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FAX MESSAGE



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Pages:

Date:

Subject: Danger Thresholds

These two papers discuss the
"Thresholds" of a generalized
epidemic.

1% national level adult prevalence
or

5% urban adult prevalence

Both can be used as indicators of
an impending rapid rise in adult infections

The Level and Distribution of HIV Infection in Developing Countries

DEVELOPING COUNTRIES FIND THEMSELVES AT DIFFERENT stages of the HIV/AIDS epidemic due largely to differences in the timing of the introduction of HIV and in sexual and drug-injecting behavior. In this section, we classify countries according to the level and distribution of HIV infection, which, as we shall see, has a significant influence on the cost-effectiveness of preventive interventions (chapter 3), and on the scope of interventions to mitigate the impact of the epidemic (chapter 4).

Despite the obvious value of a country typology, low-quality and inadequate data and our still-incomplete knowledge of the disease itself make any evaluation of a country's status very tentative. Because collecting incidence data is very costly, HIV monitoring systems collect data on prevalence. However, prevalence data are rarely collected for representative samples of the population. Our typology is therefore necessarily based on prevalence among frequently monitored groups with presumed high-risk behavior—sex workers, injecting drug users, homosexual and bisexual men, STD patients, and the military—and one frequently monitored group assumed to be at lower risk—pregnant women attending antenatal clinics. Most of these groups present significant sampling problems. For sex workers, injecting drug users, and homosexual and bisexual men, it is often impossible to identify a representative sample. Even the prevalence data for pregnant women, which may be systematically collected, are not usually nationally representative but are confined to women in urban areas who attend certain clinics. Further, because women only become pregnant if they are sexually active and most pregnant women are from younger age groups, women at antenatal clinics cannot be a proxy for the general population. Thus, much of the information about HIV prevalence comes from ad hoc samples, and in some cases the samples are very small.

Notwithstanding these and additional problems that we discuss below, by using available data from research studies and epidemiological surveillance, countries can be classified according to two broad criteria: first, the extent of HIV infection among groups of people often found to engage in high-risk behavior,¹⁷ and, second, whether the infection has spread to populations assumed to practice lower-risk behavior. The typology includes three stages of the HIV/AIDS epidemic:

- *Nascent:* HIV prevalence is less than 5 percent in all known subpopulations presumed to practice high-risk behavior for which information is available.
- *Concentrated:* HIV prevalence has surpassed 5 percent in *one or more* subpopulations presumed to practice high-risk behavior, but prevalence among women attending urban antenatal clinics is still less than 5 percent.
- *Generalized:* HIV has spread far beyond the original subpopulations with high-risk behavior, which are now heavily infected. Prevalence among women attending urban antenatal clinics is 5 percent or more.



Due to a lack of data, this typology does not address several important factors. In particular, it does not distinguish between countries based on incidence, the rate of new infections. As we have seen, because HIV cannot be cured and lasts many years, prevalence can rise even if incidence is declining. Prevalence data do not reveal whether the number of new infections is increasing, declining, or level, either in specific subpopulations or among the entire population.¹⁸ Moreover, prevalence data are available only for a few specific subpopulations. Prevalence can stabilize in one or more of these subpopulations even as it spreads rapidly through others that are not monitored. These shortcomings highlight the importance to governments of collecting additional data on HIV incidence and prevalence so that policymakers can formulate an effective response (box 2.7).

Even with much better data on incidence and prevalence, we would still lack sufficient behavioral information to confidently predict the course of the epidemic in a specific country. Surveys of sexual behavior by the World Health Organization's Global Programme on AIDS in the late 1980s and early 1990s were among the first attempts to measure behavioral risk factors for HIV infection in developing countries (Cleland and Ferry 1995). WHO also studied drug-injecting behavior and the risk of HIV infection in thirteen cities in industrial and developing countries in 1989 (WHO, Program on Substance Abuse 1994). These and more recent studies have increased our knowledge about risk factors in developing countries. Even so, almost two decades into the epidemic only a few geographical areas and a handful of developing countries have been covered. Policymakers in most countries simply do not know how many people engage in commercial sex, casual sex, or injecting drug use; how frequently they do so; or the extent to which they take actions to re-

Box 2.7 Monitoring the Spread of HIV

HIV/AIDS PROGRAM PLANNERS NEED TIMELY data on trends in HIV prevalence among certain sub-populations to design, implement, and monitor the impact of HIV/AIDS interventions. The World Health Organization and UNAIDS recommend that countries conduct periodic surveys of HIV prevalence among populations likely to engage in high-risk behavior, such as patients at STD clinics and people enrolled at drug treatment centers (AIDSCAP and others 1996, Chin 1990, Sato 1996). Residual blood collected for other tests performed at these facilities is tested for HIV after removing all information that would allow individuals to be identified, to monitor levels and trends in HIV prevalence while maintaining the confidentiality of test results. This is called the "unlinked, anonymous" method of HIV surveillance. In countries where HIV prevalence has reached significant levels in populations with high-risk behavior, surveillance should be extended to populations that practice low-risk behavior, such as women attending antenatal clinics.

Monitoring HIV prevalence of these "sentinel" populations—often referred to as "sentinel surveillance"—is preferred because large-scale surveys of

HIV and STD prevalence in the general population are expensive and often do not capture enough people with high-risk behavior to detect trends. Furthermore, for ethical reasons, HIV testing in these larger surveys can only be done with the informed consent of participants. This will bias the results if people who choose not to participate are more or less likely to engage in risky behavior than those who do participate. At any rate, HIV is unlikely to show up in a major way in the general population until fairly late in the epidemic. Important trends can be detected by monitoring sentinel populations, with the understanding that these groups are not representative of the general population and the results are not adequate to project the number of current and future AIDS cases. Sentinel surveillance should be augmented by an AIDS case-reporting system, which will help in estimating the start date of the epidemic and the impact on mortality and the health system. HIV and AIDS epidemiological surveillance is only one component of the essential information that government has a key role and comparative advantage in providing; other types of information are discussed in chapter 3.

duce their risk of contracting HIV. Basic information on the levels of condom use and partner change among the general population is also unavailable. Without this information, it is simply not possible to accurately predict the course of the epidemic.

For these reasons, we cannot predict with certainty in which low-prevalence countries HIV infection will take off or at what level prevalence will stabilize. Some countries where HIV is currently regarded as a minor problem may turn out to resemble eastern Africa, where the virus spread rapidly through groups with high-risk behavior and widely into the general population. In other countries HIV may infiltrate groups with high-risk behavior but never evolve into a generalized epidemic, even without intervention. Or, knowledge of HIV may cause people to adopt less risky behavior, with or without government urging. Countries

population
 enough peo-
 friends. Fur-
 ing in these
 re informed
 he results if
 re more or
 n those who
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 lation until
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 cause people to
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with a high incidence and prevalence of STDs other than HIV are likely to be particularly vulnerable to a large and rapidly spreading HIV epidemic, because STDs and HIV are spread by the same behavior and STDs enhance HIV transmission. However, since most other STDs can be cured, countries with low STD prevalence may still have behavior patterns that are conducive to the rapid spread of HIV.

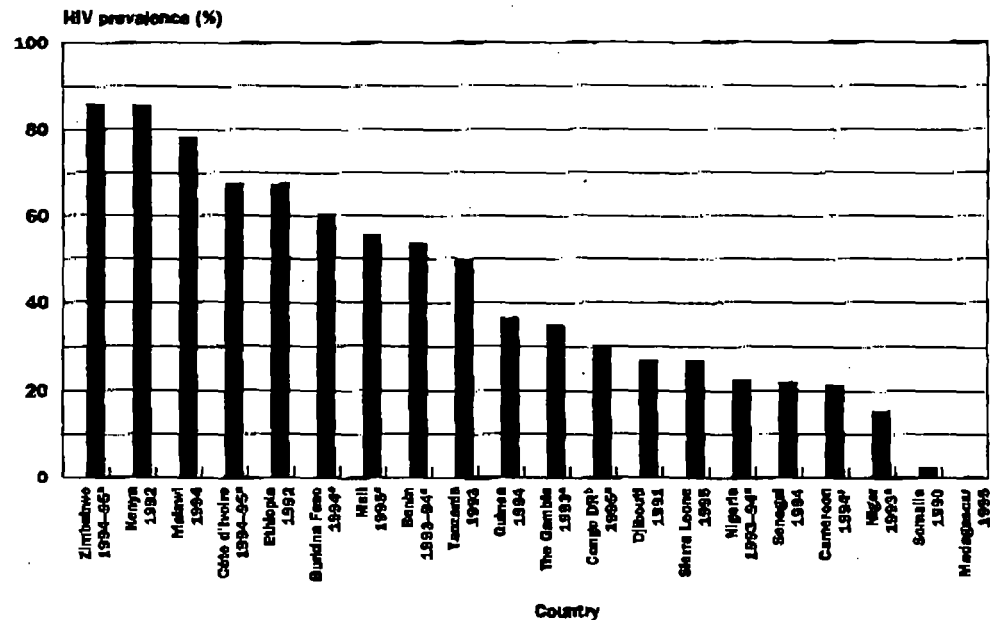
Lacking the information to predict the course of the epidemic, and given the terribly high human and financial costs of HIV/AIDS, *it would be prudent to assume the worst and act aggressively to minimize the epidemic as early as possible.* The remainder of this chapter uses this typology to outline the state of the epidemic as of mid-1996 in four developing regions. A list of countries and estimates of prevalence in different subpopulations are in table 1 of the statistical appendix to this report.

Africa

Roughly 90 percent of all HIV transmission in Sub-Saharan Africa is by heterosexual sex. HIV has spread rapidly among people with high-

In seventeen Africa countries, more than 20 percent of female sex workers in cities are infected with HIV.

Figure 2.11 HIV Infection in Urban Sex Workers in Sub-Saharan Africa, Various Years



^a HIV-1 and/or HIV-2.

^b Formerly Zaire.

Source: U.S. Bureau of the Census (database), 1997.

V. The different epidemic states

Classification of epidemic states has shifted as the world has learned more about the heterogeneity of HIV. For the purposes of surveillance, UNAIDS and WHO suggest a classification that describes the epidemic by its current state—low-level, concentrated, or generalized. This typology recognizes that a country may shift from one state to another over time. It is important to stress,

however, that such a shift is by no means an inevitable progression. The various epidemic states are described below. The rationale for categorization is given, followed by a classification based on prevalence in different populations. These numerical cut-off points are not rigid scientific classifications. They act, rather, as a convenient proxy for classification based on the dynamic of an epidemic.

Three different levels

Low-level

- **Principle:** Although HIV infection may have existed for many years, it has never spread to significant levels in any sub-population.

Recorded infection is largely confined to individuals with higher risk behaviour: e.g. sex workers, drug injectors, men having sex with other men. This epidemic state suggests that networks of risk are rather diffuse (with low levels of partner exchange or sharing of drug injecting equipment), or that the virus has been introduced only very recently.

- **Numerical proxy:** HIV prevalence has not consistently exceeded five percent in any defined sub-population.

Concentrated

- **Principle:** HIV has spread rapidly in a defined sub-population, but is not well-established in the general population. This epidemic state suggests active networks of risk within the sub-population. The future course of the epidemic is determined by the frequency and nature of links between highly infected sub-populations and the general population.
- **Numerical proxy:** HIV prevalence consistently over five percent in at least one defined sub-population. HIV prevalence below one percent in pregnant women in urban areas.

Generalized

- **Principle:** In generalized epidemics, HIV is firmly established in the general population. Although sub-populations at high risk may continue to contribute disproportionately to the spread of HIV, sexual networking in the general population is sufficient to sustain an epidemic independent of sub-populations at higher risk of infection.
- **Numerical proxy:** HIV prevalence consistently over one percent in pregnant women.



The issues faced by countries tracking HIV and risk behaviour differ in different epidemic states. The remainder of this document is therefore organised around those different epidemic states. It is recommended that each HIV and STI prevention and care programme identify which epidemic state the country is in and focus surveillance on the needs of that state.

Although the surveillance needs for low-level and concentrated epidemics differ, the issues faced by planners aiming to strengthen systems in these epidemics are largely similar. Issues faced in low-level and concentrated epidemics are therefore discussed together, although separate recommendations are made for surveillance in the two epidemic states.

Obviously, there is a certain circularity implicit in designing surveillance systems according to

epidemic state. Without surveillance systems, how can a country determine the shape and magnitude of its epidemic and so know which state it is in?

In practice, most countries have some existing surveillance systems or at least know enough about their epidemic to identify into which broad category it falls. Again, large and diverse countries may tailor surveillance systems to needs at a provincial or lower level, using data generated to plan and evaluate responses locally within a national framework.

Where no data at all are available, countries should consider following recommendations for low-level epidemics. If these initial surveillance activities reveal that the epidemic has already progressed to a concentrated stage, they can then expand surveillance activities as needed.

Working Paper:
**Accelerating the Implementation
of HIV/AIDS Prevention and
Mitigation Programs in Africa**

**September 1999
Draft in Progress**



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

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

ACCELERATING THE IMPLEMENTATION OF HIV/AIDS PREVENTION AND MITIGATION PROGRAMS IN AFRICA

1. INTRODUCTION

The growing HIV/AIDS prevalence rates in several African countries have potentially undermined the prospects for sustainable development and unraveled the social and political fabric. The problem faced in most African countries is not *what* to do in dealing with the epidemic, as proven packages of interventions exist. The problem is *how* to provide these packages on a large scale and in a concerted and timely manner to make a difference. This will require an unconventional mobilization of all sectors of the economy and all sections of the society in the fight against the disease.

The purpose of this paper is twofold:

- To share experiences in dealing with constraints to expanding and improving HIV/AIDS program implementation based on USAID's work in the field over the past 15 years.
- To identify new issues, raised by country missions and partners in the field, in developing a bolder response commensurate with the gravity of the expanding HIV/AIDS pandemic in the region.

The main points of the paper are outlined in the executive summary. The details, not necessarily in the same order, are presented in section three, addressing the implementation constraints.

2. EXECUTIVE SUMMARY

Common knowledge of HIV/AIDS implementation programs in African countries indicates the following basic requirements for success:

- **Commitment** on the part of the policy makers, implementers, civil society, and donors to prevent the disease and mitigate its impact within a defined period of time.
- **Capacities to plan, manage, and implement**, on a countrywide basis, a set of interventions that have already proven effective on a smaller scale.
- **Coordination** among the donors and agencies involved in HIV/AIDS program implementation to use resources most effectively for meeting priority needs.
- **Cost** and the cost-effectiveness of different program interventions.

- Improving the capacity of the public sector to procure commodities in a timely manner.
- Coordination
 - Forming a coalition among bilateral and multilateral donors to work centrally and at the country level.
 - Providing substantial funding to provide local agencies with the technical and administrative support needed to ensure that commodities are procured and distributed in a timely fashion.
- Cost
 - Working with HIV/AIDS country programs to provide adequate funding and technical assistance to implement proven intervention packages on a national scale.
 - Engaging in concerted and targeted actions in high transmission areas to achieve synergy and maximum impact.
 - Undertaking cost-effectiveness studies for different individual and packages of interventions to make best use of available resources.

3. ADDRESSING IMPLEMENTATION CONSTRAINTS

A. STRENGTHENING COUNTRY COMMITMENT

Political and public commitments are critical for mobilizing financial and human resources, for stimulating behavior change, and for creating a supportive environment for program implementation. Commitment is singularly important for mounting the type of effort required at this stage.

USAID field missions in all sub-Saharan African countries, with the exception of Uganda, Senegal, and recently Zambia, have reported consistently that levels of country commitment do not correlate with the seriousness of the HIV/AIDS situation. While political will at the highest level is critical, commitment is important at all levels and from all agencies—including governmental and non-governmental agencies responsible for different sectors, opinion leaders, community leaders, business and labor leaders, parliamentarians, religious leaders, and youth and women groups. In addition, commitment must be sustained until the epidemic is under control.

HIV testing and counseling resulted in behavior changes of individuals and couples. Obviously, the currently limited scale of voluntary testing and counseling provision requires rapid expansion.

Focusing on the stigma for women and orphans: HIV/AIDS presents a number of issues specific to women, their role in society, and their relationships to men. In Africa, women are disenfranchised in terms of their relative risk for HIV. In addition to their increased risk for transmission, they are at greater risk than men for increased poverty given their lack of inheritance rights and overall social standing. Special emphasis on the issues facing women is necessary, including the implications of the stigma associated with the disease. In several countries, women on the economic brink have strongly expressed desire and readiness to undertake activities to improve their status. Organizations like the Foundation for International Community Assistance (FINCA) have responded to these demands by providing seed money and training in a few countries, on a limited scale. These economic activities go beyond poverty reduction; they have the potential to prepare women to deal with societal stigma.

Economic activities should also be focused on young men and women who are unemployed and do not have access to information and counseling. This population is especially vulnerable and wary of seeking information about HIV/AIDS, due to fear of stigma.

Orphans in Africa are another vulnerable population with special problems. To date, the U.S. government has earmarked \$10 million for the care of orphans, of which \$7 million has already been allocated to several African countries. USAID has made additional funds available through the Displaced Children and Orphans Fund (DCOF). This fund has thus far supported a number of community-level activities for the care of orphans and displaced children. These activities have been useful for the care of orphans and for helping to reduce the stigma of AIDS by involving communities and their leaders.

Identifying and supporting champions: Individuals who are well respected and admired by the public, such as celebrities, sports figures, film actors, and others, could make a difference by speaking out and championing the fight against HIV/AIDS. HIV-positive individuals are even more compelling, but may feel too unsafe to speak out. To encourage HIV/AIDS-infected and affected individuals to raise their voices for the cause, protective regulations and laws and supportive statements by public leaders are very important.

c. Encouraging Policy Dialogue among Country Officials and Donors

Given the seriousness of the HIV/AIDS situation, country leaders need to provide strong, sustained commitment to prevention efforts. USAID experience demonstrates that ambassadors, UN agency representatives, and other high-level officials can effectively communicate the continuous need for national governments and civil society to address HIV/AIDS. The dialogue is most effective when the message is taken beyond the ministry of health and includes all relevant ministries (finance, labor, education, and others). Analyses showing the devastating impact of AIDS, contained in USAID's AIDS Impact Model and the World Bank's economic reports, have been used to sensitize country leadership. While these analyses have generated temporary increased attention at the policy level, too often they fail to translate into budget and

working to improve surveillance frameworks and evaluation methods as part of its MEASURE Project, and has collaborated with the Centers for Disease Control. In addition, it is undertaking a sub-regional initiative in Southern Africa to help standardize the system among countries.

A growing number of surveillance (or monitoring) tools can be applied. One example is the policy implementation-monitoring tool, developed by the Commonwealth Regional Health Community Secretariat (CRHCS) for its member states in East and southern Africa.

f. Expanding Information Dissemination

USAID experience shows that HIV/AIDS prevention messages are more effective by—

- Engaging all sectors of the economy in conveying prevention messages since HIV/AIDS has an impact on all sectors.
- Strengthening health education systems so they integrate health, family planning, and HIV/AIDS information.
- Combining mitigation and prevention efforts, particularly at the community level.
- Strengthening the capacity of the media to convey correct information and facilitate open discussion about HIV/AIDS. Such efforts contribute to reducing the stigma associated with the disease. Training the media has been instrumental in extending coverage of HIV/AIDS issues in Sahel countries.
- Creating HIV/AIDS information centers to provide adequate information on HIV/AIDS. These have made a difference in selected urban areas of Uganda and are now being expanded to other parts of the country, though they still are not able to meet the tremendous demand for information.
- Using the private sector to convey HIV/AIDS messages. Some private sector companies, such as Coca-Cola and beer marketers, can reach remote areas.
- Establishing mechanisms to incorporate the views and wisdom of people on HIV/AIDS in designing care and prevention programs.

B. EXPANDING LOCAL CAPACITY FOR HIV/AIDS PREVENTION AND MITIGATION

Scaling up interventions will be possible only by tapping the institutions, agencies, and sectors that have not yet been utilized fully in implementing key components of HIV/AIDS programs and simultaneously building new capacities within these organizations.

Similar successes in community efforts have been achieved through USAID-supported projects in selected communities in Zambia and Uganda. And examples of successful projects funded by other donors or communities themselves also exist in other countries, notably in Zimbabwe. The details of these programs are available in the USAID-sponsored paper, *Community Mobilization to Mitigate the Impacts of HIV/AIDS*.

c. Strengthening Non-Governmental Organizations for Community Outreach

The most effective community-level HIV/AIDS prevention and mitigation efforts are being carried out through non-governmental organizations. These NGOs deserve support for expanding their capacity and creating a network in Africa. In addition, all NGOs with outreach capability, irrespective of whether their primary focus is health, should be trained to deal with HIV/AIDS. In Zimbabwe, for example, over 60 non-governmental organizations requested training in HIV/AIDS. Clearly, effective program implementation in Africa will be contingent upon strengthening the capacity of non-governmental organizations, coordinating activities among them, and building partnerships between them and the government. USAID has recently provided funding to a London-based organization, Alliance, to discuss with NGOs and CBOs ways to expand successful community efforts.

d. Assessing HIV/AIDS Sectoral Impact

HIV/AIDS has an impact on almost all sectors of the economy. While no hard data exist, anecdotal evidence suggests that the ministries of agriculture, education, and health may lose about one-fifth of their employees to HIV/AIDS. The ministries and local governments need to assess impact of HIV/AIDS on their capacity to deliver services and on the demand for these services. Hardest hit sectors need an emergency plan to replace the lost manpower and to meet the demand for services.

With USAID support the Economics Department of the University of Natal in South Africa has prepared tool kits to help assess the impact of HIV/AIDS on different sectors and to formulate an action plan to reduce the impact. The ministry of agriculture in Malawi has already used this tool kit successfully. USAID plans to convene a consultative meeting in Washington to discuss multi-sectoral approaches and HIV/AIDS as a development issue in September 1999.

e. Establishing Mechanisms for Multi-Sectoral Program Implementation

HIV prevention requires sectors to work together. In Mali, USAID developed a youth program in collaboration with the ministry for youth that integrates health, education, and income generation activities. This program is now carrying out a study and testing mechanisms to encourage these different sectors to work together. Similar efforts are underway in other countries. These experiences need to be reviewed and discussed with governments and among donors.

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

i. Encouraging Greater Involvement of the Private Sector

Countries and donors could strengthen HIV/AIDS prevention programs by:

- Increasing involvement of the industrial and commercial sectors in HIV/AIDS prevention.
- Contracting with the private sector to expand social marketing and behavior change programs, including health education nationally.
- Using the private sector to organize skill development and income-generating activities for youth.

Private industrial, commercial, and service sectors have tremendous stakes in HIV/AIDS prevention efforts. Evidence has surfaced, now being reported by the media (e.g., *The New York Times*), that banks, insurance companies, and mining companies in certain countries are hiring extra employees to protect productivity as employees fall sick. Such increases in personnel impose additional costs to doing business and ultimately reduce profits. Yet USAID experience has shown that in some sectors, such as business and labor, only peers can influence actions to undertake more HIV/AIDS prevention efforts. To engage the interest of the private sector, countries and donors could organize a meeting of representatives of local businesses and their foreign counterparts to discuss their involvement on a large scale.

In one USAID-assisted project in Tanzania, a national trade union persuaded businesses not only to host HIV/AIDS programs in the workplace, but to contribute to the cost of running the programs. In Kenya, another USAID-supported project involving a small number of large businesses stimulated demand from other companies for prevention services, with the understanding that the companies would pay for them. And in South Africa, USAID assistance to the national trade union federations has led to the development of a common HIV/AIDS policy, now ready for implementation. Similarly, one mining company's successful STD/HIV/AIDS prevention programs inspired other mining companies to request the same programs.

Apart from the involvement of large businesses in HIV/AIDS prevention efforts, the non-profit private sector has shown its potential in social marketing of commodities and behavior change. USAID has seen that social marketing not only provides important commodities to consumers at reasonable prices, but also stimulates the growth of commercial marketing for condoms.

The private sector—both commercial and industrial—could also organize economic activities for youth to address the shortages of skilled labor. Efforts could include training in information technology and other high-demand areas, establishing a special training fund for youth, and training a cadre of youth to provide information and advice on HIV/AIDS to communities. Although few micro-enterprises presently cater to youth, USAID would like to encourage expansion of micro-enterprises for youth and make HIV/AIDS education a part of the training. On these and other proposed activities, USAID has prepared briefing materials for private businesses, and created a special project to analyze the problem of youth, called FOCUS on Young Adults. USAID has also recently started collaborating with IDRC in Canada to prepare a

b. Expanding Donors' Field Capacity

As the new partnership is being developed among donors led by UNAIDS, the agencies involved need to assign adequate resident staff to the field. Large agencies like the World Bank can help accelerate implementation of HIV/AIDS programs by maintaining staff in the field to provide administrative and technical support to implementing agencies. For example, procuring condoms and STD drugs in Kenya could have been expedited if adequate Bank staff specializing in logistics procurement/disbursement were available in-country to help troubleshoot and train local organizations.

c. Securing Coordination among Agencies

A strong HIV/AIDS national program is essential for coordinating the activities of different agencies. However, agencies carrying out similar activities can create their own coordination mechanism. For example, in Zambia a coalition of non-governmental organizations has been formed to coordinate and support the local NGO activities.

D. COST OF THE PROGRAM

a. Supporting Program Costs

USAID has provided about \$50-\$70 million per year during the last three years to sub-Saharan African countries. Through this support USAID has introduced new interventions and tested various approaches. Now the time has come to expand these and other interventions on a nationwide scale: interventions such as social marketing; accessibility to condoms, basic drugs, and information; testing and counseling; and community and home-based care and support, including the orphans. The donors together have to provide adequate funding to expand the coverage of a basic package of interventions. UNAIDS has estimated the cost of preventing HIV/AIDS in Africa at \$2 billion or \$2 per infected person. This is a modest amount to prevent this epidemic from devastating the continent.

b. Prioritizing Actions

Limited resources means prioritizing efforts. USAID has focused its support on high transmission areas to make the most impact. For example, USAID has established programs in border areas e.g. the Durban – Lusaka corridor. Similarly, high-risk districts are being identified as part of the Kenya program. A joint donor/government assessment of program requirements in high-prevalence countries should help to identify high priority areas and required interventions. Transparent policies are needed to determine which services should be available and to whom, and how to provide them. Concerted actions should help to maximize synergy and reduce costs. For example, social marketing in one area and mass media without social marketing in another area are less effective than if both are offered simultaneously in the same area.

Stimulating private sector interest

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

Intensifying efforts to make multi-sectoral programs work

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

Formulating a well-defined agenda for analytical work

A well-defined agenda for analytical work will yield immediate results by providing new insights into the determinants of risky behavior and program implementation issues. Continuous analysis of progress through surveillance data will further strengthen the program. Hearing the voices of the people and capturing their wisdom for program improvement could be part an important of the agenda.

— April 12

Sandy.

This is the study of border towns that I mentioned yesterday.

It's a very interesting study, and good luck - ground for the SADC meeting.

We are planning to conduct similar assessment in other border towns along the major roads in Southern Africa, next year.

Roxana Rogers

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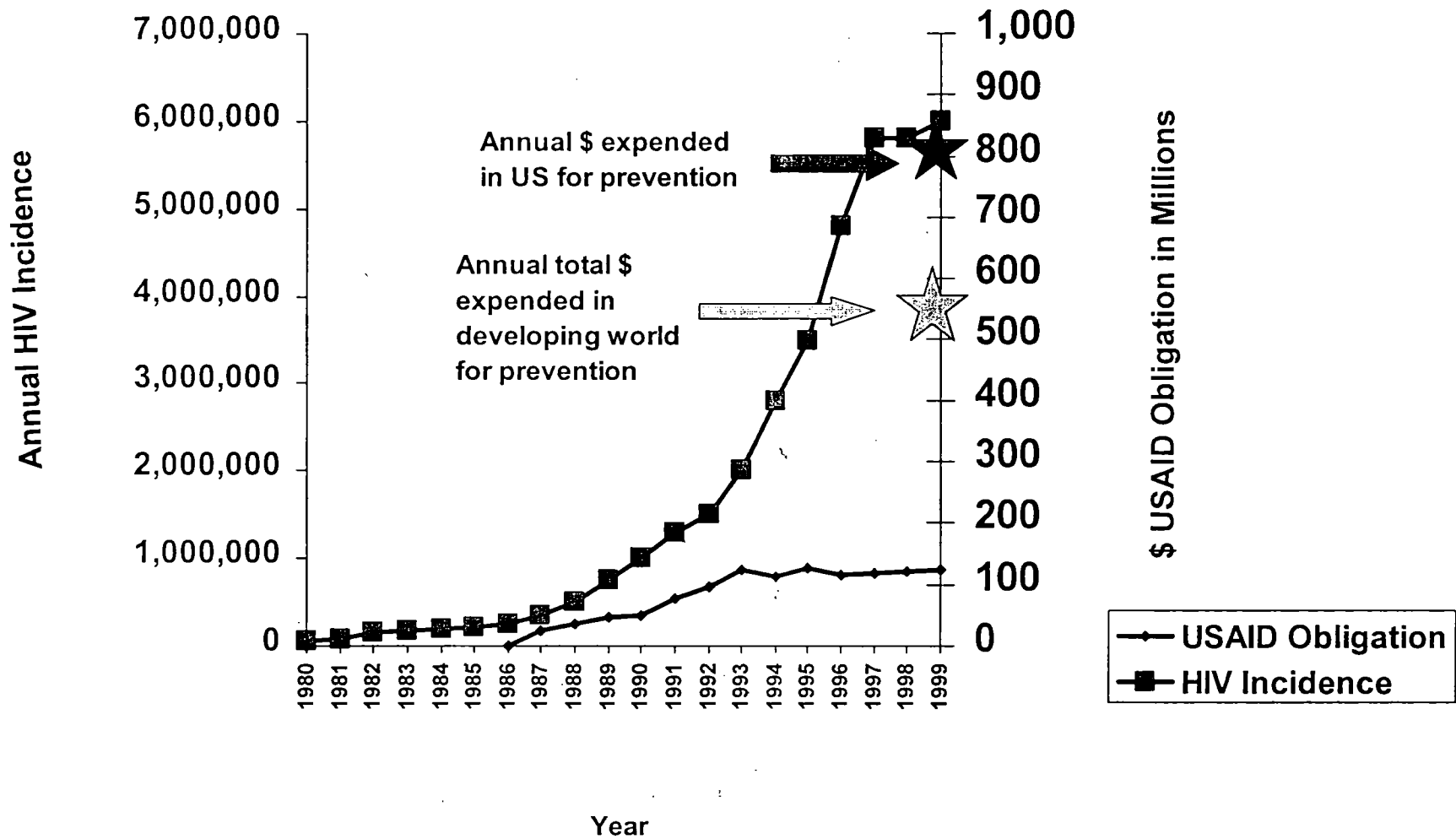
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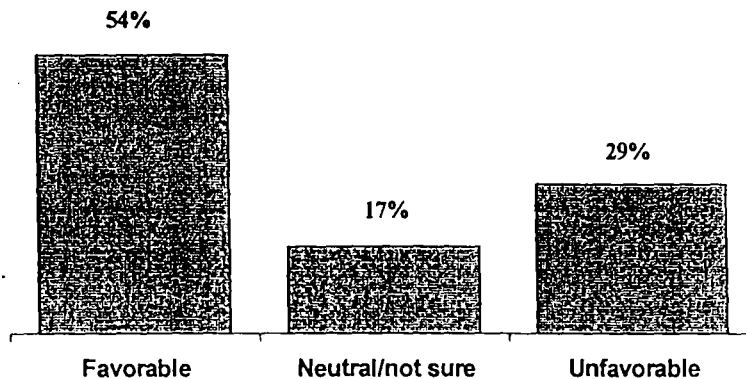
Corridors of Hope in Southern Africa

HIV Prevention Needs and Opportunities in Four Border Towns

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



Increase U.S. Assistance to Fight AIDS in Africa



Peter D. Hart Research Associates surveyed 1,411 registered voters, including 310 African Americans, by telephone between February 20 and 26, 1999, for the Children's Research and Education Institute.

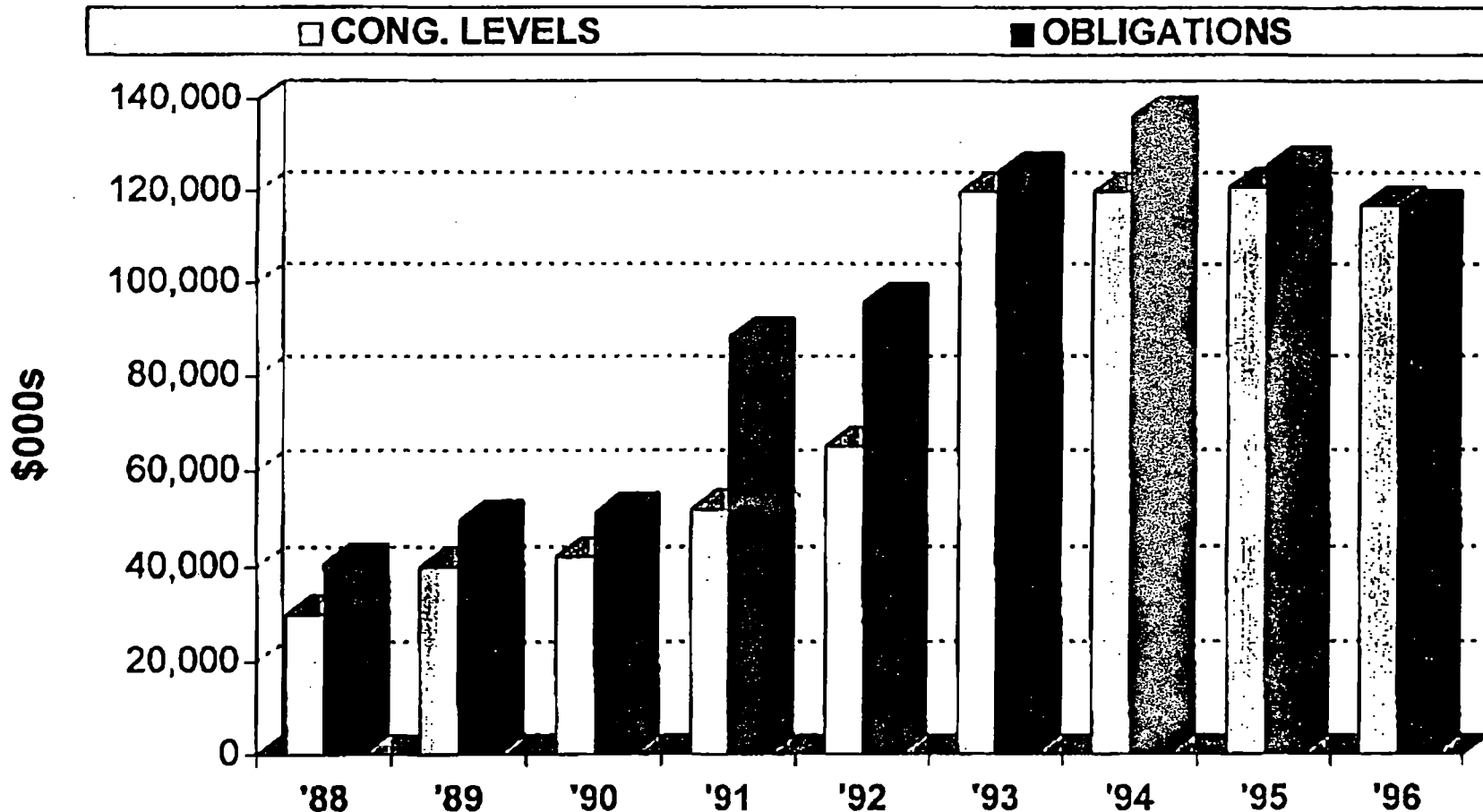
American voters view the spread of AIDS in Africa as a serious problem. Although many voters have not heard much about the issue, they nonetheless believe that it is likely to have an impact here at home. A majority of Americans have a favorable view of a proposal to increase U.S. government assistance for international AIDS programs in Africa.

- ◆ The spread of AIDS in Africa is viewed as a serious problem by two-thirds (67%) of American voters, with 45% saying that it is an extremely serious problem and an additional 22% describing it as a quite serious problem.
- ◆ The same proportion (67%) believe that it is false to say that the global AIDS crisis is coming under control.
- ◆ In addition, three-quarters (75%) of voters believe that the AIDS epidemic in Africa will affect people in the United States.
- ◆ Although the issue is important, only 19% of voters say that they have read or heard a lot about it. Nearly half (48%) say that they have heard little or nothing about it.
- ◆ A 54% majority are favorable to a proposal to increase government assistance for international efforts to fight the spread of AIDS in Africa. Only 29% are unfavorable.
 - An overwhelming 83% majority of African Americans are favorable (55% strongly favorable), and only 10% are unfavorable.
- ◆ Support for greater assistance increases when it is placed in the context of an international effort. Three-quarters (76%) of voters say that they would be more likely to support assistance to help Africa deal with the AIDS epidemic if they knew that it would be a part of a larger international effort with Europe, Japan, and other countries doing their share.

USAID



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



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

CIHI

2/7/97

USAID



Working Paper:

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

Draft in Progress
April 1999

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

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

ACCELERATING THE IMPLEMENTATION OF HIV/AIDS PREVENTION AND MITIGATION PROGRAMS IN AFRICA

EXECUTIVE SUMMARY

This paper¹ summarizes USAID lessons learned and experiences in implementing HIV/AIDS programs in Africa. It also provides perspective on newer issues. The problem faced in most African countries is not *what* to do in dealing with the disease, as there are proven packages of interventions: The problem is *how* to provide interventions on a scale large enough and in a manner concerted enough to make a difference. Based largely on feedback from USAID's country missions, particularly in East and Southern Africa, this paper offers approaches for scaling up interventions and ensuring an expanded response to HIV/AIDS in Africa. An appendix offering suggestions specific to the World Bank and donors is also included.

The purpose of this paper is twofold:

- To share experiences and lessons learned regarding constraints in expanding and improving HIV/AIDS program implementation, based on USAID's work in the field over the past 15 years. It is in the area of implementation where USAID can be most helpful, by guiding focus, energy and resources to the concrete obstacles facing countries and programs.
- To identify new issues, raised by country missions and partners in the field, in developing a bolder response commensurate with the gravity of the expanding HIV/AIDS pandemic in the region.

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

Experiences indicate that improving HIV/AIDS program implementation will require:

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

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

- Concerted actions, applying all possible interventions in one area, to be taken to ensure synergy and maximum impact, as fragmented actions lead to wasted efforts.
- Local agencies and donors to develop a coordinated operational strategy to generate and strengthen commitment at all levels to the prevention and mitigation of HIV/AIDS.
- HIV/AIDS country programs and donor coalitions, together, to ensure that increased funding and technical assistance are in place to enable the national implementation of proven intervention packages by public and private sector partners. These packages would include access to condoms, STD drugs, information, testing and counseling, and community- and home-based care and support, including care of orphans.
- Special emphasis on both prevention and mitigation and measures to reduce poverty and be integral to programs targeting women and youth.
- Governments, with the support of donors, to strengthen not only the capacity of the public sector, but also to utilize fully the available capacity of the private sector and non-governmental organizations.
- Government and donors to concentrate on mobilizing the community and all relevant program sectors through appropriate decentralized structures.
- In-country policy dialogue at the highest levels to include specific actions to improve and expand program implementation, as identified through in-country formative research and feedback from implementers and clients.
- Programs to address the interactions between prevention and care, and involve infected and affected individuals and communities.
- Program action design to be based on the voices and wisdom of local people and communities.
- Donors to establish funds for the coordinated, massive training of managers, professionals, community leaders, youth, and others involved in the program.
- Donors providing substantial funding to improve their capacity in the field to provide the timely technical and administrative support needed by local agencies.
- Commodities to be procured and made available in a timely fashion.
- Management and technical assistance to be provided to ensure that countries meet donor requirements.

INTRODUCTION

Africa is on the brink of disaster, due to current and potential rates of HIV infection on the continent. Countries with high and rising infection rates among youth are facing the loss of a substantial segment of at least one, if not two, generations. The gravity of the situation dictates rapid, concentrated actions. These include strong commitment at the highest levels to stem the tide of the epidemic, as well as measures to reduce the stigma associated with the disease. Timely program implementation will require the involvement of whole communities, through fast-paced formation of community, village, and district AIDS committees, establishment of a rapid or emergency response team for resolving implementation problems, and the use of all available resources to deal with the epidemic, including the military. AIDS is both a health *and* a development problem. Therefore, a renewed, intensive effort has to be made to mobilize and coordinate all sectors of society and the economy, sometimes in unconventional ways, in the fight against the disease.

ADDRESSING IMPLEMENTATION PROBLEMS

USAID experiences in the implementation of HIV/AIDS programs in African countries indicate that the following are basic requirements for success:

- **Commitment** on the part of the policy makers, implementers, civic society and the donors to prevent the disease and mitigate its impact within a defined period of time.

Commitment is critical for mobilizing financial and human resources, which are grossly inadequate to implement most programs at this time. The single most important element in generating country commitment is **reducing the stigma** associated with the AIDS. This is also important for stimulating behavior change and for creating a supportive environment. A comprehensive, well-coordinated operational strategy for systematically generating and sustaining commitment can be developed and applied on the basis of USAID experiences to date.

- **Capacity** to plan, manage and provide a set of interventions, already proven effective on a smaller scale, on a countrywide basis.

The scaling up of these interventions, experience shows, will be possible only by tapping the organizations, agencies and sectors that have not yet been fully utilized in the implementation of key components of HIV/AIDS programs. These include the private sector, non-governmental organizations, non-health sectors and non-formal community and youth groups.

- **Coordination** among the donors and agencies involved in HIV/AIDS program implementation to make the best use of resources for meeting priority needs.

Resource shortages are exacerbated by economic decline and underscore the importance of and need for coordinated actions. A consortium of both bilateral and multilateral donors at the country level may be an effective mechanism for such coordination. Similarly, coalitions of non-governmental organizations and of other implementers could also help coordinate actions, possibly with financial and technical support from donors.

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

The points made above are elaborated in the following sections.

STRENGTHENING COUNTRY COMMITMENT

USAID field missions in all sub-Saharan African countries, with the exception of Uganda and Senegal, have reported consistently that levels of country commitment are not commensurate with the seriousness of the HIV/AIDS situation. Commitment is singularly important to mounting the type of effort required at this stage. While political will at the highest level is critical, commitment is important at all levels and from all agencies. These include governmental and non-governmental agencies responsible for different sectors, opinion leaders, community leaders, business and labor leaders, parliamentarians, religious leaders, and youth and women groups. In addition, the commitment must be sustained until the epidemic is under control.

Operational strategies to generate commitment are currently lacking in Africa. But experience has shown that dedicated individuals and agencies are able to generate commitment. For example, non-governmental organizations influenced the thinking of policy makers as well as policies in South Africa and Kenya. And peers among policy makers and politicians in regional and sub-regional settings have influenced each other's thinking, as in the case of the South African Development Community. Thus, there are adequate experiences within and among countries and donors that can be used to develop any operational strategy to strengthen commitment at all levels. The first step in developing this operational strategy, USAID could be the sharing of experiences at country and sub-regional levels.

USAID missions and other partners in the field have observed that a major impediment to commitment to HIV/AIDS prevention efforts is the stigma associated with the disease. Concerted actions to reduce stigma (see next section) constitute an important part of an operational strategy to generate commitment. In addition to reducing stigma, the processes and elements of generating commitment that can form part of an operational strategy are as follows:

Support to Local Advocacy Groups

Providing information, technical support, and resources to local groups and organizations has been effective in building constituencies, influencing policies, and developing regulatory mechanisms, as well as in promoting and monitoring implementation. These approaches work as they foster local ownership, engage groups familiar with the internal processes and dynamics of target audiences, and help expand visible national constituencies. With support, local advocacy groups can organize rallies and marches, and mobilize grassroots support. For example, USAID/Kenya consistently supported the Kenya AIDS NGO Consortium and MAP International with resources and technical assistance to promote policy change. Both organizations have been acknowledged, both inside and outside the country, for their role in sensitizing political and religious policy makers and achieving significant policy openings. In South Africa, coalition building through NACOSA (a coalition of non-governmental organizations, unions, community groups and political parties) resulted in a draft strategy for kick-starting the new government's national HIV/AIDS preventive efforts. The strategy, with few modifications, became the national policy. More recently, USAID-supported advocacy training is helping provincial and national leaders mobilize interest and action in HIV/AIDS efforts. The tools that USAID made available to these leaders include repackaged advocacy materials that summarize the best evidence available and make specific action recommendations for selected audiences (e.g., *An Introduction to Advocacy* produced by the SARA project).

Policy Dialogue Between the Country Officials and Donors

Given the seriousness of the HIV/AIDS situation, strong, sustained commitment to prevention efforts is needed from country leaders. It has been USAID's experience that ambassadors, UN agency representatives, and other high-level officials can effectively communicate the need for national governments and civil society to address HIV/AIDS. The dialogue is most effective when all relevant ministries (Finance, Labor, Education, and others), besides Health, are included. In terms of tools, USAID's AIDS Impact Model and the World Bank's economic reports, have been used to sensitize country leadership. While these analyses have generated temporary increased attention at the policy level, too often they fail to translate into budget and program implementation actions. The reasons for this failure need to be reviewed. However, USAID's experience shows that the following additional measures could be taken by donors to make this dialogue more fruitful:

- Reach agreement with country officials on specific actions towards accelerated implementation of key program components, with definite monitoring indicators.
- Maintain consistent and regular high-level dialogues, using surveillance data to review progress at frequent intervals.
- Promote policy dialogue based on consultation with other donors and implementers and highlighting the disastrous implications of inaction for the country and different sectors. In

addition, senior donor representatives collaborating with various sectors could work actively with their counterparts to determine the actions to be taken through sectoral programs.

Establishment of Surveillance Systems

Local capability for systematic surveillance, impact analyses, and monitoring/evaluating program progress is a necessary complement to the above efforts. Policy makers and donors need to know how effectively and at what pace policies are being implemented. In addition, information on the effectiveness of interventions and their costs is essential to making appropriate decisions regarding the use of limited resources.

These data can help in developing most effective tools for policy analysis. There are a growing number of surveillance (or monitoring) tools which could be applied. One example is the policy implementation-monitoring tool, developed by the Commonwealth Regional Health Community Secretariat (CRHCS) for its member states in East and Southern Africa.

While surveillance efforts are presently ad hoc, USAID would like to suggest that countries and donors adopt a common approach. To this end, USAID/Kenya recently organized an Africa-wide workshop on monitoring and evaluation, and a resultant manual is being prepared. USAID is also working to improve surveillance frameworks and evaluation methods as part of its MEASURE Project, and has collaborated with the Centers for Disease Control. In addition, it is in the process of undertaking a sub-regional initiative in Southern Africa to help standardize the system among countries.

Reducing the stigma associated with the disease

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

Engaging Religious Leaders

Statements made by religious leaders which provide correct information about HIV/AIDS and promote behavior change are considered effective in prevention efforts. For example, one study in Uganda reported that people who listened to a trained religious leader or community worker were more likely to have correct information about HIV/AIDS, less likely to report extramarital partners and/or multiple partners, and more likely to use condoms. Religious leaders in Uganda also showed continued commitment to dealing with the problem, even after the funding for their work had run out. Training, information exchange, and study tours for religious leaders were also effective in desensitizing controversial family planning programs in the 1970s.

Providing Voluntary Testing and Counseling

In Africa the message to wear condoms does not have an impact unless people are aware of their HIV status. Unfortunately, well over 95 percent of people in Africa do not know their sero-status, and large numbers of those who are infected do not take precautionary measures. Paradoxically, a substantial proportion of those who are *not* infected believe that they are and engage in risky behaviors. Another very important AIDS issue involves couples in which one partner is infected and the other is not, but neither knows their sero-status, presenting a mutual potential risk.

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

Establishing HIV/AIDS Information Centers

Adequate information on HIV/AIDS is not readily available in Africa, even in many urban areas. While HIV/AIDS information centers have made a difference in selected urban areas of Uganda and are now being expanded to other parts of the country, they still are not able to meet the demand. Establishment of HIV/AIDS information centers is obviously a high priority.

Focusing Attention on the Special Problem of Stigma for Women, Youth and Orphans

HIV/AIDS presents a number of issues specific to women, their role in society, and their relationships to men. In Africa, women are disenfranchised in terms of their relative risk for HIV. In addition to their increased risk for transmission, they are at great risk for increased poverty given their lack of inheritance rights and overall social standing. Special emphasis is needed on the issues facing women, including the implications of the stigma associated with the disease. In several countries, women on the economic brink have strongly expressed desire and readiness to undertake activities to improve their status. Organizations like the Foundation for International Community Assistance (FINCA) have responded to these demands by providing seed money and training in a few countries, on a limited scale. These economic activities have a purpose beyond poverty reduction; they have the potential to prepare women to deal with societal stigma.

Economic activities should also be focused on young men and women who are unemployed and do not have access to information and counseling. This population is especially vulnerable and

wary of seeking information about HIV/AIDS, due to fear of stigma. Economic activities could take the shape of training in information technology and other high-demand areas, provided by the private sector--both commercial and industrial. This kind of training can be mutually beneficial. The multinationals may consider establishing a special fund for youth training. A cadre of youth can also be trained to provide information and advice on HIV/AIDS to communities. Although few micro-enterprises presently cater to youth, USAID would like to encourage expansion of micro-enterprises for youth and make HIV/AIDS education a part of the training. On these and other proposed activities, USAID has prepared briefing materials for private businesses, and created a special project to analyze the problem of youth, called FOCUS.

Orphans in Africa are another vulnerable population with special problems. To date, the U.S. government has earmarked \$10 million for the care of orphans, of which \$7 million has already been allocated to several African countries. Additional funds have been made available by USAID through the Displaced Children and Orphans Fund (DCOF). DCOF has thus far supported a number of community-level activities for the care of orphans and displaced children. These activities have been useful not only for the care of orphans but also help reduce the stigma by involving communities and their leaders. (See next section on community involvement.)

Expanding the Environment in Which Prevention Information is Disseminated

USAID experience shows that HIV/AIDS prevention message are more effective through:

- Engaging all sectors of the economy in conveying prevention messages: HIV/AIDS has an impact on all sectors, therefore the provision of prevention messages has to be part of outreach services to all sectors
- Integrating health, family planning and HIV/ AIDS education: Health education systems urgently need to be strengthened in order to provide adequate health-related information.
- Combining mitigation and prevention: The infected person, particularly at the community level, can effectively convey important prevention messages.
- Strengthening the capacity of the media to cover HIV/AIDS: Using the media to convey correct information and facilitate open discussion about HIV/AIDS contributes a great deal to reducing the stigma associated with the disease. Training of the media by USAID has been instrumental in extending coverage of HIV/AIDS issues in a few countries.
- Using the private sector to convey messages: Some private sector companies such as Coca-Cola and beer marketers are able to reach remote areas. These organizations can be utilized to convey HIV/AIDS messages.

Identifying and Supporting Champions

Individuals who are well respected and admired by the public, such as celebrities, sports figures, film actors, and others, could make a difference by speaking out and championing the fight against HIV/AIDS. HIV-positive individuals are even more compelling, but may feel too unsafe to speak out. To encourage HIV/AIDS-infected and affected individuals to raise their voices for the cause, protective regulations and laws should be instituted, and supportive statements should be made by public leaders.

EXPANDING LOCAL CAPACITY FOR HIV/AIDS PREVENTION AND MITIGATION

USAID experiences show that mobilizing the power of people or communities is the most potent and expedient way to expand implementation capacity. It is equally important to utilize the untapped capacity of the private sector (see next section), non-governmental organizations, local research institutions, informal community groups and the military. Strengthening the capacity of governmental agencies for implementing HIV/AIDS efforts is imperative, particularly through providing management training and adequate budgets.

National AIDS control programs have been criticized since the mid-1980s for managerial weakness and lack of bureaucratic influence, and non-governmental organizations have been criticized for lack of in-depth technical skills. Community groups often do not have adequate managerial or technical support, due to weak local government structures and the limited capacity of non-governmental organizations to undertake strong prevention and mitigation efforts. Thus, there is a need to rapidly up-grade skills at all levels to strengthen prevention and mitigation efforts.

Formation of District and Village AIDS Committees

HIV/AIDS prevention and mitigation efforts can only be sustained through community involvement and ownership. A number of successful pilot efforts exist, but they have not been scaled up, for various reasons. One of the reasons is that these pilot programs have been funded by donors who have not disseminated results or mobilized support for scaling up.

The usefulness of community involvement is exemplified by a project in Malawi called Community-based Options for Protection and Empowerment (COPE). COPE, funded by USAID, is implemented through Save the Children Federation. It is a systematic approach to mobilizing community-based responses to the care of orphans and other populations affected by HIV/AIDS, and works through the multilevel and multi-sectoral structure established by the government and UNICEF for prevention of HIV/AIDS and mitigation of its impact. The multilevel structure comprises district, community and village HIV/AIDS committees, while the sectors include governmental and non-governmental organizations, religious groups, the business community and other relevant community members.

Working with individual community members, COPE was able to strengthen their capacity to implement activities that assisted families in home-based care, and trained youth and other high-risk groups in HIV prevention. It also assisted families and community members in mobilizing internal and external resources to sustain the activities. COPE is in the process of linking with other programs like LIFE (Local Income and Food Enhancement) and FINCA where members of the Community AIDS Committee (CAC) will be eligible for loans to start income-generating activities.

One interesting result of this experience is that CACs are putting pressure on district-level committees to work inter-sectorally to provide comprehensive support. In addition, COPE is advocating for and influencing national policies on behalf of HIV/AIDS-affected families and children.

Similar successes in community efforts have been achieved through USAID-supported projects in selected communities in Zambia and Uganda. And there are also examples of successful projects funded by other donors or communities themselves in different countries.

Strengthening Non-Governmental Organizations for Community Outreach

The most effective community-level HIV/AIDS prevention and mitigation efforts are being carried out through non-governmental organizations, as mentioned above, while groups like TASO in Uganda illustrate other possible approaches. These types of non-governmental organizations deserve support for expanding their capacity and creating a network in Africa. In addition, all non-governmental organizations with outreach capability, irrespective of whether their primary focus is health, should be trained to deal with HIV/AIDS, such as in Zimbabwe, where over 60 non-governmental organizations came forward to request such capacity building. It is clear that effective program implementation in Africa will be contingent upon strengthening the capacity of non-governmental organizations, coordination of activities among them, and building partnerships between them and government.

Establishing Mechanisms for Multi-Sectoral Program Implementation

Donors with broader development agendas, such as the World Bank and USAID, have the capacity and legitimacy to help different sectors assess the impact of HIV/AIDS on that sector, and define the measures to be included in its prevention and mitigation activities. In developing a protocol, collaboration between agencies may help in making the multi-sectoral approach work.

Income-generating activities for youth are an extremely important element in HIV prevention, and require a mechanism to enable different sectors to work together. This mechanism exists in the form of Ministries for Youth and other such organizations, but by and large they are non-functional due to difficulty in obtaining the collaboration of other ministries. USAID launched a skills development project for youth in Mali, now in the process of carrying out a study and testing mechanisms for different sectors to work together. And similar efforts are underway in

other countries. These experiences need to be reviewed and discussed with governments and among donors.

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

Supporting the Local Institutions for Analytical Work and Generating New Ideas

In most African countries, HIV/AIDS program improvement will require expansion of local research institutions' capacity to undertake analytical work in priority areas. These areas include assessments of the impact of AIDS, analyses of surveillance data, and development of the understanding of determinants of risk behavior. Expansion is best undertaken through training and partnership with outside institutions. In addition, these institutions can provide new ideas for improving program implementation by conducting focus group discussions. Support for generating and exchanging ideas from the respective affected populations may be one of the most valuable contributions donors can make.

Targeting and Prioritizing

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

Mobilizing Military Personnel

USAID supported a Geneva-based organization called the Civil-Military Alliance to Combat HIV and AIDS. Because countries have experience mobilizing the military to assist with natural disasters, it was thought that HIV/AIDS could be treated as a disaster in the making, dictating similar, useful actions such as using military personnel on a rotation basis to deliver government commodities and services. This involvement could have the double advantage of educating military personnel, who face high HIV infection rates, and improving the availability of services to people.

Massive Training Program

As it is, African countries have a shortage of trained personnel. The situation is exacerbated by a high AIDS death rate in the educated and trained population, leading to immense requirements for training and retraining of all types.

Generous donor, university and private foundation resources made available for training have been a major factor in the success of population programs. Similar, or even larger, efforts are needed for HIV/AIDS programs. The training needs of different implementing agencies are to be assessed, then, to the extent feasible, training can be conducted on the job. To do this, the capacity of local institutions to provide quality training must be expanded, perhaps through collaboration with outside institutions. A large fund dedicated to training and orientation of community leaders, change agents, and personnel from key agencies needs to be established.

Improving Commodity Procurement and Distribution

The inadequate availability of condoms, STD drugs, testing agents, and palliative drugs and supplies for people living with AIDS and their caregivers is a serious problem for nationwide program implementation. It is due to both a lack of resources and administrative bottlenecks when resources are available. For example, in Kenya donor funding has been available, yet the shortages of commodities have seriously hampered program implementation. And in many countries, STD drugs and condoms arrive late (sometimes three years after the donor funding is made available). In addition to general shortages of commodities, other problems noted by USAID missions include the following:

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

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

Greater Involvement of the Private Sector

Private industrial, commercial, and service sectors have tremendous stakes in HIV/AIDS prevention efforts. Evidence has surfaced, now being reported by the media (e.g., *The New York Times*), that banks, insurance companies and mining companies in certain countries are hiring extra employees to protect productivity as employees fall sick. This can be a large added cost to doing business.

In one USAID-assisted project in Tanzania, a national trade union was able to persuade businesses not only to host HIV/AIDS programs in the workplace but to contribute to the cost of running those programs. In Kenya another USAID-supported project involving a small number of large businesses stimulated demand from other companies for prevention services, with the understanding that the companies would pay for them. And in South Africa USAID assistance to the national trade union federations has led to the development of a common HIV/AIDS workplace policy, now ready for implementation. Similarly, work with one mining company on STD/HIV/AIDS prevention programs inspired other mining companies to request the same programs. Moreover, it has been USAID's experience that in some sectors, such as business and labor, only peers can influence actions to undertake more HIV/AIDS prevention efforts.

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

Thus, countries and donors should strengthen HIV/AIDS prevention programs through:

- Increasing involvement of the industrial and commercial sectors in HIV/AIDS prevention.
- Contracting out to the private sector the nationwide expansion of social marketing and behavior change programs, including health education.
- Using the private sector to organize skills development and income-generating activities for youth.

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

EXPANDING FIELD CAPACITY OF DONORS TO COORDINATE, MONITOR AND FACILITATE IMPLEMENTATION

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

Large donors like the World Bank can help accelerate implementation of HIV/AIDS programs by maintaining staff in the field to provide administrative and technical support to implementing agencies. For example, the procurement of condoms and STD drugs in Kenya would not have

experienced two-year delays if there had been adequate Bank staff in the country to help in troubleshooting and training the locals in procurement and disbursements. As part of its decentralization process the World Bank is increasingly assigning staff to the field.

Programs work best when strong National AIDS Control bodies or other designated government offices provide leadership in coordinating donor assistance and program implementation. Notwithstanding the coordination by government, donors could organize the exchange of information, experiences, and ideas among themselves. This would also ensure that coordinated policy dialogue continues with the government, and important aspects of the program are funded and technical assistance provided. For this reason, it may be useful to consider the formation of donor consortia in all countries, with the purpose of jointly programming, monitoring, and carrying out policy dialogue in a more systematic way. The consortia should include multilateral as well as bilateral donors.

Actions for Accelerating Program Implementation

The following actions by countries and donors have the potential to help improve and accelerate implementation of HIV/AIDS programs in Africa:

Establish a Rapid or Emergency Response Team.

Such a team, suited for severely affected countries, should include the most influential and dynamic representatives from the general public, governmental and non-governmental organizations, and the private sector. Possible functions of the team could include identifying roadblocks to implementation and then following up with the relevant agencies in a collegial and cooperative manner. Another responsibility could include monitoring the impact of the epidemic on various sectors and identifying intervention and coping strategies.

Form donor consortia in selected countries to help accelerate implementation.

Together donors can keep accelerating program implementation by ensuring that their assistance covers all aspects of the program. This includes countrywide availability of condoms and STD drugs, voluntary counseling and testing, dissemination of information on prevention, stigma reduction, social mobilization, multi-sectoral planning and program implementation, and strengthening mitigation efforts.

Establish a training fund jointly funded by the donors.

Generous resources are needed to rapidly train and orient different categories of workers, including advocacy groups, managerial and professional workers from relevant agencies, community-level leaders, and others.

Develop operational strategies to implement advocacy efforts.

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

Stimulate private sector interest.

As a first step, private sector groups, including in-country businesses and affiliates of multinationals need to assess the impact of HIV/AIDS on these businesses and discuss ways to enlarge their role in the program.

Intensify efforts to make multi-sectoral programs work.

The multi-sectoral approaches are important to implementing youth-, women-, and orphan-related policies, particularly those focused on the link between HIV/AIDS and poverty, including the development of income-generating activities for those most vulnerable.

Formulate a well-defined agenda for analytical work.

Analytical work will yield immediate results by providing new insights into the determinants of risky behavior from the target population itself. This information will reveal how to implement the program effectively.

Appendix A

USAID PERSPECTIVE ON ISSUES RELATED TO PROCUREMENT OF COMMODITIES

Host Government Issues

- a. Inability/unwillingness to appropriately identify needs
- b. Tendering procedures that are unacceptable to the World Bank and other donors
- c. Payment delays
- d. Conflicts in authority and competition among host country ministries (e.g., customs clearance delays resulting from delays in receiving waivers for import duties or payment of VAT, i.e., lack of communication and agreement between MOH and MOF)
- e. Complex approval processes, conflicts, and breakdowns in understanding and communications within host country government departments and ministries required for planning, approval and payment
- f. Possible trade protection policies of host government make it difficult to import products that might be produced locally but at different costs and standards of quality
- g. Limited real commitment and leadership by host country government leaders to address the HIV/AIDS epidemic, as well as program delays and breakdowns resulting from procurement difficulties

Issues for World Bank and Donor Consideration

- a. Tendering rules that have negative program impacts (e.g., requirement that different drugs be tendered separately resulting in different arrival dates for products required together)
- b. Lack of technical assistance to assure that procurement is timely and meets quality and program standards (e.g., supplies are not out of date when delivered or within their projected program use)
- c. Need for attention to procurement planning and logistics management

- d. Need for World Bank staff or consultants on the ground to support and assist in program implementation
- e. Need for use of conditionality to assure that host governments focus on procurement issues
- f. Need for country ability to adequately forecast needs and assure proper products and quantities are delivered on time to avoid oversupply or stockouts
- g. Conflicts in objectives (e.g., World Bank insistence on host country paying strict attention to import tariffs while at the same time seeking to provide reproductive health commodities without adequate attention to customs charges)

General Suggestions

- a. More careful procurement planning at the project appraisal stage, including provision of specialized technical assistance or training for host country counterparts to assure quality and timely procurements
- b. Placement of competent technical staff on the ground to troubleshoot and to resolve issues as they arise
- c. Where needed, use of professional procurement services to ensure that Bank and donor rules and regulations are followed
- d. Use of conditionality to leverage host country compliance with, and attention to, procurement issues
- e. Technical assistance to host country institutions responsible for procurement
- f. Commitment to address corruption /integrity issues where needed
- g. Need to address distribution/transportation/storage issues once commodities arrive in-country
- h. Improved logistics management record keeping systems to track commodities and assure that they have not exceeded their shelf life
- i. Competent technical staff on the ground to: follow-up, conduct continuous policy dialogues, do trouble shooting on procurement and disbursement problems and work in a consortium with donors

- j. Real government/donor coordination in the design, more attention to procurement issues, and more care taken to assure that adequate Bank, donor, and government staff are available to monitor and implement the project
- k. More active and continuing donor dialogue at the field level so that joint pressure can be brought to bear to create and enforce conditionalities that will lead to smoother host country management
- l. Bank and donors must be prepared to create conditionalities that address each country's specific problems. If competency is the issue, projects should take steps to specifically address it; if integrity/corruption is the problem, projects should assure that it is controlled, etc.

Required Elements:

- improved planning and logistics
- coordinated procurement and logistics management
- planning, forecasting, assessment, and coordination
- donor coordination
- improved quality control in purchasing and in logistics management
- better financial management assures prompt payment to suppliers
- better assessment and coordination with counterpart governments
- better market research

TO: AFR Mission Directors

FM: VLD

1. USAID's leadership and expertise in combating the HIV/AIDS epidemic is internationally recognized. You have been among the first to emphasize that what is at stake is two decades and billions of dollars in investment and progress in Africa. You all know from personal and professional experience that HIV/AIDS is not merely a health issue, but must be attacked on a multi-sector basis. The fight against HIV/AIDS is not only a top priority for our health programs, it has become our priority bureau-wide, for the disease undercuts Africa's capacity to manage, govern, grow and compete in a global economy.

2. The message you have been sending in from the field for some time about the catastrophic effects of the HIV/AIDS pandemic in Africa is reverberating throughout Washington. As a result the White House, the Congress, various executive agencies, the private sector, as well as NGO's, all agree the United States (as well as other donors) must do more. What has not been agreed upon yet is exactly WHAT should be done, what, if any, new resources will be available to do it, and which agencies should carry out a vastly bigger, more effective program in Africa.

3. It is still too early to assure you that ANY new resources will be available for AFR in FY 2000, or whether USAID will be directed to "find" money within its requested budget. I do believe there will be more money to combat HIV/AIDS in Africa, but I cannot tell you how much more, and to which agencies of the USG it would be allocated, if it became available.

4. While you have earned international respect and praise for USAID, the role we play, the effectiveness of our programs and our ability to quickly respond to the challenge of fighting HIV/AIDS is not so widely understood in Washington. We cannot be mere spectators knowing as we do that USAID is the most effective agency to lead this fight, as resource issues work their way through the interagency process in Washington. In view of this, I am asking each of you to report to your country desk officer by COB Friday, July 23 the following:

A. Assuming no new resources:

1. How your mission could increase its HIV activities for FY 2000 **within** your existing SOs assuming our funding levels at the FY 2000 CP request level. That is, to review every aspect of your portfolio to describe how you would program resources to combating the spread of HIV/AIDS within your requested FY 2000 budget.

2. How your mission would propose to reallocate resources from other SOs to your HIV/AIDS SO.

3. How your mission would program FY 2000 resources for HIV/AIDS to at least double your FY 99 HIV/AIDS levels.

B. Assuming NEW resources:

1. How rapidly could you expand existing HIV/AIDS programs, add new activities, and program synergistically across your portfolio? What level of resources could you effectively program in FY 2000?

2. Are you prepared to consider adding HIV/AIDS to your portfolio and how quickly could you expand? What level of resources could you effectively program in FY 2000?

5. Again I emphasize there may be NO increased resources overall for USAID. However, all the actors stateside agree on one thing: any new resources will be channeled through a mechanism or agency which can most *effectively and immediately* absorb those funds. If USAID is unable to present how and when it could disburse any new resources, they will be channeled elsewhere, so your response to this request is critically important.

6. USAID is indispensable in the fight against HIV/AIDS, especially in Africa. With AFR support we can tame this disease and at least ameliorate its worse effects. Please give time and attention to develop a specific response. Thank you.



U.S. Agency for International
Development

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

Date:

6/3

To:

Sandy

Phone:

Fax:

From:

Shirley

Phone:

Fax:

Number of Pages Including Cover Sheet

Message

Urgent - Revised piece for
you + Paul's piece he wrote
1-2 weeks ago.

Shirley

Financing the Response to the HIV/AIDS Pandemic in Sub-Saharan Africa

Based on USAID's experience with successful programs in reducing HIV transmission in Uganda and Senegal, a minimum of \$2.00 per adult per year is necessary to mount a basic HIV primary prevention program. This includes a selected set of care and support interventions to enhance the prevention agenda. Thus, a minimum of \$500 million would be required for the African sub-continent. This is not the sole responsibility of the USG. However, the USG provides nearly 50% of development assistance funds for HIV/AIDS prevention and care and support in Africa.

Use of Additional Funds

The needs are great. Currently, USAID is spending approximately \$76 million in Africa to prevent and provide care and support for persons with and affected by AIDS (e.g., children and orphans). These funds are minimal.

Using a general formula, which would vary based on the phase of the epidemic (i.e. prevalence) and the level of response thus far, funds would be distributed as follows:

30% devoted to reduce mother to child HIV transmission and for orphan/vulnerable children support. This includes community based support services for families, for education for affected children (particularly girls), as well as to help families cope with the loss of one or two parents (e.g., support to families, microcredit approaches). In addition, support is needed to address the expanding number of children born with HIV via perinatal transmission (approximately 30% of children born to an HIV positive mother) and the 70% of children born to HIV positive women who are not infected. Innovative prevention activities (eg., drug regimens appropriate to low resource settings, better breastfeeding counseling, prevention of HIV in adult populations, and so on) require funding to reduce the number of new HIV infections, particularly among women of reproductive age.

40% for expanded "prevention to care continuum" activities to link voluntary testing and counseling to decreasing risk behaviors in HIV negative individuals and basic care and support for HIV positive persons. Funding for establishing voluntary counseling and testing (VCT) sites, as well as for developing programs delivering basic medical (e.g., TB drugs and treatment) care and social support services is greatly needed. In Uganda, with a population of only 20 million, USAID spent close to \$60 million over ten years to support their VCT and support services program. This program was instrumental in reducing HIV prevalence. Whereas 95% of Africans on the continent do not know their current HIV status, over 400,000 Ugandans have been tested thus far.

30% for expanded programs for African youth, which now represent the most critical vulnerable population for primary prevention interventions. This includes specially targeted prevention messages and campaigns and development of out-of-school programs to reach youth.

In addition to these areas, there are increasing needs to assist countries develop new strategies to combat HIV/AIDS. These include innovative approaches of working with businesses and the private sector to implement workplace-based HIV/AIDS prevention programs; efforts to assess the impact of AIDS on the nation's economy (all levels);

working with the military to implement HIV/AIDS prevention programs; efforts to reduce stigma and discrimination for persons with AIDS; and working with churches to implement HIV/AIDS programs. For the most part, USAIDS has not had the funding to implement these programs. As countries are now paying attention to the epidemic, funding needs to implement these programs are required. For example, USAID/South Africa is spending \$1 million over a few years to work with the AFL/CIO's Solidarity Center to work with the South African trade unions to implement HIV/AIDS programs—which has been a great success thus far. This is but one program in one country. We need to replicate these innovative programs.

Meeting the health and social needs of the rapidly expanding numbers of persons with AIDS in Africa will be a great challenge. More importantly, the need to prevent new infections represents the hope for Africa. Combining provision of prevention messages and services for those affected has proven to be very effective.

Criteria for Distribution of Funds

Distribution of additional funds for HIV/AIDS prevention and care and support would be based on the following criteria:

1. Prevalence rates: Funding will be distributed to achieve impacts on reducing HIV transmission in the hardest hit countries in Africa. If we use a threshold of 10% adult HIV prevalence rate, the following countries would be included: South Africa, Zimbabwe, Zambia, Uganda, Tanzania, Rwanda, Namibia, Mozambique, Malawi, Kenya, Ethiopia, Cote d'Ivoire, and Botswana. Each of these countries has a USAID mission or is served by a USAID regional program.

In addition, a second prevalence-related criterion must focus on those countries that have lower prevalence and must have resources to maintain a low prevalence rate. For example, these countries include Senegal, Ghana, Congo, and Nigeria. In particular, keeping HIV under control in countries like Nigeria with 110 million people is essential to the health and wellbeing of countries in the entire West African region as well as continent.

2. Rapidly expanding epidemics. Similar to the prevalence criteria, several countries are experiencing rapid expansion in their HIV epidemics. These include South Africa, Nigeria, Namibia, Cote d'Ivoire, and Burkina Faso. Similarly, several countries in Asia, the Newly Independent States, and Latin America are experiencing rapid growth in their HIV epidemics. It is imperative that efforts be undertaken immediately to intensify prevention activities.
3. Ability to absorb funds. The presence of USAID missions and implementing partners will greatly assist programming of new funds. Average mission HIV/AIDS programs range from \$500,000 per year to \$2 million/year. Implementing partners include a large number of contracted organizations, NGOs and PVOs, multilateral organizations, and universities. These organizations extensive international experience.

4. Need. A number of USAID missions, and African countries, have recently requested additional funds to undertake HIV/AIDS programs. These include: South Africa, Zambia, Nigeria, Namibia, Liberia, Rwanda, as well as countries such as Lesotho and Swaziland where there is no USAID mission but the US ambassadors have requested USG assistance. The demand is great and is growing.
5. Political commitment on the part of governments. The ability to scale up interventions in countries is partially dependent on the commitment of political leaders and governments to address the HIV/AIDS epidemic. An increasing number of countries are now recognizing the scourge of HIV and responding to it. These include: Uganda, Senegal, South Africa, Zambia, Namibia, Nigeria, and others. Even Zimbabwe's President Mugabe has begun speaking out about AIDS.

Distribution of Funds in a Timely Manner

USAID has programmed the entire FY 99 emergency \$10 million appropriation for AIDS orphans and vulnerable children. Proposals were reviewed and missions accepted responsibility to *expend* these funds within a three-year period. The use of these funds was narrowly limited. Missions expressed need for additional resources and for greater breadth in their use to address HIV prevention and care and support. A number of USAID missions have requested new HIV/AIDS funds to launch and expand their HIV/AIDS programs. These include South Africa, Namibia, Liberia, and Nigeria. Funds for these countries alone would amount to \$4-5 million/year. A number of US ambassadors to African countries have also requested assistance in HIV/AIDS prevention.

In addition to the USAID network of organizations (contractors, PVOs, universities, etc), USAID would develop inter-agency agreements with other federal agencies such as DHHS to apply their expertise to Africa. For example, CDC could help support the development of HIV surveillance programs in Africa—a great need. HRSA could apply their knowledge and experience from community based HIV/AIDS service programs. NIH can support training of scientists as well as vaccine-related research. Funding for these activities is needed.

USAID has established mechanisms for tracking the obligations and expenditures of HIV/AIDS funds.

Enhancing the Response to the HIV-AIDS Pandemic in sub-Saharan Africa

USAID

05/21/99

Of a total HIV/AIDS budget of \$125 million in FY 1999, USAID is expending \$74 million (60%) in sub-Saharan Africa, funding HIV/AIDS prevention and mitigation programs in 24 sub-Saharan countries. An additional \$7 million is being expended in Africa from the *Supplemental Fund for Children Affected by AIDS*. The USG provides nearly 50% of development assistance monies for sub-Saharan Africa and has invested over \$650 million dollars in Africa for HIV/AIDS since the beginning of USAID support in 1986.

In addition to this substantial effort, the following activities represent new, or expanded initiatives to accelerate and enhance the response to the pandemic, especially in the most severely impacted countries, most of which are in sub-Saharan Africa.

1. **FY 2000 Budget Request:** In the Bureau Budget Submission, for FY 2000, USAID has requested increased funding at \$127 million. The additional \$2 million is intended to increase the scale of our program in India from one to two Indian States, Tamil Nadu and Maharashtra.
2. **Increased USAID Funding:** Based on our experience with the successful programs in Uganda and Senegal, a minimum of \$2.00 per adult per year is necessary to mount an basic HIV primary prevention program, that includes a selected set of care and support interventions to enhance the prevention agenda. Thus, a minimum of \$500,000,000 would be required for the African sub-continent. It should not be the sole responsibility of the USG to contribute this sum. Other donors, lending agencies, host country governments, and corporations must also increase their financial contributions. An additional \$20 million/year for the USAID HIV/AIDS budget would focus on sub-Saharan Africa and would achieve the following (These proportions would vary in each country based on the phase of the epidemic and the level of the response, thus far): Approximately 30% would be devoted to reduce mother-to-child HIV transmission and for orphan support. 30% would be devoted for expanded programs for African youth, who now represent the most critical vulnerable population for primary prevention interventions. 40% would be expended for "prevention-to-care" continuum activities that link voluntary HIV testing and counseling to decreasing risk behaviors in HIV negative individuals and basic support and care for HIV positive persons.
3. **Debt Relief:** USAID will assist with exploring debt relief options. We are currently working with the Department of Treasury and other relevant organizations to explore the innovative use of debt relief, rescheduling or swap mechanisms in order to increase host country resources.
4. **Storm Warning Initiative:** USAID will devote an additional \$750,000 for regional activities for six southern African countries (Malawi, South Africa, Zambia,

Zimbabwe, Tanzania, and Mozambique) There are four basic components for this initiative: targeting cross border transport corridors, improving policy dialogue tools, enhancing sharing of "lessons learned, and improving region wide HIV surveillance.

5. **The African Partnerships Initiatives:** Working closely with UNAIDS (new partners-CEOs and Foundations), USAID will focus on four critical areas: assist in the development of a Technical Support Platform to increase technical assistance capacity; explore increased resources through dialogue with U.S. based Foundations; enhance the U.S. Diplomatic initiative by linking with the efforts of other Ambassadors; and improving the exchange of best practice and lessons learned within the region.
6. **Diplomatic Initiative:** In collaboration with the Department of State, USAID is currently finalizing specific African country analyses to determine strengths and gaps in the existing country response and talking points for U.S. Ambassadors on selected aspects of economic impact talking points.
7. **Follow-on activities to the African/African-American Summit:** To be determined upon the return of the U.S. Delegation.
8. **Advocacy Role:** USAID will accelerate efforts to use our role at numerous fora (Binational Commissions, SADC, OAU, Great Lakes Initiative on AIDS, etc.) to address the critical issues of political commitment, allocation of sufficient resources and dealing with stigma and discrimination.

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National AIDS Policy Office

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2007-1550-F
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Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
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- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
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PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

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**EXPANDED USAID RESPONSE TO THE GLOBAL AIDS PANDEMIC:
07/09/99-4:30pm**

Additional funding would be used to achieve global impact on the pandemic and to leverage increased resources from host country governments affected by the pandemic, other bilateral donors, foundations, private corporate sector and the international lending agencies. It is also critical to expand selected research, surveillance systems and policy coordination. With an expanded and accelerated response, focusing primarily on Africa, the following global targets have been established in consensus with the international AIDS community.

Global Targets:

1. Decreased HIV incidence rate in 15-24 year olds by 25% by the year 2005.
2. At least 75% of HIV positive persons will have access to basic care at home/community levels and drugs for common opportunistic infections.
3. Orphans will have access to education and food on an equal basis to their non-orphan peers.
4. By 2002, domestic and external resources available for HIV/AIDS responses will have increased significantly (utilizing the formula of \$2/adult/year for essential prevention services), resulting in \$600 million for sub-Saharan Africa per year. (Baseline for 1998 is \$150 million)
5. Existing initiatives will be used as opportunities to include HIV/AIDS and to involve donors and countries to commit themselves to the Partnership.

There are two types of need: reducing HIV prevalence in the hardest hit countries and maintaining low prevalence in those countries with impending epidemics. The African countries listed below represent 70% of new HIV infections in Africa. In Asia, USAID would also target India, which contributes another 600,000 new HIV infections per year to the global total.

Priority Countries for the \$50 million Scenario:

Target countries in Africa would include: South Africa, Nigeria, Kenya, Uganda, Mozambique, Zimbabwe, Senegal, Malawi, Zambia, Rwanda, and West and Southern Africa Programs. The target country in Asia is India.

All of these countries have ongoing HIV/AIDS programs and existing mechanisms. USAID would also use a variety of specific criteria to allocate these funds, which includes adult HIV prevalence rates, potential for impact, increasing incidence, status of ongoing programs, political commitment of governments, and opportunity for innovation.

EXPANDED USAID RESPONSE TO THE GLOBAL AIDS PANDEMIC (FY 2000)

Category of Activities	Scenario 1 (Additional \$25 million to be expended in 9 key countries)	Scenario 1 Results Indicators	Scenario 2 (Additional \$50 million to be expended in 12 key countries)	Scenario 2 Results Indicators (in addition to Scenario 1 Results)
1. Primary prevention and stigma reduction: Targeted and population - wide HIV education, with focus on vulnerable youth; increased commitment by community leaders; increased access to HIV voluntary counseling and testing (VCT); Sexually Transmitted Infections (STI) diagnosis and treatment	\$10M	% increase in knowledge of means to prevent HIV/AIDS risk % of people expressing supportive attitudes to persons living with HIV/AIDS (PLWHA). - Increased # of people receiving treatment for sexually transmitted infections from a qualified health provider.	\$20M	- Increased # of sites providing quality VCT services - Decreased discrimination and stigmatization of Persons Living with HIV infection or AIDS. (PLWHA) - Reduced # of casual sexual partners. - Increased use of condoms in casual sexual contacts.
2. Home and community based care for HIV infected persons: counseling, psychosocial support, palliative and opportunistic infection care through community based clinics and home workers.	\$5M	% of local governments supporting care and support activities % of primary health facilities providing treatment for opportunistic infections	\$10M	% of HIV infected persons receiving TB care % of nonhealth sector programs that incorporate STI/HIV/AIDS.
3. Caring for children affected by AIDS: assist families and communities in caring for affected children; increasing access to services to reduce mother to child HIV transmission (MTCT).	\$5M	% of households caring for children/orphans. - Increased # of children affected by AIDS who are attending local schools.	\$10M	% of HIV infected pregnant women utilizing MTCT services - Increased # of children affected by AIDS accessing social services (food, health)
4. Infrastructure and capacity development: strengthen government, private sector, NGOs, & research institutions to plan and implement interventions, including surveillance systems.	\$5M	- increased # of people receiving HIV/AIDS prevention/care services - Improved provider performance - Increase Monitoring & Evaluation (M&E) capacity	\$10M	- Increased # of people receiving quality HIV/AIDS services. % countries with functioning basic surveillance systems - Expanded M & E capacity.

Expected results:

With an additional \$25 million dollars available for HIV prevention and mitigation services, all of the following results could be achieved in the 9 countries listed:

- 700,000 persons would receive intensive interpersonal HIV testing, education and counseling to reduce risk behaviors.
- 100,000 HIV infected persons would receive preventive therapy to eliminate active tuberculosis.
- 25,000 HIV infected pregnant women would receive interventions to reduce HIV infection of the newborn infant- resulting in 3000 infants being spared from HIV infection.
- All 9 countries would have functioning HIV surveillance systems.

If an additional \$50 million were available for prevention and mitigation services, the following results could be achieved in the 12 countries listed (in addition to those noted above):

- Mass media services could be delivered to 100 million persons in order to increase awareness about the risks of HIV: infection and ways to prevent transmission.
- 500,000 HIV infected persons would receive treatments for simple opportunistic infections.
- 50,000 AIDS orphans would receive support, allowing them to remain with extended families within their communities.
- 500,000 counselors, educators, trainers would receive training to improve quality of prevention interpersonal services.
- 3 candidate microbicide compounds will undergo Phase III clinical field trials and a rapid/simple/inexpensive diagnostic test for gonorrhea and chlamydia would be undergoing final field feasibility trials.
- By the Year 2002, through strategic leveraging of the USG contribution, the total resource funding level for Africa from all sources (bilateral donors, lending agencies, foundations, and host governments) would double to \$300 million / year.

AFR Bureau: Reprogramming to accommodate Additional HIV/AIDS Directive

- The Africa Bureau is committed to doing more to combat HIV/AIDS in Africa. We will be requesting significantly higher funding levels in our FY 2001 budget request, and hope that additional funding over our FY 2000 CP request levels can be secured.
- We have made HIV/AIDS our number one sectoral priority. Should additional funding not be secured in FY 2000, and should we be required to realign our FY 2000 CP request, we would make changes to those remaining sectors where we maintain a modicum of flexibility, but where significant lost impact will be keenly felt. We would not propose shifting allocations from high scrutiny Congressional and Administration priority areas such as Child Survival, Infectious Diseases, Agriculture, Basic Education or Population sectors. Instead, we propose the following very painful cuts:
 - To meet an overall internal budget realignment of \$15 million for HIV/AIDS, we would:
 - Reduce our Economic Growth request by approximately 7% (\$10 million), and apply these funds to HIV/AIDS. This includes a \$3 million cut to the \$30 million Africa Trade and Investment Program (ATRIP). Historically, our greatest flexibility in responding to development challenges has been through scarce Economic Growth funds. Our latest reviews show that 92% of our Economic Growth strategic objectives met or exceeded their performance targets. Cuts in this already extremely scarce resource undermine our efforts to bring good performing partners into the mainstream of the world trade economy, and lessens our ability to strengthen key economic programs which in many cases help support hard fought political and social stability.
 - Reduce our Environment request by approximately 5% (\$5 million), and apply these funds to HIV/AIDS. This will reduce our ability to provide innovative solutions to the critical problems of environmental degradation. This will also jeopardize our successful community wildlife management initiatives, now reaching a critical stage in their development.
- To meet an overall internal budget realignment of \$32 million for HIV/AIDS, we would take the following additional measures:
 - Reduce our minimal Democracy/Governance request by approximately 13% (\$9 million), and apply these highly valued funds to HIV/AIDS, thereby decimating the D/G program in Africa. The D/G sector is traditionally oversubscribed by missions requesting funds to strengthen and support newly emerging democratic institutions and provide key support to civil society growth.
 - Reduce our Promoting Health request by approximately 17% (\$2.0 million), and apply these funds to HIV/AIDS. This reduced funding would result in serious cuts in programs that support health care financing, policy reform and African health capacity building. We will not cut programs directed at reducing maternal mortality rates in Africa which are the highest in the world. We cannot cut deeper in this sector without placing our efforts to reduce unnecessary mortality due to complications during pregnancy and poor essential obstetric care practices across the region at risk.
 - Further reduce our Economic Growth request by approximately 2% (\$3 million), bringing the total EG request down by over 9% and apply these funds to HIV/AIDS, further eroding the progress that we are making in sustaining and rewarding good performing partners.
 - Further reduce our Environment request by approximately 3% (\$3 million), and apply these funds to HIV/AIDS.

IMPACT OF HIV INITIATIVE ON OTHER GLOBAL BUREAU PROGRAMS

Question: What would be the impact of taking \$7 million, and \$15 million out of the G FY 00 budget?

Answer:

- There is simply no place to take this money from.
- 94% of the G budget is allocated to programs that are earmarked, directed, or administration priorities.
- The small, remaining part of the budget is allocated to high priority programs, e.g. trade facilitation and a foreign policy response capability, that have already been cut too far.
- G proposes that its contribution be reallocated from population. While it would not be pain free, taking the funding from the FY00 request level of \$141.7 million would cause the least disruption to the G portfolio.

Operationalising HIV and AIDS: Strategies for USAID

Draft Paper prepared by Alan Whiteside for AFR/SD November 29, 1998.

Preamble

In late 1997 the University of Natal in Durban, South Africa, was commissioned by the Africa Bureau's Office of Sustainable Development (AFR/SD), Award No. AOT-G00-97-00375.00 to look at how HIV and AIDS issues can be operationalised in development. AFR/SD recognised that "development occurs primarily in the human realm"¹. It follows that a disease that causes large number of prime age adults to fall ill and die must be a threat to development, thus AIDS was seen as a key issue.

The study was, in part, to build on the work already done by the principal investigator. (A full description of the project is given in Appendix 1). There are five broad components:

1. Update and develop new AIDS Briefs for sectoral planners and managers;
2. Develop AIDS Briefs for professionals;
3. Develop tools for individuals, ministries and departments in developing country governments to put HIV into their activities;
4. Examine how HIV and AIDS can be incorporated into USAID operations; and
5. Provide training.

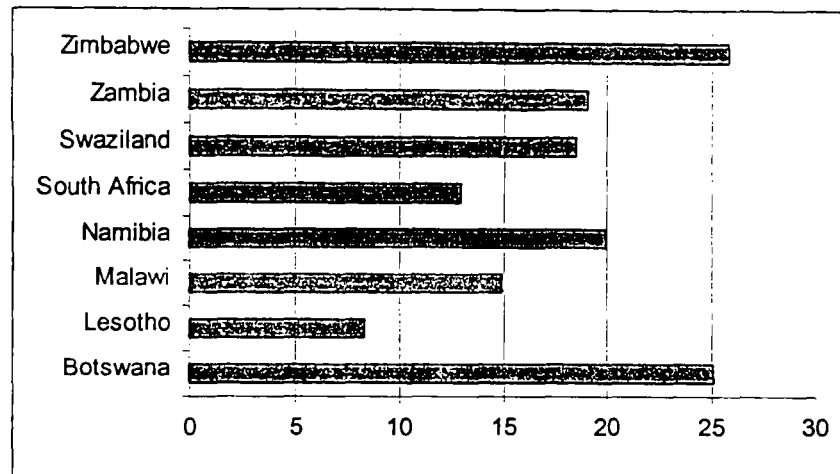
This paper forms the basis of item 4, the USAID focused activities. USAID has, as a strategic objective, "to increase use of improved, effective and sustainable responses to reduce HIV transmission and mitigate the impact of the HIV/AIDS epidemic". The response is coordinated by the HIV/AIDS Division, a part of the Office of Health and Nutrition in USAID Centre for Population, Health and Nutrition of the Bureau for Global Programs, Field Support and Research. The paper recognises the considerable resources allocated to these activities and the many achievements of USAID programs. It argues that AIDS will have adverse consequences in many of USAID's non-health activities, and the most successful prevention will be that where AIDS is seen as an issue by all development programmes and staff.

The Problem

"There is not one single project in Tanzania that has not lost staff from AIDS". Head of Country Section, Tanzania, GTZ Head Office.

Since 1985 HIV has spread, virtually unchecked, through much of the developing world. In the past few years the Eastern Europe/New Independent States have begun to experience an explosion of HIV in some marginalised population groups. Few countries have succeeded in halting or reversing the epidemic (data from Uganda and Thailand suggest that prevalence there may be decreasing while some countries may have halted the spread of HIV - Senegalese data suggest this is the case there). In parts of Southern Africa HIV prevalence rates have risen to over 20 per cent among adults, as is shown in Figure 1, while in Asia huge numbers of people are being infected, although proportionately they make up small percentages of the population.

¹ USAID, Africa Bureau, Office of Sustainable Development, Strategic Plan (FY) Washington 1998 – 2003, April 1997.

Figure 1 Adult HIV Prevalence in Selected African Countries 1998

"It is essential to understand that there is nothing special about HIV/AIDS - it is just another disease; but there is something special about the epidemic of prime-age adult illness and death that the rapid and invisible spread of HIV is causing".² AIDS means that unprecedented numbers of young adults will fall ill and die. In some countries rates could be as high as forty per cent of this age cohort.³ Furthermore, this level of mortality is inevitable: no matter how sustained or successful prevention efforts are, the people who will fall ill and die are already infected.

The impact of AIDS in the early stages is incremental not catastrophic.

As there is a period between HIV infection and illness, variously estimated at between five and eight years, present illness and deaths reflect the prevalence rates of the early 1990s while the current infections will only become apparent in the new millennium. This is one of the major problems facing those trying to develop responses to the epidemic: it is not yet visible. Furthermore, in the early stages the impact is incremental rather than catastrophic. What this means is that initially a clinic will see one or two AIDS cases after a few years 15 per cent of the patients may have AIDS, but the increase is gradual so their staff adapt to it. The same is true of the private sector and families. However it should be noted that responses involving actions for short-term survival may be at the cost of long-term investment: the example of taking female children out of school can be cited.

The expected consequences of the epidemic are:

- Increased demands for health care in the public sector. Already in many African countries up to 50 per cent of public sector hospital medical ward beds are occupied by people with HIV-related diseases. At the same resources, both human and financial, are diminishing.
- Decreases in life expectancy. These are shown for some of the worst affected African countries in Table 1. One important point about life expectancy is that it accounts for a third of the weight of the Human Development Index. The effect of AIDS deaths is dramatically to reduce life expectancy, in effect reversing development gains. AIDS also pushes up infant and child mortality, two other important indicators of development.

² Peter Godwin, in "AIDS in India: Looming Epidemic" Mosaic Press, New Delhi, 1998.

³ It has been calculated that in Kenya the adult HIV prevalence of only 7.5 per cent for the population aged 15 and over translates into a lifetime risk of dying of AIDS of 30 per cent. John Blacker and Basia Zaba, "HIV Prevalence and lifetime risk of dying of AIDS" Health Transition Review, Supplement to Volume 7, 1997.

- AIDS has a drastic effect at the household level. For households and families an AIDS case is disastrous socially, psychologically and economically. The cost of care, special foods and so on increases demands on the household resources. At the same time, if the person is an adult, their illness and death reduce household production capacity, and may result in a decline in household income. Thus, households are caught in a double bind of needing more resources at the very time when these are reduced. Households experiencing an adult death may: adjust household size; reduce labour supply to farming, wage employment and non-farm self-employment; experience a decline in income and consumption; face an increase in expenditure in medical treatment and funeral costs; and take female children out of school.⁴
- Rapid growth in the number of orphans. The people who are falling ill and dying are often parents. Women who are infected have a 30 per cent chance of passing the infections onto their infants. Their infants however, have a close to 100 per cent chance of being orphaned.⁵ Orphans have poorer life chances than other children and there is a real danger of a 'lost generation'.

Table 1 Demographic Indicators for 1998 with and without AIDS

<i>Country</i>	<i>Life Expectancy</i>		<i>Child Mortality Rate</i>	
	<i>With AIDS</i>	<i>Without AIDS</i>	<i>With AIDS</i>	<i>Without AIDS</i>
Botswana	40.1	61.5	121.1	57.4
Lesotho	54	62	120.2	98.3
Malawi	36.6	51.1	231.6	190.3
Namibia	41.5	65.3	125.5	62.1
South Africa	55.7	65.4	95.5	69.7
Tanzania	46.4	55.2	160.1	137.8
Zambia	37.1	56.2	181.2	125.7
Zimbabwe	39.2	64.9	123.4	50.5

Source: United States Bureau of the Census, *World Population and Vital Statistics Yearbook 1998*, Population Programme Centre, Washington DC, 1998.

The Implications for USAID

What has all this got to do with sections of USAID not directly concerned with health and population issues? The answer is, a great deal. The disease and its consequences have the potential to undermine all development efforts, and the way development is undertaken could have a significant impact on the number of people infected and the way they cope.

**HIV is no longer an epidemic.
In much of Africa it is now endemic.
This requires rethinking responses.**

There is one crucial point. AIDS is here to stay for the next decade at least and probably longer, and we will be dealing with its consequences for many years hence. There is a need to realise that in many

⁴ The World Bank found these responses in the Kagera study, see The World Bank, *Confronting AIDS: Public Priorities in a Global Epidemic*, A World Bank Policy Research Report, Oxford University Press, New York, 1997.

⁵ Some of the best work on orphaning as a result of AIDS has been done under the auspices of USAID. See for example Hunter, Susan & John Williamson, "Children on the Brink: Strategies to Support Children Isolated by HIV/AIDS", prepared by the Health Technical Services Project for the United States Agency for International Development, 1998, 56 pages.
Hunter, Susan and John Williamson, "Responding to the Needs of Children Orphaned by the HIV/AIDS, Discussion paper number 7, prepared by the Health Technical Services project for the United States Agency for International Development, June 1998, 30 pages.

countries HIV is no longer an epidemic - it is endemic. This is very important because it means we need to operationalise our response to HIV and AIDS. It no longer requires a special task force or budget line and there is no quick fix.

How HIV/AIDS will impact on USAID can be illustrated by looking at the agency's mission and goals. USAID's mission is to contribute to "US national interests through the results it delivers by supporting the people of developing and transitional countries in their efforts to achieve enduring economic and social progress and to participate more fully in resolving the problems of their countries and the world."⁶ USAID works through a strategic plan which sets out goals, objectives and performance measures for its major functions and operations.⁷ "USAID has defined its major functions and operations in terms of sustainable development; i.e. actions that lead to a lasting increase in the capacity of society to improve the quality of life of its people". It sets six overarching goals. Again it needs to be stressed that for each goal the consequences of AIDS may be far-reaching and prevent the agency from achieving the goals. Furthermore, in the process of moving towards each goal the various divisions of the agency may make major contributions to HIV prevention and mitigation. This is illustrated in Figure 2.

Figure 2 USAID Goals. AIDS as a Threat and Contributions to Prevention

<i>Goal</i>	<i>How AIDS Threatens the Goal</i>	<i>How Achievement Of The Goal Helps HIV Prevention</i>
1. Broad-based economic growth and agricultural development encouraged.	Public funds diverted to care and welfare. Loss of skilled human resources. Private sector impact. Business environment. Agriculture labour lost. Food/ subsistence crops replace cash crops.	Economic opportunities for poor and women. Equity reduces forced commercial sex. Increased tax base gives resources for prevention. Growth builds civil society.
2. Democracy and good governance strengthened.	Loss of political and civic leadership. Uniformed services particularly susceptible to HIV infection = instability. Government less efficient.	Building civil society decreases HIV transmission. Destigmatisation of HIV and AIDS more likely in democratic, accountable society.
3. Human capacity built through education and training.	People die after being trained and educated. Trainers and educators fall ill and die. Girls and orphans less likely to be educated.	Education means knowledge. Female education = female empowerment. Education increases capacity to respond.
4. World population stabilised and human health protected.	Health deteriorates. Population structure and dependency ratios adversely affected. TB increases. Health indicators show retreat. Future generations at risk of poor health.	Better health - decreased risk of HIV transmission. STD treatment crucial. Condom use for population control = AIDS control.
5. The world's environment protected for long-term sustainability.	Resources diverted from environment. Poverty increased - environmental degradation. Rural/urban migration.	Environmentally efficient fuel, e.g. electricity instead of coal, saves female labour, others.
6. Lives saved, suffering associated with natural or man-made disasters reduced, and conditions necessary for political and/or economic development re-established.	AIDS creates instability and insecurity leading to civil unrest and conflict. AIDS diverts resources. AIDS affects conditions for economic and political development.	End of conflict means demobilisation and return of combatants to barracks. Caring societies build civil society.

⁶ U.S. Agency for International Development, 1997 Agency Performance Report, Centre for Development Information and Evaluation, Washington D.C.

⁷ U.S. Agency for International Development, USAID Strategic Plan, http://www.info.usaid.gov/pubs/strat_plan 1998.

The purpose of this paper is not to argue that the people in, for example, democracy and governance undertake AIDS prevention exclusively! Rather that they should consider AIDS as an issue and ask:

- 1 What impact might the disease have on our achieving our objectives and how can we avoid this?
- 2 What contribution can we make to preventing and mitigating the disease?

There are some examples of how this might be done. The European Union looked at how HIV/AIDS might be incorporated into three sectors: education, rural development, and transport.⁸ The transport example shows how AIDS can be an "add on". When, in 1996, new Transport Sector Guidelines were published by the EU, they noted, "while new and improved infrastructure brings economic and social benefits, it can also facilitate the spread of disease. Opening up new traffic routes and improving access and personal mobility can contribute to the rapid spread of communicable disease such as AIDS. Extra health measures must be taken by health agencies and contractors during the construction stage when there might be many temporary migrants in a community. When works are complete, health agencies must cope with the greater number of travellers who can both bring and carry away infections".⁹

Working with people in the transport sector, a 'tool' was developed. This looked at how and why those involved in transport might be more susceptible to HIV infection and the possible impact this might have on the sector. Four key groups were identified - those building and maintaining transport infrastructure; the operators; management; and the users or travellers. However not all are equally at risk - there must be differentiation. A bus driver transporting commuters is different from one transporting passengers over long distances and spending days away from home. The 'tool' includes a table which sets out activities, possible problems, potential remedies and wider action. This is shown in Figure 3.

⁸ Considering HIV/AIDS in Development Assistance: A Toolkit, Commission of the European Community, 1997.

⁹ Towards sustainable transport infrastructure; a sectoral approach in practice. Director-General for Development European commission, July 1996.

Figure 3 A Response for the Transport Sector

<i>Activity</i>	<i>Possible Problems</i>	<i>Potential Remedies</i>	<i>Wider Action</i>
Building/maintenance			
Mobility of workers.	Increase in sexual partners due to separation from family and relative wealth of labour force.	Increase use of local labour. Contract tender documents to include: i Required health & education measures. ii Distribution of condoms. iii Treatment of STIs.	Liaise with Ministry of Health and AIDS Control Programme
	Increased illness and death among workers.	Plan human resources and benefits to take account of this.	Companies and government liaise on human resource requirements.
Transport Service			
Mobility of service operators.	Highly mobile group with likely increased exposure to STIs and HIV/AIDS.	Targeted health education, AIDS prevention and condoms. Reduce time away from home. Provide controlled rest areas. Reduce time at border posts.	AIDS Control, NGOs and operators. Operators. Operators. Governments.
Management			
Planning and running transport.	Professional and skilled cadres also experience illness and death and are hard to replace. Govt. benefits allow long periods of sick leave.	Identify key personnel, human resource plans to take account of increased morbidity and mortality.	Government. Operators.
Increase mobility of the population for trade, employment and leisure.	People who travel away from families and home are more likely to have sexual partners.	Transport sector should monitor traffic flows (and types) of movement and inform others who will provide appropriate education.	Government. AIDS Control programme.

What Next

It is possible, under the project, to examine in more detail how HIV spread may be helped or hindered by USAID activity, and how the AIDS epidemic may affect USAID's development efforts. In addition there is provision for training in analysis and application of the lessons learned - but this will need the support of staff.

Alan Whiteside, Health Economics and HIV/AIDS Research Division, University of Natal, Durban 4041, South Africa. Whitesid@shep.und.ac.za Tel. 27 31 2602592 Fax 27 31 2602587

Appendix 1

OPERATIONALISING HIV AND AIDS ISSUES FOR DEVELOPMENT - SCOPE OF WORK

INTRODUCTION

It is over 15 years since the disease AIDS was first identified. During this time it has spread to virtually all corners of the world. There have been unprecedented scientific advances and, in the west HIV may become a treatable, long-term chronic infection with the numbers infected remaining low.

However, more than 90 per cent of all adult HIV infections are situated in developing countries. UNAIDS estimated that of the 22.6 million people living with HIV/AIDS in December 1996, some 14 million were in sub-Saharan Africa, and 5.2 million in South and South-east Asia. For the majority of people these new treatments remain inaccessible. Furthermore, the epidemic continues to spread, and the response has been inadequate.

HIV/AIDS was initially seen as a health issue and health ministries were expected to "solve the problem". A further complicating factor was that the international donor community saw the potential problem more clearly than national governments (which had many, and more immediate, problems to deal with). The result was that ownership of the issue did not lie with nationals and so was not incorporated into national planning. Some of those working in the AIDS field were also remiss, assuming that others would share their concerns and want to respond to the epidemic with the same degree of urgency.

It became apparent that the key to getting HIV and AIDS issues into planning and policy-making was to provide a methodologies and ways in which it could be incorporated. The first attempt to do this was in 1994, when the WHO Global Programme on AIDS commissioned two sample AIDS briefs for sectoral managers and planners. In late-1995 a further six were commissioned and typeset. With the closure of the GPA it appeared that the briefs would languish; but, fortunately, USAID had sight of them and decided to publish them through AED and the SARA and HHRAA projects. These briefs - on Commercial Agriculture, Subsistence Agriculture, Education, Health, Manufacturing, Mining, Tourism and Military Populations - have been widely used. They have been translated into French, Spanish, and Portuguese. A further two briefs - the Finance and Transport Sectors - are being prepared with the support of a South African insurance company.

At the same time, as the briefs were being prepared, Professor Whiteside was working for the European Union on a project on the Socio-Economic Impact of HIV/AIDS in the Developing World. The aim was to develop ways of integrating HIV/AIDS issues into planning, both in the developing countries and in the European Union. To this end, extensive fieldwork was carried out and two workshops were held - one in Durban for developing countries, and one in Brussels to look at EU procedures.

The results of the Durban workshop was a published proceedings. Unfortunately, this did not really address the issue of how to incorporate HIV/AIDS into the developing country planning. The participants at this workshop were drawn from the wrong sectors. The project then commissioned a practising developing planner to prepare a short manual on "The Integration of HIV/AIDS into

National Development Planning". This, while containing some very practical ideas, is 72 pages long.

The Brussels workshop also resulted in a proceedings publication "HIV/AIDS and Development Assistance", and as a result of the workshop and fieldwork, a Toolkit was produced - "Considering HIV/AIDS in Development Assistance". This comprises a folder and eight documents, and is designed for busy professionals, both at headquarters and delegations. The documents are, with one exception, all four pages or less and comprise:

An Introduction to HIV/AIDS; Assessing the National Importance; A Sectoral Checklist - and three supplementary sectoral checklists for Education, Transport, and Rural Development; Guidelines for Project Cycle Management; and Including HIV/AIDS in Consultants' Terms of Reference.

OBJECTIVES OF THE PROJECT

This proposed project will build on and add to the work that has been done and, ensure that the issues of HIV/AIDS can be operationalised in donor agencies, governments and the private sector. The following outputs are envisaged:

1. **AIDS Briefs for Sectors.** The existing eight AIDS briefs will be revisited and, where necessary, revised in the light of new developments. A further eight briefs will be prepared on additional sectors. These will include fishing, civil service, small- and medium-scale enterprises. Others will be decided in conjunction with USAID.

2. **AIDS Briefs for Professionals.** The aim of these AIDS briefs will be to provide short guidelines for professional people in order to inform consideration of HIV/AIDS issues in their work. Growing globalisation and setting of world-wide standards make this timely. The briefs will set out the international norms as well as suggested actions. Initially, we propose to prepare briefs for the following professions or occupational groupings:

- General practitioners
- Town and regional planners
- Lawyers
- Social workers
- Politicians
- Development aid administrators, NGOs, and government.

We will establish four other groups in conjunction with USAID.

3. **Considering HIV/AIDS in Development Assistance : Toolkit.** The existing toolkit needs to be adapted to USAID and additional sectoral checklists developed. These could include agriculture, livestock, private sector, tourism, infrastructure other than transport, health, urban development, environment, women and development, poverty alleviation, structural adjustment, governance, and social development.

4. **Considering HIV/AIDS in National Development Planning Toolkit.** The project will develop a toolkit for developing country governments. This toolkit will be similar to the EU toolkit and will build on the manual, but will also set out the way in which each ministry should integrate HIV/AIDS issues into its procedure for planning, policy-making, and operating.

5. **Regional Workshops.** The one drawback with producing all these materials is that, although they are designed to be user-friendly, applicable, and as simple as possible, they are not necessarily used and are very generic. In order to ensure that the products are used, it is intended that three regional workshops be held. The aim of the workshop would be to: (a) disseminate the materials; (b) teach people how to use them; and (c) teach people how to adapt them to their own circumstances. Each workshop would be one-week long and would be structured as follows:

Days 1 and 2 AIDS Briefs for Sectors

Day 3 AIDS Briefs for Professionals

Days 4 and 5 Toolkits.

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OFFICE OF NATIONAL AIDS POLICY
EXECUTIVE OFFICE OF THE PRESIDENT
THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

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PLEASE DELIVER TO MICHAEL ISKOWITZ

Dear Sandy and Michael-

Alex just called. He said that out of the AIDS orphan money, Rwanda will get an additional \$1 million to the \$3.5 million already confirmed, for a total of \$4.5 million. It is also highly probable that they will get funds from food aid, but the amount depends on how much the mission asks for after discussions with you and USAID here.

I hope this is helpful for the press conference.

Talk to you tomorrow!

Cheryl

736 Jackson Place
Washington, DC 20503
(202) 456-2437
(202) 456-2438 (fax)



OFFICE OF NATIONAL AIDS POLICY
EXECUTIVE OFFICE OF THE PRESIDENT
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FACSIMILE TRANSMITTAL SHEET

TO: **Sandra Thurman** FROM: **Cheryl Bauerle**
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PLEASE DELIVER TO SANDRA THURMAN

Dear Sandy and Michael-

Alex just called. He said that out of the AIDS orphan money, Rwanda will get an additional \$1.1 million to the \$3.5 million already confirmed, for a total of \$4.5 million. It is also highly probable that they will get funds from food aid, but the amount depends on how much the mission asks for after discussions with you and USAID here.

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Enhancing the Response to the HIV-AIDS Pandemic in sub-Saharan Africa

USAID

05/21/99

Of a total HIV/AIDS budget of \$125 million in FY 1999, USAID is expending \$74 million (60%) in sub-Saharan Africa, funding HIV/AIDS prevention and mitigation programs in 24 sub-Saharan countries. An additional \$7 million is being expended in Africa from the *Supplemental Fund for Children Affected by AIDS*. The USG provides nearly 50% of development assistance monies for sub-Saharan Africa and has invested over \$650 million dollars in Africa for HIV/AIDS since the beginning of USAID support in 1986.

In addition to this substantial effort, the following activities represent new, or expanded initiatives to accelerate and enhance the response to the pandemic, especially in the most severely impacted countries, most of which are in sub-Saharan Africa:

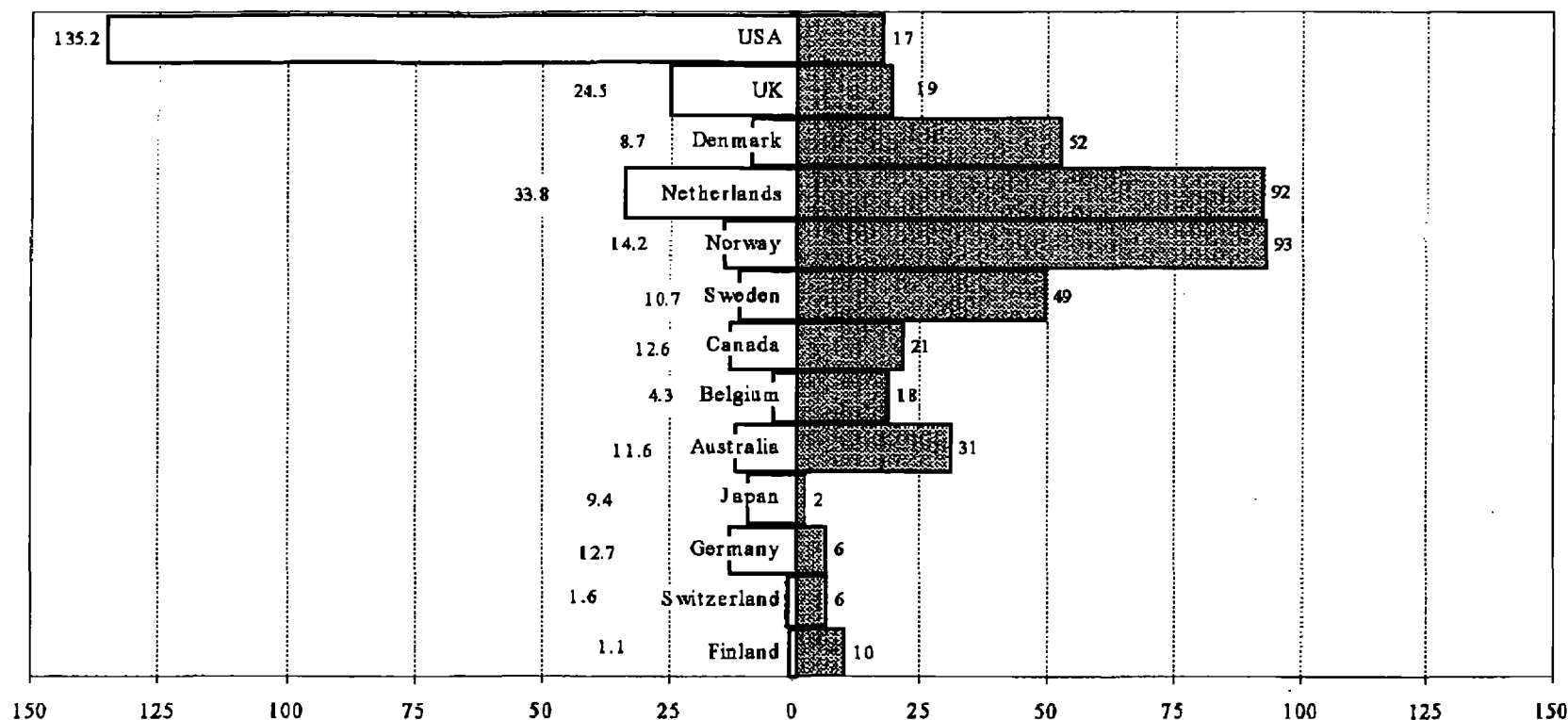
1. **FY 2000 Budget Request:** In the Bureau Budget Submission, for FY 2000, USAID has requested increased funding at \$127 million. The additional \$2 million is intended to increase the scale of our program in India from one to two Indian States, Tamil Nadu and Maharastra.
2. **Increased USAID Funding:** Based on our experience with the successful programs in Uganda and Senegal, a minimum of \$2.00 per adult per year is necessary to mount an basic HIV primary prevention program, that includes a selected set of care and support interventions to enhance the prevention agenda. Thus, a minimum of \$500,000,000 would be required for the African sub-continent. It should not be the sole responsibility of the USG to contribute this sum. Other donors, lending agencies, host country governments, and corporations must also increase their financial contributions. An additional \$20 million/year for the USAID HIV/AIDS budget would focus on sub-Saharan Africa and would achieve the following (These proportions would vary in each country based on the phase of the epidemic and the level of the response, thus far): Approximately 30% would be devoted to reduce mother-to-child HIV transmission and for orphan support. 30% would be devoted for expanded programs for African youth, who now represent the most critical vulnerable population for primary prevention interventions. 40% would be expended for "prevention-to-care" continuum activities that link voluntary HIV testing and counseling to decreasing risk behaviors in HIV negative individuals and basic support and care for HIV positive persons.
3. **Debt Relief:** USAID will assist with exploring debt relief options. We are currently working with the Department of Treasury and other relevant organizations to explore the innovative use of debt relief, rescheduling or swap mechanisms in order to increase host country resources.
4. **Storm Warning Initiative:** USAID will devote an additional \$750,000 for regional activities for six southern African countries (Malawi, South Africa, Zambia,

Zimbabwe, Tanzania, and Mozambique) There are four basic components for this initiative: targeting cross border transport corridors, improving policy dialogue tools, enhancing sharing of "lessons learned, and improving region wide HIV surveillance.

5. **The African Partnerships Initiatives:** Working closely with UNAIDS (new partners-CEOs and Foundations), USAID will focus on four critical areas: assist in the development of a Technical Support Platform to increase technical assistance capacity; explore increased resources through dialogue with U.S. based Foundations; enhance the U.S. Diplomatic initiative by linking with the efforts of other Ambassadors; and improving the exchange of best practice and lessons learned within the region.
6. **Diplomatic Initiative:** In collaboration with the Department of State, USAID is currently finalizing specific African country analyses to determine strengths and gaps in the existing country response and talking points for U.S. Ambassadors on selected aspects of economic impact talking points.
7. **Follow-on activities to the African/African-American Summit:** To be determined upon the return of the U.S. Delegation.
8. **Advocacy Role:** USAID will accelerate efforts to use our role at numerous fora (Binational Commissions, SADC, OAU, Great Lakes Initiative on AIDS, etc.) to address the critical issues of political commitment, allocation of sufficient resources and dealing with stigma and discrimination.

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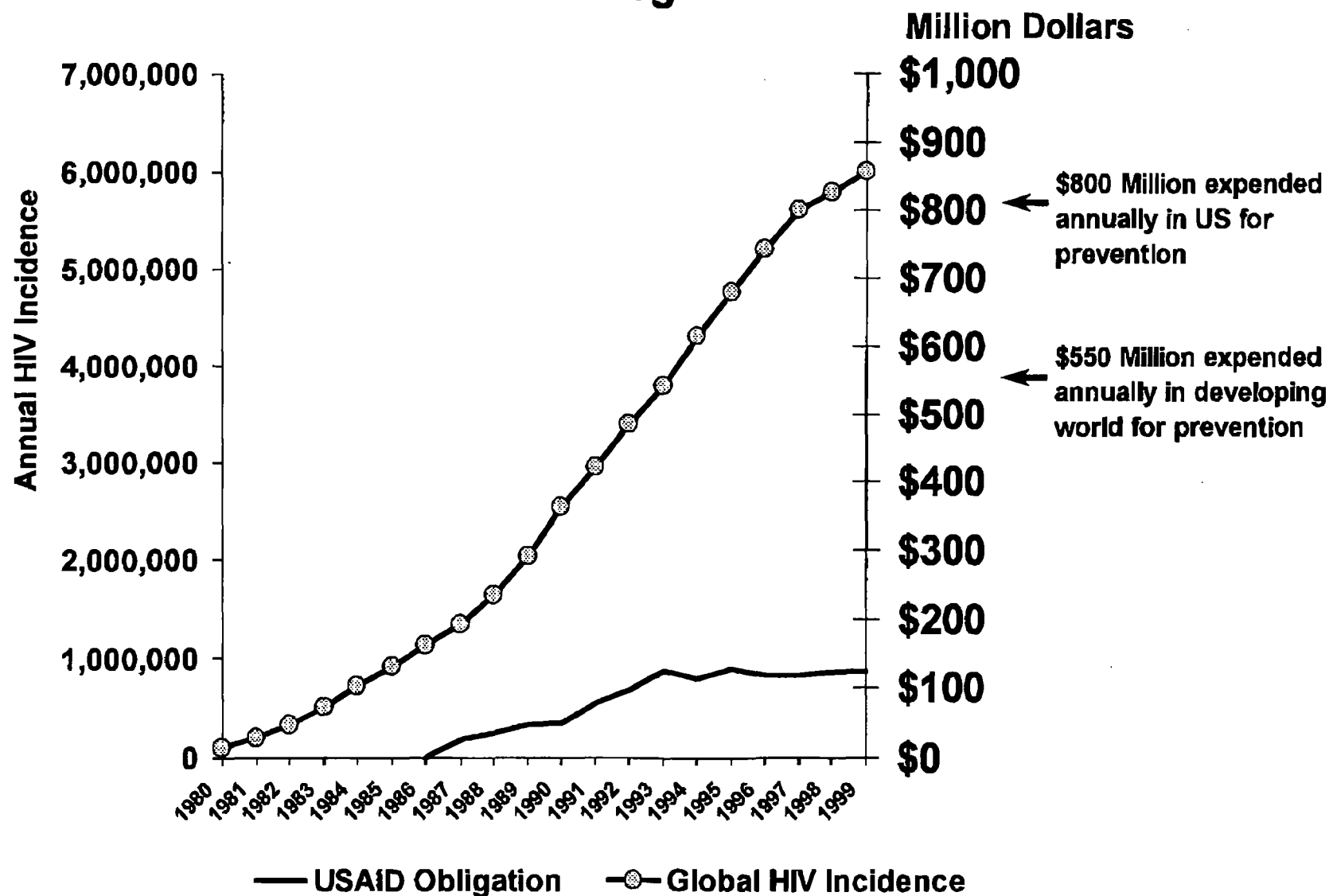
FIGURE 1
HIV/AIDS ODA as reported by 13 ODA Agencies:
Total amount obligated, 1997, in \$US million and
Obligations reported by ODA agencies per \$US million 1997 GNP



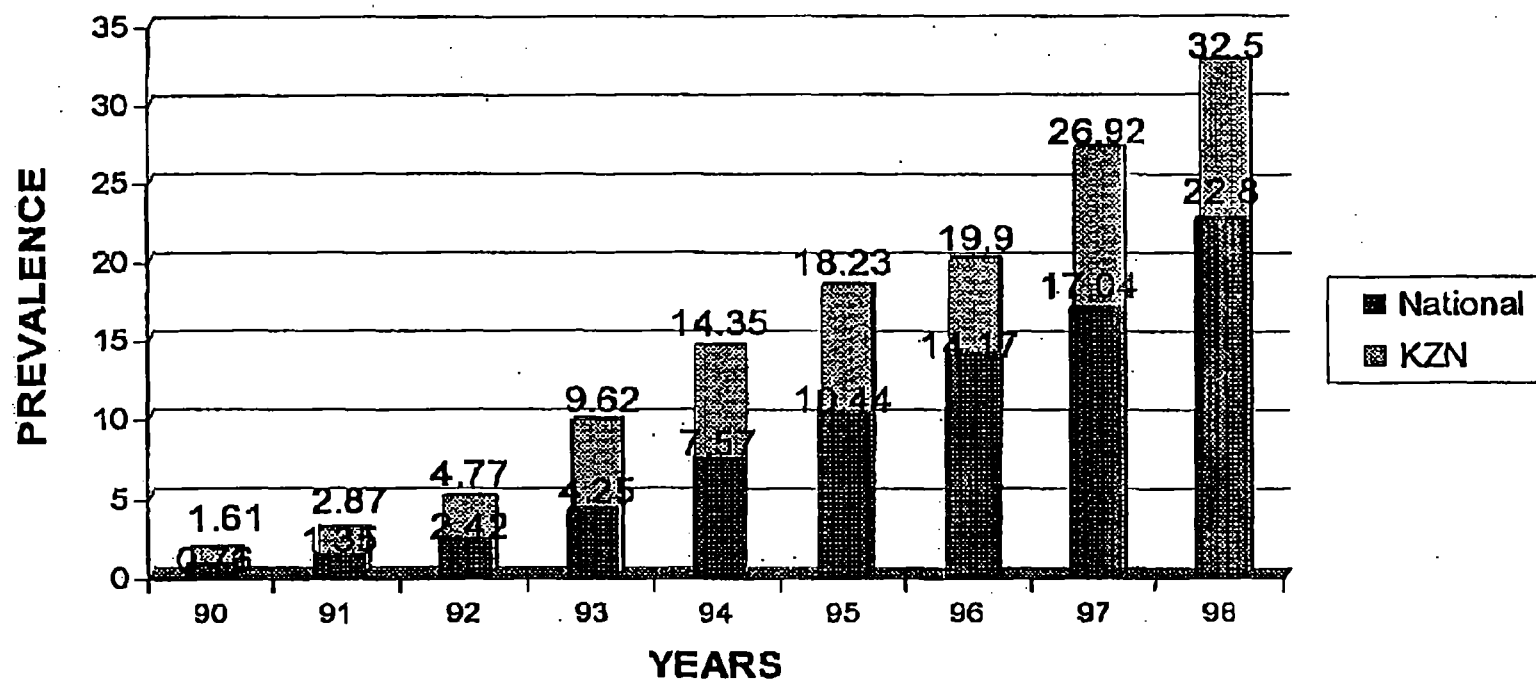
HIV Funding in \$US million
 Total: \$US 314.64 million

HIV Funding in \$US
 per \$US million GNP

FIGURE 2
Annual HIV Incidence (# of new HIV infections/year)
Compared to Annual USAID \$ Obligation for HIV/AIDS
Programs



NATIONAL & KZN HIV PREVALENCE ANTENATAL CLINICS



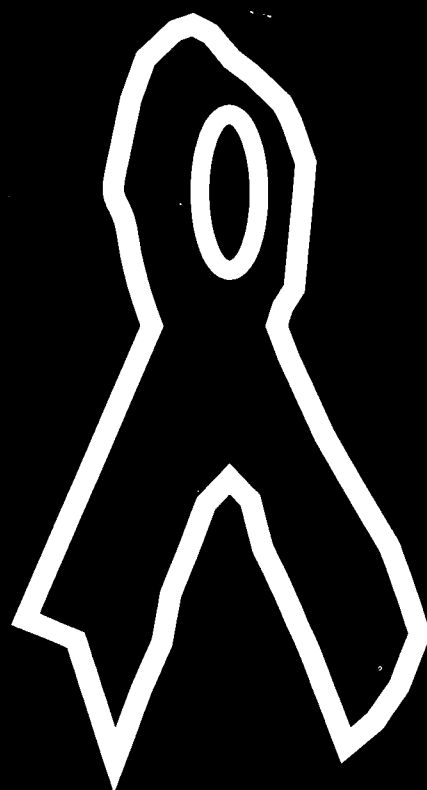
Professor A.N.Smith, Department of Virology, University of Natal

Table 7: Comparison of International Targets of HIV/AIDS Prevention and Care

	Prevention of Sexual Transmission	Prevention of Mother-Child Transmission	Care	Orphans
Possible USG Targets for an expanded response (with additional resources)	50% decrease in HIV incidence in Africa 30% decrease in HIV incidence elsewhere	50% of HIV infected women will have access to interventions to reduce mother-to-infant HIV infection	At least 30% of HIV infected persons will have access to basic care and support services.	At least 30% of AIDS orphans will have access to basic community support services.
USG LIFE Initiative Targets	10% decrease in HIV incidence among 15-24 year olds	10% decrease in perinatal infections	50% of district/provincial governments will be able to implement care and support activities	50% of households caring for children affected by AIDS will receive assistance from an institution or group outside the family
International Goals to which LIFE is contributing (including goals identified at the ICPD +5 meeting)	25% decrease in incidence among 15-24 year olds	50% of HIV-infected pregnant women will have access to interventions to reduce mother-to-child transmission	75% of HIV infected persons will have access to basic care and support services at the home and community levels, including access to drugs for common opportunistic infections	Orphans will have access to education and food on an equal basis with their non-orphaned peers
International Partnership Against AIDS in Africa (IPAA) Targets (UNAIDS)	25% decrease in incidence among 15-24 year olds in the most affected countries	At least 50% of HIV-infected pregnant women will have access to testing, counseling, treatment and replacement feeding programs	50% of all HIV+ persons will have access to drugs for common OIs	50% of families of children affected by AIDS will have access to an essential package of services, including health, education and food

Table 7: Comparison of International Targets on HIV/AIDS Prevention and Care

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**Report on a
Consultative Meeting on
*AIDS as a Developing Crisis in Africa:
Rethinking Strategies and Results*
Washington DC
September 29 - October 1, 1999**

USAID/AFR/SD



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USAID/AFR/SD

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The Meetings

This report summarizes three meetings held in Washington DC from September 29–October 1, 1999 to discuss the HIV/AIDS crisis in Africa. There were—

- (i) A Consultative Meeting on "AIDS as a Development Crisis" held over two days and attended by staff of USAID, the World Bank, NGOs and other partner agencies to discuss scaling up and acceleration of the response to HIV/AIDS in Africa;
- (ii) An internal USAID meeting to review the proceedings of the consultative meeting and suggest ways forward;
- (iii) A roundtable discussion between USAID and other agencies with representatives of the private sector to decide ways in which the corporate sector can contribute to the fight against AIDS.

Summary

Experts from different development sectors and HIV/AIDS programs deliberated for two days on the development crisis resulting from high and growing HIV/AIDS prevalence rates in Africa. Specifically, they discussed the ways to assist countries with two types of multi-sectoral actions to deal with the epidemic. First, the actions each sectoral ministry can undertake, *intra-sectorally*, to prevent the epidemic and reduce its impact on the sector. Second, the actions, mostly *inter-sectoral*, that local governments and communities can undertake synergistically to improve prevention and care programs. The two sets of actions can potentially reinforce each other.

For the first set of intra-sectoral actions, the meeting reviewed the tool kits or framework for different sectors developed by Abt Associates and the University of Natal in South Africa. The participants found these tool kits extremely useful for initiating sectoral involvement in HIV/AIDS. The Malawi Ministry of Agriculture's experience in using the toolkit has been encouraging. The important elements of success are a ministry's ownership of the process, its commitment to take actions, and sustained donor financial support to implement the actions.

For the second set of intersectoral actions, participants discussed a model for scaling up community-level programs presented by the World Bank and the local government tool kit developed by the University of Natal. A critical lesson from the experiences with decentralization and rural development program is that a top-down flow of funds and other assistance is ineffective. A mechanism needs to be created by countries and donors to channel funds directly to communities through district and village HIV/AIDS committees. The model discussed suggested that these committees could be formed and made functional in most countries within one year. These committees will need technical support from non-governmental organizations involved in program implementation. The NGO representative from the Global Health Council and National Organizations Responding to AIDS (NORA) referred to the unused capacity of NGOs that donors, particularly USAID, have built during the past several years.

If the above two actions—one led sectorally and centrally and the other led locally and inter-sectorally—are undertaken in the same communities in a coordinated and concerted manner, HIV/AIDS programs will be immediately strengthened and expanded. The paradox of unspent donor funds, on the one hand, and critical shortages of funds for various programs, on the other, were highlighted. Thus, the main challenge is to find ways to channel funds where and when they are needed. The apparent capacity constraint can be reduced by involving and using existing capacities of a large number of communities and agencies for scaling up HIV programs.

The private sector can supplement the efforts of governmental and non-governmental organizations. Companies that participated in the meeting's private sector roundtable discussions expressed strong interest in adopting HIV/AIDS prevention and care programs within their companies and in supporting national programs, particularly at community levels.

Participants identified a number of actions that can be undertaken by USAID staff and possibly others to support the field missions in their efforts to assist the countries in adopting multisectoral approaches. A few general recommendations for USAID, particularly for AFR/SD's consideration, are summarized below:

- Select a few countries, such as those targeted in the LIFE initiative, to support the missions in adopting multisectoral approaches in a concerted and coordinated manner to obtain results in a relatively short period.
- Form rapid response teams consisting of USAID staff and its contractors to provide ready technical support to Missions in designing and evaluating the above mentioned programs.
- Follow-up on the private sector roundtable discussions, particularly on private sector interest in community-level activities and on their involvement in HIV/AIDS programs, in priority countries mentioned above.
- Review procurement procedures and mechanisms to facilitate missions in channeling funds directly to the communities.
- Continue and formalize inter-agency sectoral groups formed at the consultative meeting to exchange experiences and, more importantly, to coordinate efforts and to mobilize resources at the headquarters level.
- Document and disseminate on a regular basis notable actions by different missions. For example, a few missions such as South Africa, Zimbabwe, Zambia, Malawi, Senegal, Tanzania, and Uganda have already initiated multisectoral programs and their experiences will be valuable to other missions who plan to initiate similar activities.

Detailed Report

Introduction

HIV/AIDS is a major development crisis in sub-Saharan Africa. At the recent *International Conference on AIDS and STDs in Africa* (ICASA) in Lusaka, Zambia, ten countries declared HIV/AIDS a national disaster. The epidemic, in terms of loss of manpower and changes in demand for services, adversely affects almost all sectors of the economy and all sections of society. Therefore, it is imperative to rethink development objectives, strategies, and processes in light of the growing epidemic and mounting evidence of the severity of its impact on different sectors and communities. A few USAID field missions and other donor and development agencies have started the process of involving different sectors in HIV/AIDS multi-sectoral programs. To discuss the strengthening of USAID's efforts in this area, the Bureau for Africa's Office of Sustainable Development has formed a multisectoral HIV/AIDS Working Group that brings together the sectoral staff from Africa and the Global Bureau. To further advance these efforts in a collaborative manner with other agencies, the group organized a consultative meeting, September 29–October 1, 1999 in Washington, DC.

Purpose and Expected Outcome of the Consultative Meeting

The main purposes of the meeting were to—

- sensitize the sectoral staff about the HIV/AIDS impact in their respective sectors,
- discuss potential sectoral actions to reduce the impact and prevent the epidemic taking into account the African perspective presented at ICASA, and
- discuss ways to strengthen support to field missions to accelerate USAID response to the crisis.

The expected outcomes of the meeting were to—

- encourage sectors to address the implications of HIV/AIDS for their respective operations and adopt measures to deal with them,
- identify areas of collaboration in these efforts among agencies and between sectors, and
- propose changes in USAID operational strategies to facilitate and expedite the implementation of its HIV/AIDS programs.

Agenda

During the first two days, participants reviewed the data and information available on the magnitude of HIV/AIDS and the severity of its socio-economic impact on different sectors and communities. Each sector discussed the implications of HIV/AIDS for its own operations and identified actions that could be taken by the sector to assess the impact of HIV/AIDS and reduce its severity. A set of toolkits developed by Abt Associates and the University of Natal, South Africa, provided the framework for such analysis and actions. Professor Alan Whiteside of the

University of Natal and his associate from the University of East Anglia, Tony Barnett, facilitated the meeting.

The two-day meeting was followed by an internal USAID discussion on the morning of the third day. The purpose of the this discussion was to identify the changes in internal processes and procedures required to implement the actions identified during the first two days and ways to provide stronger support to missions to implement multi-sectoral approaches. The meeting recognized that a few missions have already taken the lead in adopting multi-sectoral approaches and learning from their experiences will be an important next step.

On the afternoon of the third day, a private sector roundtable was held on ways to enhance the participation of the private sector in HIV/AIDS programs in Africa. (Agenda is given in Annex 1.)

Participants

The participants included USAID staff from the Africa and Global Bureaus in different sectors including: agriculture and natural resource management, democracy and governance, education, and health. In addition, staff engaged in inter-sectoral programs such as economic growth, community mobilization including micro-enterprise, and crisis, conflict and disaster preparedness also attended. Ms. Sandra Thurman, Director of the White House Office of National AIDS Policy, opened the meeting. Staff from two USAID regional centers in eastern and southern African and from the Senegal, Zimbabwe, and Tanzania missions also joined. Views from other field missions were solicited before the meeting. The Ethiopia, Madagascar, and Zambia missions provided excellent perspectives (see attachment A). The health attaché from the South African embassy to the US attended.

The World Bank, UNICEF, UNAIDS, Global Health Council, AFL-CIO and other non-governmental and technical organizations joined the discussions on the first two days.

Representatives from Coca-Cola, Chevron, SmithKline Beecham and Daimler Chrysler, participated in the roundtable discussions in addition to the Constituency for Africa and AFL-CIO. (The summary of roundtable discussions is in Attachment B and the list of participants is in Annex 3).

Synthesis of Discussions

Ms. Thurman opened the meeting with remarks on the development of the Administration's recent LIFE initiative, as well as her belief that multisectoral approaches to combating HIV/AIDS in Africa were critical to successful efforts to reduce transmission of the disease. Mr. Alex Ross, AFR/SD and Dr. Paul Delay, G/PHN/HIV-AIDS also made opening remarks.

Extent and Severity of Impact

After presenting the available data on HIV/AIDS prevalence, Mr. Peter Way from the U.S. Census Bureau stated that HIV/AIDS would substantially change the demographic profile of

countries in sub-Saharan Africa by 2010. Countries—such as Zimbabwe, South Africa, Kenya, Nigeria, Cote d'Ivoire, and Cameroon—that were approaching a life expectancy of close to 60 years in the early 1990s will experience a significant decline of 20 years or more by 2010. These countries are geographically dispersed throughout Africa and show the potential pervasiveness of the HIV/AIDS problem. The rate of population growth will be less than 1% by 2010 instead of close to the 2% expected without HIV/AIDS in three of the countries most affected by HIV/AIDS, namely Kenya, South Africa, and Zimbabwe. However, the population size is expected to change only marginally by 2010.

The impact of current prevalence rates and even the future disease pattern can be predicted accurately in countries where surveillance data are available. This analysis can provide valuable input to plan and prepare for the increase in death rates. Yet establishing a reliable surveillance system is slow and its ability to analyze disaster preparedness is rare. Establishing a standardized surveillance system should be a priority both in West Africa and in southern and eastern Africa. Because prevalence of the disease is less, countries in West Africa can still contain the problem and avert a crisis.

Karen Foreit from the Futures Group's POLICY project pointed out that 65 percent of new adult infections occur under the age of 30. This disease affects persons in the most productive age group in whom substantial human capital investments have been made. All sectors of the economy bear the burden and experience losses due to heavy turn over, higher payment of employee benefits, training of substitute labor and reduction in investments. She gave some facts to show the severity of the problem: in a transport company in Zimbabwe about one-third of the workers are HIV/AIDS positive; the payment of benefits to workers in Malawi tea production increased by 34 percent due to HIV/AIDS. Such benefit costs exceeded \$250 per worker in diamond companies in Botswana.

The effort to generate human capacity through education is hampered by the loss of teachers. According to a recent study on Zambia's teaching force, the mortality rate among educators in 1998 was 70 percent higher than that of the 15-49 age group in the general population. In the same year over 1300 Zambian teachers died, compared to 400 during the previous year. Deaths of working teachers were equivalent to the loss of about two-thirds of the total annual output of the country's education training colleges. Other countries in the region are also suffering devastating losses of teachers.

The negative impact on labor threatens to roll back gains made in increased access and quality of services in many African countries during the reforms of the 1990s. In the light of emerging shortages of skilled manpower due to HIV/AIDS and sharp increases in labor cost emanating from large payment in benefit packages, the industrial sector might need to substitute capital for labor. The latter strategy would be disastrous, as it would exacerbate the currently high unemployment problem, which could lead to social and political unrest. The analysis presented in this meeting underscored the importance of rethinking both sectoral and development strategies. Can there be alternative ways of reducing the impact on sectors and businesses? This issue needs to be addressed urgently by countries and donors. It will require surveillance data by sectors or occupation to show the extent of loss of manpower to different ministries and businesses.

International Partnership in Intensifying HIV/AIDS Programs

International agencies represented at the meeting reported having to develop strategies to intensify their efforts in the field by providing more resources and staff for HIV/AIDS programs. The following summarizes the presentations by UNICEF, World Bank, USAID, NGOs and companies in the private sector:

UNICEF: Sheldon Schaeffer stated that UNICEF has allocated additional manpower to HIV/AIDS programs in Africa (+12 FTEs). Its East Africa office has made a strong commitment to support these programs. The four priority areas are: mobilizing commitment and community capacity; supporting policies for HIV affected peoples rights and access to services such as counseling and testing; and support for the prevention of mother-to-child transmission and care of orphans.

World Bank: Keith Hansen outlined the seriousness of the situation and the Bank's current response. He described the unexpected speed with which the epidemic has spread in Africa particularly in southern Africa. The 1993 World Development Report on health projected only 2 million HIV/AIDS cases in Africa. But, the disease has taken everyone by surprise and, as we know, the actual situation is much worse. He highlighted the devastating impact on manpower intensive sectors such as health and education and, more importantly, on the social fabric of the society. The intensified action program of the World Bank calls for scaling up successful interventions by allowing undisbursed funds under various projects to be used for HIV/AIDS activities. The undisbursed funds could amount to over \$2 billion. The Bank is now changing its procurement and disbursement procedures to channel funds directly to communities. Including HIV/AIDS issues in all development programs is being emphasized. In addition, the Bank has raised the profile of HIV/AIDS activities within the organization and has formed a task force called ACT to support the implementation of HIV/AIDS multi-sectoral activities.

ONAP: Sandy Thurman discussed the Clinton Administration's LIFE initiative, which, if approved by Congress, will enhance the USAID's HIV/AIDS budget by about \$55 million. An additional \$45 million will be available through the U.S. Department of Health and Human Services and the U.S. Department of Defense. These resources will be allocated to over a dozen severely affected countries.

Non-governmental Organizations: Ron MacInnis representing the Global Health Council and NORA, pointed out that NGOs are emerging as an important force in HIV/AIDS programs. The contributions of private foundations such as Gates and Turner are reaching the level of financial commitments of multi-lateral institutions. These funds are channeled through NGOs. The number of NGOs dealing with HIV/AIDS is growing and increasing numbers of persons living with HIV/AIDS are forming non-governmental groups. The experience thus far indicates that involving people living with HIV/AIDS in planning and implementing programs is highly effective.

Capacity among the NGOs has grown over the past ten years, but has yet to be fully utilized. USAID and other donors have to put HIV/AIDS programs in the hands of the people for which NGOs are indispensable. The Global Health Council has a database of NGOs.

Private Sector: The Associates for Global Change, an organization based in Washington, DC has a contract with a mining company in South Africa to develop a framework for the company to assess the impact of HIV/AIDS. The actual burden of the disease is not known due to lack of data. Therefore, Associates for Global Change has developed a framework for risk assessment through actuarial analysis based on benefit packages. A separate surveillance system for the company will be set up. The analysis indicates that the company will be losing 200 persons per year at the cost of \$5 million. Each new infection averted will save \$10,000. The framework draws heavily on USAID's work in the area of HIV/AIDS and business. This analysis is expected to lead to much more interest from the business community.

It was clear from the discussion that the constraints on accelerating the HIV/AIDS programs may not be the available resources, but the willingness at the country level to use those resources and the ability to channel them meet the a need and the capacity to use them. The challenge for USAID and other partners is to address these issues in policy dialogues with governments and other agencies at the field level.

Scaling up of Multisectoral Programs – Tools and Methods

The meeting discussed two types of multi-sectoral approaches for scaling up, accelerating HIV/AIDS activities, and making them part of development programs.

Sector specific actions by different ministries: This approach encourages a sector or a business to assess the impact of HIV/AIDS on its own operations and services. The ministry or business then formulates and implements actions for reducing the impact on staff and services nationwide. This top-down approach was exemplified by the experience of the Ministry of Agriculture in Malawi, presented at the meeting, as well as the actions taken by a few private companies.

Inter-sectoral actions at the community level: Under this approach different sectors work together to provide services to the community. The program is given to community leaders by channeling funds and technical assistance directly to them. A number of successful examples were presented as well as a possible approach to scale up such efforts.

Tool kits or methodologies are available for sectoral and business assessments as well as for decentralizing HIV/AIDS programs. The approaches and toolkit applications discussed at the meeting are explained below.

a. Sector Specific Actions – Assessment of the Sectoral Impact of HIV/AIDS and the Formulation of Sectoral Response through the Application of Toolkits

The toolkits, developed by Alan Whiteside and his associates, contain the sectoral framework for dealing with HIV/AIDS. They are divided into three parts. The first assesses the impact of HIV/AIDS on the ministry's budget, manpower, and management. The second part assesses the

impact on services provided by the concerned ministry, and the third part helps ministries formulate of action plans to prevent the spread of the epidemic among employees and to reduce its impact.

Toolkits have been developed for agriculture, education, health, infrastructure, mining, housing, and local government. The most successful applications of the toolkits, according to Whiteside, have been in the transport sector through the support of European Union and in agriculture through the World Bank.

European Union staff who worked with transport were very involved in developing the toolkit. Hence, HIV/AIDS prevention was potentially part of transport policies and programs supported by the EU. For example, providing health services could be required in contracts for transport projects that employed a certain number of workers. Dedicating one EU staff person to use the toolkit to do something about HIV/AIDS made a tremendous difference.

Wendy Roseberry reported on the World Bank experience in using the toolkit with the Ministry of Agriculture in Malawi. Grace Malindi, a gender specialist in the ministry took the lead. A participatory approach to assess and formulate action plans was adopted. A survey with open-ended questions, followed by focus group discussions, was undertaken. The discussions sensitized the staff to the HIV/AIDS problem and helped reduce stigma. In addition, the approach helped create a feeling of togetherness and management interest in this problem. Useful ideas for actions emerged. The agency dealing with the civil service will estimate the extent of manpower losses and the impact on various sectors. A national survey, which includes the farmers as beneficiaries, is planned to determine the impact on services and to assist in developing a national program.

The keys to success in Malawi have been the combination of ownership by the sectoral staff and having a champion to take up the cause. The process has opened the door for actions and has created a supportive environment. The ultimate success will depend on donors providing necessary resources for follow-up and sustainability of interest by the ministry. The process has the potential to mobilize the sector to prevent HIV and reduce the severity of its impact.

Andy Agle, from the Task Force for Child Survival, made an interesting short presentation on Quality Protein Maize (QPM). QPM was introduced, with the help of Sasakawa Global 2000, to reduce infant mortality in Malawi, as consumption of maize is very high there. It has additional ingredients that make it a complete meal. QPM can be a valuable product for areas with high HIV/AIDS prevalence and food shortages.

The participants suggested that donors set targets for helping several of the worst affected countries to apply the toolkits in at least one or two sectors by the end of 1999.

b. Inter-sectoral Community Level Actions – National Coverage Possible within a Year with Donor Determination and Coordination

Hans Binswanger, a rural development specialist from the World Bank, passionately appealed for reaching the people with an HIV/AIDS programs as soon as possible. He gave the Kagera

Region in Tanzania as an example of limits of program coverage. Ten NGOs cover only two of the five districts and only 5 percent of children. Two of these NGOs have stopped programs due to funding problems. Other NGOs are also facing problems. This is an ultimate indictment of the donors and explains why, after 18 years, the disease is not under control. Prevention has not been given a chance to work.

How can the coverage be scaled up to the national level within a year by inter-sectoral prevention and care programs? Binswanger suggested that we have to learn from the experience of the rural development programs that have failed. The main reason for the failure was the centralized nature of the operations. The money was stuck at the central level and, despite the interest and readiness of the communities, the money did not reach communities at all, or in time, to sustain the interest. The lesson is that the donors must find a mechanism to provide funding to the community leaders directly.

One possible way to get to the communities directly is by forming multisectoral village and district HIV/AIDS committees. This model is close to the successful COPE model in Malawi. Membership in these committees will be entirely voluntary and no payment to the members will be involved, except for transportation costs or transportation itself. These committees will work closely with local government structures. The village and district committees will be helped by technical expertise from NGOs in determining care and prevention actions. The committees will be responsible for managing the money and they will be accountable to the beneficiaries or village or community members, rather than just the central government. Thus, the accountability will be downwards as well as upwards. The money will be replenished as soon as the activities agreed upon have been completed. To reduce chances of corruption, random audits will be conducted. In addition, punitive measures, such as dropping the corrupt committees or corrupt members, can be built into the system. The key will be for NGOs or local leaders to inform the community and affected families about the availability of funds and facilities.

The HIV/AIDS program or NGOs working in the country can achieve national coverage within a few months by advertising on the radio or through local networks for the volunteers to form HIV/AIDS village committees. Then the NGO or HIV/AIDS program would arrange to train and brief these volunteers in a school or some other place. These volunteers would then be asked to form a village and district committee and to develop a program for HIV/AIDS prevention and care within a couple of weeks in collaboration with vulnerable groups and affected families. The committee will get the funds for implementing the program after proper reviews by NGOs and other qualified reviewers. After six months of operation this program could be assessed and modified or dropped depending on the results of the assessment.

Participatory appraisals carried out in a number of countries indicated that communities are more concerned about their livelihood than HIV/AIDS. Stigma and denial reduce opportunities for communities to talk about the problem. Thus, the strategy is to integrate HIV/AIDS into development programs that are high priority to communities and let them decide how to allocate resources. If the community does not allocate adequate resources to HIV/AIDS, the money will have to be earmarked for specific HIV/AIDS activities.

The main constraints to the above approach include the capacity of NGOs to handle the scaling up, the commitment of the community leaders or others to volunteers, and possible corruption and misuse of funds. These constraints are real, but not insurmountable, if donors have the determination to support this approach. For example, capacity exists both with the local and international NGOs to undertake the work if they are properly trained and briefed. Persons living with HIV/AIDS can be the most useful volunteers. A certain degree of misuse of money will have to be accepted and the challenge will be for the financial institutions and experts to come up with innovative funding mechanisms to reduce it. The commitment among the community leaders will have to be generated by the NGOs.

The challenges for USAID and other donors are to find ways to channel funds directly to the communities and to help countries adopt parallel top-down, multisectoral and bottom-up inter-sectoral approaches for maximum synergy and coverage. Specific suggestions for actions to be considered by USAID, and possibly other agencies that emerged from the discussions are outlined in the next section.

Suggested Actions

The thrust of the small group discussions was on the future, specifically what can be done differently to make an impact. USAID and other agency staff jointly led the small groups, along sectoral lines.

General

- The urgency of the situation as reflected in the analyses presented at the consultative meeting requires an accelerated implementation of multi-sectoral HIV/AIDS programs. In this respect it is better to have concerted and focused efforts in a few countries, possibly those selected for the LIFE initiative, to make a difference.
- The inter-agency groups formed at the meeting around different sectors and themes should continue to work together to share experiences and exchange information on the activities of different agencies. The groups should develop ways to link with regional African institutions, USAID regional offices, and interested PHN officers. This exchange of information will help to avoid costly mistakes, unnecessary replication of studies, and re-inventing the wheel. The results of the discussion should be conveyed to field missions.
- Rapid response teams consisting of USAID technical staff and contractors should be formed around sectors and inter-sectoral themes to provide ready support to missions and field offices in designing and evaluating programs. These teams will have the opportunity to constantly sharpen their skills through sharing experiences.
- A few missions such as South Africa, Zimbabwe, Zambia, and Tanzania have already started incorporating HIV/AIDS in different sectors. Their experiences need to be documented and disseminated. Similarly, the best practice paper on community mobilization should be updated in the light of recent successes.

Agriculture, Natural Resource Management

As the majority of population, almost 70-90 percent, is sero-negative even in the most severely affected countries, the agriculture sector has a special responsibility to help maintain the current status. In the short term, the most important activity to be supported by donors is including HIV/AIDS messages in agriculture extension work and protecting extension workers. The short-term indicator of the extent of the agricultural sector's involvement should be the proportion of agricultural programs that have included HIV/AIDS messages in their core business. In addition, agricultural practices and cropping patterns may need to be reviewed to determine the changes necessary to adjust to labor shortages and provide for food and other basic needs of affected families. Suggested actions—

- The agriculture tool kits need to be refined and widely disseminated to missions and to design teams for discussions with the ministries and possible application.

- The U.S. Government should accept HIV/AIDS as a natural disaster--as declared by ten countries at ICASA--and consider providing PL 480 assistance for HIV/AIDS programs.
- A working group on food security of HIV/AIDS-affected populations should be established. The group may develop short-term strategies for using Food Aid for prevention and care of HIV/AIDS affected populations. The group should also look at long-term food security issues, technological and nutritional interventions, community mobilization, and research and data needs.
- The Natural Resource Management Group should find ways to link its community mobilization efforts with those being carried out for HIV/AIDS in order to provide synergy.
- HIV/AIDS questions should be included in relevant agriculture surveys and studies, supported by the donors, to get better data and information.

Education

The heavy loss of teachers due to HIV/AIDS combined with the increasing number of orphans and the imperative of accelerating girls' education is making educators rethink the whole strategy of education in severely affected countries. In addition, special attention is required to provide vocational and livelihood training to unemployed youth. Education for All goals and indicators are being revised in light of HIV/AIDS. Suggested actions—

- USAID work with UNICEF, UNDP, and the World Bank head offices staff to—
 - Encourage and support missions and host-country ministries to assess impact of HIV/AIDS on the education sector and develop action plans following the assessment using the toolkits.
 - Have each agency listed above take responsibility for selected countries in consultation with their respective field offices.
 - Promote a regional network of Africans to share experiences in assessing impact and in implementing HIV/AIDS action plans; the network should be managed by African institutions, such as the Education Research Network for East and Southern Africa.
 - In countries where the assessments are advanced, USAID, in collaboration with other agencies, should start funding the action program that emerges from the assessments. (Note: Subsequent research found that there are few countries with advanced assessments.)
- Simultaneous to the assessments and the development of action plans USAID should organize an inter-agency coordination of information about—

- School-based programs to prevent HIV/AIDS among youth. For this purpose USAID and partner agencies need to synthesize the best practices in youth education to keep HIV/AIDS prevalence low, as in Senegal and Mali.
- Accelerating prevention education for girls under 15 and programs to reduce their vulnerability to HIV/AIDS.

Health

The increasing number of HIV/AIDS cases in hospitals most heavily burdens the health sector. The health sector in most countries is in a state of collapse. Health sector reforms are underway in many countries, but the impact of these reforms on HIV/AIDS programs and vice versa needs to be carefully reviewed. The most important issue is the shortage of trained health workers. HIV/AIDS is increasingly being integrated into reproductive health programs and this process needs to continue with special focus on adolescents. Indicators of progress could be the establishment of a surveillance system and the extent to which HIV/AIDS is integrated into reproductive health services. Suggested actions are for USAID to—

- Review the impact of health sector reforms on HIV/AIDS and vice versa.
- Promote collaboration between democracy and governance and health sector decentralization (based on Senegal and Tanzania mission examples).
- Help to improve the ability of surveillance systems to document HIV/AIDS impact on different sectors.
- Define technical approaches to integrate HIV activities into different programs of the ministries of health such as reproductive health, training, and education.
- Strengthen the National AIDS Control Program organization and administration in different countries.

Democracy and Governance

All components of democracy and governance will be influenced by the increase in mortality and morbidity due to HIV/AIDS. The loss of leaders or potential leaders--from the young and educated, the election process, the weakening of service provision and law and order, greater financial burden on the state, reduction in institutional capacity--can have devastating influence on democratic processes and good governance. The democracy and governance sector can improve HIV/AIDS prevention and care by generating leadership commitment, improving the information flow about HIV/AIDS, mobilizing community and civil society to support HIV/AIDS programs, promoting respect for human rights of those living with HIV/AIDS, and supporting gender empowerment. The indicators of success may lie in reduced number of by-elections, reduced number of cases of human rights violations, and changes in discriminatory practices against women.

Suggested actions—

- Develop a toolkit to provide a framework for assessing the impact of HIV/AIDS on democratic processes and good governance through the University of Natal.
- Discuss HIV/AIDS issues at the meeting of USAID democracy and governance field officers in December.
- Synthesize best practices in democracy and governance linkages with health and HIV/AIDS, such as in Tanzania.
- Develop programs in consultation with the group already formed at the meeting to help field missions to—
 - Improve the flow of information to the civil society on HIV/AIDS and obtain the views of the civil society and those living with HIV/AIDS.
 - Generate commitment among various leaders to take action against HIV/AIDS
 - Include HIV/AIDS in the inter-sectoral program of democracy and governance already underway.

Economic Growth, Private Sector, and Community Mobilization

A number of policy issues related to economic growth and poverty reduction, such as flow of resources, debt reduction, and regulatory frameworks, were highlighted. However, actions at the community level will make an immediate impact and are essential for HIV/AIDS prevention and care. The indicators of progress are the numbers of communities provided with resources and the level and amount of resources available to undertake HIV/AIDS activities. Suggested actions by USAID include—

- Utilize the Microenterprise Coalition, associations of large and small businesses, trade unions and other NGOs/PVOs to promote support for HIV/AIDS programs.
- Identify typology of countries and communities to develop best approaches to HIV/AIDS prevention and care; avoid the “one-size fits all” approach.
- Organize a working group—consisting of the concerned HPN officers, the World Bank, UNICEF, other agencies including NGOs—to discuss the sites where catalytic funds can be made quickly effective by using the existing implementation capacity and where immediate scaling up of community mobilization for HIV/AIDS can begin.
- A high-level decision within USAID needs to be taken to change procurement and funding procedures to make funds easily available to communities, so they do not get stuck at the center or capital cities of a country.

- Persuade governments to implement effective economic reforms for achieving equity and growth. This will provide for future additional resources that will enable a healthier infrastructure and environment and more potent attack on morbidity and mortality.
- Utilize sympathetic and responsive private sector organizations in the fight against HIV/AIDS, such as Chevron, Coca-Cola, Daimler/Chrysler, and SmithKline Beecham.
- Push the U.S. Government for compulsory licensing and parallel import of HIV/AIDS drugs at lower cost.
- Add questions on impact of the disease in informal sector surveys.
- Micro-finance institutions should not specifically target HIV/AIDS clients but may well develop micro-lending and savings in infected communities, selecting clients on the basis of their ability to save or repay.

Conflict, Crisis, and Disaster Planning

A substantial population is affected by conflict and natural or manmade crises in Africa and yet little is known about the impact of these crises on the epidemic. The epidemic has been declared as a disaster by at least ten countries and still no systematic planning or preparedness exists for disaster management. The military has the potential to help in these situations and can be an excellent way to increase capacity of the civilian programs. The group recommended the following actions—

- Establish an inter-disciplinary strategic advisory group to provide guidance to USAID on HIV/AIDS programs in conflict situations and to prepare for disaster planning. The advisory group should be composed of selected staff from AFR/SD, REDSO, and other interested parties.
- Advocate using USAID humanitarian and emergency funds to provide crisis intervention packages that include procuring HIV/AIDS prevention and care and support commodities.
- Provide more support for African institutions and networks such as the Civil-Military Alliance (CMA) for HIV/AIDS prevention activities among military populations and their families:
 - Link CMA activities to some of the REDSO/ESA networking initiative activities.
 - Document and share lessons learned from African countries with active CMA chapters such as Zambia, Ghana, Senegal, and Uganda.
- Advocate for introducing HIV/AIDS prevention interventions into demobilization and briefing programs for peacekeeping forces in Africa.

Future Challenges

Professor Tony Barnett summarized the explicit and implicit themes of the meeting in terms of challenges to USAID—the meeting sponsor. He pointed out that among the challenges that USAID must confront, are recognizing that—

- HIV/AIDS is not only, or even, most importantly, a medical problem - it is an issue of social and economic policy both in relation to its causes and its consequences.
- There have been fashionable swings of the policy pendulum from state to local modes of working and that these are just fashions. Within the U.S. policy environment, it may be hard to recognize that sometimes the state is the right locus of action and that a pragmatic and non-ideological position must inform policy and practice.
- USAID's current administrative structures and operating procedures may be inappropriate. In particular, its policies on accountability, procurement, auditing, and fundability may require review if it is to operate effectively in this field.
- A sectoral approach may be entirely inappropriate and multi-sectoral thinking is very desirable.
- Prevention programs must be balanced by impact mitigation programs.
- Long-term commitment is of the greatest importance and that short-term intervention may be worse than no involvement at all.

Thus, he suggested USAID should—

- Consider its internal procedures and technical assumptions and ask how these fit with the special challenges of the HIV/AIDS epidemic.
- Recognize that USAID is a latecomer to this multisectoral scene and that it must learn from what has been tried and build on that experience with the innovativeness and energy that can characterize the best of U.S. action in the world.

Missions' Perspectives on Multisectoral Programs

A few missions have initiated multisectoral and community-based programs such as Ethiopia, Malawi, South Africa, Senegal, Tanzania, Uganda, and Zambia. Several other missions are starting to initiate them, including Ghana, Guinea, Madagascar, and Mozambique. This attachment gives the views and experiences contained in notes received from three missions: Zambia, Ethiopia, and Madagascar. Interestingly, these three countries represent a different status of the epidemic i.e. severe, moderate, and low, as well as the varying degree of multisectoral responses.

Zambia

A number of multisectoral actions suggested at the meeting have already been initiated by the Zambia mission.

USAID/Lusaka has formed an HIV/AIDS and Orphans working (HOW) group which consists of members in each of the four SO Teams as well as the program and controllers office. The group meets each month and has been working on a mission-wide approach to HIV/AIDS and Orphan and Vulnerable Children (OVC) programs. The HOW group was directly involved in the ICASA Conference and each person attended specific sessions and wrote a summary report. The HOW group has reviewed several proposals to strengthen mission-wide programs in HIV/AIDS.

The mission is working on several multi-sectoral approaches to HIV/AIDS. In the agriculture sector, the mission has worked with Sasso Fertilizer Company to print 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. The message on the fertilizer bag reads, "To grow properly, your crops need fertilizer. To grow up properly, your children need you! Protect yourself against HIV/AIDS. Use a condom every time. Thank you. Maximum Use It!"

USAID/ Lusaka has been working on a proposal through the education sector to increase HIV/AIDS messages to school children as well as through distant teaching programs to orphans and vulnerable children. In the democracy area, the mission is helping to review child protection laws and is exploring ways to strengthen the training of lawyers and judges in issues which directly affect OVCs. Finally, the micro-credit program will be reviewed to determine how it can be strengthened to make an impact on families that care for OVCs.

In addition, the U.S. ambassador to Zambia has taken a strong interest in HIV/AIDS. A number of activities across the mission are being undertaken as indicated in the attached memorandum from the ambassador.

Ethiopia

The main issue in the multisectoral program highlighted by Ethiopia mission related to the enabling environment, data and information, and sustainability of efforts as detailed below.

1. Enabling Environment: The experience in Ethiopia shows that the main obstacle in developing effective partnerships is lack of clear policies and guidelines that encourage development partners to forge a partnership. In the early days of the epidemic, clear medium-term plans encouraged many government and NGO partners to shoulder responsibilities in the fight against HIV/AIDS. In the transition of government power, commitment declined sharply. Again recently, the government formulated a comprehensive policy that emphasizes a multisectoral approach to contain the problem. High-level advocacy by bilateral and multilateral organizations (including exemplary efforts by the ambassador and USAID/Ethiopia) have encouraged major religious groups in Ethiopia to make HIV/AIDS a prime issue on their agendas. Following the policy endorsement, Ethiopia drafted a multisectoral strategy where development partners are expected to include HIV/AIDS interventions into their systems.

Bottom-line: For an effective multisectoral approach to respond to the HIV/AIDS problem, high local government commitment (expressed by policy and resource allocations) is essential.

2. Understanding the problem: The major drawback in HIV/AIDS programs in Ethiopia, and most likely in other sub-Saharan African countries, is lack of relevant, powerful, and convincing HIV/AIDS impact data that is easily understandable to key development partners. The conflicting idea between "high population growth" and "growing HIV/AIDS" need to be defined in simple terms for key decision makers. The definitions used for prioritizing of health problems in terms of "mortality" need to be simplified and justifiably expressed in-terms of "Burden of Disease." In the Ethiopian case, key decision makers find it difficult to prioritize their meager resources between HIV/AIDS and competing and compelling problems like malaria, TB, etc. Thus, the need to justify the synergy between various infectious diseases, agricultural production, and overall national development is critical.

Bottom-line: A dire need exists for multiple, targeted advocacy tools (like the one providing impact of HIV/AIDS on Kenyan sugar industries) that are relevant, convincing, and easy for non-health workers to understand.

3. Sustaining Effort: The experience in Ethiopia shows that when efforts are interrupted, not only the sustainability of results and the commitment of development partners to carry on HIV/AIDS activities suffers. One alternative approach to promote sustainability is to work within the existing system of development partners. For example, USAID/Ethiopia promotes using existing infrastructures and resources of religious organizations to provide HIV/AIDS interventions in communities. As the structures exist, the mission has not created new ones that are not sustainable. Moreover, the fact that these organizations carry the full brunt of the impact, encourages them to commit themselves to prevention, care, and support.

Bottom-line: To the extent possible, development partners with community-level presence, should be encouraged and supported to improve their capacity to undertake HIV/AIDS prevention and mitigation efforts within existing structures.

Madagascar

Madagascar has a unique opportunity to contain the spread of HIV, however a concentrated and targeted effort will be required. Madagascar still has a low prevalence of HIV (less than 1 percent) in comparison to other countries in East and southern Africa and East Asia.

While Madagascar seems to still have low prevalence of HIV, classic sexually transmitted infections (STIs) such as syphilis, gonorrhea, and chlamydia are very high. Syphilis prevalence in pregnant women was as high as 14.8 percent in 1998, and over 35 percent among sex workers in some regions. Madagascar has among the highest STI prevalence rates in the world. And STIs are a central public health concern for Madagascar. In some regions of the country, studies indicate that over 45 percent of the population have an active STI at any given time. STIs are the fifth leading cause of morbidity in Madagascar. Thus, control and prevention of STIs are critical.

High STI prevalence along with widespread poverty, illiteracy, and limited sexual decision making power among women are preconditions for a potential explosive growth of the HIV epidemic in Madagascar.

How can existing programs be strengthened so as to reduce the impact of the HIV/AIDS pandemic?

Current efforts in STI/HIV prevention in Madagascar have focused on improving STI management, expanding condom distribution, and behavior change communication interventions primarily with traditional core groups such as STI patients, youth, CSWs and their clients, and transport workers including truck drivers, rickshaw workers, dock workers and taxi drivers. These current efforts must be strengthened and expanded to prevent a full-blown AIDS epidemic. Strengthening and expanding current programs requires additional resources.

How can existing activities in the various development sectors be broadened to include HIV/AIDS prevention and/or care components?

Existing multisectoral HIV prevention and care activities are limited in Madagascar. Outside of the Ministry of Health and Population, limited efforts have been made within the education and youth and sports sectors. The Ministry of Education with support from UNFPA pilot tested teaching materials for reproductive health. These efforts could be expanded to include institutionalizing the use of standard curricula for STI/HIV prevention and reproductive health to be used in all primary and secondary schools. Literacy programs could include STI/HIV prevention materials (such as those used in programs in Nepal). The Ministry of Youth and Sports could train outreach workers to provide accurate STI/HIV prevention messages and support Anti-AIDS youth clubs.

USAID/Madagascar believes that one of the most effective methods for encouraging a multi-sectoral approach to STI/HIV prevention is to engage a high level of commitment from a core group of political leaders. One approach to garner this high-level, political commitment would be to organize a study tour to a country with higher prevalence that has begun a multisectoral approach to HIV/AIDS prevention and care. The participants on the study tour would be high ranking officials from various ministries (e.g. tourism, environment, finance, education, health, youth and sports, agriculture, mining and energy, interior, planning, etc.) along with select representatives from the private sector. The study tour would be followed by a strategic working session that could include a modeling exercise to determine potential impacts of the epidemic on Madagascar and strategic approaches to prevention. The working session might culminate in each representative developing a one-year action plan. Ideally, the core group would continue to meet periodically to ensure coordination among sectors.

Report from the Roundtable on Private Sector Participation in HIV/AIDS Programs in Africa Washington, DC October 1, 1999

Introduction

The USAID/Africa Bureau/Office of Sustainable Development organized a roundtable discussion on private sector participation in HIV/AIDS as part of the consultative meeting on HIV/AIDS as a Development Crisis: Rethinking Strategies and Results.

Five companies participated in the meeting including Chevron, Coca-Cola, Daimler/Chrysler and SmithKline Beecham. In addition, representatives from Constituency for Africa, Solidarity Center, AFL-CIO, Embassy of South Africa, US-South Africa Business Council, Associates for Global Change, World Bank, UNAID, International Finance Corporation, and concerned staff of USAID and the Academy for Educational Development attended (list of participants attached). Prof. Alan Whiteside from the University of Natal chaired the meeting.

Ms. Rita Aggarwal of USAID opened the meeting by discussing current USAID efforts in partnering with the private sector. She mentioned the multi-country policy analyses supported by USAID called EAGER- Economic Growth and Equity through Economic Research. The analyses focus on the constraints of economic growth in Africa, including private investments. These studies are being carried out by a consortium of researchers led by the Harvard Institute of International Development, in collaboration with senior African researchers. In addition, USAID is involved in the Clinton Administration's initiative called ATRIP- African Trade and Investment Policies and Programs, which has a private sector component to link up with businesses in Africa.

Impact of HIV/AIDS on Business

Professor Whiteside made a brief presentation titled *How AIDS Will Impact on Your Business*. He quoted the HIV/AIDS prevalence data from the anonymous testing done by a few companies such as diamond mines in Botswana and South Africa. About 28–30 percent of the workers are HIV positive including almost one-fifth of the managers. The “business” of private sector is business and therefore the private sector is expected to move toward greater capital intensity and replace labor for capital. This will aggravate the already serious problem of unemployment that reaches 33 percent in most countries of southern Africa. In fact, HIV/AIDS will seriously impact the market for goods and services and the efficiency of governments and the business environment itself. The question is whether business should get involved in HIV/AIDS prevention and care and link business responsibility with social responsibility. The purpose of this meeting was to discuss where we go from this perspective. He called upon the companies participating at the meeting for comments.

Business Response

Coca-Cola: Mr. Percy Wilson participated in the meeting by phone from Lusaka. He stated that Coca-Cola considers health as a private matter between company and employee. For them confidentiality is extremely important. They have worked with the First Lady of Uganda on her project related to care of orphan and families and nothing beyond that. In responding to several questions of the participants Mr. Wilson pointed out that—

- Coca-Cola, to the extent he knows, does not have a worldwide HIV/AIDS policy.
- The company has not yet felt an impact of HIV/AIDS on the work force or the market in Africa. In fact, the sales are increasing and therefore no alarm has been felt yet.
- Recognizing the seriousness of the situation, they would be open to discussing how to work on HIV/AIDS problems in partnership with governments and regional associations. Regarding the Bristol Myers pattern of contributing to the AIDS Marshall Plan, proposed by the Constituency for Africa (CFA), Mr. Wilson suggested that a pharmaceutical company's case is different as they have a direct interest in health. He will, however, follow-up on the suggestion on his return to Washington.
- He is willing to explore further with Art Westneat and others, as suggested by Dr. Glaudine Mtshali of the Embassy of South Africa, how to use Coca-Cola's leadership in successful product marketing to convey HIV/AIDS messages. If the Government of South Africa, for example, launches an HIV/AIDS prevention campaign, Coca-Cola could consider working in partnership with the government. Coca-Cola's experience with the distribution of rehydration therapy with UNICEF was not entirely satisfactory due to some legal issues.

Daimler Chrysler: The experience of Daimler Chrysler was similar to that of Coca-Cola as the sales and profits have not yet been adversely affected by HIV/AIDS. Notwithstanding this situation, Mr. Peter Hartman of Daimler Chrysler stated that HIV/AIDS is a development challenge of the highest order in Africa. Daimler Chrysler has health education programs in all of their plants. They have two plants and one distribution center in South Africa, Nigeria, and Côte d'Ivoire. These plants and the business centers all over Africa employ about 5000 persons. Besides autos (the South Africa plant produces right hand drive vehicles for all countries), they produce trucks, buses, locomotives, and aircraft. Daimler Chrysler has been engaged in promoting African business interests and has launched an initiative called SAFRI- South African Business Initiative. An Africa Day is planned in Berlin on April 27, 2000. The purpose is to attract European and American investments in Africa. Several heads of state will attend and HIV/AIDS will be on the agenda for discussion. The president of Daimler Chrysler lived in South Africa for fifteen years and, therefore, has a special interest in Africa's development. Daimler Chrysler is working with the Clinton Administration on its Transportation Initiative. During discussions the following points emerged—

- To date, no systematic study has been conducted of the impact of HIV/AIDS on the productivity of Daimler Chrysler workers. The human resource divisions must be analyzing it at the company level, but the results are not made available on a company-wide basis.

- Daimler Chrysler managers may be engaged in discussions on HIV/AIDS with different governments, but any effort is individual and ad hoc.
- Daimler Chrysler would like to join any business coalitions in Africa to help to deal with social and business issues. Currently only two countries are known to have coalitions—South Africa and Botswana; another is being formed in Zambia.
- Private-public partnerships can develop, in the opinion of Daimler Chrysler, if the private sector is involved in networks and discussions on a country's development. The International Economic AIDS network was cited as an example of a network where the private commercial or business sector is not part of the network.

Chevron: Mr. Mamadou Beye from Chevron started by describing his personal experiences and losses due to HIV/AIDS. He stated that Chevron is very much concerned with the problem and has already initiated programs both at the headquarters in San Francisco and in the field. Their main interest is going directly to the communities where the problem and the solution lie. They are not interested in supporting programs based in or directed from New York or Washington. The only exception they made in this respect was giving Rev. Sullivan's IFESH program \$5 million. They have established health centers and blood banks for their workers and their families in areas (such as Angola) where Chevron has offices. In addition, Chevron is also building community schools to promote educational programs. They have given grants to the youth on the street to start their own businesses. Chevron has so far given 10 million each for social programs in Angola and Nigeria. The following points emerged during the discussion—

- If any agency is interested in developing a partnership with Chevron it has to go the plant areas and plant managers. Chevron has considerable business interests in Angola, Nigeria, and Congo. They also operate with Caltex in other countries in Africa.
- Personnel policies of Chevron help prevent HIV/AIDS. Chevron allows its expatriate staff to bring their families and for the local staff it has a "28-28 days" policy. The latter means that for every 28 days that workers stay away from the families they get 28 days off to go back home.
- If governments were committed, they could make it mandatory for all business contracts to allocate a certain percentage of the contract to HIV/AIDS as part of social responsibility.

SmithKline Beecham: Ms. Debbie Myers said that her company shares Chevron's strong interest in community-level programs. SmithKline Beecham does not have any drugs for HIV/AIDS, but has other businesses in almost all countries in Africa. They have supported the World Bank's HIV/AIDS project in Uganda and may also do the same in Senegal, Côte d'Ivoire, and Zambia. However, they would like to directly support communities where the need is the greatest. Therefore, they are open to collaborating with USAID and other agencies on community-level activities.

Constituency for Africa

Lauri Fitz-Pejado, Vice President, Iridium, representing the Constituency for Africa (CFA) strongly stated that there is no future for Africa if the HIV/AIDS epidemic continues unabated.

The Africa Growth and Opportunities Act, presently before the U.S. Congress, will not have an impact, as the population will be dissipated due to HIV/AIDS. Consequently, the CFA Board has declared HIV/AIDS as its highest priority. The chair of the Board, Mr. Ron Dellums has proposed an HIV/AIDS Marshall Plan. Thus corporate America, interested in business in Africa, has to support both the legislation and HIV/AIDS programs. She reflected on the experience of HIV/AIDS in United States (whereas the epidemic was hitting the gay, white community in the beginning, it has now become a disease of the black minority, particularly women) and her work with the late Ron Brown in Haiti. She made the following concrete recommendations—

- To USAID she suggested using Ron Brown's name and his work in Haiti to mobilize corporate America for HIV/AIDS programs. This could be the first priority area of work for the Ron Brown Institute.
- She urged the businesses present at the meeting to take leadership in their respective industries or sectors in dealing with HIV/AIDS and to set the standards for others to follow. The industry could set regional targets for their own work in this area.

US-South Africa Business Council

Mr. Chuck Diettrich stated that as many as 60 companies are members of US- South Africa Business Council. It represents one-third of the foreign investments in South Africa. HIV/AIDS has been the topic of discussion at its high level meetings. They have formed a sub-committee to look at the HIV/AIDS issues. The Council can be a channel for distributing messages and materials on HIV/AIDS.

AFL-CIO

Juliette Lenoir from the AFL-CIO emphasized the fact that the disease knows no boundaries, and the control of the epidemic is in the national and global interest. She also pointed out that much of the attention to HIV/AIDS in United States can be attributed to the lobbying skills of the gay community and there are lessons for other countries. She concluded that HIV/AIDS is the most important issue for Africa.

International Finance Corporation

The International Finance Corporation, part of the World Bank Group, dealing with the private sector, pointed out the difficulty in finding local businesses wishing to get involved in social issues. This is a great challenge. The imperative is to develop the capacity of the local private sector to participate in social programs.

Conclusions

In his concluding remarks, Dr. Whiteside, highlighted four points—

- HIV/AIDS is out of the health box and all sectors of the economy have a stake in the problem. This three-day consultative meeting has been remarkable in delineating the responsibilities of different sectors within USAID.
- Solutions to the problem of HIV/AIDS are local, and therefore it is important to think globally and to act locally.
- Partnerships between public and private sectors and donors in the fight against HIV/AIDS are crucial.
- The social responsibility of the private sector has to be encouraged by the governments through business incentives such as tax breaks on expenditures allocated for HIV/AIDS.

At the end, Hope Sukin of USAID asked the question as to how USAID can respond to these four issues and how USAID can develop better partnerships with the private sector. Due to a shortage of time, Whiteside requested that the participants provide thoughtful answers to Ms. Sukin's questions through e-mail, as this was the crux of the afternoon meeting. The participants were given e-mail addresses for Mrs. Ishrat Husain and Professor Whiteside.

Follow-up Actions

- Ms. Rita Aggarwal will remind participants to send their views on USAID's role as requested at the meeting to Mrs. Husain via e-mail.
- Ms. Aggarwal will follow up on the suggestion of CFA to mobilize the private sector through the Ron Brown Institute. In addition she may explore the possibility of forming an ad hoc group of private sector companies to discuss progress on their leadership roles and ways to strengthen partnerships with them from time to time.
- Mr. Art Westneat will follow up with Mr. Percy Wilson on Coca-Cola's role, leadership and possible contributions in this area.
- Mrs. Husain will provide Chevron and SmithKline Beecham with community mobilization best practice papers and other proposed actions at that level.

U.S. Agency for International Development Bureau for Africa
"AIDS as a Development Crisis: Rethinking Strategies and Results".
A Consultative Meeting , September 29 – October 1, 1999
AED , 1825/1875 Connecticut Avenue, NW
Washington, DC

AGENDA- Day 1 – Boardroom, 1875 Connecticut, 8th Floor

Wednesday, September 29, 1999 : SETTING THE SCENE

- 8:30 am Continental Breakfast and Registration
- 9:00 – 9:15 **Opening**
 Introduction – Alex Ross
 Welcome Remarks – Sandy Thurman, Director of The Office of National AIDS Policy, White House
- 9:15 – 10:00 **Setting the Scene** , Paul Delay, chair
 The magnitude of the HIV/AIDS Problem in Africa – Peter Way, US Bureau Census
 Impact of AIDS on Various Sectors – Karen Foreit, Policy Project
- 10:00 – 10:15 **The Consultative Meeting Process**, Paul Delay, chair
 Objectives and Expected Outcomes – Ishrat Husain
 Background and methods, and multi-sectoral toolkit approach – Alan Whiteside
- 10:15– 10:30 Coffee/Tea Break
- 10:30 – 11:30 **Perspectives on HIV/AIDS and Development**
 Paul Delay, Chair/Introduction
 World Bank – Keith Hansen
 UNDP- TBD
 NGO perspective – Ron MacInnis, Global Health Council
 Private sector perspective – Felipe Tejeda, Associates for Global Change
- 11:30 -12:00 Discussion of Processes and Expected Outcomes of Each Working Group - Alan Whiteside
- 12:00 – 13:00 Lunch Break
- 13:00 – 15:45 **Dealing Better with HIV/AIDS in the context of development - Small Working Groups:**
 Assessing the impact of HIV/AIDS on development and on various sectors. What are the indicators we can look for and how do we measure them? Determining key actions that need to be taken to reduce the severity of this impact and to prevent the spread of the epidemic.
- Breakaway Groups, proposed facilitators:
- Education** – Brad Strickland and Alan Whiteside
- Democracy and Governance** -- Robert Groelsema and John Langlois
- Agriculture, Energy and Environment** – George Gardner and Wendy Roseberry
- Population, Health and Nutrition** -- Alex Ross and J. L. Lamboray
- Economic and Community Development** (including Microenterprise) – Bob Young and Tony Barnett

Crisis, Conflict and Disaster Management – Bill Lyerly and Sambe Duale

15:45 – 16:00 Coffee/Tea Break

16:00 – 17:30 Reporting back from small working groups and plenary discussion - Paul Delay, Chair

17:30 – 19:00 **Reception** with Sandy Thurman at AED.

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AGENDA – Day 2, September 30 - Academy Hall, 1825 Connecticut Ave, 8th floor

Thursday, September 30, 1999 : THE WAY AHEAD - Hope Sukin, Chair

9:00 – 10:00 **Rethinking development in the era of AIDS** – Lessons Learned

Operationalizing New Approaches - A Whiteside

Agricultural HIV/AIDS Experience in Malawi - Wendy Roseberry

Scaling up Decentralized, Participatory, Multi-Sector, National HIV/AIDS Programs - Hans Binswanger

10:00 – 10:15 Discussion on Expected Outcomes of each Working Group – Alan Whiteside

10:15 – 10:30 Coffee/Tea Break

10:30 – 13:00 **New Directions for Operational Strategies - Small Working Groups (same groups as Day 1):**

What do we do? What do we do differently? How do we proceed? What is required to move forward?
What collaborations are necessary with other partners? Proposed countries?

13:00 – 14:00 Lunch Break

14:00 - 15:45 Reporting back from small working groups and plenary discussion – Hope Sukin, Chair

15:45 - 16:00 Coffee/Tea Break

16:00 – 16:45 **Synthesis and recommendations** – Tony Barnett

16:45 – 17:00 **Next Steps and Closure** - Hope Sukin, Alan Whiteside

Friday, October 1, 1999 - Day 3

9:00 – 12:00 USAID Multi-sectoral Planning meeting for Africa (USAID staff only) Room 7.8 c&d
Ronald Reagan Building

14:00 - 16:00 Private Sector Roundtable Discussion (By invitation only) Vista Rooms, 1825
Connecticut Ave, 8th floor

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Rethinking Strategies and Results'
Washington DC
September 29 – 30, 1999

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Composition of Small Working Groups
Consultative Meetings on ‘AIDS as a Development Crisis in Africa:
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Washington DC
September 29 – October 1, 1999

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