sanitation services (Rosen and Vincent 1999). Significant progress cannot be

made in the fight against diarrheal diseases by the health sector alone—investment by government agencies responsible for infrastructure is an absolute requirement.

Household (family) behaviors are the key to preventing disease and managing illness. Families manage their micro-environments, initially recognize ill health, and make the decisions on when and where to seek health care services. Families need to have access to the financial resources and information needed to avoid preventable diseases. They need to have sufficient resources to access adequate quality, cost-effective care when illness strikes. Information and medical technology are important, but poverty alleviation is the essential prerequisite for improving health status for many African families.

II. Recommendations

The preceding section draws attention to several of the most urgent public health problems affecting sub-Saharan Africa in the 1990s. It is also clear that there is great variability across the continent, in both the relative importance of different diseases and the resources that can be brought to bear to control them. Because of this variability, recommendations that apply generally to the entire region must be made with caution, and with the understanding that each recommendation must ultimately be tailored to the country or community to which it is applied. Regardless, the facts summarized in the preceding section and our assessment of the public health issues in sub-Saharan Africa lead us to make eight key recommendations for addressing the public health crisis of the new millenium. These recommendations can be organized into three areas: mobilize more resources; use the resources more efficiently; and promote new approaches to public health financing and service delivery.

1. Mobilize more resources for public health

As noted above, there is a severe shortfall in the human and financial resources available to improve health in sub-Saharan Africa. African nations are simply not spending enough on health at the current levels to improve the health status of their populations. While it must be recognized that mobilizing additional resources is critical and plans need to be made for how these funds will be raised, it is also important to realize that funds alone will not provide a complete solution to the public health crisis. Resource identification is a necessary, but not sufficient prerequisite, for achieving widespread, sustainable health improvements.

In an era of massive public debt and relentless pressure from international lenders and investors to control budget deficits, mobilizing significant new resources for public health will require new and ambitious initiatives and perhaps even a re-framing of conventional economic policy. We recommend two unconventional ideas and one old approach.

Recommendation #1: Swap debt for health

African countries currently bear an external debt burden of $227 billion. Service on this debt, some $14.5 billion per year, is equal to 5 percent of the region's GDP and consumes nearly 15 percent of export earnings (World Bank 1998). Many people believe that debt relief is essential

for economic growth and development in sub-Saharan Africa. But, it offers one of the most promising approaches for targeting significant new resources at the health crisis, we believe that debt relief is also essential for improving health.

For debt relief to be politically acceptable to creditor countries, it must promise measurable benefits to African people—especially the poor. Health offers such an opportunity. We propose a "Debt for Health" swap program. In exchange for some level of debt relief, African countries will commit to using a portion of the resources spent on debt servicing for a major expansion of public health services, with an emphasis on HIV/AIDS, children's health, and infectious disease prevention and treatment. African governments are currently spending approximately 2 percent of GDP on health services (Gupta 1998), relieving Africa of 40 percent of its external debt would thus allow a *doubling* of spending on health care. Benefits from such a program would accrue to both sides—African countries would enjoy improved public health and economic productivity, and donor countries would see tangible improvements in both indicators as well as improved public support that such a program is likely to generate.

Recommendation #2: Declare war on infectious disease

In 1990, Africa's casualty rate from three infectious diseases—AIDS, malaria, and tuberculosis—exceeded its casualty rate from all forms of violence—war, crime, and others—by a factor of three (Murray and Lopez, 1996). Infectious disease is the most serious security threat facing African nations in the world today. Any one of the two resurgent epidemics, malaria and tuberculosis, or the new scourge, HIV, would be sufficient to stifle human development. Acting together, these diseases are threatening to drain the vitality from every effort to improve welfare and promote development. They are the most serious external threat facing any sub-Saharan country today, and a portion of the resources that typically are invested in more traditional national security activities should be directed to fighting this enemy.

We recommend that African governments declare war on infectious disease and re-direct a share of their national defense budgets to fighting this war. *Governments must recognize that they are facing an enemy that has already declared war on them and is imposing intolerable casualty rates on their populations.* Only by recognizing infectious diseases as a grave threat to national security can governments mobilize the resources and the commitment needed to interdict the public health crisis on an effectively large scale.

Massive cuts in defense spending may not be required (even if appropriate). If developing nations were simply to freeze defense expenditures at current levels and redirect the 7.5% annual increase that would otherwise occur, 10-15 billion dollars per year would be available for health expenditures (UNDP, 1991). Though individual and community risk reduction measures are essential to combat infectious diseases, the commitment of government leaders at all levels to prioritizing the efforts to fight infectious diseases and their willingness to convey this commitment to their constituents at every level of the political process will be crucial. Cutting or freezing defense spending and re-allocating the savings to fighting infectious diseases would send a clear message to the populace and foreign governments of the priority and seriousness with which the national government considers the threat from infectious diseases.

Recommendation #3: Capture and mobilize domestic expenditures on health

African families, in every income group, spend money on health and health care. Too often, the middle and upper income families preferentially access the heavily subsidized urban, curative care hospitals for their health care needs. These hospitals, financially supported by central government revenues, are providing subsidized care to the portion of the population most able to pay for services. Initiation of user fees and cost sharing/cost recovery mechanisms have been shown to be effective if quality services, including an ensured supply of essential drugs, are provided in a timely fashion. Experience has shown that willingness to pay for quality services is not limited to the wealthy alone; even low and moderate-income households will pay for services if they are getting value for their money. Ending the subsidies for the people able to pay and re-directing the revenues to the provision of an essential package of services for the more needy components of the population has both efficiency and equity benefits.

2. Allocate public health resources more efficiently

No matter what level of resources is available for public health, better allocation of those resources is critical to achieving real improvements in public health. Several of the steps needed to prevent the most important public health problems are relatively inexpensive on a per capita basis, and much can be achieved if resources are used efficiently. We have five specific recommendations for doing this.

Recommendation #4: Create and fund an "Essential Package of Services"

Each country should identify a set of high priority health services that it will strive to provide to every citizen and should allocate its national health budget accordingly. The widely held belief, based on the past half-century of experience, is that immunization services, sexually transmitted diseases (STD) and AIDS education, family planning, integrated management of childhood illness, safe motherhood interventions, and childhood nutrition support are likely to be the most cost-effective measures countries can take to reduce morbidity and mortality. The recommendation to focus on a package of essential services—that is, provide a limited number of services very well, rather than a large number poorly—is consistent with current approaches of the WHO and the World Bank and is thus likely to garner external donor support.

By focusing on a small number of critical interventions that provide large benefits, health systems are likely to deliver higher quality services at much lower cost and to a larger share of the population than they currently reach. The World Bank 1994 estimate for a low-income African country of one possible package of essential services, including basic clinical services, water supply and sanitation investments, and institutional support, was $13 per person per year. In a higher income country, the estimate only increased to $16 per person per year. While these estimates are just rough indicators of anticipated costs and are likely to vary widely among individual countries and communities, they suggest that paying for a package of essential services is not beyond the means of many African countries. These costs are reasonable, particularly if the costs are shared among governments, households, and donors. In 1990, total health expenditures equaled or exceeded $16/capita in about a third of the countries in Africa; in

the remainder, they averaged about half this amount. For the latter group, paying for a package like this will require new resources to be invested in public health, but the costs remain within a feasible range (World Bank 1994).

It is important to note that in selecting the services for the package, countries will have to make explicit their priorities and acknowledge that there is a limit to the services that governments can provide. The package chosen by a country should reflect its own health conditions and resources, so that delivery of these services to the majority of citizens is a realistic goal. Delivery should be monitored carefully to ensure that targets are met and to justify the resources that are devoted to the package.

Recommendation #5: Reallocate resources from expenditures for urban curative care to disease prevention.

For a number of historical and political reasons, a disproportionate share of health resources has traditionally been allocated to curative care for urban populations, particularly for the most affluent households. Sub-Saharan Africa allocates a larger share of its health resources to curative care than any other region of the world: 62 percent in 1994 (Gupta et al. 1998). If the public health crisis is to end, more resources will need to be dedicated to broad-based, cost-effective health interventions, with a focus on the infectious diseases discussed in the previous section: childhood diseases, malaria, HIV/AIDS, and tuberculosis.

Arguably the best investment of public health dollars available is on effective childhood vaccination programs. The savings in health care dollars not spent on the clinical management of the numerous vaccine preventable childhood diseases far exceeds the costs of effective vaccination programs, including the added costs of mobilizing national immunization days. Other efficient and cost-effective preventive measures which, if effectively implemented will decrease public expenditures on health care, are maternal and child nutrition programs that promote well-balanced nutrition comprised of locally available foodstuffs.

By far the most successful intervention in slowing the spread of sexually transmitted diseases, including HIV/AIDS, is the promotion of condom use and safe sexual practices. Prior to the development of an effective HIV/AIDS vaccine, which is <u>not</u> a realistic probability in the near future, education and social mobilization are the most cost-effective and only realistic choices facing most sub-Saharan countries. In the case of tuberculosis, interrupting the foci of spread by the identification and treatment of active cases is the cornerstone of control. Moreover, huge efficiencies in control can be achieved by interventions that are both early and focused on the populations with the highest risk of contracting and spreading the disease. For these two closely linked epidemics, interventions that target commercial sex workers, attendees to STD clinics, truck drivers, prisoners, or refugee populations, etc. are preferred. From a public health standpoint, "an ounce of prevention among high-risk groups is worth 10 pounds of cure".

Recommendation #6: Promote private sector provision of health services

In many countries, the private sector—both NGOs and for-profit firms—has proven to be a lower-cost provider of some health services than the government sector. Government regulation of the health sector continues, but the government is no longer the sole, or in some cases, even the major, health service provider. The government role may be more appropriate as the financing agency, rather than the service delivery unit, for health services. For the private sector to operate effectively, direct and indirect constraints on its activities must be removed. These include inappropriate regulations that constrain private sector provision of health services, for example, long delays and prohibitive fees for licensing private sector providers, or customs and excise systems that delay or charge duties on health products such as medicines or bednets. In addition, economic incentives should be created to encourage private sector provision of public health measures that promote healthful behavior in workplaces and schools (e.g. smoking or alcohol abuse programs and distribution of condoms and sex education materials).

In addition to private sector firms being encouraged to expand their share of the health services market, larger scale industrial or manufacturing firms and trade union associations should be encouraged to assume even greater responsibility for the health of the workforce. Currently, much of the cost of sustaining a healthy workforce is shifted onto the government. As governments struggle to meet this burden, there is an economic (as well as social) argument for firms and labor unions to meet worker health needs directly.

One of the largest components of the cost of production in the private sector is often labor and worker training. The costs of replacing workers and productive time lost by diseases such as HIV/AIDS, tuberculosis, malaria, and alcohol abuse affecting the working population are substantial. This is particularly true of HIV/AIDS that disproportionately affects the technical and managerial echelons of the private and public sectors. The production inefficiencies and real costs associated with the need to hire and train additional managers or technicians for positions regularly vacated due to disease are substantial. This is in addition to the direct financial losses due to illness, absenteeism, health care, and funeral costs. Research is ongoing on the costs to competitiveness and profitability paid by those companies located in areas of high disease prevalence, in the hope that the results will provide an economic rationale for them to assume a greater role in providing basic health services to their employees.

Recommendation #7: Improve drug supply systems

Many of the infectious diseases that are taking such a heavy toll on African lives can be treated using well-known, widely available drugs. World Bank and WHO research indicates that African clinics typically spend 20-30 percent of their budgets on drug purchases, making pharmaceuticals the second largest health expenditure, after personnel costs. In the late 1980s, drug purchases accounted for 0.76 percent of GDP. Despite this significant allocation of budget resources, however, studies in the late 1980s estimated that 60 percent of Africans do not have access to the drugs they need.

The average cost of providing medications for 85 percent of the infectious diseases in Africa (with the important exception of AIDS) is estimated at $1.60 per person per year. In the late 1980s, the most recent period for which information is available, African countries spent an

average of $2.10/capita/year on pharmaceuticals. Given these figures, it is difficult to argue that the shortfalls in drug availability can simply be attributed to "too little money".

Although in some cases more resources will be needed, especially for the poor, the main impediment in preventing Africans from having access to a reliable supply of essential drugs is inefficiency and waste in drug procurement. *On average, $88 out of every $100 spent on pharmaceutical purchases in Africa is lost.* The losses occur at each stage of the procurement and distribution process, roughly as follows:

Initial investment	$100
Purchase of the most expensive drugs rather than low-priced equivalents	-$10
Absence of bulk purchasing—buying small quantities rather than large	-$13
Lack of competitive bidding by prospective suppliers	-$27
Poor storage, inventory control, and distribution processes	-$19
Excessive prescriptions, so that some patients acquire unnecessary drugs	-$15
Incorrect use of drugs by patients	-$3
Real benefits to African patients	$12

For every $100 spent, African patients receive only $12 of benefits (World Bank 1994).

A number of steps can be taken to improve drug procurement in Africa and recover some of the value that is now wasted. These include:

1) developing and using a list of essential drugs for each level of the health system and allocating budget resources accordingly;
2) improving understanding of drug needs and of international pharmaceutical markets so that bulk purchases of cost-effective drugs can be made;
3) encouraging the development of private sector—both commercial and NGO—pharmaceutical suppliers; and
4) strengthening monitoring of drug distribution to reduce theft and losses due to poor management.

Recommendation #8: Promote infrastructure investments that enhance public health

Basic infrastructure improvements—particularly in the area of water supply and sanitation—have the potential to reduce the burden of disease in Africa significantly, and might be a prerequisite for the success of other public health interventions. Although most of the analytic work is from outside Africa, the health effects of water supply and sanitation improvements are profound. Studies have estimated these interventions reduce morbidity from diarrheal diseases—one of the main killers of children—by an average of 26 percent, and child mortality by an average of 55 percent (Esrey et al. 1991). Although water supply and sanitation improvements alone do not always ensure major health benefits, most researchers have concluded that long-term, sustainable improvements in health cannot be achieved without them. Water supply improvements also create substantial health and economic benefits to poor households in terms of time and energy saved from carrying water (Rosen and Vincent 1999). Roads and electricity are also like to have significant positive public health externalities.

While resources for infrastructure investments of all kinds are scarce in Africa, we recommend that existing resources be allocated to maximize benefits to public health. In some cases, this will mean shifting resources away from expensive, high technology projects and toward basic water, sewage, and electrical connections.

3. Summary and conclusion

The state of public health in sub-Saharan Africa reviewed above outlines the observation noted at the beginning of this paper: public health in the region is a disaster and impairs economic development in Africa. We make this point not to detract from what has been accomplished in past years, but to emphasize that the health situation is worsening and urge African policy makers to regard health as a national emergency and to respond accordingly. It has been said that "desperate times call for desperate measures," and these are indeed desperate times in the state of African's health.

We offer three comments in summary

Comment 1:The public health crisis is a pressing national issue.

The health crisis is not solely the concern of the Health Minister or limited to the health sector. The impact of the health crisis on national security and its deterrent effect on economic growth and development force the problem onto the desk of the senior Executive (President or Prime Minister) and the senior economic management team (Ministers of Finance, Treasury, Planning, and Trade). The longer sub-Saharan African nations wait to substantively address this crisis, the more extensive and the more constrained the policy and program options will be, and the higher the costs to confront the issue will become. The health problems are accelerating, compounding, and spreading to other sectors of the society. Delays will incur high human and economic costs that will impose themselves on this generation and the next. To promote social stability, human development, economic prosperity and to save untold millions of lives, immediate action is required.

Comment 2:Recognize the transboundary nature of many health problems and develop regional responses.

Many of the infectious diseases taking such a toll on sub-Saharan African households represent regional, rather than just national, problems. Just as rivers that flow from one country to another and water resources must be managed regionally, so must diseases like HIV/AIDS, resurgent tuberculosis, and resistant strains of malaria. Even in the absence of social dislocations such as war, famine and large migrations of refugees which accelerate the cross border flow of disease, all of these public health problems are regional and cannot be contained within any set of conventional borders. Sector and regional alliances must be made and cross-border cooperation in fighting these diseases must be fostered and maintained.

Comment 3: Encourage and support innovative approaches by communities, health providers, and other sectors to promote public health.

Although a few specific public health policies and programs in selected countries in sub-Saharan Africa have been successes, it is difficult to avoid the conclusion that overall public health is in retreat on the continent. In some cases, effective and affordable tools do not yet exist; in other cases, and perhaps more often, tools do exist but have not been applied effectively. In either case, new approaches to confronting the public health crisis are needed. Both government agencies and non-governmental organizations must be encouraged to develop and implement innovative approaches to promote public health programs which mobilize and empower the communities in which they will be applied. It is only through widespread community participation that effective public health measures will be delivered to the people who have the greatest need. We believe that innovation in program development is necessary to find new and effective means to confront this challenge.

Addressing the public health crisis in sub-Saharan Africa will require acts of commitment from national leaders and regional institutions. It will also require major collaborative from donor nations and development banks. We hope the discussions emerging from the Partnership for Economic Growth and Opportunity in Africa Initiative will provide a forum for these issues to be discussed with the USG.

References

Bhattacharya, A., et al. 1997. "Private Capital Flows to Sub-Saharan Africa: An Overview of Trends and Determinants," in Z. Iqbal and R. Kanbur (eds.) *External Finance for Low-Income Countries* (Washington: International Monetary Fund).

Esrey, S. A., et al. 1991. "Effects of improved water supply and sanitation on ascariasis, diarrhoea, dracunculiasis, hookworm infection, schistosomiasis, and trachoma." *Bulletin of the World Health Organization* 69 (5): 609-21.

Ettling, M., et al. 1994. "Economic impact of malaria in Malawian households." *Tropical Medicine and Parasitology* 45: 74-79.

Findlay, R, 1996, "Modeling Global Interdependance: Centers, Peripheries and Frontiers," *American Economic Review* (May).

Fischer, S., et al. 1998. "Africa: is this the turning point?" IMF Paper on Policy Analysis and Assessment. International Monetary Fund. Online. http://www.imf.org/external/pubind.htm.

Gallup, J. L., and J. D. Sachs. 1998. "The economic burden of malaria." Center for International Development, Harvard University.

Gupta, S., et al. 1998. "Public spending on human development." *Finance & Development* 35 (3). Online. http://www.imf.org/external/pubs/ft/fandd/1998/09/gupta.htm.

MFI. 1998. "Malaria background information, May 1998." Malaria Foundation International. Online. http://www.malaria.org/BGINFO.HTM#ECONOMIC.

Murray, C. J. L., and A. D. Lopez. 1996. *The Global Burden of Disease*. Global Burden of Disease and Injury Series Volume 1. World Health Organization.

Rosen, S., and J. R. Vincent. 1999. "Household water resources and rural productivity in sub-Saharan Africa: a review of the evidence." HIID Development Discussion Paper No. 673. Cambridge, MA: Harvard Institute for International Development.

Shepard, D. S., et al. 1991. "The economic cost of malaria in Africa." *Tropical Medicine and Parasitology* 42: 199-203.

UNDP. 1991. *Human Development Report*. United Nations Development Programme, New York, NY, Oxford University Press.

World Bank. 1994. *Better Health in Africa: Experience and Lessons Learned*. Washington, DC: World Bank.

World Bank. 1997a. *Health, nutrition & population. Sector Strategy*. Human Development Network. World Bank, Washington DC.

World Bank. 1997b. *Confronting AIDS: Public Priorities in a Global Epidemic*. Oxford University Press. Online. http://www.worldbank.org/aids-econ/confront/index.htm.

World Bank. 1998. "World Development Indicators 1998." CD-ROM.

WHO. 1996. *Investing in Health Research and Development.* Report of the Ad Hoc Committee on Health Research Relating to Future Intervention Options. Geneva: World Health Organization.

WHO. 1999. "Maternal mortality fact sheet." Safe Motherhood Initiative, World Health Organization. Online. http://safemotherhood.org/init_facts.htm.

APPENDIX

No.	Recommendation	Lead Agency	In Cooperation With
	Mobilize more resources for public health		
1	Swap debt for health	Ministry of Finance	International lenders
2	Declare war on infectious diseases	Entire government	Donor agencies/regional countries
3	Capture and mobilize domestic expenditures on health	Ministries of Health and Finance	Provincial, state, and district health system
	Allocate public health resources more efficiently		
4	Create and fund a "Package of Essential Services"	Ministry of Health	WHO, UNICEF, and other public health institutions
5	Reallocate resources from expenditures for urban curative care to disease prevention.	Ministries of Health, Planning, and Finance	Multilateral and bilateral donors
6	Promote private sector provision of health services	Ministry of Finance and Ministry of Health	Whoever sets the rules for the private sector
7	Improve drug procurement procedures	Ministry of Health and Ministry of Finance (Customs and Excise Dept.)	Whoever regulates imports
8	Promote infrastructure investments that enhance public health	Ministries of Finance, Public Works, Planning, and Health	Donor nations/development banks
	Summary Comments		
1	Recognize the public health crisis as a national issue	Entire government	Donor nations/development banks
2	Recognize the transboundary nature of many health problems and develop regional responses	Ministry of Foreign Affairs	Ministry of Health
3	Encourage and support experimentation and innovation by health providers from all sectors	Entire government with Ministry of Health key to changes in the health sector	Private sector, NGOs, donor agencies

OFFICE OF THE DIRECTOR

NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES

NATIONAL INSTITUTES OF HEALTH

FACSIMILE TRANSMISSION

DATE: June 3, 1999

TO: Ms. Sandra Thurman

FROM:
Anthony S. Fauci, M.D.
Building 31, Room 7A-03
31 CENTER DR MSC 2520
Bethesda, MD 20892-2520
Phone: 301 496-2263

OUR FAX #: 301 496-4409

TOTAL NUMBER OF PAGES BEING TRANSMITTED *INCLUDING THIS COVER SHEET*: 3

REMARKS:

Dear Sandy:

As per our recent telephone conversation, please find attached a list of NIH AIDS research being done in Africa. Thank you and best personal regards.

Sincerely,

Tony

A.S. Fauci

NIH AIDS Research in Africa

According to UNAIDS, 16,000 new infections occur every day. More than 90% of these infections occur in the developing world. A recent report by the World Health Organization showed that the prevalence of HIV infection is highest in the African nations of Botswana and Zimbabwe, where more than 25 percent of adults are now HIV-infected.

NIAID supports vaccine preparedness studies, infrastructure development and feasibility studies, and prevention strategies to stop the spread of AIDS in Africa. Prevention approaches include STD treatment, microbicides, prophylaxis to prevent mother to child transmission, behavioral risk reduction strategies, and most recently vaccines. Over 20,000 African volunteers have enrolled in NIAID-supported studies, primarily through the NIAID supported HIV Network for Prevention Trials (HIVNET). NIAID supports seven HIVNET sites in the following African countries: Malawi, South Africa (2), Uganda (2), Zambia, and Zimbabwe.

Microbicides- An inexpensive, reliable, female-controlled method for preventing STDs is needed so that women can protect themselves. Ideally, chemical barriers, known as topical microbicides, should be invisible, non-irritating, and inexpensive. Several studies have been conducted or are underway in Africa.
-A phase I study of Buffergel has been completed in Zimbabwe/Malawi.
-A phase III study of N9 film in Cameroon enrolled 1200 women. N9 film had no effect on transmission of HIV/AIDS, gonorrhea or chlamydia infections when provided as part of an overall HIV/STD prevention program
-A phase I study of PRO2000 is scheduled to start in South Africa in early summer. A second study in South Africa is planned for later this year. This study will use Caregeenan microbicide.
-A phase III study of an N9 gel is planned for Malawi and Zimbabwe.

Prevention of maternal-infant transmission
Initiation of treatment with zidovudine prior to birth, during delivery, and to the infant has significantly reduced the incidence of maternal-fetal HIV transmission in the United States. However, this protocol is not easily applied in developing countries because of cost factors and lack of health care infrastructure. Simpler and less expensive antiretroviral regimens for interruption of vertical transmission are being tested by NIH in Africa. These include:

-A phase I study of safety and pharmacokinetics of nevirapine in HIV-1 infected Ugandan women and neonates born to HIV-infected mothers is being conducted in Uganda.
-A phase III efficacy trial of oral AZT versus oral nevirapine for the prevention of vertical transmission of HIV-1 in pregnant Ugandan women and their neonates is being conducted in Uganda.
-A phase III study of HIVIG is planned in Uganda.

AIDS Vaccines
Earlier this year, NIAID opened the first AIDS vaccine trial in Africa, an important step for global vaccine development. This small study in Uganda will help determine if it is necessary to tailor-make vaccines for different parts of the world. The vaccine being tested is based on subtype B, the HIV variant most often found in the United States and Europe. The researchers will determine if the immunized volunteers develop immune responses that in laboratory experiments cross-react to the two other HIV subtypes, A and D, the cause of most infections in Uganda.

Virologic and immunolgical studies of HIV infection in newly infected individuals are also planned for several African sites.

STD treatment-
A large study in 12,000 Ugandans showed that although treatment of sexually transmitted diseases (STDs) does reduce the incidence of STDs, it has little impact on HIV transmission in a population with a high prevalence of HIV infection.

Behavioral interventions
In a large phase III study conducted in Zimbabwe, peer counseling was shown to reduce the incidence of new infections by 30 percent.

A phase I trial of an intervention to increase condom use by HIV discordant couples is being conducted in Uganda.

Other NIH-supported activities

NIH fosters basic research that will facilitate development of vaccines and other prevention strategies for Africa.

An epidemiologic study to address the influence of oral and injectable contraceptives on the spread of HIV infection is being conducted in Uganda.

Investigators from Johns Hopkins University are studying the impact of HIV infection on the fertility of women of reproductive age in Uganda.

To help build capacity in developing countries, the NIH funds the AIDS International Training and Research Program (AITRP). The AITRP provides research training to foreign scientists through grants to U.S. universities. The program has provided training in the U.S. for more than 1400 scientists from developing countries in Africa, Asia, and Latin America, and over 600 training courses have been conducted in 60 countries.

NIH-supported HIV-related research helps to build laboratory capacity in developing countries where the research is conducted through purchase of laboratory equipment and transfer of research technology.

USG Current Program Elements on HIV/AIDS in South Africa

USAID

$10 M, 5 year bilateral, starting now.

Public awareness campaigns, and related message crafting and training ($8M)

Funding for AFL-CIO Solidarity Center to work with unions

STD control: some studies and training ($1 M)

Support for vaccine development initiative: scientist exchanges with NIH, planning for delivery of vaccines, and so on. No basic science research ($1 M)

Mechanisms: a) using USAID contractors to provide assistance and b) an inter-agency agreement between USAID and HHS (to access CDC, NIH, Health Resources and Services Administration, and others).

$??, probably in the hundreds of thousands of dollars. As part of the broader $50 M Equity Project in the Eastern Cape which is designed to support broad health systems development in that province, USAID is assisting with TB and HIV services in some parts of the province (mostly rural).

$1.5 M in new money about to be obligated to the USAID mission for three community based projects to deliver services for children with AIDS. Money must be expended in three years (per US Congress).

$11 M. NGO HIV/AIDS project to support community based delivery of services under development. Your support will be helpful. **Funds are not yet available.**

$200,000. USAID grant to the University of Natal to develop information briefs on multisectoral action on AIDS, training, etc.

$600,000 for TB work (which is heavily linked to HIV). More funds for TB are likely.

Some funding possible from USAID education sector for the National Youth Commission to support HIV/AIDS and youth.

HHS/NIH

NIH allocates over $1M/year of its own funds to support two HUV-NET sites. These are located at Chris Hani Baragwanath Hospital (Soweto) and at the Medical Research Council in Durban. These are research sites where mother-child transmission and heterosexual transmission issues will be researched.

HHS/CDC

CDC assistance is providing limited assistance. USAID supports one CDC assignee working on AIDS surveillance issues in the SA Dept of Health. USAID will also be supporting CDC technical assistance for a few studies on sexually transmitted diseases, TB, and technical assistance in working with the labor unions (majority of USAID assistance, however, is to the AFL-CIO Solidarity Center) and the business community outreach.

URGENT

Prof-
EOA

Joint United Nations Programme on HIV/AIDS
UNAIDS
UNICEF • UNDP • UNFPA • UNDCP
UNESCO • WHO • WORLD BANK

Facsimile

456-2437

To: Jacob Gayle
UNAIDS Technical Adviser
World Bank
Washingon

Fax: 001 202 522 3234

Pages: 4

Ref.: OED

From: Frances McCaul

Date: 28 May 1999

Subject:

Jacob

Attached as discussed.

Frances

SANDY THURMAN

NIX - multi-sectoral

SA / Botswana
Ford + Volvo
~~Southwest~~ Bell —
South African Air —

UNAIDS • 20, avenue Appia • CH-1211 Geneva 27 • Switzerland
Tel. (+41)22 791 3666 • Fax (+41)22 791 4187 • e-mail <unaids@unaids.org> • http://www.unaids.org

COMPANIES INVOLVED IN THE GLOBAL BUSINESS COUNCIL

1. Members

COMPANY	CHIEF EXECUTIVE	CONTACT PERSON
1. GLAXO WELLCOME	Sir Richard Sykes Chairman Glaxo Wellcome plc Glaxo Wellcome House Berkeley Avenue Greenford GB-UB6 0NN Middlesex Tel. 44 171 493 4060	Ms Nicky Davies Positive Action Co-ordinator HIV Policy & Therapeutic Issues Glaxo Wellcome Research Development Greenford Road Greenford GB-Middlesex UB6 OHE Tel. 44 181 966 4513 Fax: 44 181 966 8827
2. LONDON INTERNATIONAL GROUP	Mr Nick Hodges Chief Executive 35, New Bridge Street GB-London EC4V 6BJ	Mr Clive Kitchener Group Director of Strategy 35 New Bridge Street GB-London EC4V 6BJ Tel.:44 171 489 1977 Fax: 44 171 489 0962
3. LEVI STRAUSS	Mr Anders Malmsalt Vice President of Levi Brand Avenue Fraiteur 15-23 1050 Brussels Belgium	Mr Alan Christie Director of Public Affairs Avenue Fraiteur 15-23 1050 Brussels Belgium Tel. 322 641 6233 Fax: 322 641 6262
3. MTV	Mr William H. Roedy President, International MTV Networks 180 Oxford Street GB-London W1N ODS	Ms Michelle Langer Communications Manager International MTV Networks 180 Oxford Street GB-London W1N ODS Tel.: 44 171 478 6511 Fax: 44 171 478 6023
4. EDELMAN Public Relations Worldwide	Mr Richard Edelman President and CEO 1500 Broadway New York, NY 10036	Mr Nick May Global Sector Head Healthcare Haymarket House 28/29 Haymarket GB-London, SW1Y 4SP tel: +44 171 344 1207 (direct) tel: +44 171 344 1200 (main) fax: +44 171 344 1222 e-mail: nmay@edeluk.com

5. THE BODY SHOP	Ms Anita Roddick Board Chairman The Body Shop International plc Watersmead Littlehampton GB-West Sussex, BN17 6LS	Ms Jacqui MacDonald General Manager Fair Trade Horthorn Road Wick Littlehampton GB-West Sussex BN17 6LS Tel. 44 1903 731 500 Fax: 44 1903 726 250
6. TELEPAR	Mr Alvaro Dias President Avenida Manuel Ribas 115 Mercês Curitiba Brazil	Mr Amadeu Colombo Cavalcante Director de recursos humanos Ms Carolina Bocchi Maia Avenida Manuel Ribas 115 Mercês Curitiba Brazil Tel. 55 41 305 2400, 305 1898 305 2441 Fax: 55 41 305 1896
7. INDUSTRIAS VILLARES S.A.	Sergio Mario R. Villares Av. Interlagos 4455 Sao Paulo SP-Brazil 04669-900	Dr Sergio Candio Manager Av. Interlagos 4455 Sao Paulo-SP-Brazil 04669-900 Tel.: 55 11 247 9811; 525 3775 Fax: 55 11 246 1238 Mrs Eliza Villares Lenz Cesar Chairperson Deliberative Council of Sociedade Beneficiente Carlos Dumont Villares
8. CALVIN KLEIN	Mr Calvin Klein President Calvin Klein Inc. 205 West 39th Street New York 10018 USA	Mr Robert Triefus Senior Vice President of communications Calvin Klein Inc. 205 West 39th Street New York 10018 Tel. 1 212 719 2600 Fax: 1 212 730 4818
9. GODREJ & BOYCE MFG Co. Ltd.	Mr Jamshyd N. Godrej Past President, CII & Managing Director Pirojshanagar, Vikhroli Mumbay - 400 079 India Tel. 91 22 5171352/5170488 Fax: 91 22 5172248/5170900	Mr Nadir B. Godrej Managing Director Godrej Soaps Ltd. Pirojshanagar, Vikhroli Mumbay – 400 079 India Tel. 91 22 517 1641/517 1161 Fax: 91 22 517 2455
10. THE TATA IRON & STEEL COMPANY LTD.	Dr Jamshed J. Irani Past President and Chairman, CII Social Development Council & Managing Director Jamshedpur - 831 001 Bihar, India Tel. 91 657 431024 Fax: 91 657 431818	

11. POLAROID	Mr Brian Poggi Vice President, Europe Polaroid Europe, Ltd. 3, Furzeground Way Stockley Park Uxbridge, Middlesex UB11 1DW United Kingdom Tel.: 44 181 606 2000	Mr Christophe Valentin European Marketing Manager POLAROID La Clef de Saint Pierre 12 bis avenue Gay-Lussac -BP 7 F-Elancourt Cedex 78996 Tel.: 33 1 30 68 38 23 Fax: 33 1 30683816/30683832 Email: valentc@polaroid.com

2. Partners

COMPANY	CHIEF EXECUTIVE	CONTACT PERSON
1. CONFEDERATION OF INDIAN INDUSTRY	Mr Tarun Das Director General 23, 26 Institutional Area, Lodi Road New Delhi 110 003 India	Mr Ajay Khanna Jawaharlal Nehru Stadium, Gate No.31, North block Lodi Road New Delhi 110 003 Tel. 91 11 462 9994-7 Fax: 91 11 463 3168 Ms Supriya Banerji Director CII London Tel. 44 171 8364121/3797400 Fax: 44 171 240 1578
2. PRINCE OF WALES BUSINESS LEADERS' FORUM	Mr Robert Davies Chief Executive 15-16 Cornwall Terrace Regent's Park GB-London NW1 4QP	Mr Julian Parr Regional Manager - South Asia & Middle East The Prince of Wales Business Leaders Forum 15-16 Cornwall Terrace, Regent's Park GB-London NW1 4QP Tel.: 44 171 467 3635 Fax: 44 171 467 3610
3. SOUTH AFRICA FOUNDATION	Mr Neil van Herden Executive Director P.O.Box 7006 Johannesburg 2000 Republic of South Africa Tel.: 27 11 726 6105 Fax: 27 11 726 4705	Mr Paul Runge Director South Africa Foundation Pilrig Place, 5 Eton Road Parktown 2193 Republic of South Africa Tel.: 27 11 726 6105 27 11 465 6770 (H) Fax: 27 11 726 4705 E-mail: safound@ibm.net

FINAL DRAFT (26.5.1999)

MEETING STATEMENT ON THE AFRICA PARTNERSHIP AGAINST HIV/AIDS 23/24th April 1999

1. Preamble

On the basis of new evidence it is now apparent that the impact of the HIV/AIDS epidemic has reached far beyond that initially recognised. The response of the past decade has not been commensurate with the scale of the problem and falls far short of current needs. Transmission of HIV and its devastating personal and social consequences, are preventable with tools available today. HIV/AIDS can no longer be seen as a health issue alone, but must be recognised as a critical development problem threatening the economic and social development of African nations and communities.

For many countries in Africa HIV/AIDS become has a complex epidemic, building on and exacerbating the severe poverty crisis that grips most of the continent, and reversing decades of progress in social and economic development. More than 23 million people are currently living with HIV and AIDS and UNAIDS estimates that 150 million Africans are directly or indirectly affected by the epidemic. AIDS has now become the number one killer in Africa with 2 million deaths in 1998. Four million new HIV infections occurred in Africa last year. In the most severely affected countries, a quarter of the adult population is infected.

By killing large numbers of productive and reproductive adults AIDS:

- erodes human, social, economic and infrastructure development
- increases health and welfare demands, adding to the cost of providing services
- increases the total number of children orphaned or living in families profoundly disrupted by AIDS
- reduces formal and informal sector productivity
- increases labour costs due to staff turnover, absenteeism, loss of skills, and increased recruitment and training costs

As the epidemic unfolds, it places new burdens on countries, peoples and their development partners. The consequences of these burdens are felt today and will be present for years to come. Yet the ultimate human, societal, and economic toll of this epidemic depends on actions taken or not taken over the next two to five years. In order to meet this challenge, there is a need for an improved, broader, intensified and more substantial response from all actors and at all levels.

In response, UNAIDS, donors, and governments have acknowledged the need for means to unite all parties' efforts to scale up responses to the AIDS epidemic in Africa. To accomplish this goal, UNAIDS has begun the development of an African Partnership Against HIV/AIDS. Consultations have begun with African governments and NGO leaders to shape this partnership, and these will continue.

At a meeting held in Annapolis in January 1999, the UNAIDS Cosponsoring agencies and Secretariat resolved to martial local and international forces to develop an Africa

Partnership Against HIV/AIDS. As the next step eleven donor countries, UNAIDS and six cosponsors met informally in London, from 23rd-24th April 1999 and expressed a commitment to actively participate in the further development of the Africa Partnership. Subject to endorsement by all actors involved, the Partnership will endeavour to pursue the vision, principles and next steps described in this document.

2. Partnership Vision and Goal

The overarching goal of the Partnership is to save the lives of millions by halting the spread of HIV/AIDS and sharply reducing its devastating impact on human suffering and social and economic development. The vision of the Partnership is that within the next decade African nations will be implementing larger and more effective national responses to HIV and AIDS that will: substantially reduce new HIV infections; provide a continuum of care and support to people living with and affected by HIV and AIDS; counteract the negative effects of HIV/AIDS on individuals, communities and societies; and support the human rights of all those affected.

The Partnership will enable national governments, international development agencies, civil society, and the private sector to work together effectively, within common strategic frameworks to support sustained national responses.

At the international and regional level the Partnership will work together to create a policy and social environment conducive to successful action with national and regional leadership, and to mobilise the additional human and financial resources necessary for impact on a bigger scale and in a more strategic and focused manner. The Partnership will provide relevant, accessible and high quality technical and logistical support to national level responses. It will also support networking, joint advocacy and sharing of lessons learned.

3. Principles

The following core principles of the Partnership were identified:

- placing HIV/AIDS high on the political agenda
- recognising that HIV/AIDS is a development problem not just a health issue
- national commitment and ownership
- implementation plans based on local contexts and priorities
- supporting the development and implementation of joint national strategic action plans involving all relevant sectors
- intensifying and expanding efforts and improving quality and effectiveness of responses while not creating new structures
- improving co-ordination among all partners
- building on the comparative advantages of actors in the Partnership

- utilising and reinforcing existing mechanisms and structures

- UNAIDS (secretariat and co-sponsors) taking the leading role in moving the Partnership forward in collaboration with international development agencies, NGOs, private sector and national government partners

4. What's different about the Partnership?

In responding to HIV/AIDS in Africa the Partnership:

- provides a common framework for re-vitalised action by all partners at national, regional and global levels
- validates the need for an expanded, multi-sectoral and multi-partner effort in order to make significant gains
- galvanises the political support required to commit increased resources
- sets common targets for which partners at all levels are accountable, and establishes monitoring systems to measure progress and resources
- facilitates new partnerships such as with religious leaders, military and the private sector
- offers each partner feasible opportunities for concrete actions to advance toward the goals
- enables better and more timely exchange of information among and between partners
- links regional resources and networks to national efforts in a more concerted manner
- develops the Partnership in an interactive manner consulting all partners

5. Mechanisms for sustaining partnership

We agree :

That the Africa Partnership will be sustained over five to ten years through both short-term and long term actions which will be developed over the course of 1999 and beyond, and will be characterised by :

At the international/regional level:

An international coalition which sets out our intentions to achieve the goal and vision of the Partnership including:

- More effective use of existing co-ordination mechanisms and initiatives to act as a platform for advocacy and improved co-ordination for national programmes. These include mechanisms such as the EU; G8; OECD; UNAIDS and its co-sponsors; UNDAF; UNDG, the Pan African org, OUA and ECA . Existing sub-regional mechanisms should also be explored, such as SADC and ECSA.

- A consultative mechanism for UNAIDS to draw on and interact with in the evolution of the Partnership, through an informal and inclusive contact group of partners.

- Mechanisms to maximise the existing technical resource platform (the totality of donor and UN agency technical resources available in Africa) coupled with improved systems and to build additional technical and institutional capacity to make this expertise available to national programmes.

- Mechanisms to co-ordinate, and build upon existing regional initiatives and fora to act as platforms for advocacy, and improved co-ordination for country programmes.

At country level:

A partnership between external stakeholders and national governments and key national stakeholders (including people living with HIV/AIDS, civil society, private sector, military, religious groups) characterised by

- statement of intent
- shared analysis, including priorities for action
- nationally negotiated, costed, joint action plans
- agreed milestones and indicators of achievement
- agreed working arrangements and responsibilities such as national co-ordination mechanisms; common design and appraisal; implementation; monitoring and evaluation; use of technical collaboration; and mechanisms for resource transfer; communications
- mechanisms for expanding the Partnership to include diverse and non-traditional partners
- commitment to additional resources from host country governments

At all levels:

Secretariat functions, performed by UNAIDS, to ensure maximum communication, co-ordination, facilitation, standard setting and impartial information and advice to all actors with the Africa Partnership.

Mechanisms for channelling resources at regional and country level

6. Targets and resources

Targets:

Meeting participants agreed on the need for measurable targets/indicators for the Africa Partnership. It was recognised that measurable targets will need to be defined and agreed in the process of consultation with all actors in the Partnership. However some initial targets for participating countries were suggested, including:

- the incidence of HIV among those 15-24 years old should be reduced by 25% by 2005

- at least 75% of all HIV-positive persons will have access to basic care at home and community levels and drugs for common opportunistic infections (TB, pneumonia, diarrhoea etc.)

- orphans will have access to education and food on a equal basis with their non-orphan peers

- by 2002 domestic and external resources available for HIV/AIDS responses in Africa will have increased significantly

- existing initiatives, (such as the 20/20 initiative) be used as opportunities to include HIV/AIDS and to ~~tools to~~ involve donors and countries to commit themselves to the Partnership

Resources

Current spending on AIDS in Africa, estimated at about $150 million a year, needs to be increased substantially. Reliable estimates of the funding requirements for an intensified effort need to be developed as soon as possible. Current estimates range from between $500 to $800 million, into the billions of dollars.

To meet the current challenges in Africa, the meeting recognises the need to

(i) identify and use existing resources more effectively; including such resources not primarily earmarked for specific HIV and AIDS activities but which contribute to achieving the goals of the Partnership
(ii) eliminate duplication
(iii) increase synergy
(iv) aim for consistent funding over a long period of time
(v) increase the volume of aid, inter alia by non-traditional partners such as the business community, foundations and local communities and the private sector.
(vi) increase the predictability of aid, and flexibility in the allocation of aid
(vii) identify processes to strategically allocate and prioritise available resources reflecting national and community needs.

7. Next Steps

1. The meeting participants agreed that the issue of HIV/AIDS should be recognised as having catastrophic social and economic implications for Africa, and as a human rights issue requiring a complex strategic response. HIV/AIDS in Africa should therefore be made one of the highest priorities of the UN and all governments of the members of the General Assembly.

2. The meeting participants agreed that all participants (bilaterals, multilaterals and UNAIDS) would pursue contact with national governments committed to placing

HIV/AIDS high on the development agenda, and to communicate the outcomes of the meeting to country governments, and to donor headquarters and regional and country offices by the June PCB meeting.

3. UNAIDS will consult with African governments and NGO leaders to discuss the role and evolution of the AP.

4. UNAIDS is tasked to share the outcome of the meeting with other bilateral partners, the EU, and other interested partners to enlist their participation in the Africa Partnership Against HIV/AIDS.

5. UNAIDS is tasked to facilitate a further series of consultations to broaden commitment to and participation in the Partnership by governments, African governments, international donors, other regional and multilateral partners (e.g. FAO, ILO, ADB, UNHCR), civil society and the private sector.

   In co-ordination with UNAIDS, international development agencies should actively take opportunities to discuss with government representatives, civil society, regional project teams, private sector and other representatives how to rapidly expand the response to AIDS at country or sub-regional level. The Africa Partnership will continue to be developed through such initiatives.

6. During the meeting each participant was asked to consider a matrix of specific actionable items to which they will contribute in furthering the Partnership's development. The following categories requiring bilateral inputs were identified: partnership design; regional technical platform; advocacy strategy; resource mobilisation; and technical gaps. These items will follow from the definition of the tasks as identified below.

In the evolution of the Partnership UNAIDS will have the following tasks, and in the process of developing the Partnership will draw upon an informal and inclusive consultative group of partners who wish to contribute to:

- Drawing up clear and transparent Terms of Reference for, and setting up the consultation mechanisms
- Developing a draft concept paper elaborating on the design of the partnership to be used in up-coming consultations
- Elaboration of regional technical platform
- Advocacy strategy
- Resource mobilisation (and streamline procurement procedures)
- Identify and develop strategy for addressing gaps (costing, cost- effectiveness, national programme management, training and basic care).
- Social and economic analyses

6) The UN Theme Group on HIV/AIDS should be expanded immediately to include broader participation at the country level, including people living with HIV and AIDS; NGOs, host country governments, and bilateral donors. In addition, participants agreed that in some countries, bilateral donors could take the lead vis a vis donor coordination.

June 21, 1999

MEMORANDUM

TO: Terence Brown, M/AA
Vivian Lowery-Derryck, AFR/AA
Sally Shelton-Colby, G/AA
Duff Gillespie, G/DAA/PHN
Verne Newton, AFR/DAA
Jay Smith, AFR/DP
Jerry Wolgin, AFR/SD

FROM: Alex Ross, AFR/SD
Paul Delay, G/PHN

SUBJECT: Draft Presidential Initiative on AIDS in Africa – **INFORMATION**

This memo provides information on the development of a Presidential Initiative on AIDS in Africa. Ms. Sandy Thurman, Director, White House Office of National AIDS Policy, is taking the lead in developing this initiative. She is expected to submit her report and recommendations to the President within a week.

This memo also serves as background to the upcoming OMB meetings and the internal meeting scheduled for Monday at 4:00 PM. At the latter meeting, we expect to discuss at least two issues, identifying a common agency voice on this initiative and to investigate possible budget implications of various scenarios.

I. BACKGROUND ON THE THURMAN PRESIDENTIAL INITIATIVE

Ms. Sandy Thurman led two trips to Africa this year at the specific request of President Clinton, which he announced in his World AIDS Day 1998 speech. Upon her return, Ms. Thurman drafted a report to the President. A first draft, which contained no specific recommendations was submitted to the President who received it favorably. We have not seen a copy of this memo. It was labeled "internal-classified." He asked Ms. Thurman to expand the recommendations, prepare the memo for general release, and to convene and chair a global AIDS emergency working group, which would make recommendations for an enhanced effort.

Ms. Thurman's recommendations have developed over the past 2-3 months. USAID had been asked to provide specific technical information and possible spending scenarios. Different sets of targets and figures are being used and this has led to various interpretations and misperceptions. Initially, two scenarios were discussed: a onetime $100 million initiative vs. a five year $100 million target (i.e., $20 million per year). These scenarios at first were used to explore what USAID and others could use as well as what was needed. One problem became that these initial sets of scenarios became targets (or were interpreted as such). However, this was not intended. In addition, discussions took place with external parties to the agency which led to misinterpretations that a $20 million/year level was the most that USAID could absorb (i.e., could use even if it were new money). Ms. Thurman was concerned that this was the wrong message to send and that it would undercut her efforts to obtain more resources and contradict a broader presidential initiative. As a result, Ms. Thurman has requested that we not use any specific numbers. Ms. Thurman has indicated her intention all along to secure new funds. However, it has not been clear as to the support for this from OMB or the Hill.

As of this date, Ms. Thurman is pushing for "package" that would total an additional $100 million in the FY 2000 budget for international AIDS efforts, but specifics for any one agency have not been identified.

EXPECTED RECOMMENDATIONS

Based on conversations with Ms. Thurman, her staff, and from discussions at the first meeting of an emergency inter-agency working group convened by Ms. Thurman, we expect the following recommendations to be included in the report. Some of these involve funding requirements, and others represent efforts to educate key actors and do not have significant funding implications. It is important to note that these recommendations represent moving targets.

Recommendations Requiring Funding

From discussions to date, there are two recommendations that have USG funding implications:

- Recommendation 1. Increasing the President's FY 2000 budget for AIDS in Africa. Expectations are that this package will total $100 million in the first year. Outyear levels are unknown. Such an initiative would involve a combination of several components: additional resources for USAID for HIV/AIDS programming and use of other USG agency existing resources (such as HHS, DOD, State, etc) for AIDS in Africa work. Individual amounts for each of these components have varied over time. In discussions with USAID staff, some targets were mentioned but these too have varied over time. They included upwards of $50 million (or more) being designated in FY 2000 for USAID with the remainder coming from other USG agencies and could also include the debt relief intiatives discussed below. One scenario could have

USAID redirecting resources to AIDS from other sectors in the current FY 2000 request levels (i.e. $20 or 30 million), with the remainder. being new funds for FY 2000. Prospects for new money in FY 2001 and beyond are greater as the agency budgets have not been developed as yet.

- Recommendation 2: Debt relief benefiting national AIDS efforts. The G8 meeting this weekend announced a major debt relief for developing countries initiative to benefit social sector spending and particularly AIDS. How Treasury, OMB, and Ms. Thurman's office score this from a budget standpoint is unknown. For example, Zambia has proposed a debt forgiveness approach to fund HIV/AIDS activities. With the G8 announcement, there will be many details to be worked out, including how many countries, what mechanisms, who will monitor and so on. One thing is clear, however. With generally weak national AIDS control programs and structures, USAID assistance for technical assistance to leverage these national forgiven funds will be greatly needed. This represents another rationale for increased USAID funding for AIDS.

Recommendations Not Requiring Significant Funding

Among the ideas being discussed is:

- Increase public-private partnerships- especially religious and business/labor sector partnerships. A White House conference for AIDS and religious leaders is being considered, involving African religious leaders and US. This would build on ongoing USAID efforts with the World Council of Churches, World Parliament of Religions, and the Interfaith AIDS Network. Recent discussions with Rev. Leon Sullivan (including his visit with President Clinton) and Rev. Jesse Jackson indicate their interest to encourage a more concerted response by faith communities. Another proposal is the development of public-private partnerships for AIDS involving the business, labor, and foundation communities. To date, USAID/South Africa has developed a partnership with the AFL-CIO to support AIDS activities. Recent USAID meetings with the Department of Commerce hold promise for increased collaboration with that Department to reach US multinational corporations to further their commitment to AIDS work in Africa and other developing countries.

- The need to speak with one voice leading to a consistent and coordinated U.S response. The goal is to assure that the multiple US Agencies that work in Africa will incorporate the issues that surround the global AIDS pandemic in a consistent manner. For example, it is important that the approach to the complex issue of access to AIDS drugs and the protection of intellectual property rights is treated in a consistent and strategic manner.

- Mobilizing other donors. There are currently a series of initiatives underway to bring together these various partners for a concerted effort to increase resources, including

the recent meeting that was co-hosted by the British government and UNAIDS in London, that included the major bilateral donors to AIDS overseas development assistance. There will be follow-up to these discussions at the next meeting of the UNAIDS Program Coordinating Board on June 28 and 29th.

- Encouraging African Leadership
  Possible activities, which would lead to increased African ownership, could include Summits that involve the First Lady, the President, and other key U.S. figures. A U.S. diplomatic initiative, involving U.S. Ambassadors, is now underway under DOS. This could be accelerated to achieve increased action.

II. CONGRESSIONAL INITIATIVES, INTEREST AND ACTORS

On June 16, Reps. Lee, Jackson Lee and Kilpatrick sent a letter to Mr. Jacob Lew, OMB, endorsing the impending report from Ms. Thurman on AIDS in Africa as well as the expected request for increased funding for USAID programs. We expect that the Congressional Black Caucus will similarly send a "Dear Colleague" letter requesting support for an additional $100 million in FY 2000. Rep. Kilpatrick is also expected to release a letter to her House Appropriations Committee chair requesting support for this $100 million initiative before the House marks up in July. Senator Leahy recently issued an op-ed piece in USA Today calling for additional AIDS resources for Africa. He authored a Senate Appropriations committee amendment that added $25 million to the USAID HIV/AIDS earmark raising it to $150 million (with $5 million of the increase slated for microbicide research thus far).

III. OTHER INITIATIVES

Former Rep. Ron Dellums is advocating for an "AIDS Marshall Plan for Africa" calling for hundreds of millions of dollars to support AIDS drugs, and now prevention, care and research for Africa. His is a public-private matching fund concept. Rep. Barbara Lee is expected to submit new legislation to Congress this year that would enact some form of Dellums' AIDS fund concept. This could require over $100 million in USG seed money and matching funds.

Rev. Leon Sullivan will release soon his new Sullivan Principles for U.S. investors in Africa which call for corporate social responsibility in developing countries. These principles will also include AIDS as an issue for business to be concerned about. Rev. Sullivan also prominently included AIDS as a major agenda issue at the recent African – African American Summit. He plans to hold a follow up meeting on AIDS in Africa in Ethiopia in February 2000. Rev. Jesse Jackson has recently become engaged in AIDS in Africa issues.

IV. THE ROLE OF USAID: WHAT WOULD WE DO WITH EXTRA FUNDS?

Given the paucity of US and international funding for AIDS, an influx of funds would significantly help to prevent new infections. As noted earlier, the US is the world's leader in HIV/AIDS activities. New funds would enhance existing efforts through the following four activities: focus on enhanced prevention; supporting basic care and social support which in turn maximize prevention efforts; care for children affected by AIDS (orphaned by AIDS or infected from birth); and invest in the infrastructure and capacity development of various sectors and institutions. In-country funding delineations would depend on the nature and stage of the local epidemic and the existing foundation program being enhanced. USAID is currently using this strategy and additional funds will allow us to scale up our activities. USAID would use a variety of criteria to allocate funds: prevalence rates, potential for impact, rapidly expanding epidemics, ongoing programs, need, and political commitment of governments, and opportunity for innovation.

To secure broad based ownership and input, USAID would propose the convening of a meeting of all relevant interested parties to identify respective roles and responsibilities within an expanded USG response. This process worked extremely well for the initiation of the Infectious Disease earmark.

CURRENT FUNDING LEVELS

In FY 1999, the USAID AIDS funding levels were as follows. Total funding was $135 million. During this Fiscal Year, a one-time emergency appropriation of $10 million for AIDS orphans and vulnerable children augmented the regular appropriation of $125 million. Of the $125 million, approximately $56 million were obligated to USAID Africa missions. Of the $10 million supplemental, $7 million was devoted to Africa. Finally, the Global Bureau estimates that out of its obligation, it devoted $13 million for Africa (core funds). Hence, last year, Africa received approximately $76 million of the $135 million total. In addition, USAID contributed $15.2 million to the UNAIDS program (out of the $125 million level) as required by Congress.

OFFSETS

In FY 2000, USAID may be required to redirect some of the funds in the current FY 2000 request to support a new AIDS initiative. How much is NOT known. From a planning perspective, we can expect that the funds could be taken from existing agency health and non-health accounts. Those accounts protected by earmarks may not be available. The idea of using ESF funds has surfaced and may be useful. Moreover, ESF funds were recently made available to support the US-SADC Forum. Of $2 million, approximately $350,000 has been set aside to support AIDS work with SADC (agreement pending).

Funding any increase for HIV/AIDS from the current FY 2000 request would result in critical shortfalls for democracy, agriculture and economic growth programs, especially

in countries that have proven to be good performers and good development partners. In the absence of a total funding increase, these sectors would have to targeted for major reductions because of existing Congressional earmarks and directives and Administration priorities in all other sectors of assistance, e.g. Child Survival, Polio, Infectious Diseases, Population, Microenterprise and Environment. However, some funds could be used—e.g., 10% of TB cases were HIV positive and thus some TB fund could be appropriately used for AIDS.

Some novel approaches that are worthy to explore:

EXPANDING THE RESPONSE TO AIDS – TWO NEW OPTIONS

Option 1: AIDS is now a development problem. Countries, UNAIDS, the President and Ms. Thurman, and now USAID have all recognized this fact. AIDS has a direct impact on the results of other sector's development work as well as on the sustainability of these efforts.

One way to approach it is that USAID could identify funds within existing sectors that should be used for AIDS. At a minimum this would keep funds within the sector, although they would have to be redirected away from other sector programming. There are opportunities within the education, agriculture, D/G, and economic growth.

Option 2: Obtaining other USG resources for USAID. Currently, NIH contributes a few million dollars via USAID to support microbicide research. Could we obtain other USG resources to support other aspects of AIDS work e.g., AIDS in the military, other aspects of AIDS research, and so on?

VI. ISSUES, PENDING OMB MEETING, AND NEXT STEPS

Issues

There are a number of outstanding issues:

- When and where the President will announce an initiative.
- Effect of advocacy groups. A fringe advocacy group has been following VP Gore in his recent campaign stops. Whereas this is annoying, we do not expect that it will interfere with a presidential initiative.
- The imperative NOT to send a message outside USAID that we cannot use new resources for AIDS. Clearly the needs are great and the Africa Bureau alone has received requests for AIDS funding that it cannot fulfill given current levels that amount over $10 million—this is in the absence of any notification of the possibility of new

funding. Moreover, we are aware that other USG agencies have also requested new funds for AIDS in Africa work (e.g., CDC for $38 million in FY 2000).

- Moving targets. As had been noted, there has been a fair amount of confusion over budget figures recently. USAID needs to be careful regarding which figures are being discussed and the nature of the source of those funds.
- Differentiate funding needs from staffing needs. For the most part we can program additional funds into ongoing programs which should obviate the need for new OE-funded staff. Where there are new programs being contemplated (as in West Africa regional and Namibia), we can hire program-funded staff to help implement these programs. Ideally, Ms. Thurman's recommendations should mention the need for commensurate USAID staffing to help manage the influx of new monies.
- Need to plan for increases in the **FY 2001** budget now. We expect Ms. Thurman to recommend a multi-year initiative. Thus, the agency should be planning for a significant increase in FY 2001 funds for HIV/AIDS.
- The FY 2000 budget situation may yield changes in caps as well as in supplemental funding scenarios.
- OMB is sending several messages a) there will be no new money for FY 2000 b) what is it that USAID wants for AIDS in FY 2000? c) how much can it redirect if there are no new funds? However, USAID needs to wait for instructions from the Hill and from the President. It is quite possible that the President may instruct OMB to come up with additional resources for USAID.

NEXT STEPS

- **Develop a fact sheet for internal USAID purposes that delineates the USAID position and options as concerns this initiative. LPA as well as other agency units could use this.**

- **Convene a working group of USAID office representatives, including DP offices, to monitor developments and to develop contingency plans. Ms. Thurman may need additional details on what USAID will do in FY 2000 in order to complete her report. However, additional guidance from Ms. Thurman will be required to complete this exercise.**

- **Develop a contingency plan in consultation with OMB and possibly Congress to deal with any possible offset requirements. It is important to note that FY 2000 funds are being obligated now. Thus, the longer this issue remains unresolved, the more difficult it will be to identify funding for any offsets.**

Cc: Paul Knepp, AFR/DP
Hope Sukin, AFR/SD

Clearances:

G/PHN/HN:JRiggs-Perla_____	Date_____
DAA/G:DGillespie____cleared in draft_____	Date___06/21/99____
SDAA/G:BTurner_____	Date_____
AAFR/DP:Pknepp_____cleared in draft_____	Date___06/21/99____

AFR/SD:ARoss:ar:06/21/99:219-0476:prsinit5

White House-OMB Interagency Meeting on HIV/AIDS
USAID
06/22/99

WHAT WOULD WE DO WITH AN ADDITIONAL $50 MILLION FOR AIDS IN FY 2000?

With $50 million in additive funds to its FY 2000 budget, USAID could make a significant impact on reducing HIV/AIDS cases in Africa and in India. New funds would enhance existing efforts through the following four activities:

1. **Focus on enhanced prevention;**
2. **Support basic care and social support, which in turn enhance and maximize prevention efforts;**
3. **Children affected by AIDS, including care for children orphaned by AIDS and immediate affected family members; and**
4. **Invest in the infrastructure and capacity development of various sectors and institutions.**

In-country funding delineations would depend on the nature and stage of the local epidemic and the status of the existing program. Details for each of these four activities and the approximate overall funding proportion are as follows:

1. **Primary prevention and stigma reduction strategies-40%-** targeted and population wide HIV education and communication programs, with a special emphasis on vulnerable youth; engagement of political, religious, and other leaders to increase commitment and reduce stigma/discrimination; increasing access to voluntary counseling and HIV testing; managing and preventing sexually transmitted infections; ensuring access to critical tools to reduce infections, such as male and female condoms; and increasing opportunities (education, income generation), especially for women and youth;

2. **Home and community-based care-20%-** deliver basic counseling, support, and AIDS care (treatment for STDs, TB, other opportunistic infections, and malaria) through community-based clinics and home based care workers, enabling parents with AIDS to continue to care for their children, and to plan for their future;

3. **Caring for children affected by AIDS-20%-**assist families, extended families, and communities in caring for their children through a multi-sectoral response including increasing access to interventions that will reduce mother-to-child HIV transmission (MTCT); orphan support that could include micro-finance, child survival, education/training, health, mental health, and nutrition assistance;

4. **Infrastructure and capacity development-20%-**strengthen the capacity of government

agencies, the private sector, and non-governmental organizations, and local research institutions to plan and implement the expansion of effective interventions to scale through appropriate training, technical assistance, and other support. It is critical that local capacity for communities and governments to respond to this pandemic over the long term be built to ensure sustainability.

How much does it cost to run a successful program?
The successful programs in Uganda and Senegal illustrate a need for a minimum of $2 per adult per year. This includes selected, basic support for HIV infected persons and their families. For Africa, that would amount to $550 million per year. (Currently, only $150 million is expended per year in sub-Saharan Africa)

WHERE WOULD WE TARGET NEW FUNDS?

- Uganda has shown us the critical need for stable and sustainable funding over time.

- There are two types of need: reducing HIV prevalence in the hardest hit countries and maintaining low prevalence in those countries with impending epidemics.

  -Africa:

  - USAID would focus on a subset of countries with greatest need. All of these countries have ongoing HIV/AIDS programs and existing mechanisms.
  - Target countries can include South Africa, Nigeria, Zimbabwe, Kenya, Mozambique, Ethiopia, and Tanzania. Attention will also be given to Botswana where a regional center exists.
  - These countries represent 70% of the 4 million new infections in Africa.

  -Asia:

  - USAID will also target India, which contributes another 550,000 infections per year to the global incidence.

- USAID would use a variety of criteria to allocate funds. These would include prevalence rates, potential for impact, rapidly expanding epidemics, status of ongoing programs, need, political commitment of governments, and opportunity for innovation.

Management CONSIDERATIONS FOR Additional Funds

- USAID has existing mechanisms and programs to program additional funds. These obviate the need for additional management staff time to procure new contracts.

- To secure broad based ownership and input, USAID would propose the convening of a meeting of all relevant interested parties to identify respective roles and

responsibilities within an expanded USG response. USAID would work with its multilateral, bilateral, NGO and business sector partners that comprise the Partnership Against AIDS in Africa. This process worked extremely well for the initiation of the Infectious Disease earmark.

- Using bilateral existing contract and grant mechanisms, as well as field support, USAID could reasonably program $50 million in new funds in FY 2000.

- There are several categories of existing mechanisms available to USAID to program:
  -Missions: 19 missions in Africa have ongoing AIDS programs in Africa in FY 99, along with 4 regional programs covering additional countries. Each of these uses a combination of bilateral and field support mechanisms.
  -AID/W: The Global, Africa, and ANE Bureaus have existing mechanisms to program funds. For many of these, actions are simple involving field support transfers and/or annual amendments to grants. Examples include:
  --Global Bureau HIV/AIDS CAs such as the IMPACT project (prevention and service delivery), AIDSMARK (social marketing), HORIZONS (operations research), International Alliance Against AIDS (NGO), Peace Corps, and the US Bureau of the Census.
  --Other Global Bureau CAs: Numerous other health and population contractors; as well as non-health contractors such as the AFL-CIO, microenterprise, and education.
  --Africa Bureau has existing mechanisms with several institutions in Africa, as well as a PASA with HHS and a support project.
  -PASAs with other USG Agencies: AID/W has several agreements with other USG agencies. AFR Bureau has an existing agreement with HHS to access all HHS agencies (CDC, NIH, HRSA, AHCPR, HCFA), as well as agreements with USDA and the Department of Labor; G/PHN has a PASA with CDC; G/PHN has an existing agreement with CDC, NIH, the US Bureau of the Census, and with the Peace Corps.
  -Multilateral Organizations: USAID has relationships with multilateral organizations. They can be accessed based on programming decisions. These include: WHO/AFRO, WHO/Geneva, UNICEF, UNAIDS (for access to the seven co-sponsoring UN agencies)....

- The absorptive capacity of these mechanisms is high and has been tested.

- AIDS programs have been in place for up to ten years. This is not the same situation as the infectious disease earmark where we had to market to our missions. Mission and country demand for resources are high.

INTERNAL USAID OFFSETS

- If forced to offset existing funds to support an HIV/AIDS initiative in FY 2000, the following represent possible sources.
- G/PHN: Population funds: $1.5 – 2.0 m
  Health funds: $3.0 million
- Other G Centers: Unknown
- AFR: Upwards of $20 million.

- We must increase resources for programs that reduce primary sexual transmission of HIV. Using these resources, we must build the capacity for communities and governments to respond to this pandemic over the long term.
- Stronger, more coordinated and broadly based advocacy to increase political commitment from African governments and other leaders is critical. It not only garners the necessary resources, but even more important, it creates a conducive and enabling environment for the delivery of critical prevention and support to those populations that need them the most.
- Resources for mother-to-child HIV prevention efforts, family planning, and for orphan support must be additive to those for primary prevention. It does not make sense to damage campaigns to protect men and women from becoming infected in the first place, in order to pay for protecting newborns and to support orphans.
-

REQUEST FOR $100,000,000 OVER THE NEXT FIVE YEARS ($20 million/year):
Provided additional funding could be secured, programming could be quickly expanded. Using criteria, based on severity of HIV prevalence and degree of negative impact on communities and specific labor sectors, this funding would be geographically targeted as follows: 50% for sub-Saharan Africa, 30% for Asia, 10% for Latin America, 10% for the Newly Independent States. Funding at this level would first support services for AIDS affected families and children. Protecting adults from becoming infected and maintaining their roles as parents is a critical. Relying primarily on community based non-governmental organizations with appropriate assistance to public sector services, additional funds would be used to expand education and communication strategies to achieve behavior change, voluntary testing and counseling, condom social marketing advocacy and policy dialogue. In addition, appropriate care and support services increase the impact of prevention programs and reduce the suffering of individuals, families and communities. Sustainable care and support services that can be provided in an equitable manner despite severe resource shortages include linking clients of Voluntary Counseling and Testing services to psychosocial support networks (often linked to faith networks); provision of treatments for opportunistic infections, especially tuberculosis which is the leading killer of HIV infected persons in Africa; and developing means to permit effective and compassionate care of people with advanced HIV disease that utilizes a home based care approach, thus alleviating some of the burden on children as care-givers for their parents.

REQUEST FOR $100,000,000 IN FISCAL YEAR 1999:
Funding at this level would also utilize the same geographic proportionality. In addition to supporting programs that address community based support for orphans, expanded interventions to reduce mother-to-child transmission of HIV and the integration of prevention and care at community level, these additional funds would also be used to support key multisectoral activities that influence vulnerability for acquiring HIV infection. These would include microcredit schemes and improved agricultural productivity at the household level to provide safety nets for families that have lost one or more adults to AIDS; and increased access to education, particularly for girls, in order to reduce vulnerability; and increasing local capacity in both public and private sector to shore up fragile social sector infrastructures in those countries most severely affected, particularly health services delivery. Commensurate with this expanded funding would be the need to increase staff ability to assist countries in the design, implementation, and monitoring of programs.

- WHO/AFRO for training for Africa. They have been the primary implementor for malaria and infectious diseases training and are primed to do more in HIV/AIDS.
    - UNICEF for EPI work. They are also a key actor in mother to child transmission and breastfeeding issues, for working with youth a primary target for AIDS education, and for community mobilization.
    - All of HHS through a PASA. We can access any HHS agency through this mechanism.
- ____ Bilateral missions use field support mechanisms
- The key Global Bureau existing mechanisms include In addition, there are a host of other existing Global Bureau mechanisms that involve upwards of ____ contreacts and coopertive agreements.

THE DEBT RELIEF INITIATIVE TO COMBAT HIV/AIDS

WHAT IS DEBT RELIEF?

- Developing country governments have borrowed billions of dollars from the multilateral institutions, bilateral assistance organizations and from private sources.
- This debt has to be repaid, and where the borrower has not used the loans to grow its economy, the debt service payments (interest and repayment of principle) become onerous in two ways: (1) they use up scarce foreign exchange needed for imports and (2) they use up scarce government revenues needed to provide critical services.
- Debt relief can come in the form of writing off debt or rescheduling (postponing) debt payments.

WHAT IS THE DEBT INITIATIVE PUT FORWARD BY THE ZAMBIAN GOVERNMENT?

- The Zambian Government proposes an agreement with its creditors to use the resources that would have been used to pay creditors (now averaging about $120 million per year) to combat the HIV/AIDS epidemic.

HOW WOULD THIS WORK?

- There are a number of possible mechanisms. For the U.S., the Treasury would write off the amount of debt service expected. This might or might not involve a budgetary cost, but the Treasury has authority and has some resources available in FY 99 to do so. In return, the U.S. (or the donor community) would negotiate over the use of the freed-up resources.

WOULD A DEBT SWAP BE A BETTER MECHANISM?

- Debt swaps usually involve a PVO buying private debt on a secondary market (where, because full payment of the debt is not expected, the IOUs are heavily discounted to 5-10% of their face value).
- The PVO would then sell the debt back to the debtor government for local currency at some value between the face value of the debt and the actual amount paid for the IOU (say 25%).
- The PVO would probably have received the dollars to purchase the debt from a donor; its agreement with the borrower government would include how the local currencies could be used to deal with a development problem (in this case, combating HIV/AIDS).

ARE DEBT SWAPS TO BE PREFERRED TO DEBT RELIEF?

Debt swaps have many disadvantages as compared to debt relief:

- They are complicated
- They require USAID funds
- They have high overhead costs
- They take time
- They exacerbate a country's budgetary problems (because they require local currency transfers equal to a percentage of the debt that is probably much larger than the debt service which the government is probably not paying anyway)

HOW DOES ALL THIS FIT IN WITH THE DEBT RELIEF INITIATIVES BEING DISCUSSED FOR COLOGNE?

- There will probably be some progress made around the HIPC (Heavily-Indebted Poor Country) Initiative, which will broaden and deepen the debt relief, make it more flexible, and reduce the waiting period.
- HIPC is an economic growth initiative and its parameters do not center on debtor country abilities to provide social services.
- Given the difficulties of negotiation, the result is not likely to be radical

WHAT COULD/SHOULD THE U.S. DO?

- The U.S. could unilaterally adopt a debt relief initiative to combat HIV/AIDS by negotiating relief of African debt owed the U.S. for both concessional debt (largely PL480) and for non-concessional debt (largely EX-IM). The table on the next page presents the possible scope of such relief.
- For HIPC countries, the debt relief--AIDS nexus is strongest in Cote d'Ivoire, Ethiopia and Zambia, while two of the non-HIPC countries (Nigeria and Zimbabwe) might be interesting if their economic policies improve (budget scoring for South Africa and Botswana would probably be one-for-one).
- Neither DROC nor Sudan would be eligible for any debt relief.
- More generally, the U.S. could shape its proposals for the G-7 to focus more on government expenditure targets and providing debt relief tied to both economic policy and a strong commitment to investment in human resources -- education, health and especially HIV/AIDS.