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: 21074

FolderID:

Folder Title:
Background for Report [Folder 2] [1]

Stack:	Row:	Section:	Shelf:	Position:
S	67	1	2	2

HIV/AIDS Care and Support for Persons Living in Developing Countries
Discussion Paper on Access to Antiretroviral Drugs

HIV/AIDS care and support entail a set of interventions whose purpose is to mitigate the impact of the epidemic on individuals, families, communities, and nations. This includes activities such as protection of human rights, access to voluntary counseling and testing, psychosocial support, basic medical and palliative care, treatment and prevention of opportunistic infections, (especially tuberculosis), and community-based support for children affected by AIDS. It is increasingly clear that selected care initiatives substantially enhance efforts to prevent HIV transmission

In the last five years, advances in HIV/AIDS therapy have made it possible to halt and reverse the damage caused by HIV. This is accomplished by combining of two or more classes of antiretroviral drugs into a "cocktail" referred to as Highly Active Anti-retroviral Therapy (HAART). The cost and complexity of HAART cast doubt on its suitability for use in many developing countries. It also raises fears that scarce resources will be diverted from prevention programs and care activities that could substantially prolong and improve the quality of life for many persons living with HIV/AIDS (PLHA). This document summarizes these issues and suggests an alternative approach for improving care and support for persons in developing countries.

HAART is a very expensive therapy that is unaffordable for most persons in developing countries. In the US the price of HAART ranges from $10,000 to $15,000 per person per year. Even with a one hundred-fold decrease in price, annual drug expenditures to treat PLHA in sub Saharan Africa would exceed $2 billion. To contrast this figure, UNAIDS estimates that total annual expenditure for HIV prevention in sub Saharan Africa is only $140 million per year.

Use of HAART requires access to trained healthcare workers and properly equipped labs. HAART is complex. Treatment failures are common and are often due to poor prescribing practice. Health care workers caring for persons using HAART require specialized training and access to laboratories that are able to monitor viral load, CD4 counts and signs of drug toxicity. Few health care systems in developing countries have the capacity to provide basic care to people with HIV/AIDS. Even fewer have the capacity to effectively use HAART.

Use of HAART requires access to a sustainable supply of drugs. HAART does not cure AIDS; it only suppresses viral activity. Treatment is for life and must not be interrupted since stopping and starting therapy results in resistant virus and treatment failure. Provision of HAART from unpredictable sources (donations of surplus drug or one time funding mechanisms) will do more harm than good. In fact misuse of HAART could lead to widespread multi-drug resistant virus rendering the therapy ineffective.

HAART does not reduce the number new HIV infections. Data from the US Centers for Disease Control confirm that while deaths due to AIDS have declined sharply in the U.S., the number of new HIV infections occurring each year has stayed the same. Recent studies suggest that even those who achieve excellent results with HAART may still be able to transmit HIV through sexual contact. Clearly the need for prevention activities is unchanged even in settings with excellent access to treatment.

The biological suitability of HAART in developing countries is unknown. Because the drugs used in HAART were developed in and for northern markets, there are almost no data on the efficacy of these drugs for people infected with the subtypes of HIV predominant outside the U.S. and Europe.

A comprehensive approach to improving HIV/AIDS care and support is called for. Because of its cost and complexity it is unlikely that HAART will benefit more than a small fraction of the world's 34 million PLHA. However by supporting interventions that have broad impact it is possible to substantially prolong and improve the quality of life for a large proportion of the world's PLHA. This approach supports a wide spectrum of activities aimed at mitigating the impact of the epidemic at all levels. This includes efforts to

- **Expand voluntary HIV counseling and testing**. Only 5 to 10% of all PLHA have ever been tested. Identifying persons for care interventions is an essential first step in a care program.
- **Support and strengthen home based care**. Home based care provided by NGOs and church groups is a cost-effective way to provide care to PLHA and their families. Staff and volunteers provide HIV/AIDS psychosocial support, education, and training to PLHA and their family members. They also play a key role in community based prevention activities.
- **Support and strengthen clinic-based care**. Health systems in developing countries especially those in high-prevalence countries need additional training and resources to provide basic health care and palliative care to PLHA.
- **Prevent and treat tuberculosis and other opportunistic infections**. TB is the most common opportunistic infection in the world and the leading cause of death for PLHA. Because TB deaths often occur early in the course of HIV disease, preventing TB death results in substantial prolongation of life. Treating TB also has an enormous public health benefit by reducing the spread of new infections.
- **Reduce Stigma and Discrimination of PLHA.** Programs to reduce the stigma associated with HIV/AIDS are essential to the success of both care and prevention activities. HIV disproportionately burdens the poor, minorities, and marginalized people. Prejudice makes health care providers less sensitive to the needs of PLHA, while stigmatized people fear disclosure, violence and loss of livelihood. This makes them unwilling to participate in both prevention and care programs.
- **Strengthen Families and communities to care for vulnerable children including orphans.** In the developing world children often are care takers to sick parents and become heads of households to younger siblings after their parents die. Access to education is limited and orphaned children often migrate to urban centers where they are at high risk for sexual abuse and HIV infection. Programs that strengthen the extended family and the community make it possible for children to receive the assistance they need to stay in school and be appropriately socialized.
- **Link HIV prevention programs to care and support programs**. Care and support activities improve the ability of prevention programs to reach infected and vulnerable populations; give credibility to prevention programs and to the leaders who advocate for them; and by strengthening communities create a sense of ownership for the solution as well as the problem.

USAID is directly supporting this comprehensive approach to HIV/AIDS care and support by funding expanded voluntary counseling and testing; NGO programs which provide psycho-social and home based care; policy reform to protect PLHA; and operations research to test and evaluate innovative strategies for care and support.

Final

FOR INTERNAL USE ONLY
May 18, 1999

Qs and As on NIH Response to the AVAC report, "Eight Years and Counting"

Q. What is the NIH response to the report?

A. Developing an AIDS vaccine is a priority for us all and AVAC should be commended for its rigorous advocacy for research and development of an AIDS vaccine.

Q. Where are we on developing an AIDS vaccine?

A. This Administration has responded aggressively to the significant threat posed by HIV/AIDS with increased attention to research, prevention and treatment. Significant progress has been made in the federal vaccine effort: Since May 18, 1997, when President Clinton challenged the nation to commit itself to the goal of developing an AIDS vaccine within the next ten years, a number of important steps have been taken to help fulfill this commitment, including:

- Doubling the funding for AIDS vaccine research since FY 1995. NIH plans to spend $194 million on AIDS vaccine efforts in FY 1999, up 30% from FY 1998.
- A dedicated research center for AIDS vaccine research at NIH is being established.
- As of May 1999, NIH-supported researchers had evaluated 27 vaccine candidates and 12 adjuvants (substances incorporated into a vaccine that boost specific immune responses to the vaccine) in more than 3,000 volunteers in 49 phase I/II clinical trials.
- Three key leaders have been appointed to help shepherd the aggressive federal efforts.
- In June 1998, FDA approved the first large-scale efficacy trial of an AIDS vaccine in the United States.
- Continued high-level international collaboration and outreach to scientists, pharmaceutical companies, and patient advocates to maximize the involvement of both private and public sectors in the development of an AIDS vaccine.

Q. Are we on track for an AIDS vaccine within the next decade?

A. Federal research programs are fully committed to developing a safe and effective AIDS vaccine. While we can't always predict where the science will take all partners in this important effort, we have put into place research, development and

management strategies to seize the most promising advances and translate them expeditiously into potential products, including:

- New initiatives have been launched to enhance opportunities for vaccine discovery and to help move vaccine concepts from basic research through clinical trials with the goal of increasing the number of new, innovative and promising vaccine concepts flowing through the pipeline.
- Three key leaders have been appointed to help shepherd the aggressive federal effort.
- Several scientific advances in basic immunology and new vector development have greatly enhanced our research efforts.
- More than 3,000 non-HIV -infected volunteers have enrolled in 52 NIAID-supported preventive vaccine studies involving 27 vaccines.
- In June 1998, FDA approved the first large-scale efficacy trial of an AIDS vaccine in the Unites States. The trial for AIDSVAX will include at least 5,000 volunteers from the U.S., Canada and Europe and will last up to five years. A separate Phase III trial of AIDSVAX in Thailand will enroll 2,500 volunteers.

While considerable progress has been made, progress cannot simply be measured by the number of products passing specific milestones because quality of vaccine products is much more important than the number tested. Since advancement of new candidate vaccines into phase 1 trials is an important milestone in vaccine research, we envision periodic review, at least yearly and with input from the AIDS Vaccine Research Committee, of potential candidates that might be considered for high priority advancement to phase 1 trials.

Compulsory Licensing
Parallel Imports

- More $ (not from AID) to support infrastructure
- $ must not be from other development programmes
- debt swap/debt relief for economic social + health services development as well as economic development

Big Hewlins
89th AW/CC

Brigadier General Hewlins
89th AW/CC

Billy Pitmon
Major Strader (Walt)
Major Scott Turner

Steve/Maria

Q – Eugene Dickson
Max – John Bennett

Atlanta Hawks – Mathumbo Relief Fund
NBA
John Toshiro (UNAIDS)

Nicaendeprize –
Malawi

HIV/AIDS IN ASIA: Without Further Action, A Looming Public Health Crisis

With 60 percent of the world's population, Asia will come to dominate the HIV picture in terms of total numbers infected

The HIV/AIDS pandemic's focus is shifting from Africa to Asia, the world's most populous continent. According to UNAIDS data, an estimated 5.3 million people were infected with HIV/AIDS in Asia as of the end of 1996. Current trends suggest that Asia may have surpassed Africa, in terms of the highest number of new infections per year.

In most Asian countries for which there is information, the HIV/AIDS epidemic has reached a concentrated stage either nationwide or at least in some states or provinces, meaning that HIV has risen to high levels among those practicing the riskiest behaviors and is set to spread more widely in the rest of the population, according to a World Bank report, ***Confronting AIDS: Public Priorities in a Global Epidemic***.

This includes regions of the world's two most populous countries, China and India, most of Indochina, and Malaysia. Despite some bright spots on the map in terms of effective government and non-government action, without further interventions targeted at the populations at risk-such as sex workers, homosexuals, and injecting drug users-the epidemic in these countries hold the potential to dwarf the health crisis through which Sub-Saharan Africa has suffered for the past decade.

In the remaining Asian countries, the epidemic is nascent, meaning HIV prevalence is very low; infection among those presumed to practice high-risk behavior is less than 5 percent. In these countries, investing in effective prevention now can keep infection rates very low and at relatively low cost.

East Asia

Patterns of infection in east, south, and southeast Asia have been greatly influenced by the proximity of many countries to the "Golden Triangle" of heroin production located at the border between Lao PDR, Myanmar, and Thailand, and to its distribution routes. HIV infection was first detected among those who inject drugs in Bangkok in 1987; during the next year it spread rapidly among injecting drug users in the Thai capital. The pattern was quickly repeated among injecting drug users in northern Thailand and along the border areas between southern Thailand and northern Malaysia. In 1989, HIV infection was identified in Myanmar, Yunnan Province in China, and in Manipur State in northeastern India. HIV was detected among injecting drug users in Singapore in 1990.

Injecting drug use has been the main mode of transmission in China, where the most highly infected province, Yunnan, is adjacent to international drug routes. Male injecting drug users in Yunnan account for 78 percent of HIV infections in China. In other Chinese provinces, infection rates are thought to be low, even among those who practice high-risk behavior.

Economic reforms that have helped to reduce the number of people in poverty in

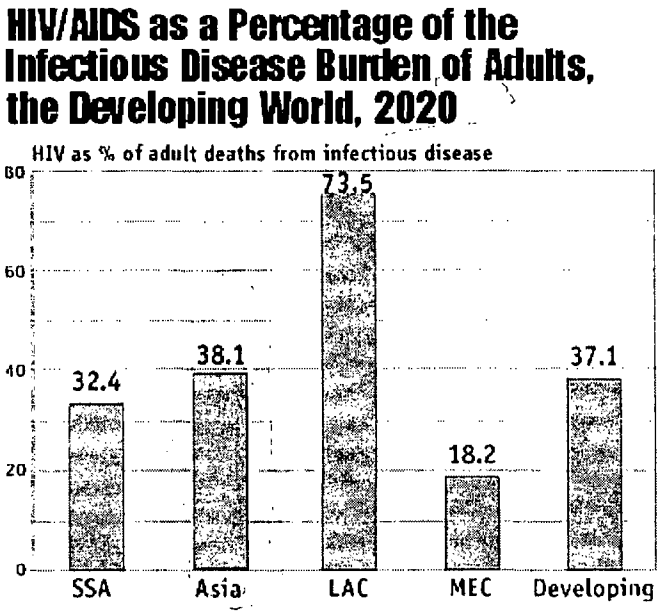
epidemics will remain at low levels once prevalence plateaus in urban centres or whether the rural areas will cause a second increase in incidence that carries total prevalence to higher levels than those projected by the United Nations.

On balance it seems that the most likely scenario is one combining the higher base- year prevalence estimates of the Census Bureau with more moderate prevalence projections, following the UN pattern. Combining these assumptions with a perinatal transmission rate of 39 per cent and a median incubation period of 7.5 years produces a projection of 1.35 million annual AIDS deaths for the period 2000-2005 in sub- Saharan Africa. This projection is about one-third of the way between the UN projection (1.01 million) and Census Bureau projection (2.16 million).

Future projections may have to expand the geographic coverage. By 2005 there may be as many AIDS deaths in Asia as in Africa. The country with the largest number of HIV infections today is probably India, where there are 2 million to 5 million HIV infections. Although the number of deaths is still small in India, since the increase in infections is recent, it will increase substantially in the coming years. HIV prevalence also seems to be increasing rapidly in China and Indonesia.

Although the levels are still low, the rapid rate of increase and the large populations in these countries make it necessary to consider them in any future projections of the demographic impact of AIDS. Since our knowledge of national prevalence rates in these Asian countries is limited, future estimates of AIDS deaths may vary even more in the future as demographers struggle to understand the scope of the epidemic in this new region.

Figure 1-5



SSA Sub-Saharan Africa
LAC Latin America and the Caribbean Countries (total)
MENA Middle East and North Africa

Source: Murray and Lopez 1996.

India

THE UNAIDS report on the global impact of HIV/AIDS presented at the XI International Conference on AIDS stated that there are an estimated 2-5 million people infected with HIV in India today. 50,000 to 100,00 cases of AIDS may have already occurred in this country with a population of over 900 million. The most rapid and well-documented spread of infection has occurred in Bombay and the State of Tamil Nadu. In Bombay, HIV prevalence has reached 50% in sex workers, 36% in STD patients, and 2.5% in women seen in antenatal clinics. The infection affects both urban and rural areas. In Bombay, seroprevalence rose from 2-3% in patients seen in STD clinics in 1990 to 36% in 1994 and in rural areas 3-4% of some populations have an STD. Source: The Status and Trends of the Global HIV/AIDS Pandemic Official Satellite Symposium presented at the XI International Conference on AIDS in Vancouver, July 5-6, 1996)

IV drug users (IDUs) present a major problem in the State of Manipur which comprises part of the Golden Triangle, the source of the world's supply of pure grown heroin, 55% of the users are HIV-infected. HIV infection among IDUs jumped from zero to nearly 70% in 1992, according to the U.S. Census Bureau.

In India, there are an estimated 1-2 million cases of tuberculosis every year. TB is the most prevalent form of POI (opportunistic infection) in over 60% of AIDS cases. In Bombay alone, 10% of the patients with TB are HIV-positive.

Tibet

The Central Administration of the Tibetan government in exile, under the leadership of His Holiness, the Dalai Lama, is located in Dharmasala, India. A Department of Health was established in 1981 to serve the needs of of all Tibetan refugees in India and Nepal and has set up 67 health centers, 8 hospitals and employs 255 field staff, most of whom are Community Health workers. Because of the HIV/AIDS situation in the host countries of India and Nepal, the Department declared 1997 as Tibetan AIDS Awareness Year. The year began with a public speech by the health minister and a series of workshops on AIDS prevention were held at various refugee settlements. The Department is now in the process of producing a short video on AIDS in Tibetan to be distributed to all of the health centers, hospital, and schools.

Kalsang Norbu, the Training and Reproductive Health Officer of the Department of Health is the coordinator of a training program for nurses and health workers which addresses the topics of HIV/AIDS

pazvakavambwab@who.ch
05/27/99 10:09:51 AM

Record Type: Record

To: mccaulf@ccm.who.ch

cc: piotp@ccm.who.ch, Sandra Thurman/OPD/EOP, hechtr@ccm.who.ch
Subject: Fwd:MTCT intervention cost figures for Peter's meeting

---

FYI

_____Forward Header_____
Subject: MTCT intervention cost figures for Peter's meeting
Author: pazvakavambwab
Date: 5/27/99 2:49 PM

Jacob,

Below are the figures for Peter's meeting.

Regards,

Brian Pazvakavambwa
Jos Perriens

====

1. Unit cost of MTCT intervention

Unit cost of MTCT intervention (zidovudine+lamivudine from 36 weeks + 1 week post partum + zidovudine/lamivudine to baby for 1 week - including all costs like VCT, follow-up, etc) = US$90 per pregnant woman (Wilkinson et al, South Africa).

This cost however excludes breastfeeding replacement, 6 months of which costs US$48 at the UNICEF negotiated price going up to US$150 on the open market.

There are other estimates, most in the realm of speculation, such as US$20 from study by Mansergh et al (using only zidovudine as in Thai Study), or Elliot and Kalin (US$48 to US$60 for drugs only).

2. MTCT Programme in South Africa (country-wide)

Expected pregnant women in 1999 = 1,327,800 (UN World Population Prospects, 1996)
Cost of intervention (not including replacement feeding = US$90 x 1,327,800
= US$120 million (assuming 100% coverage).

Experience in Cote d'Ivoire Thailand suggests that a good programme might reach about 40% of the potential beneficiaries (Payo paper). This would bring down the approximate cost of the intervention to about US$50 million or over US$240 million if replacement feeding were included.

3. References:

Wilkinson D, Floyd K, Gilks CF. Antiretroviral drugs as a public health intervention for pregnant women in rural South Africa: an issues of cost-effectiveness and capacity. AIDS 1998;12:1675-1682.

Mansergh G, Haddix AC, Steketee RW, Nieburg PI, Hu DJ, Simonds RJ et al. Cost-effectiveness of short-course zidovudine to prevent perinatal HIV type 1 infection in a sub-saharan African developing country setting. JAMA 1996;276:139-145.

Extrapolations from 5-Year aggregated expected births in "UN World Population Prospects: 1996 Rev. Ann II&III: Demographic indicators by major area, region and country)

Payo et al. Attrition in the MTCT intervention Programme in Topogon in CI. Presented by UNICEF in formulation meeting of FSTI intervention, March 1999, Abidjan

DRAFT

USAID

HIV/AIDS Care and Support for Persons Living in Developing Countries

Discussion Paper on *Mother to Child Transmission of HIV*

Sub-Saharan Africa is suffering tremendously from the HIV/AIDS epidemic. Since the beginning of the epidemic, about 35 million Africans have been infected. As of 1998, there were about 22 million Africans living with HIV, including about 1 million children. In 1998 alone, about 4 million Africans became infected with HIV. This means that every *day* about 10,000 men, women, and children are contracting the virus.

Although the vast majority of people with HIV are adults who have contracted the virus from an infected partner, the problem of mother-to-child transmission has become increasingly important, and is estimated to be the cause of about 10 percent of all *new* infections and nearly 100 percent of all cases of pediatric HIV. In other words, about a half-a-million African babies become infected with HIV every *year*. Mother-to child infections are likely to increase because of the growing epidemic among women, particularly women less than 25 years of age. Data suggest that about 55 percent of all new infections in Africa occur among women. A startling 70 percent of these occur in women between 15 and 24 years of age - these are new infections among women who are beginning their reproductive lives.

Mother-to-child transmission of HIV can occur during pregnancy, at the time of delivery, and after birth through breastfeeding. In Africa, of 10 children born to HIV infected mothers, it is estimated that 2 will be infected during pregnancy or delivery, 1 will be infected through breastfeeding, and 7 will remain uninfected, even with continued breastfeeding. There are several conditions that make a mother more likely to transmit HIV to her baby. These include:

- high viral load (amount of virus in the body) due to recent HIV infection or advanced disease (AIDS);
- maternal malnutrition (e.g., vitamin A deficiency);
- untreated sexually transmitted infections;
- prolonged rupture of membranes during labor;
- invasive delivery procedures that increase the likelihood of blood interchange between mother and baby;
- non-exclusive breastfeeding during the first months of life (i.e., breastfeeding with additional milk, formula, water, solid foods, etc.); and
- breastfeeding while experiencing breast infections, such as mastitis and abscesses.

A combination of interventions are needed to reduce mother-to-child transmission of HIV:

- Primary prevention of HIV among women, including behavior change interventions; decision making and negotiation skills; early diagnosis and treatment of sexually transmitted infections; and increased condom use are important strategies for preventing HIV infections in mothers.
- HIV voluntary and confidential counseling and testing services must be available and accessible to pregnant women and their partners so that families can make informed choices about their reproductive lives.
- Health workers and other care givers need to be skilled in counseling HIV-negative women and their partners about how to avoid risky behaviors, and in counseling HIV-positives on how to discuss their situation with their families and to live positively with the disease.
- Health workers need to understand the risk factors and practices that increase the likelihood of mother-to-child transmission of HIV; they must be able to follow safe birthing practices; and they must be able to counsel women about infant feeding options, including safe breastfeeding and appropriate replacement feeding during the first two years of life.
- A package of antenatal interventions, including essential drugs and nutritional supplements, must be available for all women without discrimination.
- Antiretroviral drugs, if available, should also be given according to locally agreed upon protocols.

Key Issues Regarding the Use of Anti-retroviral Drugs To Prevent Mother to Child Transmission of HIV (MTCT)

Recently released scientific study results show that a short course of oral antiviral medication can significantly reduce HIV transmission from mother to infant during gestation and birth.

However these interventions still have significant safety, cost, capacity, social, and ethical implications, and their ability to provide true public health impact remains in doubt. USAID is now devoting approximately $6 million to answering key questions surrounding MTCT interventions. The following issues need to be addressed:

Potential for increased deaths from the use of breast milk substitutes: Breast feeding by HIV positive mothers accounts for about one third of all MTCT. In Sub Saharan Africa, where diarrhea is the leading cause of death for children under 5, more children could die from the misuse of breast milk substitutes than would die from AIDS. Also, not breastfeeding carries other health risks, including from 2 to 20 times the risk of infant and child mortality, as well as significantly increased fertility among the mothers.

High costs in addition to the cost of AZT: Drug prices are only a small fraction of the cost of MTCT interventions. The actual cost of preventing one HIV infection could reach as high as $5000 depending on the cost of breastmilk substitutes and the proportion of pregnant women who are infected. In poor countries, health planners face difficult decisions over the best use of scare funds.

Lack of HIV testing in most of the world: More than 90% of all persons infected with HIV have never been tested. MTCT programs will need to include a substantial investment in voluntary counseling and testing programs in order to have a true impact.

Marginal health systems: Antenatal care programs are often overburdened. MTCT interventions need to be carried out in ways that do not threaten the quality of antenatal care for all women.

High risk for discrimination: Women who are infected with HIV are at great risk for discrimination, rejection, and violence by their families and communities. MTCT interventions have the potential to disclose a woman's HIV status. This could happen in the health care setting but also could result from other components of MTCT interventions. For instance taking AZT during labor essentially discloses one's HIV status to those present. In many communities breastfeeding is the norm. To be seen giving breastmilk substitutes also discloses one's HIV status.

Need for additional research: There are many unanswered questions regarding MTCT interventions. The programs involving drugs are largely untested. Some of the issues include: how prenatal clinics can best absorb new, technically complicated tests and service delivery; how best to safely inform or advise women, and the general public, about infant feeding for children with HIV positive women; how to safeguard confidentiality of participants (childbirth is a social event in many societies, with many family members in attendance, and not breastfeeding can create suspicions); how best to deal with the ethical issues of treating some women only, and/or of treating HIV positive only for a short period of time (birth of child) only; and., assessing the true cost of MTCT interventions to ensure that they are affordable and sustainable.

DRAFT

HIV/AIDS Care and Support for Persons Living in Developing Countries

Discussion Paper on *Linking HIV Prevention to Care and Support*

HIV/AIDS care and support entail a set of interventions whose purpose is to reduce the impact of the epidemic on individuals, families, communities, and nations. This includes activities such as protection of human rights, access to voluntary counseling and testing, psychosocial support, basic medical and palliative care, treatment and prevention of opportunistic infections (especially tuberculosis), and community-based support for children affected by AIDS. It is increasingly clear that selected care initiatives **substantially enhance efforts to prevent HIV transmission.** Prevention is the only sure means of reducing the numbers of persons with HIV/AIDS and thus alleviating the suffering and burden of this terrible disease.

HIV/AIDS care and support reduce the effect of HIV on individuals by providing physical, psychological and spiritual assistance, and on affected communities by reinforcing existing systems and creating new systems for coping.

Care and support for affected individuals. Country experience shows that a combination of interventions is very effective in reducing the impact of HIV on HIV positive persons. These include: protecting their human rights and reducing stigma and discrimination; providing psychosocial support to them and their care givers; providing palliative care to control pain and the symptoms of opportunistic infections (such as tuberculosis); and preventing and treating opportunistic infections to reduce suffering and prevent and delay deaths.

Reducing the effects on the community. HIV/AIDS affects an entire community—families, extended families, villages, and cities. The toll of HIV/AIDS includes orphans, disruption of village and community life, and ultimately disruption of civil and political order. To reduce these effects, providing psychosocial support to families, friends, caregivers, and communities is essential. To do so, strengthening existing community resources such as churches, NGO's, schools, and community institutions are required. Empowering communities to identify and implement the solutions is necessary—they know what works best. Creating new community-based resources to respond to the changes brought about by the epidemic such as reduced farm output, loss of teachers, and children caring for adults.

Care and Support Enhance Prevention. Protecting human rights improves the ability of prevention programs to reach infected and vulnerable populations. Care and support activities give credibility to prevention programs and to the leaders who advocate for them. Strengthening communities creates a sense of ownership for the solution as well as the problem.

Care and Support Enhance Sustainable Development. HIV/AIDS care and support activities enhance sustainable development by shoring up fragile infrastructures, and retraining personnel to take over key positions such as teachers and health care workers. Moreover, care and support activities must be conducted in the context of the existing health and social services capacity in developing countries, as well as institutional capacity, and their limitations.

The Prevention and Care Continuum. Prevention and care and support are part of a broader continuum. Care and support activities are added to, not substituted for, prevention. Decision makers must strike a balance between the need for prevention and the need for care and support. Care and

support activities become imperative as the epidemic progresses but they can be started at any stage of the epidemic. A comprehensive approach to care and support builds upon a base of activities which support the community as a whole, reaches the most people, and creates the foundation for more advanced care strategies

How USAID is supporting HIV/AIDS care and support. USAID has supported HIV/AIDS prevention for the past decade. USAID is directly supporting a comprehensive prevention and care and support approach to HIV/AIDS by funding expanded voluntary counseling and testing; NGO programs which provide psycho-social and home based care; policy reform to protect PLHA; and operations research to test and evaluate innovative strategies for care and support. By supporting this program, USAID is enhancing the lives of many persons living with HIV/AIDS as well as those families and communities affected.

Availability of Anti Retroviral Drugs. In the last five years, advances in HIV/AIDS therapy have made it possible to halt and reverse the damage caused by HIV. This is accomplished by combining of two or more classes of antiretroviral drugs into a "cocktail" referred to as Highly Active Anti-retroviral Therapy (HAART). The cost and complexity of HAART cast doubt on its suitability for use in many developing countries. It also raises fears that scarce resources will be diverted from prevention programs and care activities that could substantially prolong and improve the quality of life for many persons living with HIV/AIDS (PLHA). This document summarizes these issues and suggests an alternative approach for improving care and support for persons in developing countries. The costs are very high: in the US the price of HAART ranges from $10,000 to $15,000 per person per year. Even with a one hundred-fold decrease in price, annual drug expenditures to treat PLHA in sub Saharan Africa would exceed $2 billion—and this figure excludes the cost of testing for HIV and the medical infrastructure to deliver the drugs. To contrast this figure, UNAIDS estimates that total annual expenditure for HIV prevention in sub Saharan Africa is only $140 million per year. Moreover, only a few developing countries have the trained personnel and infrastructure to use AVR. In all likelihood would benefit only a fraction of persons with HIV infection.

DRAFT

USAID

HIV/AIDS Care and Support for Persons Living in Developing Countries

Discussion Paper on *Access to Antiretroviral Drugs*

HIV/AIDS care and support entail a set of interventions whose purpose is to reduce the impact of the epidemic on individuals, families, communities, and nations. This includes activities such as protection of human rights, access to voluntary counseling and testing, psychosocial support, basic medical and palliative care, treatment and prevention of opportunistic infections, (especially tuberculosis), and community-based support for children affected by AIDS. It is increasingly clear that selected care initiatives substantially enhance efforts to prevent HIV transmission. Moreover, prevention is the only assured means to reduce the number of persons with HIV/AIDS, and thus prevent the suffering and burden of this terrible disease.

In the last five years, advances in HIV/AIDS therapy have made it possible to halt and reverse the damage caused by HIV. This is accomplished by combining of two or more classes of antiretroviral drugs into a "cocktail" referred to as **Highly Active Anti-retroviral Therapy (HAART)**. The cost and complexity of HAART cast doubt on its suitability for use in many developing countries. It also raises fears that scarce resources will be diverted from prevention programs and care activities that could substantially prolong and improve the quality of life for many persons living with HIV/AIDS (PLHA). This document summarizes these issues and suggests an alternative approach for improving care and support for persons in developing countries.

HAART is a very expensive therapy that is unaffordable for most persons in developing countries. In the US the price of HAART ranges from $10,000 to $15,000 per person per year. Even with a one hundred-fold decrease in price, annual drug expenditures to treat PLHA in sub Saharan Africa would exceed $2 billion—and this excludes the cost of testing and of the medical infrastructure to deliver the drugs. To contrast this figure, UNAIDS estimates that total annual expenditure for HIV prevention in sub Saharan Africa is only $140 million per year.

Use of HAART requires access to trained healthcare workers and properly equipped labs. HAART is complex. Treatment failures are common and are often due to poor prescribing practice. Health care workers caring for persons using HAART require specialized training and access to laboratories that are able to monitor viral load (the amount of virus in one's body), CD4 counts and signs of drug toxicity. Few health care systems in developing countries have the capacity to provide basic care to people with HIV/AIDS. Even fewer have the capacity to effectively use HAART.

HAART requires that people know their HIV/AIDS infection status. It is estimated that over 95% of Africans do not know their HIV infection status. Developing large scale voluntary testing and counseling programs will be expensive and take time. In addition, key obstacles such as stigma and discrimination, and the lack of basic care and support, will need to be overcome in order to encourage people to get tested.

Use of HAART requires access to a sustainable supply of drugs. HAART does not cure AIDS; it only suppresses viral activity. Treatment is for life and must not be interrupted since stopping and starting therapy results in resistant virus and treatment failure. Provision of HAART from unpredictable sources (donations of surplus drug or one time funding mechanisms) will do more harm than good. In fact misuse of HAART could lead to widespread multi-drug resistant virus rendering the therapy ineffective and possibly creating an even worse epidemic.

HAART does not reduce the number new HIV infections. Data from the US Centers for Disease Control confirm that while deaths due to AIDS have declined sharply in the U.S., the number of new HIV infections occurring each year has stayed the same. Recent studies suggest that even those who achieve excellent results with HAART may still be able to transmit HIV through sexual contact. Clearly the need for prevention activities is unchanged even in settings with excellent access to treatment.

The biological suitability of HAART in developing countries is unknown. Because the drugs used in HAART were developed in and for northern markets, there are almost no data on the efficacy of these drugs for people infected with the subtypes of HIV predominant outside the U.S. and Europe.

A comprehensive approach to improving HIV/AIDS care and support is called for. Because of its cost and complexity it is unlikely that HAART will benefit more than a small fraction of the world's 34 million PLHA. However by supporting interventions that have broad impact it is possible to substantially prolong and improve the quality of life for a large proportion of the world's PLHA. This approach supports a wide spectrum of activities aimed at mitigating the impact of the epidemic at all levels. This includes efforts to:

- **Expand voluntary HIV counseling and testing**. Only 5 to 10% of all PLHA have ever been tested. Identifying persons for care interventions is an essential first step in a care program.
- **Support and strengthen home based care**. Home based care provided by NGOs and church groups is a cost-effective way to provide care to PLHA and their families. Staff and volunteers provide HIV/AIDS psychosocial support, education, and training to PLHA and their family members. They also play a key role in community based prevention activities.
- **Support and strengthen clinic-based care**. Health systems in developing countries especially those in high-prevalence countries need additional training and resources to provide basic health care and palliative care to PLHA.
- **Prevent and treat tuberculosis and other opportunistic infections**. TB is the most common opportunistic infection in the world and the leading cause of death for PLHA. Because TB deaths often occur early in the course of HIV disease, preventing TB death results in substantial prolongation of life. Treating TB also has an enormous public health benefit by reducing the spread of new infections.
- **Reduce stigma and discrimination of PLHA.** Programs to reduce the stigma associated with HIV/AIDS are essential to the success of both care and prevention activities. HIV disproportionately burdens the poor, minorities, and marginalized people. Prejudice makes health care providers less sensitive to the needs of PLHA, while stigmatized people fear disclosure, violence and loss of livelihood. This makes them unwilling to participate in both prevention and care programs.
- **Strengthen families and communities to care for vulnerable children including orphans.** In the developing world children often are care takers to sick parents and become heads of households to younger siblings after their parents die. Access to education is limited and orphaned children often migrate to urban centers where they are at high risk for sexual abuse and HIV infection. Programs that strengthen the extended family and the community make it possible for children to receive the assistance they need to stay in school and be appropriately socialized.
- **Link HIV prevention programs to care and support programs**. Care and support activities improve the ability of prevention programs to reach infected and vulnerable populations; give credibility to prevention programs and to the leaders who advocate for them; and by strengthening communities create a sense of ownership for the solution as well as the problem.

USAID is directly supporting this comprehensive approach to HIV/AIDS care and support by funding expanded voluntary counseling and testing; NGO programs which provide psycho-social and home based care; policy reform to protect PLHA; and operations research to test and evaluate innovative strategies for care and support.

05/13/99

U.S. Agency for International Development

Bureau for Africa
Office of Sustainable Development
1325 G St., NW Suite 400
Washington, DC 20005

Date: 5/26/99

To: Sandy Thurman

Phone: _____

Fax: _____

From: Alex Ross

Phone: _____

Fax: _____

Number of Pages Including Cover Sheet _____

Message

Sandy,

This is a UNICEF Executive Board document under review in USAID, & thought you'd be interested in it, at least to read the rhetoric (Public).

Alex.

Close

Executive Board Documents

Title:	**Ensuring Children's Rights in Africa**
Document Type	**Executive Board - Progress Reports**

Country	WCARO Regional	Series:	E/ICEF/1999/12
Year Published :	1999	PDF Link :	
OSEB Doctype :	Executive Board Documents		
Session :	1999 Annual Session		

(8)

▸ Detailed information (click on the twistee to see more)

Executive Summary:

AFR
Bartlett

Document Text:

Distr.
GENERAL

E/ICEF/1999/12
30 March 1999

ORIGINAL: ENGLISH

FOR INFORMATION

UNITED NATIONS CHILDREN'S FUND
Executive Board
Annual session 1999
7-11 June 1999
Item of the provisional agenda*

ENSURING CHILDREN'S RIGHTS IN AFRICA

SUMMARY

The present report was prepared in response to Executive Board decision 1997/19 (E/ICEF/1997/12/Rev.1), in which the Board recalled the UNICEF commitment to Africa as the region of greatest need and highest priority, and requested the Executive Director to report in 1999 on progress made in efforts to ensure children's rights to survival, development and protection in Africa.

Following a review of UNICEF experience of support to Africa's children during the decade of the 1990s, the report provides an update of recent trends affecting the rights of children and women on the continent. It describes the current strategic focus of UNICEF work in the main subregions of greatest need, particularly sub-Saharan Africa, and assesses the key areas in which effective partnerships and leadership will be needed if sustained progress is to be achieved.

* E/ICEF/1999/8.

I. A DECADE OF INVESTMENT IN AFRICA'S CHILDREN: DIRECTIONS AND LESSONS LEARNED

1. Childhood in Africa has been in jeopardy for most of this decade. As the continent prepares for the new century, children and women, especially in sub-Saharan Africa, remain acutely vulnerable and exposed to the combined impact of economic crisis, unserviceable international debt, armed conflicts, spreading violence and the unrelenting HIV/AIDS pandemic. To varying degrees, these crises have diverted attention and resources away from the longer-term development efforts of African Governments for investing in children, and from their essential roles in the societal effort to ensure children's and women's rights.

2. Within this challenging context, UNICEF advocacy and programme cooperation during the early part of the decade were centred on the goals adopted in 1990 at the World Summit for Children by world leaders from all continents. With the ratification of the Convention on the Rights of the Child by all African countries, except Somalia, and with the reaffirmation of commitment to the goals for children at the International Conference on Assistance to the African Child which took place in Dakar, Senegal, in 1992, under the auspices of the Organization of African Unity (OAU), most African countries produced national plans of action (NPAs) to implement these goals. In the early 1990s, these and other initiatives encouraged a stronger policy focus in many African countries on the reduction of child death rates, disease and malnutrition as well as the promotion of universal primary education.

3. In several cases, such as Nigeria, South Africa and Uganda, the NPAs for children were extended to local government levels as part of national policies for devolution. The NPAs also helped to strengthen the focus of UNICEF-assisted programmes of cooperation in Africa on the policy environment and intersectoral approaches to achieving results for children. However, the extent to which the NPA initiatives were sustained varied greatly among countries. In some cases, national goals for children, and strategies to achieve them, were integrated in overall development plans. NPAs were valuable for some countries in providing an analytical base for monitoring implementation of the Convention on the Rights of the Child and in mobilizing private sector partners. Elsewhere, however, NPAs were affected by difficulties of costing, weak monitoring and lack of mainstreaming in national planning, or were superseded by outbreaks of conflict.

4. The UNICEF contribution to the achievement of substantial results in some areas of the World Summit goals, such as health, education and clean water, was complemented, particularly in west and central Africa, by the introduction of the Bamako Initiative as a means of addressing more systemic challenges in health service delivery and financing. However, during this period, more limited focus was devoted to growing challenges such as HIV/AIDS and malaria.

5. A mid-decade review presented to the United Nations General Assembly by the Secretary-General in September 1996 showed that, despite impressive progress in areas such as salt iodization, the use of oral rehydration therapy and the reduction of cases of guinea worm, sub-Saharan Africa was generally lagging behind other regions. Immunization coverage rates, for example, had risen rapidly in the early years of the 1990s but had then tended to stagnate. Little overall progress had been registered in goals for school enrolment, sanitation access and the reduction of maternal mortality. The rate of decline in child mortality, while significant, was slower than in other regions. The review also raised concerns on the sustainability of progress and the spread of HIV/AIDS.

6. The unevenness of progress in much of Africa was a major reason for the launching of a global initiative for accelerated achievement of programme priorities within the scope of the World Summit as part of the current UNICEF medium-term plan (MTP) for the period 1998-2001 (E/ICEF/1998/13 and Corr.1). With support from the UNICEF regional offices, a clearer set of priorities has been established, for which it is considered both feasible and urgent that progress be made in sub-Saharan Africa in the remainder of the decade.

7. Many of the mid-term reviews (MTRs) of UNICEF-assisted country programmes in the second half of the 1990s have resulted in a more balanced mix of strategies and a better focusing of objectives. New country programmes of cooperation designed with Governments in sub-Saharan Africa since 1995, such as those in Ghana, Mali, Uganda and the United Republic of Tanzania, have incorporated greater attention to issues of capacity-building, the promotion of positive behavioural change and community participation. These approaches recognize the need to combine continued support to basic services delivery, with improved policies and systems for sustaining progress, and with a more explicit focus on the progressive achievement of children's and women's rights.

Strategies for capacity-building are gradually becoming more broad-based, incorporating participatory analysis of the problems

and strategic needs of institutions. While training activities have been implemented by almost every UNICEF-assisted programme, they were often focused on centrally-based civil servants and less on local-level capacity development. There is now greater appreciation of the need for systematic preparation, follow-up and assessment of the impact of training. This area continues to face challenges of cost-effectiveness and coordination, as well as difficulties posed by low levels of salaries among government workers which result in, as well as reflect, low public sector productivity.

9. Support to social policy reform, social mobilization and community capacity-building, through promotion of often innovative modes of participation, is taking on increased significance in sub-Saharan Africa within the context of rights-based programming (see the report on programming with a rights perspective (E/ICEF/1999/11) being submitted to the Executive Board at the present session). UNICEF is also increasingly providing assistance to initiatives that address legislative and policy issues related to children's and women's rights. Support to communication has been shifting from a centralized approach towards activities based on audience research, testing and feedback, with community and youth involvement.

10. Meanwhile, the escalating scope of armed conflict in parts of sub-Saharan Africa has often impeded access to children and women for the delivery of basic services and has created additional challenges of ensuring their protection against violence and abuse. Despite the difficulties, in the late 1990s, UNICEF managed to maintain a field-level presence in almost all countries in sub-Saharan Africa and to spearhead efforts for child protection, such as family tracing and reunification, the demobilization and reintegration of child combatants and the restoration of access to basic services, including education. Particularly in the late 1990s, UNICEF has spoken out internationally, at the highest levels, on major violations of children's rights arising from conflicts in Africa. Further in support of the recommendations of the Secretary-General's report on "The Causes of Conflict and the Promotion of Durable Peace and Sustainable Development in Africa" (A/52/871-S/1998/318), UNICEF has promoted children's rights and child protection issues with national leaders as a means of building commitment for peace. Country programmes in Angola, Burundi, Liberia and Mozambique have promoted community awareness of landmines and values of reconciliation in school curricula as part of a broadening range of activities to address the causes and consequences of recurrent conflict in Africa.

II. CURRENT THREATS AND CHALLENGES TO THE RIGHTS OF AFRICA'S CHILDREN

11. Large parts of Africa have seen setbacks in their development progress and prospects over the last two years. In many cases, the recovery in economic performance and gains in political stability noted in 1997 have proven fragile and vulnerable to both short-run shocks and structural factors. The stalling of progress is seen in the continued shortfalls in the achievement of the goals of the World Summit for Children and the intensifying threats to the realization of children's and women's rights.

12. The resurgence of armed conflict is having a corrosive effect on these human rights, as well as on the social and economic structures that must sustain them. With an estimated 7.2 million refugees and displaced people, Africa has experienced a growing number of international conflicts. The most extensive of these, in central Africa, has been joined by new conflicts in the Horn of the continent. Civil strife has also spread in coastal west Africa, while individual countries, most dramatically Angola and the Congo, have seen the revival of internal hostilities. Other countries have experienced political instability and widespread institutional weakness. These situations of turmoil have led to wasted resources, destroyed lives and shattered basic service systems.

13. A particular feature of several of these conflicts, such as that in Sierra Leone, has been the targeting of children, both as victims of abuse and for abduction as participants in conflict itself. Shocking manifestations of brutality have been witnessed as social structures have been undermined. Even societies not directly affected by conflict have witnessed growing levels of violence against women and children, particularly in poor urban settlements.

14. A different kind of crisis, greater even than war in its ultimate scope if not in immediate visibility, is that of the HIV/AIDS pandemic and its consequences. December 1998 estimates by the Joint and Co-sponsored United Nations Programme on HIV/AIDS (UNAIDS) confirm that gains over the last three decades in child survival and life expectancy are being undone with unexpected rapidity. Some 83 per cent of all AIDS-related deaths globally have occurred in sub-Saharan Africa, about one quarter of them among children. Evidence of the startling impact of HIV/AIDS and of other adverse trends is accumulating. The most recent Demographic and Health Survey in Kenya, for example, suggests that child mortality increased by about 40 per cent from the late 1980s to the mid-1990s and is continuing to worsen. In Zambia, the under-five mortality rate is estimated to have increased from 122 per 1,000 live births in 1990 to 202 in 1997. Meanwhile, particularly in parts of eastern and southern Africa, health services are overwhelmed with patients affected by AIDS-related conditions, while health workers, teachers and their families are also personally affected.

15. While the impact of AIDS may not have shown up clearly in macroeconomic statistics, this should not lead to complacency: the economic consequences of the pandemic for millions of individual families are catastrophic. The deaths of productive adults results in loss of basic income, the sale of household assets and often outright destitution. This greatly reduces the ability of families to contribute to realizing the rights of their children. Whether these effects widen existing disparities or not, their impact is to rapidly deepen the poverty of households and communities in large areas of the poorest region in the world.

16. Some parts of the continent, particularly in the common currency zone of west Africa, have seen a modest revival of economic prospects due to improved macroeconomic management. Medium-run prospects for recovery in west Africa may also be strengthened by the current democratization process in Nigeria, its largest nation. For many African countries, however, recent steep falls in world commodity prices are counteracting their improved policies. Very few of them have achieved the levels of investment necessary to transform the production and export base, and for rates of economic growth which will bring more jobs and better livelihoods. Following optimism in 1996, when continental gross domestic product growth was estimated at 4.5 per cent, the likelihood is that the growth of population once again outpaced that of income in 1998.

17. Meanwhile, over 8 million African children - the producers and entrepreneurs of the next decades - have already lost one or both parents to AIDS, and their numbers may grow to 10 million-14 million by the year 2001. Orphaned children and families affected by the loss of breadwinners constitute one of the greatest social welfare challenges in Africa's history. The social, psychological and cultural implications of the phenomenon of orphans in Africa have not yet been well understood. The safety nets required by affected children and families are, even in the best of cases, only partially in place.

18. A lack of open discourse on the stark challenge of the AIDS pandemic persists in many social settings, which hampers the search for decisive responses. There is some evidence that Governments have begun to increase their commitments to investing in basic services, including those related to AIDS awareness and response. However, these efforts continue to be undermined not only by low levels of efficiency in the use of resources, but also by the high proportions of national budgets devoted to debt repayment. Together with often sluggish revenue performance, and some increases in the share of military spending in the last two years, the continued burden of debt servicing reduces the scope for essential spending on children by African Governments.

19. It is not surprising, therefore, that progress in other areas of social and human development has also been limited. Considerable success has been registered since 1997 in some specific areas, including raising polio immunization rates, supported by the introduction by many countries of National Immunization Days; the wider use of vitamin A supplements, which are now received by about 60 per cent of young African children compared to one quarter in 1994; the widespread iodization of traded salt; and the dramatic reduction of guinea worm cases. These achievements now need to be sustained and extended to other key areas for human development. Maternal death rates in much of sub-Saharan Africa remain extraordinarily high, while about one third of young children are under weight for their age and one sixth have low weight at birth.

20. The risks of maternity continue to undermine the rights of African women to safe pregnancy and childbirth. This forms part of a broader set of factors which cause the systematic disadvantage of women, including: inferior social and often legal status; neglect in national policy; lack of political participation; illiteracy; excessive workload; poor nutrition; genital mutilation; early marriage and pregnancy; and unequal access to already limited services. Such factors also put younger women at disproportionate risk of HIV infection.

21. Sustained progress towards the goals of the World Summit for Children is likely to require both improvements in gender equity and a considerable strengthening of public institutions, complemented by community organization and partnerships with civil society. The current challenges are evident in other areas of basic services provision. Overall, less than two thirds of school-age children in sub-Saharan Africa are enrolled in primary education, a situation similar to that of 1990. Poor education quality; weak learning achievement and high drop-out rates are still major challenges despite efforts to adapt curricula, school timetables and language policies to local needs. Meanwhile, the weakness of public health systems is illustrated by the resurgence, across the continent, of malaria and cholera, as well as the greater incidence of meningitis. These trends also reflect the persistent lack of access among the majority of families to safe water and sanitation, a problem which is rapidly intensifying in urban areas

22. Inefficiencies in the use of public resources for social development are widely evident in the irregular payment of salaries, unreliable supplies of essential drugs and limited support capacities for the decentralized management of services. Despite those factors, the Bamako Initiative has had success in much of west Africa as well as in the Comoros, Madagascar and Mauritius as a strategy for revitalizing primary health care (PHC). A number of other countries have now initiated systemic reforms as a way of addressing these problems in social development. While positive results for children and women are yet to be realized, these sector-wide approaches may provide the starting point for building the capacity not only to address the needs of individual sectors, but to form wider partnerships for complex development challenges. Such partnerships will need to incorporate a vision of the role and responsibilities of the State in realizing the rights of citizens and meeting the needs of the most disadvantaged.

23. Sector-wide approaches, increased attention to public revenue raising and civil service reforms leading to improved pay and performance management are among the initiatives being taken by Governments to begin to address the structural factors that underlie the weaknesses of human development in Africa. International support is focusing increasingly on efforts to address such threats to children as malaria, unsafe water and HIV/AIDS. However, the key opportunities for a major revival of the prospects for Africa's new generations reside in the combined efforts of Governments and wider society. Such alliances, including for the sustained delivery of basic services and the protection of children and women, will need to be anchored in accountable relationships between the State and citizen's organizations, for which freedom of information and wider access to

technology will be important conditions. It is in such areas that, despite setbacks in political reform and economic performance in the late-1990s, the prospects for Africa's recovery are possibly most encouraging.

III. UNICEF RESPONSE: MAINTAINING PRIORITY FOR AFRICA

24. During the decade of the 1990s, UNICEF has responded to the organizational priority for Africa by strengthening its deployment of key resources. Staff numbers in sub-Saharan Africa rose rapidly after 1990 and peaked in 1995 at 42 per cent of total staff. In 1998, some 2,620 UNICEF staff were working in sub-Saharan Africa, compared to a total of 1,535 in 1990. The numbers in 1998 comprised 37 per cent of all UNICEF staff, compared to 32 per cent at the beginning of the decade. In 1998, these numbers included 28 per cent of the organization's international Professional staff, 40 per cent of the national officers and 38 per cent of the General Service staff.

25. Under the modified system for allocation of available general resources approved in 1997 (E/ICEF/1997/12/Rev.1, decision 1997/18), the share of the two sub-Saharan Africa regions in total general resources allocated to country programmes rose to 40.2 per cent in 1999, and is projected to increase further to 45.8 per cent by 2002. This compares with an average of 37 per cent of general resources in the period 1990-1998, with significant fluctuations throughout that period. The revised formula will place general resources allocations to Africa on a more consistent, as well as rising, basis.

26. In the first annual allocation of the 7 per cent of available general resources for programmes set aside for special allocation by the Executive Director, as per Executive Board decision 1997/18, the focus on Africa as the region of greatest need and priority was further reinforced. Some 65 per cent of the allocation from the set-aside was directed to programmes in sub-Saharan African countries, particularly for accelerated efforts in immunization, control of HIV/AIDS and malaria, and guinea worm eradication.

27. In agreement with funding partners, during 1997-1999, supplementary funds were allocated on a multi-country basis for a range of priority areas in sub-Saharan Africa, including for the eradication of guinea worm and polio, the elimination of iodine deficiencies, girls' education and the reduction of child labour. However, the direct availability of supplementary funds for country programme budgets approved by the Executive Board remains highly uneven among countries, and among programme areas within overall country cooperation.

A. UNICEF programme priorities in sub-Saharan Africa

28. The two UNICEF regions in sub-Saharan Africa have established clear sets of overall priorities for UNICEF work, within the scope and period of the current MTP. These have emerged from the reality of the trends affecting children and their rights at the country level, and will be adopted, in appropriate ways, through the country programming process in a majority of cases in each region. They will be the subject of intensive regional efforts, including resource allocation, multi-country fund-raising, regional office technical support, evaluation and monitoring. These regional priorities are intended to respond to the complex challenges for children's and women's rights in sub-Saharan Africa in a strategic manner, taking into account the most urgent needs, the underlying causes and UNICEF comparative advantage. This will continue to be based on an analysis of the factors affecting the realization of children's and women's rights, and of priority actions, in each country context.

29. In west and central Africa, the highest regional priority is given to the survival of children and improvements in child and maternal health, centred around the strategy of the Bamako Initiative for the revitalization of health systems and community participation. Immunization, vitamin A supplementation, safe motherhood, guinea worm eradication and local participation activities are major components of the Initiative. Regional strategies have been developed for the reduction of maternal and neonatal mortality, and will be supported in some 13 countries in collaboration with the World Health Organization (WHO) and the United Nations Population Fund if supplementary funding is secured. Activities for improved emergency obstetric care have been piloted in six countries. Advocacy, in alliance with national media, will promote increased commitment to maternal and child mortality reduction across the region.

30. The second major priority in west and central Africa will be the continuation of efforts to improve access to good quality basic education, especially for girls. Major achievements have been registered in specific areas in individual countries, such as the training of teachers, the establishment of school committees, textbook revision and provision, incentive schemes for the recruitment of female teachers, the training of educators on gender issues, social mobilization and policy development. These will be built upon and extended, with support from funding partners, and further attention will be given to improving quality and reducing drop-out rates. Innovative and non-formal methods of extending education opportunities will be sought, often as a bridge to formal systems. Work in these areas will be pursued throughout sub-Saharan Africa as part of the African Girls Education Initiative.

31. In eastern and southern Africa, many country programmes are now being reoriented to give highest priority to meeting the challenge of controlling HIV/AIDS, as a primary threat to securing human rights, and to assisting children and women affected both directly and indirectly. The second area of major priority in this region will be intensified efforts by UNICEF to support Governments and other stakeholders in the control of malaria as part of the "Roll Back Malaria" alliance of international partners. Each of these priority areas will provide close links to the reduction of maternal deaths.

32. Bringing the HIV/AIDS pandemic under control will be essential to the effectiveness of other key interventions for disease control, the reduction of malnutrition, and securing rights to basic education and protection. Based on an assessment of the impact of HIV/AIDS on children and of UNICEF comparative advantage within the framework of the UNAIDS alliance and country-level United Nations theme groups, the organization will focus its efforts in sub-Saharan Africa in five areas: prevention of HIV transmission among young people through broadly-based mobilization, communication and life skills education efforts in school and community settings; reduction of transmission from mothers to babies involving, in about a dozen countries, the provision of a minimum package of services to pregnant women, including voluntary and confidential counselling and testing, access to short-course drugs and support for informed choices in infant feeding; high-level advocacy for political action, including the mobilization of mass media, the dissemination of available data, contacts with policy makers and alliances with UNAIDS partners; advocacy and, where necessary, technical support for public safety nets and community-led programmes to ensure care and guaranteed access to basic services for orphans and children living in families affected by HIV/AIDS; and assistance to UNICEF staff members themselves through information, counselling and other forms of support.

33. Efforts in these areas were intensified in eastern and southern Africa and parts of west and central Africa in late 1998 with the preparation of pilot initiatives to reduce mother-to-child transmission of HIV in several countries with the support of funds from the United Nations Foundation. At the regional level, funds will be sought to support the acceleration of HIV/AIDS education in schools and to assess options for replacement feeding linked to the reduction of mother-to-child transmission. Efforts will be made to engage religious, private sector and regional organizations in actions to address the pandemic. Training in the design of programme interventions and advocacy to meet the challenge of HIV/AIDS will be held during 1999 for UNICEF senior staff in Africa.

34. It is fully recognized that HIV/AIDS, like malaria, is a problem directly threatening children's rights, which requires solutions based in processes of social change as well as in science and technical interventions. These processes will need to involve community-level analysis of the problem and will require the mobilization of facilitators and capacity-building for local action. The approach to external support in these areas will not be standard, and its design will need to carefully reflect and respond to local needs and perceptions.

35. With regard to the control of malaria, there is a more proven range of potential community-based actions, although the complexity of putting them in place on a sustained basis must also not be underestimated. Actions in eastern and southern Africa, for which further resources are being sought, include: the supply of impregnated bednets; building systems for bednet distribution and re-treatment; the training of health workers for improved case management; the study of drug resistance; and support to policy development and community mobilization. In west and central Africa, improved case management and community actions for malaria control will be supported under the Bamako Initiative.

36. A further priority for UNICEF in all parts of Africa will be to fully integrate preparedness and response to situations of instability and crisis in the regular country programming process. This is already being pursued in countries such as Burundi, Liberia and Somalia. Over the next few years, efforts for integration will include capacity-building among UNICEF staff to be able to meet a set of core organizational commitments in conditions of conflict to support the rights of children and women to basic services and protection.

37. Further support and advocacy will be needed for the demobilization and return to families and schools of child soldiers, and to raise awareness of the dangers of landmines and the trade in small arms. Support during and after conflict will continue to be provided for the care and counselling of unaccompanied children; family tracing and reunification; and the restoration of basic services, including education. UNICEF will remain active in all these areas, but its actions in response to crisis will need to be more predictable and systematic. They will also need to form part of longer-run efforts, within regular programme cooperation, to assist countries in restoring the social fabric, where this has been torn by conflict; to improve emergency assessment and preparedness planning; and to promote attitudes, practices and social institutions which recognize and protect the rights of children and women in all situations. Further areas in which these approaches will be needed include the prevention of child trafficking, drug abuse among young people and exploitative child labour. More broadly, UNICEF will seek to promote the respect of children's rights as a lever for building a stronger ethic for peace and reconciliation in societies recovering from the trauma of war.

38. Among the other programme priorities which form part of the MTP, attention will be given to the piloting of integrated approaches to the management of childhood illnesses in some 20 countries in sub-Saharan Africa. This will include health system interventions, communication for improved home care, case management training and planning for the availability of essential drugs. Linked to this, pilot efforts will be made to improve home and community care practices for the survival, growth and development of very young children in selected countries, including the C te d'Ivoire, the Gambia, Malawi and Namibia, and partnerships will be extended in this area with the World Bank. Sustaining immunization coverage, vitamin A supplementation in high-risk areas and the consumption of iodized salt, as well as support to breastfeeding and the reduction of maternal mortality, will all receive widespread support through country programmes. The Vaccine Independence Initiative.

which has had some success in achieving a more sustained supply of vaccines in the Sahel, will be gradually extended. In the short-term, priority will also need to be given to measles control, polio eradication and the replacement of depreciated cold chain equipment. In water and sanitation, the focus of UNICEF cooperation will continue to shift to support of improved hygienic practices, the testing of lower-cost technologies, the development of policies and partnerships, promoting the participation of women in community-based maintenance systems, and ensuring clean water and sanitation facilities in schools and health units. The challenging drive for guinea worm eradication will be continued, in close partnership with WHO, the United States Centers for Disease Control and Prevention, and the Global 2000 of the Carter Center.

39. UNICEF also will place increased emphasis on identifying the causes of major forms of violence against children and women, including female genital mutilation, and working with civic and women's groups, religious and community leaders to find solutions. Efforts to establish and improve laws, administrative codes and the work of institutions dealing with children's rights, including juvenile justice systems, will expand. Assistance to national partners in assessing progress in implementing the articles and applying the principles of the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women will be provided in appropriate forms in almost all African countries. UNICEF will also play a partnership role, as part of the concerned group of all United Nations agencies, in supporting national actions in the implementation of the Beijing Platform for Action.

B. Strategies and operational support for programme priorities in Africa

40. In support of these priorities in sub-Saharan Africa, and for other areas of priority within individual country programmes, UNICEF will develop, promote and utilize a combination of strategies. Drawing on experience from the 1990s, these will be based explicitly on a human rights perspective to cooperation and will stress the recognition of people who are poor, including children, as the key actors in their own development. Emphasis will be given to capacity-building, to enable and encourage communities to assess, analyse and take action, supported by Governments, in order to: reverse the AIDS pandemic, address its consequences; roll back malaria in the village or urban neighbourhood; and help secure good quality basic health services, primary education, clean water, environmental care and child protection.

41. These strategies of support will call for the construction of a broader range of effective partnerships among local, civil society, private, non-government and women's organizations, in alliance with government agencies. Work with district and municipal authorities has also been a successful strategy for child-focused programming, and will be continued. UNICEF will complement these local-level efforts through advocacy, analysis, social mobilization and, where necessary, support to national policy development, including in the context of sector-wide approaches. These activities will aim to create a more enabling and often less discriminatory social, legal and institutional environment for children and women within which community initiatives can take place.

42. With the limited resources available, and with major challenges ahead for the realization of rights to basic services, cost-effective approaches will need to be pursued in all areas of intervention. UNICEF regional offices and management teams in Africa, as elsewhere, will have a key role to play in the identification and verification of such approaches through such mechanisms as budget reviews and programme evaluations. The dissemination of promising experiences, and support to African countries and regional partners in gaining access to key sources of information and expertise on policy development for children, will be a further key role of UNICEF. Regional training activities for UNICEF staff will place increased emphasis on integrated planning approaches and the strategic role of operations functions in support of programme priorities. Greater sharing of technical expertise and administrative capacity among UNICEF offices in Africa, and with United Nations partners, is now taking place. Programme quality monitoring systems have been introduced in both regions in sub-Saharan Africa, and a procurement unit has been established in South Africa.

43. Monitoring of progress in key areas of outcome for Africa's children will take place through a series of end-decade surveys. In some cases, they will form part of wider national household survey exercises. In other cases, a second round of multiple indicator cluster surveys (MICS) is likely to be needed. In a number of sub-Saharan African countries lacking national data collection systems, these surveys, held initially at the mid-decade, provide virtually the sole source of social and household information. Additional indicators will be built into the new series of MICS, to be held in 1999-2000, to reflect new priorities and opportunities. In addition, a goal against which progress in the fight against HIV/AIDS can be readily measured will be established, possibly relating to the reduction of new infections among teenage girls.

44. Research and evaluation priorities for UNICEF in sub-Saharan Africa will also reflect the major priorities. Many of these will be pursued through periodic situation assessment and analysis of children's and women's rights, and in the context of MTRs. In particular, studies of knowledge, attitudes and practices regarding the causes and treatment of malaria will be extended following the striking results of the study in Zanzibar (reported to the Executive Board in document E/ICEF/1998/P/L.1). In collaboration with WHO, support will be given to training for controlled trials on decision-making for the use of anti-malarial drugs. Meanwhile, an evaluation will be held in 1999 of the regional Sara Communication Initiative, which incorporates support for AIDS awareness among older children.

IV. STRENGTHENING PARTNERSHIPS AND RESPONSIBILITY FOR CHILDREN'S RIGHTS IN AFRICA

A. UNICEF partnerships

45. As discussed throughout the present report, effectiveness in partnerships will be an essential aspect of short-term and sustainable development outcomes for Africa's children, both as a means of maximizing resources and to strengthen the platform for coordinated action. The UNICEF contribution to renewed human development in Africa has been pursued through a combination of partnerships anchored in country programmes of cooperation and alliances based around key issues for global and regional advocacy, such as the banning of landmines, the elimination of exploitative child labour, the reduction of violence against women, and the prioritization of donor and government budgets towards basic services. This approach will be continued with national partners, global allies and African regional organizations, such as OAU and the Federation of African Women Educationalists, as well as with the Save the Children Alliance, particularly on issues related to the Convention on the Rights of the Child, and with the Inter-African Committee on the Elimination of Harmful Traditional Practices on the issue of violence against women and girls.

46. The deteriorating socio-economic situation of the continent has been a constant preoccupation for the United Nations in recent years. Initiatives to address this in which UNICEF has participated, have included the United Nations Programme of Action for African Economic Recovery and Development and its successor, the United Nations New Agenda for the Development of Africa in the 1990s. UNICEF continues to cooperate with the World Bank, WHO, the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Development Programme and others in key areas of activity of the United Nations System-wide Special Initiative on Africa, launched in 1996. Efforts in basic education, for example, aim to concentrate inter-agency efforts to help improve the situation of 16 sub-Saharan African countries with very low primary school enrolment rates through the development of sector investment programmes. UNICEF is working closely with UNESCO and the World Bank in this initiative for Low Enrolment Countries and is providing advice to the design process, including for components related to the education of girls. African leadership of the Special Initiative on Africa has been registered by the adoption by ministers of health of the framework for health sector reform, and by education ministers through the Association for the Development of Education in Africa. However, the Initiative is constrained by weaknesses in country-level implementation and the lack of additional resources. Recent efforts by coalitions of international agencies, including UNICEF, to generate support for accelerated efforts by African countries to combat HIV/AIDS and malaria are expected to provide new impetus. The increasing adoption of the United Nations Development Assistance Framework and related mechanisms, such as United Nations country theme groups, will support the effective collaboration of United Nations agencies for children's and women's rights and in priority areas for action such as these.

47. There are promising signs that bilateral aid donors may be increasing the priority given to Africa, creating further opportunities for partnerships. Emerging trends also suggest that more emphasis will be placed by both bilateral and multilateral agencies on longer-term and multisectoral as well as sector-wide approaches, and on interventions that assist countries in building capacity for sustained access to basic services among families which are poor and marginalized. These trends will create further opportunities for UNICEF to provide value-added in the social development process based, for example, on its experience in support of participatory, community-led approaches and its cross-sectoral focus on the survival and growth of children.

48. UNICEF has found a particular convergence of concerns with OAU on the anti-war agenda and issues of conflict resolution and humanitarian assistance directly relevant to children and women. This partnership has provided important opportunities for advocacy, particularly with African Heads of State at their annual summits. Following the adoption of an OAU resolution on the use of landmines in Africa in 1998, UNICEF advised on a campaign for a total ban on landmines in Africa and advocated for ratification of the Ottawa convention in a number of countries. OAU also passed in 1998 a resolution banning the use of children as soldiers, while collaboration with OAU enabled the relaxation of access restrictions for essential humanitarian supplies during the imposition of sanctions on Burundi. UNICEF contributed to the drafting of the plan of action for the African Decade for Education, launched by OAU in 1997, and will support its implementation. UNICEF is also giving increased priority to promoting the wider ratification of the African Charter on the Rights and Welfare of the Child. Meanwhile, work has continued with the Economic Commission for Africa in the production of a series of analyses of social development trends in Africa. Cooperation with specific sectors of the Southern African Development Community has also been increased through support to policy design and capacity development in HIV/AIDS, sanitation and hygiene. Regular consultations with the African Development Bank (AfDB), and collaboration with AfDB-funded projects, such as in the health sector in Senegal, will be continued.

B. African leadership for children's rights

49. The strengthening of national administrative structures for the delivery of basic services will be a key element of development progress in many countries of sub-Saharan Africa. An end to conflict, accountable political systems, a fair and functioning judiciary, open debate on policies and high levels of participation of women and civil society will further support sustained economic growth and broad-based human development. They will also provide a basis for more effective action against the HIV/AIDS pandemic and its corrosive effects on children's rights. Responsibility will rest primarily with African leaders.

Governments and civil society to work towards such conditions.

50. Over the last few decades, African countries which have given priority and consistent attention to investing in human development have tended to see the benefits of increased economic growth and, where these measures have been sustained, falling levels of household poverty. Recent reforms of health and education systems in countries such as Ethiopia, Ghana and Zambia, and initiatives to rapidly expand access to primary education in Malawi and Uganda, hold the promise of improved care, learning achievement and human development outcomes. Major efforts for awareness-raising and public education on HIV/AIDS have begun to make an impact in Uganda. However, such approaches are not yet sufficiently widespread in sub-Saharan Africa. The more general pattern remains that of declining levels of investment in basic services, with often dramatic shortages of funding at district and municipal levels.

51. The responsibilities adopted by State Parties to the Convention on the Rights of the Child are now widely recognized and understood. It seems not unreasonable to suggest that a lack, in many countries, of public action to address major shortfalls in the rights of children, such as the absence of primary school places and of protection from violence, and the failure to openly confront threats to life such as HIV/AIDS, are indications of inadequate political commitment to the realization of these rights. Furthermore, without a norm of peace and freedom from conflict, guaranteed by political will and underpinned by regional cooperation, the basis will not fully exist for ensuring that children's rights are protected and fulfilled.

52. None the less, Government and civil society in a number of countries are now working together to place greater emphasis on children's and women's rights. This has been reflected in the introduction of measures to combat female genital mutilation, new provisions on violence against women, increased attention to girls' education and revisions of the constitution or legal code. Recent children's acts adopted in several countries in sub-Saharan Africa have increased the legal age of responsibility of children and provided them with protective measures through juvenile courts. Enshrining the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women in a comprehensive legal framework, combined with measures to improve the quality of, and access to education and health services, will provide a key part of the foundation for the realization of human rights.

C. Africa's partners in development

53. Although the central task of Africa's development rests primarily with its people and leaders, the international community bears a responsibility both to support the continent in its development efforts and to remove obstacles in the way of progress. With a changing focus which places greater emphasis on good government and stability, the potential exists for those countries which are reforming their political and social systems to achieve sustained growth with widespread benefits. For this to happen, Africa's partners must renew their support to the region and improve the global conditions for its development.

54. A first component of this renewed support must be a reversal in the decline in official development assistance (ODA). As a proportion of the output of industrialized countries, ODA now stands at less than one third of the target of 0.7 per cent of gross national product. The absolute amount of assistance has declined as well - by nearly 5 per cent per year since 1992. At a time when more sub-Saharan African countries are taking reform initiatives, opportunities are being missed for effective international support to this process.

55. Linked to the amount of ODA are the targeting and composition of assistance. The access of all people to basic education opportunities, health services and safe water is recognized as not only key to sustained human development and poverty alleviation, but, increasingly, as a normative issue of human rights. Investment in such services is central to reducing the worst manifestations of poverty and breaking its vicious, inter-generational cycle. The 20/20 Initiative, agreed at the World Summit for Social Development in 1995, provides a framework for translating this need for increased resources into reality. With commitment and better targeting, including to strategies for national and local capacity-building, the contribution by both Governments and international partners to basic services could increase substantially in Africa.

56. Increasing ODA and targeting it better will be of limited benefit, however, if African countries continue to be saddled with large debt burdens. For every dollar that sub-Saharan Africa received in ODA in 1996, it paid out $1.31 in debt service. The external debt of African countries rose from $340 billion in 1996 to $349 billion in 1997, representing more than 200 per cent of annual exports. Spending on debt servicing is higher than that on basic services in a number of African countries, often by a wide margin. An example is Zambia, where average annual spending on education amounted to $82 million between 1993-1996 compared to some $335 million per year in debt payments.

57. A further component of renewed support to sub-Saharan Africa is to enable resources freed by debt relief to be allocated in favour of basic education, PHC, safe water and other poverty alleviation measures. The Heavily Indebted Poor Countries (HIPC) initiative, developed under the auspices of the International Monetary Fund (IMF) and the World Bank, aims to achieve sustainable levels of debt service by providing relief not only of the bilateral debt burden, but also of debt owed to international financial institutions. Two years after the launch of the initiative, however, only Uganda has actually benefited from relief. IMF and the World Bank recently decided to extend the HIPC initiative and to ease the criteria for inclusion. There remains an urgent

need for these measures to be extended by granting deeper and earlier relief and to free additional national resources for human development. Support to local efforts to address the HIV/AIDS pandemic would be a priority use of such funds.

58. Africa's share of world trade continues to decline, shrinking to 1.9 per cent in 1997, reinforcing the continent's marginalization in the global economy. Although past experience has not been encouraging, renewed efforts are needed to diversify African economies, and both Governments and their international partners have important roles to play. Improving market access for Africa's exports and investing in business skills and access to information technology among students are relevant areas, which could involve the local private sector.

59. While the resolution of the conflicts affecting Africa is the primary responsibility of African leaders, the international community should not ignore the plight of millions of refugees and displaced people and the moral issues posed by suffering and insecurity on the continent. Political reform efforts can be facilitated through the building of experience among parliamentarians, civil servants, civic leaders, soldiers and police, including for practical measures to safeguard the rights of both children and women. The international community can assist with technical expertise and funds to encourage the development of democratic institutions, as seen in Mozambique and Namibia. The international ban on landmines needs to be fully enforced, while the proliferation of weapons needs to be stemmed and small arms everywhere kept out of the hands of children.

60. Lastly, the lessons of past experience, the trends towards sector-wide and more integrated approaches to development assistance, and the existence of a series of ratified international human rights conventions and world summit declarations from the 1990s place a responsibility on all development partners, including UNICEF, to achieve well coordinated efforts in support of the priorities and urgent needs of African countries. There is a greater potential for success when Government and partners have formed consensus on priorities, the strategies to address them and the most effective roles of different partners. The major areas of threat to the rights of African children and women described in the present report, including HIV/AIDS, malaria, conflict and the persistent weakness of public health and basic education systems, provide critical tests for effective and responsible partnerships in the years ahead.

V. CONCLUSION

61. The priority areas identified and being pursued for UNICEF work in sub-Saharan Africa in the period of the current MTP also provide a link to the proposed new agenda for children in the next decade, which will be based on human rights principles (see E/ICEF/1999/10 being submitted to the Executive Board at the present session). Conflict and insecurity, the weaknesses of institutions, low access to basic services, and the dramatic challenges of HIV/AIDS and malaria pose the greatest current threats to children's and women's rights and well-being. In many countries and local contexts, the greatest priority actions for UNICEF and partners will be, for the foreseeable future, to ensure children's and women's survival. Conflict and HIV/AIDS are factors that intensify that priority for action, while making it clear that sustained improvements will only be achieved through strategies which address the deeper causes of childhood and maternal deaths and disadvantage.

62. At the same time, the basis for future recovery and sustained development must be laid through intensified and more effective efforts, by a dynamic range of partners, to invest in the capabilities of Africa's children. The priority given by UNICEF in Africa will be to support: the strengthening of basic health care systems for child and maternal survival; the access of all children, especially girls, to good quality basic education and learning opportunities; the strengthening of community capacity and practices for the protection of women and children; the promotion of non-violence, gender equity and post-conflict recovery; and the identification of viable approaches to improved family and community care for the survival and development of young children, including those affected by HIV/AIDS. All these provide building blocks for Africa's participation in a new era based on ethical principles and responsible partnerships, which place the rights of children and women first.

Good Lyrical Reality Rhyme

Health, Demographic Change, and Economic Development in Africa

David Bloom
David Canning

Harvard Institute for International Development

March 10, 1999

Health, Demographic Change, and Economic Development in Africa

David Bloom and David Canning
Harvard Institute for International Development

Executive Summary

1. Health improvements are desirable in themselves, in terms of the improvements they bring in well-being, but they also have a direct impact on productivity and economic performance. Health improvements are not a luxury good that should await economic development; rather, they are a major factor in determining economic growth. Increased life expectancy and reduced fertility rates have a large positive effect on the growth rate of GDP per capita. Likewise, Health improvements have the potential to make a major contribution to a successful economic growth strategy in Africa.

2. The attached table sets out our estimates of the effect of health improvements on the growth rate of GDP per capita in each African country. We find large effects of increasing life expectancy from current levels to the world average of 65 years. This would increase the growth rate by more than 2 percentage points per year in some countries. Even in countries that are already above the world average level of life expectancy, further improvements would continue to have significant effects.

3. Lower fertility rates increase economic growth through increasing the ratio of working-age people to dependents. The attached figure plots the ratio of workers to dependents in Africa based on different United Nations population projections. In the table we report the estimated size of the effect on economic growth using United Nations projections assuming low, medium and high fertility. If fertility can be reduced to the level assumed in the United Nations low fertility projection the demographic gift can be quite large, adding over 1 percentage point per year to the growth rate in some countries.

4. These results imply the existence of a "demographic gift" to countries which achieve low fertility rates, but such a gift is not automatic. First, of course, it requires policies that encourage fertility to fall. In addition, economic policies must be formulated so as to allow the potential effects of demographic change to be realized. In the table we compare the effect of the "demographic gift" if a country sets policies that are as good as the world average values with the effect assuming the continuation of the policies that have been in place for the last 25 years. We find that poor policies can lead to the dissipation of most, or all, of the demographic gift.

5. The feedback from rising living standards to further improvements in health and reductions in fertility sets up the possibility of a virtuous cycle of cumulative causation.

6. We conclude that improvements in both general health and reproductive health are likely to be important parts of a successful growth strategy in Africa. Policies may include public health measures such as providing clean water and sanitation and inhibiting the transmission of malaria and HIV/AIDS as well as from improvements in the clinical health care system. The economic benefits from improved health are likely to be realized only if general economic policies are growth oriented.

Discussion

There is no doubt that good public health measures, a high quality health care system, and the benefits of a healthy population are desirable goals in all countries, including those in Africa. The difficulty is that in developing countries there is a tension between spending scarce resources on welfare projects, aimed at increasing well-being today, and investing in projects aimed at economic growth, which may increase the capacity to deliver welfare improvements in the future. In such an environment health care may be assigned a relatively low priority.

Recent economic research challenges this assessment. One of the most robust findings in economics is that, holding everything else constant, countries with higher life expectancy have significantly higher rates of growth of GDP per capita. We will discuss below why this is so by looking at the mechanisms through which higher life expectancy can increase economic activity. However, the main point is that increases in life expectancy, usually thought of as an indicator of the general health status of the population, are associated with subsequent long-run economic growth. This raises the prospect that a healthy population is not a luxury good, to be achieved when it can be afforded, but is, rather, a major determinant of economic growth and may be considered more as an investment good.

A similar story can be told for family planning activities and reproductive health. In the 1960s there was a general consensus on population pessimism, based on the idea that a high rate of population growth puts pressure on resources within a country and leads to a decline in the rate of economic growth. However, a large literature in the 1970s and 1980s largely failed to find a link between population growth and economic growth, leading to a significant weakening of the argument that family planning is an essential tool for generating growth in developing countries. Instead the policy emphasis has shifted to reproductive health as a way of directly increasing well-being, particularly women's wellbeing, with less weight being placed on the possible effects on economic growth.

Why Health and Demography Matter for Economic Growth

The rejection by most economists of population growth as a determinant of economic growth may have been premature. The problem is that the old literature failed to take account of the fact that there are two sources of rapid population growth, high fertility rates and low mortality rates. Low mortality rates lead to higher life expectancy, and have a beneficial effect on economic growth. On the other hand, a high fertility rate increases the youth dependency rate, the ratio of dependents to those of working age, and tends to reduce the rate of economic growth. Thus, it is not the total population growth, but the source of the growth that matters.

The important feature in population growth is not the overall rate of population growth but changes in the age structure of the population. Low mortality rates tend to increase population growth but the primary effect is to raise the numbers at older ages and to increase life expectancy. Improved health, as indicated by an increase in life expectancy, can increase economic growth by directly affecting labor productivity. In addition, a longer life expectancy can generate a need for retirement income, increasing savings rates during the working life.

Further, lower mortality rates increase the expected duration of working life and can raise the return to, and demand for, education. These effects all combine to encourage economic growth. Although there is clear evidence for such a growth effect, it is not yet possible to pinpoint which mechanism is most important empirically.

Eventually an increase in life expectancy raises old age dependency rates and may put a burden on social security systems. This problem is still remote in Africa and is just beginning to emerge in East Asia. To a large extent this issue only arises under a pay-as-you-go pension system in which the dependent old are reliant on the payments of current workers. In fully funded systems the old get retirement income from their accumulated savings. Channeling retirement savings into productive investment may not only be a good growth strategy, it may also avoid the financial problems a transfer-based pension system faces when the old age dependency rate increases.

Column 1 of the attached table shows the estimated impact on growth rates of GDP per capita if countries in Africa manage to raise their life expectancy levels to 65, the current world average. The effects in some countries are very large, giving an increase in growth rates of GDP per capita by around 2 percentage points a year. Some African countries have already achieved life expectancy in excess of 65. For these we do not report an impact figure but empirical results suggest that the growth effects of raising life expectancy persist even at high levels of life expectancy.

Reductions in fertility slow the rate of population growth but more importantly they lower the ratio of the young to the working age. The attached figure plots the ratio of working-age to non-working-age population in Africa using different population projections from the United Nations based on different assumptions about how fast future fertility rates in Africa fall. The ratio of working-age population to dependents is set to rise in Africa from now onwards, giving a boost to per capita incomes. If fertility rates fall as fast as is assumed in the United Nations low fertility scenario, the ratio of workers to dependents is set to rise from 1.15 today to around 1.7 in 25 years time.

The table at the end of this summary shows the effect of the "demographic gift" on economic growth for the low fertility, medium fertility and high fertility United Nations projections for African countries. The predicted effect depends on how fast the age structure of each country is projected to change. In addition, the growth impact is estimated to be larger than the pure accounting impact of the reduced dependency rate. This may occur for several reasons. For example, less time is required for child care, perhaps leading to increased labor force participation, and smaller families may allow greater investment in education per child, raising average human capital.

In addition to these effects of health and the demographic transition on economic growth there is reverse causality: economic growth, higher income levels, and higher levels of education (particularly female education) affect health, life expectancy, and fertility rates. At a technical level this raises a problem: we must be careful to establish the direction of causation, as well as a simple statistical correlation, in our analysis. Taking account of this requires that we isolate the feedback pathways in each direction.

More importantly, the presence of positive feedback raises the possibility of a virtuous growth spiral, with cumulative causality. Improvements in health lead to increased life expectancy. In addition, reductions in infant mortality can reduce the desired fertility rate due to higher survival probabilities and to a lower risk of being without care in old age. Provision of reproductive health services can help to ensure that these reductions in desired fertility lead to reductions in actual fertility. These changes in health, mortality rates, life expectancy, and fertility can be powerful forces in favor of faster economic growth. In turn, economic growth, coupled with increases in education, can promote improvements in health and reductions in fertility. This can give rise to another round of growth, and so on.

Policy Effects

The demographic gift is not automatic; it requires health improvements, including improvements in reproductive health, to generate demographic change. The effects of demographic change are largely seen in people's increased desire to work, to save, and to be educated. To realize the potential of these effects appropriate polices and institutions must be in place. Labor markets must be capable of absorbing an increasing labor force. Financial markets must be able to channel savings into productive investment. The education system must meet the demand for increased education.

The estimates of the effects of the demographic gift in columns 2, 3, and 4 of the attached table are based on each country having polices and institutions that are as good as the world average. The policies we focus on are openness (a measure of tariff rates, etc.) and government deficits. We use as a measure of institutional quality a composite index (representing the rule of law, lack of corruption, etc.). In column 5 we report our estimate of the impact of the demographic gift (United Nations medium projection) if countries follow the same policies as in the past. For all the African countries for which we have data the demographic effect is smaller, sometimes much smaller, assuming the continuation of the policies and institutions that have been employed over the last 25 years, than if policies were changed to the world average levels. Note that the difference between columns 3 and 5 is due to the impact of the demographic gift under different policy scenarios. Improving policies and institutions will have a large positive effect on growth on their own, independently of the effect of the demographic gift. Good policies are always beneficial, but they are particularly important during the demographic transition from a low life expectancy, high fertility country to a high life expectancy, low fertility country.

Conclusion

It is important to take a balanced view of economic growth and development. It is highly unlikely that there is one single factor that drives the growth process. Health, and its impact on age structure, can be an important factor, but it is not the only one. A growth policy that focuses only on one mechanism is certain to be too narrow. The argument for putting some emphasis on health and age structure as factors that affect growth is the large magnitude of the growth impacts we find from these variables in empirical studies.

Africa's demographic transition is just beginning and presents countries with an opportunity to accelerate their economic growth. The picture we see of rising life expectancy in Africa and falling fertility rates, together with increases in the working-age to non-working-age ratio, presents an opportunity to generate substantial improvements in Africa's economic performance. To take advantage of this opportunity countries must have appropriate public health policies and reproductive health policies. In addition, the "demographic gift" such policies generate can only be realized fully if labor, financial, and educational markets and institutions function well.

The appropriate health policies to generate the demographic transition are not entirely clear cut. It may be that large-scale health improvements are more closely connected to public health projects such as the provision of clean water and sanitation than to direct provision of health services. In addition, Africa faces two infectious diseases on a large scale, malaria and HIV/AIDS. Although HIV/AIDS may not be projected to have a large impact on total population numbers, it may have an effect on economic growth by removing prime-age workers from the labor force and increasing dependency rates. Tackling these diseases may require international coordination of research and of containment strategies given the obvious problem of international spillovers. It may be very difficult for one country to make much headway in combating these illnesses unless neighboring countries are also active in the effort.

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.

DEBT OWED THE U.S. BY HIPC AFRICAN COUNTRIES

	DEBT (millions of US$)	NUMBER OF PEOPLE WITH HIV/AIDS
ANGOLA	35.0	111,000
CENTRAL AFRICAN REPUBLIC	9.4	180,000
COTE D'IVOIRE	378.2	700,000
DROC	2,079.6	950,000
ETHIOPIA	90.1	2,600,000
GHANA	16.0	210,000
KENYA	126.1	1,600.000
MADAGASCAR	32.6	8,600
MALAWI	0.0	710,000
MALI	0.0	89,000
MOZAMBIQUE	49.3	1,200,000
RWANDA	1.3	370,000
SENEGAL	17.3	75,000
SUDAN	1,202.1	140,000
TANZANIA	34.9	1,400,000
UGANDA	2.6	930,000
ZAMBIA	278.0	770,000

DEBT OWED TO THE U.S. BY NON-HIPC AFRICAN COUNTRIES

BOTSWANA	24.0	190,000
NIGERIA	897.4	2,300,000
SOUTH AFRICA	143.6	?
ZIMBABWE	204.6	1,500,000

Prepared by the Office of AIDS Research, NIH
November 24, 1998

ACTIVITIES IN AFRICA

(This submission is inclusive of NIH efforts except for those funded by NIAID, which will comprise a separate document developed by NIAID.)

The National Institutes of Health (NIH) supports an comprehensive program of basic, clinical and behavioral research on HIV infection and its associated opportunistic infections and malignancies. The global nature of the HIV AIDS epidemic underscores the critical need to identify interventions that will be of use in developing countries. In this regard, the NIH supports a variety of research efforts conducted in Africa, where the epidemic began and is continuing to ravage many nations. According to the UNAIDS statistics released today, 34 people in sub-Saharan Africa have been infected and almost 12 million of them have already died. Last year alone there were over four million new infections.

Ongoing and planned NIH-supported studies in various parts of Africa are focusing on perinatal intervention studies, testing of potential microbicides and behavioral interventions, protection of the blood supply, and training and infrastructure development. Most of these studies are conducted collaboratively between U.S. and African investigators. In addition, the NIH Institutes and Centers work collaboratively to fund studies in Africa.

Mother to Child Transmission

Preventing transmission from HIV-infected mother to child is a priority of NIH intervention research. 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 NIAID.

Ongoing NIH efforts are designed to identify and test other interventions that can be used effectively and easily in diverse cultural and economic settings to further reduce the incidence of mother to child transmission. These include studies in several countries in Africa:

- NCI-funded study in Malawi to determine the role of vaginal lavage and baby washing in decreasing HIV transmission during birth;
- NICHD-funded studies in Tanzania and Malawi on the effects of vitamin A and multivitamins on decreasing vertical transmission and in Rwanda on whether vitamin A supplementation can effect outcomes for infected children;

- NICHD and NIAID-funded study in Uganda on the use of HIV-1 hyperimmune intravenous immune globulin to decrease transmission;

- NICHD-funded studies in Kenya related to prevention of transmission through breast-milk, including use of formula compared to breastfeeding, early weaning, active/passive immunization during breastfeeding, and the relationship between HIV viral load and transmission;

- NICHD-funded study in South Africa on the role of mucosal immunity in preventing transmission through breastfeeding;and

- NICHD and NIAID-funded study in Kenya to determine the relationship between genital shedding of HIV and intrapartum transmission of HIV.

Prevention Interventions

NIH sponsors an extensive biomedical and behavioral program for the discovery, development, preclinical testing, and clinical evaluation of topical microbicides and other female-controlled barrier methods for prevention of HIV transmission. Population-based research is essential to ensure both the efficacy and acceptability of these interventions to decrease or eliminate HIV transmission. It is an NIH priority to develop safe, reliable, acceptable, and inexpensive contraceptive and non-contraceptive microbicides for the prevention of HIV and other STDs. NIH activities in this area include:

- NICHD-supports several phase 1-3 clinical trials in African nations to determine the safety and efficacy of potential microbicidal substances in various populations including, a study of new formulations of Nonoxynol-9 in Kenya.

- In FY 1999, NICHD will initiate new and expand existing programs to accelerate the testing of potential spermicidal microbicides as well as other female-controlled physical barrier methods. Several of these studies will be conducted in Africa.

- NIMH is supporting a study in Uganda on the relationship between sexual behaviors, education, work histories and HIV status in adolescent women. The study will help to develop more effective HIV interventions for this target group in Uganda.

- In FY 1999, NIAID will establish the HIV Prevention Trials Network that will focus on the testing at U.S. and international sites including Africa of various interventions including microbicides. Other ICs will co-fund studies conducted at these sites. NIAID also will expand the Topical Microbicide Program Projects involving multidisciplinary research to develop and test new agents such as PRO2000, lactobacillus and PMPA.

Blood Supply Safety

The NIH is developing with WHO and other Federal government agencies a new initiative

targeted to improve the safety of the blood supply to reduce the incidence of blood-borne transmission of HIV. While this effort is still in the early stages of planning, it is hoped that NIH supported efforts to provide appropriate training for blood transfusion center personnel in HIV testing, including the rapid HIV assays, can ultimately result in protecting the blood supply of African nations.

Research Training

It is critical to the success of international studies that foreign scientists be full and equal partners in the design and conduct of collaborative studies and that they have full responsibility for the conduct of studies in-country. To help build research capacity in developing countries, the FIC funds the AIDS International Training and Research Program (AITRP). The AITRP provides research training to foreign scientists through grants to U.S. universities. During the first nine years of the AITRP, more than 450 scientists from Africa were trained through the program. AITRP is active in Botswana, Cameroon, Cote d'Ivoire, Ethiopia, Kenya, Malawi, Mozambique, Senegal, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe.

Anthony Fauci,11/24/98 1:11 PM -0500,White House request 1

From: Anthony Fauci <AFAUCI@flash.niaid.nih.gov>
To: "Varmus, Harold <hv2b>" <hv2b@nih.gov>
Cc: Anthony Fauci <AFAUCI@flash.niaid.nih.gov>,
Neal Nathanson
<nathansn@mail.med.upenn.edu>
Subject: White House request
Date: Tue, 24 Nov 1998 13:11:18 -0500
MIME-Version: 1.0

Harold:

I am listing below some areas of NIH AIDS research in Africa that can be submitted to Chris Jennings for the President. These all relate predominantly to NIAID activities. I spoke with Neal Nathanson and he will be sending you separately some items that encompass some of the other NIH ICs. If you have any questions, please give me a call.
Tony

Background:

Over the past decade the NIH has supported HIV research in more than 15 African countries. Initial projects focused on development of infrastructure and studies on the epidemiology and the regional characteristic of HIV/AIDS. More recently the research has emphasized the development of cost-effective interventions to control the spread of HIV/AIDS. The targeted interventions include development of HIV vaccines, physical barriers, microbicides and behavioral interventions to prevent sexual transmission, drugs and microbicides to prevent perinatal transmission, and treatment of sexually transmitted diseases (STDs) to reduce susceptibility to HIV infection.

Several important large-scale prevention trials of HIV interventions have been undertaken or completed, such as the following:

* Evaluation of the effect of community treatment of STDs on sexual transmission of HIV. This may provide an inexpensive way to decrease sexual transmission of HIV.

* Studies on the effect of washing the birth canal and the newborn with the common antiseptic chlorhexidine to prevent perinatal transmission in Malawi. Although this study did not have an effect on HIV transmission, it demonstrated a substantial reduction of neonatal bacterial infections.

* Demonstration that peer counseling reduces the risk of HIV infection in factory workers in Zimbabwe.

New African Projects that could be highlighted:

* First clinical trials of candidate HIV Vaccine to begin in Africa next year. NIAID/NIH supported scientists, in collaboration with Ugandan scientists, UNAIDS and other groups plan to initiate clinical trials of a candidate HIV vaccine early next year. If results from this one-year study are encouraging, they could speed the development of vaccines for Africa.

* NIH has significantly enhanced the research infrastructure in Central Africa. This effort includes the establishment of a reagent repository for HIV/AIDS, training facilities for researchers and public health specialists, as well as enhanced research laboratory capacity in the region. This NIH contribution has greatly assisted local public health authorities to confront the epidemic. This is especially so in countries such as Uganda where control of STD and HIV has improved through the introduction of improved STD control efforts (use of condoms), documentation of cases and behavioral interventions. This effort will have important spillover effects on other important infectious disease problems in the region, especially for tuberculosis.

* Established an HIV Vaccine Initiative in Southern Africa. NIH efforts have led to the establishment of a consortium of investigators from South Africa, Zambia, Malawi, Zimbabwe and their US collaborators to conduct the necessary baseline studies to develop a vaccine to combat the subtype of HIV that causes AIDS in this region of Africa. The project includes the support of a regional African laboratory to conduct the critical immunologic and virologic studies.

* Supported Clinical Trials of Topical Microbicides to Prevent HIV Transmission. In 1999 the NIH, through the HIVNET, will support a series of clinical trials of microbicide products that women can use to prevent sexual transmission of HIV. Investigators from Malawi and Zimbabwe will determine the effectiveness of common spermicide Nonoxynol 9 in a high dose gel formulation. Early clinical studies of a new generation microbicide, Pro 2000, that blocks binding of HIV to vaginal mucosal cells are scheduled to begin in South Africa in mid-1999.

* New Studies on Prevention of Mother-Child Transmission of HIV. In 1999 the HIVNET will undertake several new clinical studies in Uganda, Malawi, Zambia, Zimbabwe and South Africa that are aimed at identifying simple, inexpensive methods to prevent transmission of HIV from mother to child. The interventions include anti-HIV drugs, microbicides and HIV vaccines. Studies in Ethiopia, South Africa and Zimbabwe will also evaluate methods that prevent transmission by breast milk.

Sandy,

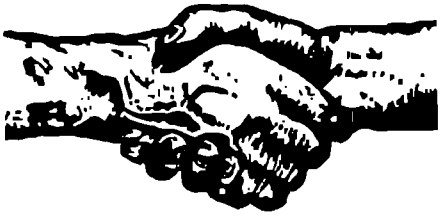
Cheryl called me this evening to say that treasury had called and wanted to meet on friday at 11:00am. Unfortunately, I had just told Marian that I would do a "where do we go from here on juvenile justice" meeting at CDF from 10:30-12:30. I dont really think it is worth having Cheryl try to get them to change it -- if it is going to just be me anyway. Hard for me to go on about how important this is to the prez. Perhaps you could call him from the plane during that time. What do you think?

Attached is the stuff from AID. We did not actually get this officially from them -- but from our friends in Zambia. It is circulating internally at AID. If you talk with the treasury guy, it seems worth talking both about debt forgiveness and about what the US might encourage the World Bank to do -- given that that is his official role over there, right?

Call me if you get the chance. I'll be on the hill most of the day.

Cheers,
Love, Michael
xo

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.

815

Ms Sandy Thurman
518

AIDS IN AFRICA IS A SERIOUS CRISIS
BUT OPPORTUNITIES EXIST FOR HELPING TO SAVE MILLIONS OF LIVES

AIDS IN SUB-SAHARAN AFRICA IS A GROWING DISASTER

- In sub-Saharan Africa, between 16% (South Africa) and 32% (Zimbabwe) of the adult population (15 to 49) is already HIV+.
- UNAIDS has declared HIV/AIDS in Africa an "epidemic out of control." Each and every day, more than 16,000 additional people become HIV+; most live in sub-Saharan Africa. In South Africa alone, each day 1,500 people become HIV+.
- 83% of AIDS deaths to date -- nearly 10 million -- have been in sub-Saharan Africa.
- There are over 5,500 funerals a day in Africa for people who have died of AIDS.
- By 2010, more than 40 million children will be orphaned by AIDS; 95% in sub-Saharan Africa.

AIDS IS REVERSING DECADES OF PROGRESS IN SUB-SAHARAN AFRICA AND STANDS AS AN OBSTACLE TO ALMOST EVERY DEVELOPMENT OBJECTIVE.

- In the coming decade, AIDS will reduce life expectancy in sub-Saharan Africa by 20 years, bringing life expectancy in South Africa from 60 to 40 years, in Zimbabwe from 65 to 39 years, in Uganda from 54 to 43 years, and in Zambia from 56 to 37years.
- In the coming decade, AIDS will double infant mortality (infants under the age of 1) in many sub-Saharan Africa countries and triple child mortality (children ages 1 to 5).

AIDS WILL NOT ONLY BRING UNFATHOMABLE HUMAN SUFFERING BUT WILL JEOPARDIZE THE ECONOMIES, THE STABILITY, AND CIVIL SOCIETY OF MANY SUB-SAHARAN AFRICAN NATIONS.

- According to *The Economist*, a recent study in Namibia estimated that AIDS cost the country almost 8% of GNP in 1996. Another analysis predicts that Kenya's GNP will be 14.5% smaller in 2005 than it would have been without AIDS, and the per capita income will be 10% lower.
- A report released by the World Bank last week states: "The question is, will this pandemic destroy the developing nations' hard earned economic gains or will governments get their act together in time? Clearly time is running out."
- Reports are that HIV/AIDS has hit professionals hard in sub-Saharan Africa, with a serious impact on civil servants, engineers, teachers, miners, and military personnel. According to one World Bank study, 34% of people with post-secondary education were HIV+, compared to 18% of those with a primary education, and civil servants were more than three times more likely to be HIV infected as farmers. Increased insurance and training costs, and disruption due to sick and bereavement leave is seriously affecting both the private and public sectors. Because advancement into management often requires an HIV test, fear of being fired often makes skilled workers remain in low level positions.
- It has been reported that most sub-Saharan nations have a high HIV prevalence in their militaries, including an estimated 80% in Zimbabwe. US military officials have raised this as a serious stability concern. Uganda, the AIDS success story, turned its epidemic around because President Museveni realized during the revolution that a high percentage of his soldiers were HIV+. When he became President he lead an all out war on the virus.

- A South African anti-crime institute has linked the growing number of children orphaned by AIDS to future increases in crime and civil unrest. Without appropriate intervention, many of the 2 million children projected to be orphaned by AIDS in South Africa will raise themselves on the streets, often turning to crime, drugs, commercial sex, and gangs for survival. This not only effects social stability but dramatically increases their risk of HIV.

THE AIDS PANDEMIC IN SUB-SAHARAN AFRICA FORESHADOWS WHAT LIES AHEAD IN ASIA, INDIA, AND THE NEWLY INDEPENDENT SOVIET STATES.

- According to UNAIDS, the worst is yet to come -- and sub-Saharan Africa provides a window on what that other parts of the world will look like. Given that the virus takes about nine years to develop into full blown AIDS, Asia and India are seen as harboring time bombs just waiting to explode.

DETERMINED LEADERSHIP AND PARTNERSHIPS HAVE MADE, AND CAN CONTINUE TO MAKE, AN EXTRAORDINARY DIFFERENCE -- AND SAVE MILLIONS OF LIVES.

- Uganda has been the world leader in demonstrating that even a country with limited resources and low levels of literacy could turn the tide on a burgeoning epidemic. President Museveni demonstrated bold leadership early on and made every government ministry take the problem seriously, and develop and implement its own plan for reducing stigma and transmission, and caring for those who become sick.

- Uganda created an enabling environment for donors, such as the US, to assist in this effort. The US invested $40 million in HIV prevention in Uganda and HIV rates among pregnant women dropped from 30% in 1991 to 15% in 1995 to 8% in 1998. This is a result of education from top officials (called ***the big noise*** in Uganda); sex/health education (peer counseling) in the schools, churches, everywhere else; the availability of HIV counseling and testing; and the aggressive treatment of STDs.

- Countries such as Zambia, Malawi, Uganda, and Kenya have begun to develop initiative programs to care for the growing number of children orphaned by AIDS. In the longstanding African tradition, communities are finding creative ways to support the village in its efforts to raise its children, but many of these villages are already overwhelmed by the growing number of orphaned children.

- Through micro-finance programs like FINCA (Foundation for International Community Assistance), women are receiving loans, starting small businesses, and with increased household incomes, taking in children orphaned by AIDS. With support of non-governmental organizations, communities are coming together to deal with school fees, nutritional assistance, immunization and oral hydration, counseling, and the range of other needs that arise for orphaned children. These efforts are low cost strategies designed to empower women, protect children, and support extended families and communities in carrying for their own. For a small fraction of the cost of one orphanage bed an entire community of vulnerable children can receive care. The problem is that only a very small number of children receive even this modest level of support.

- Luckily, as captured in song by young AIDS educators in Uganda, ***It is never too late to lead***. The crisis of children orphaned by AIDS is a horrible but still unfolding tragedy. It will continue to worsen throughout the next decade even if there are no new infections. We know this is coming, we know what works, and this knowledge beckons us to act.

U.S. Agency for International Development

Bureau for Africa
Office of Sustainable Development
1325 G St., NW Suite 400
Washington, DC 20005

Date: 5/26/99

To: Sandy Thurman

Phone: _____

Fax: _____

From: Alex Ross

Phone: _____

Fax: _____

Number of Pages Including Cover Sheet _____

Message

Sandy,
This is a UNICEF Executive Board document under review in USAID, & thought you'd be interested in it, at least to read the rhetoric (Public the).

Alex.

Close

Executive Board Documents

Title: **Ensuring Children's Rights in Africa**

Document Type **Executive Board - Progress Reports**

Country	WCARO Regional	Series:	E/ICEF/1999/12
Year Published :	1999	PDF Link :	
OSEB Doctype :	Executive Board Documents		
Session :	1999 Annual Session		

(8)

Detailed information (click on the twistee to see more)

Executive Summary:

AFR
Baillard
Gaiton
Bartlett
Halbrook
Voes
Emmy
Coly

Document Text:

Distr.
GENERAL

E/ICEF/1999/12
30 March 1999

ORIGINAL: ENGLISH

FOR INFORMATION

UNITED NATIONS CHILDREN'S FUND
Executive Board
Annual session 1999
7-11 June 1999
Item of the provisional agenda*

ENSURING CHILDREN'S RIGHTS IN AFRICA

SUMMARY

The present report was prepared in response to Executive Board decision 1997/19 (E/ICEF/1997/12/Rev.1), in which the Board recalled the UNICEF commitment to Africa as the region of greatest need and highest priority, and requested the Executive Director to report in 1999 on progress made in efforts to ensure children's rights to survival, development and protection in Africa.

Following a review of UNICEF experience of support to Africa's children during the decade of the 1990s, the report provides an update of recent trends affecting the rights of children and women on the continent. It describes the current strategic focus of UNICEF work in the main subregions of greatest need, particularly sub-Saharan Africa, and assesses the key areas in which effective partnerships and leadership will be needed if sustained progress is to be achieved.

* E/ICEF/1999/8.

I. A DECADE OF INVESTMENT IN AFRICA'S CHILDREN: DIRECTIONS AND LESSONS LEARNED

1. Childhood in Africa has been in jeopardy for most of this decade. As the continent prepares for the new century, children and women, especially in sub-Saharan Africa, remain acutely vulnerable and exposed to the combined impact of economic crisis, unserviceable international debt, armed conflicts, spreading violence and the unrelenting HIV/AIDS pandemic. To varying degrees, these crises have diverted attention and resources away from the longer-term development efforts of African Governments for investing in children, and from their essential roles in the societal effort to ensure children's and women's rights.

2. Within this challenging context, UNICEF advocacy and programme cooperation during the early part of the decade were centred on the goals adopted in 1990 at the World Summit for Children by world leaders from all continents. With the ratification of the Convention on the Rights of the Child by all African countries, except Somalia, and with the reaffirmation of commitment to the goals for children at the International Conference on Assistance to the African Child which took place in Dakar, Senegal, in 1992, under the auspices of the Organization of African Unity (OAU), most African countries produced national plans of action (NPAs) to implement these goals. In the early 1990s, these and other initiatives encouraged a stronger policy focus in many African countries on the reduction of child death rates, disease and malnutrition as well as the promotion of universal primary education.

3. In several cases, such as Nigeria, South Africa and Uganda, the NPAs for children were extended to local government levels as part of national policies for devolution. The NPAs also helped to strengthen the focus of UNICEF-assisted programmes of cooperation in Africa on the policy environment and intersectoral approaches to achieving results for children. However, the extent to which the NPA initiatives were sustained varied greatly among countries. In some cases, national goals for children, and strategies to achieve them, were integrated in overall development plans. NPAs were valuable for some countries in providing an analytical base for monitoring implementation of the Convention on the Rights of the Child and in mobilizing private sector partners. Elsewhere, however, NPAs were affected by difficulties of costing, weak monitoring and lack of mainstreaming in national planning, or were superseded by outbreaks of conflict.

4. The UNICEF contribution to the achievement of substantial results in some areas of the World Summit goals, such as health, education and clean water, was complemented, particularly in west and central Africa, by the introduction of the Bamako Initiative as a means of addressing more systemic challenges in health service delivery and financing. However, during this period, more limited focus was devoted to growing challenges such as HIV/AIDS and malaria.

5. A mid-decade review presented to the United Nations General Assembly by the Secretary-General in September 1996 showed that, despite impressive progress in areas such as salt iodization, the use of oral rehydration therapy and the reduction of cases of guinea worm, sub-Saharan Africa was generally lagging behind other regions. Immunization coverage rates, for example, had risen rapidly in the early years of the 1990s but had then tended to stagnate. Little overall progress had been registered in goals for school enrolment, sanitation access and the reduction of maternal mortality. The rate of decline in child mortality, while significant, was slower than in other regions. The review also raised concerns on the sustainability of progress and the spread of HIV/AIDS.

6. The unevenness of progress in much of Africa was a major reason for the launching of a global initiative for accelerated achievement of programme priorities within the scope of the World Summit as part of the current UNICEF medium-term plan (MTP) for the period 1998-2001 (E/ICEF/1998/13 and Corr.1). With support from the UNICEF regional offices, a clearer set of priorities has been established, for which it is considered both feasible and urgent that progress be made in sub-Saharan Africa in the remainder of the decade.

7. Many of the mid-term reviews (MTRs) of UNICEF-assisted country programmes in the second half of the 1990s have resulted in a more balanced mix of strategies and a better focusing of objectives. New country programmes of cooperation designed with Governments in sub-Saharan Africa since 1995, such as those in Ghana, Mali, Uganda and the United Republic of Tanzania, have incorporated greater attention to issues of capacity-building, the promotion of positive behavioural change and community participation. These approaches recognize the need to combine continued support to basic services delivery, with improved policies and systems for sustaining progress, and with a more explicit focus on the progressive achievement of children's and women's rights.

Strategies for capacity-building are gradually becoming more broad-based, incorporating participatory analysis of the problems

and strategic needs of institutions. While training activities have been implemented by almost every UNICEF-assisted programme, they were often focused on centrally-based civil servants and less on local-level capacity development. There is now greater appreciation of the need for systematic preparation, follow-up and assessment of the impact of training. This area continues to face challenges of cost-effectiveness and coordination, as well as difficulties posed by low levels of salaries among government workers which result in, as well as reflect, low public sector productivity.

9. Support to social policy reform, social mobilization and community capacity-building, through promotion of often innovative modes of participation, is taking on increased significance in sub-Saharan Africa within the context of rights-based programming (see the report on programming with a rights perspective (E/ICEF/1999/11) being submitted to the Executive Board at the present session). UNICEF is also increasingly providing assistance to initiatives that address legislative and policy issues related to children's and women's rights. Support to communication has been shifting from a centralized approach towards activities based on audience research, testing and feedback, with community and youth involvement.

10. Meanwhile, the escalating scope of armed conflict in parts of sub-Saharan Africa has often impeded access to children and women for the delivery of basic services and has created additional challenges of ensuring their protection against violence and abuse. Despite the difficulties, in the late 1990s, UNICEF managed to maintain a field-level presence in almost all countries in sub-Saharan Africa and to spearhead efforts for child protection, such as family tracing and reunification, the demobilization and reintegration of child combatants and the restoration of access to basic services, including education. Particularly in the late 1990s, UNICEF has spoken out internationally, at the highest levels, on major violations of children's rights arising from conflicts in Africa. Further in support of the recommendations of the Secretary-General's report on "The Causes of Conflict and the Promotion of Durable Peace and Sustainable Development in Africa" (A/52/871-S/1998/318), UNICEF has promoted children's rights and child protection issues with national leaders as a means of building commitment for peace. Country programmes in Angola, Burundi, Liberia and Mozambique have promoted community awareness of landmines and values of reconciliation in school curricula as part of a broadening range of activities to address the causes and consequences of recurrent conflict in Africa.

II. CURRENT THREATS AND CHALLENGES TO THE RIGHTS OF AFRICA'S CHILDREN

11. Large parts of Africa have seen setbacks in their development progress and prospects over the last two years. In many cases, the recovery in economic performance and gains in political stability noted in 1997 have proven fragile and vulnerable to both short-run shocks and structural factors. The stalling of progress is seen in the continued shortfalls in the achievement of the goals of the World Summit for Children and the intensifying threats to the realization of children's and women's rights.

12. The resurgence of armed conflict is having a corrosive effect on these human rights, as well as on the social and economic structures that must sustain them. With an estimated 7.2 million refugees and displaced people, Africa has experienced a growing number of international conflicts. The most extensive of these, in central Africa, has been joined by new conflicts in the Horn of the continent. Civil strife has also spread in coastal west Africa, while individual countries, most dramatically Angola and the Congo, have seen the revival of internal hostilities. Other countries have experienced political instability and widespread institutional weakness. These situations of turmoil have led to wasted resources, destroyed lives and shattered basic service systems.

13. A particular feature of several of these conflicts, such as that in Sierra Leone, has been the targeting of children, both as victims of abuse and for abduction as participants in conflict itself. Shocking manifestations of brutality have been witnessed as social structures have been undermined. Even societies not directly affected by conflict have witnessed growing levels of violence against women and children, particularly in poor urban settlements.

14. A different kind of crisis, greater even than war in its ultimate scope if not in immediate visibility, is that of the HIV/AIDS pandemic and its consequences. December 1998 estimates by the Joint and Co-sponsored United Nations Programme on HIV/AIDS (UNAIDS) confirm that gains over the last three decades in child survival and life expectancy are being undone with unexpected rapidity. Some 83 per cent of all AIDS-related deaths globally have occurred in sub-Saharan Africa, about one quarter of them among children. Evidence of the startling impact of HIV/AIDS and of other adverse trends is accumulating. The most recent Demographic and Health Survey in Kenya, for example, suggests that child mortality increased by about 40 per cent from the late 1980s to the mid-1990s and is continuing to worsen. In Zambia, the under-five mortality rate is estimated to have increased from 122 per 1,000 live births in 1990 to 202 in 1997. Meanwhile, particularly in parts of eastern and southern Africa, health services are overwhelmed with patients affected by AIDS-related conditions, while health workers, teachers and their families are also personally affected.

15. While the impact of AIDS may not have shown up clearly in macroeconomic statistics, this should not lead to complacency: the economic consequences of the pandemic for millions of individual families are catastrophic. The deaths of productive adults results in loss of basic income, the sale of household assets and often outright destitution. This greatly reduces the ability of families to contribute to realizing the rights of their children. Whether these effects widen existing disparities or not, their impact is to rapidly deepen the poverty of households and communities in large areas of the poorest region in the world.

16. Some parts of the continent, particularly in the common currency zone of west Africa, have seen a modest revival of economic prospects due to improved macroeconomic management. Medium-run prospects for recovery in west Africa may also be strengthened by the current democratization process in Nigeria, its largest nation. For many African countries, however, recent steep falls in world commodity prices are counteracting their improved policies. Very few of them have achieved the levels of investment necessary to transform the production and export base, and for rates of economic growth which will bring more jobs and better livelihoods. Following optimism in 1996, when continental gross domestic product growth was estimated at 4.5 per cent, the likelihood is that the growth of population once again outpaced that of income in 1998.

17. Meanwhile, over 8 million African children - the producers and entrepreneurs of the next decades - have already lost one or both parents to AIDS, and their numbers may grow to 10 million-14 million by the year 2001. Orphaned children and families affected by the loss of breadwinners constitute one of the greatest social welfare challenges in Africa's history. The social, psychological and cultural implications of the phenomenon of orphans in Africa have not yet been well understood. The safety nets required by affected children and families are, even in the best of cases, only partially in place.

18. A lack of open discourse on the stark challenge of the AIDS pandemic persists in many social settings, which hampers the search for decisive responses. There is some evidence that Governments have begun to increase their commitments to investing in basic services, including those related to AIDS awareness and response. However, these efforts continue to be undermined not only by low levels of efficiency in the use of resources, but also by the high proportions of national budgets devoted to debt repayment. Together with often sluggish revenue performance, and some increases in the share of military spending in the last two years, the continued burden of debt servicing reduces the scope for essential spending on children by African Governments.

19. It is not surprising, therefore, that progress in other areas of social and human development has also been limited. Considerable success has been registered since 1997 in some specific areas, including raising polio immunization rates, supported by the introduction by many countries of National Immunization Days; the wider use of vitamin A supplements, which are now received by about 60 per cent of young African children compared to one quarter in 1994; the widespread iodization of traded salt; and the dramatic reduction of guinea worm cases. These achievements now need to be sustained and extended to other key areas for human development. Maternal death rates in much of sub-Saharan Africa remain extraordinarily high, while about one third of young children are under weight for their age and one sixth have low weight at birth.

20. The risks of maternity continue to undermine the rights of African women to safe pregnancy and childbirth. This forms part of a broader set of factors which cause the systematic disadvantage of women, including: inferior social and often legal status; neglect in national policy; lack of political participation; illiteracy; excessive workload; poor nutrition; genital mutilation; early marriage and pregnancy; and unequal access to already limited services. Such factors also put younger women at disproportionate risk of HIV infection.

21. Sustained progress towards the goals of the World Summit for Children is likely to require both improvements in gender equity and a considerable strengthening of public institutions, complemented by community organization and partnerships with civil society. The current challenges are evident in other areas of basic services provision. Overall, less than two thirds of school-age children in sub-Saharan Africa are enrolled in primary education, a situation similar to that of 1990. Poor education quality; weak learning achievement and high drop-out rates are still major challenges despite efforts to adapt curricula, school timetables and language policies to local needs. Meanwhile, the weakness of public health systems is illustrated by the resurgence, across the continent, of malaria and cholera, as well as the greater incidence of meningitis. These trends also reflect the persistent lack of access among the majority of families to safe water and sanitation, a problem which is rapidly intensifying in urban areas

22. Inefficiencies in the use of public resources for social development are widely evident in the irregular payment of salaries, unreliable supplies of essential drugs and limited support capacities for the decentralized management of services. Despite those factors, the Bamako Initiative has had success in much of west Africa as well as in the Comoros, Madagascar and Mauritius as a strategy for revitalizing primary health care (PHC). A number of other countries have now initiated systemic reforms as a way of addressing these problems in social development. While positive results for children and women are yet to be realized, these sector-wide approaches may provide the starting point for building the capacity not only to address the needs of individual sectors, but to form wider partnerships for complex development challenges. Such partnerships will need to incorporate a vision of the role and responsibilities of the State in realizing the rights of citizens and meeting the needs of the most disadvantaged.

23. Sector-wide approaches, increased attention to public revenue raising and civil service reforms leading to improved pay and performance management are among the initiatives being taken by Governments to begin to address the structural factors that underlie the weaknesses of human development in Africa. International support is focusing increasingly on efforts to address such threats to children as malaria, unsafe water and HIV/AIDS. However, the key opportunities for a major revival of the prospects for Africa's new generations reside in the combined efforts of Governments and wider society. Such alliances, including for the sustained delivery of basic services and the protection of children and women, will need to be anchored in accountable relationships between the State and citizen's organizations, for which freedom of information and wider access to

technology will be important conditions. It is in such areas that, despite setbacks in political reform and economic performance in the late-1990s, the prospects for Africa's recovery are possibly most encouraging.

III. UNICEF RESPONSE: MAINTAINING PRIORITY FOR AFRICA

24. During the decade of the 1990s, UNICEF has responded to the organizational priority for Africa by strengthening its deployment of key resources. Staff numbers in sub-Saharan Africa rose rapidly after 1990 and peaked in 1995 at 42 per cent of total staff. In 1998, some 2,620 UNICEF staff were working in sub-Saharan Africa, compared to a total of 1,535 in 1990. The numbers in 1998 comprised 37 per cent of all UNICEF staff, compared to 32 per cent at the beginning of the decade. In 1998, these numbers included 28 per cent of the organization's international Professional staff, 40 per cent of the national officers and 38 per cent of the General Service staff.

25. Under the modified system for allocation of available general resources approved in 1997 (E/ICEF/1997/12/Rev.1, decision 1997/18), the share of the two sub-Saharan Africa regions in total general resources allocated to country programmes rose to 40.2 per cent in 1999, and is projected to increase further to 45.8 per cent by 2002. This compares with an average of 37 per cent of general resources in the period 1990-1998, with significant fluctuations throughout that period. The revised formula will place general resources allocations to Africa on a more consistent, as well as rising, basis.

26. In the first annual allocation of the 7 per cent of available general resources for programmes set aside for special allocation by the Executive Director, as per Executive Board decision 1997/18, the focus on Africa as the region of greatest need and priority was further reinforced. Some 65 per cent of the allocation from the set-aside was directed to programmes in sub-Saharan African countries, particularly for accelerated efforts in immunization, control of HIV/AIDS and malaria, and guinea worm eradication.

27. In agreement with funding partners, during 1997-1999, supplementary funds were allocated on a multi-country basis for a range of priority areas in sub-Saharan Africa, including for the eradication of guinea worm and polio, the elimination of iodine deficiencies, girls' education and the reduction of child labour. However, the direct availability of supplementary funds for country programme budgets approved by the Executive Board remains highly uneven among countries, and among programme areas within overall country cooperation.

A. UNICEF programme priorities in sub-Saharan Africa

28. The two UNICEF regions in sub-Saharan Africa have established clear sets of overall priorities for UNICEF work, within the scope and period of the current MTP. These have emerged from the reality of the trends affecting children and their rights at the country level, and will be adopted, in appropriate ways, through the country programming process in a majority of cases in each region. They will be the subject of intensive regional efforts, including resource allocation, multi-country fund-raising, regional office technical support, evaluation and monitoring. These regional priorities are intended to respond to the complex challenges for children's and women's rights in sub-Saharan Africa in a strategic manner, taking into account the most urgent needs, the underlying causes and UNICEF comparative advantage. This will continue to be based on an analysis of the factors affecting the realization of children's and women's rights, and of priority actions, in each country context.

29. In west and central Africa, the highest regional priority is given to the survival of children and improvements in child and maternal health, centred around the strategy of the Bamako Initiative for the revitalization of health systems and community participation. Immunization, vitamin A supplementation, safe motherhood, guinea worm eradication and local participation activities are major components of the Initiative. Regional strategies have been developed for the reduction of maternal and neonatal mortality, and will be supported in some 13 countries in collaboration with the World Health Organization (WHO) and the United Nations Population Fund if supplementary funding is secured. Activities for improved emergency obstetric care have been piloted in six countries. Advocacy, in alliance with national media, will promote increased commitment to maternal and child mortality reduction across the region.

30. The second major priority in west and central Africa will be the continuation of efforts to improve access to good quality basic education, especially for girls. Major achievements have been registered in specific areas in individual countries, such as the training of teachers, the establishment of school committees, textbook revision and provision, incentive schemes for the recruitment of female teachers, the training of educators on gender issues, social mobilization and policy development. These will be built upon and extended, with support from funding partners, and further attention will be given to improving quality and reducing drop-out rates. Innovative and non-formal methods of extending education opportunities will be sought, often as a bridge to formal systems. Work in these areas will be pursued throughout sub-Saharan Africa as part of the African Girls Education Initiative.

31. In eastern and southern Africa, many country programmes are now being reoriented to give highest priority to meeting the challenge of controlling HIV/AIDS, as a primary threat to securing human rights, and to assisting children and women affected both directly and indirectly. The second area of major priority in this region will be intensified efforts by UNICEF to support Governments and other stakeholders in the control of malaria as part of the "Roll Back Malaria" alliance of international partners. Each of these priority areas will provide close links to the reduction of maternal deaths.

32. Bringing the HIV/AIDS pandemic under control will be essential to the effectiveness of other key interventions for disease control, the reduction of malnutrition, and securing rights to basic education and protection. Based on an assessment of the impact of HIV/AIDS on children and of UNICEF comparative advantage within the framework of the UNAIDS alliance and country-level United Nations theme groups, the organization will focus its efforts in sub-Saharan Africa in five areas: prevention of HIV transmission among young people through broadly-based mobilization, communication and life skills education efforts in school and community settings; reduction of transmission from mothers to babies involving, in about a dozen countries, the provision of a minimum package of services to pregnant women, including voluntary and confidential counselling and testing, access to short-course drugs and support for informed choices in infant feeding; high-level advocacy for political action, including the mobilization of mass media, the dissemination of available data, contacts with policy makers and alliances with UNAIDS partners; advocacy and, where necessary, technical support for public safety nets and community-led programmes to ensure care and guaranteed access to basic services for orphans and children living in families affected by HIV/AIDS; and assistance to UNICEF staff members themselves through information, counselling and other forms of support.

33. Efforts in these areas were intensified in eastern and southern Africa and parts of west and central Africa in late 1998 with the preparation of pilot initiatives to reduce mother-to-child transmission of HIV in several countries with the support of funds from the United Nations Foundation. At the regional level, funds will be sought to support the acceleration of HIV/AIDS education in schools and to assess options for replacement feeding linked to the reduction of mother-to-child transmission. Efforts will be made to engage religious, private sector and regional organizations in actions to address the pandemic. Training in the design of programme interventions and advocacy to meet the challenge of HIV/AIDS will be held during 1999 for UNICEF senior staff in Africa.

34. It is fully recognized that HIV/AIDS, like malaria, is a problem directly threatening children's rights, which requires solutions based in processes of social change as well as in science and technical interventions. These processes will need to involve community-level analysis of the problem and will require the mobilization of facilitators and capacity-building for local action. The approach to external support in these areas will not be standard, and its design will need to carefully reflect and respond to local needs and perceptions.

35. With regard to the control of malaria, there is a more proven range of potential community-based actions, although the complexity of putting them in place on a sustained basis must also not be underestimated. Actions in eastern and southern Africa for which further resources are being sought, include: the supply of impregnated bednets; building systems for bednet distribution and re-treatment; the training of health workers for improved case management; the study of drug resistance; and support to policy development and community mobilization. In west and central Africa, improved case management and community actions for malaria control will be supported under the Bamako Initiative.

36. A further priority for UNICEF in all parts of Africa will be to fully integrate preparedness and response to situations of instability and crisis in the regular country programming process. This is already being pursued in countries such as Burundi, Liberia and Somalia. Over the next few years, efforts for integration will include capacity-building among UNICEF staff to be able to meet a set of core organizational commitments in conditions of conflict to support the rights of children and women to basic services and protection.

37. Further support and advocacy will be needed for the demobilization and return to families and schools of child soldiers, and to raise awareness of the dangers of landmines and the trade in small arms. Support during and after conflict will continue to be provided for the care and counselling of unaccompanied children; family tracing and reunification; and the restoration of basic services, including education. UNICEF will remain active in all these areas, but its actions in response to crisis will need to be more predictable and systematic. They will also need to form part of longer-run efforts, within regular programme cooperation, to assist countries in restoring the social fabric, where this has been torn by conflict; to improve emergency assessment and preparedness planning; and to promote attitudes, practices and social institutions which recognize and protect the rights of children and women in all situations. Further areas in which these approaches will be needed include the prevention of child trafficking, drug abuse among young people and exploitative child labour. More broadly, UNICEF will seek to promote the respect of children's rights as a lever for building a stronger ethic for peace and reconciliation in societies recovering from the trauma of war.

38. Among the other programme priorities which form part of the MTP, attention will be given to the piloting of integrated approaches to the management of childhood illnesses in some 20 countries in sub-Saharan Africa. This will include health system interventions, communication for improved home care, case management training and planning for the availability of essential drugs. Linked to this, pilot efforts will be made to improve home and community care practices for the survival, growth and development of very young children in selected countries, including the C te d'Ivoire, the Gambia, Malawi and Namibia, and partnerships will be extended in this area with the World Bank. Sustaining immunization coverage, vitamin A supplementation in high-risk areas and the consumption of iodized salt, as well as support to breastfeeding and the reduction of maternal mortality, will all receive widespread support through country programmes. The Vaccine Independence Initiative,

which has had some success in achieving a more sustained supply of vaccines in the Sahel, will be gradually extended. In the short-term, priority will also need to be given to measles control, polio eradication and the replacement of depreciated cold chain equipment. In water and sanitation, the focus of UNICEF cooperation will continue to shift to support of improved hygiene practices, the testing of lower-cost technologies, the development of policies and partnerships, promoting the participation of women in community-based maintenance systems, and ensuring clean water and sanitation facilities in schools and health units. The challenging drive for guinea worm eradication will be continued, in close partnership with WHO, the United States Centers for Disease Control and Prevention, and the Global 2000 of the Carter Center.

39. UNICEF also will place increased emphasis on identifying the causes of major forms of violence against children and women, including female genital mutilation, and working with civic and women's groups, religious and community leaders to find solutions. Efforts to establish and improve laws, administrative codes and the work of institutions dealing with children's rights, including juvenile justice systems, will expand. Assistance to national partners in assessing progress in implementing the articles and applying the principles of the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women will be provided in appropriate forms in almost all African countries. UNICEF will also play a partnership role, as part of the concerned group of all United Nations agencies, in supporting national actions in the implementation of the Beijing Platform for Action.

B. Strategies and operational support for programme priorities in Africa

40. In support of these priorities in sub-Saharan Africa, and for other areas of priority within individual country programmes, UNICEF will develop, promote and utilize a combination of strategies. Drawing on experience from the 1990s, these will be based explicitly on a human rights perspective to cooperation and will stress the recognition of people who are poor, including children, as the key actors in their own development. Emphasis will be given to capacity-building, to enable and encourage communities to assess, analyse and take action, supported by Governments, in order to: reverse the AIDS pandemic, address its consequences; roll back malaria in the village or urban neighbourhood; and help secure good quality basic health services, primary education, clean water, environmental care and child protection.

41. These strategies of support will call for the construction of a broader range of effective partnerships among local, civil society, private, non-government and women's organizations, in alliance with government agencies. Work with district and municipal authorities has also been a successful strategy for child-focused programming, and will be continued. UNICEF will complement these local-level efforts through advocacy, analysis, social mobilization and, where necessary, support to national policy development, including in the context of sector-wide approaches. These activities will aim to create a more enabling and often less discriminatory social, legal and institutional environment for children and women within which community initiatives can take place.

42. With the limited resources available, and with major challenges ahead for the realization of rights to basic services, cost-effective approaches will need to be pursued in all areas of intervention. UNICEF regional offices and management teams in Africa, as elsewhere, will have a key role to play in the identification and verification of such approaches through such mechanisms as budget reviews and programme evaluations. The dissemination of promising experiences, and support to African countries and regional partners in gaining access to key sources of information and expertise on policy development for children, will be a further key role of UNICEF. Regional training activities for UNICEF staff will place increased emphasis on integrated planning approaches and the strategic role of operations functions in support of programme priorities. Greater sharing of technical expertise and administrative capacity among UNICEF offices in Africa, and with United Nations partners, is now taking place. Programme quality monitoring systems have been introduced in both regions in sub-Saharan Africa, and a procurement unit has been established in South Africa.

43. Monitoring of progress in key areas of outcome for Africa's children will take place through a series of end-decade surveys. In some cases, they will form part of wider national household survey exercises. In other cases, a second round of multiple indicator cluster surveys (MICS) is likely to be needed. In a number of sub-Saharan African countries lacking national data collection systems, these surveys, held initially at the mid-decade, provide virtually the sole source of social and household information. Additional indicators will be built into the new series of MICS, to be held in 1999-2000, to reflect new priorities and opportunities. In addition, a goal against which progress in the fight against HIV/AIDS can be readily measured will be established, possibly relating to the reduction of new infections among teenage girls.

44. Research and evaluation priorities for UNICEF in sub-Saharan Africa will also reflect the major priorities. Many of these will be pursued through periodic situation assessment and analysis of children's and women's rights, and in the context of MTRs. In particular, studies of knowledge, attitudes and practices regarding the causes and treatment of malaria will be extended following the striking results of the study in Zanzibar (reported to the Executive Board in document E/ICEF/1998/P/L.1). In collaboration with WHO, support will be given to training for controlled trials on decision-making for the use of anti-malarial drugs. Meanwhile, an evaluation will be held in 1999 of the regional Sara Communication Initiative, which incorporates support for AIDS awareness among older children.

IV. STRENGTHENING PARTNERSHIPS AND RESPONSIBILITY FOR CHILDREN'S RIGHTS IN AFRICA

A. UNICEF partnerships

45. As discussed throughout the present report, effectiveness in partnerships will be an essential aspect of short-term and sustainable development outcomes for Africa's children, both as a means of maximizing resources and to strengthen the platform for coordinated action. The UNICEF contribution to renewed human development in Africa has been pursued through a combination of partnerships anchored in country programmes of cooperation and alliances based around key issues for global and regional advocacy, such as the banning of landmines, the elimination of exploitative child labour, the reduction of violence against women, and the prioritization of donor and government budgets towards basic services. This approach will be continued with national partners, global allies and African regional organizations, such as OAU and the Federation of African Women Educationalists, as well as with the Save the Children Alliance, particularly on issues related to the Convention on the Rights of the Child, and with the Inter-African Committee on the Elimination of Harmful Traditional Practices on the issue of violence against women and girls.

46. The deteriorating socio-economic situation of the continent has been a constant preoccupation for the United Nations in recent years. Initiatives to address this in which UNICEF has participated, have included the United Nations Programme of Action for African Economic Recovery and Development and its successor, the United Nations New Agenda for the Development of Africa in the 1990s. UNICEF continues to cooperate with the World Bank, WHO, the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Development Programme and others in key areas of activity of the United Nations System-wide Special Initiative on Africa, launched in 1996. Efforts in basic education, for example, aim to concentrate inter-agency efforts to help improve the situation of 16 sub-Saharan African countries with very low primary school enrolment rates through the development of sector investment programmes. UNICEF is working closely with UNESCO and the World Bank in this initiative for Low Enrolment Countries and is providing advice to the design process, including for components related to the education of girls. African leadership of the Special Initiative on Africa has been registered by the adoption by ministers of health of the framework for health sector reform, and by education ministers through the Association for the Development of Education in Africa. However, the Initiative is constrained by weaknesses in country-level implementation and the lack of additional resources. Recent efforts by coalitions of international agencies, including UNICEF, to generate support for accelerated efforts by African countries to combat HIV/AIDS and malaria are expected to provide new impetus. The increasing adoption of the United Nations Development Assistance Framework and related mechanisms, such as United Nations country theme groups, will support the effective collaboration of United Nations agencies for children's and women's rights and in priority areas for action such as these.

47. There are promising signs that bilateral aid donors may be increasing the priority given to Africa, creating further opportunities for partnerships. Emerging trends also suggest that more emphasis will be placed by both bilateral and multilateral agencies on longer-term and multisectoral as well as sector-wide approaches, and on interventions that assist countries in building capacity for sustained access to basic services among families which are poor and marginalized. These trends will create further opportunities for UNICEF to provide value-added in the social development process based, for example, on its experience in support of participatory, community-led approaches and its cross-sectoral focus on the survival and growth of children.

48. UNICEF has found a particular convergence of concerns with OAU on the anti-war agenda and issues of conflict resolution and humanitarian assistance directly relevant to children and women. This partnership has provided important opportunities for advocacy, particularly with African Heads of State at their annual summits. Following the adoption of an OAU resolution on the use of landmines in Africa in 1998, UNICEF advised on a campaign for a total ban on landmines in Africa and advocated for ratification of the Ottawa convention in a number of countries. OAU also passed in 1998 a resolution banning the use of children as soldiers, while collaboration with OAU enabled the relaxation of access restrictions for essential humanitarian supplies during the imposition of sanctions on Burundi. UNICEF contributed to the drafting of the plan of action for the African Decade for Education, launched by OAU in 1997, and will support its implementation. UNICEF is also giving increased priority to promoting the wider ratification of the African Charter on the Rights and Welfare of the Child. Meanwhile, work has continued with the Economic Commission for Africa in the production of a series of analyses of social development trends in Africa. Cooperation with specific sectors of the Southern African Development Community has also been increased through support to policy design and capacity development in HIV/AIDS, sanitation and hygiene. Regular consultations with the African Development Bank (AfDB), and collaboration with AfDB-funded projects, such as in the health sector in Senegal, will be continued.

B. African leadership for children's rights

49. The strengthening of national administrative structures for the delivery of basic services will be a key element of development progress in many countries of sub-Saharan Africa. An end to conflict, accountable political systems, a fair and functioning judiciary, open debate on policies and high levels of participation of women and civil society will further support sustained economic growth and broad-based human development. They will also provide a basis for more effective action against the HIV/AIDS pandemic and its corrosive effects on children's rights. Responsibility will rest primarily with African leaders.

Governments and civil society to work towards such conditions.

50. Over the last few decades, African countries which have given priority and consistent attention to investing in human development have tended to see the benefits of increased economic growth and, where these measures have been sustained, falling levels of household poverty. Recent reforms of health and education systems in countries such as Ethiopia, Ghana and Zambia, and initiatives to rapidly expand access to primary education in Malawi and Uganda, hold the promise of improved care, learning achievement and human development outcomes. Major efforts for awareness-raising and public education on HIV/AIDS have begun to make an impact in Uganda. However, such approaches are not yet sufficiently widespread in sub-Saharan Africa. The more general pattern remains that of declining levels of investment in basic services, with often dramatic shortages of funding at district and municipal levels.

51. The responsibilities adopted by State Parties to the Convention on the Rights of the Child are now widely recognized and understood. It seems not unreasonable to suggest that a lack, in many countries, of public action to address major shortfalls in the rights of children, such as the absence of primary school places and of protection from violence, and the failure to openly confront threats to life such as HIV/AIDS, are indications of inadequate political commitment to the realization of these rights. Furthermore, without a norm of peace and freedom from conflict, guaranteed by political will and underpinned by regional cooperation, the basis will not fully exist for ensuring that children's rights are protected and fulfilled.

52. None the less, Government and civil society in a number of countries are now working together to place greater emphasis on children's and women's rights. This has been reflected in the introduction of measures to combat female genital mutilation, new provisions on violence against women, increased attention to girls' education and revisions of the constitution or legal code. Recent children's acts adopted in several countries in sub-Saharan Africa have increased the legal age of responsibility of children and provided them with protective measures through juvenile courts. Enshrining the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women in a comprehensive legal framework, combined with measures to improve the quality of, and access to education and health services, will provide a key part of the foundation for the realization of human rights.

C. Africa's partners in development

53. Although the central task of Africa's development rests primarily with its people and leaders, the international community bears a responsibility both to support the continent in its development efforts and to remove obstacles in the way of progress. With a changing focus which places greater emphasis on good government and stability, the potential exists for those countries which are reforming their political and social systems to achieve sustained growth with widespread benefits. For this to happen, Africa's partners must renew their support to the region and improve the global conditions for its development.

54. A first component of this renewed support must be a reversal in the decline in official development assistance (ODA). As a proportion of the output of industrialized countries, ODA now stands at less than one third of the target of 0.7 per cent of gross national product. The absolute amount of assistance has declined as well - by nearly 5 per cent per year since 1992. At a time when more sub-Saharan African countries are taking reform initiatives, opportunities are being missed for effective international support to this process.

55. Linked to the amount of ODA are the targeting and composition of assistance. The access of all people to basic education opportunities, health services and safe water is recognized as not only key to sustained human development and poverty alleviation, but, increasingly, as a normative issue of human rights. Investment in such services is central to reducing the worst manifestations of poverty and breaking its vicious, inter-generational cycle. The 20/20 Initiative, agreed at the World Summit for Social Development in 1995, provides a framework for translating this need for increased resources into reality. With commitment and better targeting, including to strategies for national and local capacity-building, the contribution by both Governments and international partners to basic services could increase substantially in Africa.

56. Increasing ODA and targeting it better will be of limited benefit, however, if African countries continue to be saddled with large debt burdens. For ~~every dollar that sub-Saharan Africa~~ received in ODA in 1996, it paid out $1.31 in debt service. The external debt of African countries rose from $340 billion in 1996 to $349 billion in 1997, representing more than 200 per cent of annual exports. Spending on debt servicing is higher than that on basic services in a number of African countries, often by a wide margin. An example is Zambia, where average annual spending on education amounted to $82 million between 1993-1996 compared to some $335 million per year in debt payments.

57. A further component of renewed support to sub-Saharan Africa is to enable resources freed by debt relief to be allocated in favour of basic education, PHC, safe water and other poverty alleviation measures. The Heavily Indebted Poor Countries (HIPC) initiative, developed under the auspices of the International Monetary Fund (IMF) and the World Bank, aims to achieve sustainable levels of debt service by providing relief not only of the bilateral debt burden, but also of debt owed to international financial institutions. Two years after the launch of the initiative, however, only Uganda has actually benefited from relief. IMF and the World Bank recently decided to extend the HIPC initiative and to ease the criteria for inclusion. There remains an urgent

need for these measures to be extended by granting deeper and earlier relief and to free additional national resources for human development. Support to local efforts to address the HIV/AIDS pandemic would be a priority use of such funds.

58. Africa's share of world trade continues to decline, shrinking to 1.9 per cent in 1997, reinforcing the continent's marginalization in the global economy. Although past experience has not been encouraging, renewed efforts are needed to diversify African economies, and both Governments and their international partners have important roles to play. Improving market access for Africa's exports and investing in business skills and access to information technology among students are relevant areas, which could involve the local private sector.

59. While the resolution of the conflicts affecting Africa is the primary responsibility of African leaders, the international community should not ignore the plight of millions of refugees and displaced people and the moral issues posed by suffering and insecurity on the continent. Political reform efforts can be facilitated through the building of experience among parliamentarians, civil servants, civic leaders, soldiers and police, including for practical measures to safeguard the rights of both children and women. The international community can assist with technical expertise and funds to encourage the development of democratic institutions, as seen in Mozambique and Namibia. The international ban on landmines needs to be fully enforced, while the proliferation of weapons needs to be stemmed and small arms everywhere kept out of the hands of children.

60. Lastly, the lessons of past experience, the trends towards sector-wide and more integrated approaches to development assistance, and the existence of a series of ratified international human rights conventions and world summit declarations from the 1990s place a responsibility on all development partners, including UNICEF, to achieve well coordinated efforts in support of the priorities and urgent needs of African countries. There is a greater potential for success when Government and partners have formed consensus on priorities, the strategies to address them and the most effective roles of different partners. The major areas of threat to the rights of African children and women described in the present report, including HIV/AIDS, malaria, conflict and the persistent weakness of public health and basic education systems, provide critical tests for effective and responsible partnerships in the years ahead.

V. CONCLUSION

61. The priority areas identified and being pursued for UNICEF work in sub-Saharan Africa in the period of the current MTP also provide a link to the proposed new agenda for children in the next decade, which will be based on human rights principles (see E/ICEF/1999/10 being submitted to the Executive Board at the present session). Conflict and insecurity, the weaknesses of institutions, low access to basic services, and the dramatic challenges of HIV/AIDS and malaria pose the greatest current threats to children's and women's rights and well-being. In many countries and local contexts, the greatest priority actions for UNICEF and partners will be, for the foreseeable future, to ensure children's and women's survival. Conflict and HIV/AIDS are factors that intensify that priority for action, while making it clear that sustained improvements will only be achieved through strategies which address the deeper causes of childhood and maternal deaths and disadvantage.

62. At the same time, the basis for future recovery and sustained development must be laid through intensified and more effective efforts, by a dynamic range of partners, to invest in the capabilities of Africa's children. The priority given by UNICEF in Africa will be to support: the strengthening of basic health care systems for child and maternal survival; the access of all children, especially girls, to good quality basic education and learning opportunities; the strengthening of community capacity and practices for the protection of women and children; the promotion of non-violence, gender equity and post-conflict recovery; and the identification of viable approaches to improved family and community care for the survival and development of young children, including those affected by HIV/AIDS. All these provide building blocks for Africa's participation in a new era based on ethical principles and responsible partnerships, which place the rights of children and women first.

Good Luprinth Reality Effort

U.S. Agency for International Development

Bureau for Africa
Office of Sustainable Development
1325 G St., NW Suite 400
Washington, DC 20005

Date: Sandy Thurman

To: _____

Phone: _____

Fax: _____

From: Alex Ross

Phone: _____

Fax: _____

Number of Pages Including Cover Sheet _____

Message

Sandy, This is the draft of the mtg report/statement from the UNAIDS + Africa partnership's mtg in London. Of peripheral interest - but may contain some language or ideas. Just to let you know, we have problems with the

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 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.

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.

- 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 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:

The meeting 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 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
(vi) increase the predictability of aid, and flexibility in the allocation of aid

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 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 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.

4. 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.

5. 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.

   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.