

FOIA MARKER

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

Collection/Record Group: Clinton Presidential Records

Subgroup/Office of Origin: National AIDS Policy Office

Series/Staff Member:

Subseries:

OA/ID Number: 21070

FolderID:

Folder Title:

US Agency for International Development (USAID) [4]

Stack:

S

Row:

67

Section:

1

Shelf:

4

Position:

3



USAID

REGIONAL OVERVIEW OF AIDS IN AFRICA

**Prepared by Family Health International
For
USAID Global Bureau, Office of Health and Nutrition,
Division of HIV/AIDS**

March 15, 1999

REGIONAL OVERVIEW

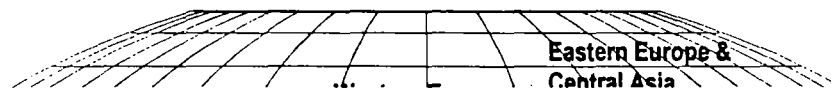
AIDS in Africa: What it is

AIDS is one of the most devastating health problems of the end of the 20th Century. The human immunodeficiency virus (HIV) which causes AIDS is transmitted through contact with specific body fluids of an infected individual. By far, the most common route of transmission is through sexual contact. However, HIV is also spread through contact with infected blood or from mother-to-child through breastmilk. AIDS is a major constraint to development since it attacks those who are most productive in society and causes the diversion of funding from economic and social investment. To date, worldwide, over 33 million people have been infected with HIV and nearly 12 million have died of AIDS.

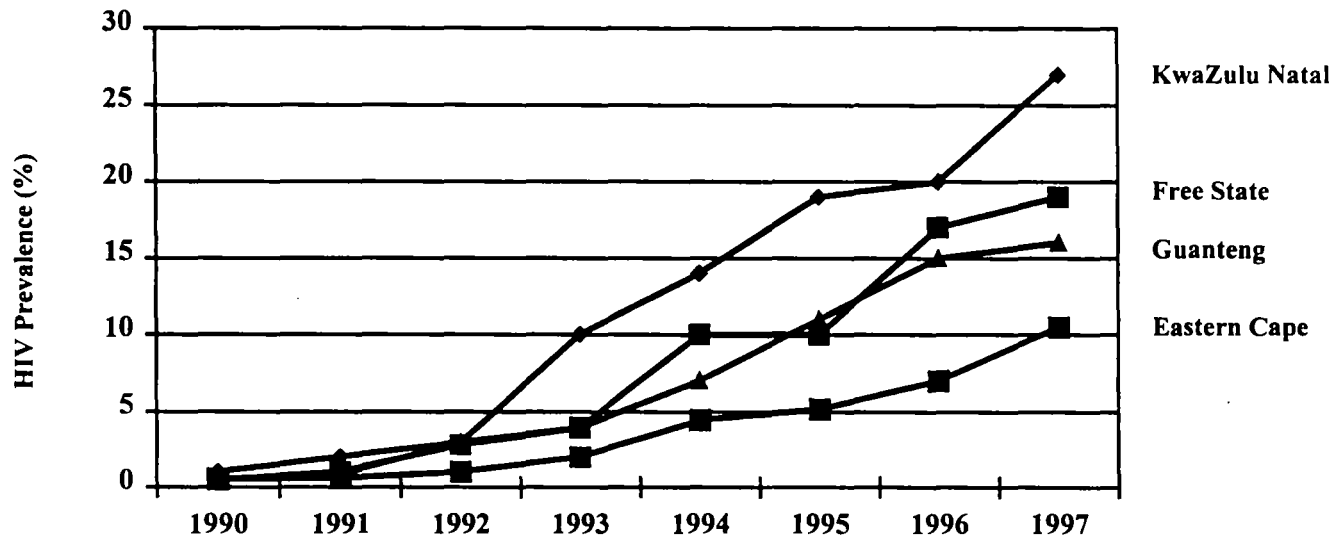
Africa always has and continues to be the continent hardest hit by the AIDS pandemic. Consider these statistics from the United Nations Joint Co-sponsored Program on AIDS (UNAIDS):

- Over two-thirds of all of the people now living with HIV in the world – nearly 21 million men, women and children – live in sub-Saharan Africa.
- Fully 83 percent of the world's AIDS deaths (9.6 million out of 11.7 worldwide) have occurred here.
- In some communities between 30-60 percent of sexually active women in the general population are HIV infected.
- In many countries, the number of HIV infections is rising most quickly among youth.

Adults and Children Currently Living with HIV/AIDS (end 1998)



HIV prevalence among pregnant women, selected provinces, South Africa, 1990-1997



Source: Department of Health South Africa

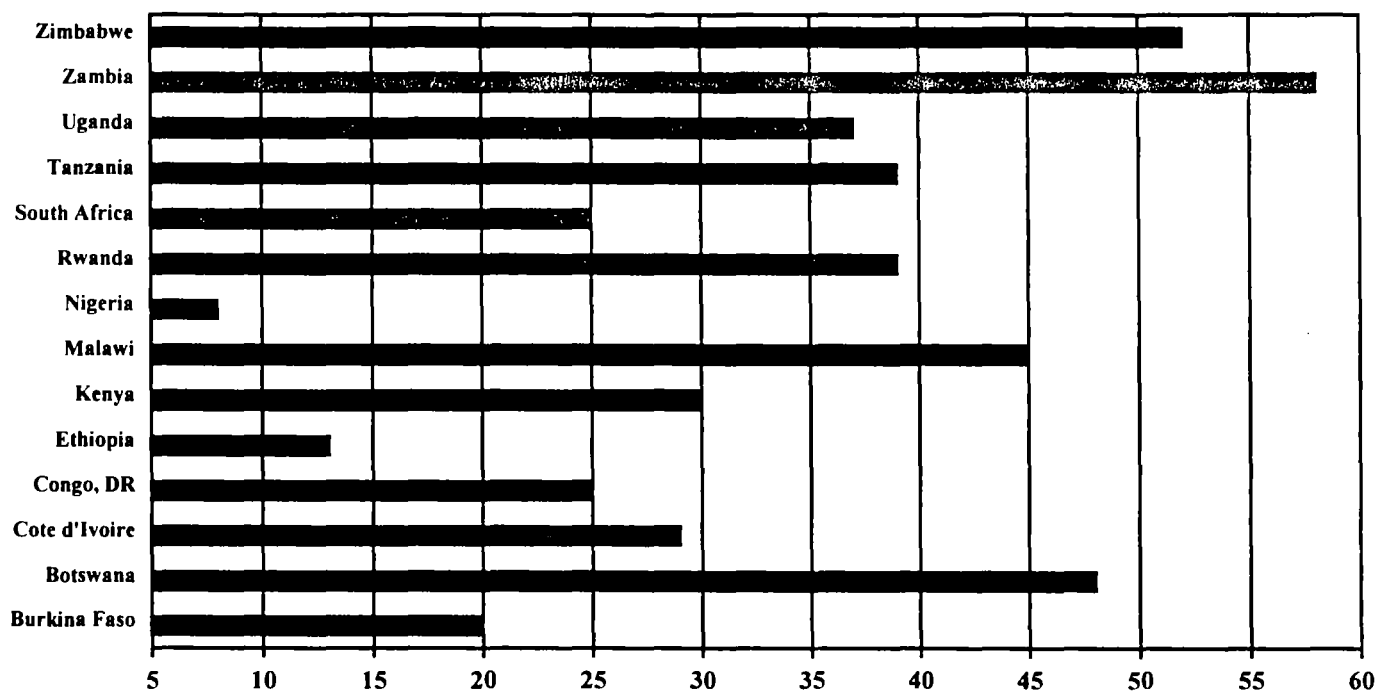
Contextual factors. The spread of HIV is fostered by many social and economic factors. For example, the migratory labor movements of truck drivers, farm workers, and miners encourages having partners – whether girlfriends or sex workers – outside of marriage. Other factors include the political and economically driven movement of refugees; poverty and the low skills base of women which can lead them to sex work; and by ignorance, the result of wide-spread stigma and discrimination that slows down prevention efforts. This virus attacks the elites of society – those with money, power and authority and whom society has invested greatly in – including government officials, police, the military, health professionals and teachers.

Why it is important

Social impact. According to UNAIDS, the AIDS epidemic is creating development havoc across Africa reversing social, economic and political gains. Across sub-Saharan Africa, AIDS is reversing 20-year trends in life expectancy and child survival:

- Adult death rates have doubled or tripled in many countries – in Zimbabwe an estimated 1400 people die every week from AIDS.

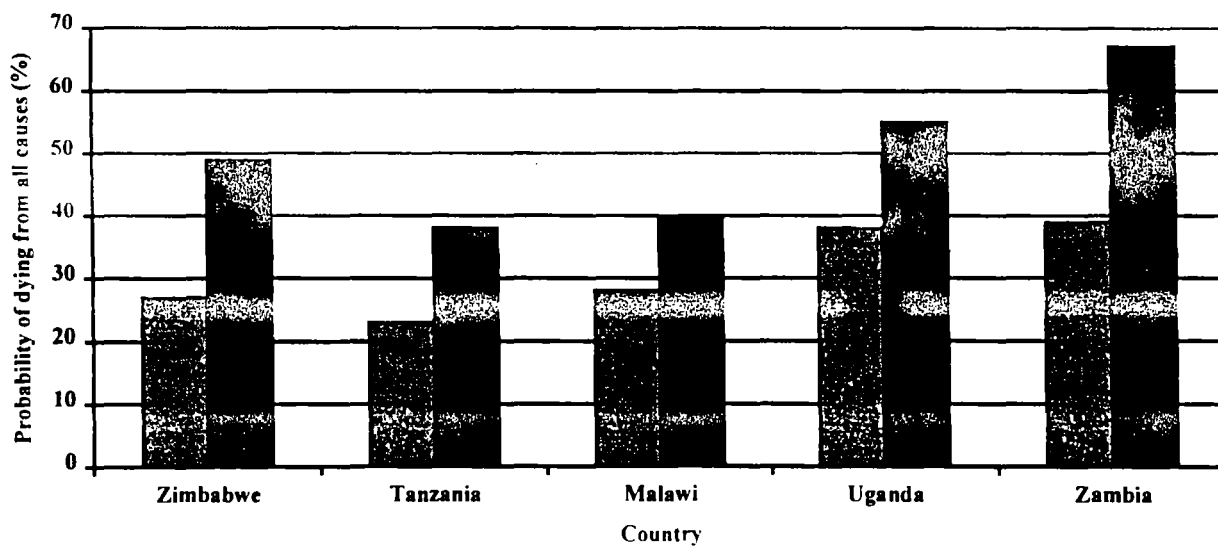
Estimated lifetime risk of dying of AIDS for selected countries



Source: AIDS Vol 12 Suppl 1 p. S38

Lifetime risk of dying of AIDS (%)

Increase in mortality among men 15-60 between 1986 and 1997, based on household reports (sibling histories), selected African countries



Prevention. In Africa, approximately 80% of HIV transmission occurs through heterosexual behavior. After nearly 15 years of experience working in HIV/AIDS we know that effective strategies are available to reduce sexually-transmitted HIV but that they need to match the state of the epidemic and the resources and given structures of each society. At all stages of the epidemic it is important to ensure that program efforts are focused on those who are at greatest risk of transmitting and acquiring HIV.

Essential strategies include:

- educating and supporting the adoption of healthy sexual behaviors through one-on-one or small group education, mass media, and voluntary HIV counseling and testing;
- increasing access to condoms through condom social marketing and improved public sector condom distribution; and
- treating and preventing the spread of other sexually transmitted diseases.

Equally important is helping the community to reshape cultural beliefs and norms that facilitate transmission and handicap prevention efforts. These strategies include:

- changing attitudes about the kinds of people who use condoms, and
- decreasing the stigma often attached to HIV and AIDS that otherwise discourages HIV-positive people from seeking help or being open about their virus status.

Key to reducing discrimination is an open, non-judgmental dialogue about HIV and AIDS by government and other opinion leaders and especially with participation of people living with HIV and AIDS.

Preventing HIV also needs to be integrated into the broader development portfolio. Non-health development strategies must be part of the solution. These include increasing access to primary education by girls; increasing access to credit by women; promoting enlightened private sector policy reform to provide family housing for migrant laborers; and providing safety nets for economic policies and structural adjustment programs that increase in the short term and may therefore increase risk behavior.

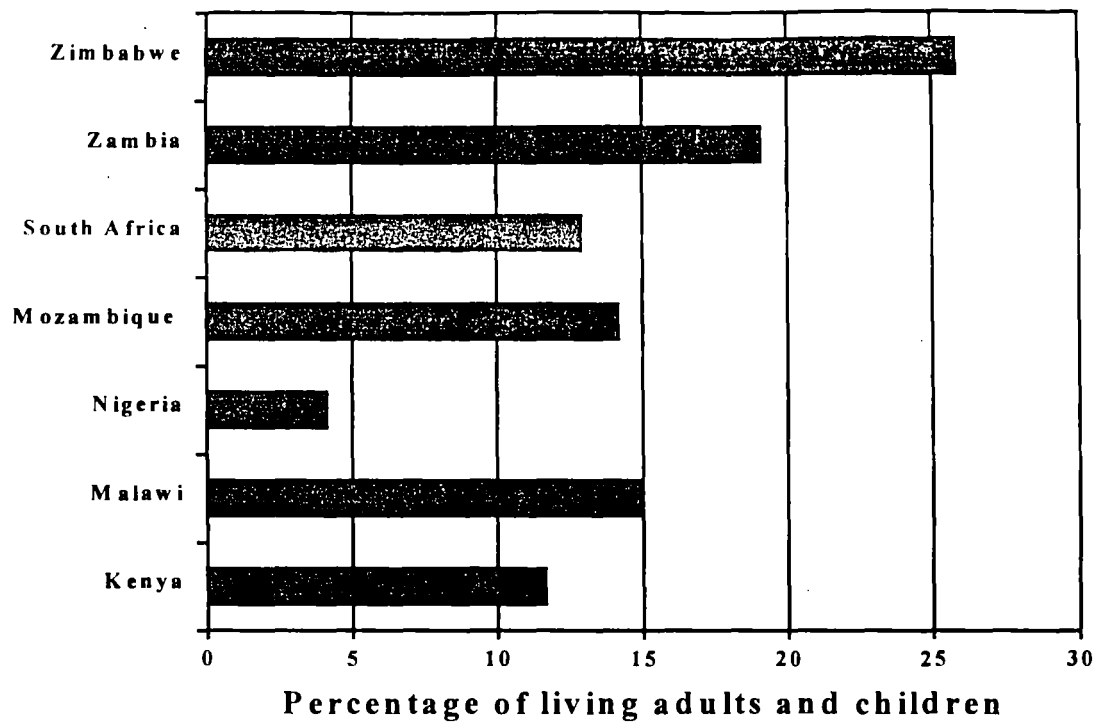
Future strategies. The use of antiretroviral drugs by pregnant women before childbirth can minimize HIV transmission from mother to child during delivery. Unfortunately due to the cost of therapy (estimated at \$50 per pregnancy), the high cost of breastmilk alternatives required, and cultural complexities severely limit the viability of this option in developing countries today. Also on the research front is the development of microbicides that would reduce sexual transmission and possible vaccines although research scientists suggest that such responses may be years away.

Care and support. As of 1998, 10.5 million of the 13 million worldwide reported cases of AIDS are found in Africa. Providing care poses a significant challenge to countries in Africa:

- Condom social marketing programs, now ubiquitous across Africa, increase condom accessibility by offering brand-name condoms at affordable prices to lowest-income consumers through a greatly expanded variety of commercial outlets (bars, hotels, kiosks, restaurants). For example, between 1991 and 1995 condom sales in Nigeria increased from 1.9 million to 34 million (1800%), and between 1991 and 1996 sales of condoms in Ethiopia increased from 3.8 million to 20.7 million.
- Improving access to services for treating sexually transmitted infections in Mwanza, Tanzania resulted in a 40% decline in new HIV infections.
- In Kenya, a program to positively engage the church about HIV through a specially-developed training program for clergy has resulted in substantially increased public involvement of pastors in HIV prevention and care and the establishment of a Kenya Christian AIDS Network with more than 30 branches country-wide. By the end of the two-year project over 55% of clergy reported that “churches were responding well” to the AIDS crisis compared to 2% who thought so prior to project launch.
- In Uganda, where over 400,000 adults have accessed widely-available HIV voluntary counseling and testing services, national level public education has been provided through mass media and governmental and non-governmental organizations, PLWHAs have access to care and support and actively participate in the national debate about AIDS, and the President has spoken openly about AIDS, the prevalence of HIV has begun to decline among pregnant women (from 30% in 1992 to 15% in 1999), 15-19 year old pregnant women (from 27% in 1991 to 11% in 1997), and military recruits (from 18.5% in 1991 to 8% in 1996).
- In South Africa and Zambia traditional healers have been trained to diagnose opportunistic infections and to refer patients to Western physicians for symptoms they cannot treat.
- In Uganda the concern of 16 citizens about the support needs of PLWAs led to the creation of The AIDS Service Organization (TASO) in 1987. By 1998 TASO served the needs of over 50,000 PLWAs.

Despite these successful “pilot level” programs for prevention and care, efforts to date are not occurring at a level to impact national trends in HIV transmission or to adequately address the needs of those for care and support. Too often the responses from the public and private profit and non-profit sectors are uncoordinated and developed without a clear focus on maximizing outcomes in resource-constrained settings. Critically needed are

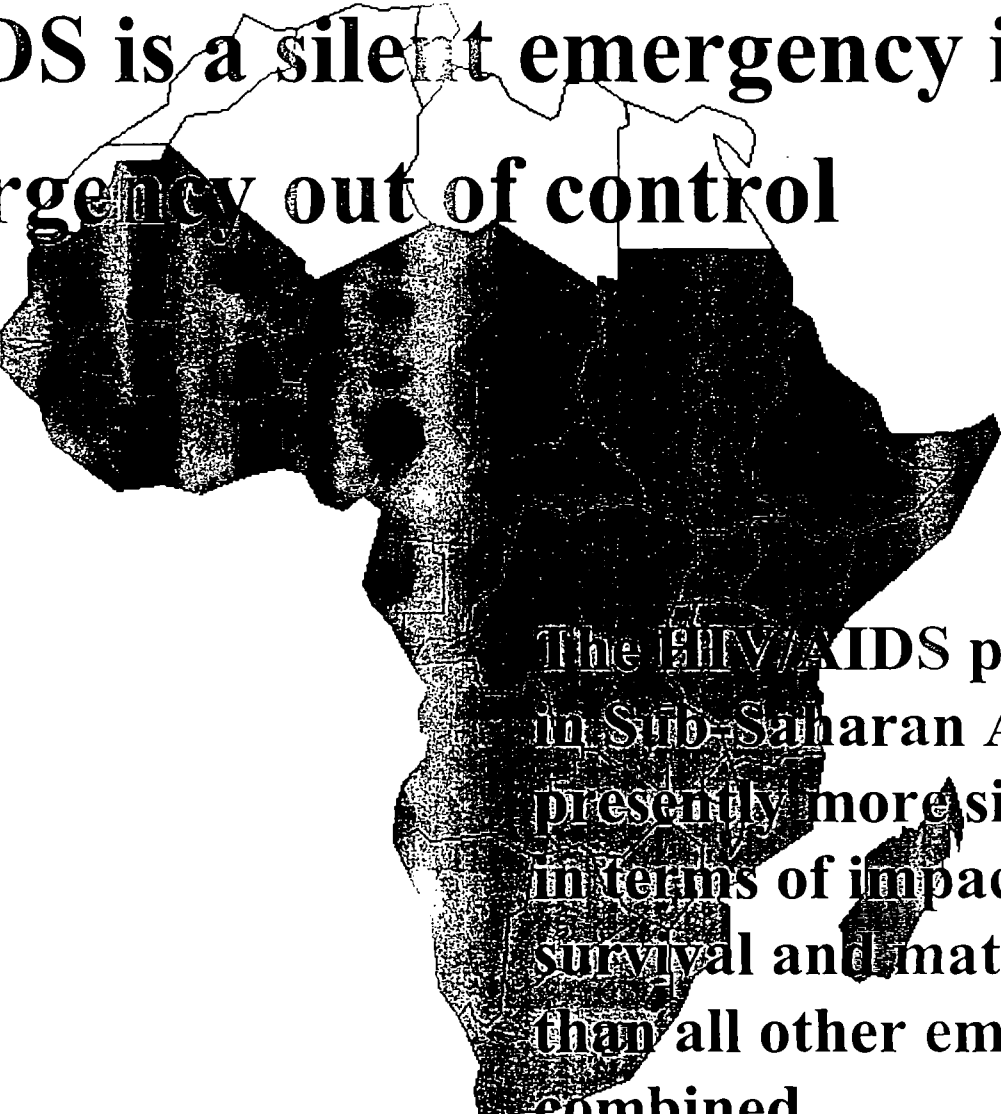
Estimated number of living adults and children with HIV, end 1997



Source: UNAIDS 1998

HIV/AIDS is a silent emergency in Africa

An emergency out of control



The HIV/AIDS pandemic in Sub-Saharan Africa is presently more significant, in terms of impact on child survival and maternal mortality than all other emergencies combined.



Sub-Saharan Africa

9.7 Million Adult and Child AIDS Deaths

83% of the World's Total

21 Million Adults and Children are Living With HIV/AIDS

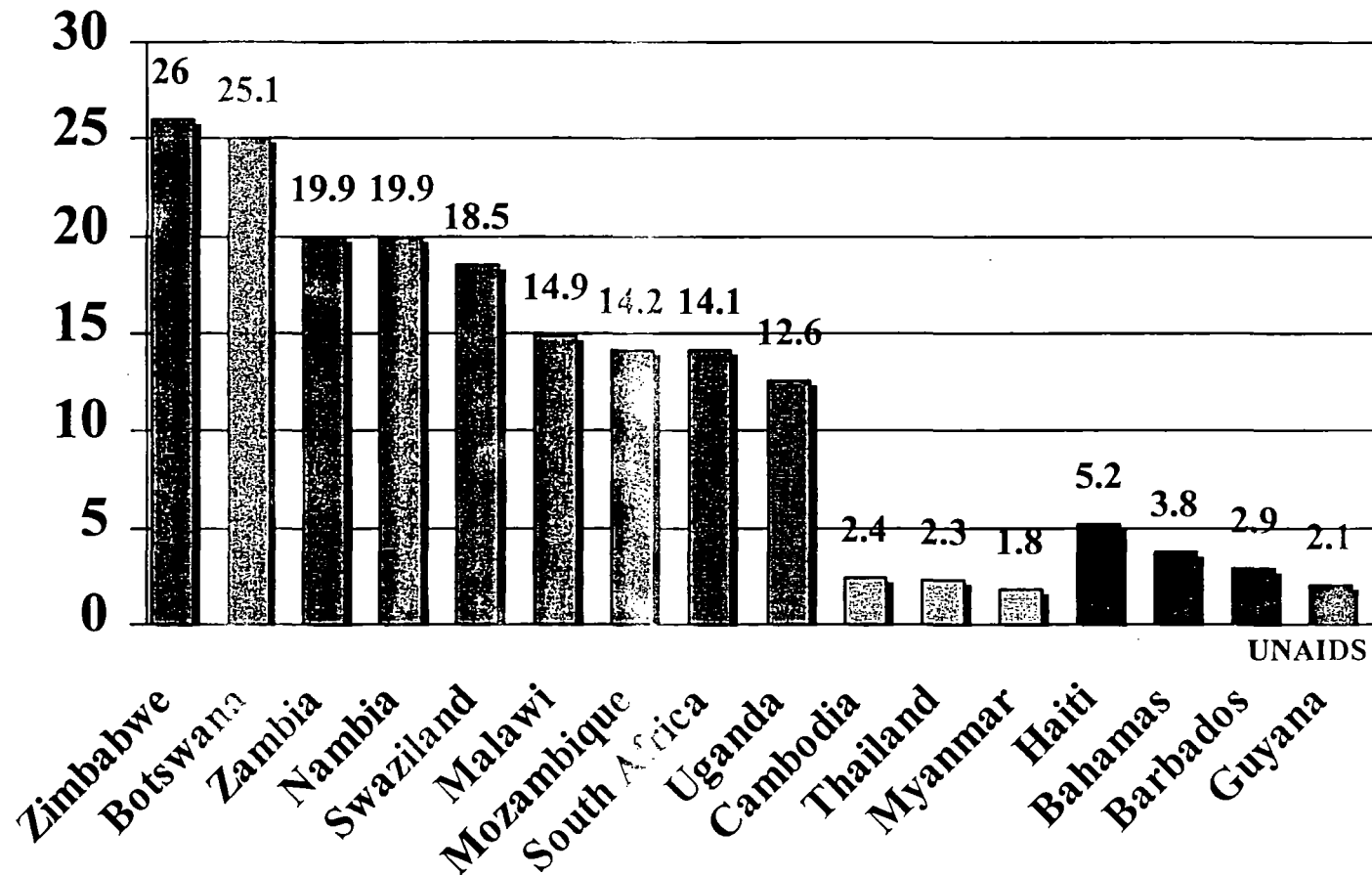
69% of the World's Total

960,000 Children are Living With HIV/AIDS

88% of the World's Total

Close to 4 Million People are Becoming Infected Yearly

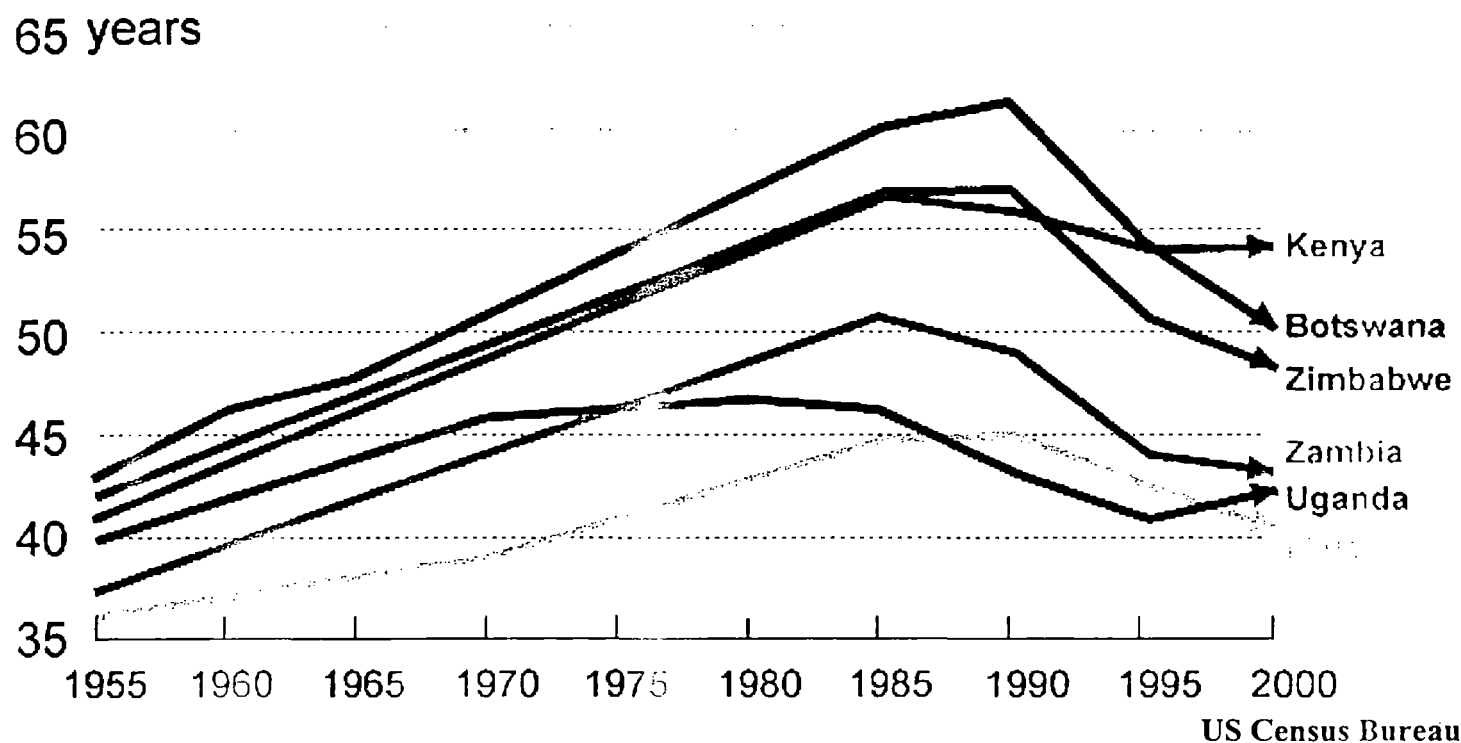
Infection Levels are Higher than Ever Imagined



And They Are Worsening



In heavily infected countries in Sub Saharan Africa, life expectancy continues to decline sharply





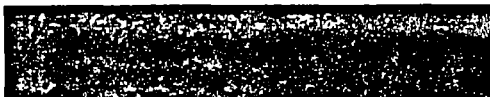
Working Paper:

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

Draft in Progress
March 1999

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

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



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

EXECUTIVE SUMMARY

This paper¹ summarizes the lessons learned and experiences of USAID operations, and perspective on newer issues, regarding the implementation of HIV/AIDS programs in Africa. The problem in most African countries in dealing with the disease is not what to do, as there are proven packages of interventions, but how to provide them on a large enough scale and in a concerted manner to make a difference. The attached paper and appendix contain approaches for scaling up interventions and ensuring an expanded response to HIV/AIDS. The appendix also focuses on suggestions specific to the World Bank and donors. The paper is largely based on feedback from USAID's country missions, particularly in East and Southern Africa.

The purpose of this paper is:

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

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

¹ This is an evolving paper. The United States Agency for International Development (USAID) developed this paper initially to share lessons learned from USAID HIV/AIDS programming with the UNAIDS program and the World Bank as they developed new initiatives for Africa.

Please forward your comments and suggestions to Dr. Ishrat Z. Husain, Senior Technical Advisor for HIV/AIDS, USAID Bureau for Africa at ihusain@af-sd.org or by mail to 1325 G Street, NW, Suite 400, Washington, DC 20005, USA

INTRODUCTION

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

ADDRESSING THE IMPLEMENTATION PROBLEMS

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

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

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

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

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

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

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

- ✓ Agreement with country officials on specific actions towards accelerated implementation of key program components with definite monitoring indicators.
- ✓ Consistent and regular high level dialogues using surveillance data to review progress at frequent intervals.
- ✓ Policy dialogue based on consultation with other donors and implementers and highlighting the disastrous implications of inaction for the country and different sectors. In addition, senior donor representatives working with various sectors should actively work with their counterparts to determine actions to be taken through sectoral programs.

► **Establishment of Surveillance System**

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

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

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

- **HIV/AIDS Information Centers**

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

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

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

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

Expanding the Local Capacity for HIV/AIDS Prevention and Mitigation

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

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

► Formation of District and Village AIDS Committees

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

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

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

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

► **Targeting and Prioritizing**

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

► **Mobilizing Military Personnel**

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

► **Massive Training Program**

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

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

► **Improving Commodity Procurement and Distribution**

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

Thus, countries and donors should strengthen the programs by:

- greater involvement of the industrial and commercial sectors in HIV/AIDS prevention.
- contracting nation-wide expansion of the social marketing and behavior change programs including health education out to the private sector.
- using the private sector for organizing skill development and income generating activities for the youth.

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

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

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

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

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

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

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

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

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

**UNITED STATES DEPARTMENT OF
COMMERCE
NEWS**
WASHINGTON, DC 20230

ECONOMICS
AND
STATISTICS
ADMINISTRATION

BUREAU OF THE
CENSUS

EMBARGOED UNTIL: 12:01 A.M. EST, MARCH 18, 1999 (THURSDAY)

Public Information Office
301-457-3030/301-457-3670 (fax)
301-457-4067 (TDD)

REVISED
CB99-53

Thomas McDevitt (General Information)
International Programs Center
301-457-1358

Karen Stanecki (AIDS Information)
301-457-1406

**AIDS Cuts Life Expectancy in Many African Countries,
Census Bureau Notes in World Population Profile**

AIDS has cut life expectancy by four years in Nigeria, 18 years in Kenya and 26 years in Zimbabwe -- only a few of the countries where mortality from the disease is having a major demographic impact, the Commerce Department's Census Bureau reported today.

"AIDS results in higher mortality rates in childhood, as well as among young adults where mortality otherwise is low," said Karen Stanecki, a contributing author of the Census Bureau's new report, World Population Profile: 1998. "As a result, AIDS deaths will have a larger impact on life expectancies than on some other demographic indicators in these nations."

The Census Bureau assessment shows 21 countries in Sub-Saharan Africa are significantly affected by AIDS. According to the report, HIV/AIDS epidemics continue to spread in Sub-Saharan Africa, particularly in Botswana and South Africa. Other severely affected countries include Namibia, Swaziland, Zambia and Zimbabwe, where 18 to 25 percent of all adults are HIV-positive.

Seven developing countries in Asia and Latin America also are significantly affected -- Guyana, Burma, Haiti, Cambodia, Honduras, Brazil and Thailand.

In addition to the update on AIDS mortality worldwide, World Population Profile: 1998 provides a comprehensive picture of population size and growth, fertility and mortality levels, and age structure in 227 countries and territories during the next quarter century.

The report also examines trends in family planning likely to play a key role in determining fertility and natural population increases during the coming decades.

Other points from the report:

- The world population will reach 6 billion in 1999.

- Between 1998 and 2025, the world's elderly population (age 65 and over) will more than double while the world's young (under age 15) will grow by only 6 percent.
- Early in the next century, international migration will become more of a critical variable in population growth in the United States and other developed countries, where the balance of births and deaths will otherwise lead to a stable or decreasing population.
- About 96 percent of world population increase now occurs in the developing regions of Africa, Asia and Latin America.
- A child born in Latin America or Asia can expect to live between seven and 13 fewer years, on average, than one born in North America or Western Europe.
- An estimated 120 million married women in the world's developing regions have an "unmet need" for contraceptive services and products, meaning they would like to regulate their fertility but currently are not using any means of contraception.

Data in the report are from the Census Bureau's International Data Base, HIV/AIDS Surveillance Data Base and unpublished tables.

-X-

The U.S. Census Bureau, pre-eminent collector and disseminator of timely, relevant and quality data about the people and the economy of the United States, conducts a population and housing census every 10 years, an economic census every five years and more than 100 demographic and economic surveys every year, all of them evolving from the first census in 1790.

[People](#) | [Housing](#) | [Business](#) | [Geography](#) | [News](#) | [Subjects A to Z](#) | [Search](#) | [Catalog](#) | [Data Tools](#) | [Census Home](#)

AIDS IN THE THIRD WORLD



A global disaster

PIETERMARITZBURG, HARARE, KAMPALA

The AIDS virus has infected 47m people, and shows no signs of slowing. It cannot be cured. Can it be curbed?

IN RICH countries AIDS is no longer a death sentence. Expensive drugs keep HIV-positive patients alive and healthy, perhaps indefinitely. Loud public-awareness campaigns keep the number of infected Americans, Japanese and West Europeans to relatively low levels. The sense of crisis is past.

In developing countries, by contrast, the disease is spreading like nerve gas in a gentle breeze. The poor cannot afford to spend \$10,000 a year on wonder-pills. Millions of Africans are dying. In the longer term, even greater numbers of Asians are at risk. For many poor countries, there is no greater or more immediate threat to public health and economic growth. Yet few political leaders treat it as a priority.

Since HIV was first identified in the 1970s, over 47m people have been infected, of whom 14m have died. Last year saw the biggest annual death toll yet: 2.5m. The disease now ranks fourth among the world's big killers, after respiratory infections,

diarrhoeal disorders and tuberculosis. It now claims many more lives each year than malaria, a growing menace, and is still nowhere near its peak. If India, China and other Asian countries do not take it seriously, the number of infections could reach "a new order of magnitude", says Peter Piot, head of the UN's AIDS programme.

The human immuno-deficiency virus (HIV), which causes acquired immune deficiency syndrome (AIDS), is thought to have crossed from chimpanzees to humans in the late 1940s or early 1950s in Congo. It took several years for the virus to break out of Congo's dense and sparsely populated jungles but, once it did, it marched with rebel armies through the continent's numerous war zones, rode with truckers from one rest-stop brothel to the next, and eventually flew, perhaps with an air steward, to America, where it was discovered in the early 1980s. As American homosexuals and drug injectors started to wake up to the dangers of bath-houses and needle-sharing,

AIDS was already devastating Africa.

So far, the worst-hit areas are east and southern Africa. In Botswana, Namibia, Swaziland and Zimbabwe, between a fifth and a quarter of people aged 15-49 are afflicted with HIV or AIDS. In Botswana, children born early in the next decade will have a life expectancy of 40; without AIDS, it would have been nearer 70. Of the 25 monitoring sites in Zimbabwe where pregnant women are tested for HIV, only two in 1997 showed prevalence below 10%. At the remaining 23 sites, 20-50% of women were infected. About a third of these women will pass the virus on to their babies.

The region's giant, South Africa, was largely protected by its isolation from the rest of the world during the apartheid years. Now it is host to one in ten of the world's new infections—more than any other country. In the country's most populous province, KwaZulu-Natal, perhaps a third of sexually active adults are HIV-positive.

Asia is the next disaster-in-waiting. Already, 7m Asians are infected. India's 930m people look increasingly vulnerable. The Indian countryside, which most people imagined relatively AIDS-free, turns out not to be. A recent study in Tamil Nadu found over 2% of rural people to be HIV-positive: 500,000 people in one of India's smallest states. Since 10% had other sexually transmitted diseases (STDs), the avenue for further infections is clearly open. A survey of female STD patients in Poona, in Maharashtra, found that over 90% had never had sex with anyone but their husband; and yet 13.6% had HIV. China is not far behind.

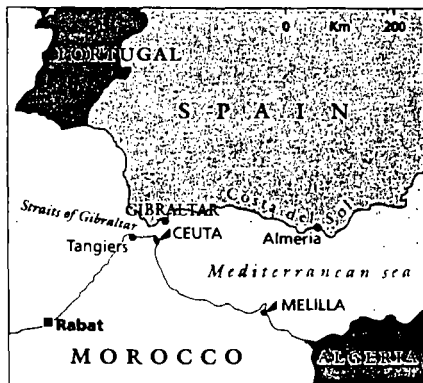
No one knows what AIDS will do to poor countries' economies, for nowhere has the epidemic run its course. An optimistic assessment, by Alan Whiteside of the University of Natal, suggests that the effect of AIDS on measurable GDP will be slight. Even at high prevalence, Mr Whiteside thinks it will slow growth by no more than 0.6% a year. This is because so many people in poor countries do not contribute much to the formal economy. To put it even more crudely, where there is a huge oversupply of unskilled labour, the dead can easily be replaced. Some people argue that those who survive the epidemic will benefit from a tighter job market. After the Black Death killed a third of the population of medieval Europe, labour scarcity forced landowners to pay their workers better.

Other researchers are more pessimistic. AIDS takes longer to kill than did the plague, so the cost of caring for the sick will be more crippling. Modern governments, unlike medieval ones, tax the healthy to

secticide. Unlike the countries of northern Europe, Spain does not penalise employers for using illegal workers: moreover, many illegals who find stable work end up with Spanish citizenship. Spain's problem is that it has to contend with a Brussels ban on work permits, whereas northern Europe was able to import its labour legally when it needed it in the 1970s.

Madrid's two North African enclaves, Ceuta and Melilla, probably offer the easiest way to break into the fortress. Earlier this year, the Spanish authorities, under orders from the EU, strung up a wire fence to keep out would-be migrants. But each night more arrive, cut through the barbed wire and demand political asylum. In Ceuta alone, the Red Cross is feeding 1,000 people. Almost all of them will eventually make it to Spain. Even if their applications are refused, Spain gives migrants a boat ride to the mainland and 15 days freedom to appeal—which is often time enough to disappear into the illegal morass.

The Red Cross camp in Ceuta is over-



flowing: refugees sleep 30 or more to a tent. Word of the backdoor to Europe has spread far: some have come from Kashmir and Iraq. Algerians are there in their scores, and West Africans—above all Nigerians—in their hundreds. They say they crossed the Sahara on foot, but many cruise the camp decked in gold chains, designer clothes and mobile phones. Spanish officials say that traffic in illegal migrants and substances goes hand-in-hand. Certainly, the sweet smell of Moroccan hashish wafts through the camps. And reports are now surfacing of a ring supplying southern Spain and Italy with child prostitutes from the deep south of Morocco.

Officials in Morocco say it is time to regulate the trans-Mediterranean traffic rather than leave the underground networks to do their worst. They suggest that the EU should replace the blanket ban on migrant workers with a quota, encouraging would-be migrants to seek a legal, safer passage to Europe. Morocco's proposal is plainly self-interested: migration is vital to the nation's economy. It acts as a safety-valve for a country that has an unemployment rate of 20%

and no welfare provision. Migration also provides Morocco with \$2 billion a year in remittances, its second-largest source of hard currency. If Europe were really to stem the flow, Morocco might implode.

Angola

Trapped in the middle

LUANDA

HELL and heaven are separated by a 20-minute drive along clogged streets. The centre of Angola's capital, Luanda, is a wasteland of piled-up rubbish, broken pavements and broken people; amputees from the war and its landmines beg at every corner. At the United Nations base on the outskirts of Luanda, freshly watered herbaceous borders run between rows of mobile homes. To keep the UN bureaucrats healthy and happy there are tennis courts and a swimming pool plus an all-American bar where beer can be bought only with dollars.

The government blames this haven of peace for the resurgence of the country's civil war in early December, venomously attacking the UN Observer Mission in Angola for incompetence. It claims that, if the UN had been doing its job properly, Jonas Savimbi, the UNITA rebel leader, would not have been able to stockpile weapons when, under the terms of the 1994 Lusaka protocol, he should have been handing them in.

They have a point. The UN's strategy was to make the most of the peace process in order to keep it going. UN officials regularly announced how many weapons had been handed in and how many soldiers and rebels were being demobilised at UN assembly points. No matter that many of the weapons were rusty and many of the UNITA "soldiers" at the centres were mere boys recruited a few weeks before.

But if the UN failed to spot Mr Savimbi's shopping habits in the world's arms markets, it also failed to draw attention to the government's crude lack of interest in a true peace. In territory abandoned by UNITA, where people were desperate for food and medicine, the government instead sent in thuggish policemen who, without supplies of their own, stole the last local food stocks.

On December 5th, the Angolan army attacked UNITA's strongholds at Andulo and Bailundo in the central highlands. At the same time, the ruling MPLA party, holding its annual congress in Luanda, replaced many veteran members with more military-minded men. The shuffle clearly signalled all-out war: the

party bosses were hoping to plant the government flag in the heart of the territory that Mr Savimbi once held.

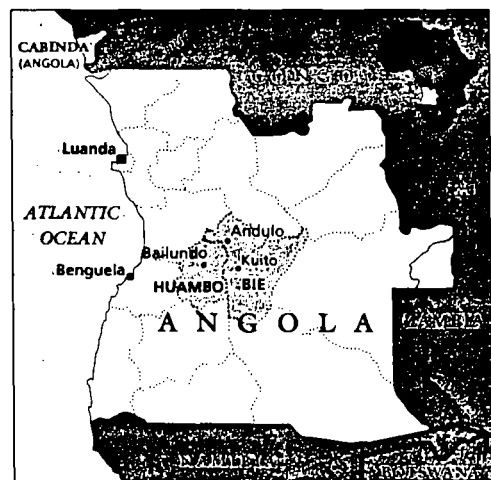
Most thought that would be easy. The rebels have no outside allies left. They are supposedly cut off by UN sanctions from both weapons suppliers and diamond buyers, and they have been weakened by attacks on their rear bases in Congo. But Mr Savimbi's forces proved stronger than expected and, by December 9th, UNITA was announcing that the government forces were in retreat "having been beaten at their own game". They were sent reeling as far as Kuito, which UNITA seemed on the point of seizing. Except that, at that point, the rebels ran out of petrol.

Angola makes \$2 billion-3 billion a year from oil, and UNITA usually has no difficulty finding supplies. This time, however, the rebels did not expect to find themselves advancing so fast. Like everyone else, they had overestimated government strength, and underestimated their own.

This gave the government a chance to regroup. The rebels set about shelling Kuito and fierce fighting is reported in Bie and Huambo provinces. On December 26th a UN-chartered flight with four crew and ten UN officials crashed near Huambo. Both sides accuse the other of shooting it down.

Four days after the crash, the UN's special representative, Issa Diallo, was still trying to get a local ceasefire to allow a search mission to look for survivors. The government said the aircraft had come down in UNITA-held territory and so it was not their business. The rebels denied having received any request from Mr Diallo until late on December 28th. UNITA also says that the government is carrying out air strikes on its headquarters, making communication impossible.

In short, neither side has shown the slightest interest in helping Mr Diallo look for the missing 14 people, let alone agreeing to a ceasefire or trying to work out a way of ending the war.



help look after the ailing, so the burden will fall on everyone. And AIDS, because it is sexually transmitted, tends to hit the most energetic and productive members of society. A recent study in Namibia estimated that AIDS cost the country almost 8% of GNP in 1996. Another analysis predicts that Kenya's GDP will be 14.5% smaller in 2005 than it would have been without AIDS, and that income per person will be 10% lower.

The cost of the disease

In general, the more advanced the economy, the worse it will be affected by a large number of AIDS deaths. South Africa, with its advanced industries, already suffers a shortage of skilled manpower, and cannot afford to lose more. In better-off developing countries, people have more savings to fall

ous, AIDS could break budgets and hobble the provision of services. In South Africa, an estimated 15% of civil servants are HIV-positive, but government departments have made little effort to plan for the coming surge in sickness. Education, too, will suffer. In Botswana, 2-5% of teachers die each year from AIDS. Many more take extended sick leave.

At a macro level, the impact of AIDS is felt gradually. But at a household level, the blow is sudden and catastrophic. When a breadwinner develops AIDS, his (or her) family is impoverished twice over: his income vanishes, and his relations must devote time and money to nursing him. Daughters are often forced to drop out of school to help. Worse, HIV tends not to strike just one member of a family. Husbands give it to wives, mothers to babies. This correspondent's driver in Kampala lost his mother, his father, two brothers and their wives to AIDS. His story is not rare.

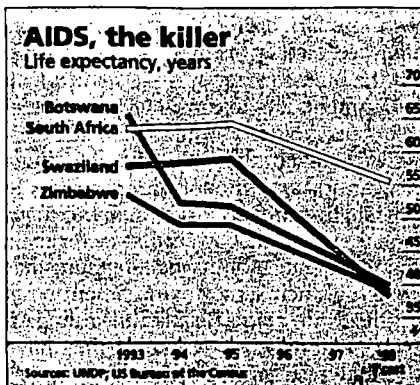
Obstacles to prevention

The best hope for halting the epidemic is a cheap vaccine. Efforts are under way, but a vaccine for a virus that mutates as rapidly as HIV will be hugely difficult and expensive to invent. For poor countries, the only practical course is to concentrate on prevention. But this, too, will be hard, for a plethora of reasons.

- Sex is fun... Many feel that condoms make it less so. Zimbabweans ask: "Would you eat a sweet with its wrapper on?"
- ...and discussion of it often taboo. In Kenya, Christian and Islamic groups have publicly burned anti-AIDS leaflets and condoms, as a protest against what they see as the encouragement of promiscuity. A study in Thailand found that infected women were only a fifth as likely to have discussed sex openly with their partners as were uninfected women.
- Myths abound. Some young African women believe that without regular infusions of sperm, they will not grow up to be beautiful. Ugandan men use this myth to seduce schoolgirls. In much of southern Africa, HIV-infected men believe that they can rid themselves of the virus by passing it on to a virgin.
- Poverty. Those who cannot afford television find other ways of passing the evening. People cannot afford antibiotics, so the untreated sores from STDs provide easy openings for HIV.
- Migrant labour. Since wages are much higher in South Africa than in the surrounding region, outsiders flock in to find work. Migrant miners (including South Africans forced to live far from their homes) spend most of the year in single-sex dormitories surrounded by prostitutes. Living with a one-in-40 chance of being killed by a rockfall, they are inured to risk. When they go home, they often infect their wives.

- War. Refugees, whether from genocide in Rwanda or state persecution in Myanmar, spread HIV as they flee. Soldiers, with their regular pay and disdain for risk, are more likely than civilians to contract HIV from prostitutes. When they go to war, they infect others. In Africa the problem is dire. In Congo, where no fewer than seven armies are embroiled, the government has accused Ugandan troops (which are helping the Congolese rebels) of deliberately spreading AIDS. Unlikely, but with estimated HIV prevalence in the seven armies ranging from 50% for the Angolans to an incredible 80% for the Zimbabweans, the effect is much the same.

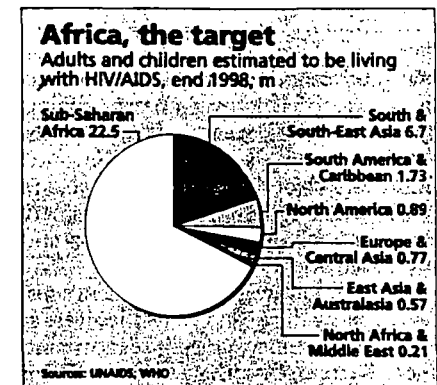
- Sexism. In most poor countries, it is hard for a woman to ask her partner to use a condom. Wives who insist risk being beaten



back on when they need to pay medical bills. Where people have health and life insurance, those industries will be hit by bigger claims. Insurers protect themselves by charging more or refusing policies to HIV-positive customers. In Zimbabwe, life-insurance premiums quadrupled in two years because of AIDS. Higher premiums force more people to seek treatment in public hospitals: in South Africa, HIV and AIDS could account for between 35% and 84% of public-health expenditure by 2005, according to one projection.

Little research has been done into the effects of AIDS on private business, but the anecdotal evidence is scary. In some countries, firms have had to limit the number of days employees may take off to attend funerals. Zambia is suffering power shortages because so many engineers have died. Farmers in Zimbabwe are finding it hard to irrigate their fields because the brass fittings on their water pipes are stolen for coffin handles. In South Africa, where employers above a certain size are obliged to offer generous benefits and paid sick leave, companies will find many of their staff, as they sicken, becoming more expensive and less productive. Yet few firms are trying to raise awareness of AIDS among their workers, or considering how they will cope.

In the public sector, where pensions and health benefits are often more gener-



up. Rape is common, especially where wars rage. Forced sex is a particularly effective means of HIV transmission, because of the extra blood.

- Drinking. Asia and Africa make many excellent beers. They are also home to a lot of people for whom alcohol is the quickest escape from the stresses of acute poverty. Drunken lovers are less likely to remember to use condoms.

How to fight the virus

Pessimists look at that list and despair. But three success stories show that the hurdles to prevention are not impossibly high.

First, Thailand. One secret of Thailand's success has been timely, accurate information-gathering. HIV was first detected in Thailand in the mid-1980s, among male homosexuals. The health ministry immediately began to monitor other high-risk groups, particularly the country's many heroin addicts and prostitutes. In the first half of 1988, HIV prevalence among drug injectors tested at one Bangkok hospital leapt from 1% to 30%. Shortly afterwards, infections soared among prostitutes.

The response was swift. A survey of Thai sexual behaviour was conducted. The results, which showed men indulging in a phenomenal amount of unprotected commercial sex, were publicised. Thais were warned that a major epidemic would strike

AIDS IN THE THIRD WORLD

if their habits did not change. A "100% condom use" campaign persuaded prostitutes to insist on protection 90% of the time with non-regular customers.

By the mid-1990s, the government was spending \$80m a year on AIDS education and palliative care. In 1990-93, the proportion of adult men reporting non-marital sex was halved, from 28% to 15%; for women, it fell from 1.7% to 0.4%. Brothel visits slumped. Only 10% of men reported seeing a prostitute in 1993, down from 22% in 1990. Among army conscripts in northern Thailand, a group both highly sexed and well-monitored, the proportion admitting to paying for sex fell from 57% in 1991 to 24% in 1995. The proportion claiming to have used condoms at their last commercial entanglement rose from 61% in 1991 to 93% in 1995.

People lie about sex, so reported good behaviour does not necessarily mean actual good behaviour. But tumbling infections suggest that not everyone was fibbing. The number of sexually transmitted diseases reported from government clinics fell from over 400,000 in 1986 to under 50,000 in 1995. Among northern conscripts, HIV prevalence fell by half between 1993 and 1995, from over 7% to under 3.5%.

Most striking was the government's success in persuading people that they were at risk long before they started to see acquaintances die from AIDS. There was no attempt to play down the spread of HIV to avoid scaring off tourists, as happened in Kenya. Thais were repeatedly warned of the dangers, told how to avoid them, and left to make their own choices. Most decided that a long life was preferable to a fast one.

Second, Uganda. Thailand shows what is possible in a well-educated, fairly prosperous country. Uganda shows that there is hope even for countries that are poor and

barely literate. President Yoweri Museveni recognised the threat shortly after becoming president in 1986, and deluged the country with anti-AIDS warnings.

The key to Uganda's success is twofold. First, Mr Museveni made every government department take the problem seriously, and implement its own plan to fight the virus. Accurate surveys of sexual behaviour were done for only \$20,000-30,000 each. Second, he recognised that his government could do only a limited amount, so he gave free rein to scores of non-governmental organisations (NGOs), usually foreign-financed, to do whatever it took to educate people about risky sex.

The Straight Talk Foundation, for example, goes beyond simple warnings about AIDS and deals with the confusing complexities of sex. Its staff run role-playing exercises in Uganda's schools to teach adolescents how to deal with romantic situations. Its newsletter, distributed free, covers everything from nocturnal emissions to what to do if raped. Visiting AIDS workers from South Africa and Zimbabwe asked the foundation's director, Catharine Watson, how she won government permission to hand out such explicit material, and were astonished to hear that she had not felt the need to ask.

The climate of free debate has led Ugandans to delay their sexual activity, to have fewer partners, and to use more condoms. Between 1991 and 1996, HIV prevalence among women in urban ante-natal clinics fell by half, from roughly 30% to 15%.

Third, Senegal. If Uganda shows how a poor country can reverse the track of an epidemic, Senegal shows how to stop it from taking off in the first place. This West African country was fortunate to be several thousand miles from HIV's origin. In the mid-1980s, when other parts of Africa were already blighted, Senegal was still relatively AIDS-free. In concert with non-governmental organisations and the press and broadcasters, the government set up a national AIDS-control programme to keep it that way.

In Senegal's brothels, which had been regulated since the early 1970s, condom use was firmly encouraged. The country's blood supply was screened early and effectively. Vigorous education resulted in 95% of Senegalese adults knowing how to avoid the virus. Condom sales soared from 800,000 in 1988 to 7m in 1997. Senegalese levels of infection have remained stable and low for a decade—at around 1.2% among pregnant women.

Contrast these three with South Africa. On December 1st, World AIDS Day, President Nelson Mandela told the people of KwaZulu-Natal that HIV would devastate their communities if not checked. The speech was remarkable not for its quality—Mr Mandela is always able to move audiences—but for its rarity. Unlike Mr Museveni, South Africa's leader seldom uses his authority to encourage safer sex. It is a tragic omission. Whereas the potholed streets of Kampala are lined with signs promoting fidelity and condoms, this correspondent has, in eight months in South Africa, seen only two anti-AIDS posters, both in the UN's AIDS office in Pretoria.

How to dither and die

South Africa has resources and skills on a scale that Uganda can only marvel at. It even has an excellent AIDS prevention plan, accepted by the new cabinet in 1994. But the plan was never implemented. The government likes to consult every conceivable "stakeholder", so new plans are eternally drafted and redrafted. Local authorities cannot act without orders from the central government. NGOs, many of them dependent on the powers-that-be for their finance, waste months making sure that enough of their senior management posts are filled with blacks to satisfy the ruling African National Congress. And they have minimal freedom to experiment.

"There's an idea that if you disagree with the government, you are betraying the liberation struggle," says Mary Crewe, head of the Greater Johannesburg AIDS project. As a result, soldiers in the South African army are so ignorant that they snip the tips off their free condoms, and HIV has spread through South Africa as fast, according to Dr Neil McKerrow of Grey's Hospital in Pietermaritzburg, as if no preventive measures at all had been taken.

Such bungling is not unique to South Africa. Most governments have been slow to recognise the threat from AIDS. From Bulawayo to Beijing, apathy and embarrassment have hamstrung preventive efforts.

In anarchic countries, such as Congo and Angola, there have been almost no preventive efforts. Many people believe that the cause—a bid to restrain one of the most basic human instincts—is hopeless. As a Zimbabwean novelist, Chenjerai Hove, puts it with disturbing fatalism: "Since our women dress to kill, we are all going to die." But if the sexual drive is basic, so is the desire to live. If governments in poor countries wake up to the need to persuade their citizens that unprotected sex is Russian roulette, Mr Hove could be proved wrong.

.....
This article is indebted to a number of UNAIDS reports, including AIDS epidemic update (December 1998), AIDS in Africa (November 1998), and "A measure of success in Uganda" (May 1998).



¹The Economic Impact of AIDS

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

Labor Supply

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

Costs

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

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

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

Economic Impact of AIDS on Households

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

- Loss of income of the patient (who is frequently the main breadwinner)
- Household expenditures for medical expenses may increase substantially

¹ This paper was prepared by Dr. John Stover, The Futures Group International for USAID. March 15, 1999

countries have shown that AIDS will have adverse effects on agriculture, including loss of labor supply and remittance income. The loss of a few workers at the crucial periods of planting and harvesting can significantly reduce the size of the harvest. In countries where food security has been a continuous issue because of drought, any declines in household production can have serious consequences. Additionally, a loss of agricultural labor is likely to cause farmers to switch to less-labor-intensive crops. In many cases this may mean switching from export crops to food crops.⁷ Thus, AIDS could affect the production of cash crops and, as a result, effect foreign exchange earnings.

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

Reduction in Production Due to AIDS Deaths in Zimbabwe	
Crops	Reduction in Output
Maize	61%
Cotton	47%
Vegetables	49%
Groundnuts	37%
Cattle Owned	29%

- In **Ethiopia**, the male head of the household is responsible for special tasks, such as oxen cultivation, harvesting, threshing and farm management. One study found that the effect of an AIDS death varied by region: it would have the most severe effect on harvesting teff in Nazareth, on digging holes for transplanting enset plants in Atat, on ploughing millet fields in Baherdar, and on picking coffee in Yirgalem. Women are generally responsible for other tasks: leveling, weeding, harvesting minor crops, transporting produce, and household duties. The death of the wife to AIDS can make it difficult for other household members to carry out these tasks, in addition to caring for children. The death of a family member because of AIDS also leads to a reduction in savings and investment. The stock of food grain can be depleted to provide food for mourners and the other expenses were met most often by selling livestock. Such loss of productive assets only makes it harder to survive in the future.⁸
- In **Kagabiro village, Tanzania**, when a household contained an AIDS patient, the household labor supply was severely affected: on average, 29% of household labor was spent on AIDS-related matters, including care of the patient and funeral duties. If two people were devoted to nursing duties, as occurred in 66% of the cases, the total labor loss was 43%, on average.⁹

- In **Malawi**, 10% of GDP comes from estate agriculture. A recent study evaluated the costs of HIV/AIDS on a tea estate there (see table at right). The study found that the costs are determined by the levels of both

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

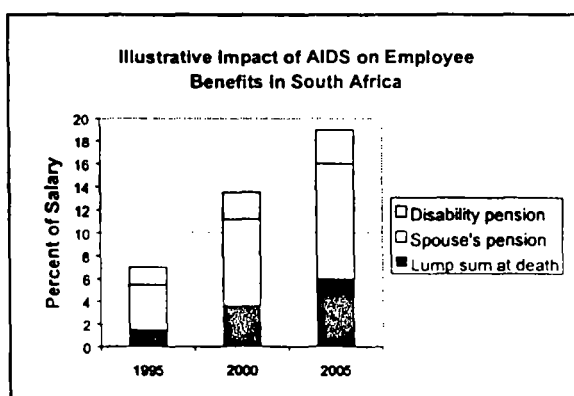
AIDS in 1996. The total costs of AIDS to the company in 1996 were estimated at Z\$39 million, equal to about 20 percent of the company's profits. More than half of this amount resulted from increased health care costs. By 2005 the cost of AIDS to the company could reach Z\$108 million. There may be indirect costs as well. The report speculates that HIV/AIDS will worsen employee morale and create greater labor-management tensions and cause a labor shortage among skilled positions.¹³

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

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

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

- The Indeni Petroleum Refinery in **Zambia** spent US\$26,400 on AIDS-related costs in 1994, more than its declared profits of US\$25,514 in that year.¹⁵
- A study in **South Africa** examined the expected impact of AIDS on employee benefits, and thus on corporate profits. It found that at current levels of benefits per employee, the total costs of benefits would rise from 7 percent of salaries in 1995 to 19 percent by 2005. Since these additional costs will have to be paid at the same time that productivity is declining, due to AIDS, the net impact on profits could be significant.¹⁶



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

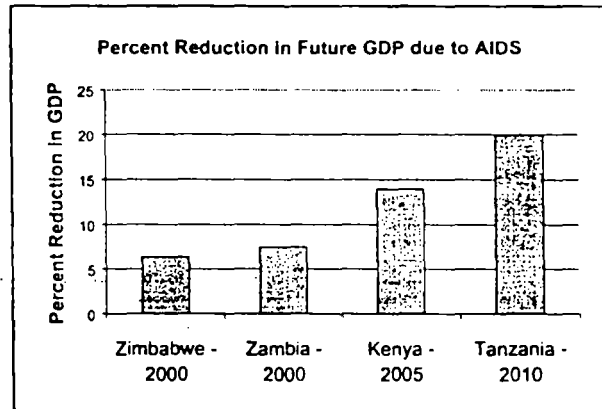
- The **Uganda** Railway Corporation has been hard hit by AIDS among its employees, experiencing a labor turnover rate of 15 percent per year in recent years.¹⁷

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

- **Mining.** The mining sector is a key source of foreign exchange for many countries. Most mining is conducted at sites far from population centers forcing workers to live apart from their families for extended periods of time. They often resort to commercial sex. Many become infected with HIV and spread that infection to their spouses and communities when they return home. Highly trained mining engineers can be very difficult to replace. As a result, a severe AIDS epidemic can seriously threaten mine production.
- **Education.** Countries invest huge sums of money in the education of their children. When an educated person dies prematurely due to AIDS, much of that investment is wasted. AIDS directly affects the education sector in at least three ways: the supply of experienced teachers is reduced by AIDS-related illness and death; children are kept out of school if they are needed at home to care for sick family members or to work in the fields; and children drop out of school if their families can not afford school fees due to reduced household income as a result of an AIDS death. Another problem is that teenage children are especially susceptible to HIV infection. Therefore, the education system also faces a special challenge to educate students about AIDS and equip them to protect themselves.
- **Water.** Developing water resources in arid areas and controlling excess water during rainy periods requires highly skilled water engineers and constant maintenance of wells, dams, embankments, etc. The loss of even a small number of highly trained engineers can place entire water systems and significant investment at risk. These engineers may be especially susceptible to HIV because of the need to spend many nights away from their families.
- **Civil servants and the military.** Senior civil servants and members of the military represent a large investment in training. Yet some of the highest HIV prevalence rates are found in these two groups. Senior civil servants have the income and mobility that can facilitate having multiple sexual partners. In a recent study in Malawi, the national Department of Human Resources and Management Development discovered that the annual adult death rate among health personnel was six times the expected death rate, predominately due to AIDS. The same pattern holds for many other government workers as well. Military men and women are often young, sexually active adults who live away from their families. AIDS deaths to the most experienced members of these groups have the potential to disrupt the smooth functioning of government and military units, threatening stability and security.

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

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



- A study of the macroeconomic impacts of AIDS in **Zambia** found that by 2000 the GDP would be 5 to 10 percent lower because of AIDS than it would be if there were no AIDS affecting the population. The authors concluded, "...without unprecedented infusions of free foreign aid to mitigate the effects of AIDS, the economy of Zambia will suffer considerable damage."²⁴
- An assessment of the macroeconomic impacts of AIDS in **Tanzania** by the Government of Tanzania, the World Bank and the World Health Organization in 1991 found that total GDP will be 15 to 25 percent smaller in 2010 because of the impact of AIDS.²⁵
- A study of the impact of AIDS on the economy of **Kenya** projected that GDP will be 14 percent lower in 2005 than it would have been without AIDS. GDP per capita will be 10 percent less in 2005.²⁶

What Can Be Done?

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

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

to individuals and community organizations involved in the AIDS programs that their efforts are appreciated and valued. Finally, it ensures that the program will receive an appropriate share of national and international donor resources to fund important programs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13410

**FY 2000 LIFE COUNTRY ACTIVITIES
FOR CHILDREN AFFECTED BY HIV/AIDS**

Ethiopia, India, Kenya, Rwanda, Tanzania, Zambia, Zimbabwe, FHA/WCA
(Reports received as of 5/18/00)

COUNTRY: Ethiopia
FY 2000

	FUNDING SOURCE (\$ 000)			Recoveries	Food Aid ¹
	NOA CSD HIV/AIDS: Non-LIFE	HIV/AIDS: LIFE	DCOF		
<i>AFR/DP FY 2000 Control Levels</i>	5000	1700	400		
CATEGORY					
I. Primary Prevention	4500	750			
II. Care and Support	150	350			
III. AIDS Affected Children/ Orphans	50	400	100 ²		
IV. Capacity Building	300	300			
TOTAL	5000	1700	100		

Narrative on Expanded and/or New Activities – FY 2000
MISSION: USAID/Ethiopia

Caring for Children Affected by AIDS

Illustrative activities:

USAID/Ethiopia activities did not emphasize on this area. However, through our discussions with major religious groups, care and support to children is now a viable option.

- Community-based support: advocacy, training and material inputs to promote care and support through extended family system and local CBOs.
- Education support: fees, cloths, and school supplies for school children.
- Sustainability: training, materials and funding for skill development and income generation.
- Food aid to affected and infected children.

Illustrative mechanisms:

- Pathfinder and sub-grantees working in support and care programs including religious organizations and community-based civic societies.
- PACT will provide capacity building support for Religious Organizations, PLWAs and Orphans Associations like “Dawn of Hope” and “Organization for Social Support for AIDS (OSSA).”

¹ FHA has food aid but money value could not be established now (will report later)

² Attributed out of 500 grant provided to PACT

COUNTRY: India
FY 2000

	FUNDING SOURCE (\$ 000)			Recoveries	Food Aid
	NOA CSD				
	HIV/AIDS: Non-LIFE	HIV/AIDS: LIFE	DCOF		
<i>AFR/DP FY 2000 Control Levels</i>	?	3000			
CATEGORY					
I. Primary Prevention		1650			
A. MTCT					
II. Care and Support	NA	250			
III. AIDS Affected Children/Orphans	600	600			
IV. Capacity Building	NA	500			
TOTAL		3000			

Narrative on Expanded and/or New Activities – FY 2000

MISSION: USAID/INDIA

Caring for Children Affected by AIDS

Illustrative activities:

The Mission will expand the CAA program of the Global Bureau. Currently the Mission is managing \$600,000 of core funds under this initiative. Activities include community care models for HIV positive children, drop in centers and shelters for street children, the inclusion of school based education and day care for children of mothers forced into commercial sex and night shelters for the protection of children of sex workers during their most vulnerable time.

Illustrative Mechanism: FHI to NGOs
LOP Funding: \$600,000 over three years

Subtotal CAA: **\$600,000**

COUNTRY: Kenya
FY 2000

	FUNDING SOURCE (\$ 000)			Recoveries	Food Aid
	NOA CSD		DCOF		
	HIV/AIDS: Non-LIFE	HIV/AIDS LIFE			
AFR/DP FY 2000 Control Levels	3200	2500	500	600	0
CATEGORY					
I. Primary Prevention	2523	1335		600	0
A. MTCT	0	0			
II. Care and Support	0	825			
III. AIDS Affected Children/Orphans	27	0	500		
IV. Capacity Building	650	340			
TOTAL	3200	2500	500	600	0

Narrative on Expanded and/or New Activities – FY 2000

MISSION: USAID/Kenya

Caring for children affected by AIDS

Illustrative Activities: This component will be integrated fully into the ongoing work with grantees to provide care and support in local communities. Strengthening families' ability to care for orphans will be supported through collaborative interventions with micro-finance institutions. This component will help HIV affected families plan for the future through accessing legal advice (with regard to inheritance), link up with potential financial assistance, and access support for affected children, e.g., school assistance, food aid as necessary. Support groups will play a critical role in assessing family situations and referring them to or providing them with the specific kind of help they need. Examples of activities include:

- Community-based services targeted at AIDS-affected children, including adolescents
- Education fees and other social support services
- Microenterprise programs for families and their children
- Legal protections for AIDS-affected children

Illustrative Mechanism: field support to FHI/IMPACT (DCOF-\$200,000)

Mission grant amendment to KREP (DCOF - \$300,000)

COUNTRY: Rwanda
FY 2000

FUNDING SOURCE (\$ 000)				Recoveries	Food Aid
AFR/DP FY 2000 Control Levels	NOA CSD HIV/AIDS: Non-LIFE	HIV/AIDS: LIFE	DCOF		
	1500	2000		1000	1500 ?
CATEGORY					
I. Primary Prevention					
A. MTCT					
II. Care and Support					
III. AIDS Affected Children/Orphans					
IV. Capacity Building					
TOTAL					

Narrative on Expanded and/or New Activities – FY 2000

MISSION: USAID/Rwanda

Caring for Children Affected by AIDS

Illustrative activities:

USAID/Rwanda has awarded grants to CARE International and World Relief to support the MOH and Ministry of Social Affairs in protecting vulnerable children from HIV/AIDS. These particular grants pre-date the LIFE Initiative, but may inspire follow-on activities. The programs will provide training in appropriate care and counseling to the care-givers of unaccompanied children and to some of the estimated 85,000 child-headed households in Rwanda. These activities will be coordinated with other IEC and counseling programs, and with the delivery of supplemental food rations from LIFE-PL480 allocations.

Through another grant to the International Rescue Committee, USAID is supporting policy and technical guidance to the Ministry of Social Affairs, the GOR oversight body for children and vulnerable groups, to develop and strengthen its ability to establish and enforce appropriate policies to protect the rights and well-being of children affected by HIV. CARE and the International Rescue Committee (IRC) are both supporting the GOR in developing effective policies and guidelines to protect children and other vulnerable groups from AIDS. (IRC has received a BHR grant to help support this)

Illustrative mechanisms:

Current grants to CARE International and World Relief. Possible future grants to other NGOs. (Currently supporting 2 bilateral grants in HIV/AIDS directed at children affected by AIDS – with CARE International and World Relief.)

COUNTRY: Tanzania
FY 2000

FUNDING SOURCE (\$ 000)					
	NOA CSD			Recoveries	Food Aid
	HIV/AIDS: Non-LIFE	HIV/AIDS: LIFE	DCOF		
<i>AFR/DP FY 2000 Control Levels</i>	3600	2500		800	
CATEGORY					
I. Primary Prevention	2,970	1,400			
A. MTCT					
II. Care and Support	420	100			
III. AIDS Affected Children/Orphans	210				
IV. Capacity Building		1,000		800	
TOTAL	3,600	2,500		800	
Total HIV/AIDS funding		6,900			

hpopub/docs/LIFE_reporting_tanzania

Narrative on Expanded and/or New Activities – FY 2000
MISSION: USAID/Tanzania

Caring for Children Affected by AIDS

Fund NGO activities at the community level with original budget. No additional activities planned with LIFE Funding.

COUNTRY: Zimbabwe
FY 2000

FY 2000					
FUNDING SOURCE (\$ 000)					
CATEGORY	NOA CSD			Recoveries	Food Aid
	HIV/AIDS: Non-LIFE	HIV/AIDS: LIFE	DCOF		
AFR/DP FY 2000 Control Levels	2000	3000		500	
I. Primary Prevention					
A. MTCT	1200	1800		300	
II. Care and Support	200	300		50	
III. AIDS Affected Children/Orphans	400	600		100	
IV. Capacity Building	200	300		50	
TOTAL	2000	3000		500	

Narrative on Expanded and/or New Activities – FY 2000
Mission: USAID/Zimbabwe

Caring for Children Affected by AIDS

Illustrative activities:

A. Sustained and replicated community programs to assist children affected by AIDS

USAID will support an umbrella program of small grants and technical assistance for community-based organizations (CBOs) in order to strengthen their capacity to deliver and sustain current community efforts to help children affected by AIDS. Small grants and technical advice on best practices will also be offered to CBOs not currently assisting communities and children affected by AIDS as incentives for them to begin work on behalf of children affected by AIDS. Networking and technical exchanges to share strategies, best practices and lessons learned will also be supported. Scholarships for school fees and other educational costs will help to address a major constrain faced by families and communities responding to the needs of children affected by AIDS.

This activity will begin cautiously, due to the many concerns that donor intervention in this sector could be disastrous. The implementor of this activity is expected to test intervention strategies in up to 8 pilot sites while conducting extensive operations research to determine the viability of the different strategies

B. Increased economic opportunities for youth with AIDS

The activities described above seek to build capacity of Zimbabwean communities and organizations that are assisting children affected by AIDS through the worst of the crisis. Many of the constraints faced by these children and their families are rooted in their poverty and the lack of economic opportunities under current conditions. As part of its Country Strategic Plan, USAID will be achieving a Special Objective: "Access to Economic Opportunity for Disadvantaged Groups Expanded". This Special Objective will be achieved through an activity to increase access to financial services and improve business capacity in underserved rural and peri-urban areas. A contractor will implement a microfinance and technical assistance program

that will also be tasked with improving economic opportunities for youth affected by AIDS. While the particulars of this assistance is still in the design stage, the purpose of this activity is to extend business training and microfinance assistance to youths affected by AIDS, thereby integrating them into programs and activities that offer opportunities.

Illustrative Mechanism:

This activity will be implemented through a contract procured through a competitive tender process in the first quarter of FY 2001

COUNTRY: FHA/WCA
FY 2000

FUNDING SOURCE (\$ 000)					
CATEGORY	NOA CSD			Recoveries	Food Aid
	HIV/AIDS: Non-LIFE	HIV/AIDS: LIFE	DCOF		
<i>AFR/DP FY 2000 Control Levels</i>	5700	1700			
I. Primary Prevention	4,522,552	500			
A. MTCT	0	0			
II. Care and Support	0	700			
III. AIDS Affected Children/Orphans	0	0			
IV. Capacity Building	450,000	500			
TOTAL	4,972,552	1,700,000			

Narrative on Expanded and/or New Activities – FY 2000

MISSION: Family Health & AIDS—West and Central Africa

Caring for Children Affected by AIDS

Illustrative activities: NO ACTIVITIES SCHEDULED



Alex Ross <aross@afri-sd.org>

07/31/2000 12:21:58 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:

Subject: RE: SANDY's MEETING -- Products needed

Duff and Hope;

Pursuant to Sandy's meeting last week, it appears to me that the following are the key documents that need to be produced (as a whole):

1. A 2-4 page document that summarizes how MTCT fits into the broader HIV/AIDS prevention to care continuum. Focus to include a broad description of MTCT and the key linkages to an array of HIV/AIDS programming. My issues list is a basis from which to build to include the key elements. Also, some mention of targets, anticipated coverage for MTCT, and costs is most likely required.

KEY USAID persons: Paul Delay, David Stanton, Alex Ross, Buck Buckingham, Linda Sussman, Ellen Piwoz, Beth Preble, Mary Lyn Field

2. A brief USG note that discusses key MTCT related issues and research needs to prepare for the Sept 25 UNAIDS meeting.

KEY USAID Persons: same as above.

3. A comprehensive USG HIV/AIDS battle plan that includes a set of scenarios and sensitivity analyses based on available resources, coverages to be achieved, and timing needs. This effort is underway given the battle plan that USAID is drafting for NSC. We need to revisit the current drafts.

KEY USAID Persons: Paul, Alex, Alan Getson, David Staton, Buck

4. Deriving from the battle plan, possible specific 2-3 page papers that deal with specific aspects of HIV/AIDS in Africa: MTCT, care/treatment/support, orphans, prevention, capacity building, USG priority countries. The intended use for such papers are to respond to OMB inquiries re: funding as well as the transition team's use in November.

In all of these cases, USAID has drafted some set of documents and I would propose that USAID lead the coordination/writing efforts. With CDC AND NIH now involved, this will get a bit more interesting re: coordination, politics, etc.

What do you think????

Thanks

O-USAID



U.S. Agency for International Development

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

Date:

10/27

To:

Sandy

Phone:

Fax:

From:

Alex

Phone:

Fax:

Number of Pages Including Cover Sheet

Message

Sandy, This is what UNICEF circulated at the meeting last week. FYI. (obviously they are at an early stage of development) - This is supposed to be their report to be released on 12/1

ADDRESSING THE ISSUES

Elements of a Strategy

The global response needs to be complemented with strategies and actions at the national and community levels so that those most affected, the children, their families and their communities, will experience the impact of the efforts being made. Broadly, there are five major strategies that may be used to address HIV/AIDS issues and orphans. These strategies can be most effective if governments, NGOs and donors work in unison with children, families and communities to cope more easily with their situations.

Strategic Action Should Cover:

Ensure access to basic services
 Assistance through specially targeted programmes
☐ Income generating
 Credit/loan schemes
 Produce food
 Child care services

1. Provision of psycho-social support **Strengthen the capacity of families and communities to cope with problems of orphans**

It is essential that families and communities be offered the possibility to build an enabling environment. In practical terms this means ensuring adequate support to families and communities. They must have improved access to basic services, including health care, safe water and sanitation, and education. And as we've seen through these country examples, families must also be assisted through specially targeted programmes, including initiatives that help them generate income, produce food, and assist caretakers with child care responsibilities. Orphans benefit when families and communities are supported and strengthened, and initiatives such as targeted programmes, cooperatives and loan schemes are part of a comprehensive response.

A vital aspect of strengthening coping mechanisms for families is providing emotional support and encouragement. Psycho-social support, through family, friends, community members or organizations can offer hope and courage to families to plan for the future. This is often an important component of home-based care programmes that may be undertaken by friends, the community or NGOs.

2. Stimulate and strengthen community-based responses

Strategic Action Should Cover:

Improve support to NGO, CBOs and other community level partners

☐ Technical assistance

Policy and planning guidance

☐ Training

Financial support

Involve communities

Identify and strengthen existing models of care and support

☐ Extended families

Substitute or foster care families

Child headed households

Orphanages

Make use of the formal social welfare system

Promote exchanges of information and experience

When families are unable to

adequately provide for themselves

it is often the community that is the next safety net, most especially in terms of caring for the children.

In addition, NGOs, churches, and community based organizations may be the ones to respond to the needs of families and communities affected by AIDS. The community must be involved in any programmes or interventions that address affected children, as they are the ones who will be able to help identify vulnerable children, their families and ways to support them in the long term. The motivation and commitment of organizations working at this level is high and although their projects are

often implemented on a small-scale, the collective impact of such efforts can be enormous. Improved support to these organizations is essential. Many of the less experienced organizations still need training, policy guidance and financial support. Local, district and national government authorities, such as those in Malawi and Botswana, can provide such support- either through training, guidance, technical assistance, or contracting out services- to strengthen a community's capacity to respond to the needs of its people. Such support can assist communities in assessing and analysing problems, formulating appropriate actions and solutions, and identifying which of those solutions can be supported from local resources and which will require other kinds of assistance.

Additionally, donors and international NGOs play an important role in supporting these grass roots initiatives through offering appropriate technical and financial support as well

as promoting widespread exchange of successful experiences and projects that have worked can stimulate and guide action in neighbouring countries. Policy makers and NGOs can borrow from these experiences and adapt elements of programmes to fit their own country's needs. International and governmental development agencies, as well as NGOs, can play an important role in facilitating such cooperation and exchange. It is important that the affected communities be directly involved in such exchanges, as they will be able to identify how best to adapt strategies to their own situations.

There are various models of care that may already be present within a community, some of which are within families, yet supported and sustained by the community, CBOs, NGOs or others. It is of utmost importance to identify these indigenous models, support them where necessary and offer alternative safety nets so that there are several possibilities to rely on in the long term. The various levels of care and support that exist include:

- *extended families*;
- *substitute or foster care families* when family members are not traceable or available, this may be either on an informal or formal basis;
- *family type groups* in which orphaned children live together in a family unit and are cared for by a carefully selected paid caregiver;
- *child-headed households* that consist of siblings remaining together with the eldest acting in a parental capacity; and,
- *orphanages* either at the community level, regional or national level

As Zimbabwe has demonstrated, orphan programmes can also be strengthened when community based programmes are integrated into a country's formal social welfare system. Such integration helps ensure that communities receive timely support and technical expertise. At the same time, the collaboration gives a voice to groups that would not otherwise be heard at a higher level.

6. Ensure that governments protect the most vulnerable children

Strategic Action Should Cover:

Obtain political commitment
 Promote and protect children's human and legal rights
 Review and reform laws dealing with children
 Monitor the impact of HIV/AIDS on children

First and foremost a forthright

commitment at the highest political level is an initial and vital step towards dealing effectively with AIDS and children affected by AIDS, and to ensure that the response is sustained over the long haul. Uganda set an example in the 1980s with strong leadership from the top. Countries such as South Africa and Botswana have more recently followed suit.

Visible and influential leadership is also essential to overcome the fear and stigma associated with HIV infection.

The multi-sectoral approach is often spoken about in terms of addressing HIV/AIDS issues. Such an approach is also appropriate when responding to the problems of children affected by HIV/AIDS. It has been shown that these children are more vulnerable than those who have become orphaned for other reasons. It is important to ensure that their human and legal rights are respected, living situations are secure, and that health and education services are available.

An important way to protect affected children is through the promotion and protection of their human rights. Children have the right to survive and develop to their full potential. (Article 6, Convention on the Rights of the Child.) They have the right to the highest attainable standards of health, to education and to the protection from abuse and neglect. National governments have a responsibility to create an environment where children can realize their rights. Under the Convention, States have a duty to act in the best interests of children when allocating the resources available in the society, no matter how small the amounts. The State must also demonstrate good faith by being able to show that actions have been or are being taken to give children the priority they deserve.

Governments also need to review and reform laws dealing with children and women, since orphans and widows risk losing their inheritance and property rights when AIDS strikes. In situations where laws protecting women and children do exist, women and children are often not aware of their rights or have the means to implement them. Strong advocacy from international and local organizations and communities in this area is essential.

Monitoring the impact of HIV/AIDS on children and families is critical towards developing an effective response to the orphan crisis. This includes having accurate information on the numbers of children orphaned, where they are, the circumstances of their lives and the nature of their needs. Information on and about orphans provides hard data for planning and determining the impact of interventions. This information can also be a very important tool to raise awareness about the social impact of AIDS, as well as in advocacy for the promoting the rights of these children in such sensitive and controversial areas as sexual health education in schools.

7. Build the capacities to support themselves

Strategic Action Should Cover:

Psycho-social support and family counselling

Enable children to get needed education and training through:

☐ Financial assistance to pay for education and training fees

Sponsorship programmes

Developing alternative education programmes

Empower children to protect themselves through life skills programmes

Addressing the emotional needs of all orphans is central in re-establishing a stable base for them to grow from. The death of a parent is always devastating. Parents with HIV or AIDS also need help to come to terms with approaching death and to plan ahead for the welfare of their children. Where possible, emotional support to AIDS-affected children and families – along with practical help for the household – should begin before the parent's death, through individual and family counselling.

This psycho-social support needs to be accompanied by ensuring that children orphaned by HIV/AIDS or for any other reason, continue their education and training that will enable them to provide for their own needs and become self reliant in the present and the future. Assistance may be needed in the form of financial support to pay for school or training fees and expenses, sponsorship for apprentice programmes, and to develop alternative education programmes for part time students.

An important component that needs to be part and parcel of any training or education for orphans is one on life skills. Zambia's Chikankata experience is one that may be used as a model to learn from. Skills that all children need for survival in the AIDS era, and most especially orphans due to their added vulnerabilities, one of which is being easy prey to being exploited both sexually and legally, include:

- ☐ How to make sound decisions about relationships and sexual intercourse, and stand up for those decisions
- ☐ How to identify their personal reasons for resisting pressures for unwanted sex or drugs
- ☐ How to recognize and avoid or leave a situation that might turn risky or violent
- ☐ How and where to ask for support and have access to youth-friendly health services
- ☐ When ready for sexual relationships, how to negotiate protected sex or other forms of safer sex
- ☐ Where to obtain information, advice and assistance about their human and legal rights in order to respond appropriately to discriminatory practices and violations of rights (including inheritance rights)
- ☐ How to care for people with AIDS in the family and community

8. The global response

Care and support for children orphaned by AIDS should be part of a global programme to alleviate the impact of HIV/AIDS on families and communities affected by HIV. Most of the current effort for orphans is provided through fostering by the extended family system or by unrelated families without any support. In the worst affected communities the breaking point has been reached. A global response should change structural conditions that will ultimately allow these communities to better access services, with special conditions included for orphans.

Strengthen global HIV prevention efforts and care and support to orphaned children by allocating more resources to the region

It is no coincidence that AIDS is disproportionately affecting the poor and disadvantaged in developing countries. Poverty, lack of appropriate development, urban-rural inequalities and a migrant labour force are key factors that can increase HIV vulnerability. With the AIDS epidemic increasingly depriving countries most affected by HIV of their skilled and trained personnel, they have to repay their foreign debts and the interest through a sizeable proportion of their gross domestic product each year. As a 1998 UNICEF-UNDP study has shown, six of the Heavily Indebted Poor Countries in sub-Saharan Africa spend more than one-third of the national budget on debt servicing, while spending only between 4 per cent and 11 per cent on basic social services, including health and education.

Global Strategic Action Should Cover:

Allocation of needed resources to the regions

Accelerate sustainable development

Financial support to local level development projects

Financial support of targeted interventions for orphans

Support of sectoral lending programmes

Improve quality and access to education including sexual and reproductive health information

Support and promote the Convention on the Rights of the Child to reduce stigma and discrimination

Financial support is clearly needed to accelerate sustainable development and promote a greater flow of financial resources to local-level development projects. As basic social services are able to improve people's lives, it is important for donors and international financial institutions to channel resources to projects specifically targeting orphans. Increases in Official Development Assistance and greater funding for sectoral lending programmes, with special emphasis on orphans are needed to meet these challenges.

Strengthen universal primary school quality education, with special efforts for the most vulnerable children

Increased and improved access to quality education and relevant information on sexual and reproductive health should be a priority effort for the international community. Orphans and especially vulnerable children should have priority access to basic education services.

Continue to promote children's rights in the context of the Convention on the Rights of the Child

The global community should continue to raise the visibility of the AIDS orphan epidemic. It must vigilantly pursue campaigns to diminish the shame and stigma connected with AIDS, and should support legislation and other measures that protect children's rights and the status of girls to break the vicious circle that place them at greater risk of contracting HIV themselves.

0 05 AID



Alex Ross <aross@afr-sd.org>

10/26/2000 02:35:41 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc: Barbara Turner <bturner@usaid.gov>, Ray Kirkland <rkirkland@usaid.gov>

Subject: Analysis of the USAID FY 2001 Approps bill: re HIV and CSD

Dear all:

In order to assist me better understand the implications of the current USAID funding bill and accompanying report language (particularly for HIV), I drafted the attached document. It lays out the levels and associated language from the report, as well as identifies key issues. There may be some inaccuracies. But, it moves the issue forward. I used both the bill HR 4811 and the relevant pages of the report.

Hope it helps,

Alex Ross

AFR/SD



- Legislative_analysis.doc

Message Sent To:

DRAFT
PRELIMINARY ANALYSIS OF FY 2001 USAID BUDGET: HIV/AIDS FOCUS

The following is based on the FY 2001 appropriations bill, accompanying report language, and other information. The table presents the levels in the bill, accompanying language, and related issues. **Key issues are at the end of the paper.**

Bold face indicates those amounts viewed as directly available for programming. *Italics* indicate those items that are set asides and are not additive. Underline are my additions for emphasis.

Highlights from the Bill HR 4881:

Overall CSD account: \$963 million

Child survival/maternal health: \$295 million

Vulnerable children: \$30 million

HIV/AIDS: \$300 million

Other infectious diseases: \$125 million

Basic education: \$103 million

UNICEF: \$110 million

Of these funds, up to:

\$50 million may be made available for Global Fund for Children's Vaccine

\$10 million may be made available for International AIDS Vaccine Initiative

\$20 million may be made available for US contribution to World Bank HIV/AIDS Trust Fund

Of the total CSD account, \$125,000 can be used to "monitor and provide oversight of child survival, maternal health, and infectious disease programs."

\$16 million can be used to support personnel

Restriction on NPA as part of CSD account still in place.

Managerial Flexibility for USAID:

Language in section 522 of the bill: "That funds appropriated by this Act that are made available for child survival activities or disease programs including activities relating to research on, and the prevention, treatment and control of, AIDS may be available notwithstanding any provision of law that restricts assistance to foreign countries."

From Report Language: "The managers are aware that the HIV/AIDS and TB crises require extraordinary efforts on the part of the U.S. Government. USAID is encouraged to use, as appropriate, its existing waiver authorities regarding financing and procurement of goods and services, and grant making, in order to expedite the provision of HIV/AIDS and TB assistance and enhance the efficiency of that assistance."

Overall DA Account: \$1,305,000,000

DA Pop: \$425 million

Of this, \$25 million for UNFPA

Of the DA account, \$1.5 million can be used to support staff.

REPORT LANGUAGE

AMOUNT	ACCOMPANYING LANGUAGE and Relevancy to HIV/AIDS Programming	ISSUES
HIV/AIDS RELATED		
\$300 million CSD for HIV	\$300 million for HIV/AIDS	
\$15 million Non-CSD for HIV	The report language states “The conference agreement includes \$315 million for HIV/AIDS, of which \$300 million is allocated <u>within this account</u> [CSD] and <u>not less than \$15 million</u> in other accounts and programs.”	The \$15 million is from non-CSD accounts. Could include FSA, SEED,, ESF,etc? Requires clarification
\$30 million CSD for vulnerable Children	“The managers note that a <u>large part</u> of the vulnerable children program assists AIDS orphans, who also benefit from the HIV/AIDS Program”	Attribute half to HIV/AIDS = \$15 million ?
<i>\$15 million for microbicides – CSD</i>	“The conference agreement does not include bill language concerning microbicides. However, the managers <u>endorse</u> the Senate report language on microbicides and direct that <u>not less than \$15 million</u> from the HIV/AIDS program and the “Development Assistance” account be made available to the Office of Health and Nutrition for microbicide research and development. These funds are to be managed by the Director of the HIV/AIDS Division. “	Approps bill is silent on this issue. What portion of the \$15 million comes from CSD HIV/AIDS and how much from DA/Pop? To date, Pop has contributed about \$2.3 million for microbicides, most if not all coming from NIH and CDC transfers to USAID. Issue of management responsibility between Paul Delay and Jeff Spieler.
<i>\$10 million for IAVI – CSD</i>	“In addition, the managers support the IAVI, which seeks to accelerate the development and distribution of an effective AIDS vaccine for developing countries. The managers <u>urge that not less than \$10 million be provided</u> as a contribution to the IAVI.	There is a contradiction between the bill that reads “up to \$10 million” and the report language reads “not less than”. The understanding is that there is some flexibility here. Discuss with the Hill on actual allocations (anywhere from \$3 million to \$7 million?)
<i>\$500,000 for UCSF proposal – CSD</i>	The managers “direct USAID to make available \$500,000 for a proposal from UCSF to develop detailed epidemiological HIV/AIDS profiles for priority countries and an online, searchable database of key comparative indicators.”	This was a surprise. The description appears to duplicate ongoing work conducted by BUCEN (with USAID support), as well as CDC. Requires discussion with Hill sponsor.

<i>No funding identification</i>	“The managers also encourage USAID to collaborate with the Peace Corps HIV/AIDS initiative, especially in supporting training activities.”	No dollar amount—left to USAID programmers discretion.
<i>\$20 million for WB HIV/AIDS Trust Fund – CSD</i>	“Within the HIV/AIDS program, authority is provided to transfer \$20 million to the fund authorized by section 141 of the Global AIDS and TB Relief Act. The managers expect the Secretary of the Treasury and the Administrator of USAID to report to the committees no later than April 30, 2001 on progress toward establishment of an international AIDS Trust Fund administered by the World Bank”	The bill says “up to \$20 million.” Report language maintains the flexibility. No language on an escape clause whereby funding reverts to USAID if the Fund is not operational. This issue is dependent on ongoing efforts to obtain other funding for the Fund via emergency supplemental authority.
<i>Earmarks for MTCT—None for FY 2001</i>	“The managers urge that expanded resources be made available to mother-to-child transmission (MTCT) programs. An effective implementation of MTCT programs will take time and testing facilities established, and community based care services for HIV positive mothers developed, USAID may not be able to meet the Global AIDS Act’s 8.3 percent funding target for FY 2001. The managers <u>expect that USAID will achieve the MTCT target by the end of FY 2002.</u> ”	The 8.3% MTCT earmark was set aside for FY 2001. Clarification is needed on the following: The authorizing Act requires 8.3% set aside for MTCT (of all HIV/AIDS funding) <u>each year</u> . Does this mean that USAID will need to meet the target for both FY 2001 <u>and</u> 2002 in FY 2002? Or, are the all of the targets pushed out a year, ie FY 2001 target to be met in FY 2002; FY 2002 target to be met in FY 2003? In the meantime, USAID must begin to strive to meet the target this year.
<i>Earmark of 65% of CSD HIV/AIDS funds to go to NGOs</i>	“The managers note that Global AIDS and TB Relief Act authorized that 65 percent of the HIV/AIDS funding be provided through non-governmental organizations. The managers concur that NGOs, including religious institutions and faith based organizations, provide invaluable services in the fight against HIV/AIDS. In anticipation of an increasing involvement of the public sector, particularly in the areas of treatment and the provision of interventions to reduce MTCT, the managers agree that <u>assistance provided through NGOs in cooperation with a foreign government or using government facilities may be counted against the 65 percent target</u> in USAID’s strategy to implement the Act.	No issue.

TUBERCULOSIS RELATED		
\$45 million from CSD/ID for TB + \$15 million from all other USAID accounts	“The conference agreement includes at least \$60 million from <u>all accounts</u> to address the global health threat from TB, including <u>not less than</u> \$45 million from the other infectious diseases program in the CSD Fund.”	Requires clarification. What other accounts? Issue: Is there interest in identifying some of this funding for joint HIV/AIDS and TB care? If so, how much?
<i>No funding level</i>	“The managers urge USAID to continue to work in close collaboration with organizations such as the US CDC, the WHO, the Gorgas Memorial Institute, and the Global STOP TB Initiative to implement effective TB control programs undertaken in cooperation with federal and state governments in Mexico, especially along Mexico’s borders with Texas, California, Arizona, New Mexico, and Guatemala.”	
OTHER INFECTIOUS DISEASES		
\$30 million CSD/ID for antimicrobial resistance and infectious disease surveillance		
\$50 million CSD/ID for malaria		
<i>\$2 million CSD/ID for malaria research centers</i>	“Drug resistant parasites and insecticide resistant mosquitoes exacerbate malaria transmission and place millions throughout the world at risk of a crippling and often fatal disease. For this reason, the managers encourage USAID to designate \$2 million to support the establishment of coordinated centers of excellence for malaria research to focus on tropical and subtropical regions., The managers support and <u>urge</u> USAID to favorably consider proposals for a concerted approach to limiting the resurgence of malaria that are submitted jointly by the University of Notre Dame’s Vector Biology Laboratory; Tulane University’s Dept of Tropical Medicine in new Orleans, and Latin American and African counterpart institutions.”	

<i>No funding level</i>	“The expected results of funds to develop and promote the use of vaccines in developing countries will also assist international travelers to endemic areas. The managers urge the Department of State and USAID to require staff, grantees, and contractors to take all feasible steps to reduce the importation of vaccine preventable infectious diseases, such as hepatitis, into the U.S.”	
OTHER SET ASIDE ITEMS IN CSD		
<i>Up to \$50 million for GAVI</i>	“Within the child survival and maternal health program, authority is provided to transfer up to \$50 million as proposed by the Senate to a fund established for child immunization by the Global Alliance for Vaccines and Immunization (GAVI). . . . The managers are supportive of the GAVI and <u>direct that</u> the Committees be informed in writing 20 days prior to the obligation of any funds for GAVI on the proposed use of any US contribution, particularly with regard to the amount to be donated for procurement of vaccines for children.”	From child survival and maternal health part of CSD.
<i>\$1.2 million for assistance for blind children</i>		Language seems to indicate this would come from the Vulnerable Children part of CSD.
<i>\$5 million for Kiwanis/UNICEF Iodine Deficiency program</i>	“\$2.5 million from CSD account and \$2.5 million from regional accounts for Europe and Eurasia.”	Which CSD account component?
<i>\$2 million for life and job skills</i>	“USAID is also encouraged to provide <u>up to</u> \$2 million to support NGOs, such as Special Olympics, that work with older children, including those with cognitive disabilities and mild mental retardation, to teach life and job skills.”	
<i>No funding level</i>	“The [CSD] Vulnerable Children program and USAID’s Office of Private Voluntary Cooperation are encouraged to provide small matching grants to American led volunteer programs in India and other nations that seek to remedy physical disabilities through reconstructive surgery.”	
<i>\$7 million for Carelift International</i>	“The managers support and urge USAID to favorably consider proposals by Carelift International. The managers anticipate that the ongoing, multiyear collaboration between USAID and Carelift International will be expanded	

	and require \$7 million including future year appropriations. The conference agreement does not include Senate language directing USAID to make available to Carelift International up to \$7 million from FY 2001 funds only.”	
<i>CSD Report</i>	USAID to issue report on CSD activities no later than Feb 15, 2001 on programs, projects and activities undertaken in FY 2000.	
<i>Administrative Expenses</i>	Exceptions to CSD intent for use of funds for programs, projects, and activities: “Authority for USAID’s central and regional bureaus to use up to \$125,000 from program funds for OE-funded personnel to better monitor and provide oversight of the [CSD] Fund; Use up to \$16 million to reimburse other government agencies and private institutions for professional services. “	

KEY ISSUE

1. **Amount available for direct HIV/AIDS programming.** This is still not clear. It will depend on several factors. Possible best and worst case scenarios are (only my guesses and assumptions):

Best:

\$300 million CSD + \$15 million non-CSD + \$15 million in CSD vulnerable children + \$7 million in joint TB/HIV care = \$337 million minus: \$0.5 million for UCSF + \$7.5 million for microbicides (half of total needed; from CSD/HIV) + \$5 million IAVI (negotiated with Hill) = \$324 million

Worst:

\$300 million CSD + \$15 million CSD = \$315 million minus \$0.5 million for UCSF + \$15 million for microbicides + \$10 million IAVI + \$20 million WB Trust Fund = \$269.5 million.

The real number will be somewhere in the middle. The factors will be:

- Attribution and use of vulnerable children funds for HIV/AIDS and children
- Negotiation with the Hill regarding how much to put into IAVI
- Negotiation with Hill sponsor of UCSF set aside
- Negotiation with Pop on microbicide issue
- Negotiation with the TB program on any linkages between HIV and TB re: care and prevention?
- Negotiation and new developments regarding the WB Trust Fund.

Draft: Alex Ross, AFR/SD 10/25/00

U.S. Agency for International Development
Washington, D.C. 20523

Advisory Committee On Voluntary Foreign Aid

September 18, 2000

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

Dear Sandra,

On behalf of Bill Reese, Chair, and the members of the Advisory Committee on Voluntary Foreign Aid (ACVFA), I would like to thank you again for participating in last Thursday's ACVFA meeting on the global HIV/AIDS pandemic. We appreciated your taking the time to be with us, especially given how tight your schedule was that day.

Your presentation was excellent and helped to broaden the participants' perspectives on the challenges of addressing this pandemic. It was clear from the many participants who approached you afterward that they thought your remarks were informative and helpful. I trust you found it useful too, and I hope you didn't mind having so many eager faces awaiting you after the session!

I will send you the meeting report as soon as it is available. Thanks again for helping to make the day a success. It was a pleasure meeting you and I look forward to seeing you again in the future.

Sincerely,



Noreen O'Meara
Director

0-USAID

**U.S. Agency for International Development**

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

Date: Oct 18, 2000To: Charly

Phone: _____

Fax: 202-456-2439From: Iqbal HussainPhone: 202-219-0477

Fax: _____

Number of Pages (Including Cover Sheet)

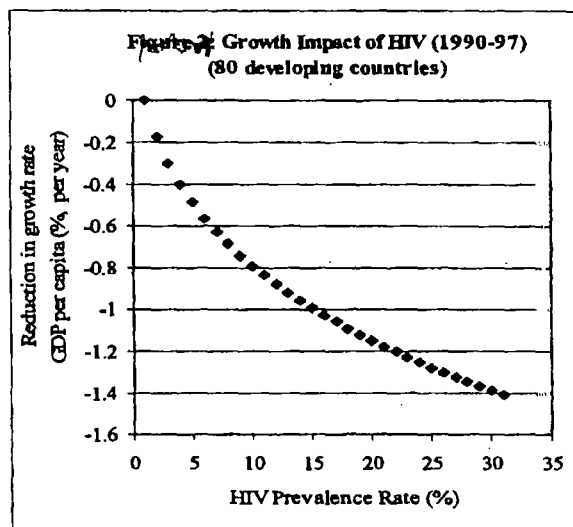
Message: Charly:

I am herewith sending summary of
David Bloem's paper and a part of a recent
report from the World Bank. Please
see p.p. 66 to 68 of that report for the
economic analysis. I am trying
to get the full paper of David Bloem

Iqbal

HIV/AIDS and Economic Stagnation

The empirical relation between HIV/AIDS and economic growth during the 1990s was investigated through a cross-country regression covering some 70-80 developing countries for which data is available. The approach that was followed consisted of estimating a system of three equations to take into account the relationships among economic growth, policy and institutional variables, and the determinants of the HIV epidemic (see Attachment for a description of the model).⁴



The main implication is that infectious disease matter substantially for economic development. Figure 2 shows the reduction in the growth rate of GDP per capita resulting from HIV/AIDS while holding constant the other factors that affect growth. Had the HIV prevalence rate not reached 3.6 percent in 1999, Africa's income per capita would have grown at 1.1 percent per year – or nearly three times the growth rate (0.4 percent per year) achieved in 1990-97.

For the countries with high prevalence rates, the economic cost of HIV/AIDS is even more staggering. In the case of a typical sub-Saharan country with a prevalence rate of 20 percent, the rate of growth of GDP would be some 2.6 percentage points less each year.⁵ At the end of a twenty year period GDP would be 67 percent less than otherwise. One reason for the large impact of HIV/AIDS is that it includes the effect of AIDS-related opportunistic infections and other communicable diseases.

HIV/AIDS and Poverty

The economic impact of HIV/AIDS will not be uniform across countries or even within countries. Countries that are well developed with a strong health infrastructure can usually mobilize the resources needed to provide care and treatment. Furthermore, because of their well-

⁴ Developed countries were excluded partly due to the lack of data concerning some of the policy variables that were used in the econometric estimation, and partly because the spread of HIV in these countries reflects different causes (non-heterosexual) than Africa.

⁵ This is the sum of the reduction in growth per capita (1.2 percent) and the shortfall in population growth (1.4 percent)

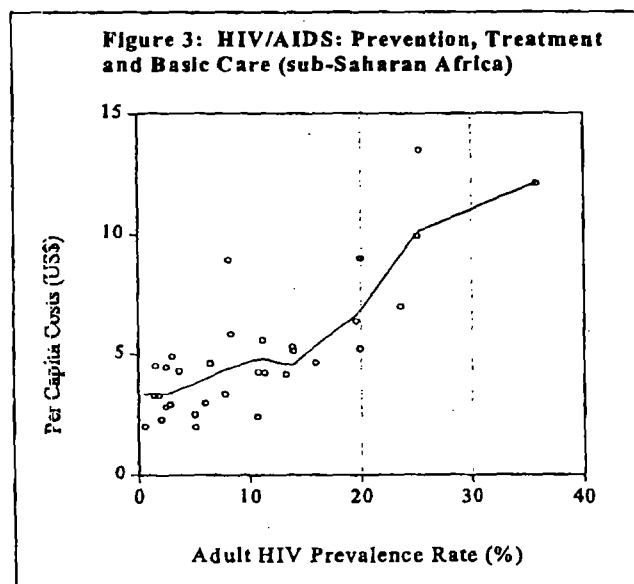
developed educational systems and stock of human capital, the AIDS-related loss of human capital does not entail the same consequences it has in countries where skilled labor is in short supply. By contrast, poor countries and poor households which do not have access to such resources are especially vulnerable to a rapid spread of HIV. The HIV epidemic creates a vicious cycle whereby HIV/AIDS reduces economic growth, slower growth increases poverty, and poverty facilitates the rapid spread of HIV/AIDS. This affects poor households through the following chain of events. When adults in a family become infected, they fall ill and stop earning. Children, especially girls, are then often taken out of school to look after the ill members of the families, which sharply constrains children's opportunities for higher income later in life. In such circumstances, the poor are forced to reduce their expenditure on food, which reduces further their resistance to the opportunistic infections made possible by HIV/AIDS. The consequence is an increase in the mortality rate and the reversal of most development gains of the last decade.

II. The Unaffordable Cost of Policy Inaction

Faced with a potentially rapid spread of HIV/AIDS, countries have the following two options:

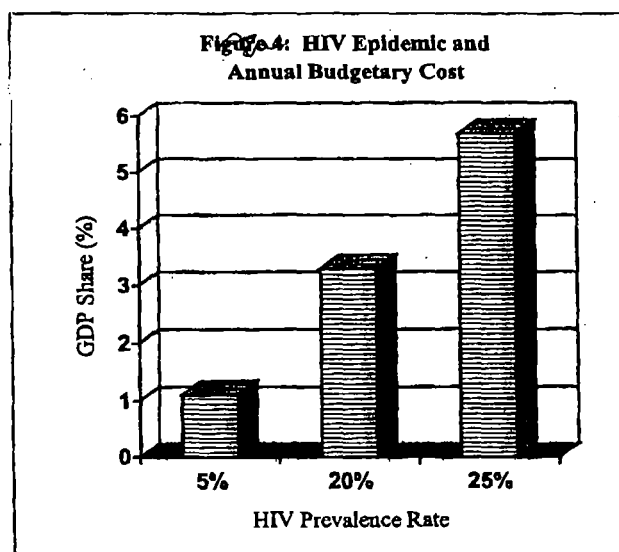
- i) delay HIV/AIDS interventions while the prevalence rate remains low and implement HIV/AIDS programs once the epidemic becomes highly visible;
- ii) implement comprehensive prevention and treatment programs early on while the HIV prevalence rate is low.

So far, most developing countries have unfortunately followed the first option. They have implemented HIV/AIDS programs, but with various lack of success in controlling the HIV epidemic due to the limited scale of these programs. This option is now no longer sustainable over the longer term due to the increasing fiscal and economic cost of delaying the implementation of a comprehensive program of interventions.



The cost of delaying action is illustrated by Figure 3. This graph shows the estimated per capita cost of implementing the package of interventions in prevention and care that would be supported under the MAP.⁶ When the HIV prevalence rate in the general population is below 5 percent, HIV/AIDS program costs about US\$3 per capita. But once the HIV prevalence rate exceeds 15%, the cost of HIV/AIDS program rises rapidly to about US\$10-12 per capita.

Few countries can afford the financial cost of inaction. In the case of a developing country with a per capita income of US\$300, the budgetary cost of implementing a national scale HIV/AIDS program amounts to 1.0 percent of GDP when the HIV prevalence rate is less than 5 percent. If the implementation is delayed so that the HIV prevalence rate reaches 20 percent of the population, the budgetary cost amounts to 3.3 percent of GDP. This cost excludes the provision of antiretroviral drugs. For illustrative purposes, Figure 4 also shows the typical cost of a HIV/AIDS program that would include the provision of antiretroviral therapy to 10 percent of the target group in a country with a prevalence rate of 25 percent. Even under the assumption that antiretroviral drugs would be provided at a reduced price, the cost would amount to 5.7 percent of GDP.⁷ However, countries that implement early on a comprehensive package of HIV prevention measures would be in a position to afford antiretroviral drugs. Due to the reduction in the number of HIV infections, the number of AIDS patients would be less, which would result in an affordable budgetary health cost.



⁶ This is based on a study of the costs of scaling up HIV/AIDS programs to a national level in some 30 sub-Saharan African countries for which data was available. The cost estimates do not include the cost of triple antiretroviral therapy with the exception of antiretroviral treatment to prevent parent-to-child transmission of HIV.

⁷ For simulation purpose the cost of the antiretroviral drugs is assumed to be US\$1,400 per patient per year, which is much lower than current commercial costs.



Health, Demographic Change, and Economic Development in Africa

**David Bloom
David Canning**

Harvard Institute for International Development

March 10, 1999

432-6659

Health, Demographic Change, and Economic Development in Africa

David Bloom and David Canning
Harvard Institute for International Development

Executive Summary

1. Health improvements are desirable in themselves, in terms of the improvements they bring in well-being, but they also have a direct impact on productivity and economic performance. Health improvements are not a luxury good that should await economic development; rather, they are a major factor in determining economic growth. Increased life expectancy and reduced fertility rates have a large positive effect on the growth rate of GDP per capita. Likewise, Health improvements have the potential to make a major contribution to a successful economic growth strategy in Africa.
2. The attached table sets out our estimates of the effect of health improvements on the growth rate of GDP per capita in each African country. We find large effects of increasing life expectancy from current levels to the world average of 65 years. This would increase the growth rate by more than 2 percentage points per year in some countries. Even in countries that are already above the world average level of life expectancy, further improvements would continue to have significant effects.
3. Lower fertility rates increase economic growth through increasing the ratio of working-age people to dependents. The attached figure plots the ratio of workers to dependents in Africa based on different United Nations population projections. In the table we report the estimated size of the effect on economic growth using United Nations projections assuming low, medium and high fertility. If fertility can be reduced to the level assumed in the United Nations low fertility projection the demographic gift can be quite large, adding over 1 percentage point per year to the growth rate in some countries.
4. These results imply the existence of a "demographic gift" to countries which achieve low fertility rates, but such a gift is not automatic. First, of course, it requires policies that encourage fertility to fall. In addition, economic policies must be formulated so as to allow the potential effects of demographic change to be realized. In the table we compare the effect of the "demographic gift" if a country sets policies that are as good as the world average values with the effect assuming the continuation of the policies that have been in place for the last 25 years. We find that poor policies can lead to the dissipation of most, or all, of the demographic gift.
5. The feedback from rising living standards to further improvements in health and reductions in fertility sets up the possibility of a virtuous cycle of cumulative causation.
6. We conclude that improvements in both general health and reproductive health are likely to be important parts of a successful growth strategy in Africa. Policies may include public health measures such as providing clean water and sanitation and inhibiting the transmission of malaria and HIV/AIDS as well as from improvements in the clinical health care system. The economic benefits from improved health are likely to be realized only if general economic policies are growth oriented.

Discussion

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

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

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

Why Health and Demography Matter for Economic Growth

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

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

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

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

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

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

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

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

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

Policy Effects

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

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

Conclusion

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

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

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



HIV/AIDS DIVISION FAX

U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

DATE: 1/11/98

TO: TOOD Summers ORGANIZATION: ONAP

FAX PHONE: 202-456-2438 OFFICE PHONE: 456-2437

FROM: ALAN OFFICE PHONE: 712-5712

FAX PHONE: 202-216-3046 NUMBER OF PAGES (INCLUDING COVER) 5

COMMENTS:

FOLKS,

HERE'S THE INITIAL ITINERARY. WE
CAN DISCUSS IT TOMORROW

Regards,

Alan

JAN-11-1999 15:36 USAID/POPULATION/POLICY

P.02/05

EASYLINK 0966419L001 11JAN99 14:36/15:01 EST

FROM: 49590234 49590234 4957 UD

AMEX-DEPARTMENT OF STATE

TO: 2022163046

TO:

ALAN GETSON

FROM:

ANNETTE

AMERICAN EXPRESS TRAVEL

NUMBER OF PAGES INCLUDING THIS COVER SHEET:4

TO: AGENCY FOR INTERNATIONAL DEVELOPMENT
1300 PENNSYLVANIA AVE
WASHINGTON, DC 20004

FOR: THURMAN/SANDRA REF: 4GR
ISCOWITZ/MICHAEL 4GR
STERNBERG/STEVEN 4GR
BLASS/EILEEN 4GR
HARRIS/WILLIAM 4GR

23 JAN 99 - SATURDAY

AIR AMERICAN AIRLINES FLT:4941 COACH
OPERATED BY AMERICAN EAGLE
LV WASHINGTON REAGAN 255P EQP: ATR 42 TURBOPROP
DEPART: TERMINAL B/C 01HR 20MIN
AR NEW YORK JFK 415P NON-STOP
ARRIVE: TERMINAL 9 REF: WQQYIA
AIR AMERICAN AIRLINES FLT:6002 ECONOMY MULTI MEALS
NEW YORK JFK-JOHANNESBURG OPERATED BY SOUTH AFRICAN AIRWAYS
LV NEW YORK JFK 620P EQP: BOEING 747 400
DEPART: TERMINAL 8 14HR 35MIN

BUSINESS -WAIT LISTED

24 JAN 99 - SUNDAY

AR JOHANNESBURG 355P
NON-STOP
REF: WQQYIA

28 JAN 99 - THURSDAY

AIR SOUTH AFRICAN FLT:54 BUSINESS SNACK/BRUNCH
LV JOHANNESBURG 1105A EQP: AIRBUS A320
02HR 00MIN
AR LUSAKA 105P NON-STOP

31 JAN 99 - SUNDAY

AIR SOUTH AFRICAN FLT:55 BUSINESS MEALS
LV LUSAKA 215P EQP: AIRBUS A300
02HR 00MIN
AR JOHANNESBURG 415P NON-STOP
AIR ZIMBABWE EXPRESS FLT:112 PREMIER CLASS DINNER
LV JOHANNESBURG 600P EQP: BOEING 727
01HR 30MIN
AR HARARE 730P NON-STOP
ARRIVE: INTERNATIONAL TERMINAL REF: J1NT4M

03 FEB 99 - WEDNESDAY

AIR KENYA AIRWAYS FLT:441 STANDARD
LV HARARE 100P EQP: BOEING 737
DEPART: INTERNATIONAL TERMINAL 02HR 50MIN
AR NAIROBI KENYATTA 450P NON-STOP
REF: PHGJGU

CONTINUED ON PAGE 2

TO: AGENCY FOR INTERNATIONAL DEVELOPMENT
1300 PENNSYLVANIA AVE
WASHINGTON,DC 20004

FOR: THURMAN/SANDRA REF: 4GR
ISCOWITZ/MICHAEL 4GR
STERNBERG/STEVEN 4GR
BLASS/EILEEN 4GR
~~HARRIS/~~WILLIAM 4GR

03 FEB 99 - WEDNESDAY

AIR KENYA AIRWAYS FLT:414 STANDARD
LV NAIROBI KENYATTA 600P EQP: BOEING 737
01HR 05MIN
AR ENTEBBE 705P NON-STOP
REF: PHGJGV

06 FEB 99 - SATURDAY

AIR ALLIANCE FLT:7 COACH
ENTEBBE-JOHANNESBURG OPERATED BY ALLIANCE EXPRESS
LV ENTEBBE 420P EQP: BOEING 737-200
04HR 20MIN
AR JOHANNESBURG 740P NON-STOP
AIR AMERICAN AIRLINES FLT:6001 BUSINESS DINNER
JOHANNESBURG-SAL OPERATED BY SOUTH AFRICAN AIRWAYS
LV JOHANNESBURG 900P EQP: BOEING 747 400
17HR 30MIN

07 FEB 99 - SUNDAY

AR NEW YORK JFK 730A 1-STOP
ARRIVE: TERMINAL 9 REF: WQYIA
VIA SAL
AIR AMERICAN AIRLINES FLT:4944 COACH
OPERATED BY AMERICAN EAGLE
LV NEW YORK JFK 1015A EQP: ATR 42 TURBOPROP
DEPART: TERMINAL 9 01HR 30MIN
AR WASHINGTON REAGAN 1145A NON-STOP
ARRIVE: TERMINAL B/C REF: WQYIA

06 AUG 99 - FRIDAY

OTHER WASHINGTON
AMERICAN EXPRESS WISHES YOU A SUCCESSFUL TRIP

CONTINUED ON PAGE 3

JAN 11 1999 15:37
SALES PERSON: AS
CUSTOMER NBR: 4539000901

USATD/POPULATION/POLICY
ITINERARY
WQOYIA

DATE: 11 JAN 99
PAGE: 03

P.03/03

TO: AGENCY FOR INTERNATIONAL DEVELOPMENT
1300 PENNSYLVANIA AVE
WASHINGTON,DC 20004

FOR: THURMAN/SANDRA	REF: 4GR
ISCOWITZ/MICHAEL	4GR
STERNBERG/STEVEN	4GR
BLASS/EILEEN	4GR
~~HARRIS~~ /WILLIAM	4GR

.....REMINDER.....
ALL FREQUENT FLYER BENEFITS EARNED ON OFFICIAL
TRAVEL ARE PROPERTY OF THE US GOVERNMENT AND
CAN NOT BE REDEEMED FOR PERSONAL USE.

.....
ALL UNUSED TICKETS ARE TO BE RETURNED TO AMERICAN
EXPRESS IMMEDIATELY UPON RETURN FROM TRAVEL OR
WHEN TRIP HAS BEEN CANCELLED.

.....
FOR AFTER HOUR EMERGENCIES
PLEASE CALL 1-800-847-0242 HOTLINE CODE S-5ZS5

.....
OUTSIDE THE USA - CALL COLLECT 1 313 271 7887
THE USER IDENTIFICATION CODE IS S-5ZS5

.....
THANK YOU FOR CHOOSING AMERICAN EXPRESS.



HIV/AIDS DIVISION FAX

URGENT

U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

DATE: 1/22/99TO: TODD SUMMERS ORGANIZATION: ONAPFAX PHONE: 456-2438 OFFICE PHONE: 456-2444FROM: ALAN OFFICE PHONE: 712-5712FAX PHONE: 202-216-3046 NUMBER OF PAGES (INCLUDING COVER) 5

COMMENTS:

THE UGAND ITINERARY & AIDS INFO
FOR THE BRIEFING. BOOK

Responding to the AIDS Epidemic in Uganda: The Collaboration between Uganda and USAID

Though AIDS was only recognized as a new disease in the U.S. in 1981, Ugandan physicians by 1982 began observing unexplained deaths in young adults, and this wasting condition was soon called "slim". Soon after taking over leadership of the country in 1986, President Yoweri Museveni confronted the growing epidemic with candor and activism, and by the end of 1986, the Ministry of Health had established an AIDS Control Programme which began collecting data and conducting public information campaigns. In 1988, the United States Agency for International Development began providing funds and technical assistance to the government of Uganda and the fledgling non-governmental organizations struggling to respond to the dual needs of preventing further infections and caring for those already infected by the virus. Also in 1988, the National Institutes of Health began providing research grants to American scientists investigating various aspects of the epidemic, including mother to child HIV transmission, the link between HIV and tuberculosis, and the epidemiology of AIDS in rural communities.

As of June, 1998, UNAIDS estimated that out of a population of over 20 million, there are 870,000 adults living with HIV infection, or 9.5% of the adult population, and an additional 67,000 children under the age of 15 who may be infected with HIV. UNAIDS also estimates that 1.8 million Ugandans have already died of AIDS.

In addition to dealing with the AIDS epidemic, by the mid to late 1980's, there was increasing recognition that the combination of civil war and the AIDS epidemic was resulting in increasing numbers of children who had lost one or both parents. The situation of AIDS orphans was particularly acute, as these children were more likely to lose both parents because of HIV transmission between couples. The current and projected numbers of orphans remain difficult to estimate, however, and estimates on the part of the government and international agencies have ranged widely, partly because of different definitions of "orphan" including children who have lost only one parent.

Based on the 1991 Uganda census, and the observations of local workers, there may be as many as 1.2 million children who have lost one parent, of whom 250,000 to 300,000 may be "double orphans" who have lost both parents. It is estimated that about half of orphans have lost parents due to AIDS; government policies however discourage identifying children as "AIDS orphans."

From 1989 to 1998, USAID provided funds to Save the Children UK (SCF) to work with the Department of Child Care and Protection (CCP) of the Ministry of Gender, Labour, and Social Development to develop national responses to the problems of orphans and children separated from their parents due to war. In 1991, USAID funded an assessment of the orphan situation in Uganda, and also funded a conference in 1992 to bring together all players in the child welfare arena. This process resulted in the GOU articulating

policies and legislation regarding orphans, and in particular, policies supporting efforts to keep orphans in the community rather than in institutions or children's homes. As a result, the number of registered children's homes or orphanages in Uganda has declined from 75 to 46, and most of the remaining homes are providing an acceptable standard of care, with support from external donors.

Government policies and the Children's Statute of 1996 continue to emphasize the importance of keeping orphaned and vulnerable children in their home communities, with relatives, and there are now an increasing number of programs to assist "orphan households", families who have taken in orphans and/or families headed by widows. These programs often provide small loans or grants to help the household begin an "income generating project" to supplement family income; some programs also provide funding for school fees for orphans.

The Uganda Women's Effort to Support Orphans, UWESO, was founded by First Lady Janet Museveni in 1986, and has provided national leadership in responding to the plight of orphaned children. Currently, UWESO emphasizes "micro-enterprise" projects to provide loans, grants, and technical assistance to help households with orphans. USAID has also provided funds for a number of projects assisting orphans; most of these funds since 1995 have been for micro-enterprise projects assisted by FINCA, The International Foundation for Community Assistance. **Overall, since 1989, the total amount of USAID funding for projects relating to orphans has totaled \$4,185,000.**

This ten-year collaboration between Uganda and the United States in the fields of HIV prevention, AIDS care, and orphan support has produced remarkable results. In terms of care and support for people living with AIDS, The AIDS Support Organization, TASO, now recognized as the premier AIDS support agency in sub-Saharan Africa, was first given USAID funds and technical assistance in 1988, and TASO continues to receive USAID support. By the end of 1998, TASO had cared for almost 50,000 clients and their families, and had trained hundreds of AIDS counselors in Uganda and elsewhere in Africa. TASO has also provided national leadership in reducing the stigma and discrimination typically associated with AIDS.

In the field of HIV prevention, by 1989 it became apparent that many Ugandans were knowledgeable about AIDS, and were eager to learn whether they had already been infected. In the absence of HIV counseling and testing sites, people were donating blood in order to learn their HIV test results, creating a serious problem for the national blood transfusion service, which was not equipped to provide intensive counseling. USAID responded quickly, and in February 1990, the AIDS Information Centre (AIC) opened its doors, the first program in Africa offering voluntary and anonymous HIV counseling and testing. By the end of 1998, almost 400,000 clients had been served, an astonishing accomplishment not yet matched elsewhere in sub-Saharan Africa. The important role of HIV counseling and testing in helping people adopt and maintain risk reduction behaviors has now been documented not only in the US but also in Uganda, Kenya, Tanzania, Rwanda, and Zambia.

USAID provided leadership, funding, and technical assistance for other AIDS prevention efforts in Uganda as well, including the first "AIDS in the Workplace" project in Africa and one of the first "AIDS in the Military" projects. By 1992, USAID was also funding community AIDS education activities implemented at the local level by churches and mosques, and by 1995, these projects had recorded contacts with over one million individuals, most of them living in rural areas. Condom education and distribution have also been funded by USAID since 1987, and in 1998, about 8 million USAID subsidized condoms were sold. **Overall, between 1988 and 1998, approximately \$40 million in USAID funds have been provided for AIDS prevention and care in Uganda.**

The cumulative impact of these intense and widespread HIV prevention efforts became apparent in 1994 and 1995, when behavioral surveys began documenting that Ugandans were reporting fewer casual sexual partners, increased condom use, and young people were reporting a delay in becoming sexually active. Social norms were also changing, with peer reinforcement of abstinence, faithfulness, and condom use. Religious leaders and parents began demanding that young couples get tested before marriage, and now one-third of the clients at the AIDS Information Centre come as couples for pre-marital counseling and testing.

Most encouraging has been the documented decline in HIV infection rates in young pregnant women. Based on routine testing of pregnant women attending antenatal clinics in a number of locations in Uganda, beginning in 1989 and continuing to the present, there is increasing evidence that HIV prevalence in Uganda is declining, especially among young women. The declines are particularly pronounced among pregnant women aged 15 to 19, but are also observed in women 20 to 24. For example, in one site in Kampala, 15 to 19 year old women had an HIV prevalence rate of 26% in 1992 but this has declined to 8% in 1997. Demographers believe this decline could not have occurred without a decline of about 50% in the rate of new infections in these young women.

What are the factors contributing to Uganda's remarkable success in responding to the AIDS epidemic? Perhaps most important has been the leadership provided by President Museveni, creating a national environment which encouraged the development of innovative and pioneering programs such as The AIDS Support Organization and the AIDS Information Centre. The courage shown by many people living with AIDS, who publicly talk about how they became infected, the importance of getting tested, and how they "live positively" with AIDS, has made a dramatic and emotionally compelling contribution to the success of HIV prevention programs. Condom education, promotion, and distribution to many areas of the country has also played an important role in enabling Ugandans to take specific HIV prevention measures. The commitment and professional competence of Ugandan public health workers, AIDS educators and activists, and health care workers has helped these programs achieve successful results. Finally, the early, intense, and sustained level of USAID funding and technical assistance given to these Ugandan partners has enabled them to achieve a first in Africa: a decline in new HIV infections in young people.

The Ugandan response to orphans has also resulted in successful models. The Children's

Statute of 1996 has codified all legislation relating to children, and has emphasized the responsibility of families and the community for the care and protection of children. This Statute is widely regarded as very progressive and a model for Africa. In spite of the large numbers of orphans, many resulting from AIDS, less than 1% are institutionalized, and communities and families have for the most part been able to support these children; the extra income provided by the various micro-enterprise projects has been of great assistance to many families.

Overall, though Uganda has high rates of HIV infection, large numbers of orphans, and inadequate government funds to deal with these problems, the last decade has seen the implementation of successful projects to respond to the AIDS epidemic and the associated increase in orphans. USAID has played a key role in providing funds and technical assistance to these efforts, and this collaboration between the US government and Uganda has resulted in successful and replicable models to control the spread of AIDS, and to mitigate the social and health impacts of the epidemic.

Prepared by: Elizabeth Marum, Ph.D.
Technical Advisor in HIV/AIDS

Annie Kaboggoza-Musoke
Project Management Specialist
USAID Uganda

Date: January 1999

South Africa Itinerary

January 24, 1999

Sunday

January 1999

February 1999

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28						

SOUTH AFRICA		Notes
Pretoria (The Villa Via)		
7 am		
8 00		
9 00		
10 00		
11 00	Briefing on SA HIV/AIDS & USAID (Villa Via)	
12 pm		
1 00		
2 00	Visit to Kalafong Hospital, Children's Home (USAID transportation)	
3 00		
4 00		
5 00		
6 00		
	7:00pm - 10:00pm Dinner	

South Africa Itinerary

January 25, 1999

Monday

January 1999

February 1999

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28						

SOUTH AFRICA		Notes
Durban (The Royal)		
7 am		
8 00	8:10am-8:20am Depart Hotel - Walk to Embassy	
	Meeting with Ambassador Joseph - Briefing on Visit and CODEL (American Embassy)	
9 00	Country Team Meeting - Briefing on CODEL & Visit (American Embassy)	
10 00		
11 00	Meeting w/ Minister Zuma/DG (DOH, USAID Transportation)	
12 pm		
1 00	1:00pm-2:45pm Site Visit to Soweto to visit community based HIV/AIDS NGO program Hope World Wide (Jabavu Clinic, White City. USAID Transportation, lunch provided.)	
2 00		
3 00	3:00pm-5:45pm Site Visit - Baragwanath Hospital & Wola Nani a Soweto family, Community Support Center (USAID Transportation)	
4 00		
5 00		
6 00		
	7:00pm - 7:30pm Depart for Durban SA 525(JHB, USAID Transportation)	
	8:10pm - Arrive Durban(USAID Transportation, Kurt Pope)	
	8:30pm - 9:00pm Travel to Royal Hotel(USAID Transportation)	
	9:00pm - 11:00pm Dinner on your own	

South Africa Itinerary

January 26, 1999

Tuesday

January 1999

February 1999

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28						

SOUTH AFRICA		Notes
Durban (The Royal)		
7 am		
8 00	Depart Hotel	
9 00		
10 00	Site Visit to Hospital (Grey Hospital, Townbush Road, Athlone. USAID Transportation)	
11 00		
12 pm	Site Visit to meet Role Players in CINDI (Project Gateway, Old Pwiburg Prison. USAID Transportation)	
1 00	1:15pm-2:00pm Visit w/Mayor of Pietermaritzburg (Parlor City Hall, Commerical Road. USAID Transportation)	
2 00	2:15pm-2:45pm Site Visit to drop in center for those affected/infected w/HIV/AIDS (Khayaletn Drop-In-Center, Methodist Church. USAID Transportation)	
3 00	3:00pm-3:45pm Site Visit to Social Welfare Project (Pietermaritzburg Child & Family Welfare Society. USAID Transportation)	
4 00	Return to Hotel (USAID Transportation)	
5 00		
6 00		
	7:00pm - 10:00pm Dinner w/ Key Partners	

South Africa Itinerary

January 27, 1999

Wednesday

January 1999

February 1999

S	M	T	W	T	F	S	S	M	T	W	T	F	S
					1	2		1	2	3	4	5	6
3	4	5	6	7	8	9	7	8	9	10	11	12	13
10	11	12	13	14	15	16	14	15	16	17	18	19	20
17	18	19	20	21	22	23	21	22	23	24	25	26	27
24	25	26	27	28	29	30	28						
31													

	ZAMBIA Lusaka (Pamodzi Hotel)	Notes
7 ^{am}		
8 ⁰⁰		
9 ⁰⁰		
10 ⁰⁰		
11 ⁰⁰	11:05am South African Flt# 64 (Depart Johannesburg.)	
12 ^{pm}		
1 ⁰⁰	1:05pm-1:35pm Arrive Lusaka	
2 ⁰⁰		
3 ⁰⁰		
4 ⁰⁰		
5 ⁰⁰		
6 ⁰⁰		
	5:30am - 6:00am Leave hotel for airport(USAID Transportation)	

South Africa Itinerary

January 28, 1999

Thursday

January 1999

February 1999

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28						

ZAMBIA		Notes
Kitwe (Sherbourne Guest House)		
7 am	Roan Air Flt#3200 (Departing Lusaka)	
	7:45am Arrive Kitwe	
8 00		
9 00		
10 00		
11 00		
12 pm		
1 00		
2 00		
3 00		
4 00		
5 00		
6 00		

South Africa Itinerary

January 28, 1999

Thursday

January, 1999

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

February, 1999

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28						

	ZAMBIA	Notes
	Kitwe (Sherbourne Guest House)	
7 am	Roan Air Flt#3200 (Departing Lusaka)	
	7:45am Arrive Kitwe	
8 00		
9 00		
10 00		
11 00		
12 pm		
1 00		
2 00		
3 00		
4 00		
5 00		
6 00		

South Africa Itinerary

January 29, 1999

Friday

January 1999

February 1999

S	M	T	W	T	F	S	S	M	T	W	T	F	S
					1	2		1	2	3	4	5	6
3	4	5	6	7	8	9		7	8	9	10	11	12
10	11	12	13	14	15	16		14	15	16	17	18	19
17	18	19	20	21	22	23		21	22	23	24	25	26
24	25	26	27	28	29	30		28					
31													

Victoria Falls (VicFalls Hotel)		Notes
7 am		
8 ⁰⁰	8:05am Roan Air Flt# 3201 (Departing Kitwe)	
	8:50am Arrive Lusaka	
9 ⁰⁰		
10 ⁰⁰		
11 ⁰⁰		
12 pm	Roan Air Flt#210 (Departing Lusaka)	
1 ⁰⁰	Arrive Livingstone	
2 ⁰⁰		
3 ⁰⁰		
4 ⁰⁰		
5 ⁰⁰		
6 ⁰⁰		

South Africa Itinerary

January 31, 1999

Sunday

January 1999

February 1999

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28						

		Notes
7 ^{am}		
8 ⁰⁰		
9 ⁰⁰		
10 ⁰⁰		
11 ⁰⁰		
12 ^{pm}		
1 ⁰⁰		
2 ⁰⁰		
3 ⁰⁰		
4 ⁰⁰		
5 ⁰⁰	5:15pm Air Zimbabwe Flt# 321 (Departing Victoria Falls)	
6 ⁰⁰	6:15pm Arrive Harare (Domestic Terminal)	

February 1, 1999

February 1999

Märch. 1999

S	M	T	W	T	F	S
1	2	3	4	5	6	
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28						

S	M	T	W	T	F	S
1	2	3	4	5	6	
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Notes	
7 ^{am}	
8 ⁰⁰	
9 ⁰⁰	
10 ⁰⁰	
11 ⁰⁰	
12 ^{pm}	
1 ⁰⁰	
2 ⁰⁰	
3 ⁰⁰	
4 ⁰⁰	
5 ⁰⁰	
6 ⁰⁰	
7:00pm - 7:30pm	

South Africa Itinerary

February 2, 1999

Tuesday

February 1999

March 1999

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28						

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

		Notes
7 ^{am}		
8 ⁰⁰		
9 ⁰⁰		
10 ⁰⁰		
11 ⁰⁰		
12 ^{pm}		
1 ⁰⁰		
2 ⁰⁰		
3 ⁰⁰		
4 ⁰⁰		
5 ⁰⁰		
6 ⁰⁰		
7:00pm - 7:30pm		

South Africa Itinerary

February 3, 1999

Wednesday

February 1999

March 1999

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28						

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Kampala (Sheraton Hotel)		Notes
UGANDA		
7 ^{am}		
8 ⁰⁰		
9 ⁰⁰		
10 ⁰⁰		
11 ⁰⁰		
12 ^{pm}		
1 ⁰⁰	Kenya Airways Flt# 441 (Departing Harare, International Terminal)	
2 ⁰⁰		
3 ⁰⁰		
4 ⁰⁰		
	4:50pm Arrive Nairobi Kenyatta	
5 ⁰⁰		
6 ⁰⁰	Kenta Airways Flt# 414 (Departing Nairobi Kenyatta)	
	7:05pm - Arrive Entebbe	

South Africa Itinerary

February 4, 1999

Thursday

February 1999

March 1999

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28						

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

	Kampala (Sheraton Hotel) UGANDA	Notes
7 am		
8 ⁰⁰		
9 ⁰⁰		
10 ⁰⁰		
11 ⁰⁰		
12 pm		
1 ⁰⁰		
2 ⁰⁰		
3 ⁰⁰		
4 ⁰⁰		
5 ⁰⁰		
6 ⁰⁰		

SANDY THURMAN VISIT
23 January - 28 January 1999
DRAFT 2: 19 January 1999
6:00PM

SO3 Contact List:

Ken Yamashita – w:(012) 323-8869 x263
h: (012) 46 8310

Nellie Gqwaru w:(012) 323-8869x
h: (012)
c:

Lulama Makena w: (012)323-8869x260
H:

Caroline Connolly w:(012) 323-8869 x257
H: (012) 468305

DATE	TIME	ACTIVITY	VENUE	CONTACT PERSON	COMMENTS
Saturday 23 January	3:55PM	Arrive in Joberg SA 6002 Pick up by USAID drive and transport to Villa Via	Accommodation: Villa Via	Robert t: 012 349 130 f: 012 349 131	Ken Yamashita will greet Ms. Thurman and party at airport
	7:00PM 3	Dinner	TBD		
Sunday 24 January	11:00AM 1	Briefing on South African HIV/AIDS situation and USAID	Villa Via	SO3 Contacts	
	2:00PM 2	Visit to Kalafong Hospital – Children's Home	Kalafong Hospital	SO3 Contacts	Transportation to be arranged by USAID
	7:00PM 3	Dinner	TBD		
Monday 25 January	8:10AM	Depart Hotel -- Walk to Embassy	Villa Via	SO3 Contacts	
	8:30AM 1/2	Meeting with Ambassador James Joseph -- Briefing on Visit and CODEL (TBC)	American Embassy	SO3 Contacts	
	9:00AM 1	Country Team Meeting -- Brief on CODEL and Visit (TBC)	American Embassy	SO3 Contacts	

	11:00AM 1	Meeting with Minister Zuma/DG (T BC)	DOH	SO3 Contacts	USAID will provide transportation
	1:00PM-2:45PM	Site Visit to Soweto to visit community based HIV/AIDS NGO program - Hope World Wide. Lunch to be provided by Hope World Wide	Hope World Wide Jabavu Clinic White City Soweto	Dr. Mark Ottenweler	USAID will provide transport
	3:00PM-5:45PM	Site Visit -- Baragwanath Hospital and Wola Nani a Soweto family and Community Support Center	Wolani Chris Bragwanath Hospital t: 011 938 8370		USAID will provide transport
	7:00PM	Depart for Durban SA 525	JHB	Penny Travkor	USAID will provide transport
	8:10PM	Arrival in Durban	Airport	Penny Travkor	USAID is hiring transport (Kurt Pope)
	8:30PM 1/2	Travel to Royal Hotel	Royal Hotel	Kisten 031 304 0331	USAID will provide transport
	9:00PM 2	Dinner on own			
Tuesday 27 January	8:00AM	Depart Hotel			USAID will provide transport
	9:30AM-11:30AM	Site visit to Hospital	Grey hospital Townbush Road Athlone	Dr. Neil Mackerro Chief Paediatrician 0331 458 181	USAID will provide transport
	12:00PM - 1:00PM	Site Visit to meet Role Players in CINDI	Project Gateway Old Pwiburg Prison Corner of Burger and Pine Street	Linda Tyers	USAID will provide transport
	1:15PM - 2:00PM	Visit with Mayor of Pietermaritzburg	Pietermaritzburg Mayor=s Parlor City Hall Commercial Road	Thobile Makkubela 0331 951 036/7	USAID will provide transport

	2:15PM - 2:45PM	Site Visit to drop in center for those affected/infected by HIV/AIDS	Khayaletn Drop-In-Center Methodist Church Corner of Church and Boshoff Street	Sally Mann Theleni Nzimande 0331 452 970	USAID will provide transport
	3:00PM - 3:45PM	Site Visit to Social Welfare Project	Pietermaritzburg Child & Family Welfare Society 42 Howelock Road Place of Safety for Children	Chris Morrison 0331 428 971	USAID will provide transport
	4:00PM	Return to Hotel			USAID will provide transport
	7:00PM 3	Dinner with Key Partners	TBD	CG	USAID will provide transport
Wednesday 27 January	5:30 AM	Leave Hotel for Airport	Royal Hotel	SO3 Contacts	USAID will provide transport
	7:00AM	Flight from Durban to JHB - SA500	Durban Airport	SO3 Contacts	USAID will provide transport
	11:05AM	Flight SAA 64 to Lusaka			

Bureau of African Affairs
Economic Policy Staff
(AF/EPS)

FAX COVER

DATE: August 10, 1999

TIME: 9:00 AM

TO: ONAP Director - Sandy Thurman
ONAP Deputy Director - Todd Summers

FROM: *AF/EPS Marlene Urbina de Breen*
647-4098

SUBJECT: HIV/AIDS in Southern Africa

Greetings! Just in case your office has not seen the incoming cable - an update on the HIV/AIDS situation in Southern Africa.

Marlene

NotesTele

TED2482
ACTION SS-00

INFO LOG-00 AF-00 AID-00 ANHR-01 TEDE-00 ADS-00 SAS-00
(ANHR-01 CIAE-00 DODE-00 EB-00 INR-00 IO-00 L-01
NSAE-00) /002W
-----EAC1EF 100958Z /38

R 100948Z AUG 99
FM AMEMBASSY LUSAKA
TO SECSTATE WASHDC 9208
WHITE HOUSE WASHDC
AMEMBASSY NAIROBI
SOUTHERN AFRICAN DEVELOPMENT COMMUNITY

UNCLAS LUSAKA 004286

AID/W FOR AFR/AA VIVIAN LOWERY DERRYCK; G/AA SALLY COLBY
SHELTON; NAIROBI FOR REDSO

WHITE HOUSE FOR ONAP DIRECTOR SANDY THURMAN

DEPT PASS TO AF - A/S SUSAN RICE; PRINCIPAL DEPUTY
ASSISTANT SECRETARY OF STATE KENNETH BRILL;
GAYLE SMITH NSC

E.O. 12958: N/A
TAGS: SOCI, TBIO, ZA
SUBJECT: HIV/AIDS IN SOUTHERN AFRICA: A STOCK TAKING

1. THIS REPORT WAS PREPARED IN THE AFTERMATH OF THE RECENT MEETING BETWEEN AMBASSADORS AND AID DIRECTORS IN THE SADC REGION IN GABORONE. IT PRESENTS AN OVERVIEW OF ACTIVITIES IN THE REGION AND THE STATUS OF EFFORTS TO COMBAT THE AIDS CRISIS. THE BOTTOM LINE IS THAT WHILE MUCH HAS BEEN ACCOMPLISHED, MUCH MORE REMAINS TO BE DONE. THE RECENTLY ANNOUNCED ADMINISTRATION INITIATIVE IS A WELCOME SIGNAL THAT THE UNITED STATES INTENDS TO DEEPEN ITS LEADERSHIP IN THE RESPONSE EFFORT. THE GAPS IDENTIFIED IN THE REPORT AND NOTED IN MORE DETAILED

NotesTele

MATRICES (SENT BY EMAIL OR FAX TO ADDRESSES) MAY BE HELPFUL TO WASHINGTON AS IT PLANS IMPLEMENTATION OF THE INITIATIVE. PARAS 8 AND 9 SUMMARIZE THE STATUS OF ONGOING EFFORTS AND GAPS.

2. BEGIN TEXT. OVERVIEW.

THE HIV/AIDS SITUATION IN SUB SAHARAN AFRICA IS GRIM. THE FIGURES ARE STARK. OVER TWENTY TWO MILLION CASES. TWO MILLION OR MORE DEATHS A YEAR. MILLIONS OF ORPHANS. INCALCULABLE PAIN AND SUFFERING. IMMENSE ECONOMIC AND SOCIAL COSTS. A POOR CONTINENT IS GROWING WEAKER AND POORER.

3. AIDS, TB AND MALARIA KILL THREE TIMES MORE PEOPLE THAN ALL CAUSES OF VIOLENCE IN AFRICA. BUT THE KILLING FIELDS OF HIV/AIDS DON'T SEEM TO MAKE GOOD ENOUGH "COPY" TO CAPTURE AND HOLD THE WORLD'S ATTENTION. MANY HAVE TACITLY ACQUIESCED IN A CONSPIRACY OF SILENCE, STIGMA AND DENIAL.

4. USAID HAS BEEN AT THE FOREFRONT OF THE FIGHT AGAINST THIS CONSPIRACY. WITH THE SUPPORT OF MANY COMMITTED AFRICANS AND OTHER PARTNERS, USAID HAS PUT MORE RESOURCES ON THE TABLE THAN ANY ONE ELSE. THOSE RESOURCES HAVE BEEN EFFECTIVELY PROGRAMMED AND HAVE LEVERAGED OTHER RESOURCES. IN UGANDA THERE IS PROMISING EVIDENCE THAT A MULTI-FACETED APPROACH HAS WORKED TO STOP THE SPREAD OF THE DISEASE. SIMILAR POSITIVE DEVELOPMENTS ARE OCCURRING THROUGHOUT AFRICA. HOWEVER, THOSE HOPEFUL SIGNS ARE OFFSET BY SEVERE COUNTERVAILING FACTORS.

5. THIS CABLE DISCUSSES SOME OF THE HARD CHOICES FACED BY DONORS AND GOVERNMENTS, SOME OF THE KINDS OF THINGS USAID AND OTHERS HAVE DONE TO FIGHT THE DISEASE IN SOUTHERN AFRICA AND IDENTIFIES SOME PROGRAM GAPS. IT UNDERLINES THE IMPORTANCE OF FIGHTING HIV/AIDS IN TANDEM WITH CONTINUING INVESTMENTS IN AFRICA'S FUTURE LONG TERM PROSPERITY.

6. HARD CHOICES.

NotesTele

FINDING A SUSTAINABLE, HUMANE AND EFFECTIVE RESPONSE TO THE EPIDEMIC PRESENTS A HUGE CHALLENGE TO AFRICAN LEADERS AND CONCERNED DONORS LIKE THE UNITED STATES. AFRICAN SOCIAL SERVICES FACE SEVERE FUNDING CONSTRAINTS. MANY STATES SPEND MORE ON DEFENSE OR ON SERVICING INTERNATIONAL DEBT THAN THEY DO ON SOCIAL SERVICES. GOVERNMENT RESOURCES ARE SOMETIMES USED UNWISELY BUT THE BURDEN OF DEBT SERVICING IS MUCH MORE CRUSHING, PERHAPS AS HIGH AS 5% OF GDP.

CLEARLY, CONSISTENT, ROBUST ECONOMIC GROWTH IS ALSO NECESSARY TO GENERATE THE NATIONAL INCOME TO BETTER FUND SOCIAL INVESTMENTS. THE ECONOMIC COSTS OF HIV/AIDS ALONE CAN CUT 1 TO 2% OFF OF GDP GROWTH PROSPECTS EVERY YEAR. IN MANY CASES THAT IS THE MARGIN BETWEEN GROWTH AND NO GROWTH. THE KIND OF GROWTH INVESTMENTS SUPPORTED BY USAID AND OTHERS ARE A CRITICAL PREREQUISITE FOR ANY DURABLE RESPONSE TO THE HIV/AIDS CRISIS. TODAY'S IMPROVED MACRO-ECONOMIC AND PRO-BUSINESS POLICY ENVIRONMENT IN MUCH OF AFRICA WARRANTS CONTINUED SUPPORT. YET, THE DEBT BURDEN, THE ABSENCE OF GROWTH AND THE COSTS OF SICK SOCIETIES MAKE IT HARD FOR GOVERNMENTS TO SUSTAIN INVESTMENTS IN SOCIAL SERVICES OR PLAN FOR THE FUTURE.

JUST AS OUR AFRICAN PARTNERS FACE CRUSHING CHOICES IN ALLOCATING THEIR MEAGER RESOURCES, DONORS LIKE THE UNITED STATES FACE EQUALLY DAUNTING TRADEOFFS. REGRETTABLY, IN THE CURRENT ZERO SUM BUDGET CLIMATE, A DOLLAR MORE FOR HEALTH IS A DOLLAR LESS FOR INVESTMENTS IN GROWTH. LIKEWISE, WITHIN THE HEALTH SECTOR, DOLLARS

SHIFTED TO HIV/AIDS CAN REDUCE RESOURCES DESPERATELY NEEDED TO ACCELERATE THE DEMOGRAPHIC TRANSITION WHICH WILL BUTTRESS ECONOMIC GROWTH PROSPECTS AND REDUCE HIGH SOCIAL DEPENDENCY RATIOS. OR IT MEANS LESS MONEY FOR FIGHTING CHILDHOOD DISEASES.

SIMILAR DILEMMAS EXIST AT THE MACRO LEVEL TO THE SECTORAL LEVEL AND WITHIN THE SECTORAL LEVEL. CONSIDER HIV/AIDS SPENDING CHOICES. A DOLLAR SHIFTED TO CARE IS A DOLLAR LESS FOR PREVENTION. THE HUMAN RETURNS ON PREVENTION ARE FAR HIGHER THAN FROM CURATIVE SERVICES.

NotesTele

A DOLLAR SPENT ON INSTITUTIONAL CARE FOR ORPHANS MEANS A DOLLAR LESS FOR MORE COST EFFECTIVE AND SELF ENHANCING, COMMUNITY BASED RESPONSES. A PROPORTIONATE MIX OF CAREFULLY TARGETED RESPONSES IS THE MOST EFFICACIOUS TACK. FINDING THAT BALANCE IS DIFFICULT.

7. KEY INTERVENTIONS.

DESPITE THESE FUNDING DILEMMAS, BASED ON INTERNATIONAL EXPERIENCE TO DATE, THERE IS GENERAL AGREEMENT THAT THERE IS A SET OF PRIORITY HIV/AIDS INTERVENTIONS THAT CAN WORK IF THEY ARE APPLIED ENERGETICALLY AND SUSTAINED-OVER TIME. SOME OF THE INTERVENTIONS, WHICH MAY COST THE LEAST, SUCH AS LEADERSHIP, PROBABLY MATTER THE MOST. EXPERIENCE SUGGESTS THAT THEY WORK BEST WHEN THEY ARE SYNERGISTICALLY APPLIED IN A FRAMEWORK WHICH CHARACTERIZES THE HIV/AIDS ISSUE AS MORE, MUCH MORE THAN "JUST" A HEALTH PROBLEM. THE CORRECT AND MOST EFFECTIVE FRAMEWORK CORRECTLY PLACES THE VARIOUS RESPONSES AS PART OF A MULTI-SECTORAL EFFORT.

THE KEY INTERVENTIONS ARE NOTED BELOW. A MATRIX FAXED AND EMAILED TO ADDRESSES PROVIDES A REPORT CARD ON WHERE WE ARE WITH EACH OF THESE INTERVENTIONS IN THE SOUTHERN AFRICAN COUNTRIES. ANOTHER MATRIX ALSO SENT TO ADDRESSES INDICATES INVESTMENTS BY USAID AND OTHERS IN THESE COUNTRIES IN THESE PRIORITY AREAS.

A. LEADERSHIP

POLITICAL, TECHNICAL, TRADITIONAL AND PRIVATE SECTOR LEADERSHIP ARE ALL ESSENTIAL TO AN EFFECTIVE HIV/AIDS RESPONSE. THE BEST LEADERSHIP WILL MOBILIZE PUBLIC AWARENESS, BUILD BRIDGES ACROSS ALL AREAS AND SECTORS OF THE COMMUNITY, CONFER LEGITIMACY TO TALKING OPENLY ABOUT THE ISSUE AND BE A POWERFUL CATALYST FOR CHANGED BEHAVIOR.

B. INFORMATION, EDUCATION AND COMMUNICATION

NotesTele

VIBRANT, OPEN AND EXPLICIT DISSEMINATION OF WHAT HIV/AIDS IS AND HOW IT CAN BE AVOIDED NEEDS TO BE UBIQUITOUS IN AFFECTED COMMUNITIES. IT NEEDS TO BE SUSTAINED, REDUNDANT, PERSISTENT AND MEMORABLE. HIGH RISK GROUPS NEED TO BE ESPECIALLY TARGETED, INCLUDING COUNSELING YOUNG PEOPLE ON ABSTINENCE AND ALTERNATIVES. WHILE THERE IS A HIGH LEVEL OF AWARENESS ABOUT HIV/AIDS IN MOST SOUTHERN AFRICAN COUNTRIES; THIS HAS NOT TRANSLATED INTO BEHAVIORAL CHANGE. NEW FORMS OF COMMUNICATION THAT TAKES CULTURALLY-SPECIFIC ATTITUDES AND BEHAVIOR ARE IMPORTANT. DECREASING STIGMA WOULD INCREASE INDIVIDUAL'S AND COMMUNITIES WILLINGNESS TO TACKLE HIV/AIDS OPENLY AND THUS IS ANOTHER CHALLENGE.

C. CONDOM AVAILABILITY

THE WIDESPREAD AVAILABILITY AND USE OF LOW COST CONDOMS AND WORK TO CREATE AWARENESS OF THE NEED TO USE THEM, PARTICULARLY FOR HIGH RISK GROUPS, IS VITAL.

D. TREATMENT OF SEXUALLY TRANSMITTED DISEASES/INFECTIONS (STDS/STIS)

IMPORTANT RESEARCH RESULTS SUGGEST THAT EARLY, AGGRESSIVE TREATMENT OF THOSE INFECTED BY SEXUALLY

TRANSMITTED DISEASES CAN BE A POWERFUL BRAKE ON TRANSMISSION RATES.

E. VOLUNTARY COUNSELING AND TESTING

ACCESS TO FAST, AFFORDABLE, RELIABLE TESTING AND PRIVATE COUNSELING HELPS TO STOP TRANSMISSION BY ENCOURAGING

NotesTele

THOSE WHO MIGHT BE INFECTED TO ADOPT SAFER PRACTICES WITH SEXUAL PARTNERS. EQUALLY IMPORTANT, EARLY TESTING AND COUNSELING CAN HELP THE VAST MAJORITY OF THE-POPULATION, WHICH IS NOT INFECTED, STAY THAT WAY.

F. SURVEILLANCE

ACCURATE INFORMATION ABOUT THE EPIDEMIC AND ITS CONTOURS IS INCREDIBLY USEFUL IN PLANNING INTERVENTIONS, MONITORING THE EFFECTIVENESS OF THOSE INTERVENTIONS AND MAXIMIZING RETURNS ON RESOURCE ALLOCATIONS.

G. SAFE BLOOD SUPPLY

MEASURES TO PROTECT NATIONAL BLOOD SUPPLIES ARE ESSENTIAL. WHILE CONSIDERABLE PROGRESS WAS MADE IN PROTECTING BLOOD SUPPLIES IN THE EARLY STAGES OF THE EPIDEMIC, SOME COUNTRIES APPEAR TO BE BACKTRACKING.

H. CARE

HUMANE, SUSTAINABLE, COMMUNITY BASED CARE PROVISION IS NEEDED FOR THOSE WHO ARE UNABLE TO CARE FOR THEMSELVES.

I. ORPHANS CARE

THE ORPHANS ISSUE AND AFFILIATED ISSUES LIKE MOTHER-TO-CHILD TRANSMISSION (MTCT) NEED TO BE ADDRESSED IN A BALANCED RESPONSE IN LIGHT OF THE EXTENT TO WHICH TRADITIONAL COPING PATTERNS HAVE BROKEN DOWN AND COMMUNITIES ARE FACED WITH EXCEPTIONALLY HIGH CARE BURDENS. COMMUNITY-BASED RESPONSES PROVIDE THE BEST NURTURING ENVIRONMENT FOR CHILDREN, INCLUDING ASSURING

NotesTele

ACCESS TO EDUCATION. COMPLEMENTARY ECONOMIC GROWTH ACTIVITIES LIKE MICRO ENTERPRISE DEVELOPMENT ARE IMPORTANT TO ENHANCE COMMUNITY CAPACITIES TO CARE FOR CHILDREN.

8. STATUS OF THE EFFORT.

BASED ON AN OVER-VIEW OF THE REGION, IT IS CLEAR THAT NATIONAL PROGRAMS THROUGHOUT THE REGION ARE HAVING MIXED IMPACTS. AWARENESS OF THE DISEASE IS NEARLY UNIVERSAL. CHANGED BEHAVIOR IS NOT, ALTHOUGH THERE IS SOME EVIDENCE THAT THERE HAS BEEN SIGNIFICANT CHANGE AMONGST ADOLESCENTS. DONOR COORDINATION IS EFFECTIVE IN ONLY A FEW COUNTRIES. DATA IS UNRELIABLE. THE SPREAD OF THE EPIDEMIC IS CONTINUING TO BUILD IN MOST COUNTRIES.

IN SOME COUNTRIES, LIKE SOUTH AFRICA, POLITICAL LEADERSHIP ON THE ISSUE IS STRONG. IN OTHERS IT LEAVES MUCH TO BE DESIRED. SEVERAL COUNTRIES HAVE HIGHLY INNOVATIVE WORK PLACE PROGRAMS. SOME HAVE SUCCEEDED IN BUILDING SURPRISINGLY EFFECTIVE ALLIANCES WITH TRADITIONAL LEADERS AND THIS IS RESULTING IN CHANGES IN SOME DANGEROUS CULTURAL PRACTICES LIKE WIDOW CLEANSING. HOWEVER, MANY OF THE COUNTRIES IN THE REGION FACE SERIOUS ECONOMIC PROBLEMS THAT DIVERT THE ATTENTION OF LEADERSHIP FROM HIV/AIDS. THE ATTENTION OF MANY POLITICIANS IS FOCUSED ON EFFORTS TO REVERSE THE IMPACT OF RECESSION ON THEIR CONSTITUENTS, AND THUS TO STAY IN POWER IN FACE OF GROWING DISCONTENT, RATHER THAN ON SOCIAL ISSUES OF LITTLE POLITICAL IMPORT SUCH AS HIV/AIDS.

REGIONALLY, ISSUES OF STIGMA, SILENCE AND DENIAL ARE STILL PREVALENT. CONDOM AVAILABILITY IS GENERALLY

EXCELLENT. TREATMENT OF STDs AND SERVICES FOR HIGH RISK GROUPS ARE POOR IN MOST COUNTRIES. VOLUNTARY COUNSELING AND TESTING, A RELATIVELY EXPENSIVE INTERVENTION, IS NOT WIDESPREAD. THE RECORD ON SURVEILLANCE IS MIXED. HOME CARE NEEDS FOR PEOPLE WITH AIDS ARE IMMENSE AND ONLY PARTIALLY BEING MET. THE BLOOD SUPPLY FOR MOST MEDICAL FACILITIES IS WELL PROTECTED. INCREASING ATTENTION IS BEING DIRECTED AT THE ORPHANS ISSUES BUT ONLY MALAWI AND ZAMBIA HAVE GIVEN

NotesTele

THIS ISSUE PRIORITY ATTENTION.

USAID IS THE PREMIER DONOR IN HIV/AIDS ACTIVITIES AND ORPHANS SERVICES. MOST OF THE MONEY IS GOING FOR A BALANCED APPROACH, WHICH INCLUDES AWARENESS RAISING, ADVOCACY, CONDOM DISTRIBUTION AND COMMUNITY LEVEL ASSISTANCE. THERE HAS BEEN RENEWED INTEREST IN SUPPORT FOR STI/STD TREATMENT, WORK WITH HIGH-RISK GROUPS AND VCT. THE ONE AREA USAID CURRENTLY HAS NOT BEEN INVOLVED IN APPEARS TO BE ENSURING A SAFE BLOOD SUPPLY. (OTHER DONORS SUCH AS THE EU OFTEN PROVIDE SUPPORT) USAID PROVIDED SUPPORT IN THIS AREA IN THE EARLY YEARS OF THE EPIDEMIC.

9. THE GAPS.

IN EVALUATING THE ACTIVITIES OF USAID, HOST COUNTRY GOVERNMENTS AND OTHER DONORS, THE BIGGEST GAPS THAT EMERGE ARE OCCASIONED BY THE SITUATION OF COUNTRIES WHICH ARE EITHER NOT SERVICED BY USAID BILATERAL MISSIONS WITH HEALTH PROGRAMS (BOTSWANA, LESOTHO, SWAZILAND) OR WHICH ARE IN CONFLICT (ANGOLA, CONGO). FRAIL SOCIAL SECTOR FUNDING FROM HOST COUNTRY GOVERNMENTS FURTHER HURTS THE EFFECTIVENESS OF THE RESPONSE. THERE IS A PRESSING NEED TO FIND WAYS TO EXTEND SUPPORT TO NON-PRESENCE COUNTRIES WITH NIMBLE AND EFFECTIVE ADMINISTRATIVE ARRANGEMENTS, PERHAPS THROUGH ACTIVITIES MANAGED BY COOPERATING NGO PARTNERS

BORDER POSTS AND INTERNATIONAL MIGRATION REPRESENT ANOTHER "GAP." SCANT ATTENTION IS PAID TO THESE HIGH-RISK AREAS AND HIGH-RISK GROUPS. THE TRANSPORTATION NETWORKS IN SOUTHERN AFRICA ARE THE BEST DEVELOPED ON THE CONTINENT AND CONSEQUENTLY THERE IS MUCH MOVEMENT BETWEEN COUNTRIES - BY MIGRANT WORKERS, BY INFORMAL TRADERS, ETC. THE TRAVELERS FACE LONG DELAYS IN BORDER TOWNS. HOWEVER, GIVEN THAT THE POPULATIONS ARE TRANSIENT, AND OFTEN FOREIGN (E.G. A ZIMBABWEAN IN SOUTH AFRICA), NATIONAL PROGRAMS HAVE NOT FOCUSED EFFORTS ON THESE PLACES OR GROUPS EVEN THOUGH THEY ARE OF VERY HIGH RISK. (MOREOVER, DURING THE COLONIAL ERA, MIGRANTS WERE TESTED FOR STDs ON AN INVOLUNTARY BASIS SO THERE IS RELUCTANCE TO APPEAR TO BE RE-INTRODUCING ANY MEASURES.) RELATED TO THIS IS THE FACT THAT MESSAGES AND SERVICES

NotesTele

IN NEIGHBORING COUNTRIES ARE NOT COORDINATED. A ZAMBIAN MINER LIVING IN SOUTH AFRICA MAY NOT RECEIVE THE SAME INFORMATION AS HIS WIFE WHO IS STILL IN THE NORTH. SENTINEL SURVEILLANCE IS AN IMPORTANT AREA IN COUNTRIES WHICH SHOW INCONSISTENT PERFORMANCE. EPIDEMIOLOGICAL SURVEILLANCE IS NOT STANDARDIZED AMONG COUNTRIES, OR EVEN WITHIN COUNTRIES. THUS IT IS VERY DIFFICULT TO UNDERSTAND NATIONAL TRENDS, OR TO COMPARE SITUATION IN DIFFERENT COUNTRIES. MOREOVER, THE LACK OF STANDARDIZATION MAKES IT DIFFICULT FOR ONE COUNTRY TO INTERPRET AND THEREBY LEARN FROM EFFORTS IN ANOTHER COUNTRY.

POLICY IS ANOTHER AREA THAT IS IMPORTANT REGIONALLY AS WELL AS NATIONALLY. AS MENTIONED ABOVE, MANY OF THE COUNTRIES IN THE REGION ARE ON THE VERGE OF ECONOMIC COLLAPSE AND OR DIVERT CONSIDERABLE RESOURCE TO NON-DISCRETIONARY EXPENDITURES SUCH AS DEBT SERVICING. AS A CONSEQUENCE SPENDING ON SOCIAL SECTOR IS FALLING. THE PUBLIC HEALTH SYSTEMS ARE IN JEOPARDY AND NATIONAL PROGRAMS ARE FLAILING. THE ATTRITION OF NURSES IS VERY HIGH - YET THEY SHOULD FORM THE BACKBONE OF THE SECTOR. PHYSICIANS GENERALLY ARE ALSO LEAVING THE PUBLIC SECTOR AND PHARMACEUTICAL SUPPLIES TEND TO BE ERRATIC. USAID FINDS THAT NGOS GENERALLY MAKE BETTER PARTNERS THAN A MINISTRY OF HEALTH WHICH LACKS CAPACITY. THIS IS VERY WORRISOME BECAUSE WHILE NGOS ARE IMPORTANT ACTORS IN THE FIGHT AGAINST HIV/AIDS, NGOS SIMPLY CANNOT DUPLICATE OR REPLACE THE PUBLIC SECTOR. USAID OF COURSE CANNOT STOP THIS HEMORRHAGE. HOWEVER, USAID MUST CONTINUE WITH

OTHER DONORS TO INSURE THAT POLICY MAKERS UNDERSTAND THE IMPORTANCE OF THE HEALTH SECTOR, AND BEGIN TO PROVIDE ADEQUATE RESOURCES TO THESE SECTORS. RAISING AWARENESS WILL CONTINUE TO BE ONE OF THE BIGGEST CHALLENGES. DONOR COORDINATION IS ANOTHER AREA THAT SHOULD BE IMPROVED. UGANDA'S SUCCESS APPEARS TO BE DUE TO THE SYNERGISTIC EFFECT OF MANY COORDINATED INTERVENTIONS OVER A LONG PERIOD OF TIME. YET MOST COUNTRIES AND PROGRAMS IN THE REGION HAVE FAILED TO ADOPT A COMPREHENSIVE NATIONAL APPROACH TO HIV PREVENTION. THIS IS PARTLY BECAUSE DONOR-FUNDED INTERVENTIONS TEND TO FOCUS ON ONE AREA OR ANOTHER AND NEGLECT COMPLEMENTARY AREAS - FOR INSTANCE, THERE MAY BE CONDOM SOCIAL MARKETING, BUT NO STD TREATMENT; OR CONVERSELY THERE MAYBE COMPLETE STD COUNSELING AT A PUBLIC SECTOR CLINIC, BUT NOT CONDOMS. BETTER COORDINATION OF EFFORTS AND

NotesTele

PROGRAMS COULD IMPROVE THIS SITUATION.

THE GROWING NUMBER OF ORPHANS IS A PROBLEM FACED BY EVERY COUNTRY IN THE AREA. THIS IS NOT A SITUATION THAT WILL BE SOLVED ON A REGIONAL BASIS - SOLUTIONS WILL HAVE TO COME FROM THE COMMUNITIES THEMSELVES. HOWEVER, THERE ARE LESSONS TO BE LEARNED AND EXPERIENCES TO BE SHARED. COMMUNITIES-BASED ORGANIZATIONS THROUGHOUT THE REGION COULD OBSERVE, AND LEARN FROM OTHER COMMUNITY EFFORTS. RECENT SHARING BETWEEN MALAWI AND ZAMBIA ORPHAN PROGRAMS PROVED VERY PRODUCTIVE AND EACH COUNTRY LEARNED A LOT FROM THE DISCUSSION OF JOINT ISSUES.

10. THE REGIONAL PROGRAM.

LAST YEAR, IN RESPONSE TO THEIR ASSESSMENT OF THE SITUATION, A GROUP OF USAID HEALTH OFFICERS MET TO BRAINSTORM ABOUT POSSIBLE REGIONAL ACTIVITIES. FOUR MODEST INITIATIVES RESULTED: A "CORRIDORS OF HOPE" EFFORT, INITIALLY ALONG THE DURBAN-LUSAKA CORRIDOR, TO PROVIDE A FULL RANGE OF SERVICES TO THE HIGH RISK POPULATIONS USING THE CORRIDOR; AN ACTIVITY TO ENHANCE REGIONAL POLICY ADVOCACY AND WORK ON IMPROVING SURVEILLANCE CAPACITY IN THE REGION. FINALLY, INCREASED INFORMATION SHARING INCLUDING A REGIONAL ADVISOR TO BE POSTED IN SOUTH AFRICA TO FACILITATE INFORMATION SHARING AND TO MANAGE THESE ACTIVITIES.

USAID IS NOW CONSIDERING MECHANISMS FOR INVESTMENTS IN COUNTRIES WITHOUT BILATERAL USAID HEALTH PROGRAMS OR SUFFICIENT OTHER DONOR/GOVERNMENT SUPPORT TO FIGHT THEIR SEVERE HIV/AIDS EPIDEMICS BUT WHO HAVE NO BILATERAL HEALTH PROGRAMS, PARTICULARLY BOTSWANA, LESOTHO AND SWAZILAND.

11. NEXT STEPS.

IN CONSULTATION WITH THE HILL AND OTHER STAKEHOLDERS, THE AGENCY NEEDS TO WORK THROUGH DIFFICULT CHOICES. ADDITIVE RESOURCES FOR HIV/AIDS AND ORPHANS ACTIVITIES COULD BE EFFECTIVELY PROGRAMMED IN THE REGION BOTH

NotesTele

BILATERALLY AND REGIONALLY AND THEREFORE THE SUCCESS OF THE PRESIDENT'S INITIATIVE IS IMPORTANT. IN THE PAST THERE HAVE BEEN NO ADDITIVE RESOURCES AND ECONOMIC GROWTH HAS BEEN THE ACCOUNT WHICH WAS USED TO FUND NEW INITIATIVES.

12. USG LEADERSHIP DOES COUNT. WITH MODEST RESOURCES, IT WOULD BE POSSIBLE TO FINALIZE PROPOSED ACTIVITIES IN WORST EFFECTED COUNTRIES WITHOUT BILATERAL PROGRAMS. IN THOSE COUNTRIES USG SUPPORT IS OUR HIGHEST PRIORITY. DIALOGUE WITH THE CONGRESS TO PERMIT SUCH PROGRAMMING IS URGENTLY REQUIRED. SIMILARLY, MORE GENEROUS FUNDING OF ONGOING REGIONAL AND BILATERAL ACTIVITIES WOULD FOSTER ACCELERATED IMPACTS. END TEXT. WHITEHEAD
NNNN

Clinton Presidential Records Digital Records Marker

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

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

CHILDREN ON THE BRINK

STRATEGIES TO SUPPORT CHILDREN ISOLATED BY HIV/AIDS

E X E C U T I V E R E P O R T



UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT