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COUNCIL ON FOREIGN RELATIONS

58 EAST 68TH STREET • NEW YORK • NEW YORK 10021
Tel 212 434 9483 *Fax* 212 861 2701

Elise Carlson Lewis
Vice President
Membership & Fellowship Affairs

February 11, 2000

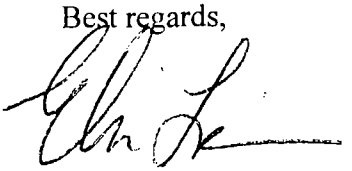
Ms. Sandy Thurman
Director
National AIDS Policy
736 Jackson Place
Washington, DC 20504

Dear Ms. Thurman:

On behalf of the Council's International Affairs Fellowship Program, I thank you for writing in support of IAF applicant Erica Barks-Ruggles.

The International Affairs Fellowship Selection Committee will meet on February 25th to choose this year's finalists. We are grateful for your interest and assure that your candidate will be given careful consideration.

Best regards,



Confirmed 11/4 - will speak to call end of Feb. or Mar. date.

COUNCIL ON FOREIGN RELATIONS

WASHINGTON OFFICE • 1779 MASSACHUSETTS AVENUE, N.W. • WASHINGTON, D.C. 20036
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Salih Booker
Senior Fellow &
Director, Africa Studies Program

O-CFR

October 17, 1999

Sandra Thurman
Director
Office of National AIDS Policy
The White House
1600 Pennsylvania Avenue
Washington, DC 20500

Dear Ms. Thurman:

On behalf of the Council on Foreign Relations, I am writing to invite you to participate in a meeting series at the Council entitled "American Policymakers on Africa." I hope that you will accept this invitation and agree to offer remarks (15-20 minutes) on the topic: "**American Interests in Combating AIDS in Africa**". We would like to schedule this meeting for April 2000 in Washington. Those in attendance would include an interesting cross section of the Council's membership and friends and your presentation would be followed by a discussion.

Please find enclosed a list of the other officials we are inviting to participate in this series. I realize that it is rather ambitious as we intend to offer one event each month in both our New York and Washington, DC offices. However, I am sure that you would agree that such a series could have a lasting impact on an important segment of American public opinion by engaging Council members in a sustained discourse on American interests in Africa.

I will follow up this letter with a call to your office to obtain your response and explore a date for the event should you accept our invitation.

Sincerely,

Salih Booker

Salih Booker

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Africa Studies Program

AMERICAN POLICYMAKERS ON AFRICA ROUNDTABLE SERIES

November: "U.S. Africa Policy - The Year Ahead"

Gayle Smith
Special Assistant to the President and Senior Director, African Affairs
National Security Council
(New York*)

Susan Rice
Assistant Secretary for African Affairs
Department of State
(Washington, D.C.*)

December: "America's Economic Interests in Africa"

Robert Mallet
Deputy Secretary
U.S. Department of Commerce
(Washington, D.C.*)

Stuart Eizenstat
Deputy Secretary
U.S. Department of Treasury
(New York*)

January: "American Interests in Expanding Trade with Africa"

James Harmon
Chairman
Export-Import Bank
(New York*)

Rosa Whitaker
Assistant to US Trade Representative for Africa
Office of U.S. Trade Representative
(Washington, D.C.*)

* Meeting venue

February: "Promoting Security in Africa - The U.S. Contribution"

Mr. Aubrey Hooks
Special Coordinator, African Crisis Relief Initiative
Department of State
(New York*)

Bernd McConnell
Principal Deputy Assistant Secretary of Defense for International Security Affairs
and Deputy Assistant Secretary of Defense for African Affairs
U.S. Department of Defense
(Washington, D.C.*)

March:

"American Interest in Investing in Africa's Future"
Jeff Griffin
Vice President for Investment Funds
Overseas Private Investment Corporation
(New York*)

"American Interests in Development Cooperation in Africa"
J. Brady Anderson
Administrator
U.S. Agency for International Development
(Washington, D.C.*)

April:

"American Interests in Combating AIDS in Africa"
Sandra Thurman
Director
Office of National AIDS Policy
The White House
(Washington, D.C.*)

"America's Changing Interests in Africa: The View from Congress"
Congressman Charles Rangel (D-NY)
Ranking Democrat, Ways and Means Subcommittee on International Trade
U.S. House of Representatives
(New York*)

* Meeting venue

May

"U.S. Interests in Supporting Debt Reduction for Africa"
Congressman James Leach (R-IO)
Chair, Committee on Banking and Financial Services
U.S. House of Representatives
(Washington, D.C.*)

"Africa, America and the World"
Ambassador Richard Holbrooke
U.S. Ambassador to the United Nations
(New York*)

* Meeting venue

O-CFR

COUNCIL ON FOREIGN RELATIONS

58 EAST 68TH STREET • NEW YORK • NEW YORK 10021
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Anne Luzzatto
Vice President, Meetings

June 22, 2000

Ms. Sandra L. Thurman
Director
Office of National AIDS Policy
736 Jackson Place, NW
Washington, DC 20503

Dear Ms. Thurman:

Many thanks for such a terrific meeting here at the Council. We appreciate your taking the time and hope very much to see you here again in the not too distant future.

Best regards and grateful thanks,

Anne Luzzatto

Anne Luzzatto

Council on Foreign Relations

Panel to discuss HIV/AIDS: A new priority for international security

5th June 2000

Briefing Pack

Joint United Nations Programme on HIV/AIDS

UNAIDS

UNICEF • UNDP • UNFPA • UNDCP
UNESCO • WHO • WORLD BANK

Council on Foreign Relations
Panel to Discuss AIDS: A New Priority for International Security
5 June 2000

Briefing Pack

Contents

1. Executive summary
2. Epidemiological summary
3. The destabilizing impact of the social and economic consequences of HIV/AIDS
4. The impact of HIV/AIDS on the military and on military/civilian interactions
5. The impact of HIV/AIDS on already complex and fragile geo-political systems
6. Responding to the epidemic
7. Financing the response
8. The International Partnership Against AIDS in Africa
9. Country fact sheets

1. Executive Summary

1. At the start of a new millenium, the Security Council debate on AIDS in Africa redefined the AIDS epidemic as a threat to human security. The epidemic has the capacity to reverse decades of national development, to widen the gulf between rich and poor nations, and to cause unprecedented social disruption. In some regions of the world, the epidemic is now more devastating than war: In 1998, 200,000 people in Africa died from conflict, but 2.2 *million* died from HIV/AIDS. More people will die from AIDS in the first 10 years of this century than died from all the wars during the entire last century. The rapid loss of human capital, from every walk of society, reflects the decimation of a major conflict, with similar consequences.

2. While the number of countries that experience this level of upheaval remains relatively small, they act as one window on the future. We know that, once the epidemic reaches a certain level – say 5 percent in the general population – the virus spreads very fast. And once this happens, huge social and economic disruption is inevitable. What has happened in the twenty one countries in the world with prevalence rates of over seven percent threatens to happen in many other developing and transition economies if action is not taken now, while the epidemic is still young. The world's steepest HIV curve in 1999 was recorded in the newly independent states of the former Soviet Union. There is evidence of worsening epidemics in Central America and the Caribbean basin. Leading indicators in many countries in South and Southeast Asia show that there is considerable cause for concern.

3. HIV/AIDS is rapidly becoming a the key global human security issues. Its effects are felt in three interrelated ways:

   Firstly in the rapidly destabilizing impact of the social and economic consequences of HIV/AIDS. These are felt in all sectors: health, education, industrial, agricultural, transport, as the skill base and other human capital is eroded. Macro-economic consequences through the gradual, but cumulative erosion of growth in GDP in heavily affected countries is becoming evident.

   Secondly, in the impact of HIV/AIDS on the military and on military/civilian interactions. War is an instrument for the spread of HIV/AIDS. The armed forces (both military and police) constitute a major population block in many societies, highly mobile and often called upon to serve at borders or to deploy outside of national boundaries. HIV infection poses a more serious threat to military populations than the inherently hazardous nature of their occupation. The impact of HIV on the *military* lies in the impact on human capital – compromising armed forces' readiness. The impact of HIV on civilian populations lies in the high rates of sexual interaction between military and civilian populations whether through commercial sex, or in rape as a weapon of war; and in the extreme vulnerability of displaced and refugee populations to HIV infection. People are six times more likely to contract HIV in a refugee camp than in the general outside population.

   Thirdly, in the impact of an epidemic of this nature on already fragile and complex geo-political systems. There were 27 conflicts in the world at the start of 2000, eleven of them are in Africa. Fifteen sub-Saharan countries are faced with food emergencies, while protracted drought in east Africa threatens further food shortages. A new, unprecedented generation of orphaned children in resource-poor environments may surely risk producing a generation of disaffected adolescents. Against this canvas, AIDS is a serious threat to the political stability of many countries.

4. The resource available to address HIV/AIDS are utterly disproportionate to the size of the problem. In 1998, major donor countries contributed approximately $300 million to the fight

against AIDS. However, current estimates suggest that between $1.6 billion and $2.6 billion a year are needed to mount an adequate response to the epidemic in sub-Saharan Africa alone. While better use can be made of the existing resources, the absolute shortage of financial and human resources to address the epidemic is critical.

5. We are not powerless against the epidemic, and large-scale successful responses have been documented. They are still too few in number. Nonetheless, we know that key elements of successful responses include strong political leadership, openness about the issues, and broad-based responses cutting across all sectors, and effective at the level of the community.

6. Evidence of good practice in relation to training of police and military personnel, in the preparation of peacekeepers, military observers and humanitarian workers, and in the demobilisation of armed forces provide the basis for scaling up national and international efforts. Similarly, the integration of HIV/AIDS awareness should characterize all preparation for dealing with humanitarian crises, and in handling the aftermath of complex emergencies, to break the cycle of these acting as fuel for the epidemic.

7. In response to the devastating effect of the epidemic in Africa, the International Partnership Against AIDS in Africa (IPAA) has been launched. If we are to alter the course of the epidemic in Africa, we need to scale-up, significantly, our collective efforts in this region. Only an urgent mobilisation of this kind can curtail the spread of HIV, sharply reduce its impact on human suffering, and halt the further reversal of human, social and economic development in Africa. The IPAA is intended to be such a mobilisation, which may become a model for other regions, as well.

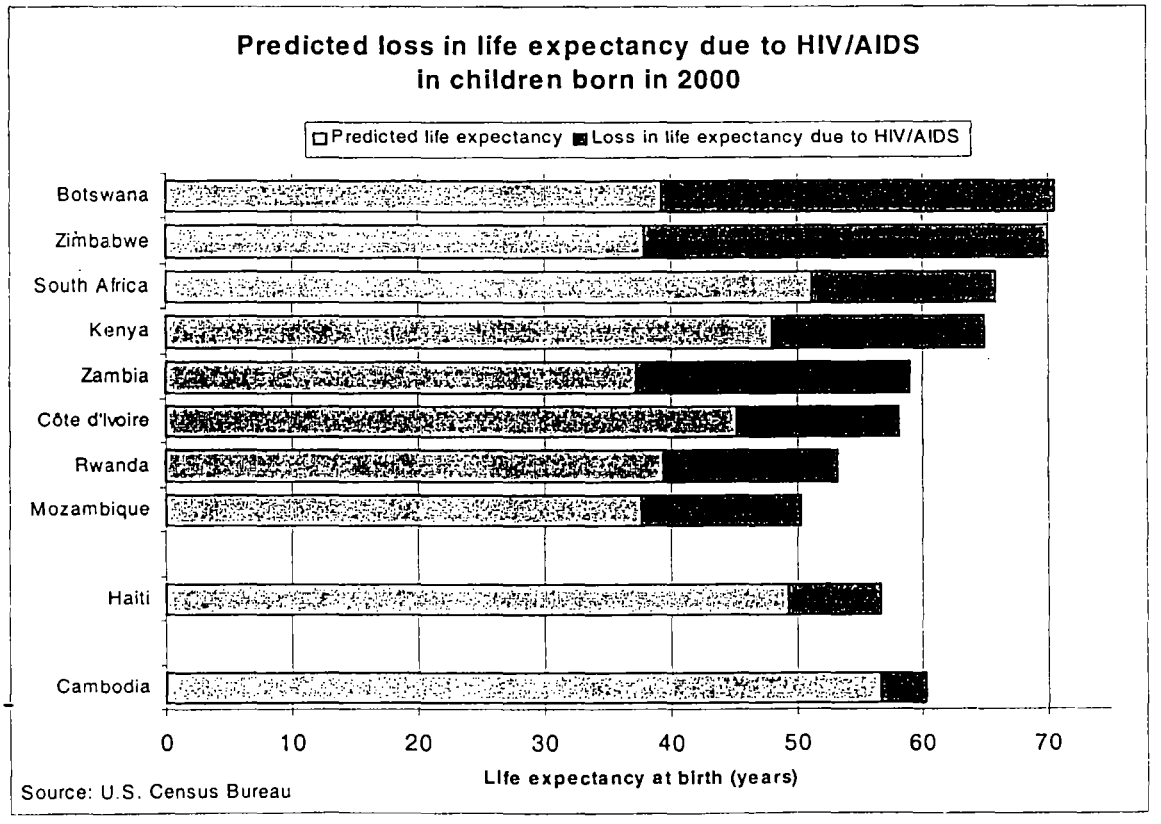
2. Epidemiological Summary

- According to estimates from UNAIDS and WHO, there were 32.4 million adults and 1.2 million children living with HIV by the end of 1999. Over the course of 1999, some 5.6 million people became infected with HIV. The year alone saw 2.6 million deaths from AIDS. With the HIV-positive population still expanding, the annual number of AIDS deaths can be expected to increase for many years before peaking.

- The impact of AIDS continues to be felt mostly in the developing world, with about 95% of the global total of people living with HIV. That proportion is set to grow even further as infection rates continue to rise in countries where poverty, poor health systems and limited resources for prevention and care fuel the spread of the virus. Hence, the huge gap in HIV infection rates and AIDS deaths between rich and poor countries is likely to grow even larger in the next century.

- Sub-Saharan Africa is the area of the world worst affected, with some 23.3 million estimated by UNAIDS/WHO to have HIV infection or AIDS. Not only are infection levels highest, but access to care is also lowest, and social and economic safety nets that might help families cope with the impact of the epidemic are badly frayed, in part because of the epidemic itself. Many African nations were evaluated downwards in this year's Human Development Index, a ranking published by the United Nations Development Programme (UNDP) to reflect health, wealth and education. Almost all of the major downward changes in rank could be ascribed to declining life expectancy – the direct result of AIDS. AIDS is now the leading killer in Sub-Saharan Africa. In 1998 in Africa, where 200,000 people died as a result of conflict of war, AIDS killed 2.2 million people. Life expectancy at birth in southern Africa, which rose from 44 years in the early 1950s to 59 in the early 1990s, is set to drop to just 45 between 2005 and 2010 because of AIDS. Figure 1 shows that a child born in Zimbabwe today has a predicted life expectancy of 38 years compared to 70 years in the absence of the AIDS epidemic.

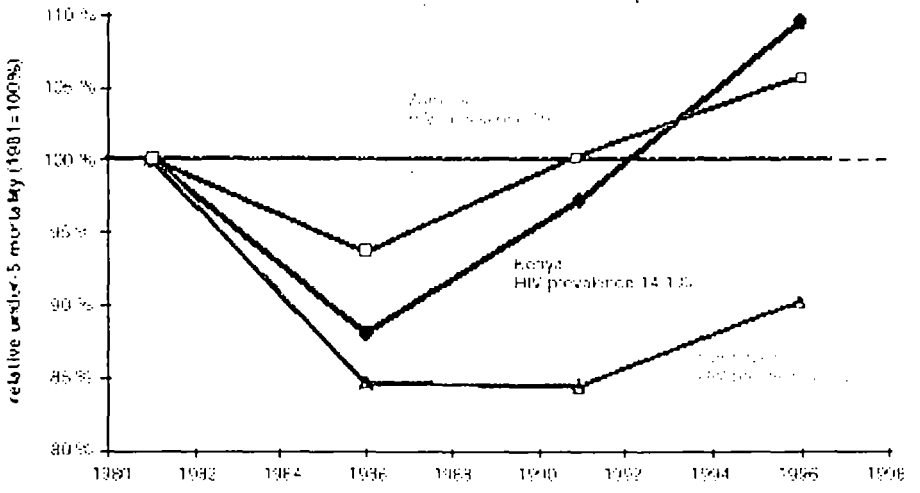
Figure 1: Predicted loss of life expectancy due to HIV/AIDS



- Figure 2 shows the demographic impact of the epidemic on under 5 mortality in selected countries. The decline of infant mortality was on of the major success stories of the 1970s and 1980s. High levels of adult HIV infection are now reflected in child mortality statistics.

Figure 2:

Trends in mortality among children under five years old and end-1999 adult HIV prevalence rate, selected African countries, 1981-1996



Source: Demographic and Health Surveys, Macro International, USA

- New information suggests that between 12 and 13 African women are currently infected for every 10 African men. There are a number of reasons why female prevalence is higher than male in this region, including the greater efficiency of male-to-female HIV transmission through sex and the younger age at initial infection for women. According to recent studies in several African populations, girls aged 15-19 are around five or six times more likely to be HIV-positive than boys their own age. The infection rate in men eventually catches up, but not until after they reach their late 20s or early 30s. Clearly, older men – who often coerce girls into sex or buy their favours with gifts -- are the main source of HIV for the teenage girls.

- Due to high levels of fertility, populations will generally continue to grow, but critical deficits will affect the economically active age groups. The situation is also highly unstable. Epidemics may suddenly explode, with rates of infection increasing several fold within only a few years, as has been observed recently in Botswana and South Africa. For example, in South Africa between 1993 and 1998, HIV prevalence in pregnant women increased from 4.3% to 22.8% in the province of Free State and from 9.6% to 32.5% in Kwazulu/Natal. In Francistown, Botswana, 47% of pregnant women aged 20-24 were living with HIV.

The table below shows the estimated prevalence in adults (age 15-49) in the 10 most affected countries in Africa.

Country	Prevalence – Year	Level/Trend
Zimbabwe	25.8 – 97	High/Stable
Botswana	25.1 – 97	High/Growth
Namibia	19.9 – 97	High/Stable

Zambia	19.1 – 98	High/Stable
Swaziland	18.5 – 97	High/Rapid growth
South Africa	16.7 – 98	High/Rapid growth
Mozambique	14.2 – 97	High/Stable
Kenya	13.4 – 98	High/Slow growth
Malawi	14.0 – 98	High/Uncertain
Rwanda	12.7 – 97	High/Uncertain

- Some Latin American countries, most notably Brazil, have expanded efforts to provide treatment to those infected. However, there is evidence that infections are on the rise in Central America and in the Caribbean basin, which has some of the highest infection rates outside Africa. The epidemic is driven by the combination of early sexual activity and high levels of partner exchange between young people. In Guatemala in 1999, some 2-4% of pregnant women tested at antenatal clinics in major urban areas were found to have HIV. In Guyana, HIV prevalence was recorded at 3.2% among blood donors - who are generally thought to represent a population at low risk of infection - while surveillance among urban sex workers in 1997 showed 46% were infected. The last time Haiti carried out HIV surveillance among pregnant women, in 1996, close to 6% tested positive for the virus. Altogether, UNAIDS/WHO estimate that some 1.7 million people in Latin America and the Caribbean will enter the 21st century with HIV infection - almost 30 000 of them children.

- In Asia, the pattern of HIV infection is lower relative to Africa. However, because of the large population sizes that exist for example in China and India, prevalence rates translate into large absolute numbers. Across the continent as a whole, UNAIDS/WHO estimate that 6.5 million people were living with HIV by the end of 1999, over five times as many as have already died of AIDS in the region. In some countries such as Thailand and the Philippines, strong prevention programmes have reduced HIV risk and lowered or stabilized HIV rates. Other countries have raised warning flags after collecting new information showing that injecting drug use is spreading and that condom use is uncommon, including among clients of sex workers and men who have sex with men. India has recently made a major effort to improve its understanding of the HIV epidemic and new results of surveillance reveal a very varied picture. In some states, principally in the south and west of the country, HIV has a significant grip on the urban population, with more than 2% of pregnant women testing positive for HIV. In the northeast, HIV infection has moved rapidly through networks of men who inject drugs and has spread to their wives. Other states of India detected their very first HIV infections only in the last year or two.

- HIV infections in the former Soviet Union have doubled in just two years. In the larger region comprising the former USSR as well as the remainder of Central and Eastern Europe, UNAIDS/WHO estimate that the number of infected people rose by a third over the course of 1999, reaching a total of 360 000. The world's steepest HIV incidence curve in 1999 was recorded in the newly independent states of the former Soviet Union, where the proportion of the population living with HIV doubled between end-1997 and end-1999. The bulk of new HIV infections were caused by unsafe injection of drugs and occurred in two countries, the Russian Federation and Ukraine. As the head of the Russian Federal AIDS Prevention Center announced recently, the true number of HIV cases in Russia may reach 300,000 or 400,000 in 2000 and about 1 million cases by 2005.

3. The destabilizing impact of social and economic consequences of HIV/AIDS

- The AIDS epidemic has become a true development crisis, now threatening the social and economic fabric of society, and the political stability of whole nations. Its impact on societies is as bad or worse, as that caused by civil strife and warfare.

- For many countries, especially in Africa, HIV/AIDS has become a complex epidemic, building on and exacerbating a severe poverty crisis and reversing decades of progress in social and economic development. As such, HIV infection has far-reaching consequences at all levels of society and its socio-economic repercussions stretch far beyond the domain of health. Yet the health sector continues to mount the front-line response.

- By killing large number 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.

- Several studies on the impact of AIDS on households have documented the tremendous burden of loss of income, large health care expenditures, and consumption of savings to pay for funeral and mourning costs. In Thailand, a study showed that 60% percent of families spent all their savings, 57% of elderly people were left to take care of themselves because of the loss of their grown children to AIDS, and 15% of affected families had to take young children out of school.

  A decrease in income will lead to a decrease in consumption and savings. In a study in urban areas in Cote d'Ivoire, outlay on school education was halved; food consumption went down 41% per capita; and expenditures to health care went up by more than 400%.

- The health systems of the countries which are hardest hit by HIV/AIDS are overwhelmed and the burden can only become heavier as those infected several years ago become ill. AIDS affects the health sector for two reasons: (1) it increases the number of people seeking services and (2) health care for AIDS patients is more expensive than for many other conditions.

  The number of AIDS patients seeking care is already overwhelming health care systems. Once HIV prevalence reaches five percent, demand for medical care is estimated to rise by at least 25 percent and to increase faster than government is able to supply it. In Cote d'Ivoire, Zambia and Zimbabwe HIV-infected patients occupy 50 to 80 percent of all beds in urban hospitals. This exacerbates problems of overcrowding and increases risks of infections such as TB and diarrhoea. Treatment facilities are often inadequate, diagnostics and drugs are in short supply and operational procedures have not been adjusted to the needs of people living with HIV/AIDS. For example, staff are often inadequately trained to identify opportunistic infections early enough, and to therefore improve quality of life through appropriate treatment. Fear and stigma may result in poor attitudes towards HIV infected patients.

  Problems of understaffing are acute. In highly affected countries, many staff are HIV infected themselves, some are seriously ill and many have died. Others are unable to continue work or are frequently absent because they are caring for their own sick relatives and, more and more often, attending funerals.

The overall result is a rise in the price of producing health care and an increased shortage of resources: beds, essential drugs, doctors, nurses, laboratory staff etc.

- AIDS affects the education sector in at least three ways. The supply of experienced teachers is reduced by AIDS related illness and death. Over 30 percent of teachers in Malawi and Zambia are already infected. Children are kept out of school to care for sick family members or to work in the fields. AIDS affected families can not afford school fees due to reduced household income.

- The epidemic is undermining private sector development by increasing expenditures and reducing revenues. An assessment of several private sector firms in Botswana and Kenya demonstrated that he most significant factors in increase labour costs were HIV/AIDS related absenteeism and burial expenses. These expenses are expected to double by 2005 if the epidemic continues to spread at its current rate.

- The loss of skilled workers is especially damaging to productivity and carries huge costs for private companies. In many industries, there are a small number of key functions on which the whole production process depends. For instance, without engineers skilled in pan boiling and centrifuging, the whole sugar industry comes to a standstill. The same is true for any small company, for which the loss of key employees is critical.

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

- Agriculture is the largest sector in many developing economies accounting for a large portion of production and a majority of employment. Studies done in Tanzania and other countries have shown that AIDS will have adverse effects on agriculture, including loss of labour supply and remittance income. The loss of a few workers at the crucial periods of planting and harvesting can significantly reduce the size of the harvest. In countries where food security has been a continuous issue because of drought, declines in household production can have serious consequences. A loss of agricultural labour causes farmers to switch to less labour-intensive crops. In many cases this may mean switching from export crops to food crops, affecting rural economies.

- The transport sector is especially vulnerable to AIDS and important to AIDS prevention. Building and maintaining transport infrastructure often involves sending teams of men away from their families for extended periods of time. A survey of bus and truck drivers in Cameroon found that they spent an average of 14 days away from home on each trip and that 68 percent had sex during the most recent trip and 25 percent had sex every night they were away. Most transport managers are highly trained professionals who are hard to replace if they die. Governments face the dilemma of improving transport as an essential element of national development while protecting the health of the workers and their families.

- Macroeconomic development: In 1993 the World Bank developed a model to calculate the macro-economic impact of the HIV epidemic at country level. The model calculated the loss per capita GDP for countries with a high HIV prevalence. The result of this exercise was that, on average, the countries lost 0.5 - 1.0% of growth per year. These figures may not appear initially alarming, but over several years the continuous loss accumulates. For a developing country like Kenya, where loss over ten years was calculated as 14.5% (1995 - 2005), the consequences for the economy are bound to take effect and seriously set back the development process of the country.

In other countries in sub-Saharan Africa where a Human Development Report on HIV/AIDS has been published, the impact on the HDI (Human Development Index) has been measured in a situation with and without HIV/AIDS. In Namibia the HDI is predicted to decrease 10% due to AIDS in 2006 (UNDP and UNAIDS, 1997), and in South Africa the HDI is predicted to decrease 15% due to AIDS in 2010 (UNDP and UNAIDS, 1998). The main indicators driving the HDI score are life expectancy and literacy rates.

4. The impact of HIV/AIDS on the military and on military/civilian interaction

- Today, the international community is challenged by the changing face of threats to peace and security – low intensity conflicts, internal emergencies, massive displacement of populations and complex humanitarian crises. In Africa alone, some 17 countries have been in open conflict or have just emerged from open conflict in 1999.

- Epidemic disease has presented a perennial problem for armed forces and for civilians with whom they come in contact. In many conflicts of the last 500 years, the impact of conflict-facilitated disease has been far, far more important than the direct impact of fighting.

- In most countries, infection rates of sexually transmitted diseases (STI) among the military are generally 2 to 5 times higher than STI rates in comparable civilian populations – even in peace times. In times of foreign deployment and in conflict situations, the risks go very much higher. This higher risk among the military also applies to the rate of infection with the HIV virus, which is, after all, one more STI.

- For example, prevalence among military conscripts in Mandalay and Yangon (Myanmar) has climbed from 0.4% in 93 to nearly 2% in '98 and, in some major cities, the prevalence among CSWs had increased to as much as 29% in '98, from 4% in '92.

- To a greater degree than in the past, peacekeeping forces and humanitarian relief missions are being deployed to address the human impact of these crises along with the already complex task of defusing smoldering internal or international conflict.

- In Africa, HIV and AIDS pose a far more serious threat to military populations than the inherently hazardous nature of their occupation. This reflects the structural nature of the risk environment for such mobile personnel, as well as the importance of the behavioural aspects of HIV transmission. The armed forces recruit people precisely in the age group at greatest risk for HIV infection - the 15-24 year old age group in which more than half of all HIV infections occur. Military personnel are particularly vulnerable since they are often away from home for long periods, and they are often in search of recreation to relieve stress and loneliness, and alcohol and drug use are often responsible for a blunting of judgement in these times of leave and recreation. They may have feelings of invulnerability, at an age and in a profession that excuses or even encourages risk-taking. Military personnel, camps and installations are known to attract sex workers and those who deal in illicit drugs. And off-duty soldiers can be counted on to have cash - but not necessarily condoms - in their pockets.

- The fact that the infection rate for the armed forces is higher than for the civilian population is an important factor to be aware of when African military and police play a role in peacekeeping. But, HIV transmission is a two-way street, and peacekeepers may be at risk of bringing HIV home with them as well as at risk of transmission to others if they bring the infection with them on the mission.

- In May 2000, Nigeria's President Obasanjo announced that about 11 percent of Nigerian soldiers in the West African peace-keeping force (ECOMOG) stationed in Sierra Leone and Liberia were infected with HIV. The Defence Minister, Theopholous Dadjuma, said the increasing involvement of Nigerian armed forces in operations abroad, and the long separation of servicemen from their spouses, had been identified as risk factors in the spread of the disease.

- A study of Dutch sailors and marines on peacekeeping duty in Cambodia found that 45 percent reported having sexual contact with sex workers or other members of the local population during a five-month tour. Even humanitarian relief and aid workers have highly elevated HIV vulnerability due to boredom and stress, resorting to sex as a key coping mechanism.

- There is evidence that during the UNTAC peacekeeping mission in Cambodia in 1992/93, the risk level for HIV transmission was raised for all groups: peacekeepers, UN personnel, relief workers, and the local population.

- There have been documented instances in which AIDS has been used as an instrument of war. Cases are cited, relating to conflicts in the Great Lakes Region of Africa, in which soldiers have raped women of "the enemy side" with the stated intent of infecting them with HIV.

- Military leaders in a number of countries are concerned that HIV and other sexually transmitted infections can compromise military readiness. The loss of training input, the loss of experience and skills, the cost of replacement training – all have their impact on military readiness. When a given military unit is missing several key members, sick for increasingly long periods or deceased and not yet replaced, it cannot be considered fully functional, and hence not deployable. Readiness is further eroded when many of those sick or lost due to AIDS are among the leadership and senior officer category. Any suggestion of diminished readiness in the security and defence establishment is a threat to peace and security.

Imperatives for action

- *Training of police and military personnel* – The training of military and police forces must cover HIV prevention and behaviour change, the basic elements of training in how to protect themselves, those whom they care about, and those whom they contact, from HIV and other sexually transmitted infections. Model curricula and briefing materials have been developed by such countries as Ghana, Morocco, South Africa and Zambia.

- *Preparation of peacekeepers, military observers and humanitarian workers* - Peacekeepers, international observers and relief/aid workers need to be well briefed, prior to arriving in the field, on HIV prevention and on the implications of the risk environment for their behaviour. Protecting themselves is important, but part of their mission is to provide and promote the restoration of security for the families and communities they serve – including protection from HIV. This kind of briefing needs to be regularly reinforced during each mission, and the means of protection (condoms) must be readily and consistently available. Briefing materials and training-of-trainer curricula for this purpose have been created and put into use by the U.N. Department of Peacekeeping Operations in collaboration with the Civil-Military Alliance to Combat HIV and AIDS.

- *Demobilisation of armed forces* – A military and police force, well trained in HIV prevention and behaviour change, can be a tremendous force for stabilisation and HIV prevention if these issues are placed high among their priorities. This can apply to their service within and outside their own countries, as well as when they return home for demobilisation. To render this a positive force in muting the threats to peace and security, preparatory training of those to be demobilised is indispensable.

  Training for demobilising troops and police needs to address:

  - the promotion of peace and security through an examination of the culture of violence and the use of force that have been fundamental elements in the crises that have faced their country in the past;
  - an understanding of the behavioural issues that underlie the structural nature of the HIV risk environment; and

- the potential for demobilised men and women to further serve their country, but now as peer educators for HIV prevention in their own communities.

5. The impact of HIV/AIDS on already complex and fragile geo-political systems

- Factors that pose a serious threat to social and economic development pose a very real threat to social and political stability. Current projections indicate a major public health and social development emergency continuing to unfold in the Sub Saharan region. The emergency is affecting all sectors of society, including the military, in much the same way as other complex emergencies do. Social disruption, poverty, hunger and the crumbling infrastructure of social services lead to a growing sense of helplessness and anger among disaffected populations. Governments are weakened by this kind of development impact, and they are perceived as less and less able to meet the needs of their people. This in itself is a threat to security.

- In these circumstances, sudden and catastrophic violence and turmoil make thousands of individuals and communities extremely vulnerable, as the humanitarian crisis in East Timor in the wake of the broader socio-political upheaval in Indonesia illustrates. The speed of the spread of HIV in Cambodia also bears testimony to the extreme vulnerability of countries that are only just emerging from decades of political and social disruption.

- Climatic vagaries, particularly drought, may contribute to a collapse in food security in parts of the region, further affecting populations already weakened by HIV/AIDS. Such a crisis in food production is currently happening in drought-affected East Africa. History has shown how much failed harvests and wide-spread hunger can compound the risks of social and political destabilisation. Some analysts have cited these as critical precipitating factors in the recent civil wars of the Great Lakes Region. Reconstruction after drought is more difficult in HIV-affected regions, where up to 25 percent of adults may be affected by AIDS.

- Changes in the population profile in heavily HIV/AIDS-affected countries mean that there are fewer adults and larger numbers of poor young people, children begin working at an earlier age (and for lower wages), and more young sex workers enter that marketplace. This leads to increasing numbers of disaffected children and adolescents in the streets, and rapid migration may act as a tinderbox to further violence and armed conflict.

- A rising middle class with high rates of HIV infection is also part of this new profile. They are people who know that drugs exist but are still too expensive to be offered by their own government: demand for expensive therapies may add to mounting political instability.

- There are currently several geopolitical systems that appear particularly vulnerable to the epidemic:

(a) the far north-east of Africa, with conflicts flaring among Eritrea, Ethiopia, Sudan and other Horn of Africa states,
(b) the Great Lakes region, where conflicts seem to be drawing the rest of Central, Eastern and Southern Africa into never-ending crises, and
(c) West Africa, with its recurring civil wars and the international "peace"-keeping forces drawn from the region fighting right along with the rest
(d) Southeast Asia, where the recent economic downturn that underscored the fragile nature of the region's economies and drew attention, among others, to the sheer scale of exchanges of cheap and vulnerable labour between and within countries.

- There is growing awareness of the "reciprocity of HIV and emergencies". Conflict is often virtually systemic – inter-ethnic, intrastate, interstate and international in nature. And the impact of this *culture of violence* on the communities and families of the countries concerned contributes greatly to the *structural nature of the risk environment* faced by both civilians and armed forces.

- Systemic conflict means refugees and displaced families are on the move all over Africa especially, people living in extremely vulnerable conditions, sharing the same space and vulnerability to HIV and other diseases with combatants and peacekeepers alike.

- The aftermath of complex humanitarian crises is consistently characterized by features which accentuate the HIV/AIDS risk climate:

  - Social disruption resulting in sudden, widespread and profound poverty. One of the first consequences of this is acute and often severe food insecurity suffered by the displaced family units.
  - The lack of income leads to the sale of sex by women – but also by children and men – as a last resource that can be resorted to for income to meet basic needs.
  - Increasing child labour, and many children living in the streets.
  - Active migration to find work, further disrupting family integrity.
  - Lives characterised by a desperation that fosters increases in sexual and domestic violence and abuse, rape, and gender inequality. Women are six times more likely to get HIV in refugee camps than in the outside general population. (In one study in Rwanda, aid workers documented the fact that 17% of raped women, previously HIV-negative, got HIV. In another study in Bosnia, an estimated 30-40,000 refugee women were raped.)
  - Decimated health infrastructure, along with a failure to maintain sexual and reproductive health services, blood safety, sterile equipment, counselling services, and facilities for care for those who are ill with HIV and TB.
  - Limited access to education, and the HIV prevention education offered may not be in tune with the people's beliefs or capacity to act.

Imperatives for action

- The aim is to mitigate the further human and social impact of HIV/AIDS as a result of these complex emergencies, and to enhance national capacities to deal with them.

- The starting point must be advocacy and awareness-raising for a more consistent and effective inclusion of HIV/AIDS prevention and care in any emergency response. This needs to address national leaders and decision-makers, as well as the administrators of aid agencies and their aid and relief workers.

- Addressing HIV-related human rights issues, and responding to violations of human rights is critical. This is an added and compelling reason to include concern for HIV prevention in these settings, with particular attention to the rights and needs of children.

- Disaster preparedness at national and international levels must include prevention of accelerated transmission of HIV/AIDS and the care of heavily infected populations as key elements of any strategy.

- All reconstruction and rehabilitation development projects must have HIV prevention components that address behaviour issues and that meet the needs of persons living with HIV and AIDS. Reconstruction and rehabilitation must draw on the experience and insight of persons living with HIV and AIDS.

- In relief and rehabilitation, it is essential to consider the special risks of women and children, their vulnerability in crisis and civil disruption, their reproductive health needs, and their need for protection (to counter the risks of bodily, sexual and psychological violence against them).

- Addressing the needs of men will also be critical, especially those whose lives have been deeply affected by the crisis, unemployed, dislocated and increasingly vulnerable to victimisation and HIV infection.

- Dealing creatively with health and social issues such as the risks of HIV transmission, and the sexual violence so often seen in humanitarian emergencies, offers a bridge for peace and conflict resolution. This needs to address:

  - An *understanding of the violence culture* that underlies the crisis being faced. This understanding will offer openings to facilitate the emergence of a *peace culture* for the populations involved, including military, police and the community. The beginnings of this type of transformation are emerging in Mozambique, and these steps need to be supported.

  - An *emphasis on behavioural issues that underlie the structural nature of the risk environment* is essential if progress in prevention is to be realised. The new models of training in HIV prevention and behaviour change for the uniformed services in use by the U.N. Department of Peacekeeping Operations, and in Ghana, Morocco, South Africa and Zambia have built on just this approach.

6. Positive responses

- We are not powerless against this epidemic, and large-scale successful responses have been well documented. Key elements of successful responses include strong leadership, openness about the issue, and broad-based "multi-sectoral" programmes at all levels in the community. Political leaders are now driving the response in many countries.

- Most governments have now understood that the first battle to be won in the war against AIDS is to break the silence and remove the stigma surrounding it—and that official recognition of the problem is the first step towards dealing with it. Many leaders have also spoken out strongly about the seriousness of the epidemic.

- When we look at successful action at country level or at state, district or community level, it has clear characteristics, which, over the past few years, UNAIDS has documented. Successful actions are characterised by 7 features:
    1. the impact of all actors coming together under one powerful strategic plan
    2. visibility and openness about the epidemic, as a way of reducing stigma and shame, and involving PWAs
    3. addressing core vulnerabilities through social policies
    4. recognising the synergy between prevention and care
    5. targeting efforts to those who are most vulnerable to infection
    6. focusing on young people, and
    7. last but not least, encouraging and supporting strong community participation in the response.

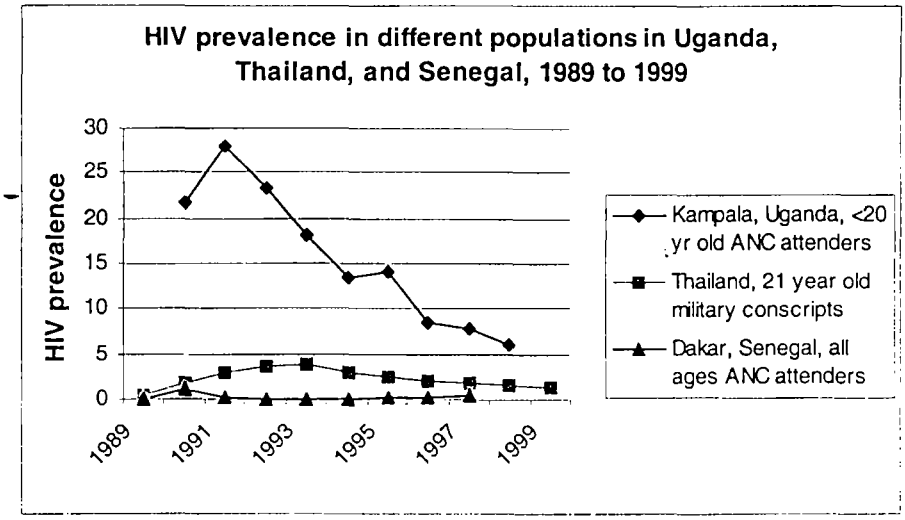
- Thailand's success in turning around its runaway epidemic therefore is characterized by the early recognition and admission of the potentially devastating impact of HIV/AIDS by the government around 1990. This led to a quick start of interventions. In a vast national study, patterns of infection of HIV among specific groups emerged, enabling the government to design a national mass media programme for the general population and to develop targeted interventions, for example among military recruits, sex workers, their clients and intravenous drug users.

- In Senegal, the battle against AIDS was given top priority in the early stages of the epidemic. In Uganda, once the extent of the epidemic became apparent, it quickly became a national priority. From the highest political level, every possible medium has been used to get the message out. As a result, Uganda has seen the levels of infection, which were climbing very fast, stabilized and in some instances, decline. Senegal has managed to keep its low level infection rates.

- Several government ministers and heads of parastatals in Ghana visited Uganda in May 2000 to understudy the Uganda AIDS Commission with a view to establishing an effective Ghana AIDS Commission. The members of the Ghanaian delegation were able to observe and hear from the horse's mouth the impact the epidemic has had on the economy, the different governmental sectors, communities and families. They learnt about the type of multisectoral responses which can reduce the spread of the infection.

- Figure 3 shows the effect of prevention in Uganda, Senegal, and Thailand.

Figure 3:



- In September 1999 during the launching of the National Strategic Plan to Combat STDs/HIV/AIDS, President Joachim Chissano stated that HIV/AIDS was an emergency for Mozambique and that it needed to be faced as the priority among priorities across all sectors.

- In February 1999 the King of Swaziland during the official opening of Parliament described HIV/AIDS as a "national disaster" and urged the launching of a nation-wide campaign to change attitudes. A National HIV/AIDS Crisis Management Committee has been established in Swaziland.

- China's State Council has declared AIDS a priority issue and issued a mid- to long-term plan in late 1998. The Plan clarifies strategies until 2010, with national targets including keeping HIV infections below a total of 1.5 million in 2010. Vice Premier Li Lan Qing has recently reiterated China's concern with AIDS and the country's commitment to keeping HIV infections low.

- On December 1, 1999 while addressing youth to mark the World AIDS day, Zimbabwe's President Mugabe declared HIV/AIDS a National Disaster. He revealed that he himself had lost members of his family to AIDS.

- In Botswana, a nationwide plan for combating AIDS was launched by the President in 1999, with 80% of the funding coming from within the country. The National AIDS Programme has been reorganized, empowered to facilitate the multisectoral mobilization. The National AIDS council is now chaired by the President himself.

- The Nigerian Defence Minister announced recently that the military had set up a committee to advise it on how to combat the spread of HIV/AIDS that is claiming the lives of many Nigerian officers and soldiers.

- In November 1998, Indian Prime Minister Vajpayee gave a watershed address to members of Parliament and the press. He spoke of the threat the epidemic posed to India, but also of the need for compassion and acceptance for people living with HIV, and for the protection of human rights.

- In a major initiative aimed at creating awareness about HIV/AIDS among the Indian citizens, the Indian government is organising a "Family Health Awareness" Fortnight from June 1 to 15, 2000.

- In Namibia, the Cabinet has approved a new national AIDS programme structure, focusing on the decentralization of the response. AIDS is now included in the agenda of the National Planning Commission, which is currently planning the use of country resources for the next decade.

- In a united effort to halt the spread of the epidemic, the Baltic states and Russia signed a $6.7 million "Baltic Sea Action Plan" for HIV/AIDS prevention. Estonia, Latvia, Lithuania and Russia noted that the window of opportunity to prevent an epidemic was closing quickly.

- In Latin America, governments have gotten together in a south-south 'horizontal' technical cooperation group which involves 21 countries and constitutes the basis of joint action and interchange in the Region. The Group has produced a collection of 'best practices in prevention and care' from the Region, has facilitated sharing of technical expertiese among countries and has worked together to establish common technical platforms on issues such as access to drugs in LAC, prevention of MTCT, management and evaluation of programmes.

- In South Africa a new partnership, involving all branches of Government and civil society, including the private sector, was launched last October.

- Community groups and non-governmental organizations also have a crucial role in the work to limit the spread of AIDS and to alleviate the suffering it causes. One such is the Women and AIDS Support Network in Zimbabwe who are educating, counseling, and organizing women and girls to make informed choices about their own health; to communicate with sexual partners about HIV and safer sex; and to lobby policy-makers for better protection of women's health. They also provide care for women affected by HIV/AIDS. The Network helped demonstrate that unequal gender relations fuel the epidemic and organized a successful petition drive to persuade the Government to make female condoms widely available.

- In the response to HIV/AIDS in Thailand, the important role of NGOs and CBOs is a key feature. Several hundred development NGOs are involved in AIDS work. Northern Thailand in particular has a number of unique models of home and community-based care.

- During a three-day conference in May 2000, Cambodian Buddhist monks learned from their colleagues from Thailand and the United States who were joined by health officials and relief workers how they can expand their roles as social leaders to fight an alarming AIDS epidemic.

- In Latin America, ASICAL - an Association of NGOs working on HIV/AIDS among men who have sex with men - has been working actively in 16 countries of the Region developing specific plans for addressing the needs and situation of this vulnerable population group.

- Private corporations, too, can play a critical role in this battle—for instance by providing premises for HIV education, by giving protection and support to their employees, and by taking a lead within the wider community.

- In South Africa, the electricity-generating company Eskom, which has over 37,000 employees, has for the last six years made HIV/AIDS one of its strategic priorities. As a result, it can now guarantee benefits to employees with AIDS and their families, and has funded clinics which offer tests, immune-system monitoring, and medical support.

- In Botswana, a number of companies have joined forces to form the Botswana Business Coalition on AIDS (BBCA). This group seeks to share information about prevention and care in the workplace. It also helps members plan to minimize the impact of HIV and keeps them up to date on legal and ethical issues raised by the epidemic.

- In Brazil, the private sector has established an active national business council on HIV/AIDS where several major national and transnational companies are active. Based on Brazil's experience, a new joint business council on HIV/AIDS of the Mercosur countries (involving Argentina, Chile, Paraguay, Uruguay, Bolivia and Brazil) is currently being established.

- In Zimbabwe, Rio Tinto has taken steps to protect its skilled workforce. It has formed AIDS action groups, led by volunteer employees, to act as counselors and lead education campaigns among their colleagues. And it is providing condoms to the largely male staff in its mining camps, many of whom face long periods of separation from their wives.

- In Thailand, the Thai Business Coalition is actively engaged in training programmes for Thai businesses.

- Throughout southern Africa medical research projects, education efforts and social support mechanisms are being backed by the new public-private partnership "Secure the Future", to which Bristol-Myers Squibb has donated $100 million for the next five years.

- In May 2000, UNAIDS announced that five pharmaceutical companies were willing to work with the UN and other partners to find practical and specific ways of making drugs for HIV/AIDS more widely available and more affordable for poor countries.

7. Financing the Response

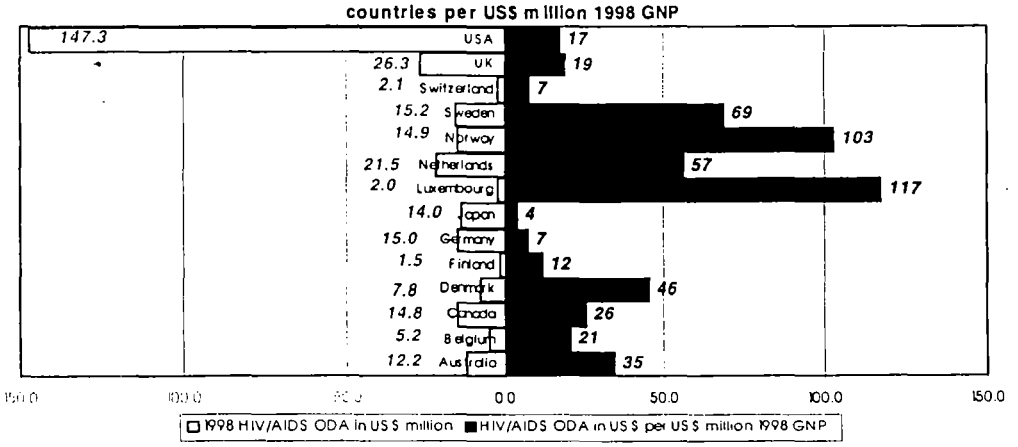
Australia, Belgium, Canada, Denmark, Finland, Germany, Japan, the Netherlands, Norway, Sweden, Switzerland, the United Kingdom and the United States reported having disbursed almost US$ 300 million for HIV/AIDS activities in developing countries and countries in transition in 1998 (Table 1).

Table 1. HIV/AIDS ODA Disbursements for Selected Donor Countries at Current Prices and Exchange Rates, 1998

Donor country	1998 HIV/AIDS ODA (US$ million)	Percent of total 1998 HIV/AIDS ODA
Australia	12.2	4%
Belgium	5.2	2%
Canada	14.8	5%
Denmark	7.8	3%
Finland	1.5	<1%
Germany	15.0	5%
Japan	14.0	5%
Luxembourg	2.0	1%
Netherlands	21.5	7%
Norway	14.9	5%
Sweden	15.2	5%
Switzerland	2.1	1%
UK	26.3	9%
USA	147.3	49%
Total	**300.0**	**100%**

The United States was by far the largest donor of HIV/AIDS ODA, disbursing US$ 147.3 million (49%). The United Kingdom and the Netherlands were the next largest donors disbursing US$ 26.3 million (9%) and US$ 21.5 million (7%) respectively. But when allocations are broken down as a proportion of gross national product (GNP) for each country, the picture is quite different.[1] Luxembourg and Norway disbursed the largest proportion of their country's GNP to HIV/AIDS activities in developing countries with US$ 117 and US$ 103 per US$ million GNP respectively (Figure 1). The United States and the United Kingdom disbursed US$ 17 and US$ 19 per US$ million GNP respectively.

Figure 1.HIV/AIDS ODA as reported by 14 donor countries: Total amount obligated, 1998, in US$ million and obligations reported by donor countries per US$ million 1998 GNP



[1] *Information on donor country GNP was taken from "Development Assistance Committee International Development Statistics." OECD website: http://www.oecd.org/dac/htm/dcdrsd-e.htm, 22 May 2000*

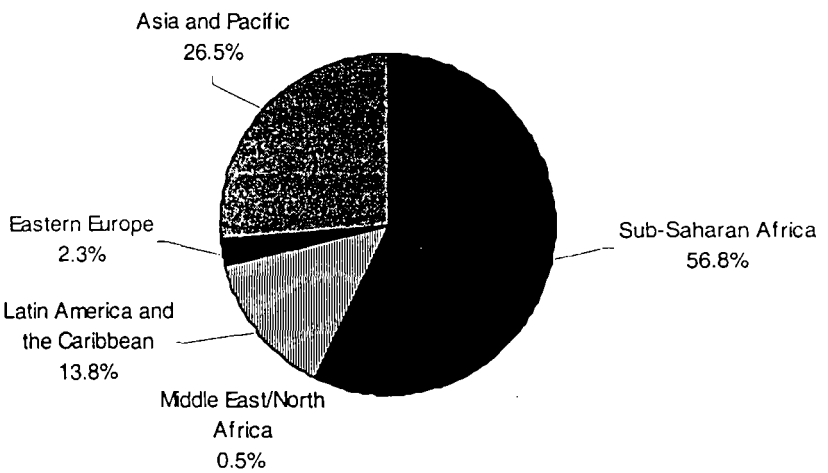
Another way to assess the level of HIV/AIDS ODA by individual donors is to consider HIV/AIDS ODA as a percentage of total ODA. In this case, Luxembourg, the United States and Australia disbursed the highest percentage of total ODA to HIV/AIDS activities with 1.8%, 1.7% and 1.3% respectively. On the other end of the scale, Japan, Switzerland and Germany disbursed 0.1%, 0.2% and 0.3% of total ODA to HIV/AIDS activities respectively. Overall, the US$ 300 million allocated to HIV/AIDS by the fourteen DAC member countries in 1998 represent 0.7% of the US$ 41 450 million that they disbursed in total ODA for that year.

Flow of 1998 official development assistance to HIV/AIDS

Of the US$ 300 million in ODA that were allocated to HIV/AIDS in 1998, 20% was channeled through multilateral agencies. Of the funds channeled through the Untied Nations and its specialized agencies, almost all (95%) were core budget contributions or supplemental funding for general agency HIV/AIDS activities. Only 5% of the funds channeled through multilateral agencies were multi-bilateral – or channeled through multilateral agencies for projects in specific countries. The large majority of the 1998 HIV/AIDS ODA reported (80%) was transferred directly to recipient governments or channeled through non-governmental organizations and other private institutions.

An additional way to assess the flow of HIV/AIDS ODA is to review the regional distribution of these funds. Over one third (35%) of the US$ 300 million reported was earmarked for "global or inter-regional activities." It is not possible to disaggregate these funds though a substantial proportion - including core contributions to the UNAIDS Secretariat – are eventually allocated to regions. Of the remaining 65% (US$ 195 million), 56.8% was earmarked for activities in sub-Saharan Africa (Figure 2), 26.5% was allocated to activities in Asia/Pacific; 13.8% to activities in Latin America/Caribbean; 2.3% to activities in Eastern Europe; and 0.5% to activities in the Middle East/North Africa region.

Figure 2. Distribution of regionally allocated HIV/AIDS ODA disbursements for selected donor countries, 1998

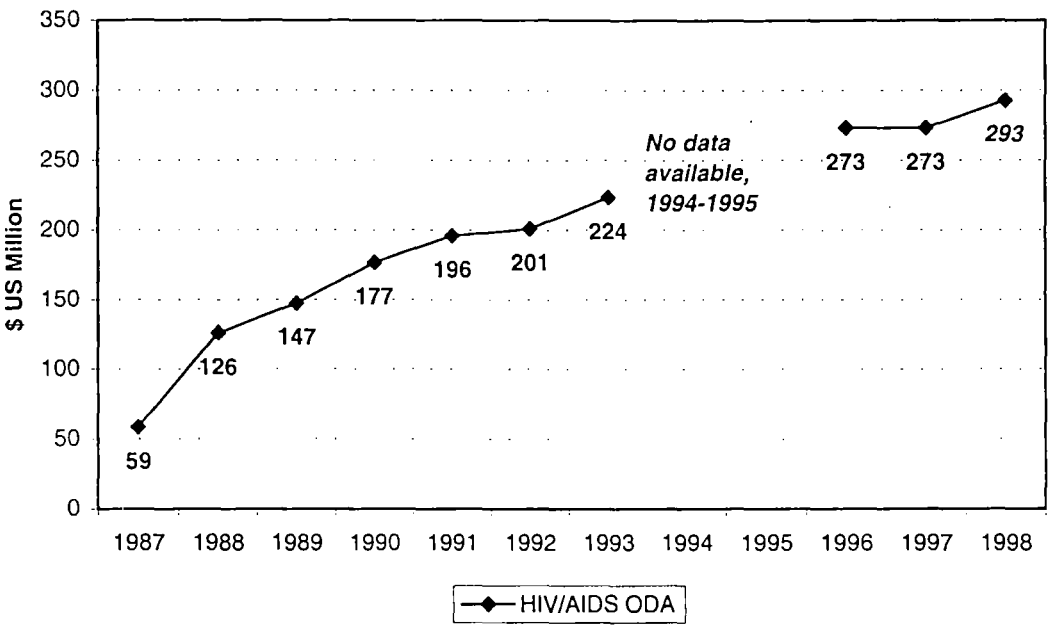


Trends in official development assistance to HIV/AIDS, 1987-1998

The 1998 data for the 10 donor countries for which data are available over time - Australia, Canada, Denmark, Germany, Japan, the Netherlands, Norway, Sweden, the United Kingdom and the United States - confirm most of the trends highlighted in the "Level and flow of national and international resources for the response to HIV/AIDS, 1996-1997."[2]

When inflation and changes in purchasing power parity are taken into account, the flow of HIV/AIDS ODA from these 10 countries increased each year from 1987 to 1996, remained stable between 1996 and 1997 and continued to increase between 1997 and 1998 (Figure 3).

Figure 3. Total HIV/AIDS ODA Disbursements by Selected Donor Countries at 1997 Prices and Exchange Rates, 1987-1998



Similarly, when trends in the flow of HIV/AIDS ODA are compared to the trends in overall ODA for these countries, the proportion of HIV/AIDS ODA within the total pot of ODA does increase slightly between 1987 and 1998 from 0.2% to 0.7%.

Finally, the trend in the decreasing flow of HIV/AIDS ODA through United Nations agencies is also confirmed with the 1998 data. This trend has been longstanding (since 1987), but reviewing only the last 3 years; donor countries decreased the HIV/AIDS ODA that they channeled through multilateral and multi-bilateral channels from 26% of all HIV/AIDS ODA in 1996 to 22% in 1997 to 20% in 1998.

[2] *Trend information also based on Mann J & Tarantola D, ed., AIDS in the World II (New York, Oxford: Oxford University Press, 1996) and Mann J, Tarantola T, eds., AIDS in the World (Cambridge, London: Harvard University Press, 1992)*

Issues and next steps in the monitoring of official development assistance to HIV/AIDS

- The UNAIDS Secretariat has made significant progress in establishing sustainable processes for the monitoring of donor country resource flows to HIV/AIDS on a long term and sustainable basis, but some key issues remain.

- Some major DAC members including France and the European Commission continue to have major difficulties in the reporting of their official development assistance allocated to HIV/AIDS.

- There continue to be differences in the ways that different donors define HIV/AIDS activities. This is particularly problematic the monitoring of HIV/AIDS components within integrated development projects or HIV/AIDS allocations within sector wide approaches and common basket funding schemes.

- Because of administrative differences among the DAC member countries, including differences in fiscal years, there is a significant delay in reporting. It is only possible to report on donor country HIV/AIDS expenditures almost 2 years late (i.e. reporting on 1998 data in mid 2000).

- Working closely with the DAC, UNFPA and the Netherlands Interdisciplinary Demographic Institute (NIDI), the UNAIDS Secretariat plans to convene a meeting of donor country representatives to agree on a common methodology for reporting on HIV/AIDS components within integrated development projects and HIV/AIDS allocations within sector wide approaches and common basket funding schemes.

- To supplement its monitoring of donor country HIV/AIDS obligations, the UNAIDS Secretariat is in the process of establishing a process to systematically monitor pledges and allocations to HIV/AIDS.

8. The International Partnership against HIV/AIDS in Africa

In May 2000, the Programme Coordinating Board of UNAIDS adopted a Framework for Action, establishing an International Partnership against AIDS in Africa. The following is a summary of the Framework for Action.

Why is the Partnership needed?

Nearly 70% of the world's infection by HIV/AIDS, and 90% of deaths from AIDS are to be found in a region that is home to just 10% of the world's population. Infection levels are highest in the sub-Saharan region, access to care is lowest, and social and economic safety nets that might help families cope with the impact of the epidemic are grossly inadequate.

The need to mount an *extraordinary response* is thus overwhelming. Current national AIDS activities in Africa must be expanded dramatically to make an impact on the epidemic. Experience shows that when governments commit their political prestige and financial resources, involve civil society fully, emphasize prevention and care, and support activities in a range of sectors, they are able to limit the spread of the epidemic and mitigate the impact, and attract international support. Only then can the rate of new infections be slowed. African leaders are demonstrating unprecedented leadership in fighting HIV/AIDS; the time is ripe for an extraordinary effort.

What is the Partnership?

The Partnership is a *coalition* of actors who, based on a set of mutually agreed principles, have chosen to work together:

- to achieve a shared vision,
- common goals and objectives, and
- a set of key milestones.

Its *purpose* is to establish and maintain processes by which governments, civil society, national and international organizations working against AIDS in Africa are enabled to work together more effectively to curtail the spread of HIV, sharply reduce its impact on human suffering, and halt the further reversal of human, social and economic development in Africa.

The *actors* of the Partnership are:

- African Governments
- The United Nations
- Donors
- The Private sector
- The Community sector

The partners believe that by acting in synergy with others the impact of individual actions can be dramatically enhanced and they can seek to build on development through best practice at every level. As such, the Partnership can be understood as a series of overlapping partnerships at different levels, and between different actors, working to common targets:

- At *country level*, members of the Partnership undertake to work under the leadership of national governments within a common, strategic framework, frequently called a "national strategic plan for HIV/AIDS". To be effective, this framework will identify core strategic and programmatic areas for intervention, and the role of different actors.

- At *regional and sub-regional level*, members of the Partnership will build on existing mechanisms for collaboration in the strengthening and development of regional resources, such as technical resource networks, available for rapid drawdown by national programmes seeking technical advice and training.
- At *global level*, the Partnership will identify processes and products in which to collectively invest. These will range from intensifying action on international public goods, to political processes, which are likely to result in greater resources and visibility for the epidemic, and where intensified and coordinated action is likely to have an impact.

Partnership: Vision, principles, international targets and the overall HIV/AIDS goal

The **vision** of the International Partnership Against AIDS in Africa is that within the next decade African nations with the support of the international community will be implementing larger-scale, sustained and more effective multisectoral national responses to HIV/AIDS.

Through collective efforts, promotion and protection of human rights and promotion of poverty alleviation, countries will:

- ***Substantially reduce new HIV infections;***
- ***Provide a continuum of care for those infected and affected by HIV/AIDS;***
- ***Mobilize and support communities, NGOs and the private sector, and individuals to counteract the negative impact of the HIV/AIDS epidemic in Africa.***

Principles are:

- African ownership and leadership of the Partnership at all levels: country and community priorities to drive the action, and implementation plans will be based on local priorities and contexts;
- Active involvement of people living with AIDS in setting the parameters of the Partnership and its design, implementation and evaluation;
- Focus on enhanced, more efficient results at country level;
- Respect, protection and fulfilment of human rights, compassion, and active opposition to all forms of stigma and exclusion of people living with HIV/AIDS;
- Promotion of public awareness both within and outside Africa of the HIV/AIDS epidemic as a development crisis that requires an urgent and sustained response on an unprecedented scale;
- Equal access to appropriate treatments and other scientific breakthroughs in prevention and care;
- Support for the development and implementation of joint national strategic action plans involving all relevant sectors;
- Partners fully committed to working jointly.

The ICPD+5 international target

The ICPD+5 United Nations General Assembly Special Session (UNGASS) set a new *internationally agreed target* for addressing HIV/AIDS in the world. While not exclusive to Africa, this valuable target focuses world attention and commitment to address the epidemic in the 25 most affected countries, 24 of which are in Africa. Governments, UNAIDS and donors have been called upon – and have agreed – to take the steps necessary to ensure that in these most affected countries by 2005:

- At least 90 percent of young men and women aged 15-24 have access to information and skills required to reduce their vulnerability to HIV infection;
- HIV incidence in 15-24 year olds is reduced by 25 per cent.

The overall HIV/AIDS goal

While reducing transmission is one critically important aspect of addressing the epidemic, this will not be achieved in isolation of concomitant efforts to:

- provide care and support to those affected;
- reduce suffering and mitigate the impact of the epidemic;
- decentralize the response through local government and community action;
- expand the response in the education, health, workplace and communication sectors, among others, through significant social and economic policy adjustments, including the strengthening of social safety nets for the most vulnerable;
- substantially increase the investment of financial, technical and political resources in HIV/AIDS-focused efforts;
- begin to deal with the challenge of children orphaned by AIDS and vulnerable children.

The IPAA contributes to the achievement of an overall HIV/AIDS goal which builds on the ICPD+5 target. It is important to note that the IPAA itself is not directly responsible for achieving the results, but rather will contribute to their achievement.

The overall HIV/AIDS goal is:

To curtail the spread of HIV, and to reduce sharply the impact of AIDS on human suffering and on the development of human, social and economic capital in Africa

Partnership: operational considerations

Outputs and milestones

In order to guide and monitor the progress of the Partnership in the early phases, *outputs and milestones* have been agreed. They provide strategic guidance on how the Partnership should be implemented over the next two years to meet the long term international AIDS goal and will be reviewed and revised as necessary annually. They have been articulated in the following areas:

- Intensified country-level action;
- National capacity strengthening;
- Agreed goals and indicators;
- Advocacy and political mobilization;
- Increased financial resources;
- Effective partnership mechanisms.

IPAA functions and mechanisms at country level

The key function of the Partnership at country level is to provide a mechanism for all actors to come together, under the leadership of government, in support of effective national strategic plans. While many countries already have national strategic plans, they have often failed to act as a platform around which all actors have been willing and able to programme their resources. The critical first step to coordinated working at country level is to develop a shared action plan, which will in most instances be incorporated into the national strategic plan; in others, they will supplement the existing national strategic plan. The key to their value lies in their role as a jointly negotiated and agreed statement of what all partners will do. For the purposes of this framework for action, they are referred to as "national action plans".

National Action Plans may include some of these:

- shared analysis and shared perspective on 'gaps';
- shared priorities;
- negotiated and costed action plans;
- agreed milestones and indicators of achievement;

- agreed working arrangements and responsibilities such as national coordination mechanisms; common design and appraisal; implementation; monitoring and evaluation; use of technical resources;
- agreed resource mobilization plans, drawing on all partners (government, donors, private sector) or potential partners;
- mechanisms to include diverse and non-traditional partners, both national and international;
- mechanisms for ensuring timely resource transfer and technical support to district/community level actions;
- mechanisms to ensure active involvement of persons living with HIV/AIDS.

Most countries are engaged in strategic planning processes. Government, civil society, the private sector and external partners are already engaged in AIDS programmes. What does the Partnership bring in which is different? We can identify a number of gains:

The value added of the IPAA lies in:

- A *co-ordinated response*: In most countries there is immediate scope for improved co-ordination. The willingness to negotiate around nationally negotiated plans to identify gaps and improve efficiency will be a significant step forward in many countries.
- A *scaled up response* by better use of existing resources and new resources. Resources are more likely to flow towards well-designed, clearly costed and well-implemented programmes, especially where it is clear that mechanisms are in place for moving resources to district and community level.
- A *linked response*: the IPAA will ensure that countries are properly linked to sub-regional, regional, and international resources and initiatives. By improving communications and the quality of information, and where necessary ensuring that brokering functions are performed, the Partnership will ensure that countries are able to benefit from other international and regional investments in addressing the epidemic, including in best practice development, information, commodities or technical expertise.
- A response based on the best practices *learned from two decades of experience with the epidemic: experience from two decades of the epidemic has generated a considerable body of good practice.*

IPAA functions and mechanisms at <u>regional level</u>

The key function of the Partnership at regional and sub-regional level is to ensure maximum impact at country level through cost-efficient high quality support for national programmes and for local initiatives within countries. Organizationally, inter-agency groups and networks of persons and institutions working on specific topics (e.g. voluntary counselling and testing, home-based care, management of STDs, AIDS and the education sector, national strategic planning, debt relief and AIDS, ethics/law and AIDS) will be the primary mechanisms for better coordination and stronger support to countries. Specific regional functions include the following:

- Coordination and strengthening of technical resources and improved mechanisms for rapid drawdown by any partner
- Support to leading institutions for training, policy analysis, research, etc.
- Use of existing coordination mechanisms to act as a platform for advocacy
- Development of mechanisms to address cross-border issues which require sub-regional perspectives
- Negotiations over the procurement of commodities, where regional/sub-regional levels have advantage over the national level.

IPAA functions and mechanisms at international level

At international level the Partnership's key function will be to support country, sub-regional and regional initiatives and to take forward international actions that will further enable effective local responses. Functions include:

- Advocacy to support the Partnership and to increase public and private (e.g. business, foundation, NGO and others) resources;
- Monitoring of the progress of the IPAA;
- More effective use of existing co-ordination mechanisms to act as platform for advocacy;
- Identification of areas, issues and mechanisms where international action, brokering, or coordination will add value to sub-regional and country-level actions: these may include negotiations over commodities such as condoms, testkits,etc.), advocacy for the development of new international public goods (particularly drugs and vaccines); amplifying the links between AIDS and poverty through the development of Poverty Reduction Strategy Papers (PRSPs), and debt reduction for Highly Indebted Poor Countries (HIPC)

The roles, responsibilities and membership of the Partnership

Members of the Partnership are those who state that they wish to work jointly with others in pursuit of an intensified response to AIDS in Africa, and are prepared to adjust their activities in line with Partnership principles. Members will be in agreement with the objectives, and milestones of the Partnership, and will be willing to act transparently, and to make information available to members of the Partnership, particularly at country level. While it is not envisioned that there will be any *formal* mechanisms in place for joining the Partnership, this internationally agreed Partnership document provides the basis for discussions and participation. At national level, the joint Action plan provides the vehicle for negotiating participation. It is clear that at each level of the Partnership, different partners will coalesce around different issues and instruments for taking forward action.

Conclusion

A significant increase in the resources committed to the Partnership is needed from all Partners. While the Framework demonstrates the intention of all Partners to use existing resources more effectively and efficiently, significant progress will not be made without increasing the human, technical and financial resources available. In anticipation of these additional inputs, this Framework sets out a working agreement as to how they might be best deployed, in support of national strategic plans, and in cooperation with all other Partners. If new and existing resources are henceforth deployed in accordance with the Partnership principles, vision, goal and purpose, set out in this document, the IPAA stands ready to make significant strides against the epidemic in Africa.

9. Country Fact Sheets

UNAIDS produces country fact sheets, which are updated regularly. The following ones are attached as examples of a cross-section of sheets. More can be obtained from the UNAIDS Secretariat.

(A) MALAWI

Socio-Economic Data

Total population (thousands), 1998	9,838	PHC [3]
% of population urbanised, 1998	14	PHC
Annual population growth rate, 1987-1998	1.9	PHC
Infant mortality rate (per 1,000 live births), 1998	137	UNICEF
Maternal mortality rate (per 100,000 births), 1990	560	WHO/UNICEF
Life expectancy, 1996	41	UNPOP
Adult literacy rate, 1995	M 72, F 42	UNESCO
Per capita GNP (US$), 1995	170	World Bank
Human Poverty Index Value (HPI), 1998	47.7	UNDP

2. Status of the Epidemic

Malawi has a mature epidemic with HIV/AIDS illness overwhelming the health delivery system. Mortality from AIDS is significantly depleting human resources in both public and private sectors.

- First 17 AIDS cases reported in 1985
- By 1996 AIDS had become the leading cause of death in population aged 15 – 49
- Life expectancy projected to rise to 57 years in 2010, will instead decrease to 44 years
- HIV prevalence in the population aged 15-49 years is 14%.
- One quarter of reported AIDS cases are in the 15-24 year age group.
- Number of female and male AIDS cases are six to one in the 15-19 age group.
- STDs are present in 43% of urban antenatal women at any one time.
- In spite of awareness levels up to 90%, behavioural change among Malawians has been limited and the number of incidences continued to increase.

3. National Response

3.1 Political Commitment

There is growing political commitment towards addressing HIV/AIDS as a priority issue. A cabinet committee on HIV/AIDS, chaired by the vice President, was established 1998 to oversee the activities of the National AIDS Control Programme and to provide support to issues requiring urgent attention. Public statements by the President and the Minister of Health in recent months show increasing political support for HIV/AIDS as a priority issue. At the launching of the Strategic Framework, the President committed himself to personally monitor the implementation of the framework. The Vice President delivered the opening address at March round table attended the full two days of the conference and then made the closing remarks.

3.2 National AIDS Programme

The National AIDS Programme operates within the Ministry of Health and Population. At central level a Secretariat and a Strategic Planning Unit has been established. The Secretariat has been strengthened by the appointment of a Programme Manager, Dr. W.C. Nkoma. In addition senior positions have been created for monitoring and evaluation, IEC/advocacy, care and social support.

[3] Population and Housing Census, 1998

At regional level (3 regions) two (full time) AIDS Co-ordinators (one female/one male) are employed and at district level (26 districts), one (part time) District AIDS Co-ordinator is positioned. Within the context of the National Strategic Planning Framework the placement, the legal status and the staffing of the National AIDS Secretariat is being reviewed to identify the changes required to enable the Secretariat to effectively manage and co-ordinate an expanded multisectoral response. An inter-ministerial committee is to be established to co-ordinate public sector interventions and to monitor the extent and the quality of mainstreaming of HIV/AIDS into the different sectors.

3.5 National Strategic Planning/Resource Mobilisation

Malawi has developed a national strategic framework which provides an important reference point for all stakeholders involved in the national response to HIV/AIDS in Malawi. The framework was launched by the President in October 99. The framework defines guiding principles, goals, objectives and strategies for improved planning, management and evaluation.

The framework has been costed at US $121 Million. A round table conference chaired by the Minister of Finance and co-chaired by the UN Resident Co-ordinator was held in March 2000. Ministers and principal secretaries from several other ministries attended the conference and made presentations about the impact of HIV/AIDS in their sectors and what they are doing about the epidemic in their ministries.

During the conference international development partners endorsed the framework and several made pledges to assist Malawi in bridging the resource gaps. The resource mobilisation round table raised in excess of US$100 million. However, the funding gap is expected to be wider when the needs of various ministries, districts and support organisations develop their operational plans and the activities of all the sectors are included in the framework.

4. Support by UN Agencies

4.1 UN Theme Group on HIV/AIDS

The UN Theme Group (TG) comprise of the Heads of all UN agencies represented in Malawi: UNDP, UNFPA, UNICEF, WHO (chair), World Bank, UNHCR, FAO, WFP, UNESCO and ILO. The TG has created a common UN identity and cohesion in support of the national response to HIV/AIDS. A UN integrated workplan is currently being developed.

Chair:	Dr. Nerayo Teklemichael, WHO Representative.
Members:	UNDP, WHO, UNFPA, UNICEF, World Bank, UNESCO, WFP, FAO, and ILO.
UNAIDS Personnel:	Angela Trenton-Mbonde, CPA Niels Sando-Pedersen, JPO

4.2 UN Technical Working Group on HIV/AIDS:

The UN Technical Working Group on HIV/AIDS (TWG) was expanded in 1998 to include members from international development agencies, international NGOs, the umbrella organisation for people living with HIV/AIDS (MANET +) and the National AIDS Secretariat. Members use the TWG for information sharing on best practices and on the current activities of their agencies. This forum also facilitates a greater understanding of the roles and mandates of other partners.

4.3 Support from UN system

Support from UN System agencies for HIV/AIDS activities in 1998-99:

Organisation	Amount US$
WHO	90,000 (99)

UNDP	870,000 (99)
UNFPA	2,000,000 (99)
WFP	
ILO	
UNESCO	5,000 (99)
UNAIDS*	174,000
Total	**3,139,000**

***PSR activities 1998-99:**
The UN Volunteer (UNV) support to PLWHA's collaborative pilot project to recruit, train and place PLWHA in strategic programmes of the national response. Ten national HIV+ UNVs have been placed and will serve for 18 months.

Pilot project to build partnerships between communities and health systems to improve access to drugs and care. The project has completed 4 rapid assessments in different regions of Malawi. Interventions have been designed to improve referral systems between hospitals, health centres and support groups; improve stock management and drug distribution, improve health workers attitudes and practices through training, expand the coverage of drug revolving funds etc. The assessment results have been used in the national strategic planning process and to co-ordinate HIV-related activities of Cosponsors.

National strategic planning:
Consultants to participate in the process with emphasis on gender and socio-cultural determinants.

Other projects:

Prophylaxis for multiple opportunistic infections among HIV-infected adults with active pulmonary tuberculosis (study ongoing but funded in 95 with GPA funds)	$95,917
To test the draft guidelines on integrating gender in national strategic planning and to contribute to "gender sensitization" of the National AIDS programme of Malawi.	$6,400
TOTAL	**$102,317**

SPDF

"Capacity building for community-based AIDS support group"	US$82,900
"HIV mobilisation, consensus building and strategy planning process: Capacity building for national response to HIV/AIDS"	US$47,000
"Improving access to care for people affected by the HIV/AIDS epidemic, particularly children, young people and their families"	US$44,700
"HIV/AIDS Distance Learning Project for Front Line Workers"	$149,900
"Developing and Implementing an HIV/AIDS workplace programme at the Ministry of Agriculture and Irrigation Development"	$31,750
"Sharing and documentation of Best Practices in Youth mobilisation for HIV/AIDS prevention".	$20,000
Total	**US$ 376,250**

5. Other External Support

5.1 Bilateral organisations in 1998-99:

Organisation	Amount US$
DFID	9,200,000 (99) [25 mill. GBP for 5 years + 900,000 1999]

USAID	3,200,000 (99)
EU	940,000 (99)
NORAD	400,000 (99)
GTZ	38,000 (99)
LUX	109,000 (99)
Others	720.000 (99)
Total	**14,498,000**

(B) NAMIBIA

1. Socio-Economic Data

Total population (thousand), 1997	1,613	UNPOP
% of population urbanised, 1996	37	UNPOP
Annual population growth rate, 1991-97	2.2	UNDP
Infant mortality rate (per 1,000 live births), 1996	58	UNICEF
Maternal mortality rate (per 100,000 births), 1997	103	WHO/UNICEF
Life expectancy, 1996	56	UNPOP
Adult literacy rate, 1996	81%	UNDP Namibia
Per capita GNP (US$), 1997	$1,984	UNDP Namibia
Human Poverty Index Value (HPI), 1998	30	UNDP Namibia

2. Status of the Epidemic

- Cumulative positive test (reported 1986 – end 1998): 53 330
- Estimated number of people living with HIV/AIDS(MOHSS/UNAIDS) 150-180 000
- Reported AIDS cases (as of 3/1997)* 6,784
- Estimated AIDS cases (UNAIDS estimate, 1998) 16,000
- Total reported deaths (MOHSS) 5 856
- Total reported hospitalisations 14 729
- Adult prevalence rate (UNAIDS estimate, 1998) 19.94 %
- Estimated number of women living with HIV/AIDS 75,000
- Estimated number of children living with HIV/AIDS 5,000

3. National Response

3.1 Political Commitment

There is a growing political commitment and willingness among senior politicians and government officials to address the problem of HIV/AIDS. The Ministry of Health has recently released a Policy on Confidentiality, Notification, Reporting and Surveillance.

3.2 Institutional arrangements for managing the national response

The National AIDS Coordination Programme (NACOP) which was launched by the President in March 1999 is under the leadership of the Ministry of Health and Social Services (MOHSS) but have a multisectoral focus.

- *The National AIDS Committee*, chaired by the Minister of Health and Social Services and co-chaired by the Minister of Local Government and Housing, is comprised of ministers from all sectors, and is intended to be the key policy making body on HIV/AIDS.

- *The National Multisectoral Committee on HIV/AIDS (NAMACOC)* is chaired by the Permanent Secretary of the MOHSS and includes regional Governors, permanent secretaries from all key ministries, representatives from NGOs, the private sector and the UN system (UN Resident Coordinator, Theme Group Chairperson and the Country Programme Advisor).

- *The National AIDS Executive Committee (NAEC),* is the key implementing body, and is chaired by the under-secretary of the MOHSS.

3.3. National Strategic Planning/Resource mobilisation

The national strategic plan was completed in 1998 and launched by the Minister of Health in March 1999. Seven major strategies, 89 targets, and hundreds of key activities with participation of all sectors

have been identified. Decentralisation of responsibility through the offices of the Regional Governors is a key component.

A considerable amount of work is currently invested in developing the implementation plan which aims to address prioritisation of current and planned activities within each sector both at central and regional level.

The National Multisectoral AIDS Coordinating Committee is currently developing a Resource Mobilisation plan.

4. Support by UN agencies

4.1 UN Theme Group on HIV/AIDS

There have been recent progress in improving communication within the TG on HIV/AIDS to ensure that all members are involved in decision-making, informed e.g. about SPDF projects. The PDO responsible for Namibia should pay a follow-up visit to support the CPA with this in July.

Chair:	UNFPA Representative, Mr. Kemal Mustafa
Members:	UNDP, UNESCO, UNFPA, UNICEF, WHO, FAO UNAIDS
Personnel:	CPA, Mrs. Mulunesh Tennagashaw
UNDP Officer in Charge:	Mr. A. Ly

The Theme Group (TG) comprises of the Heads of all UN agencies represented in Namibia. In a recent retreat of the Heads of the UN Agencies the TG on HIV/AIDS was reviewed along the lines of its function and membership. As a follow up to this retreat, the Permanent Secretary of the Ministry of Health and Social Services, Dr. K. Shangula, which is also the Chairman of the National Multisectoral AIDS Coordination Committee, has been invited to become a member of the TG. Agreement has also been reached to establish one additional Theme Group that will focus on Poverty.

Local cosponsors provided the bulk of operating expenses (administrative and programme activities) to the Theme Group secretariat (approximately US$91,000) in 1998-99 with both cash and in-kind support. The joint UN workplan (in support of the national strategic plan of action) is to be reviewed by the Theme and the Technical Working Groups.

4.2 UN Technical Working Group on HIV/AIDS

In a recent retreat of the Heads of the UN Agencies the existing three TWGs on HIV/AIDS (Communications/Youth, chaired by UNICEF, Health Sector Issues, chaired by WHO and Mitigation/Social Services chaired by UNDP), were reviewed along the lines of their function and membership. Agreement has been reached to restructure these groups. Current efforts are underway to establish two TWGs which will serve directly under the TG on HIV/AIDS, one on Mitigation and one on Communication, Youth and Education. In addition two TWGs, one on Gender and Human Rights and one on Health, will be established to serve both the TG on HIV/AIDS and the TG on Poverty.

The Chair and Deputy Chair of the Theme Group on HIV/AIDS will identify members of the Technical Working Groups. The TWGs will draw members from UN staff, government and various other partners and will be chaired by technical people from the Co-sponsoring agencies. All TWGs will develop detailed workplans. Their consolidation will result in the overall UN workplan in support of the national strategic plan on HIV/AIDS.

4.3 Support from UN System

Support from UN System agencies for HIV/AIDS activities in 1998-99:

Organisation	*Amount US$*
WHO	60,000 (in kind support to CPA)
UNDP	20,000 (in kind support to CPA)

UNFPA	698,000 (total programme)
UNESCO	5 000
UNICEF(Youth Health Development Programme)	552,737
UNAIDS*	702,808
Total	**US$ 2,038,545**

***UNAIDS**

Support to the multi-sectoral decentralised response to HIV/AIDS in Namibia (SPDF)	$180,000
National Study on HIV/AIDS Impact on farming communities in Namibia (SPDF)	$173,190
UNAIDS support to the National AIDS Executive Committee (SPDF)	$257,162
Support to inclusion of HIV/AIDS issues within National Planning Development (SPDF)	$92,456
TOTAL	**$702,808**

5. Other External Support

5.1 Bilateral organisations in 1998-99:

Organisation	*Amount US$*
Spanish Cooperation (Counselling Support Project)	184,000
Sweden (pending)	450,000
Germany (reproductive health 1999-2002)	DM 3 million
European Union	
Total	**634,000**

(C) CHINA

1. Socio- Economic Data

Total population (in thousands)		1,255,698	UNFPA 1999
Population aged 15-49 (in thousands)		704,949	UNPOP 1997
Urban population		31.9 %	UN 1996
Annual population growth rate (1997-2015)		0.7 %	UN 1998
Infant mortality rate (per 1,000 live births)		38	UNICEF 1999
Maternal mortality rate (per 100,000 live births)		900	UNICEF 1998
Life expectancy	Male 67.9	Female 72.0	UN 1998
Adult literacy rate	Male 90.8 %	Female 74.5%	UNESCO 1999
Per capita GNP (US$)		860	World Bank 1999
Human Development Index ranking		98	UNDP 1999

Source: UNFPA 1999, UNDP HDR 1999

2. HIV/AIDS Situation

	Data	Date
Reported HIV cases:	17,316	Dec 1999+
Reported AIDS cases:	647	Dec 1999+
Estimated number of adults and children living with HIV/AIDS, April 2000	500,000	1999+
Estimated number of AIDS cases	9,000	Dec 1997*
Reported cumulative AIDS related deaths	172	Dec 1997*
Selected HIV prevalence data		
IDUs in Xinjiang Province (in 1998)	40-85%	1999**
STI clinic attendees (in 1998)	0.1%	1999**
Female sex workers (in 1998)	0.1%	1999**
Antenatal clinic attendees (in 1998)	0.1%	1999**
Persons aged 15-49	< 0.1%	1999**

Source:

* UNAIDS- WHO Epi Fact sheet, data as end of 1997

** STI/HIV Status and Trends of STI, HIV and AIDS at the End of the Millennium, Western Pacific Region, WHO 1999

\+ 1999 Compendium of Provincial AIDS Surveillance data by the MOH AIDS Control Centre ('CAPM Report')

3. Status of the epidemic

- HIV prevalence data indicates focused concentrated epidemics among injecting drug users. Over 75 % of all reported HIV infections are attributed to IDU.
- As yet there is no significant documented spread in the non-IDU population. Surveillance among pregnant women remains low except for specific sites in Yunnan (Ruili county) and Xinjiang (Yining City) which have very high rates of HIV among IDUs.
- But HIV infections are also being recorded among sex workers in different sentinel sites in Guangzhou (1.1 %), Guangxi (6.3%), Xinjiang (0.7%). Together with the continuing high incidence of STIs, these suggest a real potential for significant sexual transmission of HIV.

- Overall, sharing needles among drug users remains the overwhelming mode of transmission. HIV prevalence rate among IDUs who were tested range from 44 to 85% in some communities of drug users in Yunnan and Xinjiang.
- The percentage of IDUs who report sharing of needles increased from 25% in 1997 to 60% in 1998. Highest rates of injecting among drug users were in Chongqing (86%), Hunan (85%) and Jiangxi (90%), while highest rates of IDU sharing needles were in Xinjiang (100%) Jiangxi (93%) and Hunan (75%).
- Five provinces can be said to have serious HIV epidemics among IDUs: Yunnan, Xinjiang, Sichuan, Guangxi and, more recently, Guangdong. During 1999 Guangdong experienced an explosive increase in HIV infection among drug users, from 0% in one site to 34%.

Source: Workshop for STI and HIV/AIDS Programme Managers, Manila, 29 Sep-1 Oct 1999, + CAPM report 1999

4. National Response

- The country's State Council has declared AIDS a priority issue and issued a mid to long-term plan in late 1998. The Plan clarifies strategies until 2010, with national targets including keeping HIV infections below a total of 1.5 million in 2010.
- Vice Premier Li Lan Qing has recently reiterated China's preoccupation with AIDS and the country's commitment to keeping HIV infections low.
- The authorities are concerned with the continued high number of reported STIs, but, while control of STIs is a national priority, this has yet to translate into concrete action.
- The National Programme is managed and monitored by an AIDS/STD unit within the Ministry of Health. Technical oversight and implementation is effected through a number of national specialized institutes.
- Central Government budgetary allocation for HIV has remained at the same level for the past three to four years, at around $ 2 million. But several of the more affected provinces have allocated budgets for HIV/AIDS or have taken up World Bank credits for AIDS/STD projects (e.g Yunnan, Guangxi, Xinjiang).
- Provincial planning and programming is actively promoted by the UN system and supported by the central authorities. And there are several good examples of provincial-level and decentralised responses.
- However, despite the multisectoral membership of the State Council's National AIDS Coordinating Committee, the overall response remains medicalised and narrow, with the Health Bureau supervising and guiding the programmes in all the provinces.
- Some multisectoral and non-health activities are becoming more evident but remain uneven and on a small scale.
- There are also a number of NGOs and semi-autonomous NGOs like the China AIDS Network engaged in AIDS/STD prevention work.

5. UN and bilateral support

- The UN system support is coordinated through the UN Theme Group. The Theme Group meetings are also attended by several bilateral agencies (Aus AID, EU, DFID), INGOs (Ford Foundation, SCF) and by the Government.
- Besides the World Bank's $25 million Health IX Project for AIDS/STD, there are substantial HIV-related projects executed by UNICEF (Yunnan), UNDP, WHO and UNFPA.
- Advocacy on HIV/AIDS at the highest political levels is one of the key strategies for the UN system in China, e.g the UN RC, TG Chair and UNAIDS Adviser recently sent a letter to Vice Premier Li LanQing who had himself addressed the Sate Council on the seriousness of HIV.
- There is significant support from DFID from this year (£ 15 m. 5 year project in 2 provinces, Yunnan and Sichuan) and from the EU (STD training).
- AusAID supports the work of several NGOs in selected provinces, including the development of a programme in Tibet and technical capacity building.

- Ford Foundation supports a number of sexual and reproductive health programmes in particular
- UNAIDS Secretariat supports strategic planning in selected provinces, documentation and dissemination of best practices, and innovative interventions (with the media, the workplace)

6. Issues and challenges

- HIV is still largely seen as a purely medical problem and/or a problem of IDUs.
- There are many other competing priorities in the social and developmental sector.
- Funding, and resources more generally, is inadequate. In addition the allocation of available resources may not always be strategic.
- Policies and guidelines in key areas – communication, life skills/sex education, harm reduction strategies - are lacking. Most advisory committees are dominated by medical experts.
- Political commitment at the different levels, especially at the critical provincial, county or city levels, remains insufficient.
- In the current low prevalence situation, discrimination and stigmatization are particularly common.
- Current legislation on drug use (and commercial sex work), and their negative connotations, limits effective prevention and outreach work including drug demand reduction, treatment and rehabilitation and other strategies to limit HIV transmission through drug use.
- Access to services, including voluntary counselling and testing, is very limited.
- Rate of condom use in commercial sex remains low, with more than 57% of all prostitutes interviewed never using condoms (more than 70% in Beijing and 93% in Anhui)
- Advocacy at different levels for investing in AIDS prevention programmes, for best practice policies, for an expanded response, and for increasing awareness and combating discrimination, are among the main challenges identified by the UN system. Also facilitating access to, and learning from, international experience for dealing with vulnerable populations.
- Overall, the vulnerability of China to HIV is very serious, with a veritable epidemic of risk behaviours. The authorities have reacted quickly in terms of policy, guidelines, regulations. But there remains an enormous gap between official talk and real effective preventive action.

Source: UN Common Country Assessment/UN Theme Group 2000

(D) VIETNAM

1. Socio- Economic Data

Total population (in thousands)	76,327		UNAIDS Vietnam Progress Report 1999
Population Aged 15-49 (in thousands)	29,722		UNDP HDR 1999
Urban population	19.5 %		UNDP HDR 1999
Annual population growth rate(Apr 1999)	1.76 %		UNAIDS Vietnam Progress Report 1999
Infant mortality rate (per 1,000 live births)	36.7		UNAIDS Vietnam Progress Report 1999
Maternal mortality rate (per 100,000 live births)	160		UNDP HDR 1999
Life expectancy	Male 64.9	Female 69.6	UNAIDS Vietnam Progress Report 1999
Adult literacy rate	Male 95.1%	Female 89.0%	UNDP HDR 1999
Per capita GNP (US$ in 1998)	352		UNAIDS Vietnam Progress Report 1999
Human Development Index ranking	110		UNDP HDR 1999

2. HIV/AIDS situation

	Data	Date
Reported HIV cases (as of Feb 2000):	17,596	1999***
Reported AIDS cases (as of Feb 2000):	3,142	1999***
Estimated number of persons living with HIV/AIDS (by late 1999)	88,000	1999***
Estimated number of cumulative AIDS cases	8700	Dec 1997*
Selected prevalence data		
IDUs (in 1998)	17.0 (0 – 85.0 %)	1999**
CSWs (in 1998)	2.4 (0-14.6%)	1999**
Antenatal attendees (in 1998)	0.08 (0-0.96%)	1999**
Male STD patients	0.94 (0-6.0%)	1999**
Persons aged 15-49	0.2%	1999**

Source:

* UNAIDS-WHO Epi Fact Sheet, data as of end of 1997

** STI/HIV Status and Trends of STI, HIV and AIDS at the End of the Millennium, Western Pacific Region, WHO 1999

*** UNAIDS Vietnam Progress Report 1999

3. Status of the epidemic

- Until 1997 HIV/AIDS was largely confined to the Southern and Central provinces, mainly among IDUs.
- Since 1998 there has been a rapid spread of HIV among young IDUs in the northern provinces and also among new ones in Ho Chi Minh City.

- There is evidence of increasing sexual transmission with rates having risen slowly but steadily among conscripts (from 0.03 % in 95 to 0.15 % in 98) and pregnant women (from 0.02% in '93 to 0.08 in '98)
- Official estimates of HIV infections for 2000 range between 135,000 to 160,000 (Source: National AIDS Committee)
- Two-thirds of new infections still occur among IDUs but the rising trend of infection rates among commercial sex workers (from 0.6 % in 93 to 2.4 % in 98) especially in the southern provinces bordering Cambodia is alarming.
- Currently, in the North and Central provinces the epidemic is mostly among IDUs. In the South, besides the epidemic among IDUs in Ho Chi Minh City, there is well documented heterosexual transmission in the provinces along the Cambodian border, with rates among CSWs of 14.7% in Angiang, 6.1% in Cantho.

4. National response

- The Government has acknowledged AIDS as a national priority.
- A multisectoral National AIDS Committee comprising 16 ministries and mass organizations is now chaired by a Deputy Prime Minister. It meets twice a year for policy formulation, resource allocation and planning.
- Provincial AIDS Committees are also established in all provinces, many of which have full-time staff.
- A National AIDS Bureau under the responsibility of a social scientist manages the national programme, with specific roles in monitoring, evaluation and coordination.
- A 5 year strategic plan has guided the response until this year and a new National Strategic Plan is being developed to take into account the new situation.
- The national HIV/AIDS budget has been around $ 5 million/year since 1994. Of this, about $3.2 million are allocated to prevention and advocacy activities.
- Despite the constraints of legislation and the policy of cracking down on "social evils" Vietnam has embarked on some innovative prevention activities including peer outreach programmes with IDUs and needle exchange programmes.
- Mass state organizations have become increasingly active in AIDS work, in particular the Women's Union and the Youth Union.
- A few local NGOs – the Centre for Reproductive Health, the Community Mobilization Centre, and the STD/AIDS Prevention Centre – have also emerged.
- There is some limited involvement of the private sector, notably through a project implemented by CARE with the Vietnamese Chamber of Commerce.
- Condom sales through condom social marketing (esp. DKT) have gone up from 3.5 million in 1991 to 92 million in 1998. Studies in Hanoi and HCMC show increased use of condoms by CSWs.

5. UN and Bilateral Support

- As early as 1995 the UN system through UNDP facilitated a Coordinated Programme of External Aid. This was further strengthened following the establishment of UNAIDS and the setting-up of a HIV/AIDS Action Group that brings together for regular programming the bilaterals, NGOs, UN system with the National AIDS Bureau.
- The UN Theme Group is currently chaired by the UNFPA Rep and he is supported by a UNAIDS Country Programme Adviser.
- More recently a joint UN Action Plan was prepared and has guided the support since late 1998. Within that framework there are a number of UN-funded or executed projects.
- UNDCP has a significant HIV/AIDS prevention component within its drug control collaboration programme with Vietnam.
- UNICEF through the Mekong Project supports adolescent and youth health programmes including a life skills program with the Vietnam Red Cross. Home based care activities are another focus.
- UNDP supports national capacity building, especially for management and planning and external aid coordination.

- UNFPA is supporting the integration of HIV/AIDS issues into mass organizations' programmes as well as specific programmes related to condom use and reproductive health.
- WHO provides technical assistance on surveillance and epidemiology and on improving blood safety.
- The World Bank may support blood safety initiatives and economic impact studies.
- UNAIDS Secretariat is supporting a pilot project on Access to Drugs.
- Overall the UN system in the last year has provided coordinated support in, among others, the following areas: condom promotion and distribution, youth programmes, prevention among mobile populations, PMTCT, VCT, prevention among drug users, blood safety.
- The UN TG has focused in addition on mobilizing resources, strengthening national capacity, facilitating collaboration with neighbouring countries (China, Cambodia) and tracking the epidemic.
- Bilateral assistance comes from, among others, the EU, Germany, USAID, Canada, Japan, and also includes Aus AID's support to programme development with the private sector, together with CARE Australia.
- Among INGOs active in Vietnam are the Australian Red Cross (peer education, counselling), CARE International (IEC, Social Research, Mobility), DKT (condom social marketing), PDI Asia (youth health), World Vision (IEC), Ford Foundation (Private Sector strategies), FHI (prevention and care interventions), Medecins du Monde,MSF.
- Between 97-99, the UN system has channelled US$ 4,570,000 for HIV/AIDS, 40% for capacity building, 16% for care and counselling, 10% for IEC and 12% for IDU programmes. The Secretariat's contribution was just over $900,000.
- During the same period, international NGOs and other donors have contributed $7,420,000, including 35% for capacity building.
- Government's own contribution between 1997-99 amounted to over $10,850,000.

Source of funding	Budget 97-99 US$	Percentage distribution for main programme areas					
		Capacity buiding	IEC	Care/ c'selling	Drug use/HIV	Condoms	STI / blood safety
Govt	10,850,162	8	28	52	0	0	0
UN system	4,571,949	40	10	16	12	1	20
International donors	7,422,189	35	10	26	0	19	8
Total	22, 844,300						

Source: UN Progress Report 1999

6. Issues and challenges

- The existing government decrees on the control of the "social evils" of prostitution and drug use hamper outreach prevention efforts with sex workers and drug users.
- HIV continues to be largely seen as a problem of drug users and sex workers.
- With 30% of the population aged between 10 and 24, the challenge is to mount effective sexual health education programmes.
- Despite the success of social marketing programmes, the supply of condoms and their use in risk behaviour situations remain problematic. More needs to be done in terms of social marketing, promotion of condoms.
- More recently an attempt was made to restrict the access to certain jobs of people with HIV. The decree is being amended following representations from NGOs and the UN.
- Discrimination and stigmatization therefore remain a major issue.
- IDUs and sex workers are still sent to re-education centres in many cases even though there is broad recognition of the futility of the strategy.
- Other challenges include improving access to services, particularly for voluntary testing and counselling; PMTCT; ensuring safety of injecting practices.

(E) CAMBODIA

1. Socio- Economic Data

Total population (in thousands)		10,716	UNFPA 1999
Population aged 15-49 (in thousands)		4,994	UNPOP 1997
Urban population		21.6%	UN 1998
Annual population growth rate (1997-2015)		1.8 %	UN 1998
Infant mortality rate (per 1,000 live births)		95	UNICEF 1999
Maternal mortality rate (per 100,000 live births)		340	UNICEF 1999
Life expectancy	Male 62.9	Female 65.1	UN 1998
Adult literacy rate	Male 55.2%	Female 25.4%	UNESCO 1999
Per capita GNP (US$)		300	World Bank 1999
Human Development Index ranking		137	UNDP 1999

Source: UNAIDS Country Profile, UNFPA 1999, UNDP HDR 1999

2. HIV/AIDS Situation:

	Data	Date
Reported HIV cases:	24,028	30.6.1999***
Reported AIDS cases:	4,834	30.6.1999***
Estimated number of adults and children living with HIV/AIDS	180,000 130,000	1999** Dec 1997*
Estimated number of AIDS cases	18,000	Dec 1997*
Selected HIV prevalence data		
Direct female sex workers (in 1998)	42.6%	1999**
Indirect female sex workers (in 1998)	19.1%	1999**
Police (in 1998)	Up to 25%	1999***
Hospital in-patients (in 1998)	12 %	1999***
Pregnant women/married women (1998)	Up to 6%	1999***
Male blood donors (in 1998)	4.1%	1999**
Female blood donors (in 1998)	2.5%	1999**
Persons aged 15-49 years (in 1998)	3.7%	1999**

Source:

* UNAIDS- WHO Epi Fact sheet, data as end of 1997

** STI/HIV Status and Trends of STI, HIV and AIDS at the End of the Millennium, Western Pacific Region, WHO 1999

*** STI/HIV/AIDS Surveillance Report (WHO Regional Office for the Western Pacific, Oct 1999)

3. Status of the epidemic

- Cambodia has the fastest-growing epidemic in the sub-region. There is evidence of rapid spread since 1992/93.
- The highest rates of infection are documented among direct female sex workers, with rates ranging from 21.4% in Kandal to 60% in Pursat. Among indirect CSWs, rates are between 6.7% in Takeo and 34.2% in Kampong Thom

- There are also significant prevalence rates among the police (from 0.7% in Svay Rieng to 25.8% in Koh Kong) and military.
- Among married women, sentinel surveys show rates ranging from 0.2% in Banteay Meanchey to 6% in Koh Kong. There is already significant perinatal transmission.
- The overall male/female ratio is currently estimated at 2: 1.
- The epidemic is widespread but more evident in the southeast and central provinces and along the Thai border.
- A sentinel sero-surveillance system operates since 1994, now covering 19 sites with yearly testing. (1999 data are not yet available)
- There is also a behavioural surveillance system set up in 1997 and covering 5 cities. The surveys indicate rising condom use in CSW contacts and some decrease in the use of commercial sex.

Source: *Country Profile – 3rd ed. 2000 : UNAIDS/TG/NAA/MOH Cambodia*

4. The National Response

- A National Strategic Plan – basically a Min. of Health Plan – has guided the national response since 1998.
- A National Centre for AIDS/STD Control (NCHADS) oversees the MOH response and is tasked also with providing technical support to other ministries and sectors.
- A National AIDS Authority was set up in 1999 to replace the National AIDS Committee and the National AIDS Secretariat.
- The NAA now oversees the national response. Among other roles, it coordinates the activities of different ministries and sectors, and monitors the epidemic and the response. The NAA Board is chaired by the Minister of Health and its membership is made up of secretaries of state from 12 ministries and provincial governors.
- Provincial AIDS Committees (PAC) chaired by the Governors are operational in most provinces. But their management mechanisms and capacity need strengthening.
- The capacity of non-health sectors for HIV/AIDS programming remains limited and the interest from the senior levels is variable. But there is increasing involvement from Defence, Rural Development, Women's Affairs, and Education and Youth.
- Priority ministries for expanded support are those of Interior (police) and Education (life skills for young people).
- Decentralization of the response with concurrent strengthening of the capacity at provincial level is a key priority. A central advisory team including representation from six ministries was set up by NCHADS in late 1997 to support the process.
- Quarterly meetings of the PAC have commenced this year.
- The UN sytem through UNAIDS, UNICEF and UNDP is supporting the provincial decentralization effort.
- Both international and national NGOs and CBOs are very active.
- Many of the NGOs are members of a national coordination committee (HACC) which meets regularly to coordinate efforts among NGOs as well as the NCHADS.
- In addition organizations working in the field of Health are regrouped under MEDICAM.
- A large proportion of international resources for HIV/AIDS are actually channelled to NGOs.
- For example, through KHANA (Khmer HIV/AIDS NGO Alliance), a key linking organization established through the International HIV Alliance, support is currently being provided to several national NGOs for over 35 projects in 13 provinces.
- There is also increasing involvement of religious organizations, esp. in care and support activities, including buddhist monks as well as smaller Christian groups
- With the significant contribution of the NGO/CBOs and the large number of NGOs actually engaged in HIV work, coordination and information exchange mechanisms still require strengthening.
- The growing burden of HIV/AIDS care on communities and the health system is a serious concern. Several NGOs, e.g MSF and Medecins du Monde, are providing care and support and there are attempts at developing PLWA networks.

- Involvement of PLWA in the response remains limited. There is one CBO supported through KHANA, and UNV/UNDP with UNAIDS is collaborating with the National AIDS Authority on a GIPA project.

5. UN and bilateral support

- UN system support is being coordinated by the TG chaired by the UNFPA Rep. Besides Cosponsors, the WFP, FAO, UNHCR and IOM are members of the TG. The National AIDS Authority also joins the meetings. The TG is presently discussing the expansion of its membership to include bilaterals and NGOs.
- In addition a technical focal points working group brings together international agencies and the national programme as well as the UN system.
- The focus of the UN support has latterly been on expanding the response through support to strategic planning, including provincial planning, and support to different sectors.
- The UN system also supported technically and financially the First National AIDS Conference in 1999.
- The World Bank has provided a loan aimed at building the capacity of the MOH and improving blood safety .
- UNICEF supports a community action for social development project targeting out –of –school youth, provincial programming, as well as IEC material development and PMTCT.
- WHO is providing technical support to NCHADS and pilot 100% condom programmes, programme management training STD programme planning, blood safety, and community-based care.
- Besides the GIPA initiative, UNDP supports national and provincial capacity building, and UNESCO supported the First National Conference and mass media activties.
- UNFPA works with the Ministry of Women's Affairs and on reproductive helath projects with young people (with the EC).
- Numerous multi-bilateral agencies are actively engaged in HIV activities.
- USAID notably through FHI/IMPACT is supporting a range of activities including interventions among CSWs and their clients, also the military and police, behavioural and serosurveillance surveys, condom social marketing, STD programming.
- France supports among others VCT activities in selected provinces, STD programmes, laboratory services and blood safety.
- The EC has supported AIDS/STD projects, and is partnering UNFPA on reproductive health services development projects.
- DFID is supporting condom social marketing. Condom social marketing programmes by PSI (with support from USAID as well) have been quite successful. And there are pilot interventions for the use of female condoms to be implemented through IMPACT, MSF, Horizons, PSI.
- AusAID supported the first National Conference in 1999 and has a small-grants programme for NGOs.
- Several INGOs, including CARE, MSF, Mediecins du Monde, World Vision, Red Cross and the International HIV/AIDS Alliance, support prevention as well as care and support projects.

6. Issues and challenges

- The AIDS epidemic is evolving against a background of rapid changes in the social fabric, characterised by important population movements.
- Although the commitment from provincial authorities has improved, the response at provincial level remains uneven.
- The prevalence of HIV among the large military and other uniformed forces is a worrying factor. It is compounded by varying degrees of awareness.
- There is a significant sex industry throughout the country, mostly tolerated and sometimes exploited by local authorities.
- Emerging priority vulnerable groups include seafarers and the mostly female factory workers.

- Vulnerable populations have limited access to information and services, including limited access to voluntary counselling and testing.
- The vast majority of those with HIV infection do not know their status.
- Discrimination and stigmatization are rife.
- Despite the success of the ongoing marketing programmes there is an urgent need for more effective and efficient condom promotion and programming in a country with high rates of other STI besides HIV.
- There is a rapid rise in the burden of AIDS-related illnesses placing enormous pressure on an already fragile health care system. So too is the burden on communities of PLWA but also of orphans. The development of community-based and alternative care systems will be a major challenge.
- The concomitant increase in tuberculosis and the prevalence of multi-drug resistant strains represent huge additional challenges.

(F) Ukraine

1. Socio-Economic Data

Total population (thousand), end of 1999	49,7 mln.	UNDP
% of population urbanised, 01.01.1999	67,9%	Ukraine State Statistic Committee
Mortality rate among population, 1998 (per 1000)	14,3	MoH
Infant mortality rate, 1996 (per 1000 live birth)	14,3	UNDP
Maternal mortality rate (per 100,000 births),1998	27,2	WHO/MoH
Life expectancy for males, 1998 Life expectancy for females,1998	63,3 74,0	WHO/EURO, Ministry of Health
Level of unemployment of economically active population in 1998	11,3%	Ukraine State Statistic Committee
Per capita GNP (US§), 1995		World Bank
Percentage of budget for public health to the general state budget in 1998- 2000, %%	15,77-15,73%	MoH
Percentage to GDP in 1998, 1999 and 2000, %	3,8-3,5-2,85	MoH

2. Status of the Epidemic

Estimate of PLWA	240,000
Number of HIV+ positive test results according to sero-epidemiological data	As of 1 March 2000 - 54,322
Total number of HIV infected persons registered officially since 1987	01.03.2000 - 31,360 (5434 new HIV cases in 1999), including 23,707 of IDUs
HIV Prevalence in selected groups of the population	Year, %
IDUs (in selected cities)	2000- 41% (Poltava)
Pregnant women (all age groups and regions)	1997-0,09%; 1999 - 0,16%
STD patients (all age groups and regions)	1997- 0,50%; 1999 - 0,63%
Blood donors	1997 - 0,06%; 1999 - 0,064%
MTCT (number of children born from HIV+ mothers)	1996- 92, 1997 - 197, 1998 - 389, 1999 - 696. Total number since 1987 - 1,288

3. National Response to the HIV/AIDS epidemic

Parliament of Ukraine adopted the alterations in the Law of Ukraine 'On AIDS disease prevention and social protection of the population' in March 1998. According to the Law, Ministry of Health of Ukraine was assigned as the body of central executive power responsible for the management and multisectoral coordination of AIDS response activities.

The Ministry of Health of Ukraine in cooperation with other interested ministries and departments has developed the third National Program on AIDS and Drug Abuse Prevention for 1999 – 2000, which was approved by the Cabinet of Ministers. This Program served as the basis to develop respective regional programs, to identify responses, terms of their implementation, structures and individuals responsible for their realization, sources of financing and control mechanisms, as well as to estimate their impact on the social and economic development of the country.

To ensure expanded response to the HIV/AIDS epidemics Strategic Planning Process has been initiated in Ukraine in 1999. The regional and international consultants, requested by the UN Theme Group on HIV/AIDS in co-operation with the government assisted the SPP launch. The multisectoral TWG was set up for conducting situation and response analyses.

Political Commitment / Multi-Sectoral Involvement

The National Co-ordination Council On AIDS Prevention has been established at the Cabinet of Ministers in 1999 and chaired by Vice-Prime Minister of Ukraine. The representatives from more than 25 ministries and state committees are the members of the Council. That allows to develop a comprehensive national policy and to co-ordinate multi-sectoral plans and activities of various ministries, as well as to ensure control and implement strategies to respond HIV/AIDS.

4. UN Theme Group on HIV/AIDS

Chair: Mr. Pedro Pablo Villanueva (UN Resident Coordinator, UNDP Representative)
Members: UNDP, WHO, UNFPA, UNICEF, WB, international NGOs and bilaterals, national partners.
UNAIDS Personnel: Mr Andrej Cima, Inter-Country Programme Advisor.

UN TG paid special attention to close collaboration with the Ukrainian government and non-governmental organizations in the resources mobilization for HIV/AIDS prevention. It had established regular contacts with the Ministry of Health as a coordinating body in HIV/AIDS prevention, and also with the Committee of Family and Youth, Ministry of Internal Affairs, Education, Academy of Pedagogical Sciences and with the Office of the First Vice Premier Minister.

UN TG plays an important role in providing advocacy for national strategic planning process. The SPP is linked to the UN integrated planning in support to national response.
The UN integrated workplan for 2000 has been developed. Representatives of UN country offices will continue to inform on a regular basis their respective HQs about HIV/AIDS prevention activities in Ukraine.
UN Theme Group also plays an active role in mobilizing technical and financial support to the strategic plan development and implementation (USAID, HRD Program/OSI, EC have been consider as a main partners).
The Technical Working Group under the TG was established and is co-chaired by UNAIDS and MoH. The Working Group is responsible for advice, support and facilitation of coordination. Main attention is focussed on the meetings of donors to improve the efficiency of international activities as well as to ensure proper use of limited resources.

5. Support from the UNAIDS Secretariat

SPDF 1998 –1999: USD 331,000
Activities: civil society development, HIV prevention in IDU community, prison and armed forces, assessment of youth access to the information on HIV/AIDS and drug use prevention, strategic planning, capacity building of the social services for youth.

PAF 2000-2001: USD 300,000
Plan being developed

6. Innovative current projects and initiatives supported by UNAIDS and other Cosponsors in Ukraine:

- Expanded HIV prevention activities in IDU community in the regions of Ukraine with greater involvement of the local NGOs, authorities and non-medical state services.

- Expanding response to HIV/STI in penitentiary system of Ukraine
- Promotion of peer education on Healthy lifestyles for Youth in Ukraine
- Assessment of the socio-economic impact of HIV/AIDS epidemics .
- Capacity building of Government organisations and NGOs from Ukraine and CIS (International Training Centre in Odessa)
- Implementation of the HIV sentinel surveillance in routine HIV monitoring system
- Promotion of the establishing self-support groups (associations) among FSWs to prevent HIV/STI spread.
- Expansion of HIV prevention interventions to other state sectors (armed forces, education, social services for youth, prisons etc.).

(G) Guyana

Socio-Economic Data

Total population (thousands), 1997	847,000	SBG
% of population urbanized, 1997	23	SBG
Annual population growth rate, 1995-2000	Unavailable	
Infant mortality rate (per 1,000 live births), 1995	63	
Maternal mortality rate (per 100,000 births), 1996	Unavailable	
Life expectancy, (1997-2000)	F 69 M 63	UNDP HDG/99
Adult literacy rate, 1998	95%	UNDP/99
Per capita GNP (US$), 1998	690	SBG
Human Poverty Index Value (HPI) 1998	Unavailable	UNDP

SBG - Statistical Bureau

Status of the Epidemic

Prevalence – Year	Trend
3-5% –1999	Generalised
3.7% (1993) 7.1% (1995)	Antenatal Clinic Attenders
18% - 1999	MSM
25% (1989) 25% (1993) 45% (1997)	Commercial Sex Workers
9.1% (1993) 21% (1994-5)	Male STI Patients

National Response

- The **National AIDS Programme Secretariat,** known as NAPS, operates as a unit of the Ministry of Health is the national coordinating body for the response to HIV/AIDS

National Planning

- A National Strategic Plan, 1999-2001 was developed to guide the national response. Its five components have been operationalised. These are Programme Management and Coordination, Information Education & Communication, Surveillance, Care & Treatment, Special HIV/AIDS Prevention and Control Programmes and Prevention, and Monitoring & Evaluation

Political Commitment

- The government has committed G$500,000,000 (five hundred million dollars) to assist in the implementation of the national response over the next three years. A National Policy on HIV/AIDS has been endorsed by the cabinet headed by President Bharrat Jagdeo. This will be tabled in parliament during this year.

Multisectoral Involvement

- Ministry of Health through the National AIDS Programme Secretariat is actively promoting a cross-sectoral response. This was evidence during the national consultation on HIV/AIDS which resulted in the development of the National Strategic Plan, 1999-2001 and the 1999 World AIDS Campaign.
- The NAPS also supports civil society involvement and work closely with a network of NGOs. NGOs work very closely with the NAPS.

- The NAPS works closely with the UNAIDS Theme Group.
- The National AIDS Committee has been reconstituted and is actively supporting the efforts of the national programme.

UN Theme Group on HIV/AIDS

Chair: PAHO/WHO representative Dr Bernadette Theodore-Gandi
Members: UNDP, UNESCO, WHO, UNICEF, European Union, CIDA, Ministry of Education, Ministry of Culture Youth & Sports, NAPS, Ministry of Health, G-Plus (Guyanese Network of Persons Living with HIV/AIDS.

Monetary Support from UN System Agencies for HIV/AIDS activities in 1997-1999

Organization	*Amount US$*
WHO	20,000
UNDP	9,600
UNESCO	In Kind
UNICEF	5,000
UNAIDS	205,650
Total	**239,650**

Support has been received from CAREC-GTZ. Unable to quantify these contributions as this is provided through support to consultants, surveillance and training.

(H) BOTSWANA

1. Socio-Economic Data

Total population (thousands), 1997	1,518	UNPOP
% of population urbanized, 1996	63	UNPOP
Annual population growth rate, 1980-95	3.3	UNPOP
Infant mortality rate (per 1,000 live births), 1996	40	UNICEF/UN POP
Maternal mortality rate (per 100,000 births), 1990	250	WHO/UNICE F
Life expectancy, 1996	52	UNPOP
Adult literacy rate, 1995	M 81, F60	UNESCO
Per capita GNP (US$), 1995	3,020	World Bank
Human Poverty Index Value (HPI)	22.9	UNDP

2. Status of the Epidemic

- Botswana is among the worst affected countries in the world.
- By November 1999, Ministry of Health estimates placed the HIV seroprevalence rate among the general population at approximately 19% and within the 15-49 year cohort at 29%.
- It is estimated that 100 new infections take place per day.
- AIDS is now a major cause of morbidity and mortality.
- 10% of the annual deaths are due to AIDS and HIV related conditions.
- ANC Sentinel Surveillance data indicate sharply rising seroprevalence rates in rural districts. Urban rates have been the same in the years 1996, 1997, 1998 and 1999*

ANC, Urban Areas

	1992	1999 *
⇒ Gaborone	14.9%	37%
⇒ Francistown	23.7%	43%

ANC Rural Areas

	1993	1997	1999
⇒ Lobatse	17.8%%	34%	31.34%
⇒ Serowe/Palapye	19.9%	34.4%	41.79%
⇒ Chobe/Kasane	18.3%	--	50.83%

STD Patients

1993	1995	1998
31.9%	41.6%	55.8%

3. National Response

3.1 Political Commitment

- The Government of Botswana, at its highest levels, is fully committed to tackling the HIV/AIDS epidemic.
- The President chairs the recently established National AIDS Council (NAC) and, at its first meeting in March 2000, indicated that the council was a "WAR COUNCIL," with its business having the priority and urgency attendant upon that status.

- The Minister of Health is particularly proactive in stimulating the country's response.
- The government is putting considerable resources into national AIDS prevention and care activities. For example, GOB Matches 3:1 every dollar that UNDP contributes.

3.2 Institutional Framework for managing the national response

Botswana is currently re-organising its coordinating structures and is in transition from a National AIDS Programme, which was entirely under the Ministry of Health and designated as AIDS/STD Unit.

- The National AIDS Council has been established. It is chaired by the President of Botswana and has representatives from government, NGOs, religious organisations, private sector, PLWA. Permanent Secretaries are members of NAC.
- A National AIDS Co-ordinating Agency (NACA) will serve as secretariat to the council. The Director of NACA is at the level of Permanent Secretary. NACA will be housed in the Ministry of Health. Selection of the NACA team has been moving with great deliberation.
- In each ministry (including ministry of health) a sectoral committee for HIV/AIDS has been established.
- District Multi-Sectoral AIDS Committees (DMSACs) are in place in 10 of the country's 24 districts. These pre-date the recent changes in the national coordination structure. It is planned that, by the end of 2000, another 6 DMSACs will have been formed.

3.3 National Strategic Plan

- A national AIDS Policy was produced in 1993. The current National Strategic Plan covers the period 1997 – 2002.
- An Operational Plan for the period 2000 – 2001 has been produced. The operational plan has been costed.
- However, it is anticipated that NACA, when it is established will have to revisit the National Strategic Plan with all key stakeholders and carry out a modified strategic planning exercise in order to promote multisectoral consensus and ownership for the plan. When this process has been completed, the country would then be ready for a resource mobilisation round table. But, given the fact that NACA has not yet been constituted, this may not take place until early 2001.

3.4 Multi-sectoral Involvement

- Other ministries are active in the National response to HIV/AIDS. Committees with very senior officials have been set up to address HIV/AIDS in each of the ministries.
- BONASO (Botswana National Association of AIDS Service Organisations) is the umbrella body of most NGOs involved in HIV/AIDS. It is represented on the National AIDS Council. The key roles of BONASO are co-ordination of the AIDS service organisations, information sharing, advocacy, capacity building of affiliate NGOs.
- Churches are actively involved in the national response to HI/AIDS in Botswana. Their involvement is in the areas of prevention, care, social and spiritual support.
- Private companies in Botswana have formed the Botswana Business Council on AIDS. There are different groups, which are catering for the needs of PLWAs. They are represented on the National AIDS Council.

4. Challenges to an Effective National Response

While Botswana is fortunate to have strong government leadership and financing for its response, it does have its share of challenges. Some of these are:

- The high level government commitment is not matched by similar attitudes among its middle and lower levels where the real work of translating policy and decisions into action needs to take place.
- The country is plagued by a chronic lack of qualified professionals. For NACA to be constituted, for example, most of its staff will have to be expatriates.
- Stigma, denial and discrimination are high.
-

UN Support:

UN Theme Group

- **Chair:** WHO Representative, Dr. T. Guerma
- **Members:** UNDP, WHO, UNFPA, UNICEF.
- UNHCR is the only other UN agency present in the country. It is not a TG member because it has only one officer to deal with an increasingly heavy portfolio and a wide geographic area. This leaves him no time for involvement in the Theme Group. But given the vulnerability of refugees, the CPA has initiated contact with him and, to date, has provided material relevant to HIV/AIDS management in refugee settings.
- Three GOB ministries have been included in the Theme Group (Health, Finance and Local Government).
- **CPA:** Rosalind Saint-Victor posted to Botswana in November 1999.
- The current chair of the Technical Working Group (TWG) is UNICEF. The process to upgrade the functioning and outputs of the TWG is scheduled to begin in May 2000.

The Theme Group has developed a Matrix showing the activities of each agency and is now in the process of developing an integrated plan.

Support from UN in 1999:

Organization	Amount US$
WHO	268,700
UNDP	352,831
UNFPA	204,000
UNICEF	246,000
UNAIDS*	140,000
Total	1,111,531

Other External Support

Bilateral organisations in 1998-99:

Organization	Amount US$
SIDA	1,058,493
Total	1,058,493

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