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Rigby, John T., et al. *Key Factors in Establishing Foundations and Endowments in Mali*. Washington, D.C.: USAID, 1993. PN-ABR-661.

Royal Government of Bhutan (RGOB), UNDP, and WWF. *Trust Fund for Environmental Conservation in Bhutan*. Prospectus.

Schearer, Bruce S. *The Role of Philanthropy in International Development*. Paper Prepared for the October 1995 Rockefeller Foundation Bellagio Conference on "Human-Centered Development: The Role of Foundations, FLOs, and NGOs." New York, New York: The Synergos Institute, 1995.

Schearer, Bruce S., David Winder, and John Tomlinson. *The Emerging Role of Foundation-Like Organizations in Strengthening Civil Society in Southern Nations*. New York, New York: The Synergos Institute, n.d.

Silverstein, Cathy, and James G. Herne. *An Impact Evaluation and Economic Analysis of TechnoServe's PL-480 Title II Monetization Program in Ghana*. Norwalk, Connecticut: TechnoServe, 1994.

Spergel, Barry. *Trust Funds for Conservation*. Washington, D.C.: World Wildlife Fund, 1993.

TechnoServe. *Managing a Local Currency Endowment: An Historical Guide for Title II Operators (Community Enterprise Development and Investment [CEDI] Trust)*. Norwalk, Connecticut: TechnoServe, 1993.

USAID. *Israel FY 1985 Cash Transfer*. Program Assistance Approval Document. Washington, D.C.: USAID, 1984. PD-AAY-115.

USAID. *Grant Agreement Between USAID and the Instituto Superior de Agricultura*. Washington, D.C.: USAID, 1989a. PD-KAO-729.

USAID. *A Summary of the Program of Economic and Social Cooperation Between Portugal and the United States*. Washington, D.C.: USAID, 1989b.

USAID. *Design Document for the Costa Rican Export Promotion Fund*. Washington, D.C.: USAID, 1990a. PD-ABI-614.

USAID. *Joint Local Currency Sub-Programming Agreement Between the Government of Costa Rica, the Government of the United States of America, the Central Bank of Costa Rica, and the FUNDEX Foundation*. Washington, D.C.: USAID, 1990b.

USAID. *Audit of the Regional Agricultural Higher Education Project, USAID/Costa Rica Project No. 596-0129*. Washington, D.C.: USAID, 1991. PD-ABC-560.

- USAID. *Family Planning Endowment (FLAS)*. Project Paper. Washington, D.C.: USAID, 1992. PD-ABE-948.
- USAID. *Commercial Farming Systems Project (517-0214)*. Project Assistance Completion Report. Washington, D.C.: USAID, 1993a. PD-ABH-935.
- USAID. *Options for Sustainability: Reader on Endowments as a Modality for Funding Development Work*. Washington, D.C.: USAID, 1993b. PN-ABS-327.
- USAID. *Guidelines: Endowments Financed with Appropriated Funds. Policy Determination 21*. Washington, D.C.: USAID, 1994a. PN-AAV-470.
- USAID. *Project Paper Supplement for the Swazi Business Development Project (645-0235): A Proposal to Establish an Endowment for the Swazi Business Growth Trust*. Washington, D.C.: USAID, 1994b.
- USAID. *Protected Areas Resources Conservation Project*. Project Assistance Completion Report. Washington, D.C.: USAID, 1994c. PD-ABL-899.
- USAID. *Regional Agricultural Higher Education*. Project Evaluation. Washington, D.C.: USAID, 1994d. PD-ABI-948.
- USAID. *CADERH Endowment Proposal: Basic Education and Skills Training Project (522-0388)*. Washington, D.C.: USAID, 1995a.
- USAID. *Mexico Nature Conservation Fund*. Project Paper. Washington, D.C.: USAID, 1995b. PD-ABL-583.
- USAID. *Performance Evaluation of the Costa Rica Export Fund*. Final Report. Washington, D.C.: USAID, 1995c. PD-ABM-239.
- USAID. *Trust Agreement: Ecological Trust Fund of Panama*. Washington, D.C.: USAID, 1995d.
- USAID. *Honduran Agricultural Research Foundation (FHIA)*. A.I.D. Evaluation Summary. Washington, D.C.: USAID, 1996. PD-ABM-464.
- USAID. *Model Cooperative Agreement for Establishing an Endowment*. Washington, D.C.: USAID, n.d.
- U.S. Department of the Treasury. *The Operation of the Enterprise for the Americas Facility*. Report to Congress. Washington, D.C.: U.S. Department of the Treasury, 1996.

Weatherly, W. Paul. *Endowments in Africa: A Discussion of Issues for Using Alternative Funding Mechanisms to Support Agricultural and Natural Resources Management Programs in Africa*. Draft Copy. Washington, D.C.: USAID, 1996.

Winrock International. *Escuela Agrícola Panamericana (EAP) Endowment*. Washington, D.C.: USAID, 1988. PD-AAX-992.

World Bank. *Facing the Global Environment Challenge: A Progress Report on World Bank Global Environment Operations*. Washington D.C.: World Bank, 1996.

The World Conservation Union (IUCN), The Nature Conservancy (TNC), and the World Wildlife Fund (WWF). "Report of the First Global Forum on Environmental Funds." Santa Cruz, Bolivia, May 30-June 2, 1994. IUCN, TNC, and WWF, 1994.

APPENDICES

A. Inventory of USAID-Funded Endowments

ENDOWMENT NAME	COUNTRY	REGION	DATE ESTAB.	FUNDING TYPE	USAID FUNDING (in dollars)	SECTOR
Ghana Comty Ent. Devt & Invest Trust	Ghana	AFR	1992	local currency	\$3,000,000	enterprise development
Madagascar Natl Environ Endow Fund	Madagascar	AFR	1996	local currency	\$6,000,000	environment
Swazi Business Growth Trust	Swaziland	AFR	1995	dollars	\$5,000,000	private sector development
Family Life Association of Swaziland	Swaziland	AFR	1992	local currency	\$1,681,000	health/population
Int'l Ctr for Diarrheal Disease Research	Bangladesh	ANE	1996	dollars	\$1,000,000	health
Indonesia Biodiversity Foundation	Indonesia	ANE	1995	dollars	\$16,500,000	environment
U.S.-Israel binational foundations	Israel	ANE	1980s	local currency	n.a.	industrial, agric. R&D; science; education
Korea Devt Institute; Korea Inst. for Science and Technology	Korea	ANE	n.a.	local currency	est. \$70,000,000 (KDI)	science and tech. (KIST)
Nepal National Social Welfare Association	Nepal	ANE	1993	dollars	\$600,000	education
F'dation for the Philippine Environment	Philippines	ANE	1992	local currency (debt swap)	\$18,000,000	environment
Luso-American Development Foundation	Portugal	ENI	1985	local currency (ESF)	\$118,000,000	economic, social and cultural devt
PROFAMILIA	Colombia	LAC	1993	dollars	\$6,000,000	health

ENDOWMENT NAME	COUNTRY	REGION	DATE ESTAB.	FUNDING TYPE	USAID FUNDING (in dollars)	SECTOR
Arias Foundation	Costa Rica	LAC	1993	dollars	\$500,000	sustainable development
Cordillera Devt Fdn (FUNDECOR)	Costa Rica	LAC	1990	local currency	\$10,000,000	environment
Costa Rica/USA Foundation	Costa Rica	LAC	1996	local currency	\$12,000,000	sustainable development
Agric. College of the Humid Tropical Region (EARTH)	Costa Rica	LAC	1985	local currency	\$60,000,000	agricultural education
FUNDATROPICOS	Costa Rica	LAC	1993	local currency	n.a.	agricultural education, research
Costa Rican Export Promotion Fund (FUNDEX)	Costa Rica	LAC	1990	local currency	\$27,150,000	export promotion
Agricultural Devt Fdn (FDA)	Dominican Republic	LAC	1988	local currency	\$4,000,000	agricultural research
Superior Inst. of Agriculture (ISA)	Dominican Republic	LAC	1989	local currency	\$2,400,000	agricultural education, research
Junta Agro-empresarial Dom.	Dominican Republic	LAC	1992	local currency	\$1,260,000	agricultural development
Fund. Economia y Desarrollo (FEyD)	Dominican Republic	LAC	1994	local currency	\$652,000	economic development
Pontificia Univ. Catolica Madre y Maestra (PUCCM)	Dominican Republic	LAC	1994	local currency	\$435,000	democracy
FUNDAGRO	Ecuador	LAC	1988	local currency (PL-480)	\$3,300,000	ag research, extension, educ.
Institute for Agric. Strategies (IDEA)	Ecuador	LAC	1989	local currency (PL-480)	\$400,000	agricultural policy analysis

ENDOWMENT NAME	COUNTRY	REGION	DATE ESTAB.	FUNDING TYPE	USAID FUNDING (in dollars)	SECTOR
CADERH	Honduras	LAC	1995	dollars	\$600,000	education
Hond. Agric. Re- search Fdn (FHIA)	Honduras	LAC	1993	local currency	n.a.	agricultural de- velopment
Hond. Envir. Trust Fund (Fund. Vida)	Honduras	LAC	1993	local currency (PL 480)	\$10,000,000	environment
Pan-American Agric. School (Zamorano)	Honduras	LAC	1987	local currency	\$15,000,000	agricultural edu- cation
Jamaica Natl Parks Trust Fund	Jamaica	LAC	1990	local currency (debt swap)	\$400,000	environment
Mexico Nature Conserv. Fund	Mexico	LAC	1996	dollars	\$19,500,000	environment
Ecological Trust Fund (Fund Natura)	Panama	LAC	1995	dollars	\$8,000,000	environment
Argentina EAI Fund*	Argentina	LAC	1993	local currency (EAI)	--	environment and child survival
Bolivia EAI Fund*	Bolivia	LAC	1991	local currency (EAI)	--	environment and child survival
Chile EAI Fund*	Chile	LAC	1992	local currency (EAI)	--	environment and child survival
Colombia EAI Fund*	Colombia	LAC	1992	local currency (EAI)	--	environment and child survival
Initiative for Americas Fund-El Salv.*	El Salvador	LAC	1992	local currency (EAI)	--	environment and child survival
Environmental Fdn of Jamaica (EFJ)*	Jamaica	LAC	1992	local currency (EAI)	--	environment and child survival
Fund of the Americas- Uruguay*	Uruguay	LAC	1993	local currency (EAI)	--	environment and child survival

* Financed by the U.S. government (not USAID)

B. Descriptions of USAID-Funded Endowments

1. Ghana Community Enterprise Development and Investment Trust

The Community Enterprise Development and Investment (CEDI) Trust in Ghana is one of the first created with funds generated from monetization of the U.S. PL-480 Title II Program, and one of the first created in Africa (TechnoServe 1993:2). Endowments created through Title II monetization were prohibited by U.S. law until November 28, 1990, when the Agricultural Trade Development and Assistance Act of 1954 was amended (TechnoServe 1993:1). Since 1992, TechnoServe, a U.S. private voluntary organization, has invested proceeds from the sale of Title II wheat (the local currency equivalent of approximately \$3 million dollars) in the CEDI Trust Fund. The trust is used to provide partial funding for the TechnoServe/Ghana enterprise development program. The CEDI Trust can also be used as a venture capital fund for investments, loans, or loan guarantees for rural enterprise development (USAID 1994:10).

2. Madagascar National Environmental Endowment Foundation

The Madagascar National Environmental Endowment Foundation (NEEF) was established under USAID/Madagascar's Knowledge and Effective Policies for Environmental Management (KEPEM) Project. The equivalent of \$6 million in local currency was provided for an endowment. NEEF, which was recognized as a formal institution on January 25, 1996, is a grant-making foundation that finances environmental projects. It is estimated that the foundation will be able to grant approximately \$250,000 in 1997 (Source: Information provided by Robert Hanchett, USAID/Madagascar).

3. Swaziland: Swazi Business Growth Trust

The Swazi Business Growth Trust (SBGT), an NGO, was established in 1992 as the main implementer for the Swazi Business Development Project. SBGT has operational programs in the areas of training, construction services, linkages, business planning services, marketing and credit. The SBGT program is consistent with USAID/Swaziland's strategic objective of expanding the Swazi-owned small business sector. The purposes for establishing an endowment were to help ensure the survival of the organization and to assist in leveraging other donor support. A \$5 million USAID-funded endowment was established in 1995 (USAID 1994b).

4. Swaziland: Family Life Association of Swaziland

In September 1992, USAID began a project with the Family Life Association of Swaziland (FLAS) to improve and expand family planning services, and an endowment of about \$1.7 million was created. In this case, USAID provided an endowment to an existing institution (established in 1979) that had a successful track record. Since the endowment was provided through a project arrangement, USAID plays a larger role in monitoring and oversight. During the life of the project, USAID is to work with FLAS to select activities to be supported with endowment income, monitor their implementation, and evaluate their results (USAID 1992:5).

5. Bangladesh: International Centre for Diarrheal Disease Research

A \$1 million endowment for the International Centre for Diarrheal Disease Research, Bangladesh (ICDDR/B) was authorized in May 1996. The purpose of the endowment is to insulate the organization from unexpected fluctuations in income, provide fiscal flexibility to perform opportunistic research, and maintain a competitive edge as a center of excellence. ICDDR/B was founded in 1978; since that time, USAID has invested approximately \$50 million in ICDDR/B activities. Although USAID historically has been ICDDR/B's largest donor, today the Agency provides about 25 percent of the organization's annual support. However, USAID continues to be the single largest donor in absolute terms.

The \$1 million endowment is expected to leverage an additional \$3 million within one year of its disbursement, and an additional \$6 million (for a total endowment of \$10 million) after four years. An endowment of \$10 million could be expected to provide almost 10 percent of ICDDR/B's annual budget. The endowment funds are managed by the Child Health Foundation, a U.S. NGO, on behalf of ICDDR/B (Sources: (1) Interview with Caryn Miller and Claire Komives of G/PHN, 5/31/96. (2) Oot, David, n.d.)

6. Indonesia Biodiversity Foundation

The Indonesia Biodiversity Foundation (also known as KEHATI) was established in 1994 to make grants to Indonesian NGOs and scientists for environmental activities, and to provide technical leadership in the area of biodiversity conservation. Once KEHATI was established, it took about 15 months to meet the USAID "grant-worthiness" requirements in order for the endowment to be funded. A total of \$19 million was provided to the new foundation; of that, \$16.5 million became the endowment principal. Of the remaining funds, \$1.25 million went to KEHATI's initial operating costs, and the remaining \$1.25 million was used for an interim grants program. The cooperative agreement requires that a certain percentage of the annual earnings from the endowment be added to the endowment principal, as a hedge against inflation (so the dollar value of the endowment will remain constant over time). There was no firm requirement for additional fund-raising (only on a "best-efforts"

basis), and the endowment is meant to exist indefinitely. Setting up the new foundation and endowing it was very time consuming, requiring about three years of full-time effort (over a six-year period) (Sources: (1) Information provided by Jerry P. Bisson, G/ENV/ENR. (2) Interview with Jerry P. Bisson, G/ENV/ENR, 5/29/96).

7. Israel: U.S.-Israeli Binational Foundations

Local currency generated from a 1985 cash transfer grant to Israel was used to expand the endowments of three U.S.-Israeli foundations: the Binational Industrial Research and Development Foundation, the Binational Science Foundation, and the Binational Agricultural Research and Development fund. Funds also were used to establish an endowment for the U.S.-Israeli Educational Foundation, which had existed for many years and had been funded exclusively by the U.S. Information Agency (USAID 1984:12).

8. Korea Development Institute and Korean Institute for Science and Technology

The endowments for the Korea Development Institute (KDI) and the Korean Institute for Science and Technology (KIST) were set up consciously as part of the USAID "graduation" process. The intent was to leave behind two independent institutions that would further contribute to Korea's development. Although the organizations were not explicitly designed to promote U.S.-Korea linkages, that eventually occurred. Both endowments were funded with local currency; the KDI endowment was in the range of \$70 million (Source: Information provided by Charles F. Weden, Jr., DAA/ANE).

9. Nepal National Social Welfare Association

A \$600,000 endowment was established in 1993 with Save the Children-U.S. (SCUS) on behalf of a local NGO, the Nepal National Social Welfare Association (NNDWSA). The purpose of the endowment is to provide educational scholarships for orphans and other disadvantaged, low caste youths. The scholarships pay for secondary school and/or vocational schools. Over the past three years, more than 1,300 students have received scholarships. USAID has two voting positions on the NNDWSA Board of Directors for the duration of the cooperative agreement that established the endowment, and for seven years thereafter. The endowment funds are managed by SCUS, and are invested in the United States. There is no requirement to leverage funds from other donors, and the endowment was set up to exist indefinitely (Source: Information provided by Nancy Langworthy, USAID/Nepal).

10. Philippines: Foundation for the Philippine Environment

The Foundation for the Philippine Environment (FPE), an NGO, was established in 1992 to manage a proposed USAID-funded endowment. The purpose of the foundation is to provide grants for environmental activities to Philippine NGOs. When the foundation was being established, extensive nationwide consultations were held to provide input on the purpose of the foundation and to nominate representatives to the Board of Directors. USAID provided \$18 million for two debt-for-nature swaps, which yielded \$22 million for the endowment principal and additional funds for the foundation's initial operating costs and an interim grants program. Philippine Business for Social Progress (PBSP), a well-respected Philippine NGO, managed the foundation's initial program activities until permanent staff were selected. The FPE debt swaps were handled by the World Wildlife Fund, which also provided initial financial management for the foundation. There was no requirement to leverage funds from other donors; however, the FPE endowment also includes a small grant from the Bank of Tokyo. The FPE endowment is meant to exist indefinitely; there is no provision for drawing down the principal (Sources: (1) Information provided by Richard Edwards, USAID/Morocco. (2) Phone interview with Richard Edwards, USAID/Morocco, 6/14/96).

11. Portugal: Luso-American Development Foundation

The Luso-American Development Foundation (FLAD), a Portuguese organization, was created in 1985. Its goal is to contribute to Portugal's economic and social development by promoting cooperation between Portugal and the United States in the areas of science, technology, culture, education, commerce and entrepreneurship. The foundation served as the focus of USAID/Portugal's "graduation" strategy, receiving an endowment of approximately \$118 million in local currency derived from Economic Support Funds. Originally, there was extensive U.S. involvement in the management of the foundation; the U.S. Ambassador served as an active board member and the USAID Representative served as the foundation's first executive director. However, the direction and management of the foundation eventually became predominantly Portuguese, and the U.S. Ambassador no longer serves on the Board. The foundation has international recognition, but there is mixed reaction regarding the extent to which its U.S.-Portuguese "partnership" objective has been achieved. There have been no formal evaluations of the endowment (Sources: (1) Interview with David Leibson, G/ENR/UP, 6/13/96. (2) USAID 1989b).

12. Colombia: PROFAMILIA

In October 1993, USAID funded a \$6 million endowment to PROFAMILIA, the International Planned Parenthood Federation (IPPF) affiliate in Colombia. PROFAMILIA is the largest family planning provider in that country, accounting for over 65 percent of all services offered. PROFAMILIA concluded that an endowment, combined with increased

cost-recovery and diversification of services, would be the most effective financial mechanism to increase its revenues. The endowment's primary investment strategy is to guarantee PROFAMILIA a consistent annual source of income in anticipation of USAID's phase-out of population activities in Colombia.

The endowment fund has a three-member Board of Directors and is managed by a U.S.-based investment bank. The fund was financed with an initial tranche of \$4 million; \$2 million was disbursed in the second year. In September 1996, after the endowment's initial appreciation, PROFAMILIA will begin receiving 95 percent of the interest/dividends earned from the \$6 million investment fund (Source: Information provided by Craig Carlson, G/PHN/POP/FPS).

13. Costa Rica: Arias Foundation

USAID funding of the Arias Foundation is an example of support to an existing local foundation. Former Costa Rican President Oscar Arias Sánchez founded the Arias Foundation for Peace and Human Progress, endowing it with the monetary award received from his 1987 Nobel Peace Prize. Its mission is to promote sustainable development in Central America through programs focusing on women, conflict resolution, demilitarization and disarmament, and philanthropy. The Arias Foundation has an endowment of approximately \$2 million, as well as a diverse funding base. In 1993, USAID provided a \$500,000 endowment, the earnings of which are to cover part of the Foundation's operating expenses, to help ensure the financial sustainability of the organization (Sources: (1) Information provided by Rosie Murillo, USAID/Costa Rica. (2) Phone interview with Rosie Murillo, USAID/Costa Rica, 5/24/96).

14. Costa Rica: Foundation for the Development of the Central Volcanic Cordillera Region

In April 1989, USAID and the Government of Costa Rica signed a bilateral agreement for a \$17.5 million project (FORESTA) to support the sustainable development of the Central Volcanic Conservation Area of Costa Rica. Under this project, the Foundation for the Development of the Central Volcanic Cordillera Region (FUNDECOR) was established to promote natural forest management and reforestation of the area. FUNDECOR functions as a regional development agency, an integrated forest consulting firm, and a credit agency. One of the reasons for setting up this endowment was to fund the operations of the foundation after FORESTA project support ended. USAID provided FUNDECOR with a \$10 million endowment from host country-owned local currency, the income from which covers operating expenses. FUNDECOR did not start using the endowment until March of 1996, but it had been capitalizing since 1990.

FUNDECOR has a Board of Directors that makes technical decisions about programs and activities, and there is a separate five-member Board of Trustees that manages the endowment. The role of the Board of Trustees is to ensure accountability; it commissions an annual audit and approves FUNDECOR's annual budget. There also is a built-in periodic program evaluation of FUNDECOR. The endowment funds are invested, through a private, local bank in Costa Rica, in the stock market and in government bonds (Sources: (1) Phone interview with Anne Lewandowski, USAID/El Salvador, 6/3/96. (2) Church et al. 1994a).

15. Costa Rica/USA Foundation

The recently created Costa Rica/USA Foundation is an example of an endowment with a broad scope. CRUSA is a grant-making foundation that supports sustainable development through technical cooperation, training, and technology transfer between the United States and Costa Rica. One of its priorities is to provide technical assistance to the Costa Rican government in reform of state institutions, local governance strengthening, and decentralization. The foundation was created to continue development activities when the USAID Mission closes in 1996. To establish the endowment, the foundation will receive resources remaining in selected local currency trust funds managed by USAID/Costa Rica. The endowment currently is worth \$12 million, but is expected to reach \$25 million.

CRUSA has an assembly of ten founding members, half Costa Rican and the other half American. It also has a five-member Board of Directors, one of whom is appointed by the U.S. Ambassador to Costa Rica. Since USAID will no longer have an in-country presence, the endowment funds will be monitored by the founding members and annually reviewed by the Controller General of the Republic of Costa Rica (Sources: (1) Information provided by USAID/Costa Rica. (2) Phone interview with Betsy Murray, formerly with USAID/Costa Rica, 5/24/96).

16. Costa Rica: Agricultural College of the Humid Tropical Region

In 1985, USAID and the Government of Costa Rica agreed to jointly fund the establishment of the Agricultural College of the Humid Tropical Region (EARTH), a four-year undergraduate institution. To achieve the long-term financial viability of the College, a \$60 million local currency endowment fund was established. The endowment was designed to help cover the College's operating expenses. A Board of Trustees manages the income from the endowment, which is invested in the Central Bank of Costa Rica. USAID also provided grants to EARTH during the 1985-1995 period, mainly for the construction of the university (Sources: (1) Phone interview with Arturo Villalobos, USAID/Costa Rica, 5/29/96. (2) Hansen 1990).

17. Costa Rica: FUNDATROPICOS

In 1993, local currency was made available to establish an endowment for a new foundation, FUNDATROPICOS. The income from the endowment supports the programs of the Tropical Agricultural Center for Research and Education (CATIE) in Costa Rica. CATIE's activities include scientific research in agriculture and natural resources in the American tropics, and graduate education and training (USAID 1994d:3).

18. Costa Rican Export Promotion Fund

The Costa Rican Export Promotion Fund (FUNDEX) was set up to provide grants to organizations and agencies that promote foreign investment and exports. In October 1990, the Government of Costa Rica and USAID agreed to allocate \$27.15 million to FUNDEX from ESF local currency. The main beneficiary of FUNDEX was the Costa Rican Coalition for Development Initiatives (CINDE), a private sector institution established in 1982 with USAID support. In terms of USAID oversight, USAID was to assume an active role in monitoring of fund operations during the first four years. FUNDEX was managed by a five-person Board of Directors, and the endowment funds were invested in Central Bank bonds to avoid the effects of inflation (Sources: (1) Interview with Kenneth A. Lanza, G/EG/EIR, 5/22/96. (2) Phone interview with Luis Solera, USAID/Costa Rica, 6/4/96. (3) USAID 1990a).

19. Dominican Republic: Agricultural Development Foundation

USAID provided a grant to the Agricultural Development Foundation (ADF) in 1987 to promote research in nontraditional crops, establish a rapid-response capability for agribusiness and farmers, establish a technical information center, and set up an endowment to support the foundation. The endowment was established in 1988 with approximately \$4 million in local currency. The purpose of the endowment was to finance the operational costs of the ADF, as well as to support agricultural investigations through subgrants to other agricultural institutions (Sources: (1) USAID 1993a. (2) Information provided by Luis C. Gonzalez, USAID/Dominican Republic).

20. Dominican Republic: Superior Institute of Agriculture

USAID has been providing support to the Superior Institute of Agriculture (ISA) since its creation in 1962. In 1989, USAID and the Government of the Dominican Republic agreed to provide ISA with a large grant to enhance its educational and research capacities in nontraditional agricultural exports (Hansen 1990:16). The grant provided for the "strengthening" of an endowment fund to generate sufficient income to meet ISA core costs and to provide faculty and staff adequate salary levels (USAID 1989a:11). The endowment

was established with \$2.4 million in local currency generated from Economic Support Funds (Hansen 1990:16).

21. Dominican Republic: Junta Agroempresarial Dominicana

The Junta Agroempresarial Dominicana (JAD) is a Dominican NGO whose main purpose is to support, promote and foster nontraditional agricultural development through technical assistance for agricultural projects in the Dominican Republic. The endowment was established in 1992 using host country owned local currency from PL-480 commodity sales and ESF agreements; the current dollar value of the endowment is \$1,260,000. The purpose of the endowment is to encourage the financial sustainability efforts of JAD, a promising NGO partner; in reality, the endowment will provide more of a financial "cushion" than independence. There is a requirement for leveraging the endowment funds; if the match is not met within a specified time frame, the endowment grant will revert to a loan. The endowment funds are invested and managed locally (Sources: (1) Phone interview with J. Michael Deal, USAID/Dominican Republic, 6/4/96. (2) Information provided by Luis C. Gonzalez, USAID/Dominican Republic, 6/3/96).

22. Dominican Republic: Fundacion Economia y Desarrollo

The Fundación Economía y Desarrollo (FEyD) is a Dominican NGO that promotes the economic advantages of an open and free market and encourages the adoption of economic policies to support development. The endowment for FEyD was established in 1994 using host country-owned local currency from PL-480 commodity sales and ESF agreements. The purpose of the endowment is to encourage FEyD's financial sustainability. The current dollar value of the endowment is \$652,000. Endowment earnings will provide about 30 percent of FEyD's basic annual income. There is a requirement for leveraging the endowment funds; thus far, FEyD has raised 7.5 million pesos of the 9 million pesos required for the match. The endowment funds are invested and managed locally (Sources: (1) Phone interview with J. Michael Deal, USAID/Dominican Republic, 6/4/96. (2) Information provided by Luis C. Gonzalez, USAID/Dominican Republic).

23. Dominican Republic: Pontificia Universidad Catolica Madre y Maestra

An endowment was established for Pontificia Universidad Católica Madre y Maestra (PUCCM) under USAID/Dominican Republic's Democratic Initiatives project. The purpose of the PUCCM activity is to encourage the expansion and consolidation of democratic institutionalization processes in the Dominican Republic. The endowment, established in 1994, has a current dollar value of \$435,000. The endowment was established using host country-owned local currency from PL-480 commodity sales and ESF agreements. The purpose of the endowment is to encourage PUCCM's financial sustainability, although

PUCCM, a large organization, does not rely heavily on the endowment. There is a requirement for leveraging the endowment funds; the endowment principal will revert to a loan if the required match is not met. The endowment funds are invested and managed locally (Sources: (1) Phone interview with J. Michael Deal, USAID/Dominican Republic; 6/4/96. (2) Information provided by Luis C. Gonzalez, USAID/Dominican Republic).

24. Ecuador: Foundation for Agricultural Development

In 1986, the Government of Ecuador established the Foundation for Agricultural Development (FUNDAGRO), which was designed to achieve a more integrated research, extension, and education system (Hansen 1990:12). FUNDAGRO works with public and private sector institutions in the joint selection, planning, and funding of long-term applied commodity research and extension programs. In 1988, USAID provided FUNDAGRO the local currency equivalent of \$3 million from PL-480 funds for an endowment (Hansen 1990:13).

25. Ecuador: Institute for Agricultural Strategies

The Institute for Agricultural Strategies (IDEA) was created in 1985 under a grant agreement between USAID and the Government of Ecuador. The purpose of IDEA is to stimulate agricultural policy analysis, discussion, and debate within the private sector. A \$400,000 endowment for IDEA was established in 1989 by USAID from PL-480 local currency. The rationale for establishing both FUNDAGRO and IDEA was to support independent, private sector institutions that could perform development tasks more effectively than the public sector (Hansen 1990:3).

26. Honduras: CADERH

In August 1995, USAID established a \$600,000 dollar-funded endowment for the Centro Asesor para el Desarrollo de los Recursos Humanos (CADERH), which was formed in 1982. The endowment will be used to support CADERH's assistance to vocational skills training institutions for low income Hondurans (USAID 1995a).

27. Honduran Agricultural Research Foundation

In 1984, USAID helped establish the Honduran Agricultural Research Foundation (FHIA), awarding a 10-year grant to assist with the foundation's operating and program expenses (Hansen 1990:14). In 1993, USAID and the Government of Honduras granted funds to FHIA for the establishment of an endowment. Local currency for the endowment was generated from Economic Support Funds. There is a requirement for FHIA to match a

percentage of the total USAID/Government of Honduras contribution to the endowment. The formula was designed to encourage FHIA to expand the endowment and build a long-term support constituency for its research (Hansen 1990:14).

28. Honduran Environmental Trust Fund

The Honduran Environmental Fund project agreement was signed by USAID/Honduras in 1993 to capitalize an Environmental Protection Fund (FOPMA). The purpose of the project is to strengthen and expand environmental protection and natural resource management activities carried out by NGOs. Funds for the endowment include \$10 million in local currency generated from PL-480. The FOPMA is managed by the Honduran Foundation for Environment and Development (VIDA), and funding is made available to VIDA for environmental NGO subprojects (Source: Information provided by Victor Bullen, PPC/ENV).

29. Honduras: Pan-American Agricultural School

The Pan-American Agricultural School in Zamorano, Honduras (also known as Zamorano), was established in 1942 as a private, post-secondary school to train agriculturalists throughout Latin America. From 1942 to 1957, Zamorano covered its finances from a trust fund established by the United Fruit Company, and after that, from additional funds generated by student fees, private and public donations, and sales of products grown at the school (Winrock International 1988). In 1987, negotiations were conducted between Zamorano, the Government of Honduras, and USAID regarding the possibility of securing a USAID grant to expand the endowment. Negotiations were concluded that same year, and a project agreement provided Zamorano with the local-currency equivalent of \$15 million to establish an endowment. The objectives of the endowment were to provide a secure source of funding for the institution and to assist and encourage Zamorano in its efforts at long-term capitalization (Winrock International 1988:17-18). There is a 25 percent matching requirement to encourage the school to mobilize funds from other sources (Hansen 1990:17).

30. Jamaica National Parks Trust Fund

The Jamaica National Parks Trust Fund was established under the Protected Areas Resources Conservation (PARC) Project, which started in 1990. The project was designed to implement two pilot national parks and fund a series of activities leading to the establishment of a National Parks and Protected Areas System. The purpose of the trust fund was to provide for the long-term financial solvency of the new park system (Church et al. 1994c:4). USAID negotiated with the Nature Conservancy and the Government of Jamaica to convert approximately \$400,000 in U.S. dollar debt to a local currency endowment held

by a national environmental NGO, the Jamaica Conservation and Development Trust (JCDDT) (Church et al. 1994c:5-6).

31. Mexico Nature Conservation Fund

USAID provided \$19.5 million to establish an endowment for an environmental grant-making foundation in Mexico, the Mexican Fund for the Conservation of Nature (FMCN). The endowment will enable FMCN to finance biodiversity grants to Mexican NGOs. Project funding was reserved as "parallel financing" under the U.S. Government commitment to the Global Environment Facility (GEF), and was subsequently apportioned to the USAID/Mexico budget.

FMCN has a 21-member Board of Directors who are responsible for approving an overall strategic plan, an annual operating plan and budget, and the portfolio of projects recommended for funding. The endowment agreement calls for USAID oversight for ten years, during which time USAID will retain the right to approve FMCN investment management contracts for the USAID account. USAID also will receive annual financial audits, annual financial and operating plans, evaluations, and other reports necessary to monitor FMCN. The endowment is structured to ensure that FMCN attracts matching funds. FMCN is required to raise at least \$10 million in contributions by December 30, 1998; failure to reach this goal may lead to restrictions on the disbursement of endowment income. USAID also can terminate the endowment and recover all funds if the full \$10 million is not raised by the year 2000 (Sources: (1) USAID 1995b. (2) Interview with Eric D. Fajer, LAC/ENV, 5/22/96).

32. Panama: Ecological Trust Fund

A \$25 million Ecological Trust Fund was established in Panama in 1995. This endowment is part of USAID's Natural Resources Management (MARENA) project, which was designed to help Panama's public and private organizations manage the country's renewable natural resources, especially in the Panama Canal Watershed. The \$25 million endowment was funded by USAID (\$8 million), the Nature Conservancy (\$2 million), and the Government of Panama (\$15 million, consisting of reflows from a previous USAID project). The endowment is set up as a trust agreement, with the Nature Conservancy as trustee. The Natura Foundation, a Panamanian NGO, is the endowment beneficiary. Half of the endowment earnings are designated for the Government of Panama's Institute for Renewable Natural Resources to carry out environmental activities related to the MARENA project; the remainder is for grants to Panamanian NGOs. The activities of the Natura Foundation will continue after the MARENA project ends and USAID/Panama closes (Sources: (1) USAID 1995d. (2) Interview with Michael C. Trott, M/AS/OMS, 5/24/96. (3) Conference call with Guy Branch, George E. Like, and Jesus Saiz, USAID/Panama, 5/28/96).

33. Argentina EAI Fund

The Argentina fund was established under the Enterprise for the Americas Initiative - (EAI), a U.S. government program of debt forgiveness in exchange for the commitment of developing country resources for sustainable environmental and child survival activities. The operating by-laws of the Argentine Americas Board were provisionally approved by the EAI Americas Board in September 1995. Argentina has appointed members to its local Board of Directors, but as of May 1996, had not approved projects or disbursed funds (U.S. Department of the Treasury 1996:4,20).

34. Bolivia EAI Fund

The Bolivia EAI fund, the first to be established and evaluated, is an EAI Environmental Account of \$21.8 million in a government agency, FONAMA (the National Environmental Fund) (Asselin et al. 1996:7). It began operations in September 1992. A January 1996 evaluation pointed out a number of problems with implementation of the fund due to its links to a government agency (Asselin et al. 1996). Most of the other EAI funds are private foundations established specifically to administer the EAI program (Asselin et al. 1996:35). A lesson learned from Bolivia's experience is the importance of insulating a fund from "national political currents" and turnover in ministries (Asselin et al. 1996:37).

35. Chile EAI Fund

The Chile EAI Fund totalled almost \$12 million as of May 1996 (U.S. Department of the Treasury 1996:18). Chile's Americas Board awarded grants in 1995 for activities to conserve natural resources, improve local environmental conditions for children, and prevent air contamination (U.S. Department of the Treasury 1996:17).

36. Colombia EAI Fund

The Council of the Americas in Colombia, the name of the local America's Board of Directors, was formally installed on April 22, 1995 (U.S. Department of the Treasury 1996:20). The Council consists of five representatives from local NGOs, two representatives from the Government of Colombia, and one from the United States Government. As of May 1996, it had not approved projects or disbursed funds (U.S. Department of the Treasury 1996:4).

37. El Salvador EAI Fund

The Initiative for the Americas Fund in El Salvador began operating in November 1994. In January 1995, it awarded \$3.6 million in grants for projects related to reforestation, nurseries, agroforestry, and soil and water conservation. The fund is overseen by an Administrative Council composed of a representative from the U.S. government (the USAID director), two representatives from the government of El Salvador, and four from NGOs (U.S. Department of the Treasury 1996).

38. Jamaica: Environmental Foundation of Jamaica

The Environmental Foundation of Jamaica (EFJ) was established in 1991 under the Enterprise for the Americas Initiative. The foundation's endowment principal is expected to reach about \$18 million over the course of 10-12 years of payments. The endowment is established in perpetuity, with no provision for drawing down the principal. The EFJ was a new organization established for the purpose of managing the endowment. The U.S. government representative, who was USAID/Jamaica's Deputy Mission Director, was a full board member, and one of three individuals responsible for setting up the foundation. The board and the foundation now are managed primarily by Jamaicans, with the U.S. representative in a less prominent role. Although the foundation initially had more than adequate funding available for project proposals, Jamaican NGOs now must compete among themselves for funds. The result is increased competence among Jamaican NGOs (Source: Phone interview with Marilyn A. Zak, USAID/Dominican Republic, 6/4/96).

39. Uruguay EAI Fund

The agreement between the Republic of Uruguay and the United States that created the Fund of the Americas in Uruguay was signed in 1991. On July 25, 1995, about \$2 million was approved for the first 35 projects. One of the projects combined both environmental and child survival activities. Christmas cards made of recycled paper were distributed to homeless children who affixed local flowers to the paper. The project helped to nourish the children and teach them about the diversity of Uruguay's flora (U.S. Department of the Treasury 1996:19).

C. Descriptions of National Environmental Fund (NEF) Endowments

Bhutan Trust Fund for Environmental Conservation

The Bhutan Trust Fund for Environmental Conservation (BTF), created in 1991 by the United Nations Development Program (UNDP), the World Wildlife Fund (WWF), and the Royal Government of Bhutan (RGOB), is designed to provide a secure source of financial support for a variety of conservation programs in the country. The Global Environmental Facility (GEF) has committed \$10 million to the Fund, while the Netherlands and Norwegian governments and WWF each have contributed \$1 million. The goal is to raise \$20 million for the endowment, which should generate approximately \$1 million per year in interest (The World Conservation Union et al. 1994:39). The BTF Management Board has five members, including one each from the UNDP and WWF and three from the RGOB. The Management Board decides policy issues and reviews and approves projects and work plans. UNDP manages the assets and invests them in U.S. and European Government bonds (The World Conservation Union et al. 1994:38).

Key features of the BTF include the following:

- The RGOB is committed to preserving the country's current percentage of forest cover in perpetuity as well as the current percentage of the country's area that is under protected area status (The World Conservation Union et al. 1994:40).
- The disbursement of GEF funds to the BTF is contingent upon contributions from other co-financing sources. This stipulation was seen as an effective way of requiring the BTF to solicit contributions to the trust (IPG 1995b:14).
- According to a GEF annual report, financial returns have been disappointingly low under UNDP fund management. Earnings have barely covered recapitalizing the Fund's principal. In response, a new private asset manager has been selected to pursue a more aggressive investment strategy (World Bank 1996).

National Trust Fund for Protected Areas (FONANPE-Peru)

The National Trust Fund for Protected Areas (FONANPE) was created by Decree Law in 1992 as a trust fund designed to provide sustainable funding for Peru's protected areas. At the same time, the Government of Peru created PROFONANPE, a nonprofit institution, to manage the Fund and direct the use of its investment proceeds (The World Conservation Union et al. 1994:88). The PROFONANPE by-laws established a long-term endowment. PROFONANPE is managed by a Board of Directors comprised of seven members, including three from the Peruvian Government, three Peruvian conservation NGOs, and one from the German Technical Cooperation Agency (GTZ) (The World Conservation Union et al. 1994:88).

PROFONANPE has set a target of \$40 million for the trust fund principal. PROFONANPE received its initial support from the Canadian International Development Agency (CIDA), which provided offices and vehicles in Lima. GTZ covered PROFONANPE's operational costs for the first two years while the endowment was being capitalized (The World Conservation Union et al. 1994:88). Germany and Finland have committed additional bilateral debt reduction resources to be channelled through PROFONANPE (GEF 1995:6). Key features of FONANPE include the following:

- Seven NGOs were involved in the design of PROFONANPE. This effort has helped build stakeholder capacity at the national level by forging partnerships among local NGOs and community level participants (IPG 1995b:14).
- During its first year, PROFONANPE strengthened itself by conducting an institutional strategic planning exercise involving a dozen NGOs. It also has developed criteria for managing its small grants program, has issued requests for proposals, and has negotiated Peru's first debt-for-nature swap (GEF 1995:2).
- The financial stability provided by the trust will alleviate the Peruvian park system's inability to retain qualified personnel because of low salaries and insecure job tenure that results from budget fluctuations (GEF 1995:5).
- PROFONANPE provides a reliable window for debt donations for environmental and development purposes, an option that Peru did not have available before the GEF promoted the creation of the fund (GEF 1995:5).

D. Individuals Interviewed for the Study

USAID staff

Jerry P. Bisson, G/ENV/ENR
Guy Branch, USAID/Panama contractor (phone)
Terrence J. Brown, DAA/ANE
Victor Bullen, PPC/ENV
Ramon E. Daubon, DAA/LAC
J. Michael Deal, USAID/Dominican Republic (phone)
Richard Edwards, USAID/Morocco (phone)
Eric D. Fajer, LAC/ENV
Robert Hanchett, USAID/Madagascar (email)
Gary E. Hansen, G/DG
James S. Hester, PPC/ENV
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David Leibson, G/ENV/UP
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George E. Like, USAID/Panama (phone)
Drew Luten, GC/AFR
Michael Maxey, USAID/Costa Rica (email)
Caryn Miller, G/PHN/HN
Rosie Murillo, USAID/Costa Rica (phone)
Betsy Murray, formerly with USAID/Costa Rica (phone)
Julie Otterbein, ENI/EEU/NR
Jesus Saiz, USAID/Panama (phone)
Robert A. Siegel, PPC/ECON
Scott E. Smith, PPC/CDIE
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Michael C. Trott, M/AS/OMS
Arturo Villalobos, USAID/Costa Rica (phone)
Charles F. Weden, Jr., DAA/ANE (email)
Stephen Wingert, former USAID officer (phone)
Marilyn A. Zak, USAID/Dominican Republic (phone)

Donors Providing Information

Laura Bocalandro, Inter-American Development Bank
Bert Brueckner, German Technical Cooperation Agency (email)
Jose Corbello, Inter-American Development Bank (phone)

Ruben Echeverria, Inter-American Development Bank
Tijan Jallow, Office to Combat Desertification and Drought, United Nations (phone)
Kah Hie Law, World Bank (phone)
Andrew Leslie, Overseas Development Administration, Great Britain (fax)
Matthew Levin, Embassy of Canada (fax)
Beatrice Meyer, Swiss Agency for Development and Cooperation (fax)
Kiyoshi Miyoshi, Japan International Cooperation Agency (phone)
Tatsushi Nishioka, Embassy of Japan (fax)
Erling Remestad, Embassy of Norway (fax)
Rachel Weaving, World Bank (phone)
Douglas Williams, Canadian International Development Agency (fax)

Others

Robert Bonardi, Deputy Director, PROFIT (Promoting Financial Investments and Transfers)
Project (phone)
Leslie M. Fox, Independent Consultant
Jonathan Margolis, U.S. Department of State (phone)
W. Paul Weatherly, Independent Consultant



C D C F O U N D A T I O N

The National Foundation for the Centers for Disease Control and Prevention, Inc. (the CDC Foundation) is dedicated to creating public-private partnerships to promote the vision of CDC: "Healthy People in a Healthy World--Through Prevention."

A federal agency located in Atlanta, Georgia, CDC addresses current and emerging health risks to protect citizens of this country and our global village from unnecessary disease, injury, death, and their associated costs. CDC's record of achievement, unique scientific expertise, and ability to respond to urgent public health threats have led to increased demands--nationally and internationally--for assistance. These demands have fueled CDC's need for new, supportive partnerships.

Established by Congress in 1992, the CDC Foundation began operation in 1995 as an independent, not-for-profit corporation in support of CDC's mission. The Foundation has been a shared dream of CDC leaders for two decades. They know that the goals of public health are greater than a single government agency. With the support of private funding, individuals, corporations, foundations, and organizations could join CDC scientists in designing innovative solutions to specific public health problems. The Foundation seeks gifts to extend federally funded CDC programs into new programs of research and service.

The CDC Foundation seeks gifts and grants for three general purposes:

- providing philanthropic investments for innovative research and replicable community-based programs;
- enhancing CDC's ability to attract talented scientists and health leaders for short-term assignments; and
- encouraging sound public health policies.

The CDC Foundation Board of Directors has established four themes to provide vision and the framework for CDC Foundation programs and funding priorities: global health, promoting healthy lifestyles, communication and information systems, and prevention through health care systems.

Senior staff of the CDC Foundation include C. Charles Stokes, executive director; Susan B. Green, senior development director; Linda Kay McGowan, senior program director; and Kelley Mouchabeck, director of finance.

USAID Africa Bureau Country Briefs





U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

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FOR IMMEDIATE RELEASE
Monday, July 3, 2000

USAID SITE VISIT SCHEDULE

XIII INTERNATIONAL AIDS CONFERENCE DURBAN, SOUTH AFRICA

The U.S. Agency for International Development will sponsor several site visits open to a limited number of media representatives during the XIII International AIDS Conference in Durban, South Africa. To sign up for these site visits, please contact Dick Custin, U.S. Embassy Public Affairs, by noon on Monday, July 10, at (012) 342-3006, ext. 2217.

Tuesday, July 11

**Ndwedwe District Child Survival Project
Medical Care Development International**

Depart 10:30 a.m.

Accompany Sandy Thurman (The White House) and USAID officials to Ndwedwe (about one hour outside of Durban), where USAID is funding a child survival project that has introduced family and community care for children affected by AIDS. The HIV/AIDS epidemic is outstripping initial expectations, so the situation has reached emergency status. The project is in an under-served rural community in the worst affected province of KwaZulu-Natal.

Wednesday, July 12

Ntinga Microenterprise Support Project

Depart 1:00pm

Cato Manor Development Association (assisted by Project Preparation Trust)

(Ntinga—1:30-2:30pm, Cato Manor 3:00-4:00pm)

AIDS is not an isolated health issue. Over the past two years, USAID has been determining how to incorporate HIV/AIDS prevention programs into other projects. Wednesday's site visits will be to two USAID programs to discuss how they aim to do this through community approaches. (1) The Thekwini Business Centre, supported by USAID through the Ntinga Microenterprise Support Project, is looking at new ways to target and prevent HIV/AIDS through entrepreneurial business programs. (2) The area of Cato Manor was heavily affected by forced removals imposed during apartheid that caused families to become displaced and prevented cohesive development efforts. Several groups organized by the Cato Manor Development Association will speak about their housing and community development actions, highlighting their pilot efforts to also address HIV/AIDS. A drive-through the community will follow the group discussions.

Friday, July 14

Orphan and vulnerable children site TBD

Depart 7:30 a.m.

Accompany Ambassador Delano Lewis (U.S. Ambassador to South Africa), Sandy Thurman (The White House), Vivian Lowery Derryck (USAID) and Achmet Dangor (CEO, Nelson Mandela Children's Fund) on a site visit to a program for orphans and vulnerable children. This visit will offer strong visuals of the type of project the Nelson Mandela Children's Fund will support through its USAID grant, which will be announced later Friday morning.

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U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT **MEDIA ADVISORY**

WASHINGTON, DC
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FOR IMMEDIATE RELEASE
Monday, July 3, 2000

USAID PRESS CONFERENCE SCHEDULE

XIII INTERNATIONAL AIDS CONFERENCE DURBAN, SOUTH AFRICA

Monday, July 10

**The AIDS Pandemic in the 21st Century:
The Demographic Impact in Developing Countries**

USAID will release new Census Bureau data showing the tremendous impact of AIDS on the developing world. Life expectancy, population growth and infant mortality rates have all been dramatically affected.

9:45 - 10:45 a.m. Ground level of International Convention Center

Tuesday, July 11

LIFE: One Year Later

Three senior officials will discuss LIFE, the Clinton administration's \$100 million initiative to fight AIDS.

9:15 - 10:15 a.m. Ground level of International Convention Center

Speakers:

Sandy Thurman, The White House
Vivian Lowery Derryck, USAID
Dr. Helene Gayle, CDC

Wednesday, July 12 HIV/AIDS at Work

A recent study shows that over the next decade GDP growth will be lowered because of HIV/AIDS. Several issues will be covered including sector-specific impact and economic impact.

10:15 - 11:15 a.m. Ground level of International Convention Center

Speakers:

Paurvi Bhatt, USAID HIV/AIDS
Dr. Johannes van Dam, Population Council/HORIZONS
Dr. Godfried Asiamah, Chief Superintendent of Police, and FHI/IMPACT-Ghana
Neal Cohen, USAID Economist

Thursday, July 13 Children on the Brink

USAID will release a new report on AIDS orphans, which predicts the number of AIDS orphans over the next ten years, and discusses strategies to assist vulnerable children.

9:00 - 10:00 a.m. Ground level of International Convention Center

Friday, July 14

USAID Awards Grant to Nelson Mandela Children's Fund

The U.S. government and the Nelson Mandela Children's Fund join forces to meet the complex challenges of children living in a world of AIDS.

9:00 - 10:00 a.m. Royal Hotel

Speakers:

The Honorable Nelson Mandela
Ambassador Lewis, U.S. Ambassador to South Africa
Sandy Thurman, The White House
Vivian Lowery Derryck, USAID

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HISTORY

From 1985 to 1994, USAID support was provided through non-governmental organizations (NGOs) and international scholarships to the U.S. Partnership with the South African government began after the 1994 democratic elections. NGOs have historically been an important part of the transformation process in South Africa and continue to be a pivotal component of USAID's program.

TODAY'S PARTNERSHIPS

USAID works with civil society groups and key government ministries and departments in South Africa. Development programs are supported with training and technical assistance. USAID also encourages partnerships between government and NGOs to maximize the outreach to the majority of the country's people.

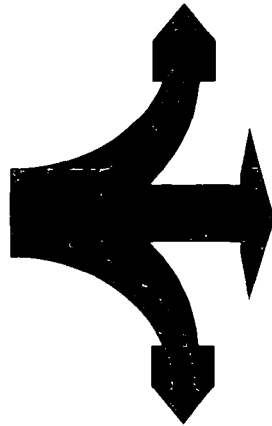


Launch of Adult Basic Education

BENEFITING SOUTH AFRICANS

USAID activities are designed to benefit people who were disadvantaged by apartheid. Their victory over decades of racial oppression has been noted as one of the great events in the 20th century. Transformation continues as they exercise their fundamental rights as citizens, economically active individuals and builders of South Africa's future.

USAID activities involve numerous participants:



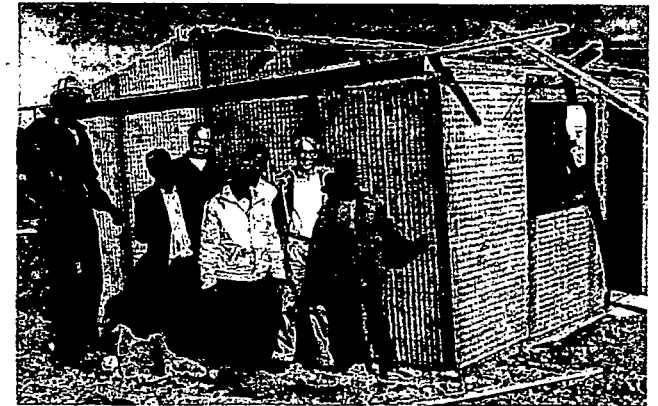
- National, provincial and local governments;
- Civil society;
- Educators and students;
- Primary health care providers and users;
- Economic policy makers;
- Micro-, small- and medium-sized enterprises;
- Communities requiring houses and services;
- Environmental organizations;
- NGOs, community-based organizations



Community Housing Construction



UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT



MAKING A DIFFERENCE

The United States Agency for International Development (USAID) manages the U.S. government's development assistance throughout the world. USAID's mission is to support people's efforts to develop themselves and their countries. By partnering with governments and communities, we work together to find effective development solutions.

PRIORITIES

USAID's goal is to assist the South African government and civil society to realize sustainable transformation through the political, social and economic empowerment of the historically disadvantaged majority. The Mission's strategy encompasses six strategic areas:

Democracy and Good Governance—strengthen democratic institutions through civil society participation

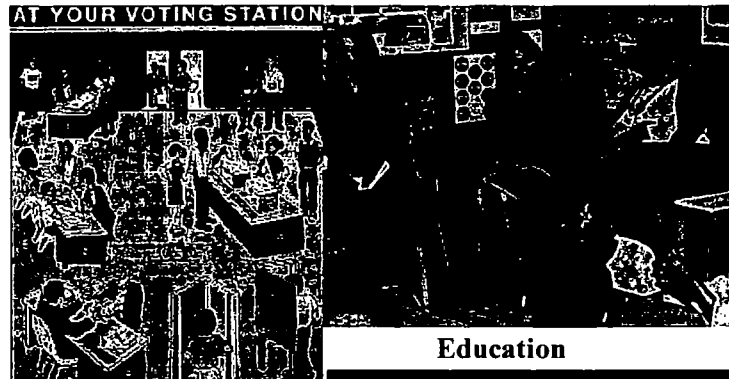
Education—increase access to high quality education and training

Health—increase the use of essential primary health care and HIV/AIDS services and practices that are patient-focused in a caring environment

Economic Analysis Capacity—strengthen the capacity of key government and non-government entities to formulate, evaluate and implement sound economic policies

Sustainable Employment—promote economic growth, creation of jobs and access to financial markets for people denied access under apartheid

Housing and Urban Environmental Services—improve access to housing and, urban services for the majority population while encouraging environmentally sound development practices



Democracy &
Governance

Education



Health

Mandela Economic
Scholars

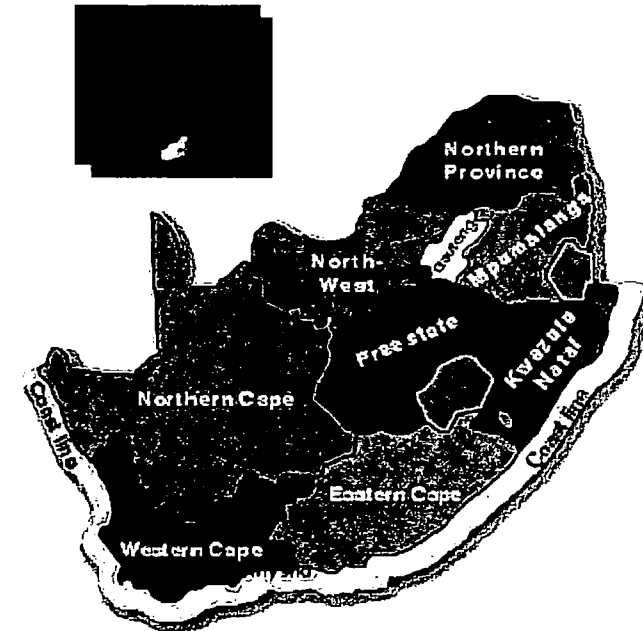
HIV/AIDS



Employment
Opportunities



Housing & Urban Environmental
Services



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USAID/SA TODAY

United States Agency for International Development in South Africa

HEALTH DEVELOPMENT

July 2000



USAID manages the U.S. government's development assistance throughout the world. USAID South Africa's activities are designed to benefit people who were disadvantaged by apartheid, working through government and civil society partnerships in six key areas:

- 1) Democracy and governance
- 2) Education
- 3) Health and HIV/AIDS
- 4) Economic analysis capacity
- 5) Sustainable employment
- 6) Housing, urban and environmental services

SUPPORTING A UNIFIED HEALTH SYSTEM

The major health care challenge for South Africa is to provide equity in basic health care for all South Africans. A highly fragmented public health system served different population groups in the past. Compounded by a focus on curative treatment and lack of community participation, the majority population was deprived of even basic primary health care (PHC). Emphasis is now on developing an integrated PHC program as the cornerstone of South Africa's new health system.

Deaths from HIV/AIDS in Southern Africa are reported to be the highest in the world. Recent estimates suggest that over 22 percent of pregnant women in public health facilities in South Africa are HIV positive, with rates as high as 32 percent in KwaZulu-Natal Province. The government has responded to the crisis with a comprehensive national action plan, embodied in the "Partnership Against AIDS" campaign, in which every South Afri-

can is urged to unite to conquer HIV/AIDS.



HIV/AIDS prevention is being tackled creatively in child survival schools

USAID works with South Africans to address two key health issues: combating HIV/AIDS and improving PHC. An important goal is to enable South Africa's health care officials to provide professional services that are patient-focused in a caring environment. The following objectives are emphasized:

- Increased use of essential PHC services and practices;
- Increased use of HIV/AIDS prevention and mitigation services and practices.

Equity in Integrated Primary Health Care Project

The EQUITY signed in September 1995, assists the South African government to strengthen the health delivery system so that high quality essential services can be made available to all South Africans.

Equity is a seven-year, \$50 million project. The South African government demonstrates strong support for this project by providing counterpart funds of 34 percent of the total project budget.

The ultimate beneficiaries of improved health systems are those individuals previously denied adequate health care, particularly mothers and children in the rural areas, who will soon have access to adequate, integrated PHC services. The intermediate beneficiaries are the provincial and local government health departments and health training institutions.

Two years into the full implementation of this project, the National Department of Health (NDOH) and the Eastern Cape Department of Health (ECDOH),



Treating tuberculosis

supported by Management Sciences for Health (MSH), have made significant progress towards the goal of improving the access and quality of PHC services to historically disadvantaged population groups, accomplishments including:

- A unified drug logistics system has been fully implemented in the Eastern Cape and is being adapted nationally.
- The Directly Observed Treatment System (DOTS) methodology for diagnosis and treatment of tuberculosis is being implemented for the first time in multiple sites in the Eastern Cape.
- Condoms are widely and freely



available in public sector institutions of the Eastern Cape for the first time without need for prior consultation with a medical official.

- Public/private partnerships involving the administration and manage-



Helping improve drug logistics in clinics

ment of small hospitals have been successfully initiated in the Eastern Cape.

Mitigating the Impact of HIV/AIDS

Since 1992, USAID/SA's HIV/AIDS strategy has been to support educational and prevention efforts. Accomplishments include:

- Community outreach and AIDS awareness activities for those "at risk", especially youth and women;
- Mining communities in Lesedi and Carltonville have been helped to reduce STDs among mine workers, their families and surrounding communities through the training of educators and motivators. A staffed mobile health clinic also takes service directly to the people who most need assistance.
- Prevention workshops provided for

youth in urban, rural and informal settlement areas;

- Capacity building and technical assistance to NGOs in program design, implementation and development of education materials;

A seven-year, \$21 million HIV/AIDS program was developed in 1998 to support the South African government's Partnership Against AIDS and to assist NGOs and community based organizations. The focus of the program is on prevention efforts, such as awareness raising, addressing sexually transmitted infections, improving the diagnosis and care of tuberculosis, and building capacity of NGOs to program and deliver HIV/AIDS services. The USAID program will support efforts in various sectors, including labor, business, media, and local government. Support is also being provided to government Sectors, including Public Service Administration, Education, Finance, and Welfare. Additional support is planned for Justice and Housing. A new orphans and vulnerable children's program that will focus support for NGOs and the Department of Welfare is currently being planned.

The South Africa Demographic and Health Survey (SADHS)

The SADHS, is the first of its kind in South Africa after 1994, and marks an extensive collaboration between the DOH, the Medical Research Council (MRC) and USAID. The information provides data on key maternal and child health indicators, including medical care for mothers during pregnancy, immunization coverage, family planning, women status, and reproductive health. The data will provide a wealth of information on women and children, and will be of enormous utility to policy makers, program managers, and researchers.



White House AIDS Advisor visits South African children

Reducing Violence

As a special emphasis area for mitigating the impact of HIV/AIDS, USAID is supporting the Amy Biehl Foundation Trust to reduce violence, especially towards young women: "Weaving a Barrier Against Violence" is a program of the Amy Biehl Foundation Trust (ABFT) in the Western Cape that honors the memory of the Fullbright scholar whose life was lost in Gugulethu in 1993. The project helps disadvantaged youth between the ages of 10 and 15 and their families in health care, first aid training, education, skills development, after school programs, income generation, recreational therapy, and counselling. A unique feature of this program is the community based integrated development approach of ABFT. An income generation scheme featuring bread production will ensure the long term sustainability of ABFT, as well as providing much needed jobs for youth in the community.

Further information is available from USAID/SA's Health Development Team Leader, Dr. Ken Yamashita: (Tel) 012-323-8869 ext 231 or (Fax) 012-323-6443 P.O Box 55380, Arcadia, Pretoria, 0007, South Africa. * Website: <http://www.sn.apc.org/usaidsa>



USAID/SA TODAY

United States Agency for International Development in South Africa

EDUCATION DEVELOPMENT

JULY 2000

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- 2) Education
- 3) Health and HIV/AIDS
- 4) Economic Analysis Capacity
- 5) Sustainable employment
- 6) Housing, urban and environmental services

Education is an essential building block for economic growth, effective democratic participation, and poverty alleviation. It is one of South Africa's top development priorities. In collaboration with the South African government and civil society, USAID channels its resources into three sub-sectors of South African education: (1) Basic Education (2) Market Oriented Training (3) Higher Education.

1. BASIC EDUCATION

USAID's commitment to improved quality of primary education targets the four poorest provinces: Northern Province, KwaZulu Natal, Eastern Cape, and Northern Cape. The program supports several activities towards primary education:

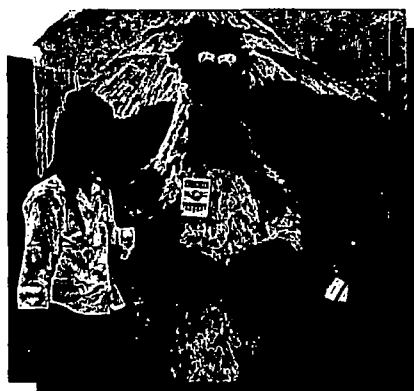
The District Development Support Program (DDSP) (1995-2003): This \$33 million program aims to effect positive change in schools through a district development strategy. Specifically, the DDSP supports: (a) the improvement of teaching and learning in the classroom, (b) an improvement in the quality of management provided by school management teams (principals, other staff and school governing bodies), and (c) an improvement in the quality of support that schools receive from educa-

tion support officers at the circuit, district and regional office levels.

South African Qualifications Authority (SAQA): Supporting SAQA to establish, train and address HIV/AIDS. Responding to the epidemic of HIV/AIDS in South Africa, Basic Education is conducting a nation-wide review of the implementation of the Life Skills curriculum in secondary school, especially in terms of HIV/AIDS education. This feedback will provide valuable information for the improved implementation of an HIV/AIDS education at the elementary school level." In addition, USAID has funded an HIV/AIDS Coordinator to work out of the Minister of Education's office.

Takalani Sesame: A partnership between government, business and media supports the development of a special early education program for radio and television called *Takalani* ("be happy") *Sesame*. USAID is providing \$5 million for this important, 65-part multilingual series. Children's Television Workshop has trained SA producers in the special techniques developed through *Sesame Street*. Teachers, parents and other caregivers will be assisted through community outreach materials to maximise their impact on early childhood development in South Africa.

Box Libraries – In order to provide South African children with the reading materials they desperately need, USAID is providing box libraries to approximately 400 schools in four provinces.



USAID with Moshe, the Meerkat

Education Foundation – A grant to the Education Foundation is providing critical assistance to provinces in implementing the National Norms and Standards for School Funding.

2. MARKET ORIENTED TRAINING

Consistent with the needs expressed by the South African government, USAID is focusing on strengthening the skills of the workforce, for youth and adults. The grouping of the following three Results Packages supports that goal in three unique ways.

Adult Basic Education and Training Youth and Further Education and Training Workforce Development

Adult Basic Education

IKHWELO Project (\$4.5 million): Links adult learners from literacy courses to two skills areas: (1) agriculture (2) small, medium and microenterprises. USAID collaborates with Project Literacy and the AET



Literacy and Skills Development Student and Teacher

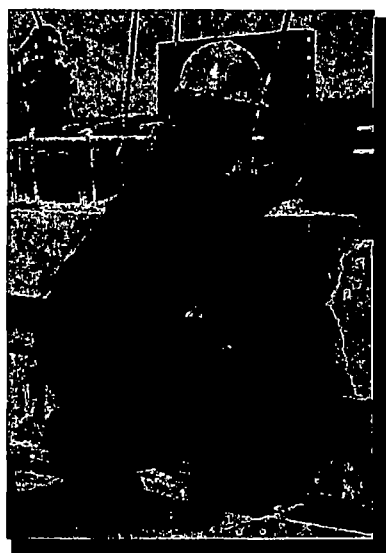
Directorate to administer the project in two pilot provinces: Eastern Cape and Northern Province.

Youth and Further Education and Training

USAID's efforts in the youth and FET sub-sectors are aimed at assisting three million disadvantaged young adults who were unable to complete their education due to the struggle against apartheid.



USAID assistance is channeled through the national Department of Education (DOE) and the South African National Youth Commission (NYC). A \$13 million contract to ABT Associates supports the implementation of activities in FET and the youth development sector. Abt has provided technical assistance and short-term training services in the development of the FET three-year implementation strategy; the youth service draft policy framework, the guide to government youth development programs, and facilitated the youth sector HIV/AIDS study tour to Uganda.



Skills training

Future activities include the provision of technical assistance to the DOE to implement the FET curriculum. Support provided to the systems' institutional and learner levels will be targeted through two provincial education departments for a minimum period of four years.

In the youth area, support includes the development of the youth service policy, support to the implementation of the youth information service activity, a national clearinghouse on youth employment and entrepreneurship, HIV/AIDS and health, technical assistance on the development of research tools and their strategic use in the youth development sector.

Also, the South Africa Opportunities Industrialization Center is a skills training and vocational education center located in Kwa-Zulu Natal. Training is provided in the building construction trades, life skills and business skills to youth and young adults, to gain employable skills that improve their competitiveness in the job market

Workforce Development

Workforce development has been a component of USAID programming since the inception of foreign aid. Its importance to USAID in general, and USAID/SA in particular, is highlighted by world-wide trends that impose rigorous private sector standards on developing countries. USAID/SA's workforce development program is evolving from its bursary program begun in 1984 to one that looks at how South Africa's disadvantaged population can gain the necessary skills to find or create jobs. Activities to date have included bursaries and scholarships that are administered by the South African Institute of Race Relations, the Educational Opportunities Council, Medical Education for South African Blacks, the Catholic Education Aid Program and the Institute of International Education. A work-study program that provides skills and financial assistance to students is administered by the Desmond Tutu Educational Trust. USAID/SA is in the advanced stages of negotiating a Bilateral Agreement with the Republic of



An Adult Learner

South Africa (RSA). The objective of the Agreement is to assist the RSA, through the Department of Labor (DOL) to implement its skills development strategy and to assist the RSA in addressing the human resource constraints to job creation.

USAID will assist by providing technical assistance and training to increase the capacity of the DOL, the newly created Sector Education and Training Authorities (SETAs) and other institutions that manage the new skills development systems.

3. HIGHER EDUCATION

The primary objective of the USAID higher education program is to assist 17 historically disadvantaged universities and technikons to improve the quality of education that they offer. Support is provided through technical assistance, linkages between U.S. and South African institutions of higher learning, and support to the National DOE.

Tertiary Education Linkages Project (TELP, 1995-2004, \$50 million): The primary goal of TELP is to help improve the quality of education at 17 historically disadvantaged institutions (HDIs)—Technikons and Universities—and to support DOE initiatives to transform the higher education sector. USAID assists the HDIs in: (1) revising their curricula (2) developing student assessment and support programs that provide bridging support for Math, English and Science (3) developing the management, administrative and leadership capacity to effectively develop and implement three-year rolling plans (4) developing research capacity and (5) staff development.

During the past four years, TELP has also provided support to the National Commission on Higher Education in the development of a new higher education policy. Discussions are underway with the DOE and 17 HDI Vice Chancellors to identify ways of more effectively utilizing TELP resources to address key management challenges at the HDIs.

Bursary Support (\$5 million): Through grants and contracts to the Institute for International Education, the African America Institute, and the South African Institute for Race Relations, USAID has supported 220 scholarships to HDI staff to pursue masters and doctoral degrees.

Further information is available from USAID/SA's Education Development Team Leader,

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USAID/SA TODAY

United States Agency for International Development in South Africa

SUSTAINABLE EMPLOYMENT OPPORTUNITIES

MARCH 2000

USAID manages the U.S. government's development assistance throughout the world. USAID South Africa's activities are designed to benefit people who were disadvantaged by apartheid, working through government and civil society partnerships in six key areas:

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- 4) Economic analysis capacity
- 5) Sustainable employment
- 6) Housing, urban and environmental services



Shop Owner in Nancefield Hostel

- Scores of SMMEs have been helped to reach the "bankable" stage and access nontraditional sources of capital.

- Sources of long-term risk capital have been provided to emerging enterprises in South Africa valued at millions of Rands and creating more than 500 jobs.

- More than \$22 million in contracts have been awarded by South Africa's corporate and government sector to historically disadvantaged small and medium enterprises.

USAID is developing new ways to increase opportunities for sustainable employment. Activities valued at \$5 million are being planned for fiscal year 2000, with a total funding of \$44 million requested through fiscal year 2005.

The new program will address three major sectors:

- (1) Small-, medium- and micro-enterprises (SMMEs);
- (2) Agriculture; and
- (3) Trade and Investment.

USAID has invested \$113 million in private sector development in South Africa since 1987. A summary of activities is outlined:

Bilateral Agreement with the Department of Trade and Industry (DTI): (FY96-FY99) \$2.5 million—Grant to DTI to develop and implement SMME programs and address trade and investment policies.

South African International Business Linkages (SAIBL): (FY99-FY2001) \$3 million—Cooperative Agreement with Corporate Council on Africa and its partners (Ebony Consulting International, SA On-Line and Phoenix Venture Partners). Commercially viable business relationships are promoted to assist SMMEs to increase trade and investment and the transfer of technology between South Africa and the U.S. Tools include research, development, marketing, match-making and aftercare.

Improved Microenterprise Access to Liquidity (IMALI): (FY99-FY2001) \$3.6 million—Cooperative Agreement with ACDI/VOCA and partners (Alliance for Microenterprise Practitioners, Africa Institute for Policy Analysis (AIPA) and the University of Pretoria) to institutionalize village banking in six provinces. The FinanSol group (Financial Solutions) will establish more than 50 financial services cooperatives (FSC) in rural areas within three years. Savings, loan, fund transfer and investment services are provided to the unserved rural poor. The FinanSol and FSCs emphasize savings, cash management, capital formation and local ownership to ensure sustainable microcredit programs and loyal customers.

Equity Access System (EASY): (FY96-FY99) \$7.0 million—Technical assistance to improve access to equity and long-term loans for entrepreneurs. Contracts have been awarded to Eccles Associates and Phoenix Ven-

SUSTAINABLE EMPLOYMENT

The most important purpose of USAID's Sustainable Employment Program is to promote economic growth and creation of jobs. It helps people who were denied access to credit, training and business opportunities under apartheid. Positive improvement of South Africa's economy is promoted by partnerships with the South African government and non-governmental organizations (NGOs) that develop and expand microenterprises, small businesses and international links to investment and joint ventures.

Small businesses are a vital force in generating employment, improving competition and stimulating a healthier economy. USAID has helped small and medium enterprises (SMME) across the country to expand their businesses to better serve their communities.

- USAID's assistance in the microenterprise arena has created a minimum of 25,000 jobs in South Africa.



ture Partners in three geographically inclusive clusters for the following purposes: (1) To bring historically disadvantaged SMMEs to the "bankable" stage by increasing their qualifications for venture capital investment and/or loan financing; and (2) To assist these enterprises to achieve sustainability after financing is obtained.

Bilateral Agreement with the Ministry of Public Enterprises: (FY97-FY2000) \$2.1 million—Bilateral agreement to assist the Department of Public Enterprises to advance and implement the restructuring of State assets and analyze the potential privatization of public enterprises.

GEAR—Privatization Project: (FY98-FY99) \$1.7 million—Deloitte & Touche was contracted to assist potential bidders on privatization transactions to advance their bids and transfer related skills to local financial intermediaries to enable them to work independently on future privatization transactions.

Volunteers in Technical Assistance (VITA)/ Microenterprise Support Project: (FY97-FY99) \$3.1 million—the following activities have been supported: (1) A retail loan fund issued as working capital loans to growth-ori-

active small business skills training program delivered via radio soap opera episodes with core business themes; (3) A study of the policy, regulatory and administrative constraints encountered by microentrepreneurs.

World Education/Ntinga Microenterprise Support Project:

(FY97-FY00) \$2.9 million—A contract with World Education partners and two South African institutions: Khuphuka and Rural Finance Facility—and the Kenya Rural Enterprise Program (K-REP), to implement this activity. The Ntinga Project works with South African SMME support agencies and microfinance institutions (MFIs) to improve the quality and quantity of services provided to the microenterprise sector. Available assistance includes: (1) Improve the enterprise training capacities of SMME support agencies; (2) Increase the volume of small loans available to informal sector entrepreneurs by expanding the capacity of existing MFIs; (3) Facilitate access to relevant information about financial and non-financial services available; and (4) Help identify and address policy, regulatory and administrative constraints and to encourage expansion of credit and other services to SMMEs.

International Foundation for Education and Self-Help II (IFESH II):

(FY95-FY00) \$1.3 million—IFESH is implementing training to strengthen financial and management skills primarily for bankers from the disadvantaged population.

Southern Africa Enterprise Development Fund (SAEDF):

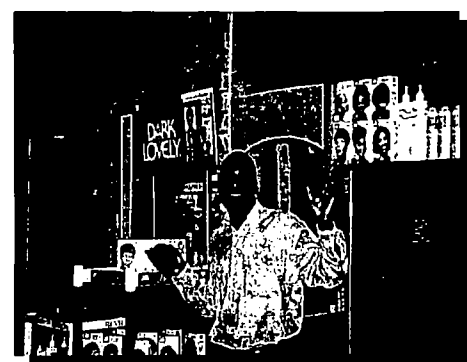
(FY98-FY2003) \$50.0 million—The "Enterprise Fund" provides long-term debt and/or equity financing to promising SMMEs. This is creating a sustainable mechanism to support the

growth of indigenous and disadvantaged SMMEs that have lacked access to capital. The SAEDF invests its resources both directly and through intermediaries, such as financial institutions, NGOs and Private Voluntary Organizations.

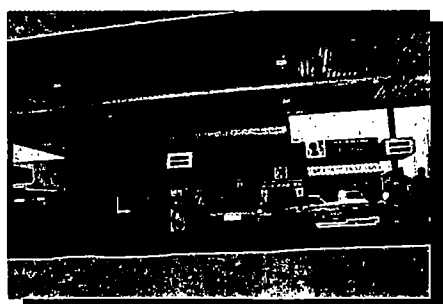


Trained bankers with sponsors

Loan Portfolio Guaranty Program: (FY92-FY2002) \$13.5 million in guaranty authority representing \$27 million in loans—This activity, funded from USAID/Washington, leverages private sector South African financial resources utilizing a 50 percent guaranty on loans to SMMEs. Six South African banks participate in this risk-sharing scheme.



Hair salon in Soweto



Petrol station in Dobsonville

ented disadvantaged black microentrepreneurs; (2) An inter-

Further information is available from USAID/SA's Private Sector Development Team Leader, Bill Brands: (Tel) 012-323-8869, ext. 220, or (Fax) 012-323-6443

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USAID/SA TODAY

United States Agency for International Development in South Africa

DEMOCRACY AND GOVERNANCE

JULY 2000

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DEMOCRACY AND GOVERNANCE

USAID supports South Africa's efforts to consolidate its young democracy. Before the 1994 democratic election USAID worked only with local civil society organizations (CSOs) to assist South Africa's historic transition to democracy. USAID has supported local non-governmental organizations (NGOs) and CSOs engaged in community and leadership development, human rights advocacy, and conflict resolution. During the 1994 election, USAID supported voter education and the electoral process.

Since 1994, USAID has continued to assist CSOs and also began bilateral support to the government to assist them in the democratization process. USAID began several long-term programs in support of access to justice, conflict resolution, and public participation in policy-making in response to South Africans' expressed desire for the transformation to a representative, non-racial democracy where demo-

cratic norms are observed, human rights respected, and good governance practiced. A comprehensive assessment of the constraints and opportunities for furthering democratic consolidation in 1997 prompted USAID to focus its program in the following three areas:

1) Strengthened Rule of Law and Respect for Human Rights

Improved access to justice and civic education are crucial to reverse the legacy of apartheid. Through a bilateral agreement with the Ministry of Justice, USAID funds technical assistance and training to make the justice system more accessible, efficient, transparent, and representative of the historically disadvantaged population. USAID and the South African government are designing a major criminal justice program as a follow-on to the current agreement. This program will support the Bi-National Commission's Jus-



USAID Mission Director with law graduates

tice and Anti-Crime Committee. USAID's Rule of Law assistance has contributed to:

- steady annual increases in South African's awareness of their civil and human rights from an estimate of about 20% in 1996 to 51% in 1998 as indicated by the survey on

the awareness of rights amongst the people of South Africa;

- the development of landmark legislation, Employment Equity Act, and the Equality Act Legislation;
- training of over 1,400 historically disadvantaged legal practitioners and law students
- placement of 300 historically disadvantaged law graduates in private law firms, law school and state institutions to serve their articles of clerkship
- refurbishment of 19 courthouses in the former Transkei



Refurbished courthouse

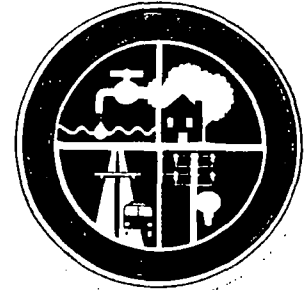
2) Democratic and Effective Local Governance

Through a bilateral agreement with the Department of Provincial Affairs and Local Government, USAID supports the development of national policies and programs that enable effective and democratic local governance; direct assistance to selected municipal governments to develop models for effective and democratic local governance; and a program of networked learning to facilitate sharing of best governance practices among municipalities. The agreement is implemented in coordina-

tion with and to support South Africa's Local Government Transformation Program.

USAID assistance has helped local governance by:

- defining the policy framework for



Local Governance Program



Local Government Transformation

post apartheid local government through technical assistance to inform the drafting of the Local Government White Paper and local government revenue policy;

- strengthening the capacity of South Africa's Local Government Transformation Programme to coordinate the process of establishing developmental and democratic local government per the Constitution; and
- train numerous councillors and of-

ficials to carry out their functions effectively and democratically.

3) *Civil Society Strengthening Program*

The sustainability of a healthy and vibrant civil society sector is an important element of the consolidation of South Africa's democracy. In close collaboration with government and civil society key players, USAID recently designed and is now initiating a program to support strategic partnerships between government and civil society to jointly address policy developments and effective service delivery. This sector strengthening program will be implemented in coordination with civil society partners.

USAID's longstanding support to civil society organizations has:

- helped reduce democracy-threatening conflict in violence prone areas of South Africa;
- strengthened democratic pluralism through supporting public participation in many key pieces of legislation covering a variety of sectors including justice, rights, social welfare, private sector development, labor, and other areas;
- fostered partnerships for local socio-economic development between community groups, local governments, and the private sectors; and contributed to the strengthening institutional capacity sustainability of non-governmental organizations through technical assistance for improved management practices.

In addition to the above, USAID supported the Independent Electoral Commission (IEC) in carrying out the re-



Two South African government officials display their class photo from the Harvard-WITS Senior Executive Program (SEP). Studies involved training with government, business and public enterprise leaders.

cent national and provincial elections and will support voter education for upcoming local elections. USAID also funds executive level training for senior public sector managers.



The Family Preservation Project makes the Pretoria Children's Court more friendly

**Further information is available from USAID/SA's Democracy and Governance Development Team Leader, Elizabeth Hogan: (Tel) 012-323-8869, ext. 231, or (Fax) 012-323-6443
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USAID/SA TODAY

United States Agency for International Development in South Africa

SUPPORTING HOUSING AND URBAN DEVELOPMENT

JULY 2000

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SHELTER, MUNICIPAL INFRASTRUCTURE, AND ENVIRONMENT

Historically disadvantaged South Africans have, in the past, been prohibited through legislation from owning key economic goods such as homes



Housing development in the
Western Cape

and businesses and from obtaining vital socio-economic services. The most glaring mark of the economic disempowerment has been lack of access to housing and basic urban services. Today an estimated one million historically disadvantaged households live in squatter settlements in appalling conditions. Current estimates call

for the construction of about 300,000 housing units per annum over the next ten years and expenditure of an additional 17.5 billion U.S. dollars in urban infrastructure to bring the majority of historically disadvantaged households up to the minimum acceptable standard.

The goal of our housing and urban development program is to improve access to housing and environmentally sustainable urban services (i.e., water, electricity and sanitation) for the historically disadvantaged population.

This will be achieved through a focus on four specific areas:

- Support for policy development;
- Provision of shelter and infrastructure finance;
- Assistance to shelter sector NGOs; and,
- Improve urban environmental management capacity.

For the period between 1992-2002, nearly \$175 million in loan guarantees and over \$90 million in grants, technical assistance and training will be provided.

Specific Support

Support for Policy Development — USAID supplies technical assistance to support the South African government's development of a positive policy environment and framework.

Activities include two bilateral agreements with the Department of Housing (DOH) and one with the Department of Provincial and Local Government Affairs (DPLG).

- The first agreement, signed in 1994, provided the DOH with the expertise necessary to craft a series of policies to rationalise the shelter provision system.

- The second agreement, signed in 1996, intends to make the DOH's "People's Housing Process" a reality. It also provides technical assistance to the National Housing Finance Corporation to monitor and evaluate shelter delivery, and to the Social Housing Finance Corporation.
- The third grant agreement with the DPLG: (a) Focuses upon the implementation of the government's Municipal Infrastructure Investment Framework; (b) Provides support for the development of the appropriate legal and regulatory framework for public-private partnerships linked to infrastructure provision; and (c) Provides support to a special Municipal Infrastructure Investment Unit.

Provision of Shelter Infrastructure Finance —

USAID provides loan funding for shelter credit to private financial institutions. Through these programs, private local financing totaling an estimated \$450 million will benefit approximately 459,700 households. Activities include three Housing Guarantee (HG) Projects with two major South African banks--NEDCOR and First National Bank, as well as a HG with New Infrastructure Finance Institution (INCA):

- Private Sector Housing Guarantee Program (PS-HG) — The objectives of this \$75 million program are to encourage existing financial institutions to invest in housing for employed black South Africans and to expand opportunities for black-owned and managed businesses in such areas as mortgage lending, contracting and building supplies.



- **Basic Shelter and Environment Housing Guarantee Program (BSE-HG)** — The objective of this \$95 million program is to increase access to capital for expanded ownership of shelters through strengthened financing mechanisms focusing on the role of the private sector.
- **Municipal Environmental Infrastructure Housing Guarantee Program (MEI-HG)** — The objective of this HG, which is with INCA, is to increase the availability of finance for municipal infrastructure destined for low-income communities.

USAID's shelter program also provides grants to NGOs to encourage the development of alternative shelter finance mechanisms including: leveraging of shelter funds through three project preparation trusts that makes loans available to community groups to prepare projects that qualify for funding, guarantees on loans to emerging contractors through a grant to the National Housing and Urban Reconstruction Agency (NURCHA), and innovative credit mechanisms that provide



Housing development in the Eastern Cape

funds for a number of entities involved in harnessing community resources to provide loans to its members.

Assistance To Shelter Sector NGOs — USAID has provided support to over 15 shelter sector NGOs working with disadvantaged communities in the area of housing and urban service provision. Of special importance are programs that encourage self-help and that target women-headed households. This program features grants to ten of the most effective shelter sector NGOs, all of which have demonstrated their ability to obtain housing and key urban services for their constituents. Grantees include: People's Dialogue, Urban Sector Network, Cooperative Housing Foundation and Habitat for Humanity — to name but a few.

Smaller grants are provided to NGOs and CBOs (community based organisations) to provide construction skills and training to black contractors to enable them to improve managerial and technical capacity and to render legal assistance and support on shelter-related matters to low-income communities and developers.

Finally, USAID assists a number of institutions that provide training in key aspects of municipal management to local-level officials.

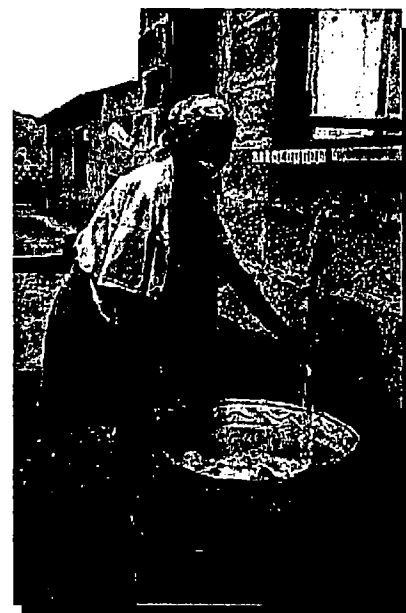
Improving Urban Environmental Management Capacity —

USAID is also working with the South African government to develop a program to address global climate change issues.

Activities include:

- A bilateral grant agreement with the Department of Water Affairs and Forestry to create a water management institution in the Mpumalanga Province and to build capacity among local authorities in the area of water and sanitation provision;

- The Agenda 21 Sustainable Communities Program in Johannesburg, Pretoria and Cape Town;
- An urban environmental education grant with the Wildlife and Environment Society of South Africa to enhance environmental awareness and capacity in urban communities;
- A bilateral grant agreement with the Department of Environmental Affairs and Tourism to address issues related to global climate change;
- An agreement involving the Urban Environment Unit of the University of Cape Town and the Department of Environmental Affairs and Tourism to provide training for local and provincial government officials on issues of environmentally sustainable development and to



Water facilities in Soweto

organize and implement a nationwide Local Agenda 21 campaign.

**Further information is available from USAID/SA's Housing and Urban Development Team Leader, Joel Kolker: (Tel) 012-323-8869, ext. 217, or (Fax) 012-323-6443
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USAID/SA TODAY

United States Agency for International Development in South Africa

ECONOMIC POLICY CAPACITY DEVELOPMENT

MAY 2000

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ECONOMIC CAPACITY BUILDING

USAID's economic program areas were selected in close consultation with the South African government, universities, economic think tanks, and business to address critical problems. The objective of USAID/Pretoria's economic work in South Africa is to "improve the capacity of key government and non-government entities to formulate, evaluate and implement economic policies." Emphasizing the improvement in the economic skills of historically disadvantaged people does this.

USAID is doing this because:

- increased economic growth with improved equity is essential to the sustainable transformation of South Africa, to job creation and increasing incomes;
- sustainability of social reforms necessitates a vibrant economy able to finance these reforms;
- the economic development of eastern and southern Africa depends on a vibrant, growing and economically liberal South Africa; and
- the needed policy changes will be difficult to design and implement; success requires active involvement of all South Africans, especially those previously excluded from decision-making.

USAID is not targeting specific policy changes but assisting government and non-governmental institutions to improve the quality of economic analysis. These institutions determine the economic policies where assistance is required. Good economic analysis is necessary to good economic policy.

USAID, the South African government and non-governmental institutions developed the program that supports government's efforts to formulate and implement growth and job creating policies, and enhance the capabilities of historically disadvantaged South Africans to participate in the process.

The bilateral grant agreement (Support for Economic Growth and Analysis/Mandela Economic Scholars Program – SEGA/MESP) was signed in September 1996 and commits \$30 million in USAID resources over nine years, with \$19.2million provided to date.

A consortium of US and South African companies, led by Nathan Associates, was awarded the contract to implement much of USAID's Economic Capacity Building work with additional work done through Inter-Agency Agreements with other US Government departments and private contractors.

Collaborative Work

Human Resources

The Mandela Economic Scholarship Program gives scholarships for post-graduate economics training in the US to individuals from the historically disadvantaged community. All are contractually bound to work for government upon completion of their studies.

Seventy-two scholars have already been sent with eighteen already back and working as professional economists. An estimated 40 bursaries are provided each year for university education in economics and accounting in South Africa. In addition, over 1200 people have received short-term training in economics



Nelson Mandela with some of the Mandela Economics Scholars going to the U.S. in 2000

Government Departments

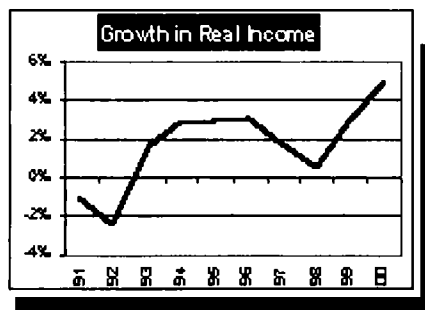
Technical assistance, short-term training and research funds are provided to government departments heavily engaged in economic analysis with an emphasis on the Departments of Finance, Labour, Trade and Industry, Environmental Affairs and Tourism, and Agriculture. USAID is also working with the Office of the Presidency on infrastructure development and Government's Spatial Development Initiative.

• *Department of Finance* – USAID provides through the U.S. Treasury Department one long-term advisor on inter-governmental fiscal relations and one advisor on tax-policy. Another long-term advisor is assisting on public-private partnerships. Short-term technical assistance is being provided on strengthening medium-term expenditure



diture planning, econometric modeling, analysis of labor markets, the economic impact of HIV/AIDS and prioritizing spending in areas such as the criminal justice system.

USAID is also working to strengthen the collection and audit abilities of the



South African Government chart

SA Revenue Service (SARS), and strengthening the Johannesburg financial market to become the financial center for sub-Saharan African governments and companies.

• *Department of Labour* – USAID, in collaboration with the U.S. Department of Labor – US-DOL, is providing assistance implementing the Employment Equity Act. This includes developing procedures, audits, codes of good practice and IT systems. USDOL, with USAID resources, is helping improve labour market information, statistics and analysis, training occupational health and safety inspectors and strengthening research capabilities of the Department. Studies being completed include the impact of current labor legislation on job creation, determinants of unemployment, and determinants of migration. USAID has trained over 150 Department personnel on basic economic literacy.

• *Department of Trade and Industry* – USAID is assisting in developing guidelines on promoting high-tech venture capital enterprises, analyzing the

determinants of global competitiveness, and understanding WTO sanitary and phytosanitary standards (SPS). USAID is training officials on global trade agreement requirements and procedures. The Program is also helping develop the capacity of the *Competition Commission* to analyze company anti-competitive behavior.

• *Department of Agriculture* – USAID is providing (through the U.S. Department of Agriculture) assistance in improving agricultural statistics and analyzing those statistics, plus analysis of the implications for South African agricultural commodities on global agreements that impact trade (bio-safety and SPS). Future work will involve USDA's Economic Research Service in helping the National Department of Agriculture.

• *Department of Public Enterprises* – work to privatize major state corporations, including Eskom, Telkom, Transnet and Denel.

Think-Tanks

USAID works with non-governmental organizations (NGOs) and univer-



Partners in South African economic development

sity think tanks to do policy-oriented research. Some of the institutions assisted include:

- *Trade and Industrial Policy Secretariat* (TIPS – trade statistics and analysis),
- *National Institute for Economic Policy* (NIEP – macro-economic policy analysis),

- *Labour Research Service* (LRS – training of labor economists),
- *African Institute for Policy Analysis* (AIPA – analysis of agricultural policy, training of black economists),
- *Economic Policy Research Institute* (EPRI – macro-economic policy analysis),
- the *Disabled Persons of South Africa* (DPSA – economic problems of disabled persons) and
- *LIMA* (land reform in traditional areas).

This assistance provides independent analysis of economic policies and programs for input into policy decision-making.

Center of Economic Excellence

Technical assistance, commodities and short-term training are being provided to the University of the Western Cape's (UWC) Department of Economics to become a Centre of Economics Excellence. This includes strengthening traditional and non-traditional teaching, research, and out-reach programs to benefit historically disadvantaged institutions. UWC is also providing technical assistance and training to provincial governments in the Cape provinces. Thirty bursaries are provided for undergraduate and honours education.

ECONews is a weekly publication that summarizes economic developments in SA. The *Week in Review* summarizes recent Economic SO activities. They are available on USAID/SA's website.

Further information is available from USAID/SA's Economic Policy Team Leader,

Neal P. Cohen: (Tel) 012-323-8869, ext. 231, or (Fax) 012-323-6443

P.O. Box 55380, Arcadia, 0007, Pretoria, South Africa * Website: <http://www.sn.apc.org/usaidsa>

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT



USAID Mission to South Africa

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Pretoria, South Africa

Telephone: (27 12) 323-8869 • Fax: (27 12) 323-6443

Website: <http://web.sn.apc.org/usaidsa>

Sites: Lilly of the Valley Children's Home	Location: KwaZulu-Natal Province
Meeting Date: Monday 10 July 2000 Time: 02:00pm	
Address: Farm Killarney, Eston	Directions: 45 – 60 mins drive from Pietermaritzburg. Take N3 to Durban, take Richmond/Eston turn-off.
Key Site Contacts: Ms Anita Keyzer (031-781-1063)	
Summary Description: Lilly of the Valley Children's Home is a 59 acre property in Eston, KwaZulu/Natal, purchased by Anita and Kees Keyzer in 1994. In 1995 the Home was officially opened. The mission of the Home is to "reflect the compassion of Jesus Christ in providing care, love and support to terminally ill AIDS children including children abandoned due to parental AIDS suffering". The Home caters for 45 children, at the moment they have 35 children. Sixty percent of HIV positive children sero-convert. The Home has 6 cottages, each has a house mother and 6 children. At the Home the group will be met by Anita, and will have a discussion over lunch. After lunch there'll be a tour of the Home.	

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South Africa

Project Name: Project Preparation Trust/Cato Manor **Site Sheet:** Gauteng

Activity: The Cato Manor Development Association, supported by USAID through the Project Preparation Trust (PPT) of KwaZulu-Natal	Location: Cato Manor area of Durban in KwaZulu-Natal (KZN) Province
Partners: Project Preparation Trust, Cato Manor Development Association, various community-based organizations and local authorities in the KwaZulu-Natal region; Provincial Housing Board of KwaZulu-Natal; Built Environment Support Group (BESG)	Project Duration: September 1 1993 – September 30, 2000
Meeting Date: July 12, 2000 Time: 3:00-4:00pm	Grant Amount: \$2,000,000
USAID Strategic Mission Objective: Increasing community access to housing and urban services	Activity Officer: Rebecca Black Telephone: 083 381 5195
Key Site Contacts: Shelly Grielink, Cato Manor Development Association Public Relations Director	
SUMMARY: USAID's supports the Project Preparation Trust's efforts to assist communities and their local authorities in identifying capital for housing and environmental infrastructure projects for previously disadvantaged people. The Trust works specifically with community-based organizations and their local authorities in KwaZulu-Natal, making zero-interest loans to community organizations and their local authorities to package housing and infrastructure projects. The Trust has worked with over 90 different community improvement projects, helping them to access more than \$30 million in capital for housing and infrastructure. As a result, 52,000 historically disadvantaged households have obtained better housing and/or services. The Trust has worked with the <u>Cato Manor Development Association</u> (CMDA) in financing and managing housing and infrastructure projects. Cato Manor is an area in northwest Durban that once housed a mixed-race population. The Apartheid system's Group Areas Act resulted in the forced removal of the resident population to in the 1960s to "appropriately segregated" homelands and townships. Cato Manor was left undeveloped. As the demand grew for housing closer to the urban center, informal settlers began to build makeshift houses in the area. The Cato Manor Development Association is working with the City of Durban and other entities to redevelop the area into a healthy, inclusive, and sustainable community. In the Wiggins area, the Trust has helped CMDA access over 700 housing subsidies for new or upgraded housing for local residents. Several groups will assemble at the Multipurpose Centre/Library (stocked with books donated by a U.S. organisation) for a 30-minute discussion from four groups. Housing and community development actions will be covered and pilot efforts to address HIV/AIDS highlighted. CMDA is a multi-sectoral organisation committed to the redevelopment of the Cato Manor area undertaking housing, micro-business, recreational and other training activities. The Built Environment Support Group (BESG) is a housing/urban NGO supported under an AID umbrella grant that is undertaking housing activities that will provide an environment for care of HIV/AIDS orphans; the Durban Unicity Commission is involved with the HIV/AIDS database project that USAID is funding that will be useful as the newly created unicity is in the process of restructuring. A drive-through the community will follow the group discussions.	



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South Africa

Project Name: Ntinga Microenterprise Support Project **Site Sheet:** Kwa-Zulu Natal

Activity: Ntinga Microenterprise Support Project	Location: Durban in KwaZulu-Natal (KZN) Province
Partners: World Learning, US PVO	Project Duration (Start and End Dates): September 1996- September 2001
Meeting Date: Wednesday July 12, 2000 Time: 1:30pm – 2:30pm	Grant Amount: \$2, 900,000 (Phase One) \$700,000 (Proposed Phase Two)
USAID Strategic Mission Objective: Increased Market-Driven Employment Opportunities	Activity Officer: William Brands Telephone: (083) 417-6855

Key Site Contact: Francois Du Toit 031-207-2170 (NTINGA) Protas Madlala 031-3090-5432 (Thekwini)

SUMMARY

The goal of the Ntinga Microenterprise Support Project is to support the South African aim for increased employment, income generation, and economic equity through promoting the growth and success of the country's small micro-enterprise sector. Specifically, Ntinga seeks to increase the micro-entrepreneurs' access to financing through enhancing their skills, performance and profitability; in other words, helping the enterprises to become more bankable.

Ntinga's assistance has focused during the last three years on the following:

- Improving the enterprise training capacities of SMME (Small microenterprise) support agencies, through strengthening and supplementing the skills and offerings of their training staff, and assisting with organizational development, program management and systems.
- Increasing the volume of small loans available to informal sector entrepreneurs, primarily through expanding outreach capacity and lending systems of existing financial institutions.
- Facilitating the access of SMME agencies, micro-finance institutions, and micro-entrepreneurs to relevant information about financial and non-financial services available from banks, donors, and training organizations, as well as information about existing and new business opportunities, legislation and other factors affecting them.

The Ntinga Project has worked in partnership with 16 South African SMME support agencies and 8 micro-finance institutions to improve the quality and quantity of services provided to the micro-enterprise sector. Through joint consultation and discussion of needs and priorities, the project established "working agreements" with such organizations to develop their capacity to effectively address specific operational factors as well as longer-range institutional issues. Over 1300 individuals have already received training through this project.

One site will be visited to demonstrate the project:

Thekwini Business Development Center (TBDC) was established three years ago as a project of the Durban Metro Council in partnership with the private sector in order to promote the development of the black business sector. TBDC provides tender advice and training, business information, management services, business linkages, manufacturing opportunities and export training to thousands of micro-entrepreneurs in the Durban area. The Center is also used to provide information on HIV/AIDS. After conducting an institutional assessment, Ntinga provided a number of strategic interventions to maximize TBDC's effectiveness. Ntinga conducted strategic planning exercises, trained staff in leadership and time management, and held workshops on industrial and human relations. Protas Mdala, CEO of TBDC noted that, "TBDC is regarded nationally as a model Local Business Service Center and Tender Advice Center due largely to Ntinga's involvement in strengthening the management and leadership of the organization." Francois Du Toit, Director of Ntinga, and Mr. Madlala will provide a tour of the Center and discuss the major aspects of their work.

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South Africa

Project Name: Ndwedwe District Child Survival Project **Site Sheet:** Kwa-Zulu Natal

Activity: Ndwedwe District Child Survival Project	Location: KwaZulu-Natal (KZN) Province
Partners: Interim District Health Management Team, Oakford Clinic and Priory, Training Resources in Early Education and traditional birth attendants	Project Duration (Start and End Dates): October 1, 1995 March 31, 2001
Meeting Date: Tuesday, 11 July 2000 Time: Depart Royal Hotel at 11am for arrival at site at noon. Site visit will last 2 hours	Grant Amount: \$1,668,519
USAID Strategic Mission Objective: Increased use of essential primary health care and HIV/AIDS prevention practices	Activity Officer: Anita Sampson Telephone: (012) 323-8869, x.261 (012) 804 2979
Key Site Contact: Mr. David Patterson, Tel; (031) 260-1622; cell (082) 659 5441; Fax: (031) 260 1606	
SUMMARY The Ndwedwe district in the Kwa-Zulu Natal Province is an under-served area in which violence is endemic and paved roads are largely non-existent. Overall the terrain is rough and hilly; the settlement pattern is widely dispersed. The area is traditionally organized into 18 tribal divisions headed by traditional tribal leaders. Medical Care Development International (MCDI) is a non-profit organization dedicated to the goal of improved quality of life for all people regardless of income or location. In 1995, MCDI received a 2-year child survival grant from USAID to establish the Ndwedwe District Child Survival Project (NDCSP). After the successful completion of the planning grant, MCDI was awarded in 1997 another grant from USAID for a four year project to continue and expand the activities that had been initiated. The goals of the NDCSP have been to reduce morbidity and mortality among children under five years of age and to improve the health status of women of childbearing age by reducing the risks associated with reproduction. As a means of achieving these goals, the project initiated a series of interrelated activities that operate at the community level, the clinic and hospital level and at the district-level Department of Health. Based on the results of 1996 baseline survey and an final evaluation of the project, the current activities emphasize four key interventions areas: maternal and newborn care, immunizations, pneumonia case management and control of diarrhea. Recently MCDI secured funding from USAID/South Africa to incorporate activities that will improve community care of children affected by AIDS. Over the three years that MCDI has been working in Ndwedwe, it has become apparent that the HIV/AIDS epidemic is outstripping initial expectations, and that the situation has reached emergency status. WHO estimates that South Africa has the highest incidence of HIV with 1,600 new infections per day. KwaZulu-Natal leads South Africa's HIV/AIDS infection with over two thirds of the currently estimated 1.8million cases. According to the Children in distress (CINDI) group, four out of ten young adults in KZN are expected to die of AIDS in the next 15-20 years. A surveillance of antenatal clinics in KZN shows that 24 to 33 percent of all women are testing positive for HIV. In response to the increasing awareness of the severity of the HIV/AIDS epidemic, MCDI new activities include: - Strengthening the coping capacity of families affected by HIV/AIDs through training in home-care and exploring income-generation activities; and - Stimulating and strengthening a community response.	

FYE XX, Bill Harris

THE BOSTON SUNDAY GLOBE WORLD DECEMBER 5, 1999

AIDS crisis spreads across India

10 million may be HIV positive; misconceptions are rampant

By Marion Lloyd
GLOBE CORRESPONDENT

MIRAJ, India - In a squalid hut on the outskirts of this thriving sugar cane center, a young woman lay dying, her half-naked body resting limply on a rough straw cot. She had never heard of the disease that has transformed her once-rounded figure into that of a starving child.

The disease is AIDS, and it has killed 20 women this year in the sprawling red-light district of Miraj. Of the 2,000 sex workers, more than half are believed to be infected with the HIV virus and most will probably die from it over the next decade.

"A doctor came and told me I had too much water in my stomach. He injected some needles and now I cannot eat," said Yellava Gaste, who started working as a prostitute 10 years ago but said she had never heard of AIDS or condoms. "I must have done something wrong to deserve this," she said, referring to the traditional Hindu belief that misfortunes are the result of sins committed in a past life.

Officially, India has 3.5 million to 4 million people infected with HIV, a figure that places it ahead of even the worst-hit African countries in terms of the sheer number of HIV cases. But some specialists say the real number may be closer to 10 million, a critical 1 percent of the population that indicates the start of a full-blown epidemic.

Miraj, an eight-hour train ride from Bombay, is at the epicenter of the AIDS crisis. One in 20 people here is believed to be infected with the disease, compared with the national average of one in 200. The town's location at the crossroads of several major national highways, its proximity to Bombay, and its sprawling red light district also make it a prime feeder of the disease across Maharashtra state and beyond.

Despite a seven-year government campaign to stem the spread of HIV, 6 million more Indians will become infected by 2005 if the current trend continues, according to World Health Organization estimates. Most, like Gaste, will be left to die as the country's overtaxed health system struggles to cope with the spreading disease.

"It is very difficult for the government to think about the people who are suffering from AIDS. They want to stop more people from getting infected," said Ravi Tate, a government doctor in Miraj.

So far, that goal has meant focusing on so-called target groups, mainly prostitutes, truck drivers, and drug users, in what critics say has fed the general misconception that only marginal groups are at risk.

"By this kind of targeting, you've ensured that certain groups are seen as high-risk groups, but anyone who doesn't belong to that group is safe," said Angeli Gopalan, director of the Delhi-based Naz Foundation, a non-governmental organization that provides counseling to AIDS patients.

She and other AIDS activists are pushing the government to invest more in AIDS education and treatment. "The government should be doing something, forget about more," she said. "They should accept that we have a problem."

Government officials deny they are taking the disease lightly. The government recently signed on for a \$191 million loan from the World Bank, most of which will pay for treatment of AIDS-related infections, though officials say they cannot afford to treat the disease itself.

Even if locally produced drugs are substituted for pricier Western ones, the cost of the standard AIDS treatment is \$400 a month - four times the \$100 average salary in cities and eight times the average rural earnings.

Much of the World Bank loan will go toward training health workers to provide better care to HIV-positive patients, many of whom have been denied access to hospitals once their infected status is revealed. Bombay, which has been hardest hit by the disease and is at the forefront of AIDS prevention, recently issued strict guidelines forbidding discrimination of HIV-infected patients in government hospitals. However, cities such as New Delhi and Calcutta, which have fewer AIDS cases, lag far behind in teaching health workers to cope with the disease.

"We are now at a stage where Thailand was three years ago," said J.V.R. Prasada Rao, the head of India's AIDS control program, at an AIDS conference last week. He was referring to the point at which the epidemic in Bangkok began to level off, largely due to a massive public awareness drive. However, he added, "any slackening can loosen our grip on the situation."

Critics dismiss such statements as overly optimistic. They say that while there are signs that cities like Bombay and Chennai have managed to slow the spread of the disease, much of the country has yet to wake up to the threat.

"We may see that the number of cases are evening out, but there are so many hidden foci of AIDS ... what we see doesn't even touch the reality," said Dr. Hema Jerajani, an AIDS specialist at Sion public hospital in Bombay. She said the governments of populous states like Uttar Pradesh, Bihar, and Madhya Pradesh "are refusing to accept that their people are getting infected," warning of a "huge epidemic" in those areas if officials there continue to drag their feet on AIDS prevention.

In Miraj, most of the prostitutes said they had heard of AIDS but did not know what it was. Their confusion stems in part from a deliberate policy among health workers of providing limited information. One doctor working in the red light district said he chose not to inform women who were HIV-positive of their status, because "they might become too depressed and commit suicide and then we would be blamed."

Dr. R.R. Gawai said health workers had been able to increase condom use from virtually nil in 1992 to more than 90 percent today by convincing prostitutes of the need to protect against "a deadly disease."

Despite the government awareness campaign, AIDS remains a taboo subject in most rural areas, where there is little understanding of the ways in which the disease is spread. As a result, women, whose social status is generally lower than that of men, are typically accused of contracting the virus.

One, Sangita Pramod Nhalve, was forced from her home and barred from seeing her two daughters after her husband died of AIDS-induced tuberculosis last year. She now lives at a home for HIV-infected women and orphans in the nearby town of Sangli.

"They said, 'You are a bad omen in our house and you should be

shunned,'" said Nhalve, breaking into tears as she related how her husband's family held a meeting to decide whether she should be allowed to continue to live with them. When they turned her out, forcing her to leave her children behind, she went to her parents for help. "But I was turned down in my own house," said Nhalve, who tested positive for HIV but has yet to show signs of the disease.

Ironically, the tendency to blame women has diverted attention from a high-risk group - gay men. In Bom-

bay, more than half of the men who underwent testing at a center for gay men were HIV-positive, according to the center's director, Ashok Row Kavi. Kavi has been running a condom distribution program in gay cruising areas and pressuring the government to include gay men in its awareness campaign.

"I'm saying stop targeting the women. Look at male sexuality," said Kavi, who said he is torn between the need to halt the spread of the disease and his fears that such a campaign will trigger a backlash against gays in India. He asserted that the government is shying away from focusing on gay men because "they don't want to acknowledge that we exist."

MINI REVIEW ARTICLE : CANADIAN JOURNAL OF GASTROENTEROLOGY

The Economic Impact of AIDS in Africa

by

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Abstract.

The experience of AIDS in Africa is very different from that in the developed world. In the West AIDS affects few people, and for those who are infected it is an increasingly manageable illness. In Africa huge numbers are being infected, mainly young adults through sexual intercourse. This is having a dramatic effect on key demographic indicators. Child mortality in some countries has doubled, while up to 25 years of life expectancy has been lost. The economic impact of AIDS is difficult to establish, but it is certain that it is leading to increased poverty in African families and communities. Development advances are being reversed, but the impact is incremental rather than catastrophic.

Key words: HIV, AIDS, economic, Africa, demography, development.

INTRODUCTION

AIDS is the first, and so far, the only disease to have a United Nations Agency (UNAIDS) established especially to deal with it and its consequences. To people living in the developed world, this might seem puzzling. In these countries the massive HIV epidemic feared in the mid-1980s has not materialised, and the prevalence is low. Where HIV is still spreading is among clearly defined, usually disadvantaged groups.¹ For those unfortunate enough to be infected, AIDS is no longer the automatic death sentence it once was. The introduction of highly active antiretroviral therapy (HAART) means that mortality rates among people with HIV infection have begun to decline in the developed world.² Increasingly, HIV-related illness is seen as a chronic but manageable illness, albeit at a price. It is estimated that antiretroviral therapy costs between US\$8,000 and US\$12,000 per patient per annum.³

The situation in Africa is very different. Sub-Saharan Africa has the worst epidemic in the world. In 1998, it was estimated that over two-thirds of those living with HIV were in Africa, and 83 per cent of global AIDS deaths have been here.⁴ The HIV and AIDS epidemics are very different in Africa from the rest of the world. Distinguishing characteristics are:

- **Modes of Transmission.** In Africa the vast majority of infections are heterosexually transmitted. - as many as 80 per cent - and the balance are mainly mother to child infections.
- **The Location of the Epidemic.** Figure 1 shows a typical age and gender profile of the epidemic. In general, more females than males are infected, and women are infected at a younger age than their male counterparts.

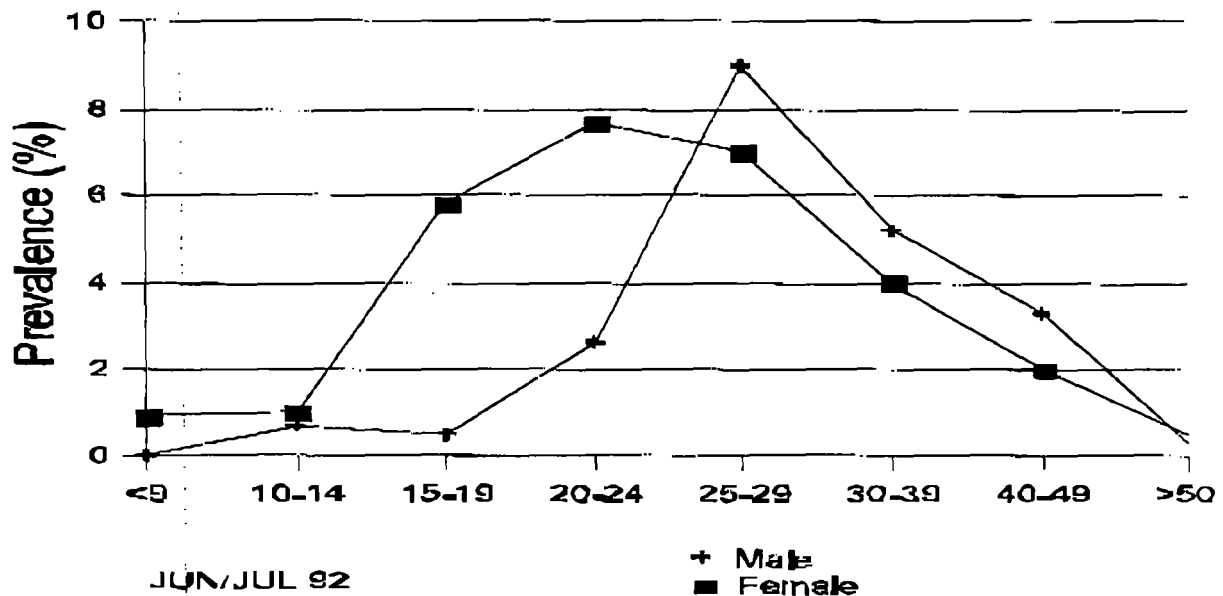
¹ Schechter, Martin T; Strathdee, Stephanie A; Cornelisse, Peter G.A., et al. "Do needle exchange programmes increase the spread of HIV among injection drug users?: an investigation of the Vancouver outbreak", AIDS 1999; 13:F45-F51.

² See, for example, the editorial in The New England Journal of Medicine, 26 March 1998, 338:13 which reports that, in New York City, rates of death from AIDS fell 28 per cent for 1995-1996 and a further 44 per cent from mid-1995 to mid-1997. In Canada, France, Germany and Switzerland, HIV related morbidity and mortality decreased by 60-80 per cent with the introduction of AZT.

³ The World Bank: Confronting AIDS : public priorities in a global epidemic. A World Bank Policy Research Report, New York : Oxford University Press, 1997.

⁴ Report on the Global HIV/AIDS epidemic. June 1998. Geneva: UNAIDS/WHO, 1998.

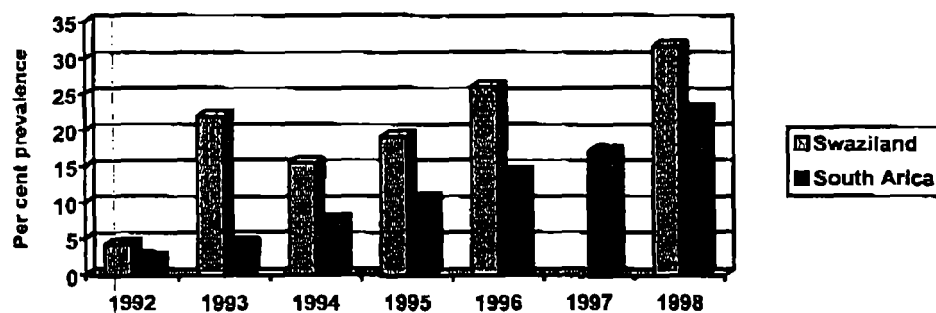
Figure 1 Age and Gender differences in HIV infection in rural KwaZulu-Natal - 1992



- The Scale of the Problem.** The main sources of data are the antenatal clinic attendee surveys. While these have their limitations,⁵ they provide the best and often the only source of information. In Western Europe, the highest recorded HIV prevalence was 0.42 per cent among females attending ANCs in urban areas (in France in 1994). By contrast, in Eastern and Southern Africa, the lowest urban ANC prevalence recorded in the 1990s was 1.2 per cent in Angola, and the highest was Botswana with 38.5 per cent.⁶ The ANC HIV prevalence rates for Swaziland and South Africa are shown in Figure 2 and these are typical for the region.

Figure 2 National HIV Prevalence in Swaziland and South Africa.⁷

Note: No figures were available for Swaziland in 1997.



- The Prognosis.** While in the developed world the period from infection to illness and death was estimated to be 10 years and, with the introduction of HAART, increasing, in Africa it is much shorter. Estimates of time from infection to AIDS range from 2-7.5 years, but these are seroprevalent rather than seroincident cohorts.⁸ Recently a group of

⁵ "UNAIDS Best Practice Collection. Reading regional consensus on improved behavioural and sero-surveillance for HIV". Report from a regional conference in East Africa, June 1998, UNAIDS.

⁶ Report on the global HIV/AIDS epidemic. June 1998. Geneva: UNAIDS/WHO, 1998, P70-71.

⁷ Results of the National HIV Surveys of Women Attending Antenatal Clinics as published by the National AIDS Control Programmes of the two countries.

⁸ Grant Alison D, Ojomond Gaston, and De Cock Kevin M. "Natural territory and spectrum of disease in adults with HIV/AIDS in Africa", AIDS 1997, (Supp. B) S43-S54.

demographers modelling the epidemic for Southern Africa used the period of 6.5 years after infection to death.⁹

THE IMPACT OF AIDS

Clearly a disease that is so widespread, and with such effects on morbidity and mortality, will have serious implications for Africa. The situation is made even more bleak by the lack of resources, both for prevention and for dealing with the impact, in most of the continent. A discussion of the economic impact is, however, only part of the picture. The extent of the economic impact will depend on the demographic impact. Furthermore, the economic impact as measured by economists may not be that apparent, and other indicators may be more important, in particular the effect on development.

Demographic Effects of AIDS.

As AIDS means significant numbers of adults and children will die, it affects the major demographic processes of mortality and fertility. Since HIV is spread mainly through sexual transmission, most of those infected will be between 20 and 40, and they will die 5-10 years later.

AIDS has been identified as the major cause of death in adults aged 15-44 years in Abidjan and in adults aged 15-59 years in Tanzania.^{10,11} In a rural Ugandan cohort, with an adult HIV prevalence of about 14 per cent, AIDS accounted for approximately 40 per cent of deaths of all adults.¹² AIDS is now the single most important cause of death in Africa, and given the age of those dying it is also, a major cause of orphaning. The World Health Organisation (WHO) estimated that, in Africa, as many as 10 million children have been orphaned since the beginning of the epidemic.¹³ A study in rural Tanzania found that 9 per cent of children were orphans and 14 per cent of households had at least one orphan.¹⁴ In Masaka, a rural part of Uganda, approximately 10 per cent of children were orphans.¹⁵

Women who are infected may pass on the infection to the foetus before birth, or to the child during delivery, or through breast feeding. In Africa, it is believed about 30 per cent of children will be infected (although there are various interventions that can reduce this). As

⁹ Gregson Simon, Zaba Basia, Garnett Geoffrey P, and Anderson Roy M. "Projections of the Magnitude of the HIV/AIDS Epidemic in Southern Africa" in Whiteside Alan, ed. *Implications of AIDS for Demography and Policy in Southern Africa*. Pietermaritzburg: University of Natal Press, 1998 : 27-60.

¹⁰ Adetunji J A. "Assessing the mortality impact of HIV/AIDS relative to other causes of adult deaths in sub-Saharan Africa". Socio-Demographic Impact of AIDS in Africa Conference. Durban, February 1997.

¹¹ Boerma J T, Ngalula J, Isingo R, et al. "Levels and causes of adult mortality in rural Tanzania with special reference to HIV/AIDS". Socio-Demographic Impact of AIDS in Africa Conference. Durban, February 1997.

¹² Nunn A J, Mulder D W, Kamali A, et al. "Five-year HIV-1 associated mortality in a rural Ugandan population". Socio-Demographic Impact of AIDS in Africa Conference. Durban, February 1997.

¹³ WHO. "The current global situation of the HIV/AIDS epidemic". Global Programme on AIDS. Memo 3. Geneva: World Health Organisation, 1996.

¹⁴ Urassa M, Ng'weshemi J Z L, Isingo R, Kurnogola Y, Boerma J Y. "Orphanhood, child fostering and the AIDS epidemic in rural Tanzania". Socio-Demographic Impact of AIDS in Africa Conference. Durban, February 1997.

¹⁵ Kamali A, Whitworth J A G, Ruberantwari A, Carpenter L M. "Impact of the HIV-1 epidemic in orphan mortality in a rural Uganda population cohort". Socio-Demographic Impact of AIDS in Africa Conference. Durban, February 1997.

most infected children will die before their fifth birthdays, the result is to increase the levels of child and infant mortality. A child born of an HIV-infected mother may only have a 30 per cent chance of being infected, but has a close to 100 per cent chance of being orphaned. The increased rates of orphaning may, in turn, also increase child mortality rates. Orphans in Africa may be cared for by the extended family, the community or siblings. Very rarely is there state or NGO support. As numbers rise so these systems are coming under increasing pressure, and it is likely orphans mortality will rise. Table 1 shows the modelled impact of AIDS on child mortality rates in some of the worst affected countries in Africa.

Table 1 Child Mortality Rates per 1 000 with and without AIDS in Selected Countries¹⁶

	1998		2010	
Country	Without AIDS	With AIDS	Without AIDS	With AIDS
Malawi	190.3	231.6	136.0	202.6
Zambia	125.7	181.2	96.9	160.7
Namibia	62.1	125.5	37.5	118.8
Botswana	57.4	121.1	38.3	119.5
Swaziland	83.8	103.4	77.5	152.2
Kenya	64.9	107.0	45.4	105.2
South Africa	69.7	95.5	48.5	99.5
Zimbabwe	50.5	125.4	31.8	115.6

A further major demographic impact of AIDS is on life expectancy. The deaths of children and young adults has a very adverse effect on this. This is shown in Table 2. According to the models developed by the US Bureau of the Census, some countries in Southern Africa had already lost over 20 years of life expectancy in 1998, and the situation was certain to get very much worse.

Table 2 Life Expectancy with and without AIDS in Selected Countries.¹⁷

Country	1998			2010		
	Without AIDS	With AIDS	Years Lost	Without AIDS	With AIDS	Years Lost
Malawi	51.1	36.6	14.5	56.8	34.8	22.0
Zambia	56.2	37.1	19.1	60.1	37.8	22.3
Swaziland	58.1	38.5	19.6	63.2	37.1	26.1
Zimbabwe	64.9	39.2	25.7	69.5	38.8	30.7
Botswana	61.5	40.1	21.4	66.3	37.8	28.5
Namibia	65.3	41.5	23.8	70.1	38.9	31.2
Kenya	65.6	47.6	18.0	69.2	43.7	25.5
South Africa	65.4	55.7	9.7	68.2	48.0	20.2

¹⁶ US Bureau of the Census, Report WP/98, World Population Profile : 1998, US Government Printing Office, Washington DC, 1999.

¹⁷ Ibid.

Economic Impacts.

The economic effect of AIDS will not be uniform across countries or even within societies. The impact will be felt at various levels and to varying degrees. These effects derive from the fact that the individuals who fall ill and die are all economic actors, i.e., producers or consumers. The effect of an infection is felt first and most immediately by the person who falls ill and by their family. It then ripples through the household, community, and eventually the country as a whole.

What, then, is known of the economic effects? There is actually surprisingly little evidence.

Households.

At the household level, AIDS cases may be disastrous. The infected individual will require medical care and possibly special foods, thus increasing demands on household resources. At the same time, if the person is an adult, the illness and death will reduce the household production capacity, resulting in a decline in household income. Thus, households are caught in a double-bind of needing more resources at the very time when these may be reduced.

There is only one recent detailed study of the impact of AIDS on households in Anglophone Africa - from the Kagera region of Tanzania. The first results of this study have been reported at various conferences but are not yet available in a comprehensive published form. Households experiencing an adult death respond by voluntary adjustments in household size and reducing their supply of labour to farming, wage employment and non-farm self-employment in the first three months after the death. In addition there is a decline in per capita growth rates of both income and consumption; medical treatment and funeral costs pose a major financial burden; and female children may be taken out of school.¹⁸

Research across the Ugandan border, in the Rakai district, found that adult mortality leads to a decline in household economic status. This was measured through the possession of durable goods such as bicycles or vehicles. The death of an HIV-positive adult was more likely to lead to the sale of such goods than the death of an HIV-negative adult, indicating HIV-affected households have far fewer resources, either before or after the infection.

A source of concern is that there is no published information on the effects of AIDS in urban and peri-urban areas in Africa. Growing numbers of people make their homes here (in 1995 it was estimated that 37 per cent of Africans lived in urban areas and that this would rise to 41 per cent by 2000).

Firms and Enterprises.

The next level at which impact might be expected is on firms or production units. AIDS will affect workplaces because of its impact on: (1) productivity; (2) costs; and (3) the national economic environment.

¹⁸ These results have been presented at various conferences. For a listing see Whiteside Alan and Stover John. The demographic and economic impact of AIDS in Africa, AIDS 1997, 11 (suppl B): S55-S61.

Key questions regarding the impact of AIDS on productivity relate to who, in terms of skills and productivity, in the private sector are affected and the nature of the labour market in the country and the sector. If, for example, there is a large pool of unemployed or underemployed people and the cost of replacing labour is low, then AIDS may have little impact. If, on the other hand, skilled or scarce labour are affected then impact may increase.

Productivity will be affected if employees fall ill but remain on the payroll, and when skilled or experienced staff fall ill or die. Research in Zambia has shown that the mortality rate among formal sector employees rose from 0.24 per cent in 1987 to 2.1 per cent in 1993.¹⁹ This means that a company with 1000 employees might expect about 21 employees to die each year, and 19 of the deaths may be attributed to AIDS.

In Kenya, a survey of five companies found AIDS was costing US\$45 per employee annually (3 per cent of company profits), and it could rise as high as US\$120 per employee (8 per cent of profits) by 2005.²⁰ A comparison of research in the private sector in Kenya, Zambia and Malawi shows that absenteeism accounts for between 25-54 per cent of costs; to this must be added lower productivity, and loss of experienced staff.²¹ By contrast, a study of the Makandi Tea and Coffee Estate Limited in Malawi found that 'the effects of HIV/AIDS on current levels of expenditure at Makandi are negligible. The major components of HIV/AIDS-related expenditure are the estimated attributable cost of employee medical service provision and the unexpected pension scheme commitments resulting from the higher death in service rate.'²²

The cost of AIDS cases to employers will depend on conditions of employment, level of the staff, and benefits that are provided. It is possible that more advanced African economies will be more adversely affected. For example, in South Africa, benefits will include group life insurance, pensions and medical aid. A rather sobering calculation performed by Metropolitan Life is shown in Table 3 (P Doyle, personal communication, 1996). If payroll costs do not rise, benefits will be reduced.

Table 3 Impact of AIDS on employee benefits. Costs as a per cent of Salary

	1995	2000	2005
Lump sum at death	1.5	3.7	6.0
Spouse's pension	4.0	7.5	10.0
Disability pension	1.5	2.3	3.0
Total	7.0	13.5	19.0

The effect of AIDS on the economic environment is harder to assess. The private sector may be able to adapt to increased morbidity and mortality in the workforce. Government and many

¹⁹ Baggeley R, Chilangwa D, Godfrey-Faussett P, Porter J. "Impact of AIDS on Zambian business". VII International Conference on AIDS in Africa/VIII African Conference on Sexually Transmitted Diseases, Marrakech, December 1993 (abstract W R T 0031).

²⁰ Forsyth S, Rau B (eds). "AIDS in Kenya: Socio-Economic Impact and Policy Implications". Arlington: Family Health International/AIDSCAP, 1996.

²¹ Lowenson R, Whiteside A. "Social and Economic Issues of HIV/AIDS in Southern Africa". Harare. S.AfAIDS; 1997.

²² Jones C. "The Microeconomic implications of HIV/AIDS". Dissertation, East Anglia: University of East Anglia; 1996:42.

of the service providing parastatals do not have this ability: when their employees fall ill they may be retained on the payroll for months, during which time their jobs may simply not be done. Thus the business environment may suffer. Two other concerns for the private sector are the impacts on markets, especially luxury purchases and investment. It is difficult to assess the market impact of AIDS. Investment effects may be clearer. In the more developed African countries life insurance and pension funds are important sources of capital for both the private sector and government. AIDS means that both these instruments of investment will suffer, insurance companies will seek to avoid insuring both HIV-positive people and those they fear may become HIV-positive. Pension funds will see members withdrawing before reaching pensionable age and consuming their accumulated benefits.

Macroeconomic Impact.

Will the epidemic have an impact at the macroeconomic level? There is no hard evidence. There have been attempts to model the macroeconomic impact, but this is fraught with difficulty. Overviews²³ identify the mechanisms through which the epidemic may affect macroeconomies as a result of the illness and death of productive members, and the diversion of resources from savings (and eventually investment) to care. There have also been attempts to model the economic impact for specific countries, including Tanzania,²⁴ Cameroon,²⁵ and Zambia²⁶. These models show that HIV may well reduce the rate of economic growth and, over a period of 20 years, this may be significant (up to 25 per cent lower than it would otherwise have been). However, in order to make this prediction, projections of both the AIDS epidemic and economic trends have to be combined. Both are difficult to model and combining them compounds the uncertainty. The dire macroeconomic predictions are undermined by the economic growth rates in Uganda (2.7 per cent between 1985 and 1995) and Botswana (6.1 per cent)²⁷, Uganda has perhaps the most mature AIDS epidemic, while Botswana has the fastest growing one.

Health Care Costs.

One question that must be asked is what is the effect of AIDS on health care costs? The answer depends on who bears these costs. In most African societies the bulk of formal Western health care facilities are provided by the state. In theory the increase in HIV and AIDS cases should lead to government planning treatment regimes which would provide the most cost-effective care for patients, taking into account the other demands for care. The data in Figure 3 show that government expenditures on health has not increased as a proportion of the budget.

²³ Over M. "The Macroeconomic Impact of AIDS in sub-Saharan Africa". African Technical Department, Population, Health and Nutrition Division, Technical Working Paper No. 3. Washington, D C. World Bank, 1992.

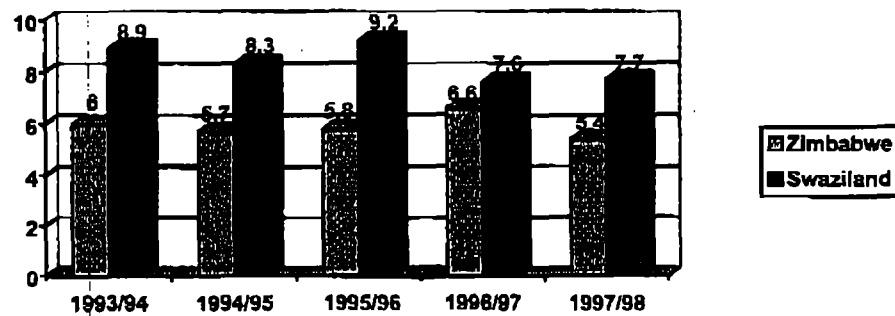
²⁴ Cuddington J T. "Modelling the macroeconomic effects of AIDS, with an application to Tanzania". World Bank Economic Rev 1992. 7:403-417.

²⁵ Kambou G, Devarajan S, Over M. "The economic impact of AIDS in an African country: simulations with a computable general equilibrium model of Cameroon". J Afr Economics 1992. 1:109-130.

²⁶ Forgy L, Mwanza A. "The Economic Impact of AIDS in Zambia". Lusaka: Ministry of Health, 1994.

²⁷ The World Bank, World Development Report 1997, Oxford University Press, New York, 1997.

Figure 3 Expenditure on Health as a Percentage of Central Government Recurrent Revenue.²⁸



There are three possibilities, given the lack of increase in revenue:

- The health sector is coping with its current resources and is reallocating them to provide for the increased demand for care.
- Patients with HIV-related illness are not receiving care from the state sector, but the burden and costs are being borne by the individuals and households.
- The health sector is trying to cope, but lacks a system of allocation of resources so is doing more with the same quantity, and consequently all care is suffering.

Unfortunately the preliminary evidence suggests that it is the second and third options that are in operation in much of Africa. Under this scenario AIDS does not have a direct and measurable economic impact, but the households and communities face increased impoverishment. Furthermore the health status of the nation will suffer in the long run.

DEVELOPMENT IMPLICATIONS

Obtaining a clear picture of the economic implications of AIDS is somewhat confounded by the very complex nature of economic interactions; the fact that coping mechanisms come into play at all levels; and that many "economic" transactions may not be measured. Traditionally the gross domestic product (GDP) of a country is deemed to be that which either enters the marked place, or to which a value can be assigned (for example subsistence crops). This means many of the things that make up the fabric of society are not measured, child care for example, is never measured as an economic output.

The inadequacy of economic measures such as GDP was recognised by the United Nations Development Programme in 1990 and an alternative measure was introduced - the Human Development Index (HDI). It was designed to capture as many aspects of human development as possible in one simple composite index, and includes three fundamental dimensions, a long and healthy life, knowledge, and a decent standard of living. Longevity is measured by life expectancy at birth; education attainment by adult literacy (two-thirds weight) and combined

²⁸ Central Bank of Swaziland, Annual Report Financial Year 1997/98, Mbabane, 1998 p. 44 and The Economist Intelligence Unit, Zimbabwe Country Profile 1998-1999, London 1998.

primary, secondary and tertiary enrolment ratios (one-third weight); and standard of living by the real GDP.

The first Human Development Report to consider the impact of AIDS on life expectancy was published in 1993. The next two reports have considered HIV in the demographic predictions but not, it seems, consistently. This is shown in Table 4.

Table 4 Life Expectancy and Place in the HDI²⁹

	<i>1996</i>		<i>1997</i>		<i>1998</i>	
	<i>Life Expect.</i>	<i>Rank</i>	<i>Life Expect.</i>	<i>Rank</i>	<i>Life Expect.</i>	<i>Rank</i>
Botswana	65.2	71	52.3	97	51.7	97
South Africa	63.2	100	63.7	90	64.1	89
Swaziland	57.8	110	58.3	114	58.8	115
Namibia	59.1	116	55.9	118	55.8	107
Zimbabwe	53.4	124	49	129	48.9	130
Kenya	55.5	128	53.6	134	53.8	137
Zambia	48.5	136	42.6	143	42.7	146
Malawi	45.5	157	41.1	161	41	161

Quite certainly the impact of AIDS goes far beyond the economic. AIDS is resulting in growing impoverishment and stress in household and communities across the continent. At the national level it is having a damaging affect on development indicators.

CONCLUSION

It is clear that the AIDS epidemic in Africa presents an enormous challenge to the governments of the region. AIDS will have an impact on their demographic make-up and trends, and will cause a reversal in improvements in many of the development indicators. The economic impacts will be complex and take a long time to develop. What is certain is that the impact on the people of Africa will be very serious, and will lead to increased immiserisation. This may all seem very far away to people living in the developed world, and it will be even less obvious because the impact is incremental rather than catastrophic.

²⁹ United Nations, Human Development Reports, Oxford University Press, New York, 1996, 1997, & 1998. Note that the life expectancies used for calculating the Human Development Index are for 1993, 1994 & 1995 respectively.

TIMES

OF ZAMBIA

Forward with the nation

Wednesday December 1, 1999

AIDS IS EVERYONE'S BABY **...only collective efforts will do**

By DAVID DUNN

AS the new American Ambassador to Zambia, this writer has had a very warm welcome and I am excited to be here. I am very impressed with Zambia's gracious citizens, its natural resources, its rich history and rich culture.

During my initial meetings with a broad spectrum of Zambian society, I have become aware of some of the important issues and challenges facing Zambia. Clearly, one of the biggest problems now and in the foreseeable future is HIV/AIDS.

The HIV/AIDS epidemic is a development crisis. With more than 19 per cent of persons aged 15 to 49 infected, it is undermining many of the social and economic development efforts here in Zambia. A comprehensive response is urgently needed.

Government sectors, private enterprise, NGOs, the churches, schools, traditional leadership and many other groups and individuals need to be engaged.

The current epidemic will require everyone to work with a sense of collective responsibility if it is to be curtailed. Virtually every Zambian citizen is affected, some with the disease, many losing family members. All sectors of the society are impacted, including the US embassy family. Zambia's ability to develop, thrive and continue to play its rightful role in the region and the world could be compromised by the social and economic

effects of HIV/AIDS.

While we don't have a medical cure for HIV/AIDS, we do know that there is much we can do. We can talk openly about the problem of HIV/AIDS; we can support safe sex practices. We should not discriminate against people living with HIV/AIDS. Sharing of collective responsibility and maintaining an openness to talking frankly and forthrightly about HIV are important weapons we have as concerned and caring individuals and citizens.

At present, the social stigma attached to anyone identified as HIV positive remains very strong, just as it was in my country when the disease began to take a serious toll. But, as experience in the US clearly has shown, overcoming the stigma is one of the most effective ways of checking the spread of the disease, and it can be achieved with very little financial effort.

On this World AIDS Day, I urge us all to give HIV/AIDS prevention and care top priority in our lives. We all need to speak out about HIV/AIDS and to help spread the word about ways to prevent the disease, to care for those who are dealing with HIV/AIDS, and to mobilise our communities to take greater action to address the pandemic. Together we can overcome this deadly virus.

• THE author has been US ambassador to Zambia since August and presented his credentials to President Chiluba on September 2.

MEMORANDUM FROM THE AMBASSADOR

TO: U.S. HIV/AIDS COORDINATING GROUP (See Distribution)

SUBJECT: FOLLOW-UP FROM MEETING OF NOVEMBER 18, 1999

I would like to thank all of you who attended the first U.S. HIV/AIDS Coordination Group meeting on November 18, 1999. A lot of good ideas were generated and I am encouraged by the potential of our joint action. To keep us on track, I've listed the follow-up actions below. The first few are items that are time sensitive or high priorities. Please give these your immediate attention. Our next meeting will be held in mid December, and it will focus on HIV/AIDS in the US Workplace.

FOLLOW-UP ACTIONS:

1. Op Ed piece for Worlds AIDS Day – December 1, 1999

Action Person: Robin

2. Journalist Prize : First award to focus on the ICASA Reporting

Action Person: Robin

3. Arrange meeting for Ambassador with Winston Zulu, head of Network of People Living with HIV/AIDS

Action Person: Robert

4. Arrange meeting for Ambassador with Tom Goliber, Policy Project to help develop a set of speaking materials.

Action Person: Karen/Robert

5. World AIDS Day: Assist in the planning and identify key role for Ambassador in planned events.

Action Person: Robert/Karen

6. Arrange for field visits of Ambassador to key HIV/AIDS sites around Zambia. Ensure adequate press coverage for these visits.

Action Persons: Walter, Robert, Karen, and Robin

7. British Petroleum (BP) - Send a follow-up letter to the chairman

Action Person: Troy

8. Coordinate the visit of the new Southern HIV/AIDS advisor to Zambia

Action Person: Robert

9. Ensure that HIV/AIDS is a topic in the Zambia MPP process

Action Person: Bob

10. Identify a "Magic Johnson" sport figure to go public with HIV/AIDS

Action Persons: Robert/Karen

11. Contact Ms. Zambia to see if she will take on HIV/AIDS advocacy

Action Person: Robin

12. Mobilize other Donors to support HIV/AIDS programs and funding

Action Person: Walter/Ambassador Dunn

13. Self Help: Place special emphasis in the self help program on HIV/AIDS

Action Person: Robin

14. Look at education programs to see if school fees could be waived for OVC

Action Person: Kent

15. Explore Tax Incentives for grants to NGO, especially for HIV/AIDS work

Action Person: Troy

16. Assist local police and security guard companies to develop HIV/AIDS awareness programs

Action Person: John

17. Contact Rotary and Lions clubs regional officials and write them offering to do talks

Action Person: Troy

18. Work with Labor Unions on HIV/AIDS issues

Action Person: Lisa

19. Ensure that Peace Corps had appropriate HIV/AIDS materials for pre-service training.

Action Person: Brian

20. Explore the use of PVC to promote HIV/AIDS Awareness in their postings

Action Person: Brian

21. Seek ways for the military assistance programs to address HIV/AIDS

Action Person: Vicky

22. Include HIV/AIDS on the agendas of the visits of Holbrook/Feingold and the House Codel

Action Person: Bob

23. Address the US Business Community on the importance of HIV/AIDS

Action Person: Troy

24. Provision of Free Condoms for U.S. Employees

Action Person: SFH

25. Arrange for event at Chirundu for Ambassador Dunn and McDonald when activities are ready to start implementation.

Action Person: Walter/Robert

26. Hold additional HIV/AIDS information meetings and include FSN families and children.

Action Person: Karen/Robin

27. Hold an American Community Town Meeting to discuss the issues of HIV/AIDS.

Action Person: Bob

28. Put HIV/AIDS Council and Secretariat on the agenda for high level discussions.

Action Person: Bob

29. Strengthen our Voluntary Counseling and Testing (VCT) program

Action Person: Karen/Robert

30. Ensure NIH and CDC research proposals are thoroughly reviewed by Zambian scientific peer review committees

Action Person: Karen/Troy

Distribution

Brian Cavanagh, Peace Corps
Robert Clay, USAID
Mindi Cohen, American Embassy
Troy Fitrell, American Embassy
Mara Hayes, American Embassy
Victoria Haskins, American Embassy
Clyde Jardine, American Embassy
George Newman, American Embassy
Walter North, USAID
Siza Ntshakala, American Embassy
Lisa Peterson, American Embassy
Karen Shelley, USAID
John Walker, American Embassy
Robert Whitehead, DCM
Robin Yeager, American Embassy

To: Patricia Stephenson@G.PHN.HN@AIDW
From: Shirley Coly@G.PHN.OFPS@AIDW
Cc:
Subject: Zambia: President urged to declare crisis
Attachment: BEYOND.RTF
Date: 12/16/1999 12:53 PM

FYI-Share as Appropriate

Chiluba asked to declare crisis of orphans a disaster

By Brighton Phiri

The Post-Zambia's Leading Independent Newspaper , December 16, 1999

PRESIDENT Frederick Chiluba has been asked to immediately declare the crisis facing orphans and other vulnerable children in the country as a national disaster.

According to a United Nations Children's Fund (UNICEF) statement released yesterday, this was a key recommendation from a three-day national planning workshop for orphans and other vulnerable children in Lusaka last week.

³The 200 delegates unanimously approved the workshop's resolution which proposed that the disaster mitigation and management unit in the Office of the Vice-President should develop an appropriate response to the disaster, in collaboration with other ministries and organs of civil society,² read part of the statement.

According to the statement, among other recommendations were that structures should urgently be mobilised at all levels from grassroots to government and that a workable mechanism be urgently established to facilitate communication, co-ordination and access to resources among all actors dealing with orphans and vulnerable children.

The delegates also discussed issues affecting children such as education, health services, psycho-social distress, HIV/AIDS and children's life on the streets.

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UNCLAS

LUSAKA 06309

LUSAKSVA:

INFO: DCM AMB

Lasers:

ACTION: AID

DISSEMINATION: AAID

CHARGE: AID

APPROVED: AID: WNORTH

DRAFTED: AID: RCLAY

CLEARED: AID: DSOROKO

03 DEC 1999

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RUEHZO/OAU COLLECTIVE

BT

UNCLAS LUSAKA 006309

AID/W FOR AFR/AA VIVIAN LOWERY DERRYCK; AFR/SD HOPE SUKIN; ALEX ROSS; G/AA BARBARA TURNER; G/PHN/HN FOR PAUL DELAY, JOY RIGGS-PERLA; G/EGAD EMMY SIMMONS, JOHN LEWIS.

E.O. 12958: N/A

TAGS: EAID, OAU

SUBJECT: SASOL FERTILIZER COMPANY LAUNCHES INNOVATIVE NATIONAL HIV PREVENTION PROGRAM

1. IN NOVEMBER 1999 SASOL FERTILIZER COMPANY LAUNCHED THE FIRST PHASE OF AN INNOVATIVE HIV PREVENTION PROGRAM. SASOL IS A SOUTH AFRICAN GROUP OF COMPANIES THAT COMPRISES DIVERSIFIED FUEL, CHEMICAL, AND RELATED MANUFACTURING AS WELL AS OIL, GAS EXPLORATION AND PRODUCTION. IN ZAMBIA, HOWEVER, SASOL IS ONLY SELLING FERTILIZER. USING CORPORATE FUNDS, SASOL IS PRINTING HIV PREVENTION AND CONDOM PROMOTION MESSAGES ON 950,000 FERTILIZER BAGS THAT WILL BE DISTRIBUTED TO 100,000 - 120,000 RURAL SMALL-SCALE FARMERS OVER THE NEXT TWO MONTHS.

2. THE MESSAGE ON THE FERTILIZER BAG READS, "TO GROW PROPERLY, YOUR CROPS NEED FERTILISER. TO GROW UP PROPERLY, YOUR CHILDREN NEED YOU! PROTECT YOURSELF AGAINST HIV/AIDS. USE A CONDOM EVERYTIME. THANK YOU. MAXIMUM (TM) USE IT!" THE INITIATIVE OF SASOL, AS A PRIVATE SECTOR COMPANY, IS THE FIRST

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LUSAKA 06309

OF IT'S KIND IN ZAMBIA. ALTHOUGH THIS YEAR'S MESSAGE IS IN ENGLISH, SASOL HAS EXPRESSED ITS INTENTION OF DISTRIBUTING FUTURE FERTILIZER BAG MESSAGES IN NYANJA AND BEMBA, ZAMBIA'S MOST WIDELY USED LOCAL LANGUAGES.

3. THE HIV/AIDS PREVENTION MESSAGES ON FERTILIZER BAGS ARE TARGETING HARD-TO-REACH RURAL POPULATIONS WITH EXPLICIT CONDOM PROMOTION MESSAGES. FERTILIZER BAGS ARE THOUGHT TO BE AN INNOVATIVE VEHICLE FOR HIV/AIDS MESSAGES BECAUSE THEY ARE REUSED FOR UP TO ONE YEAR FOR STORING GOODS BY FARMERS AND THEIR FAMILIES. IT IS THEREFORE, ANTICIPATED THAT AT LEAST 500,000 ZAMBIAN ADULTS WILL HAVE REPEATED EXPOSURE TO HIV PREVENTION/CONDOM PROMOTION MESSAGES.

4. THE SOCIETY FOR FAMILY HEALTH (SFH)/POPULATION SERVICES INTERNATIONAL (PSI), A USAID-FUNDED COOPERATING AGENCY, PROVIDED THE ARTWORK AND TECHNICAL ADVICE TO SASOL DURING THE DESIGN OF THIS CAMPAIGN. DISCUSSIONS ARE UNDERWAY BETWEEN SFH/PSI AND SASOL TO EXPAND THIS EFFORT WITH MORE DETAILED HIV/AIDS PREVENTION PAMPHLETS AND POSSIBLY FOR THE LAUNCHING OF CONDOM DISTRIBUTION THROUGH COMPANIES THAT PURCHASE SASOL FERTILIZER. THIS EFFORT WAS FACILITATED BY USAID'S AGRICULTURE AND PHN PROGRAMS. IT DEMONSTRATES HOW TEAMWORK AND SYNERGIES CAN BE USED TO DELIVER VALUABLE SERVICES, ACROSS SECTORS, TO ZAMBIAN RURAL FAMILIES.

BT

#6309

NNNN

Draft HIV/AIDS Speaking Notes for Ambassador David Dunn

Leadership Audiences

(These are written in sequential paragraph form. The slide references are to the AIDS Impact Model (AIM) overhead transparencies.)

1. The HIV/AIDS epidemic is a development crisis in Zambia and will be the most significant problem facing the country over the next decade. AIDS is not just one more problem among many in Zambia. The epidemic is a development crisis that is ravaging the country and undermining all social and economic development efforts. A radical response that mobilizes all of Zambian society is required. Government sectors, private enterprise, NGOs, the churches, the schools, the traditional leadership and many other groups and individuals need to be engaged in the effort to combat HIV/AIDS.
2. Zambian leaders, such as yourselves, have a critical role to play in stopping this epidemic. Leaders can help make programs work by speaking out often and strongly about the devastating nature of HIV/AIDS and the need for a broad and unequivocal response.
3. I am going to use some transparencies prepared by the Central Board of Health to guide my remarks today. (Slide 1)
4. To remind ourselves, HIV is a virus. HIV stands for Human Immunodeficiency Virus. It causes the disease AIDS, or Acquired Immune Deficiency Syndrome. (Slide 4)
5. HIV destroys the biological ability of the human body to fight off opportunistic infections such as tuberculosis. AIDS itself is defined in terms of how much deterioration of the immune system has taken place as seen by the presence of opportunistic infections. Virtually all infected persons die from the disease. (Slide 5)
6. The major mode of transmission of HIV in Zambia is heterosexual contact. As an offshoot, the second major mode of transmission is from HIV-infected mothers to their infants. (Slide 7)
7. Even after becoming infected with HIV, a person does not develop AIDS immediately. Rather, there is often a lengthy incubation period. In Zambia, the majority of infected adults develop AIDS from 2 to 12 years after infection. Some develop AIDS more quickly; others more slowly. For most of this incubation period, the person may not have any symptoms and therefore may not even be aware that he or she is infected. This contributes to the spread of HIV, since the person can transmit the infection to others without realizing it. (Slide 9)

8. The lengthy incubation period is one reason that HIV/AIDS is often called a “hidden epidemic.” The idea of a “hidden epidemic” can be seen in this graph which shows the HIV/AIDS pyramid. The tip shows estimated AIDS cases. But this represents only about 9% of all HIV infections. The dark portion of the pyramid indicates the much larger number of people who are infected with HIV but have not yet developed AIDS. Many of these people show no symptoms and do not even know they are infected. The top part of the pyramid is ten times larger than the red tip. The worst of the epidemic is yet to come as HIV infected people develop AIDS. (Slide 12)
9. (empty)
11. UNAIDS measures prevalence in a country by the percentage of 15 to 49 year olds who are infected. In Zambia, the Central Board of Health estimates that 19.7 percent of Zambians in this age group are HIV-infected. This means that the country has one of the worst HIV/AIDS epidemics in the world. (Slide 15)
12. While prevalence can vary from province to province, the important message is that HIV has spread into all corners of Zambia. (Slide 17)
13. The next few transparencies look at some projections about the epidemic in Zambia. (Slide 27)
14. More than a million persons were already HIV-infected in 1999 and the number is still rising. The number would increase even faster except that so many people are dying from AIDS. (Slide 29)
15. However bad the HIV/AIDS epidemic in Zambia has been to date, in many ways the full brunt of the epidemic is yet to come. For example, somewhere around 600,000 Zambians have probably died from AIDS since the beginning of the epidemic. Over the first fifteen years, perhaps another 1.7 million Zambians will die from the disease. And most of these deaths will be to people who are already HIV-infected. (Slide 33)
16. Especially noteworthy is how many deaths will be to persons in the economically productive ages, 15 to 49. Already, more than 2 out of 3 deaths in this age group can be directly attributed to HIV/AIDS. (Slide 35)
17. The next few transparencies look at some of the impacts of the epidemic in Zambia. (Slide 37)
18. But HIV/AIDS also affects all of development in Zambia. (Slide 38) For example:
 - In health, the epidemic drains resources needed to address other serious problems, malaria and tuberculosis, for example. Many urban health

facilities already report that more than half of available beds go to treating HIV/AIDS patients.

- In education, badly needed trained teachers are being lost to the epidemic. Teacher absenteeism increases as the opportunistic infections associated with HIV/AIDS afflict the body. More students, especially girls have to leave school to care for sick family members or to help replace lost family income.
- Because of the high number of deaths to economically productive persons ages 15 to 49, the labour force is disrupted. (More than 2 out of every 3 deaths in this age group can be directly attributed to HIV/AIDS.)
- Especially when deaths occur to trained and educated persons, the overall economic development of the country can be disrupted.
- Infection rates are very high among transport workers, especially truckers, because these are people who are extremely mobile and who have some disposable income.
- Every study in Zambia shows that agricultural productivity drops in households affected by HIV/AIDS.

19. HIV/AIDS seems to have an especially hard impact on women, children and families. This is an important issue – the innocent suffer terribly from this epidemic. A woman who is faithful to her husband can become infected if he is not faithful to her in turn. Young women can be forced by the dire poverty of the country into circumstances where they need to exchange sexual favors for food or clothing or education. Thousands of infants are infected each year because, through no fault of their own, they are born to HIV-infected mothers. (Slide 39)

20. And one of the worst problems in the country is the rapid increase in the number of children who are orphaned because of HIV/AIDS. (UNICEF counts maternal and double orphans – a child who has lost his/her mother or both parents to AIDS.) The number of maternal and double orphans due to AIDS is now probably over 500,000 and it will increase to over 974,000 by 2014. How can one measure the societal impact in a country which will have such a relatively huge number of orphans in its population? (Slide 41)

21. Finally, I want to ask the question: what can Zambia do about this epidemic? (Slide 41)

22. First, we simply can't look for a medical solution to this problem. For all the vaccine research that has taken place to date, only one vaccine has reached the final testing stage in the entire world. Most vaccine research takes place in North America and Europe where the strains of HIV are different than those found in this part of Africa. Even the greatest optimists – those who have committed their lives to developing a vaccine – don't see the possibility of one being available for 10 or 15 years, if then. That is much too late for Zambia. (Slide 59)

23. What is needed in the end is behavioral change. Interventions are required to

- Encourage voluntary counseling and testing so that people know their status;
 - Promote abstinence and faithfulness;
 - Reduce the overall number of sexual partners;
 - Delay the beginning of sexual activity among adolescents;
 - Promote the use and availability of condoms;
 - Control other sexually transmitted diseases, the presence of which greatly facilitates the transmission of HIV. (Slide 61)
24. We also need programs to help prevent mother-to-child transmission and some of the recent drug research is promising. We need to treat those already infected with HIV in a manner that allows them to live full and humane lives and we need to avoid all forms of stigmatization or discrimination. And we need to deal with those otherwise affected by the epidemic, especially orphans.
25. This is a horrible epidemic in Zambia and no one can ignore that reality. And yet the final message has to be one of hope. Zambia does not have to be passive in the face of the epidemic. We know from other countries – Thailand and Uganda, for example – and from pilot projects in a number of countries that interventions can work and that risky sexual behavior can change. If nearly 20 percent of Zambia adults are infected, that means that more than 80 percent are uninfected. Each and every one of the latter can take active measures to remain free from HIV. Infection rates are negligible among 5 to 14 year olds. A strong emphasis on programs in the schools and among out-of-school youth can help protect the rising generation and change the course of the epidemic in Zambia.
26. The United States can help. We have already initiated programs in policy and information dissemination, in the social marketing of condoms and in other prevention interventions, and in the care of orphans. We can do more. But ultimately, all the United States and the other donors can do is to help. If this epidemic is to be brought under control, it will be because of Zambian leadership and Zambian determination and Zambian programs.
27. Zambian leaders have a critical role to play. We know from health programs around the world that strong and consistent support from leaders can be a critical factor in helping programs work over the long-term. And HIV/AIDS is a long-term problem that will require sustained attention. Leaders need to speak out often and strongly about the devastating nature of HIV/AIDS and the need for a broad and unequivocal response. If Uganda is doing somewhat better in controlling this epidemic than other countries in the region, it is in part because President Museveni has provided such strong leadership for a long period of time. (Slide 65)
28. Slides 66 – 69 give some suggestions about what certain leadership groups might do immediately to help control the epidemic. Slide 66 is for Parliamentarians; slide 67 is for NGOs and community leaders; slide 68 is for community leaders; slide 69 is for district leaders

Draft HIV/AIDS Speaking Notes for Ambassador David Dunn

Public Audiences

(These are written in sequential paragraph form. The slide references are to the AIDS Impact Model (AIM) overhead transparencies.)

1. The HIV/AIDS epidemic is a development crisis in Zambia and will be the most significant problem facing the country over the next decade. The United States can help in combating this epidemic. I am going to use some transparencies prepared by the Central Board of Health to guide my remarks today. (Slide 1)
2. To remind ourselves, HIV is a virus. HIV stands for Human Immunodeficiency Virus. It causes the disease AIDS, or Acquired Immune Deficiency Syndrome. (Slide 4)
3. HIV destroys the biological ability of the human body to fight off opportunistic infections such as tuberculosis. AIDS itself is defined in terms of how much deterioration of the immune system has taken place as seen by the presence of opportunistic infections. Virtually all infected persons die from the disease. (Slide 5)
4. The major mode of transmission of HIV in Zambia is heterosexual contact. As an offshoot, the second major mode of transmission is from HIV-infected mothers to their infants. (Slide 7)
5. Even after becoming infected with HIV, a person does not develop AIDS immediately. Rather, there is often a lengthy incubation period. In Zambia, the majority of infected adults develop AIDS from 2 to 12 years after infection. Some develop AIDS more quickly; others more slowly. For most of this incubation period, the person may not have any symptoms and therefore may not even be aware that he or she is infected. This contributes to the spread of HIV, since the person can transmit the infection to others without realizing it. (Slide 9)
6. The lengthy incubation period is one reason that HIV/AIDS is often called a "hidden epidemic." The idea of a "hidden epidemic" can be seen in this graph which shows the HIV/AIDS pyramid. The red tip shows estimated AIDS cases. But this represents only about 9% of all HIV infections. The dark portion of the pyramid indicates the much larger number of people who are infected with HIV but have not yet developed AIDS. Many of these people show no symptoms and do not even know they are infected. The top part of the pyramid is ten times larger than the red tip. The worst of the epidemic is yet to come as HIV infected people develop AIDS. (Slide 12)
7. (empty)

8. UNAIDS measures prevalence in a country by the percentage of 15 to 49 year olds who are infected. In Zambia, the Central Board of Health estimates that 19.7 percent of Zambians in this age group are HIV-infected. This means that the country has one of the worst HIV/AIDS epidemics in the world. (Slide 15)
9. While prevalence can vary from province to province, the important message is that HIV has spread into all corners of Zambia. (Slide 17)
10. The next few transparencies look at some projections about the epidemic in Zambia. (Slide 27)
11. More than a million persons were already HIV-infected in 1999 and the number is still rising. The number would increase even faster except that so many people are dying from AIDS. (Slide 29)
12. However bad the HIV/AIDS epidemic in Zambia has been to date, in many ways the full brunt of the epidemic is yet to come. For example, somewhere around 600,000 Zambians have probably died from AIDS since the beginning of the epidemic. Over the first fifteen years, perhaps another 1.7 million Zambians will die from the disease. And most of these deaths will be to people who are already HIV-infected. (Slide 33)
13. Especially noteworthy is how many deaths will be to persons in the economically productive ages, 15 to 49. Already, more than 2 out of 3 deaths in this age group can be directly attributed to HIV/AIDS. (Slide 35)
14. The next few transparencies look at some of the impacts of the epidemic in Zambia. (Slide 37)
15. But HIV/AIDS also affects all of development in Zambia. (Slide 38) For example:
 - In health, the epidemic drains resources needed to address other serious problems, malaria and tuberculosis, for example. Many urban health facilities already report that more than half of available beds go to treating HIV/AIDS patients.
 - In education, badly needed trained teachers are being lost to the epidemic. Teacher absenteeism increases as the opportunistic infections associated with HIV/AIDS afflict the body. More students, especially girls have to leave school to care for sick family members or to help replace lost family income.
 - Because of the high number of deaths to economically productive persons ages 15 to 49, the labour force is disrupted. (More than 2 out of every 3 deaths in this age group can be directly attributed to HIV/AIDS.)
 - Especially when deaths occur to trained and educated persons, the overall economic development of the country can be disrupted.

- Infection rates are very high among transport workers, especially truckers, because these are people who are extremely mobile and who have some disposable income.
 - Every study in Zambia shows that agricultural productivity drops in households affected by HIV/AIDS.
16. HIV/AIDS seems to have an especially hard impact on women, children and families. This is an important issue – the innocent suffer terribly from this epidemic. A woman who is faithful to her husband can become infected if he is not faithful to her in turn. Young women can be forced by the dire poverty of the country into circumstances where they need to exchange sexual favors for food or clothing or education. Thousands of infants are infected each year because, through no fault of their own, they are born to HIV-infected mothers. (Slide 39)
 17. And one of the worst problems in the country is the rapid increase in the number of children who are orphaned because of HIV/AIDS. (UNICEF counts maternal and double orphans – a child who has lost his/her mother or both parents to AIDS.) The number of maternal and double orphans due to AIDS is now probably over 500,000 and it will increase to over 974,000 by 2014. How can one measure the societal impact in a country which will have such a relatively huge number of orphans in its population? (Slide 41)
 18. Finally, I want to ask the question: what can Zambia do about this epidemic? (Slide 41)
 19. First, we simply can't look for a medical solution to this problem. For all the vaccine research that has taken place to date, only one vaccine has reached the final testing stage in the entire world. Most vaccine research takes place in North America and Europe where the strains of HIV are different than those found in this part of Africa. Even the greatest optimists – those who have committed their lives to developing a vaccine – don't see the possibility of one being available for 10 or 15 years, if then. That is much too late for Zambia. (Slide 59)
 20. What is needed in the end is behavioral change. Interventions are required to
 - Encourage voluntary counseling and testing so that people know their status;
 - Promote abstinence and faithfulness;
 - Reduce the overall number of sexual partners;
 - Delay the beginning of sexual activity among adolescents;
 - Promote the use and availability of condoms;
 - Control other sexually transmitted diseases, the presence of which greatly facilitates the transmission of HIV. (Slide 61)
 21. We also need programs to help prevent mother-to-child transmission and some of the recent drug research is promising. We need to treat those already infected with HIV in a manner that allows them to live full and humane lives and we need

to avoid all forms of stigmatization or discrimination. And we need to deal with those otherwise affected by the epidemic, especially orphans.

22. This is a horrible epidemic in Zambia and no one can ignore that reality. And yet the final message has to be one of hope. Zambia does not have to be passive in the face of the epidemic. We know from other countries – Thailand and Uganda, for example – and from pilot projects in a number of countries that interventions can work and that risky sexual behavior can change. If nearly 20 percent of Zambia adults are infected, that means that more than 80 percent are uninfected. Each and every one of the latter can take active measures to remain free from HIV. Infection rates are negligible among 5 to 14 year olds. A strong emphasis on programs in the schools and among out-of-school youth can help protect the rising generation and change the course of the epidemic in Zambia.
23. In the final analysis, the fight against this epidemic is going to be won because a million smaller battles are won. So, I want to conclude by asking you to think about this epidemic as individual Zambians.
 - You should ask yourself whether you know your HIV status. If you have any doubt at all, you should be tested. Then you can answer the question: Am I or am I not infected?
 - If you are HIV-infected, then you have to ask yourself other questions. What can I do to live a positive and health lifestyle for as long as possible? What can I do in my personal life to keep from infecting others?
 - If you are not infected, then you must ask yourself another question. If I am not infected, what can I do to avoid getting infected? It is your responsibility as Zambians and as human beings (and as Christians or Muslims or Hindus) to guard jealously your HIV negative status every day for the rest of your life.
 - Regardless of whether you HIV positive or negative, you may ask yourself the question: How can I help those already infected or otherwise affected by the epidemic?
24. If Zambians win those millions of individual battles, then the course of this epidemic can be changed quickly. It is then that the HIV/AIDS epidemic can be relegated to its proper position – nothing but an unpleasant historical memory in the long-term development of the country.

Draft HIV/AIDS Speaking Notes for Ambassador David Dunn

Visiting U.S. Delegations

(These are written in sequential paragraph form. The slide references are to the AIDS Impact Model (AIM) overhead transparencies.)

1. The HIV/AIDS epidemic is a development crisis in Zambia and will be the most significant problem facing the country over the next decade. The United States can help in combating this epidemic.
2. While HIV/AIDS is a worldwide problem, the epidemic strikes most heavily in sub-Saharan Africa. UNAIDS estimates that
 - At the end of 1999, there were 33.6 million people living with AIDS in the world. About 23.3 million, or 70 percent, were in sub-Saharan Africa.
 - Worldwide, about 16.3 million people have died from AIDS since the beginning of the epidemic. More than 13.7 million of these deaths have been in sub-Saharan Africa.
 - In 1999, 5.6 million people became newly infected with HIV. Of these new infections, 3.8 million were in sub-Saharan Africa. By comparison, there were 44,000 new infections in all of North America in 1999.
 - In 1999, 2.6 million people died from AIDS around the world, the large majority of whom were Africans.
 - In 1999, about 570,000 children became newly infected with HIV, most of whom were infants born to HIV-infected mothers. Nine out of ten newly infected infants were in sub-Saharan Africa.
3. Even in Africa, the seriousness of the epidemic varies dramatically among countries. The highest level of infections is found in a belt of countries in eastern and southern Africa. And Zambia is right in the middle of the AIDS belt.
4. UNAIDS measures prevalence in a country by the percentage of 15 to 49 year olds who are infected. In Zambia, the Central Board of Health estimates that 19.7 percent of Zambians in this age group are HIV-infected. This means that the country has one of the worst HIV/AIDS epidemics in the world. (Slide 15)
5. Besides the magnitude, the major modes of transmission of the virus are different in Zambia than they are in the United States. In Africa, the major mode of transmission is sexual contact between men and women. As an offshoot, the second major mode of transmission is transmission from HIV-infected mothers to their children. Homosexual contact or the sharing of needles by drug users are not significant ways that HIV is transmitted in Zambia. (Slide 7)
6. At present, more than a million Zambians of all ages are HIV-infected. And possibly more than 100,000 persons are becoming newly infected every year. (Slide 28)

7. To get some perspective on what this means for Zambia, think what it would be like if 30 million Americans were infected with a killer virus, virtually all of whom were going to die over the next 10 years. Also, think what it would be like if another 3 million Americans were becoming infected with this same virus every year. Think what the economic impact and the social disruption and the political repercussions would be like in these circumstances. That is what is happening to Zambia.
8. However bad the HIV/AIDS epidemic in Zambia has been to date, in many ways the full brunt of the epidemic is yet to come. For example, somewhere around 600,000 Zambians have probably died from AIDS since the beginning of the epidemic. Over the first decade of the new century, perhaps another 1.2 million Zambians will die from the disease. And most of these deaths will be to people who are already HIV-infected. (Slide 33)
9. The loss of life is certainly the highest cost of the HIV/AIDS epidemic. This can be seen when looking at life expectancy at birth. Life expectancy is an average – the average number of years that children born today could be expected to live given current circumstances. In Zambia, life expectancy is probably already in the 35 to 37 year range. (This can be contrasted to a life expectancy at birth well over 70 years in the United States and Canada.) Life expectancy in the 30s is what was found in much of Africa after World War II when modern health and medicine came into this part of the world in a broad manner. The HIV/AIDS epidemic has wiped out the gains of decades. (Slide 36)
10. But HIV/AIDS also affects all of development in Zambia. (Slide 38) For example:
 - In health, the epidemic drains resources needed to address other serious problems, malaria and tuberculosis, for example. Many urban health facilities already report that more than half of available beds go to treating HIV/AIDS patients.
 - In education, badly needed trained teachers are being lost to the epidemic. Teacher absenteeism increases as the opportunistic infections associated with HIV/AIDS afflict the body. More students, especially girls have to leave school to care for sick family members or to help replace lost family income.
 - Because of the high number of deaths to economically productive persons ages 15 to 49, the labour force is disrupted. (More than 2 out of every 3 deaths in this age group can be directly attributed to HIV/AIDS.)
 - Especially when deaths occur to trained and educated persons, the overall economic development of the country can be disrupted.
 - Infection rates are very high among transport workers, especially truckers, because these are people who are extremely mobile and who have some disposable income.

- Every study in Zambia shows that agricultural productivity drops in households affected by HIV/AIDS.
11. HIV/AIDS seems to have an especially hard impact on women, children and families. This is an important issue – the innocent suffer terribly from this epidemic. A woman who is faithful to her husband can become infected if he is not faithful to her in turn. Young women can be forced by the dire poverty of the country into circumstances where they need to exchange sexual favors for food or clothing or education. Thousands of infants are infected each year because, through no fault of their own, they are born to HIV-infected mothers. (Slide 39)
 12. And one of the worst problems in the country is the rapid increase in the number of children who are orphaned because of HIV/AIDS. (UNICEF counts maternal and double orphans – a child who has lost his/her mother or both parents to AIDS.) The number of maternal and double orphans due to AIDS is now probably over 500,000 and it will increase to over 900,000 during the first decade of the century. How can one measure the societal impact in a country which will have such a relatively huge number of orphans in its population? (Slide 41)
 13. We simply can't look for a medical solution to this problem. For all the vaccine research that has taken place to date, only one vaccine has reached the final testing stage in the entire world. Most vaccine research takes place in North America and Europe where the strains of HIV are different than those found in this part of Africa. Even the greatest optimists – those who have committed their lives to developing a vaccine – don't see the possibility of one being available for 10 or 15 years, if then. That is much too late for Zambia. (Slide 59)
 14. What is needed in the end is behavioral change. Interventions are required to
 - Encourage voluntary counseling and testing so that people know their status;
 - Promote abstinence and faithfulness;
 - Reduce the overall number of sexual partners;
 - Delay the beginning of sexual activity among adolescents;
 - Promote the use and availability of condoms;
 - Control other sexually transmitted diseases, the presence of which greatly facilitates the transmission of HIV. (Slide 61)
 15. We also need programs to help prevent mother-to-child transmission and some of the recent drug research is promising. We need to treat those already infected with HIV in a manner that allows them to live full and humane lives and we need to avoid all forms of stigmatization or discrimination. And we need to deal with those otherwise affected by the epidemic, especially orphans.
 16. This is a horrible epidemic in Zambia and no one can ignore that reality. And yet the final message has to be one of hope. Zambia does not have to be passive in the face of the epidemic. We know from other countries – Thailand and Uganda, for example – and from pilot projects in a number of countries that interventions

can work and that risky sexual behavior can change. If nearly 20 percent of Zambia adults are infected, that means that more than 80 percent are uninfected. Each and every one of the latter can take active measures to remain free from HIV. Infection rates are negligible among 5 to 14 year olds. A strong emphasis on programs in the schools and among out-of-school youth can help protect the rising generation and change the course of the epidemic in Zambia.

17. The United States can help. We have already initiated programs in policy and information dissemination, in the social marketing of condoms and in other prevention interventions, and in the care of orphans. We can do more. The HIV/AIDS epidemic is one of the great tragedies of the modern world and we can help fight back both at home in the United States and here in Africa.



NIGERIA

U.S. Agency for International Development (USAID)
Population, Health, and Nutrition Briefing Sheet

Country Profile

With over 100 million inhabitants, or roughly 14 percent of the entire population of sub-Saharan Africa, Nigeria is Africa's most populous nation. The country has been under military rule for 30 of its 36 years. Although rich in natural resources, Nigeria's rapid population growth and uneven economic development have resulted in an increasing poverty rate. The country's thriving petroleum industry in the late 1960s and 1970s transformed it from an agriculture-based economy to one focused on oil production. About half the population is Muslim, 40 percent is Christian, and 10 percent follows indigenous beliefs.

USAID Strategy

In 1994, due to sanctions against the Nigerian government, USAID ceased all activities with the public sector and began working exclusively through nongovernmental organizations (NGOs). USAID's population and health program focuses on 14 selected states that include more than half of the country's population. The current USAID strategy combines efforts to strengthen NGO management and build sustainability, with technical support in child survival, family planning, and HIV/AIDS prevention. These activities are complemented by and closely integrated with the mission's program in democracy and governance, which assists NGOs working toward women's empowerment.

Major Program Areas

Maternal and Child Health Services. With USAID support, local NGOs receive training and technical assistance to improve basic maternal and child health services such as immunizations, oral rehydration therapy, and malaria treatment and control. USAID plays a major role in planning and coordinating NGO participation in Nigeria's National Immunization Days (NIDs) and is promoting the endorsement of integrated management of childhood illness (IMCI) as the foremost case management strategy. USAID also supports NGO training in epidemic preparedness and response, including mass mobilization efforts.

HIV/AIDS Prevention. USAID works with community-level NGOs to provide HIV/AIDS prevention information, condoms, and peer educator training to truck drivers, dock workers, commercial sex workers, students, and others at high risk of HIV infection. USAID also supports a nationwide condom social marketing effort that uses mass media messages and innovative distribution methods, and is promoting acceptance of the syndromic management of sexually transmitted infections (STIs) as an effective means to curb the spread of HIV/AIDS.

Family Planning. USAID supports the integration of family planning into existing NGO health services, establishment of networks of community-based distribution (CBD) of contraceptives, and a contraceptive social marketing program using radio advertisements, flyers, posters, and billboards and peer educators to spread family planning information in communities.

Results

- There were higher levels of polio immunization coverage, particularly in USAID focus states. After the first round of NIDs in 1997, coverage with two doses of oral polio vaccine was 29 percent higher in the 14 USAID focus states than in the remainder of the country.
- There has been an increased use of modern contraceptives from just under 4 percent of women in 1990 to over 11 percent in 1994 (when USAID support for family planning efforts was greatly reduced).
- There is an increased availability of contraceptives in rural and peri-urban areas through USAID-supported CBD outlets; the number of outlets increased from 1,300 in 1996 to 1,809 in 1997.
- There have been explicit national advertisements for contraceptives on 14 radio and 10 television stations that reached an estimated audience of 57.2 million people in 1997.



Bureau for Africa

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- There is an enhanced demand for condoms for family planning and HIV/AIDS prevention, as evidenced by nearly 200 million condoms sold since 1991.
- There is increased condom use among high-risk target groups, including dock workers (14 percent used a condom in the most recent sexual encounter with a nonregular partner in 1995 vs. 45 percent in 1997) and long-distance truck drivers (21 percent in 1993 vs. 45 percent in 1997), as well as commercial sex workers and tertiary school students.

Success Stories

Innovative Private Sector Models for Community-Based Health Care. The BASICS project has pioneered the creation of vibrant partnerships between a wide range of community groups and private health care providers in urban areas of Nigeria. The "Community Partnerships for Health" program has helped neighborhood, professional, religious, youth, and other social groups rally around common needs to gain access to quality health care and information on health-related issues. BASICS estimates that the CPH program has provided nearly one-half million family members in Lagos alone with improved access to private health care. With USAID support, the CPH model is being expanded in Lagos and Kano, with plans for extension elsewhere.

Donor Coordination and Sector Leadership. USAID has intensified efforts to encourage other donors and the commercial sector to become more involved in promoting family planning in Nigeria, stimulating increased participation by the British Department for International Development (DFID) and the United Nations Population Fund (UNFPA). In child survival, USAID's collaboration with DFID, UNICEF, and the World Health Organization, and with private voluntary organizations such as Rotary International and Polio-Plus, has been pivotal to Nigeria's successful NIDs since 1996. In preparation for the NIDs, USAID and its implementing partners played an important role in strengthening partnerships among donors, NGOs, local governments, and the Federal Ministry of Health, a role for which the agency has received national recognition from the federal and participating state governments.

Continuing Challenges

Nigeria continues to experience severe epidemics of preventable diseases and remains among the world's greatest focal points for polio cases, HIV infections, and overall population growth. USAID continues to focus on private sector solutions to these problems but is limited by severe budget constraints as well as the tenuous political environment. The Federal Government of Nigeria has finally accepted the need to work closely with NGOs in the health sector; as a result, the government is now working with donor agencies to review and formulate health policies. To advance its NGO-based program and achieve common goals in family planning and health, however, USAID needs a more stable and productive working relationship with the government, increased empowerment of state and local governments, and a renewed commitment to Nigeria, particularly in the area of family planning, within the agency as well as rest of the donor community.



Bureau for Africa

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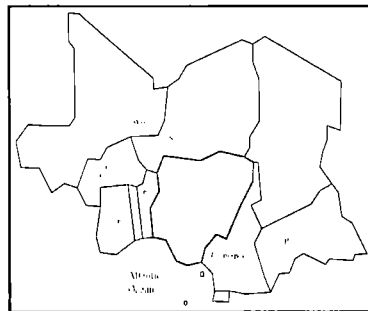
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USAID Country Program Brief, October 1998

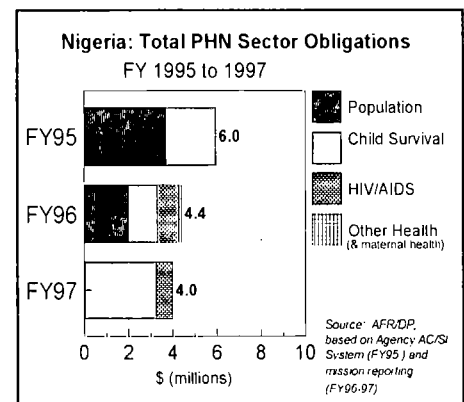
Family Planning and Health Activities in

Nigeria



Population:	106 million
Infant mortality rate:	87 deaths per 1,000 births (1990 DHS)
Adequate nutrition (wt.-for-age):	55% of children age 12–23 months (1990 DHS)
Total fertility rate:	6.0 children per woman (1990 DHS)
Contraceptive prevalence rate:	7% (modern methods, 1995 MICS)
Demographic and Health Surveys:	1986 (Ondo State), 1990 (nationwide)
Multi-indicator cluster survey:	1995 (UNICEF)

Because of U.S. government sanctions against Nigeria, USAID/Nigeria is restricted to working with nongovernmental organizations (NGOs) for specific humanitarian assistance only. As a result, the mission's program has a strong focus on NGO capacity-building and the integration of private and community-based family planning and health services. Though some mission activities are national in scope, the program is primarily active in 14 focus states in the north, southwest, and southeast. Declining USAID funding for family planning and health in Nigeria is summarized for FY 1995–97 in the figure to the right. The mission submitted a country program strategic plan in December 1992 but revised its strategy in November 1994. The mission is pursuing the following strategic objectives and intermediate results (IRs) in family planning and health; these objectives are complemented by a closely integrated special objective in democracy and governance that promotes women's political, economic, and personal empowerment.



Strategic Objective 1: Increase voluntary use of family planning.

IR 1.1: Increase demand for modern contraceptives.

IR 1.2: Increase availability of modern contraceptives.

Strategic Objective 2: Improve maternal and child health practices.

IR 2.1: Improve immunization practices and coverage.

IR 2.2: Improve case management of the sick child.

Special Objective 1: Increase the use of improved, effective, and sustainable responses to reduce human immunodeficiency virus (HIV) transmission and to mitigate the impact of HIV and acquired immune deficiency syndrome (AIDS) pandemic.

IR 1: Increase awareness of HIV/AIDS and sexually transmitted infections (STIs) and how to prevent transmission.

IR 2: Increase availability of condoms.

IR 3: Mitigate impact of AIDS through community, home-based care of people living with AIDS and people affected by AIDS.

Activities in Family Planning and Health

Promotion of Family Planning. Pursuing a community-based strategy, the mission is promoting increased use of family planning through support for distribution of contraceptives; a variety of information, education, and communication (IEC) activities such as radio spots and training of peer educators; institutional development of NGOs, and training of community-based distribution agents and traditional birth attendants. Nationwide, the mission's contraceptive social marketing program is promoting sustainable supply and use of a variety of contraceptives through a grant to Population Services International and PSI's local affiliate, the Society for Family Health.

Child Survival. The mission's child survival program promotes the development of health care alternatives through the private sector, providing local NGOs with the capacity necessary to sustain services for maternal and child care. Of particular importance have been technical and material assistance to NGOs and IEC activities in preparation for Nigeria's national immunization days (NIDs). The mission is promoting adaptation of the integrated management of childhood illnesses (IMCI) approach, improved control and treatment of malaria and diarrheal diseases, improved polio surveillance, and an epidemic preparedness and response (EPR) initiative designed to help NGOs and communities more effectively respond to periodic outbreaks of meningitis, cholera, yellow fever, and other infectious diseases.

Prevention and Control of HIV/AIDS. The mission has a buy-in to the AIDSCAP Project, whose NGO subprojects have promoted institutional capacity building and IEC activities that target higher-risk groups. AIDSCAP has created guidelines and training for treatment of STIs, a mass media awareness campaign, employee education for a variety of commercial and industrial organizations, and works with people living with AIDS to spread awareness at the community level. PSI's social marketing campaigns have also contributed greatly through media spots, IEC, and training of peer educators. Integrated health programs supported by other partners also promote the use of condoms, reduction in numbers of sexual partners, and treatment of STIs. The mission plans to work with community- and home-based organizations that assist patients with AIDS and people affected by HIV/AIDS.

Donor Coordination, Collaboration, and Sector Leadership. Through Nigeria's interagency coordinating committee (ICC), the mission and its partners have successfully coordinated NID inputs and promoted IMCI and EPR approaches in child survival. In family planning, where levels of USAID support have diminished greatly since 1993, the mission has worked closely with other donors to help fill the gap in contraceptive supply; UNFPA, DFID, and the Planned Parenthood Federation of Nigeria (PPF-N) have responded with increased support for distribution of contraceptives in Nigeria.

Global Bureau and USAID/Nigeria Joint Programming Activities

Access to Family Planning Through Women Managers Project (ACCESS) seeks to improve access to quality family planning and reproductive health services by using the resources of trained women managers. In Nigeria, partner organizations started nine subprojects and trained more than 1,300 men and women to serve as distribution agents for family planning services in nine states.

AIDS Control and Prevention Project, is also supporting behavioral research on sexuality and STIs in teenagers. AIDSCAP received a bridging grant in 1997–98 to lead into HIV/AIDS activities to be conducted under the AIDSMARK and IMPACT projects.

Basic Support for Institutionalizing Child Survival is helping to expand health care coverage for lower-income residents of Lagos and Kano through the Community Partnerships for Health program, a model of collaboration between community-based organizations and private providers. The project is also engaged in the formulation and implementation of training curricula and treatment guidelines for use by NGOs receiving USAID support.

Centers for Disease Control and Prevention (CDC) is working to increase the technical capacity of NGO family planning and health services. Of particular significance has been assistance to NGOs preparing for immunization campaigns during epidemic outbreaks in the north. CDC is also supporting efforts of the River Blindness Foundation to eradicate onchocerciasis.

Johns Hopkins University/Population Communication Services conducts training in IEC material development for USAID-supported NGOs active in family planning and health.

Bureau for Humanitarian Response, Office of Private & Voluntary Cooperation

Carter Center/Global 2000 Program is receiving matching grant funding for river blindness eradication.



This USAID Country Program Brief was prepared for the Human Resources Division, Office of Sustainable Development, USAID Africa Bureau (AFR/SD/HRD), by the Center for International Health Information (CIHI). Questions and comments can be directed to CIHI (info@cihi.com).



GHANA

U.S. Agency for International Development (USAID)
Population, Health, and Nutrition Briefing Sheet

Country Profile

Ghana is a newly democratic West African nation of roughly 18 million. Although political and economic progress in Ghana has been substantial in the 1990s, the country continues to face many of the severe challenges to development that afflict the region as a whole, including rapid population growth, widespread poverty, and generally poor health conditions.

USAID Strategy

USAID health programs are working to:

- Increase the use of more effective family planning methods and improve the sustainability of family planning services;
- Promote and support a more effective response to HIV/AIDS, particularly improvement in the prevention and control of HIV and other sexually transmitted infections (STIs); and
- Increase the use of child survival interventions, including immunization, oral rehydration to treat diarrheal diseases, and improved breastfeeding and weaning practices.

Major Program Areas

Expanding and Improving Family Planning Services. Working closely with the Ministry of Health, National Population Council, nongovernmental organizations (NGOs), and donors, USAID/Ghana promotes policy reforms, improved distribution of family planning commodities, and a strengthened private sector role in providing family planning services. The mission supports training, facility rehabilitation, and commodity supply in both the public and private sectors to increase access to and use of modern contraceptive methods, particularly more effective, long-term methods.

HIV/AIDS Information and Prevention. As a leading donor to HIV/AIDS prevention in Ghana, the mission supports the development of more effective HIV/STI diagnosis and surveillance, and provides local NGOs and U.S. private voluntary organizations (PVOs) with

training in prevention and counseling. USAID also supports information, education, and communication activities to promote safer sexual behavior and has developed a policy-making model that shows the potentially severe economic and health impacts of HIV/AIDS in Ghana.

Results

- The proportion of women using modern contraceptives has risen from just 5.5 percent in 1988, to 10 percent in 1993, and an estimated 22 percent in 1995. Fertility has dropped from 6.4 children per woman in 1988 to an estimated 5.2 children per woman in 1997.
- Condom distribution has increased more than five-fold since 1986, the year the first AIDS case was identified in Ghana.
- The Ghanaian Registered Nurse Midwives Association has trained more than 400 service providers, particularly in rural areas, to promote increased use of quality contraceptive methods.
- Through USAID support, Ghana has developed one of the most advanced national HIV/AIDS/STI sentinel surveillance systems in Africa.
- The commercial sector's contribution to the provision of short-term contraceptive methods, such as pills and condoms, grew from 50 percent in 1993, to 72 percent in 1995.
- With USAID support, UNICEF has responded quickly to crisis situations, such as yellow fever and cerebral spinal meningitis outbreaks, and worked to develop sustainable child survival services. In 1996, USAID contributed funds to immunize more than 370,000 infants against childhood diseases.

Success Stories

- Facilitated by USAID, policy dialogue has been a critical element in the success of Ghana's family planning efforts since 1994 and has helped establish the National Population Council (NPC) as an effective



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tive national coordinating body. The NPC has deployed regional population officers nationwide, formed regional committees to promote the twin concepts of population and development, and directed the public sector promotion of long-term contraceptive methods. The NPC has also effectively helped raise the importance of adolescent reproductive health programs.

- A major 1997 accomplishment was the establishment of an endowment fund to support activities of the Ghana Social Marketing Foundation (GSMF), the first such endowment ever in social marketing. Along with the Planned Parenthood Association of Ghana, the principal NGO distributor, GSMF has expanded the range of contraceptives available in the private sector to include a variety of effective, long-term methods such as injectables, intrauterine devices, and Norplant[®] implants.

Continuing Challenges

The mission has successfully accomplished its family planning policy objectives after only three years of an anticipated five-year program. To maintain the program's momentum, the mission is planning to shift remaining resources to expand preservice training (in collaboration with the Japanese government), mass media campaigns, and social marketing activities. USAID plans to promote increased child survival activities using U.S. PVOs and local NGOs. Special emphasis will be given to polio eradication and infectious disease initiatives.

There is consensus among Ghanaian officials, USAID, and other donors that not enough is being done to slow down the spread of HIV in Ghana. As the major donor in this area, USAID has moved from its previous emphasis on testing and counseling to a more proactive stance. The mission will continue to urge the Ghanaian government to allocate more resources to the problem and will target preventive interventions to a new, expanded set of high-risk groups that include young men, transport workers, and migrant workers. USAID will also continue to ensure that Ghana's regional HIV/AIDS/STI laboratory network provides proper surveillance.



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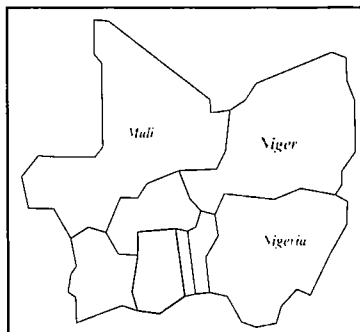
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Ghana



Population:	18.4 million (UN estimate for 1997)
Infant mortality rate:	66 deaths per 1,000 births (1993 DHS)
Adequate nutrition (wt.-for-age):	65% of children ages 12–23 months (1993 DHS)
Total fertility rate:	5.5 children per woman (1993 DHS)
Contraceptive prevalence rate:	10.1% (married women/modern methods, 1993 DHS)
Demographic and Health Surveys:	1988, 1993, 1998
Multi-indicator cluster survey:	1995 (UNICEF)

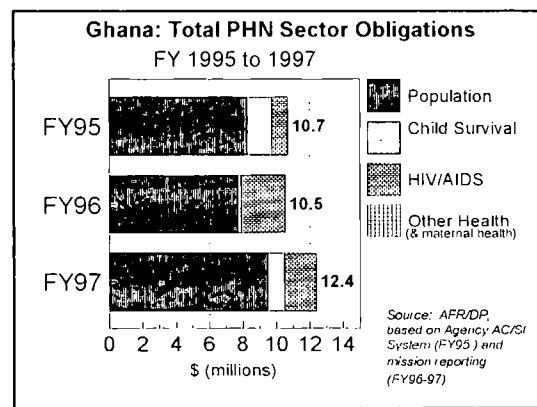
USAID/Ghana is operating under a country strategic plan for 1997–2001 with an overall goal to promote sustainable market growth. Many activities under the Family Planning and Health Project (1991–96) have been bridged into the mission's Ghana Population and AIDS Project (1994–2000). Agencywide funding trends for family planning and health activities in Ghana in 1995–97 are summarized in the figure to the right. The mission is pursuing the following strategic objective and intermediate results (IRs) in family planning and health.

Strategic Objective 3: Improved family health.

IR 3.1: Increased use of family planning service.

IR 3.2: Increased use of proven human immunodeficiency virus (HIV) and sexually transmitted infection (STI) prevention services.

IR 3.3: Increased use of selected child survival services.



Activities in Family Planning and Health

Promotion of Family Planning. Working in conjunction with Ghana's National Population Council, Ministry of Health (MOH), local nongovernmental organizations (NGOs), the World Bank, the Government of Japan, and the United Nations Fund for Population Activities (UNFPA), USAID/Ghana is focusing on promoting policy reform, facilitating the flow of family planning commodities, and strengthening the role of the private sector in providing family planning services. Key to the mission's activities is support for the two private family planning organizations, the Ghana Social Marketing Foundation and the Planned Parenthood Association of Ghana. The mission's strategy in family planning is to support the following priority areas of intervention identified by the MOH and NGOs:

- Information and education campaigns to increase understanding of the health benefits of family planning;
- Expanded access to more effective family planning methods, particularly Depo-provera, Norplant®, and sterilization;
- Increasing public and private sector resource allocation to population activities; and
- Improving the distribution of family planning information and services to males, adolescents, and people in rural areas.

In addition to policy, communication, and marketing activities, the mission is supporting training for pharmacists and practitioners in family planning counseling and the provision of longer-term methods. A draft adolescent reproductive health strategy, drawn up with the National Population Council, is designed to lead to more effective programming for youth.

Prevention and Control of HIV/AIDS. As a major donor in acquired immune deficiency syndrome (AIDS) prevention in Ghana, USAID/Ghana is building upon successes in developing local capacity for diagnosis and surveillance of HIV and other STIs. The mission is supporting continued collection and analysis of data to monitor the spread of HIV and working to further increase knowledge about HIV/AIDS and STIs; reduce high-risk sexual behavior; and increase use of condoms through targeted information, education, and communication (IEC) activities. Grants provided to local and U.S. private voluntary organizations (PVOs) support prevention activities aimed at specific high-risk groups such as adolescents and the police.

Child Survival. USAID/Ghana is providing grants to UNICEF, Africare, and local NGOs to strengthen child survival interventions such as immunization and oral rehydration through support for cold chain supplies and equipment; IEC activities; and health worker training and social marketing of oral rehydration therapy. The mission has contributed to a vaccine stabilization fund within the MOH and helped to draft a national child survival strategy that focuses on breastfeeding, nutrition, immunization, integrated management of childhood illnesses, and neonatal care. Outside of the mission's portfolio, PL 480 Title II resources support training of community health workers by the Adventist Development and Relief Agency and Catholic Relief Services.

Global Bureau and USAID/Ghana Joint Programming Activities

Access to Family Planning Through Women Managers Project improves access to quality family planning and reproductive health services.

AVSC International is working with the MOH to improve access to and quality of family planning services in the public and private sectors.

Family Planning Logistics Management Project assists the MOH, the Ghana Social Marketing Foundation, and community-based distribution networks in management, training, and distribution of contraceptives for family planning and AIDS prevention programs. The project has also helped the MOH prepare a long-range strategic plan for strengthening contraceptive logistics.

IMPACT is conducting a comprehensive HIV/AIDS/STI needs assessment with the United Nations Development Programme.

Johns Hopkins Program for International Education in Reproductive Health is working to strengthen family planning skills among private sector physicians.

Johns Hopkins University/Population Communication Services conducts training in IEC materials development.

POLICY Project works toward a supportive policy environment for family planning and reproductive health programs.

Primary Providers' Education and Training in Reproductive Health

Private Initiatives for Primary Healthcare provides technical assistance to support the development of local initiative groups that represent different models of private sector health care and local management groups, which may serve health care providers as long-term sources of technical assistance.

Strategy for Improving Service Delivery/Operations Research is working to develop and test an approach to family planning and primary health care that is appropriate for rural villages in northern Ghana, including attention to gender issues, female genital mutilation, and reproductive tract infections.

U.S. Centers for Disease Control and Prevention is assisting with child survival program management.

BASICS is working with the MOH to strengthen the child survival program.

Bureau for Humanitarian Response, Office of Private & Voluntary Cooperation Child Survival Grantees as of 1998

Plan International received a BHR/PVC child survival grant for activities in 1997.



This USAID Country Program Brief was prepared for the Human Resources Division, Office of Sustainable Development, USAID Africa Bureau (AFR/SD/HRD), by the Center for International Health Information (CIHI). Questions and comments can be directed to CIHI (info@cihi.com).



SOUTH AFRICA

U.S. Agency for International Development (USAID)
Population, Health, and Nutrition Briefing Sheet

Country Profile

Richly endowed with human and natural resources, South Africa is the fourth most populous nation and has the largest and most developed economy in sub-Saharan Africa. Still recovering from a legacy of social and political inequities, South Africa faces the challenges of pervasive poverty and the need to improve services for the disadvantaged.

USAID Strategy

USAID's program in South Africa began in 1995, the country's first full year of a democratically elected government with a constitution, bill of rights, and policy of transformation to foster equity among all its citizens. The South Africa mission has launched a 10-year program (1996–2005) that supports the development objectives of the Republic of South Africa, USAID, and the U.S.-South Africa Binational Commission. USAID's health activities are addressing inequities in access to primary health care (PHC) among South Africans. The strategy includes

- Expanding PHC services to all South Africans under a unified system.
- Improving management of the health care delivery system, and
- Increasing the capacity to deliver prevention and treatment services for HIV/AIDS and sexually transmitted infections (STIs).

Major Program Areas

Primary Health Care System Strengthening. The "Equity Project," a seven-year initiative of health training and sector reform activities, is USAID's main activity for strengthening PHC. Initial activities are designed to strengthen PHC management and service delivery systems in the Eastern Cape Province; the intention is to formulate successful activities into models for nationwide replication. In addition to technical emphases on improving the quality of reproductive and child health care and nutrition, the initiative includes support to develop effective health information and referral systems.

HIV/AIDS Prevention Activities. USAID supports a number of nongovernmental organizations (NGOs) and the national Department of Health with training of staff and community leaders in HIV/AIDS prevention. Workshops and group presentations focus on HIV/AIDS prevention messages and emphasize educating adolescents and other high-risk groups. A major new initiative is designed to help build capacity to plan and implement HIV/AIDS programs in the national Department of Health and at provincial and district levels.

Demographic Health Survey (DHS). Working with the Government of South Africa, USAID will help implement and disseminate the findings of the 1998 South Africa DHS. The DHS will establish baseline data for health sector planning and monitoring.

Results

- Publication and provincewide introduction of a standardized national PHC package in the Eastern Cape Province; this is the only province where the national policy has been interpreted and realized. With USAID assistance, 43 percent of clinic professional nurses in the Eastern Cape were trained in PHC clinical skills, and by 1997, 46 percent of clinics had at least one staff member who was trained in management skills.
- A National AIDS Strategy that resulted from a USAID-supported National AIDS Convention. A National STI/HIV/AIDS Review will guide the strategy's implementation through regional coalitions among policy and civic leaders.
- A USAID-supported NGO developed a legal charter to prevent discrimination against persons living with AIDS.
- More than 220 nurses were trained in the "syndromic approach" to HIV/AIDS diagnosis, a cost-effective method based on diagnosing by symptom rather than by running clinical tests.



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Success Stories

USAID has supported extensive policy dialogue and an exploration of enhanced cost-recovery methods to improve PHC services' financial sustainability in South Africa. A USAID-funded study of the Uitenhage Hospital contract with a private provider group showed that public/private partnerships can result in improved quality for all patients and generate increased resources that can be used in under-funded facilities. USAID plans to provide technical assistance to replicate such partnerships elsewhere.

With USAID technical assistance, Eastern Cape Province developed and established clear guidelines for referrals to reduce the burden on hospitals. As a result, hospital outpatient load diminished significantly. For example, the Umtata General Hospital, the largest hospital in the province's poorest region, closed its outpatient department for general walk-in services, reducing the patient load in the hospital by nearly 40,000 patients per month. Meanwhile, with assistance from the Kellogg Foundation, the Eastern Cape Department of Health created four community-based rural health centers serving the catchment area around the town of Umtata, resulting in significant financial savings and reducing the hospital's burden.

USAID-assisted NGOs have been providing a substantial contribution to community outreach and HIV/AIDS awareness activities in rural and informal settlement areas. Interventions designed and implemented by community members target the general population and individuals at increased risk for HIV infection, such as adolescents. Peer-led prevention education programs have been successful in creating a nonjudgemental environment for the exchange of ideas on issues such as sexuality, STIs, reproductive health, values clarification, and decision-making skills. The USAID-funded AIDSCAP Project played a pivotal role in connecting these NGOs to a variety of information, technology, and resources that not only facilitate their understanding of HIV/AIDS issues, but also help in project implementation.

Continuing Challenges

South Africa's major health care challenge is to achieve an equitable distribution of basic health care. Unifying two vastly different health systems in South Africa requires that USAID's technical assistance promote appropriate health systems management and development. In addition, USAID's integrated PHC project must integrate HIV/AIDS/STI information and counseling into basic community-level health services.



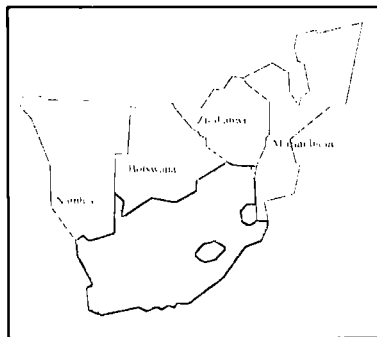
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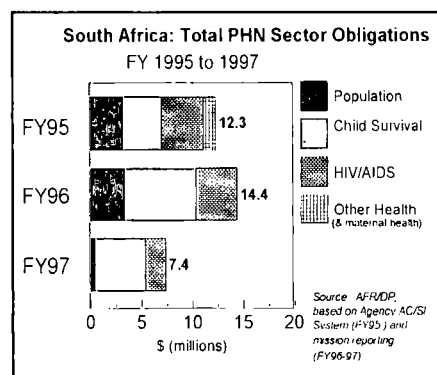
USAID Country Program Brief, October 1998

Health Development Activities in South Africa



Population:	40.6 million (1996 Census)
Infant mortality rate:	48 deaths per 1,000 births (UN est. for 1997)
Adequate nutritional status:	not available
Total fertility rate:	3.8 children per woman (UN est. for 1997)
Contraceptive prevalence rate:	60% (all women/modern methods, 1994)
Demographic and Health Survey:	1998 (planned)

The South Africa mission has launched a 10-year program (1996–2005) to support the development objectives of the Republic of South Africa and USAID as well as the U.S.-South Africa Binational Commission. The mission submitted a revised country strategic plan in March 1997 specifying a goal of support for sustainable transformation and a subgoal of political, social, and economic empowerment. The program of assistance is assessed on an annual basis in a joint, bilateral exercise with the government of South Africa. Agencywide funding trends for health development activities in South Africa in 1995–97 are summarized in the figure to the right. The mission's results framework includes one strategic objective (SO) and five intermediate results (IRs) in health development. Activities under this objective are complemented by efforts under other SOs to strengthen local government (SO1) and to improve municipal service delivery (SO6).



Strategic Objective 3: More equitable, unified, and sustainable systems delivering integrated primary health care (PHC) services to all South Africans.

IR 3.1: Increase access to integrated package of PHC services.

IR 3.2: Effective health care referral systems are operational first in the pilot province (Eastern Cape) and then nationally.

IR 3.3: Improve management of integrated PHC [including human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) and sexually transmitted infection (STI)] delivery systems at the provincial level.

IR 3.4: PHC training program is strengthened and institutionalized at the provincial level initially in the pilot province (Eastern Cape).

IR 3.5: Increase capacity of the PHC system to deliver appropriate HIV, STI, and tuberculosis (TB) prevention and treatment.

Activities in Health Development

The EQUITY Project. This seven-year bilateral program, nearing its first full year of implementation, is the centerpiece of the mission's program for integrated primary health care. The initial activities focus on strengthening management, financial, and service delivery systems for primary health care in the Eastern Cape Province. Successful activities will serve as lessons, pilots, and models for replication on a nationwide basis. After one full year of implementation, a number of results are already evident:

- A unified drug logistics system has been fully implemented and is being scaled up to the national level.
- The health information system, developed under Equity, is being implemented in the Eastern Cape Province and will be scaled up nationally.
- Implementation of the health care referral system has started in the Eastern Cape.
- The DOTS methodology for tuberculosis diagnosis and treatment is being implemented for the first time in ten locations in the Eastern Cape.
- Condoms are widely and freely available in health clinics throughout the Eastern Cape Province, without the need for consultation with health personnel.

- Public/private partnerships involving the administration and management of small hospitals has been successfully initiated in the Eastern Cape.

The HIV/AIDS Project. This new, five-year program follows mission support in the area of HIV/AIDS since 1991, and is in response to the government of South Africa's recently launched "Partnerships Against AIDS" campaign. The main areas of support will include awareness raising and capacity strengthening, support for the establishment of a national STI reference center, and collaboration with ongoing South African initiatives for vaccine development. These activities will be carried out in close collaboration with the US Centers for Disease Control, the US National Institutes of Health, and USAID/Global Bureau Cooperating Agencies.

To date, mission initiatives in HIV/AIDS have focused on training, community outreach, and institutional capacity building. These have been carried out with the assistance of CDC and Global Bureau Cooperating Agencies. Key results with USAID funding include:

- The National AIDS Convention prepared a national AIDS strategy plan, which has been the backbone of the country's response to the epidemic.
- Work by a local NGO led to the development of a legal charter to prevent discrimination against people living with AIDS.
- A pilot program in a mining community to address STIs has led to the mining company picking up costs of the service delivery, with replications likely in other mining communities.
- The major labor unions have drafted a consensus position document on workplace policies and guidelines on AIDS.

The Amy Biehl Foundation. This foundation is a community-based NGO that focuses on integrated health and community development in key townships surrounding Cape Town. Established shortly after the killing of Amy Biehl in 1993, the Foundation's activities include youth-centered reproductive health and HIV/AIDS education, community development, outreach, and training. Virtually all of the Foundation's programs are carried out in close collaboration with the public sector and with specialized local NGOs.

The Binational Commission (BNC). The Gore-Mbeki Binational Commission establishes a framework for the collaborative relationship between the US and South Africa in all matters, including development assistance. USAID forms part of the health working group of the BNC and, as such, looks for collaborative opportunities that are consistent with USAID and USG priorities. USAID partners closely with the US Centers for Disease Control and the US National Institutes for Health in identifying and implementing joint programs. USAID has also been in discussions with the Medical University of South Africa (MEDUNSA), School of Public Health, in identifying further areas of collaboration.

USAID/Global Bureau and USAID/South Africa - Joint Programming Activities

Demographic and Health Surveys (DHS), working with the government of South Africa, will help implement the 1998 South Africa DHS and to disseminate the survey's findings. While developing baseline data for health sector planning and monitoring, the DHS will also increase local capacity to replicate these efforts in the future with little or no USAID assistance.

Environmental Health Project

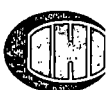
POLICY Project has been assisting with AIDS awareness raising activities, and with technical projections. Staff from the Policy Project have facilitated capacity building workshops and seminars with provincial and community-based organizations to strengthen their capacity to raise awareness amongst their target populations. The Project has also assisted in analyzing, estimating, and projecting the pattern of the epidemic into the future. This last activity is an excellent example of donor coordination, as the European Union, DfID, and USAID all participate and share the costs of the technical meetings.

Other Collaborative Efforts. A number of Global Bureau Cooperating Agencies are working in the area of linkages between reproductive health and HIV/AIDS, including FHI, AVSC, and Pathfinder; the QAP project is coordinating with the Council for Health Service Accreditation of Southern Africa to experiment accreditation processes for clinic and other lower level facilities; ILSI and OMNI are working closely with the National Department of Health in implementing the Department's Micronutrient Fortification Strategy.

USAID/Bureau for Humanitarian Response, Office of Private & Voluntary Cooperation Child Survival Grantees as of 1998

Medical Care Development, Inc. is focusing on the prevention and control of common childhood illnesses, maternal and newborn care, and improved immunization coverage in KwaZulu/ Natal Province.

World Vision Relief and Development, Inc. has a four-year project (through August 1999) focusing on nutrition, HIV/AIDS, childhood diseases, immunization, family planning, and maternal and newborn care in KwaZulu/Natal Province.



This USAID Country Program Brief was prepared for the Human Resources Division, Office of Sustainable Development, USAID Africa Bureau (AFR/SD/HRD), by the Center for International Health Information (CIHI). Questions and comments can be directed to CIHI (info@cihi.com).



ZIMBABWE

U.S. Agency for International Development (USAID)
Population, Health, and Nutrition Briefing Sheet

Country Profile

Zimbabwe is a country with enormous development potential. It is endowed with a wealth of human and natural resources, an evolving industrial base, diversified economy, and well-developed infrastructure. After South Africa, Zimbabwe is the most highly developed country in the southern Africa region, however, Zimbabwe also faces serious development problems. These include recent economic stagnation, deepening poverty among the majority of the population, and a government that appears increasingly remote from its citizens. Most grave of all, among the 11 million adults, an estimated 22 percent are HIV positive, and nearly 200,000 AIDS-related deaths occur annually.

USAID Strategy

USAID's objective in family planning and health is aimed at reducing two key threats to sustainable development in Zimbabwe: rapid population growth and the spread of HIV/AIDS. USAID has had a long and highly productive development partnership with Zimbabwe, and the country is projected to graduate from USAID assistance in 2003. As the lead donor to family planning efforts, USAID has contributed significantly to rapidly increasing the use of modern family planning in Zimbabwe. Intensified assistance to promote HIV/AIDS prevention has also helped establish a variety of potentially effective programs in the public and private sectors. The greatest challenge now is to ensure that the positive impacts of USAID programs are sustained beyond Zimbabwe's scheduled graduation from USAID assistance.

Major Program Areas

Improved Quality and Availability of Family Planning Services. USAID works with public and private providers to increase demand for and quality of family planning services, promoting a range of contraceptives, including the use of longer-acting contraceptive methods, and their increased availability, particularly to adolescents. USAID is the leading supplier of oral contraceptives in Zimbabwe and recently introduced the female condom. USAID is also helping both the public and private sectors address contraceptive supply and management needs.

Improved Capacity for Service Delivery. USAID is working with the Government of Zimbabwe and non-governmental organizations to improve their capacity to provide a wide range of reproductive health services, including HIV/AIDS prevention. USAID also supports improved health care financing mechanisms, particularly cost recovery systems. In the policy arena, USAID is working to reduce barriers to reproductive health services, such as tariffs on contraceptives, and promoting improved policies relating to HIV/AIDS prevention.

Improved Behavior Change Communication. USAID's support promotes changes in high-risk behavior among women and young adults, and in selected occupational groups. Efforts to improve prevention of HIV/AIDS in Zimbabwe include condom social marketing, peer educators, and voluntary counseling and testing programs.

Results

- Increased use of modern contraceptives from 26 percent of women in 1984 to 42 percent in 1994.
- Reduced rates of fertility, from 6.5 children per woman in 1984 to 4.3 in 1994.
- Increased choice of contraceptive products. In 1997, the CARE™ female condom in Zimbabwe was the first female condom to be marketed in Africa. Over 126,000 were sold, three times more than expected, empowering women to determine choices about family planning and HIV prevention behavior.
- Increased perception of the personal risk of acquiring HIV, from 3 percent of males in 1994 to 22 percent in 1997, and from 7 percent of females in 1994 to 23 percent in 1997.

Success Stories

Zimbabwe's family planning program, which USAID has supported since 1980, is possibly the highest-impact program in sub-Saharan Africa. Since 1984, the contraceptive prevalence rate has increased by 55 percent and the total fertility rate—the average number of children the average Zimbabwean woman will have in



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her lifetime—has declined by a third. Due in large measure to USAID assistance, Zimbabwe now has the lowest recorded total fertility rate in sub-Saharan Africa. USAID continues to support efforts to increase the range and quality of family planning services available in Zimbabwe and is exploring various means to ensure that these services are sustained after USAID support ends.

In the face of the public sector financial crisis, USAID has helped ensure that Zimbabwean women can receive high-quality reproductive health services at affordable prices from technically qualified private providers. When the Zimbabwe National Family Planning Council, a government parastatal, asked USAID to help facilitate a larger private sector role in the promotion and provision of family planning, USAID collaborated closely with the Council to launch a successful new initiative in 1997. The Zimbabwean private sector participated with great enthusiasm; training courses were over-subscribed, and pharmacists, not in the original design, asked to be included. The results were outstanding: 211 new family planning sites have opened; 53 physicians, 85 nurses and 92 pharmacists were trained; several handbooks were duplicated; and counseling rooms opened in seven model pharmacies. USAID assistance, including extensive consultations with Zimbabweans, was at the right place at the right time.

Continuing Challenges

USAID/Zimbabwe's portfolio in family planning and HIV/AIDS prevention will be brought to a conclusion over the next two to five years. With the public sector fiscal crises, there is a growing need to firmly establish sustainable private sector alternatives. And as the HIV/AIDS pandemic worsens in Zimbabwe, the need for sustainable preventive programs becomes even more urgent. Awareness of HIV/AIDS has become nearly universal, but as the pandemic worsens, USAID is shifting from a peer education strategy to one emphasizing voluntary testing and counseling services. In both areas, USAID's programmatic emphasis will be on ensuring program sustainability after the agency's departure. The successful transition to self-supporting programs will be the most important USAID legacy in Zimbabwe.



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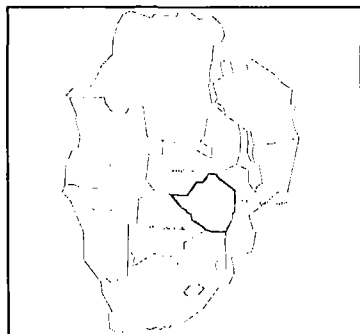
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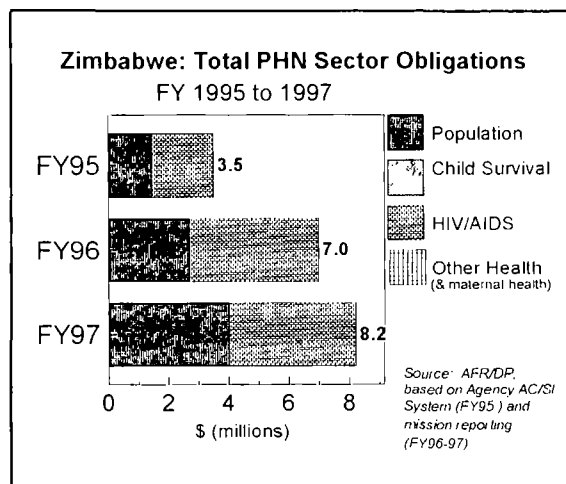
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USAID Country Program Brief, October 1998
Family Planning and Health Activities in
Zimbabwe



Population:	11.7 million (UN estimate for 1997)
Infant mortality rate:	53 deaths per 1,000 births (1994 DHS)
Adequate nutrition (wt.-for-age):	77% of children age 12–23 months (1994 DHS)
Total fertility rate:	4.3 children per woman (1994 DHS)
Contraceptive prevalence rate:	31.1% (all women/modern methods, 1994 DHS)
Demographic and Health Surveys:	1988, 1994, 1999 (planned)
Multi-indicator cluster survey:	1996 (UNICEF)

USAID/Zimbabwe is the lead donor in family planning efforts in Zimbabwe and has intensified its assistance to promote prevention of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS). The mission is currently operating under a close-out country strategic plan (CSP) for fiscal years 1997–2003, during which all USAID assistance will be gradually phased out, and plans to end assistance in family planning and health by 2002. The greatest challenge is to ensure that positive effects of USAID programs are sustained beyond the country's graduation, which is scheduled for 2003. A summary of agencywide funding trends for family planning and health activities in Zimbabwe in 1995–97 is provided in the figure. The mission's results framework includes the following strategic objective and intermediate results (IRs) in family planning and health.



Strategic Objective 3: Reduce fertility and increase use of HIV/AIDS prevention measures.

IR 3.1: Increase contraceptive use.

IR 3.2: Increase availability and knowledge of proven HIV/STD prevention services.

Activities in Family Planning and Health

Improved Quality of Family Planning. The mission works with public and private providers to increase demand for and quality of family planning services, promoting contraceptive diversity, with emphasis on longer-acting methods, and increased availability to adolescents in particular. USAID is the leading supplier of oral contraceptives in Zimbabwe and recently introduced the female condom. Support to the public sector is being phased out while private sector efforts, particularly those under the PROFIT project, have been intensified.

Contraceptive Supply and Logistics. USAID/Zimbabwe is supporting both the public and private sectors, particularly the parastatal Zimbabwe National Family Planning Council, to address contraceptive supply and management needs. A recently initiated five-year condom social marketing program being implemented by Population Services International (PSI) aims to improve HIV/AIDS prevention. The mission has worked with the Government of Zimbabwe to decentralize all services and to include a greater proportion of the private sector and nongovernmental organizations (NGOs) in efforts to increase availability of contraceptives.

Improved Policies for Reproductive Health. The mission is working with the Government of Zimbabwe to reduce tariffs on contraceptives and other barriers to reproductive health services and promoting improved policies for HIV/AIDS and associated interventions. The mission also supports improved health care financing mechanisms, particularly cost recovery systems.

Improved Capacity for Service Delivery. The mission is working with the Government of Zimbabwe and NGOs in the health sector to improve their capacity to provide a wide range of reproductive health services. In particular, PACT is implementing a five-year program to bolster NGO capacity to provide expanded and improved HIV/AIDS prevention and counseling services.

Improved Behavior Change Communication. USAID's interventions have supported changes in high-risk behavior in selected occupational groups, including uniformed services, commercial farmers, university students, and factory and transportation workers. The mission is now focusing on women and young adults and seeks to enhance the role that NGOs currently play in behavior change communication efforts. Emphasis has recently been shifted from a strategy based on peer education to facilitating voluntary counseling and testing.

Global Bureau and USAID/Zimbabwe Joint Planning Activities

AIDS Control and Prevention Project has worked with various target groups to:

- Develop an HIV/AIDS prevention program in Bulawayo to increase the adoption of safer sexual behaviors by vulnerable groups, particularly commercial sex workers and their clients;
- Develop prevention interventions in conjunction with other partners targeting high-risk behaviors among defined groups, including rail workers, truckers, and armed forces members and their families;
- Train peer education trainers for a large department store chain; and
- Expand peer education programs and reinforce existing pilot activities involving a single women's association, school children, people living with AIDS, and small businesses.

AVSC International, in conjunction with the Zimbabwe National Family Planning Council, is working to expand the availability of long-term contraception.

Family Health International, in conjunction with the University of Zimbabwe, is conducting a study assessing the impact of contraceptive availability and usage on secondary and college students' vocational and academic pursuits, women's self-esteem, and women's economic decision-making and participation within the workforce, as well as the effects of male attitudes and related gender issues on women's experience with family planning.

Johns Hopkins Program for International Education in Reproductive Health is providing on-site clinical training for health care workers to improve quality of services and is working through the University of Zimbabwe, Department of Obstetrics and Gynecology, to assess the value of certain clinical procedures.

Johns Hopkins University/Population Communication Services

Population Council is working with the Zimbabwe National Family Planning Council to improve its evaluation and research unit and is researching means to integrate sexually transmitted infection information into family planning services more effectively.

SOMARC is working to expand condom distribution to independent distributors and entrepreneurs in areas not covered by the existing system.

SEATS provides training in quality improvement among select family planning service providers.



This USAID Country Program Brief was prepared for the Human Resources Division, Office of Sustainable Development, USAID Africa Bureau (AFR/SD/HRD), by the Center for International Health Information (CIHI). Questions and comments can be directed to CIHI (info@cihi.com).



GHANA

U.S. Agency for International Development (USAID)
Population, Health, and Nutrition Briefing Sheet

Country Profile

Ghana is a newly democratic West African nation of roughly 18 million. Although political and economic progress in Ghana has been substantial in the 1990s, the country continues to face many of the severe challenges to development that afflict the region as a whole, including rapid population growth, widespread poverty, and generally poor health conditions.

USAID Strategy

USAID health programs are working to:

- Increase the use of more effective family planning methods and improve the sustainability of family planning services;
- Promote and support a more effective response to HIV/AIDS, particularly improvement in the prevention and control of HIV and other sexually transmitted infections (STIs); and
- Increase the use of child survival interventions, including immunization, oral rehydration to treat diarrheal diseases, and improved breastfeeding and weaning practices.

Major Program Areas

Expanding and Improving Family Planning Services. Working closely with the Ministry of Health, National Population Council, nongovernmental organizations (NGOs), and donors, USAID/Ghana promotes policy reforms, improved distribution of family planning commodities, and a strengthened private sector role in providing family planning services. The mission supports training, facility rehabilitation, and commodity supply in both the public and private sectors to increase access to and use of modern contraceptive methods, particularly more effective, long-term methods.

HIV/AIDS Information and Prevention. As a leading donor to HIV/AIDS prevention in Ghana, the mission supports the development of more effective HIV/STI diagnosis and surveillance, and provides local NGOs and U.S. private voluntary organizations (PVOs) with

training in prevention and counseling. USAID also supports information, education, and communication activities to promote safer sexual behavior and has developed a policy-making model that shows the potentially severe economic and health impacts of HIV/AIDS in Ghana.

Results

- The proportion of women using modern contraceptives has risen from just 5.5 percent in 1988, to 10 percent in 1993, and an estimated 22 percent in 1995. Fertility has dropped from 6.4 children per woman in 1988 to an estimated 5.2 children per woman in 1997.
- Condom distribution has increased more than five-fold since 1986, the year the first AIDS case was identified in Ghana.
- The Ghanaian Registered Nurse Midwives Association has trained more than 400 service providers, particularly in rural areas, to promote increased use of quality contraceptive methods.
- Through USAID support, Ghana has developed one of the most advanced national HIV/AIDS/STI sentinel surveillance systems in Africa.
- The commercial sector's contribution to the provision of short-term contraceptive methods, such as pills and condoms, grew from 50 percent in 1993, to 72 percent in 1995.
- With USAID support, UNICEF has responded quickly to crisis situations, such as yellow fever and cerebral spinal meningitis outbreaks, and worked to develop sustainable child survival services. In 1996, USAID contributed funds to immunize more than 370,000 infants against childhood diseases.

Success Stories

- Facilitated by USAID, policy dialogue has been a critical element in the success of Ghana's family planning efforts since 1994 and has helped establish the National Population Council (NPC) as an effective



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tive national coordinating body. The NPC has deployed regional population officers nationwide, formed regional committees to promote the twin concepts of population and development, and directed the public sector promotion of long-term contraceptive methods. The NPC has also effectively helped raise the importance of adolescent reproductive health programs.

- A major 1997 accomplishment was the establishment of an endowment fund to support activities of the Ghana Social Marketing Foundation (GSMF), the first such endowment ever in social marketing. Along with the Planned Parenthood Association of Ghana, the principal NGO distributor, GSMF has expanded the range of contraceptives available in the private sector to include a variety of effective, long-term methods such as injectables, intrauterine devices, and Norplant[®] implants.

Continuing Challenges

The mission has successfully accomplished its family planning policy objectives after only three years of an anticipated five-year program. To maintain the program's momentum, the mission is planning to shift remaining resources to expand preservice training (in collaboration with the Japanese government), mass media campaigns, and social marketing activities. USAID plans to promote increased child survival activities using U.S. PVOs and local NGOs. Special emphasis will be given to polio eradication and infectious disease initiatives.

There is consensus among Ghanaian officials, USAID, and other donors that not enough is being done to slow down the spread of HIV in Ghana. As the major donor in this area, USAID has moved from its previous emphasis on testing and counseling to a more proactive stance. The mission will continue to urge the Ghanaian government to allocate more resources to the problem and will target preventive interventions to a new, expanded set of high-risk groups that include young men, transport workers, and migrant workers. USAID will also continue to ensure that Ghana's regional HIV/AIDS/STI laboratory network provides proper surveillance.



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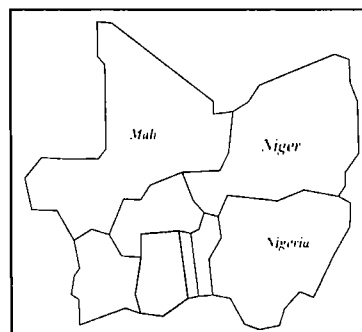
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Ghana



Population:	18.4 million (UN estimate for 1997)
Infant mortality rate:	66 deaths per 1,000 births (1993 DHS)
Adequate nutrition (wt.-for-age):	65% of children ages 12–23 months (1993 DHS)
Total fertility rate:	5.5 children per woman (1993 DHS)
Contraceptive prevalence rate:	10.1% (married women/modern methods, 1993 DHS)
Demographic and Health Surveys:	1988, 1993, 1998
Multi-indicator cluster survey:	1995 (UNICEF)

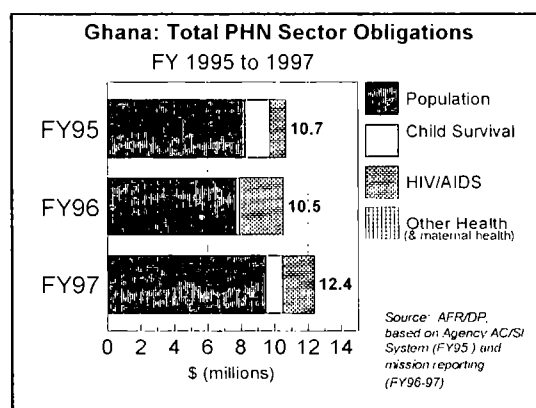
USAID/Ghana is operating under a country strategic plan for 1997–2001 with an overall goal to promote sustainable market growth. Many activities under the Family Planning and Health Project (1991–96) have been bridged into the mission's Ghana Population and AIDS Project (1994–2000). Agencywide funding trends for family planning and health activities in Ghana in 1995–97 are summarized in the figure to the right. The mission is pursuing the following strategic objective and intermediate results (IRs) in family planning and health.

Strategic Objective 3: Improved family health.

IR 3.1: Increased use of family planning service.

IR 3.2: Increased use of proven human immunodeficiency virus (HIV) and sexually transmitted infection (STI) prevention services.

IR 3.3: Increased use of selected child survival services.



Activities in Family Planning and Health

Promotion of Family Planning. Working in conjunction with Ghana's National Population Council, Ministry of Health (MOH), local nongovernmental organizations (NGOs), the World Bank, the Government of Japan, and the United Nations Fund for Population Activities (UNFPA), USAID/Ghana is focusing on promoting policy reform, facilitating the flow of family planning commodities, and strengthening the role of the private sector in providing family planning services. Key to the mission's activities is support for the two private family planning organizations, the Ghana Social Marketing Foundation and the Planned Parenthood Association of Ghana. The mission's strategy in family planning is to support the following priority areas of intervention identified by the MOH and NGOs:

- Information and education campaigns to increase understanding of the health benefits of family planning;
- Expanded access to more effective family planning methods, particularly Depo-provera, Norplant[®], and sterilization;
- Increasing public and private sector resource allocation to population activities; and
- Improving the distribution of family planning information and services to males, adolescents, and people in rural areas.

In addition to policy, communication, and marketing activities, the mission is supporting training for pharmacists and practitioners in family planning counseling and the provision of longer-term methods. A draft adolescent reproductive health strategy, drawn up with the National Population Council, is designed to lead to more effective programming for youth.

Prevention and Control of HIV/AIDS. As a major donor in acquired immune deficiency syndrome (AIDS) prevention in Ghana, USAID/Ghana is building upon successes in developing local capacity for diagnosis and surveillance of HIV and other STIs. The mission is supporting continued collection and analysis of data to monitor the spread of HIV and working to further increase knowledge about HIV/AIDS and STIs; reduce high-risk sexual behavior; and increase use of condoms through targeted information, education, and communication (IEC) activities. Grants provided to local and U.S. private voluntary organizations (PVOs) support prevention activities aimed at specific high-risk groups such as adolescents and the police.

Child Survival. USAID/Ghana is providing grants to UNICEF, Africare, and local NGOs to strengthen child survival interventions such as immunization and oral rehydration through support for cold chain supplies and equipment; IEC activities; and health worker training and social marketing of oral rehydration therapy. The mission has contributed to a vaccine stabilization fund within the MOH and helped to draft a national child survival strategy that focuses on breastfeeding, nutrition, immunization, integrated management of childhood illnesses, and neonatal care. Outside of the mission's portfolio, PL 480 Title II resources support training of community health workers by the Adventist Development and Relief Agency and Catholic Relief Services.

Global Bureau and USAID/Ghana Joint Programming Activities

Access to Family Planning Through Women Managers Project improves access to quality family planning and reproductive health services.

AVSC International is working with the MOH to improve access to and quality of family planning services in the public and private sectors.

Family Planning Logistics Management Project assists the MOH, the Ghana Social Marketing Foundation, and community-based distribution networks in management, training, and distribution of contraceptives for family planning and AIDS prevention programs. The project has also helped the MOH prepare a long-range strategic plan for strengthening contraceptive logistics.

IMPACT is conducting a comprehensive HIV/AIDS/STI needs assessment with the United Nations Development Programme.

Johns Hopkins Program for International Education in Reproductive Health is working to strengthen family planning skills among private sector physicians.

Johns Hopkins University/Population Communication Services conducts training in IEC materials development.

POLICY Project works toward a supportive policy environment for family planning and reproductive health programs.

Primary Providers' Education and Training in Reproductive Health

Private Initiatives for Primary Healthcare provides technical assistance to support the development of local initiative groups that represent different models of private sector health care and local management groups, which may serve health care providers as long-term sources of technical assistance.

Strategy for Improving Service Delivery/Operations Research is working to develop and test an approach to family planning and primary health care that is appropriate for rural villages in northern Ghana, including attention to gender issues, female genital mutilation, and reproductive tract infections.

U.S. Centers for Disease Control and Prevention is assisting with child survival program management.

BASICS is working with the MOH to strengthen the child survival program.

Bureau for Humanitarian Response, Office of Private & Voluntary Cooperation Child Survival Grantees as of 1998

Plan International received a BHR/PVC child survival grant for activities in 1997.



This USAID Country Program Brief was prepared for the Human Resources Division, Office of Sustainable Development, USAID Africa Bureau (AFR/SD/HRD), by the Center for International Health Information (CIHI). Questions and comments can be directed to CIHI (info@ciji.com).



NIGERIA

U.S. Agency for International Development (USAID)
Population, Health, and Nutrition Briefing Sheet

Country Profile

With over 100 million inhabitants, or roughly 14 percent of the entire population of sub-Saharan Africa, Nigeria is Africa's most populous nation. The country has been under military rule for 30 of its 36 years. Although rich in natural resources, Nigeria's rapid population growth and uneven economic development have resulted in an increasing poverty rate. The country's thriving petroleum industry in the late 1960s and 1970s transformed it from an agriculture-based economy to one focused on oil production. About half the population is Muslim, 40 percent is Christian, and 10 percent follows indigenous beliefs.

USAID Strategy

In 1994, due to sanctions against the Nigerian government, USAID ceased all activities with the public sector and began working exclusively through nongovernmental organizations (NGOs). USAID's population and health program focuses on 14 selected states that include more than half of the country's population. The current USAID strategy combines efforts to strengthen NGO management and build sustainability, with technical support in child survival, family planning, and HIV/AIDS prevention. These activities are complemented by and closely integrated with the mission's program in democracy and governance, which assists NGOs working toward women's empowerment.

Major Program Areas

Maternal and Child Health Services. With USAID support, local NGOs receive training and technical assistance to improve basic maternal and child health services such as immunizations, oral rehydration therapy, and malaria treatment and control. USAID plays a major role in planning and coordinating NGO participation in Nigeria's National Immunization Days (NIDs) and is promoting the endorsement of integrated management of childhood illness (IMCI) as the foremost case management strategy. USAID also supports NGO training in epidemic preparedness and response, including mass mobilization efforts.

HIV/AIDS Prevention. USAID works with community-level NGOs to provide HIV/AIDS prevention information, condoms, and peer educator training to truck drivers, dock workers, commercial sex workers, students, and others at high risk of HIV infection. USAID also supports a nationwide condom social marketing effort that uses mass media messages and innovative distribution methods, and is promoting acceptance of the syndromic management of sexually transmitted infections (STIs) as an effective means to curb the spread of HIV/AIDS.

Family Planning. USAID supports the integration of family planning into existing NGO health services, establishment of networks of community-based distribution (CBD) of contraceptives, and a contraceptive social marketing program using radio advertisements, flyers, posters, and billboards and peer educators to spread family planning information in communities.

Results

- There were higher levels of polio immunization coverage, particularly in USAID focus states. After the first round of NIDs in 1997, coverage with two doses of oral polio vaccine was 29 percent higher in the 14 USAID focus states than in the remainder of the country.
- There has been an increased use of modern contraceptives from just under 4 percent of women in 1990 to over 11 percent in 1994 (when USAID support for family planning efforts was greatly reduced).
- There is an increased availability of contraceptives in rural and peri-urban areas through USAID-supported CBD outlets; the number of outlets increased from 1,300 in 1996 to 1,809 in 1997.
- There have been explicit national advertisements for contraceptives on 14 radio and 10 television stations that reached an estimated audience of 57.2 million people in 1997.



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- There is an enhanced demand for condoms for family planning and HIV/AIDS prevention, as evidenced by nearly 200 million condoms sold since 1991.
- There is increased condom use among high-risk target groups, including dock workers (14 percent used a condom in the most recent sexual encounter with a nonregular partner in 1995 vs. 45 percent in 1997) and long-distance truck drivers (21 percent in 1993 vs. 45 percent in 1997), as well as commercial sex workers and tertiary school students.

Success Stories

Innovative Private Sector Models for Community-Based Health Care. The BASICS project has pioneered the creation of vibrant partnerships between a wide range of community groups and private health care providers in urban areas of Nigeria. The "Community Partnerships for Health" program has helped neighborhood, professional, religious, youth, and other social groups rally around common needs to gain access to quality health care and information on health-related issues. BASICS estimates that the CPH program has provided nearly one-half million family members in Lagos alone with improved access to private health care. With USAID support, the CPH model is being expanded in Lagos and Kano, with plans for extension elsewhere.

Donor Coordination and Sector Leadership. USAID has intensified efforts to encourage other donors and the commercial sector to become more involved in promoting family planning in Nigeria, stimulating increased participation by the British Department for International Development (DFID) and the United Nations Population Fund (UNFPA). In child survival, USAID's collaboration with DFID, UNICEF, and the World Health Organization, and with private voluntary organizations such as Rotary International and Polio-Plus, has been pivotal to Nigeria's successful NIDs since 1996. In preparation for the NIDs, USAID and its implementing partners played an important role in strengthening partnerships among donors, NGOs, local governments, and the Federal Ministry of Health, a role for which the agency has received national recognition from the federal and participating state governments.

Continuing Challenges

Nigeria continues to experience severe epidemics of preventable diseases and remains among the world's greatest focal points for polio cases, HIV infections, and overall population growth. USAID continues to focus on private sector solutions to these problems but is limited by severe budget constraints as well as the tenuous political environment. The Federal Government of Nigeria has finally accepted the need to work closely with NGOs in the health sector; as a result, the government is now working with donor agencies to review and formulate health policies. To advance its NGO-based program and achieve common goals in family planning and health, however, USAID needs a more stable and productive working relationship with the government, increased empowerment of state and local governments, and a renewed commitment to Nigeria, particularly in the area of family planning, within the agency as well as rest of the donor community.



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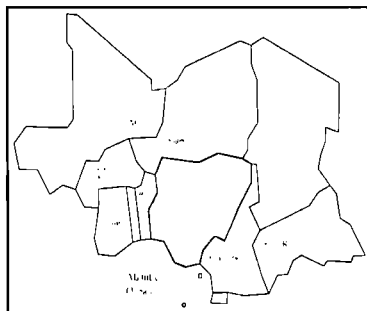
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USAID Country Program Brief, October 1998

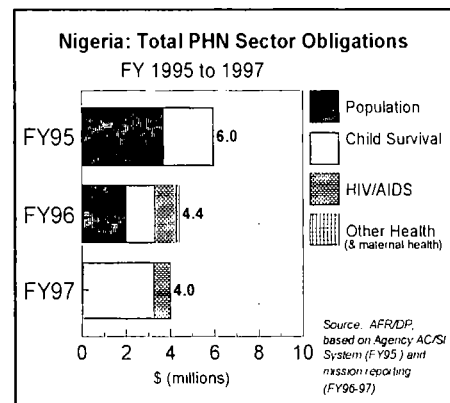
Family Planning and Health Activities in

Nigeria



Population:	106 million
Infant mortality rate:	87 deaths per 1,000 births (1990 DHS)
Adequate nutrition (wt.-for-age):	55% of children age 12–23 months (1990 DHS)
Total fertility rate:	6.0 children per woman (1990 DHS)
Contraceptive prevalence rate:	7% (modern methods, 1995 MICS)
Demographic and Health Surveys:	1986 (Ondo State), 1990 (nationwide)
Multi-indicator cluster survey:	1995 (UNICEF)

Because of U.S. government sanctions against Nigeria, USAID/Nigeria is restricted to working with nongovernmental organizations (NGOs) for specific humanitarian assistance only. As a result, the mission's program has a strong focus on NGO capacity-building and the integration of private and community-based family planning and health services. Though some mission activities are national in scope, the program is primarily active in 14 focus states in the north, southwest, and southeast. Declining USAID funding for family planning and health in Nigeria is summarized for FY 1995–97 in the figure to the right. The mission submitted a country program strategic plan in December 1992 but revised its strategy in November 1994. The mission is pursuing the following strategic objectives and intermediate results (IRs) in family planning and health; these objectives are complemented by a closely integrated special objective in democracy and governance that promotes women's political, economic, and personal empowerment.



Strategic Objective 1: Increase voluntary use of family planning.

IR 1.1: Increase demand for modern contraceptives.

IR 1.2: Increase availability of modern contraceptives.

Strategic Objective 2: Improve maternal and child health practices.

IR 2.1: Improve immunization practices and coverage.

IR 2.2: Improve case management of the sick child.

Special Objective 1: Increase the use of improved, effective, and sustainable responses to reduce human immunodeficiency virus (HIV) transmission and to mitigate the impact of HIV and acquired immune deficiency syndrome (AIDS) pandemic.

IR 1: Increase awareness of HIV/AIDS and sexually transmitted infections (STIs) and how to prevent transmission.

IR 2: Increase availability of condoms.

IR 3: Mitigate impact of AIDS through community, home-based care of people living with AIDS and people affected by AIDS.

Activities in Family Planning and Health

Promotion of Family Planning. Pursuing a community-based strategy, the mission is promoting increased use of family planning through support for distribution of contraceptives; a variety of information, education, and communication (IEC) activities such as radio spots and training of peer educators; institutional development of NGOs, and training of community-based distribution agents and traditional birth attendants. Nationwide, the mission's contraceptive social marketing program is promoting sustainable supply and use of a variety of contraceptives through a grant to Population Services International and PSI's local affiliate, the Society for Family Health.

Child Survival. The mission's child survival program promotes the development of health care alternatives through the private sector, providing local NGOs with the capacity necessary to sustain services for maternal and child care. Of particular importance have been technical and material assistance to NGOs and IEC activities in preparation for Nigeria's national immunization days (NIDs). The mission is promoting adaptation of the integrated management of childhood illnesses (IMCI) approach, improved control and treatment of malaria and diarrheal diseases, improved polio surveillance, and an epidemic preparedness and response (EPR) initiative designed to help NGOs and communities more effectively respond to periodic outbreaks of meningitis, cholera, yellow fever, and other infectious diseases.

Prevention and Control of HIV/AIDS. The mission has a buy-in to the AIDSCAP Project, whose NGO subprojects have promoted institutional capacity building and IEC activities that target higher-risk groups. AIDSCAP has created guidelines and training for treatment of STIs, a mass media awareness campaign, employee education for a variety of commercial and industrial organizations, and works with people living with AIDS to spread awareness at the community level. PSI's social marketing campaigns have also contributed greatly through media spots, IEC, and training of peer educators. Integrated health programs supported by other partners also promote the use of condoms, reduction in numbers of sexual partners, and treatment of STIs. The mission plans to work with community- and home-based organizations that assist patients with AIDS and people affected by HIV/AIDS.

Donor Coordination, Collaboration, and Sector Leadership. Through Nigeria's interagency coordinating committee (ICC), the mission and its partners have successfully coordinated NID inputs and promoted IMCI and EPR approaches in child survival. In family planning, where levels of USAID support have diminished greatly since 1993, the mission has worked closely with other donors to help fill the gap in contraceptive supply; UNFPA, DFID, and the Planned Parenthood Federation of Nigeria (PPF-N) have responded with increased support for distribution of contraceptives in Nigeria.

Global Bureau and USAID/Nigeria Joint Programming Activities

Access to Family Planning Through Women Managers Project (ACCESS) seeks to improve access to quality family planning and reproductive health services by using the resources of trained women managers. In Nigeria, partner organizations started nine subprojects and trained more than 1,300 men and women to serve as distribution agents for family planning services in nine states.

AIDS Control and Prevention Project, is also supporting behavioral research on sexuality and STIs in teenagers. AIDSCAP received a bridging grant in 1997–98 to lead into HIV/AIDS activities to be conducted under the AIDSMARK and IMPACT projects.

Basic Support for Institutionalizing Child Survival is helping to expand health care coverage for lower-income residents of Lagos and Kano through the Community Partnerships for Health program, a model of collaboration between community-based organizations and private providers. The project is also engaged in the formulation and implementation of training curricula and treatment guidelines for use by NGOs receiving USAID support.

Centers for Disease Control and Prevention (CDC) is working to increase the technical capacity of NGO family planning and health services. Of particular significance has been assistance to NGOs preparing for immunization campaigns during epidemic outbreaks in the north. CDC is also supporting efforts of the River Blindness Foundation to eradicate onchocerciasis.

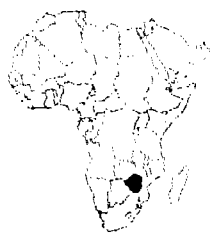
Johns Hopkins University/Population Communication Services conducts training in IEC material development for USAID-supported NGOs active in family planning and health.

Bureau for Humanitarian Response, Office of Private & Voluntary Cooperation

Carter Center/Global 2000 Program is receiving matching grant funding for river blindness eradication.



This USAID Country Program Brief was prepared for the Human Resources Division, Office of Sustainable Development, USAID Africa Bureau (AFR/SD/HRD), by the Center for International Health Information (CIHI). Questions and comments can be directed to CIHI (info@cihi.com).



ZIMBABWE

U.S. Agency for International Development (USAID)
Population, Health, and Nutrition Briefing Sheet

Country Profile

Zimbabwe is a country with enormous development potential. It is endowed with a wealth of human and natural resources, an evolving industrial base, diversified economy, and well-developed infrastructure. After South Africa, Zimbabwe is the most highly developed country in the southern Africa region, however, Zimbabwe also faces serious development problems. These include recent economic stagnation, deepening poverty among the majority of the population, and a government that appears increasingly remote from its citizens. Most grave of all, among the 11 million adults, an estimated 22 percent are HIV positive, and nearly 200,000 AIDS-related deaths occur annually.

USAID Strategy

USAID's objective in family planning and health is aimed at reducing two key threats to sustainable development in Zimbabwe: rapid population growth and the spread of HIV/AIDS. USAID has had a long and highly productive development partnership with Zimbabwe, and the country is projected to graduate from USAID assistance in 2003. As the lead donor to family planning efforts, USAID has contributed significantly to rapidly increasing the use of modern family planning in Zimbabwe. Intensified assistance to promote HIV/AIDS prevention has also helped establish a variety of potentially effective programs in the public and private sectors. The greatest challenge now is to ensure that the positive impacts of USAID programs are sustained beyond Zimbabwe's scheduled graduation from USAID assistance.

Major Program Areas

Improved Quality and Availability of Family Planning Services. USAID works with public and private providers to increase demand for and quality of family planning services, promoting a range of contraceptives, including the use of longer-acting contraceptive methods, and their increased availability, particularly to adolescents. USAID is the leading supplier of oral contraceptives in Zimbabwe and recently introduced the female condom. USAID is also helping both the public and private sectors address contraceptive supply and management needs.

Improved Capacity for Service Delivery. USAID is working with the Government of Zimbabwe and non-governmental organizations to improve their capacity to provide a wide range of reproductive health services, including HIV/AIDS prevention. USAID also supports improved health care financing mechanisms, particularly cost recovery systems. In the policy arena, USAID is working to reduce barriers to reproductive health services, such as tariffs on contraceptives, and promoting improved policies relating to HIV/AIDS prevention.

Improved Behavior Change Communication. USAID's support promotes changes in high-risk behavior among women and young adults, and in selected occupational groups. Efforts to improve prevention of HIV/AIDS in Zimbabwe include condom social marketing, peer educators, and voluntary counseling and testing programs.

Results

- Increased use of modern contraceptives from 26 percent of women in 1984 to 42 percent in 1994.
- Reduced rates of fertility, from 6.5 children per woman in 1984 to 4.3 in 1994.
- Increased choice of contraceptive products. In 1997, the CARE™ female condom in Zimbabwe was the first female condom to be marketed in Africa. Over 126,000 were sold, three times more than expected, empowering women to determine choices about family planning and HIV prevention behavior.
- Increased perception of the personal risk of acquiring HIV, from 3 percent of males in 1994 to 22 percent in 1997, and from 7 percent of females in 1994 to 23 percent in 1997.

Success Stories

Zimbabwe's family planning program, which USAID has supported since 1980, is possibly the highest-impact program in sub-Saharan Africa. Since 1984, the contraceptive prevalence rate has increased by 55 percent and the total fertility rate—the average number of children the average Zimbabwean woman will have in



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her lifetime—has declined by a third. Due in large measure to USAID assistance, Zimbabwe now has the lowest recorded total fertility rate in sub-Saharan Africa. USAID continues to support efforts to increase the range and quality of family planning services available in Zimbabwe and is exploring various means to ensure that these services are sustained after USAID support ends.

In the face of the public sector financial crisis, USAID has helped ensure that Zimbabwean women can receive high-quality reproductive health services at affordable prices from technically qualified private providers. When the Zimbabwe National Family Planning Council, a government parastatal, asked USAID to help facilitate a larger private sector role in the promotion and provision of family planning, USAID collaborated closely with the Council to launch a successful new initiative in 1997. The Zimbabwean private sector participated with great enthusiasm; training courses were over-subscribed, and pharmacists, not in the original design, asked to be included. The results were outstanding: 211 new family planning sites have opened; 53 physicians, 85 nurses and 92 pharmacists were trained; several handbooks were duplicated; and counseling rooms opened in seven model pharmacies. USAID assistance, including extensive consultations with Zimbabweans, was at the right place at the right time.

Continuing Challenges

USAID/Zimbabwe's portfolio in family planning and HIV/AIDS prevention will be brought to a conclusion over the next two to five years. With the public sector fiscal crises, there is a growing need to firmly establish sustainable private sector alternatives. And as the HIV/AIDS pandemic worsens in Zimbabwe, the need for sustainable preventive programs becomes even more urgent. Awareness of HIV/AIDS has become nearly universal, but as the pandemic worsens, USAID is shifting from a peer education strategy to one emphasizing voluntary testing and counseling services. In both areas, USAID's programmatic emphasis will be on ensuring program sustainability after the agency's departure. The successful transition to self-supporting programs will be the most important USAID legacy in Zimbabwe.



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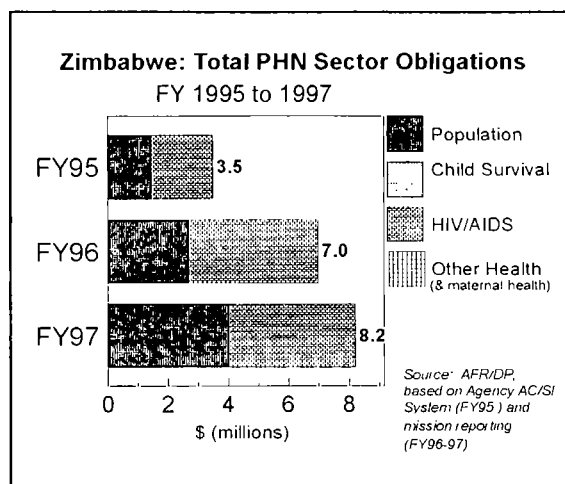
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USAID Country Program Brief, October 1998
Family Planning and Health Activities in
Zimbabwe



Population:	11.7 million (UN estimate for 1997)
Infant mortality rate:	53 deaths per 1,000 births (1994 DHS)
Adequate nutrition (wt.-for-age):	77% of children age 12–23 months (1994 DHS)
Total fertility rate:	4.3 children per woman (1994 DHS)
Contraceptive prevalence rate:	31.1% (all women/modern methods, 1994 DHS)
Demographic and Health Surveys:	1988, 1994, 1999 (planned)
Multi-indicator cluster survey:	1996 (UNICEF)

USAID/Zimbabwe is the lead donor in family planning efforts in Zimbabwe and has intensified its assistance to promote prevention of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS). The mission is currently operating under a close-out country strategic plan (CSP) for fiscal years 1997–2003, during which all USAID assistance will be gradually phased out, and plans to end assistance in family planning and health by 2002. The greatest challenge is to ensure that positive effects of USAID programs are sustained beyond the country's graduation, which is scheduled for 2003. A summary of agencywide funding trends for family planning and health activities in Zimbabwe in 1995–97 is provided in the figure. The mission's results framework includes the following strategic objective and intermediate results (IRs) in family planning and health.



Strategic Objective 3: Reduce fertility and increase use of HIV/AIDS prevention measures.

IR 3.1: Increase contraceptive use.

IR 3.2: Increase availability and knowledge of proven HIV/STD prevention services.

Activities in Family Planning and Health

Improved Quality of Family Planning. The mission works with public and private providers to increase demand for and quality of family planning services, promoting contraceptive diversity, with emphasis on longer-acting methods, and increased availability to adolescents in particular. USAID is the leading supplier of oral contraceptives in Zimbabwe and recently introduced the female condom. Support to the public sector is being phased out while private sector efforts, particularly those under the PROFIT project, have been intensified.

Contraceptive Supply and Logistics. USAID/Zimbabwe is supporting both the public and private sectors, particularly the parastatal Zimbabwe National Family Planning Council, to address contraceptive supply and management needs. A recently initiated five-year condom social marketing program being implemented by Population Services International (PSI) aims to improve HIV/AIDS prevention. The mission has worked with the Government of Zimbabwe to decentralize all services and to include a greater proportion of the private sector and nongovernmental organizations (NGOs) in efforts to increase availability of contraceptives.

Improved Policies for Reproductive Health. The mission is working with the Government of Zimbabwe to reduce tariffs on contraceptives and other barriers to reproductive health services and promoting improved policies for HIV/AIDS and associated interventions. The mission also supports improved health care financing mechanisms, particularly cost recovery systems.

Improved Capacity for Service Delivery. The mission is working with the Government of Zimbabwe and NGOs in the health sector to improve their capacity to provide a wide range of reproductive health services. In particular, PACT is implementing a five-year program to bolster NGO capacity to provide expanded and improved HIV/AIDS prevention and counseling services.

Improved Behavior Change Communication. USAID's interventions have supported changes in high-risk behavior in selected occupational groups, including uniformed services, commercial farmers, university students, and factory and transportation workers. The mission is now focusing on women and young adults and seeks to enhance the role that NGOs currently play in behavior change communication efforts. Emphasis has recently been shifted from a strategy based on peer education to facilitating voluntary counseling and testing.

Global Bureau and USAID/Zimbabwe Joint Planning Activities

AIDS Control and Prevention Project has worked with various target groups to:

- Develop an HIV/AIDS prevention program in Bulawayo to increase the adoption of safer sexual behaviors by vulnerable groups, particularly commercial sex workers and their clients;
- Develop prevention interventions in conjunction with other partners targeting high-risk behaviors among defined groups, including rail workers, truckers, and armed forces members and their families;
- Train peer education trainers for a large department store chain; and
- Expand peer education programs and reinforce existing pilot activities involving a single women's association, school children, people living with AIDS, and small businesses.

AVSC International, in conjunction with the Zimbabwe National Family Planning Council, is working to expand the availability of long-term contraception.

Family Health International, in conjunction with the University of Zimbabwe, is conducting a study assessing the impact of contraceptive availability and usage on secondary and college students' vocational and academic pursuits, women's self-esteem, and women's economic decision-making and participation within the workforce, as well as the effects of male attitudes and related gender issues on women's experience with family planning.

Johns Hopkins Program for International Education in Reproductive Health is providing on-site clinical training for health care workers to improve quality of services and is working through the University of Zimbabwe, Department of Obstetrics and Gynecology, to assess the value of certain clinical procedures.

Johns Hopkins University/Population Communication Services

Population Council is working with the Zimbabwe National Family Planning Council to improve its evaluation and research unit and is researching means to integrate sexually transmitted infection information into family planning services more effectively.

SOMARC is working to expand condom distribution to independent distributors and entrepreneurs in areas not covered by the existing system.

SEATS provides training in quality improvement among select family planning service providers.



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SOUTH AFRICA

U.S. Agency for International Development (USAID)
Population, Health, and Nutrition Briefing Sheet

Country Profile

Richly endowed with human and natural resources, South Africa is the fourth most populous nation and has the largest and most developed economy in sub-Saharan Africa. Still recovering from a legacy of social and political inequities, South Africa faces the challenges of pervasive poverty and the need to improve services for the disadvantaged.

USAID Strategy

USAID's program in South Africa began in 1995, the country's first full year of a democratically elected government with a constitution, bill of rights, and policy of transformation to foster equity among all its citizens. The South Africa mission has launched a 10-year program (1996–2005) that supports the development objectives of the Republic of South Africa, USAID, and the U.S.-South Africa Binational Commission. USAID's health activities are addressing inequities in access to primary health care (PHC) among South Africans. The strategy includes

- Expanding PHC services to all South Africans under a unified system,
- Improving management of the health care delivery system, and
- Increasing the capacity to deliver prevention and treatment services for HIV/AIDS and sexually transmitted infections (STIs).

Major Program Areas

Primary Health Care System Strengthening. The "Equity Project," a seven-year initiative of health training and sector reform activities, is USAID's main activity for strengthening PHC. Initial activities are designed to strengthen PHC management and service delivery systems in the Eastern Cape Province; the intention is to formulate successful activities into models for nationwide replication. In addition to technical emphases on improving the quality of reproductive and child health care and nutrition, the initiative includes support to develop effective health information and referral systems.

HIV/AIDS Prevention Activities. USAID supports a number of nongovernmental organizations (NGOs) and the national Department of Health with training of staff and community leaders in HIV/AIDS prevention. Workshops and group presentations focus on HIV/AIDS prevention messages and emphasize educating adolescents and other high-risk groups. A major new initiative is designed to help build capacity to plan and implement HIV/AIDS programs in the national Department of Health and at provincial and district levels.

Demographic Health Survey (DHS). Working with the Government of South Africa, USAID will help implement and disseminate the findings of the 1998 South Africa DHS. The DHS will establish baseline data for health sector planning and monitoring.

Results

- Publication and provincewide introduction of a standardized national PHC package in the Eastern Cape Province; this is the only province where the national policy has been interpreted and realized. With USAID assistance, 43 percent of clinic professional nurses in the Eastern Cape were trained in PHC clinical skills, and by 1997, 46 percent of clinics had at least one staff member who was trained in management skills.
- A National AIDS Strategy that resulted from a USAID-supported National AIDS Convention. A National STI/HIV/AIDS Review will guide the strategy's implementation through regional coalitions among policy and civic leaders.
- A USAID-supported NGO developed a legal charter to prevent discrimination against persons living with AIDS.
- More than 220 nurses were trained in the "syndromic approach" to HIV/AIDS diagnosis, a cost-effective method based on diagnosing by symptom rather than by running clinical tests.



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Success Stories

USAID has supported extensive policy dialogue and an exploration of enhanced cost-recovery methods to improve PHC services' financial sustainability in South Africa. A USAID-funded study of the Uitenhage Hospital contract with a private provider group showed that public/private partnerships can result in improved quality for all patients and generate increased resources that can be used in under-funded facilities. USAID plans to provide technical assistance to replicate such partnerships elsewhere.

With USAID technical assistance, Eastern Cape Province developed and established clear guidelines for referrals to reduce the burden on hospitals. As a result, hospital outpatient load diminished significantly. For example, the Umtata General Hospital, the largest hospital in the province's poorest region, closed its outpatient department for general walk-in services, reducing the patient load in the hospital by nearly 40,000 patients per month. Meanwhile, with assistance from the Kellogg Foundation, the Eastern Cape Department of Health created four community-based rural health centers serving the catchment area around the town of Umtata, resulting in significant financial savings and reducing the hospital's burden.

USAID-assisted NGOs have been providing a substantial contribution to community outreach and HIV/AIDS awareness activities in rural and informal settlement areas. Interventions designed and implemented by community members target the general population and individuals at increased risk for HIV infection, such as adolescents. Peer-led prevention education programs have been successful in creating a nonjudgemental environment for the exchange of ideas on issues such as sexuality, STIs, reproductive health, values clarification, and decision-making skills. The USAID-funded AIDSCAP Project played a pivotal role in connecting these NGOs to a variety of information, technology, and resources that not only facilitate their understanding of HIV/AIDS issues, but also help in project implementation.

Continuing Challenges

South Africa's major health care challenge is to achieve an equitable distribution of basic health care. Unifying two vastly different health systems in South Africa requires that USAID's technical assistance promote appropriate health systems management and development. In addition, USAID's integrated PHC project must integrate HIV/AIDS/STI information and counseling into basic community-level health services.



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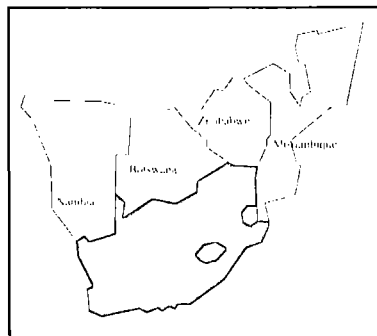
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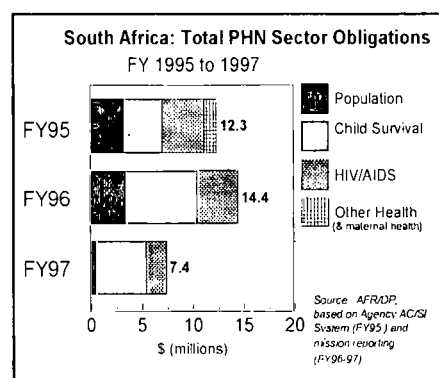
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USAID Country Program Brief, October 1998
Health Development Activities in
South Africa



Population:	40.6 million (1996 Census)
Infant mortality rate:	48 deaths per 1,000 births (UN est. for 1997)
Adequate nutritional status:	not available
Total fertility rate:	3.8 children per woman (UN est. for 1997)
Contraceptive prevalence rate:	60% (all women/modern methods, 1994)
Demographic and Health Survey:	1998 (planned)

The South Africa mission has launched a 10-year program (1996–2005) to support the development objectives of the Republic of South Africa and USAID as well as the U.S.-South Africa Binational Commission. The mission submitted a revised country strategic plan in March 1997 specifying a goal of support for sustainable transformation and a subgoal of political, social, and economic empowerment. The program of assistance is assessed on an annual basis in a joint, bilateral exercise with the government of South Africa. Agencywide funding trends for health development activities in South Africa in 1995–97 are summarized in the figure to the right. The mission's results framework includes one strategic objective (SO) and five intermediate results (IRs) in health development. Activities under this objective are complemented by efforts under other SOs to strengthen local government (SO1) and to improve municipal service delivery (SO6).



Strategic Objective 3: More equitable, unified, and sustainable systems delivering integrated primary health care (PHC) services to all South Africans.

IR 3.1: Increase access to integrated package of PHC services.

IR 3.2: Effective health care referral systems are operational first in the pilot province (Eastern Cape) and then nationally.

IR 3.3: Improve management of integrated PHC [including human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) and sexually transmitted infection (STI)] delivery systems at the provincial level.

IR 3.4: PHC training program is strengthened and institutionalized at the provincial level initially in the pilot province (Eastern Cape).

IR 3.5: Increase capacity of the PHC system to deliver appropriate HIV, STI, and tuberculosis (TB) prevention and treatment.

Activities in Health Development

The EQUITY Project. This seven-year bilateral program, nearing its first full year of implementation, is the centerpiece of the mission's program for integrated primary health care. The initial activities focus on strengthening management, financial, and service delivery systems for primary health care in the Eastern Cape Province. Successful activities will serve as lessons, pilots, and models for replication on a nationwide basis. After one full year of implementation, a number of results are already evident:

- A unified drug logistics system has been fully implemented and is being scaled up to the national level.
- The health information system, developed under Equity, is being implemented in the Eastern Cape Province and will be scaled up nationally.
- Implementation of the health care referral system has started in the Eastern Cape.
- The DOTS methodology for tuberculosis diagnosis and treatment is being implemented for the first time in ten locations in the Eastern Cape.
- Condoms are widely and freely available in health clinics throughout the Eastern Cape Province, without the need for consultation with health personnel.

- Public/private partnerships involving the administration and management of small hospitals has been successfully initiated in the Eastern Cape.

The HIV/AIDS Project. This new, five-year program follows mission support in the area of HIV/AIDS since 1991, and is in response to the government of South Africa's recently launched "Partnerships Against AIDS" campaign. The main areas of support will include awareness raising and capacity strengthening, support for the establishment of a national STI reference center, and collaboration with ongoing South African initiatives for vaccine development. These activities will be carried out in close collaboration with the US Centers for Disease Control, the US National Institutes of Health, and USAID/Global Bureau Cooperating Agencies.

To date, mission initiatives in HIV/AIDS have focused on training, community outreach, and institutional capacity building. These have been carried out with the assistance of CDC and Global Bureau Cooperating Agencies. Key results with USAID funding include:

- The National AIDS Convention prepared a national AIDS strategy plan, which has been the backbone of the country's response to the epidemic.
- Work by a local NGO led to the development of a legal charter to prevent discrimination against people living with AIDS.
- A pilot program in a mining community to address STIs has led to the mining company picking up costs of the service delivery, with replications likely in other mining communities.
- The major labor unions have drafted a consensus position document on workplace policies and guidelines on AIDS.

The Amy Biehl Foundation. This foundation is a community-based NGO that focuses on integrated health and community development in key townships surrounding Cape Town. Established shortly after the killing of Amy Biehl in 1993, the Foundation's activities include youth-centered reproductive health and HIV/AIDS education, community development, outreach, and training. Virtually all of the Foundation's programs are carried out in close collaboration with the public sector and with specialized local NGOs.

The Binational Commission (BNC). The Gore-Mbeki Binational Commission establishes a framework for the collaborative relationship between the US and South Africa in all matters, including development assistance. USAID forms part of the health working group of the BNC and, as such, looks for collaborative opportunities that are consistent with USAID and USG priorities. USAID partners closely with the US Centers for Disease Control and the US National Institutes for Health in identifying and implementing joint programs. USAID has also been in discussions with the Medical University of South Africa (MEDUNSA), School of Public Health, in identifying further areas of collaboration.

USAID/Global Bureau and USAID/South Africa - Joint Programming Activities

Demographic and Health Surveys (DHS), working with the government of South Africa, will help implement the 1998 South Africa DHS and to disseminate the survey's findings. While developing baseline data for health sector planning and monitoring, the DHS will also increase local capacity to replicate these efforts in the future with little or no USAID assistance.

Environmental Health Project

POLICY Project has been assisting with AIDS awareness raising activities, and with technical projections. Staff from the Policy Project have facilitated capacity building workshops and seminars with provincial and community-based organizations to strengthen their capacity to raise awareness amongst their target populations. The Project has also assisted in analyzing, estimating, and projecting the pattern of the epidemic into the future. This last activity is an excellent example of donor coordination, as the European Union, DFID, and USAID all participate and share the costs of the technical meetings.

Other Collaborative Efforts. A number of Global Bureau Cooperating Agencies are working in the area of linkages between reproductive health and HIV/AIDS, including FHI, AVSC, and Pathfinder; the QAP project is coordinating with the Council for Health Service Accreditation of Southern Africa to experiment accreditation processes for clinic and other lower level facilities; ILSI and OMNI are working closely with the National Department of Health in implementing the Department's Micronutrient Fortification Strategy.

USAID/Bureau for Humanitarian Response, Office of Private & Voluntary Cooperation Child Survival Grantees as of 1998

Medical Care Development, Inc. is focusing on the prevention and control of common childhood illnesses, maternal and newborn care, and improved immunization coverage in KwaZulu/ Natal Province.

World Vision Relief and Development, Inc. has a four-year project (through August 1999) focusing on nutrition, HIV/AIDS, childhood diseases, immunization, family planning, and maternal and newborn care in KwaZulu/Natal Province.



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