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Global estimates

One adult in 100 worldwide is infected with HIV

New estimates show that HIV infection is far more common in the world than previously thought, and that it is continuing to spread rapidly. Over 30 million people are believed to be living with HIV infection at the end of 1997. That is one in every 100 adults in the sexually active ages of 15 to 49 worldwide. The overwhelming majority - more than 90 percent - live in the developing world, and most do not know that they are infected.

This year's estimates indicate that 5.8 million people were infected with the virus that causes AIDS in 1997, 590,000 of them children. Overall, that is equivalent to nearly 16,000 new infections every day of the year. With unbroken trends in many parts of the world it is estimated that about 40 million people will live with HIV by the year 2000.

Some 2.3 million people died of AIDS in 1997 -- a fifth of all the 11.8 million AIDS deaths since the beginning of the epidemic in the early 1980s. Of the people who died of AIDS this year, 45 percent were women and 460,000 were children under the age of 15. (Although virtually all countries in the world do have AIDS reporting systems, in most countries only a small part of all AIDS cases are reported due to the limited resources available. Tables with the number of reported AIDS cases are available as an annex to this report).

Of those currently living with HIV, 1.1 million are children. Most of the rest are men and women in their sexually active years. Since children are generally infected around the time of birth, their infections are also considered to be the result of sexual activity in the adult years. So that comparisons can be made between countries, UNAIDS and WHO in general express proportions infected in a population as the proportion of infections in the adult population between the ages of 15 and 49.

Regional estimates

It is becoming increasingly clear that although almost every country in the world is touched by HIV, the virus spreads very differently in different parts of the world. There are even important differences in patterns of spread in different communities and different geographic areas within the same country.

AIDS is falling in the industrialised world

The gap between the developed and the developing world continues to grow. In industrialised countries, newly-available drugs are reducing the speed at which people who are infected with the HIV virus develop AIDS. In Western Europe evidence suggests that new AIDS cases will drop by around 30 percent in 1997 compared with 1995, before antiretroviral treatment to prolong life became available. The fall is greatest in countries in which infection has been concentrated in homosexual men. In Portugal and Greece, where injecting drug use is the main mode of transmission, new AIDS cases are still showing substantial rises over a year ago.

It is estimated that 30,000 Western Europeans were newly infected with HIV in 1997. Treatment given to the mother during pregnancy and the availability of alternatives to breastfeeding kept mother-to-child infection low -- it is estimated that fewer than 500 children under the age of 15 were infected with HIV in 1997.

In the United States, newly-published figures show that new AIDS cases fell by 6 percent in 1996 and an even bigger decrease is expected in 1997. The largest falls -- down by 11 percent -- were in homosexual men, the very group which saw the most open exchange of information about the risks of unprotected sex in the early years of the epidemic. In some disadvantaged sections of society, however, AIDS continues to rise. New AIDS cases rose by 19 percent among heterosexual black men and 12 percent among heterosexual black women in the United States in 1996. In the Hispanic community, there were 13 percent more cases among men and five percent more among women than a year earlier. This is partly because these communities may find it hard to access the expensive new drugs that could stave off the onset of AIDS. It is partly, too, because early prevention efforts were targeted among homosexual men, and proved quite successful in that group. Change in risk behaviour among heterosexuals has been less marked.

North America estimated it had around 44,000 new HIV infections in 1997. As in Western Europe, transmission from mother to child was low, with fewer than 500 new cases.

Drug use drives HIV in Eastern Europe

Drug injection is driving a dramatic rise in HIV infection in several Eastern European nations, contributing the majority of the 100,000 new infections estimated to have taken place in 1997. In Ukraine, where around 70 percent of infections have been in drug users over the last three years, some 25,000 cases of HIV infection have been reported so far, half of them in 1997. It is possible that a similar pattern will be seen elsewhere in the region. Russian officials estimate there are about 350,000 regular drug users in the country, many of them sharing injecting equipment. The possibility for sexual spread also exists. A Polish study published this year recorded that nearly half of a group of 400 women examined were infected with a sexually transmitted disease. In Russia, Belarus and Moldova, new cases of syphilis had rocketed from negligibly low levels in the late 1980s to close to two per thousand by 1995, with continuously increasing trends.

Unprotected sex takes infection to new levels in Sub-Saharan Africa

Unprotected sex between men and women accounts for most of the 3.4 million new HIV infections estimated among adults in sub-Saharan Africa in 1997. Because drugs, information and alternatives to breast feeding are not easily available, mother-to-child transmission is far more common in Africa than in the industrialised world. Infected mothers passed the virus on to over half a million children in 1997 -- more than 90 percent of the world total.

Although heterosexual transmission accounts for most infection throughout Africa, there is a huge variety of levels of infection across the continent. In general, West Africa has seen rates of infection stabilise at much lower levels than in the countries of East and Southern Africa. However some of the most populous countries in West

Africa are the exception to that rule. For example, the National AIDS Programme estimates that 2.2 million people are currently living with HIV in Nigeria, a country whose response to the epidemic has so far been limited.

Southern Africa continues to be the region worst affected by HIV. By early 1997, the government of South Africa estimated that 2.4 million South Africans were living with HIV, up by over a third as compared to 1996. In Botswana, the proportion of the adult population living with HIV has doubled over the last five years. In 1997, 43 percent of pregnant women tested in the major urban centre of Francistown were HIV positive. In Zimbabwe, infection was estimated at one in five adults in 1996. Although levels in cities were slightly higher than in rural areas, the difference was not great. In one town with a large population of migrant workers, seven pregnant women in 10 tested HIV positive in 1995.

East Africa was one of the first areas to suffer a massive regional epidemic, and one country in the region, Uganda, was among the first to respond with open and concerted efforts to prevent the spread of the virus. For Uganda, this seems to be paying off. 1997 data currently being analysed shows that the proportion of Ugandan adults infected is continuing to drop, with a fall of about a fifth in all three of the sites for which figures are now available, to levels of between five and nine percent. The fall has been particularly marked among the younger age groups, indicating that young people nowadays may be adopting safer sexual behaviours than was common 10 years ago.

Infection rates in Asia are lower, but the numbers are large

The diversity within Asia is greater even than that in Africa. Levels of infection vary enormously, and routes of transmission are much more varied. Often there are a variety of epidemics running concurrently within a single country. New genetic typing procedures (which allow researchers to investigate how different strains of the virus are spreading through the population) show that there is often remarkably little overlap between HIV among injecting drug users and commercial sex workers, for instance.

The epidemic is newer in Asia than in Africa, and only a few countries in the region have developed sophisticated systems for monitoring the spread of HIV. So estimates of HIV in Asia often have to be made on the basis of less information than in other regions. Because over half of the world's population lives in the region, small differences in rates can make huge differences in the absolute numbers of people infected. For example, a difference of one infected person in every 1000 Chinese adults will make a difference of over 700,000 infected individuals.

At the moment, the Chinese Academy of Preventive Medicine's AIDS Surveillance Unit estimates there are 400,000 people living with HIV in the country, where there are two major epidemics under way. One is in injecting drug users in the mountainous southwest of the country. The other, newer epidemic is now surfacing among heterosexuals, especially along the prosperous eastern seaboard where prostitution is re-emerging as the gap grows between rich and poor. The warning signs of high-risk behaviour are worryingly clear: sexually transmitted diseases have shot up in recent years, and there are no suggestions that the upward trend will be broken.

(graphic)

In India, infection rates, at under one percent of the adult population, are still low by the standards of many countries, although over 10 times higher than in neighbouring China. Surveillance is at best patchy, but all indications are that between three and five million people are infected in the country. Even at the bottom of that range, India would be the country with the highest number of cases in the world.

Recent testing of pregnant women in Mumbai shows infection rates around 2.4 percent in 1996. In Pondicherry, the rate among pregnant women is around 4 percent. Among truck drivers in the southern state of Madras, HIV infection quadrupled from 1.5 percent in 1995 to 6.2 percent just one year later. In the northeastern state of Manipur, where the epidemic took off quickly among male drug injectors, some drug clinics were registering HIV rates of as high as 73 percent in 1996.

There is limited information about HIV infection in other parts of south Asia, but it is clear that many people are having unprotected sex with non-monogamous partners. A recent study among sex workers in Bangladesh showed that 95 percent had contracted genital herpes, mostly from their clients, while 60 percent had syphilis.

Despite well-documented commercial sex industries, rates of HIV infection remain low in several southeast Asian nations. In Indonesia, Malaysia, the Philippines and Singapore, for instance, infection rates are well under half of one percent. Other countries in the region, however, show much higher levels of HIV spread.

Thailand, which has experienced what is probably the best-documented epidemic in the developing world, is continuing to produce solid evidence that the levels of new infection are falling, especially among sex workers and their clients -- the groups who have accounted for the majority of the some 750,000 person currently infected representing 2.3 percent of the adult population. However rates among drug users remain high, and it is becoming increasingly apparent that men who have sex with other men have not adopted safer behaviour as quickly as mainstream groups.

In Indochina the picture is mixed. It is bleakest in Cambodia, where one in 20 pregnant women, one in 16 soldiers and policeman and one in two sex workers tested positive in sentinel HIV surveillance. While condom use has grown very rapidly (condoms sales have risen from virtually nothing to around a million units a month in the space of under three years) commercial sex remains very common -- in a recent survey three quarters of respondents in the military and the police force and two fifths of students said they had visited a sex worker in the last year. In neighbouring Vietnam and in Myanmar, HIV infection is also rising rapidly. In Myanmar, HIV infection among sex workers has risen from four percent in 1992 to over 20 percent in 1996, while two out of three injecting drug users are infected. Among pregnant women in the general population, a relatively constant two percent are infected.

Overall, about 6.4 million people are currently believed to be living with HIV in the Asia Pacific region -- just over one in five of the world's total. By the year 2000, just

three years from now, that proportion is expected to rise to one in four. Around 92,000 children now live with HIV in Asia.

AIDS mortality on the rise in Latin America

In Latin America the picture is heterogeneous. In general, HIV is concentrated in the so called high risk populations of men having sex with men and intravenous drug users. Systematic data collection is difficult in these groups and information is rather scarce as of today. Rates in drug users vary from 5-11 percent in Mexico to about 30 percent in studies Peru and Brazil. However, increasing trends in women show that heterosexual transmission is becoming more prominent. Although rates in pregnant women are still comparably low in general, it reached levels of 1 in a hundred in Honduras and more than 3 in a hundred in Porto Alegre, Brazil. Rates were substantially higher in Haiti with more than 8 percent of pregnant women carrying the virus already in 1993, but no recent information is available here.

The impact of AIDS, however, can best be shown when looking at mortality rather than HIV prevalence. In Mexico AIDS was the third leading cause of death in men between 25 and 34 years of age in 1995 with increasing trends. In the state of Sao Paulo, Brazil, AIDS is the leading cause of death in 20 to 34 year old women since 1992. It is estimated that mortality due to AIDS will increase fourfold for both women and men by the year 2000 when compared to the levels in 1990.

YOUTH

In some parts of the world, the proportion of the total adult population living with HIV has stabilised or begun to fall. While this is good news, it can hide an unpleasant truth: infection rates in the youngest age groups can go on rising even as the proportion of people living with AIDS is falling. This is because HIV is a long-term infection. In the early years of the epidemic, people of all ages are becoming infected, and very few are dying. After a few years, most of the people in each age group who are likely to be exposed to infection will have contracted the disease. They will continue to be counted among the proportion of infected people until they die. Some years after the first wave of infection comes the first wave of deaths. If there are no new infections, then the prevalence figures, those that measure the proportion infected, will fall. But if prevalence remains stable, it means there is at least one new infection for every person dying or dropping out of the testing group. The majority of these new infections will be in the younger age groups.

Infection rates and risk behaviour among young people remain high

In most parts of the world, the majority of new infections are in young people between the ages of 15 and 24, sometimes younger. In one study in Zambia, over 12 percent of the 15 and 16 years olds seen at antenatal clinics were already infected with HIV.

Girls appear to be especially vulnerable to infection. Uganda has recently shown encouraging evidence that in some city sites infection rates have halved among

teenage girls since 1990. But the rates remain unacceptably high, with up to one pregnant teenager in 10 testing HIV positive. That rate is six times as high as it is for boys in the same age group.

In South Africa, infections among pregnant 15 to 19 year-olds rose to 13 percent in 1996 from around half that just two years earlier. In Botswana the infection rate stood at 28 percent for the same group in 1997. In Maharashtra state in India, where the epidemic is in its early years, some 3.5 percent of pregnant teenagers tested HIV positive in a recent study.

In many countries, young people are denied access to information about HIV and safe behaviour, or are unable to buy condoms or attend STD clinics. This is usually because older adults believe such information and services will actually encourage young people to increase their sexual activity. In fact, the reverse is true according to a newly-published review of data from four continents. Good quality sex education helps delay first intercourse and leads to lower levels of pregnancy and STDs. In the years after Switzerland launched an active and very open campaign about sex aimed at informing young people about healthy behaviours, the proportion of 17 year old girls and boys who never had sex -- a proportion that had been dropping for many years -- began to show a marked rise.

What is abundantly clear is that young people all over the world engage in risky sexual behaviour. In Mongolia, there has been a recent jump in sexually transmitted diseases in children under 15, indicating that they are exposed to high-risk sexual activity. One study shows that since 1994, STDs in the under 15s has shot up by more than 10-fold. In Namibia, 37 percent of 12 to 18 year-olds report that they have had sex, nearly half of them with more than one partner. Most reported that they believed their own partners had had other partners, too. In Tanzania, 12 percent of teenage men and 37 percent of 20-24 year-olds report that they have had multiple sexual partners in the last year. In Mali, two out of five sexually active men in their teens said they last had sex with a prostitute or casual partner. In Switzerland, 17 percent of young women and 18 percent of young men aged 17-19 reported sex outside a regular partnership in the last six months. Over half the women and a quarter of the men said they had not used a condom with their last casual partner. In the United States, genital herpes has jumped more than four-fold among white teenagers since the 1970s, with close to one in 20 now infected. Among white Americans in their 20s, the rate is one in seven.

People often take risks with their health because they don't know about the dangers or how to avoid them, because they are unable to access the services they need to help them protect themselves, or because their social or economic situations leave them with no alternatives. But there are other reasons, too. Sometimes, young people know of the risks of unprotected sex but feel HIV couldn't possibly happen to them. In Malawi, most young men and women know how HIV is transmitted and how it can be prevented. However, many felt invulnerable to the virus. Some 90 percent of teenage boys said they were at no risk or at minimal risk of infection, even though nearly half of them reported at least one casual sexual partner over the last year, and condom use was low.

Even in countries such as Thailand -- which has been among the most successful in encouraging young people to adopt safer sexual behaviour and has been rewarded by seeing a marked fall in both HIV infection and other STDs -- there are groups of young people that fall through the net. A study of street children in Thailand showed that over 90 percent of the small sample tested had a sexually transmitted disease.

But behaviour is beginning to change

Despite unacceptably high levels of risk behaviour and STD and HIV infection among young people, there are signs from some areas that more and more young people are beginning to choose safer behaviours. Thailand and Uganda have already been mentioned. In Tanzania, 16 percent of sexually active teenage women had used a condom in 1996. While this may seem woefully low, it is certainly a vast improvement on the five percent recorded in 1990. The proportion of teenage men who had ever used a condom rose from 14 to 38 percent in the same period. In Zambia, too, condom use has risen among young people, to 31 percent among sexually active teenage women throughout the nation in 1996 from (*check) in 1989 (*check) in the capital Lusaka, where condom use has always been highest (*check). Among boys, condom use rose to 51 percent nationwide from (*check) in the capital in seven years. In Switzerland, levels of casual sex among young people have remained more or less constant since the late 1990s, but consistent use of condoms with those partners has risen dramatically.

The need to know more

HIV is a disease that thrives on ignorance. Individual ignorance about personal HIV status, group ignorance of the dangers of HIV transmission and how to minimise them, community ignorance about supporting and sharing lives with people who have AIDS, national ignorance about the levels of infection, its impact and how to cope with it.

Knowing about HIV, AIDS and risk behaviour

The first step in increasing knowledge about HIV and AIDS is to fill in the gaps that remain in knowledge about the disease itself, how it is transmitted, and how it can be avoided. Research in 1996 shows an impressive level of knowledge in many African countries, where more than nine people in 10 know about AIDS and are well-informed about routes of transmission. However there are still great gaps in knowledge in parts of the world where risk behaviour is high and the virus is spreading. In Nepal, for instance, a recent survey showed that just over one woman in four had ever heard of AIDS and even of that minority, a third had no idea how to avoid it.

To plan for HIV, AIDS and their social and economic consequences, governments and communities need as much information as possible about the virus and the behaviours that spread it. Sentinel surveillance -- which tracks the spread of the virus through different populations -- is in place in many countries. However, there are many countries where the virus appears to be spreading rapidly but where information is at best sporadic. And there are others, particularly with maturing epidemics, where there is virtually no information on behaviour that could help explain the relationship between total numbers infected and new infections.

Behavioural information functions as an early warning system, even before HIV is introduced into a community. Information on sexual and other risk behaviour helps countries to gauge who may be vulnerable to HIV infection and to act early to help people protect themselves before the virus takes hold. And it helps measure the impact of past prevention messages. Behavioural information in Thailand and Uganda, both of which have active prevention campaigns, have shown drops in risky behaviour over time. These behaviour changes have since been mirrored in drops in HIV infection.

HIV testing and counselling

UNAIDS estimates that over 30 million people are currently living with HIV, but the vast majority have no idea they are infected. The estimates of levels of HIV infection come mostly from sentinel surveillance, the routine testing of blood which was collected for other purposes (such as syphilis screening or blood donation). These samples only cover a very small fraction of the population and cannot be traced back to an individual. In knowledge of HIV status -- as in so much linked to the epidemic -- the gap between the developing and the industrialised world is vast.

In the United States, the Centre for Disease Control estimates that two in three people living with HIV know about their infection. In Germany, the proportion of AIDS

patients who knew their HIV status at least six months before an AIDS diagnosis was steady at close to three quarters in 1994 and 1995. Since 1995, when drugs that can delay the onset of AIDS came on to the market, the proportion has actually dropped to two thirds. This is because people who do know their status early have been treated and have been able to delay the onset of AIDS. People who do not know their status are more likely to go on and develop AIDS. The availability of treatment is a powerful incentive to get tested early.

In the developing world, the picture is very different. Few people have any hope of treatment, so there is little incentive to get tested. In many countries, there simply are no voluntary testing and counselling facilities; people have no acceptable way of learning if they are HIV infected. An ongoing study at a rural hospital in South Africa suggests that only two percent of people who are HIV positive know their status. The situation in urban Kenya seems to be as bad. Of 63 randomly chosen women who tested HIV positive in one study, just one was already aware that she was infected. The fact that current testing procedures usually require at least two visits to a test site further complicates the general lack of access to testing. This can be difficult or expensive for people living in isolated areas. In rural South Africa, just 17 percent of the people who asked to be tested came back for the results and the advice and support that goes with it. When an on-the-spot test was tried, nearly everyone (96 percent) chose to know the result.

Perhaps 27 million people don't know they are infected with HIV

Since the epidemic is concentrated in parts of the world where voluntary testing and counselling is rare, a conservative estimate might suggest that nine out of 10 infected people in the world do not know their HIV status. At current estimates, that would suggest there are over 27 million people in the world today who have the capacity to pass on a deadly virus but who have no idea they are infected.

Increasingly, ways are being found to prevent transmission, delay symptomatic AIDS or treat the infections which feed on people whose immune systems have been attacked by the virus. Not all of these are prohibitively expensive. The more people are aware of their infection, the more they can make informed and responsible decisions about their future. They may choose, for instance, to use condoms consistently to protect their partners from infection. In one study in Thailand, over 80 percent of study participants who tested HIV positive and received counselling to help cope with the consequences said they subsequently cut down on or eliminated unprotected sex. People may choose to become more actively involved in helping others in their community avoid the disease or cope with its consequences. They may choose to plan ahead for the welfare of their families after their death.

Women who know they are carrying the HIV virus may choose, where they can, to find a safe alternative to breastfeeding. New research shows that mothers are more likely to infect their children through breastfeeding than was previously thought. In the developing world, around two children in five born to an HIV-infected mother will be infected with the virus, more than half of them through breastfeeding. That means that by current estimates, some 300,000 children were infected with HIV in 1997 because of breastfeeding.

In many societies the stigmatisation of people with HIV is so great -- even where hundreds of thousands of people are currently infected -- that many people would rather not know their status. They fear they would be isolated and rejected. In fact, the more people know about their own infection, the more likely they are to get together to support one another. In countries with high levels of infection such as Uganda, communities began to organise to protect themselves against a further spread of the virus precisely because people started to speak out about their own infection and that of their families.

The impact of HIV on lives and economies

As the true magnitude of the global HIV epidemic becomes clearer, more thought has gone in to assessing its impact on societies and individuals.

A leading cause of death, HIV wipes out gains in life expectancy

HIV is systematically eating in to life expectancy in the countries where it is most common. The gains achieved over the last few decades in much of the developing world will in some places be eaten away by HIV. Life expectancy in Botswana rose from under 43 years in 1955 to 61 years in 1990. Now, with between 25 and 30 percent of the adult population infected with HIV, it is expected to drop back to levels last seen in the late 1960s. By the end of the decade, Zimbabwe will see 10 years wiped off the life expectancy of a child born in 1990. In Uganda, one study in a rural area measured the lifespan of the population as a whole and compared it with that of those people who were not HIV-infected. It concluded that where some eight percent of the population was HIV positive, the presence of AIDS in the community cut overall life expectancy by 16 years.

(GRAPHIC, from UN pop division data)

In many countries AIDS is the leading cause of death in adults. In the United States, after combination therapy to slow down the progression to AIDS was introduced in 1996, AIDS dropped into second place among leading causes of death in people aged 25-44 for the first time since 1992. Accidental injury took over in first place. In rural Uganda, AIDS accounted for 41 percent of adult death in one study. For men between 25 and 44, and for women between 20 and 44, AIDS caused seven out of every 10 deaths. In trading centres which are home to large numbers of younger adults, a third of whom are HIV-infected, nearly nine adult deaths in 10 are HIV-related. In Namibia, HIV causes nearly twice as many deaths across all ages as malaria, the next most common killer.

The high mortality due to HIV/AIDS also has major impacts on families. It is estimated that since the beginning of the epidemic more than 8 million children have lost their mothers due to AIDS below age 15. Many of these also lost their fathers, often putting themselves in hopeless situations. It is estimated that this figure will almost double by the year 2000.

The worst is still to come. Since the beginning of the epidemic, it is estimated that 11.8 million people around the world have died of AIDS and HIV-related causes. That is just a third of the number currently infected. Indeed, half as many people were infected this year alone as have died in the whole epidemic to date. Since an affordable cure for the vast majority of all people living with HIV is nowhere in sight, most of the 30 million people currently infected will probably die in the relatively near future, perhaps within the next decade.

Infant and child deaths rise, too

Developing nations have made great strides in reducing infant and child mortality in recent decades. These gains, too, are threatened by HIV. Already, a quarter more babies under the age of one in Zimbabwe and Zambia are dying than would be the case if there were no HIV. By 2010, the infant mortality rate is expected to rise by 138 percent because of AIDS, and the under-five mortality rate by 109 percent. In Cote d'Ivoire, child mortality will rise by over two thirds, and in Brazil by nearly a third.

(GRAPHIC?)

The financial burden of HIV

Estimates for Namibia put the medical expense of caring for HIV and AIDS patients at US\$ 28.6 million in four years time, up from 4.9 million now. If indirect costs of the epidemic such as lost productivity are factored in, the total would be 22 times that projected amount. The cost of HIV to the Namibian economy is expected to rise from 3.2 percent to 16.3 percent of gross domestic product. Unless radical moves are taken to prevent further transmission of HIV in Cambodia, it is estimated that the already resource-strapped country will over the next few years lose US\$ 2.8 billion in productivity and expenditure. Even in Indonesia, where HIV rates have remained low, one report estimates that less than 10 years from now, the government will be spending one third of its current health budget on treating AIDS patients. That does not include providing expensive retro-viral therapy.

Better estimation techniques reveal epidemic is worse than previously thought

These newly-released figures reveal that there are about a third more people living with HIV than was thought to be the case this time last year. This is for two reasons. Firstly, new infections are taking place at an alarming rate -- some 16,000 infections a day have added 5.8 million cases of HIV infection to the total in 1997 alone. Secondly, it now appears that previous estimates grossly underestimated the rate of transmission, particularly in Sub-Saharan Africa where the bulk of infections are concentrated.

Why do estimates change?

Estimates are based on certain assumptions about the start of the epidemic, the rate of new infections in urban and rural areas, the time between infection and death, and the maximum level of infection in the population. Until very recently these data were available for only a smattering of countries. It was assumed that the pattern of infection in other countries in the same region would follow those seen in countries where data was available. It seemed reasonable, then, to construct models to estimate the epidemic region by region.

This was first done for 1995. Information about levels of infection dating from 1994 or earlier was collected from as many countries as possible. From the proportion of people currently infected in various sentinel groups in each region and other available data, models were made to estimate the rate of growth of the epidemic and the total number of people currently infected, region by region. Extrapolations from this model was used to calculate the extent of the epidemic in 1996. It yielded an estimate of 3.1 million new infections over the year and brought to 22.6 million the number of people thought to be living with HIV.

By 1997, far more data were available and it became clear that there were huge differences in the way the epidemic developed in different countries and communities within the same region. So this year, UNAIDS improved its estimation techniques. The regional models were replaced by separate models constructed for each country, which were based on better measures of levels of infection and took into account the variations in patterns of infection, in survival time etc. New estimates were made country by country, and then added together into new regional totals. The resulting estimates, given in this report, showed that global levels of infection were underestimated in 1996 by over a third.

New infections in 1996 were in fact closer to 5.3 million than to the 3.1 million originally reported. The total number of people living with HIV in 1996 was in the range of 27.5 million, rather than 22.6 million as previously believed. That means that although this year's estimates are still shockingly high, there has been nothing like the doubling of new cases that might be suggested by looking at last year's published figures. Accounting for previous underestimates, there are some nine percent more new infections this year than last, and the number of people living with HIV has grown by 12 percent.

Where did the differences appear?

To see how much of the new totals were due to a rise in new infections and how much due to underestimates of previous levels, UNAIDS recalculated the totals for 1996 using the new methods of estimation. The results showed that previous estimates were correct for most of the world.

The bulk of the difference was in Sub-Saharan Africa. While infections there were originally estimated at 14 million in 1996, new information shows that the total would at that time have been closer to 18.3 million, against 20.8 million in 1997. New infections in 1996 would with current information have been estimated at 3.3 million in Africa alone. Two countries with large populations make up the bulk of the difference -- Nigeria and South Africa.

Why was infection in Africa underestimated by so much?

At the time the regional model for Sub-Saharan Africa was constructed, few countries had much reliable data and some, notably Nigeria, South Africa and Zimbabwe, had virtually none. The country with the best surveillance system was Uganda, and that showed that infection rates were beginning to level off, with new infections dropping in younger age groups. This was taken as a model for the whole region.

Unfortunately, infection in other countries has not followed the pattern seen in Uganda. The government commitment to responding to HIV that accounted for the good surveillance systems also encouraged an active response to the epidemic. Ugandans provided open information campaigns about the dangers of AIDS and communities organised to support safe behaviour. This contributed to a levelling off in infection rates. But in many other countries in the region, no such commitment has been seen, and infection rates have continued to climb beyond the levels thought possible in 1994, when data for the regional models was collected.

So are the new estimates definitive?

In general, none of the estimates given can be seen as precise numbers. They rather present the "best estimate" in a range of plausible numbers. UNAIDS and WHO believe that the new estimates given in this paper are as accurate as is possible with available data. But there is much that is still not known about HIV. More information about the course of infection, its impact on fertility and mortality, and the transmissibility of different strains of the virus will change some of the assumptions made in the current models. A clearer picture of current levels of infection, particularly for countries with large populations and poor data such as India, will improve future estimates. And the efforts governments and communities put into changing the course of the epidemic in their countries should have an impact on the rate of new infections and so on estimates and projections.

UNAIDS and WHO will continue to improve estimation methods as new information becomes available.

UNAIDS Fact Sheet 1997: Global Summaries for HIV/AIDS.

VARIABLE:	BY:	YEAR 1996	YEAR 1996 ALT. ESTIMATE §	YEAR 1997	YEAR 2000*
Number of persons	Total	3.1 million		5.8 million	
newly infected with	Adults	2.7 million	4.8 million	5.2 million	
HIV	Women			2.1 million	
(HIV incidence)	Children <15 years	400,000		590,000	
Current number	Total	22.6 million		30.6 million	40.8 million
HIV infected	Adults	21.8 million	26.1 million	29.5 million	37.8 million
(HIV/AIDS prevalence)	Women	9.2 million		12.1 million	15.1 million
	Children <15 years	830,000		1.1 million	1.5 million
Cumulative	Total	29.4 million		42.5 million	61.5 million
number of	Adults	26.8 million		38.7 million	55.6 million
HIV infected	Women	11.3 million		16.1 million	22.9 million
	Children <15 years	2.6 million		3.8 million	5.9 million
Cumulative	Total	8.4 million		12.8 million	> 22.2 million
number of	Adults	6.7 million		10.1 million	> 17.8 million
AIDS cases	Women	2.8 million		4.4 million	> 7.7 million
	Children <15 years	1.7 million		2.7 million	> 4.4 million
Number of	Total	1.5 million		2.3 million	> 3.3 million
new AIDS deaths	Adults	1.1 million		1.8 million	> 2.7 million
	Women	470,000		820,000	> 1.2 million
	Children <15 years	350,000		460,000	> 620,000
Cumulative	Total	6.4 million		11.8 million	> 20.7 million
number of	Adults	5.0 million		9.1 million	> 16.3 million
AIDS deaths	Women	2.1 million		4.0 million	> 7.1 million
	Children <15 years	1.4 million		2.7 million	> 4.4 million
Cumulative number				8.2 million	> 14.6 million
orphans to AIDS *					

*An orphan is defined as an HIV-negative child <15 years of age who lost mother/parents to AIDS

** Year 2000 projections for HIV incidence, prevalence and cumulative HIV figures are based on the assumption that HIV incidence for 1997=1998=1999=2000 in the western world (e.g., West Europe, North America, Australia and New Zealand).

Year 2000 projections for Cumulative AIDS and incidence and cumulative AIDS deaths are based on the conservative assumption that no AIDS deaths will occur in western countries after 1997

§ The alternative HIV incidence and prevalence estimates for adults are generated using the new modeling approach that were used to generate 1997 and year 2000 data. The discrepancy between numbers published in the fact sheet of 1996 and those alternative numbers are largely explained by a profound underestimation of the magnitude of the HIV-AIDS epidemic in South Africa and Nigeria.

Two tables for Factsheet 1997

REGION	CURRENT ESTIMATES, DEC 1997				PROJECTIONS FOR YEAR 2000		
	Children living with HIV/AIDS	Children who ever died of AIDS (cumulative)	Children orphaned due to AIDS (cumulative)		Children living with HIV/AIDS	Children who ever died of AIDS (cumulative)	Children orphaned due to AIDS (cumulative)
West Europe	5,200	2,800	8,700		5'200	>2'800	>8'700*
Sub-saharan Africa	1.0 mil	2.5 mil	7.8 million		1.2 million	4.1 mil	13.7 million
South & South-East Asia	89,000	100,000	220,000		140,000	230,000	610,000
North America	10,000	7,600	27,000		10'000	>7'600	>27'000*
North Africa & Middle East	7,000	4,400	14,200		9,500	8,000	30,000
Latin America	16,000	22,700	91,000		20,000	35,000	150,000
East Europe & Central Asia	4,600	4,200	30		12,000	10,000	4,500
East Asia, Pacific	3,200	1,700	1,900		11,000	6,000	9,000
Caribbean	9,200	14,100	48,000		12,000	22,000	79,000
Australia & New Zealand	30	50	300		3	> 1	> 300*
TOTAL	1.1 mil	2.7 mil	8.2 million		1.5 million	4.4 mil	14.6 million

	REGION	Total population 1997	Distribution of total population on regions	Prevalence of all HIV (adult+children numbers) infection using the total population as denominator	Adult Population aged 15 to 49 years, 1997	Distribution of adult population aged 15 to 49 years on regions	Adults & children living with HIV/AIDS in 1997	Current prevalence rate (adults 15-49 years of age)	Projection Year 2000: Adults & children living with HIV/AIDS	Percent of HIV-positive that are Women	Main mode(s) of transmission for those living with HIV/AIDS in 1997 (ranked)
10	West Europe	402 million	7%	0.13%	203 million	7%	530,000	0.3%	530,000	20%	M-M, IDU, H
9	Sub-saharan A	566 million	10%	3.68%	268 million	9%	20.8 million	7.4%	25.3 million	50%	H
8	South & South	1810 million	32%	0.33%	955 million	31%	6.0 million	0.6%	8.6 million	25%	H
7	North America	293 million	5%	0.29%	156 million	5%	860,000	0.5%	860,000	17%	M-M, IDU, H
6	North Africa &	310 million	5%	0.07%	164 million	5%	210,000	0.13%	220,000	20%	IDU, H
5	Latin America	446 million	8%	0.30%	240 million	8%	1.3 million	0.5%	1.6 million	19%	M-M, IDU, H
4	East Europe &	396 million	7%	0.04%	205 million	7%	150,000	0.07%	420,000	25%	IDU, M-M
3	East Asia, Pac	1430 million	25%	0.03%	815 million	27%	440,000	0.05%	1.3 million	11%	IDU, H, M-M
2	Caribbean	30.3 million	0.5%	1.03%	16.4 million	0.5%	310,000	1.9%	390,000	33%	H
1	Australia & N	21.7 million	0.4%	0.06%	11.5 million	0.4%	12,000	0.1%	12,000	5%	M-M, IDU, H
	TOTAL	5.7 billion	100%	0.54%	3.0 billion	100%	30.6 million	1.0%	39.2 million	41%	

THE NEW GLOBAL STATISTICS

People news infected with HIV in 1997	Total	5.8 million
	Adults	5.2 million
	Women	2.1 million
	Children < 15	590,000
No. of people living with HIV/AIDS	Total	30.6 million
	Adults	29.5 million
	Women	12.1 million
	Children < 15	1.1 million
AIDS deaths in 1997	Total	2.3 million
	Adults	1.8 million
	Women	820,000
	Children < 15	460,000
Total # of AIDS deaths since beginning of	Total	11.7 million
	Adults	9.0 million
	Women	4.0 million
	Children <15	2.7 million
No. of AIDS orphans since beginning of epidemic		8.2 million
Estimated no. of AIDS orphans by 2010		40 million

TALKING POINTS FOR GLOBAL AIDS INCREASE

11/26/97

The UNAIDS Program is releasing new estimates of the number of persons infected with HIV throughout the world. These estimates show an increase from 3 million new infections per year to 5.8 million per year. Over 90% of these infections are occurring in the developing world.

What does this mean?

These new estimates show that the epidemic is much larger than expected, primarily in the developing world. Part of this increase is attributable to the spread of HIV, and part is due to improved data collection by UNAIDS and the World Health Organization.

What is the impact?

This epidemic continues to take a devastating human toll. And in many of the developing countries in which it is raging, AIDS represents a major threat to economic stability because it is decimating people in their most productive years.

What is the US response?

The United States has always been a leader in the global fight against AIDS. We are the largest contributor to UNAIDS, and one of the principal sources of prevention and care through USAID. In addition, the investment made in AIDS research will benefit not only those in this country but around the world. President Clinton's recently announced AIDS Vaccine Initiative, in which he established a goal of finding a vaccine against HIV within ten years, is absolutely critical. This epidemic cannot be stopped without a vaccine, and the United States is leading the world in this quest.

OTHER QUESTIONS THAT MAY BE RAISED RELATING TO HIV/AIDS

With the new treatments and the decrease in AIDS deaths, are we seeing the end of the epidemic?

The new drug treatments have helped many people with HIV and AIDS live longer and more productive lives, but they are a treatment, not a cure. We do not have any evidence that the rate of new infections has slowed this country. Globally, UNAIDS just released its estimate of new annual infections, which nearly doubled from 3 million per year to 5.8 million per year. More accurately, we are at the end of the beginning and not the beginning of the end. We must not let the good news of these promising treatments make us complacent.

What is the Administration doing on needle exchange?

This Administration fought to maintain the authority of the Secretary of HHS to remove the restriction on allowing states to use federal funds for needle exchange programs. The Secretary is gathering the scientific data on this issue in compliance with the directive of Congress. Decisions of this kind should be made by public health experts and scientists.

What is the US doing to help with the global epidemic?

The United States is the largest contributor to the UNAIDS program, a multinational effort to address the global AIDS pandemic. In addition, the USAID program through the Department of State is a leader in the provision of technical assistance, support, and prevention efforts in the developing countries where the epidemic is raging. The President's recent HIV Vaccine Initiative established a goal of finding a vaccine against HIV within ten years, and is the best hope of stopping this epidemic.

Are AIDS programs getting an unfair proportion of funding?

No. The AIDS epidemic is special. It is a contagious disease that strikes disproportionately in the young and the poor, and has a devastating impact on those who are in the most productive years of their lives. In addition, our investments in AIDS research provide a wealth of basic science information that benefits all diseases, including cancer and Alzheimer's.

How is the Administration helping to expand access to the new drug treatments?

We have increased funding for the AIDS Drug Assistance Program 450% since 1992, and have tripled funding for the program that helps people access and maintain care (Ryan White CARE Act). This is a growing challenge that will require a partnership between the federal, state and local governments and private industry.

effective vaccine, AIDS will soon overtake tuberculosis and malaria as the leading cause of death among persons between 25-44 years of age. Between 650,000-900,000 Americans are estimated to be living with HIV disease, and over 300,000 Americans have already died from AIDS.

Clinton Administration Accomplishments on HIV/AIDS. The Clinton Administration has made a sustained commitment to addressing the HIV epidemic through investments in prevention, research and treatment.

- **Increased funding for the NIH vaccine by 33 percent.** Funding for NIH vaccine research and development has increased over 33 percent in the last two years -- from \$111.1 million in FY 1996 to \$148 million proposed in the President's FY 1998 budget.
- **Funding for AIDS research, prevention and care increased by more than 50 percent in the first four years of the Clinton Administration.** Funding for AIDS Drug Assistance Programs (ADAP), which help low-income people purchase needed therapies, has tripled, while funding for the Ryan White CARE Act increased 158 percent. The approval of new AIDS drugs has greatly accelerated, with 16 new AIDS drugs and two diagnostic tests.

*Kwayulu - Natal
Northwest Prov
Mpamalang.*

SO 3 Results Package:
Enhanced Capacity to Provide Effective HIV/AIDS, STD,
and TB Prevention, Care, and Treatment (IR 5)

- I. Problem Statement
- II. Relationship to USAID/South Africa's Strategy
- III. Analytical/Consultation Process
- IV. Summary of Expected Results and Illustrative Activities
- V. Feasibility Analysis
- VI. Customer Service
- VII. Implementation/Management Plan
- VIII. Financial Plan
- IX. Performance Monitoring Plan
- X. Annexes
 - A. Results Framework
 - B. Performance Monitoring Plan
 - B. Assistance Checklist
 - C. Congressional Notification (as appropriate)
 - D. Initial Environmental Examination
 - E. Feasibility Analysis (National HIV/AIDS/STD Review: Volume I, Executive Summary)

GLOSSARY

AIDS	Acquired Immunodeficiency Syndrome
AIDSCAP	USAID Global Bureau HIV/AIDS Project (now completed)
ALP	AIDS Law Project
BNC	Vice President Gore-Deputy President Gore-Mcbecki Binational Commission
CDC	U.S. Centers for Disease Control and Prevention
CSW	Commercial Sex Worker
DFID	British Department of ____ International Development
D/G	Democracy and Governance
DOH	National South African Department of Health
EU	European Union
GP	General Practitioner
HCFA	U.S. Health Care Financing Administration
HHS	U.S. Department of Health and Human Services
HIV	Human Immunodeficiency Virus
HRSA	U.S. Health Resources Services Administration
ILRA	Intervention-linked Research Activities
IR	Intermediate Result
NACOSA	National AIDS Convention of South Africa
NAPWA	National Association of Persons With AIDS
NIH	U.S. National Institutes for Health
NGO	Non-governmental Organization
PASA	Participating Agencies Services Agreement
PCM	Prevention Case Management
PHC	Primary Health Care
PHN	Population, Health and Nutrition
PMP	Performance Monitoring Plan
PPASA	Planned Parenthood Association of South Africa
PSAP	Private Sector AIDS Presentation
PWA	Persons with AIDS
REDSO	USAID's Regional Economic Development Support Office
RF	Results Framework
RP	Results Package
SA	South Africa
SAG	South African Government
SANTA	South Africa National Tuberculosis Association
SOAG	Strategic Objective Agreement
STD	Sexually Transmitted Diseases (also Infections)
TB	Tuberculosis
USG	United States Government

I. Problem Statement

[TO BE DRAFTED -- CONTENT SUMMARIZED BELOW]

- {Severity of HIV/AIDS in South Africa and what it portends
- {Reference to major key findings of National Review
- {TB-HIV-STD link and integrated approach
- {provincial vs national coverage
- {process of collaboration
- {Focus on skills building as most sustainable strategy
- {Flexibility in programming given uncertainty in South African health care system

II. Relationship to USAID/South Africa's Strategy

The assistance described in this results package (RP) represents one of two key components of USAID/South Africa's health development strategic objective (SO3). The other is the Equity in Integrated Primary Health Care Project (the EQUITY Project). Together, these programs aim to improve the health care system and its delivery of health services in South Africa. While the EQUITY Project will strengthen the broader national integrated primary health care (PHC) program, this HIV/AIDS/STD activity will focus on critical priorities in strengthening the national HIV/AIDS/STD program itself. The activity described in this RP is solidly based on several key South African and USAID strategies and documents:

- ◆ Reconstruction and Development Plan
- ◆ The DOH White Paper for the Transformation of the Health System in South Africa (April 1997)
- ◆ The 1994 NACOSA/National AIDS Plan
- ◆ The July 1997 National HIV/AIDS and STD Review
- ◆ The October 1997 National HIV/AIDS Strategic Planning Meeting
- ◆ The USAID Strategy for Sustainable Development
- ◆ The USAID/South Africa Country Strategic Plan
- ◆ The USAID Global Bureau/PHN Center's HIV/AIDS Results Framework and USAID Bureau for Africa strategies.

The proposed HIV/AIDS activities are fully supportive of the National AIDS Plan and respond to many of the key findings from the National Review conducted in July 1997. As discussed elsewhere in this document, the National HIV/AIDS and STD Review was a major national activity sponsored by the national Department of Health to assess the status and gaps in implementation of the National AIDS Plan. Moreover, each of the results and illustrative activities identified in this RP are responsive to strategies and activities identified in the National AIDS Plan.

Results and illustrative activities contained in this RP are in agreement with the USAID/South Africa goals and objectives. The goal of the USAID/SA program is Support for Sustainable Transformation. The expected result from this program is to increase the capacity of the health care system, particularly at the provincial level, to deliver HIV/AIDS/STD and related services. In order to achieve this, the activities and strategies identified in this RP will contribute to the overall health care system's transformation, and ultimately to the national transformation.

SO3 Linkages

The ability to deal effectively with a rapidly expanding HIV/AIDS epidemic, along with its STD and TB co-factors, is a critical component of an equitable, unified, and sustainable health care system. The SO3 strategic objective is stated as "more equitable and sustainable system delivering integrated PHC services to all South Africans." There are important linkages and synergies among the five SO3 intermediate results (IRs). For example, IRs 1-4 address expected results surrounding increasing access to and the effectiveness of management of integrated PHC delivery systems, including training, referral and management skills development. The activities under this RP will maximize the synergy with the other four IR activities, which are initially focused on the Eastern

Cape Province. This will include USAID program management coordination, sharing of EQUITY Project materials with the RP implementation team, and providing opportunities for co-training opportunities. In particular, the RP implementation team will coordinate fully with the HIV/AIDS program elements being implemented within the EQUITY Project.

Linkages with Other USAID SOs

Given the multisectoral nature of HIV/AIDS/STDs, the RP implementation team will seek opportunities to work with other SO teams within the mission. In particular, Education (SO2) provides special opportunities given the relationship between schools and HIV education, and Democracy/Governance (SO1) offers linkages with respect to increasing political commitment and advocacy. The other three SOs (economic policy, private sector, and housing) can work with SO3 in assessing the potential impact of HIV/AIDS and addressing multisectoral issues; and may be able to benefit from involvement with HIV/AIDS issues through education and distribution of information.

III. Analytical/Consultation Process

The development of the IR 5 results framework and package is based upon the historic program of HIV/AIDS assistance directed primarily at NGOs regarding capacity building and service delivery (since 1991). The new program was planned using reengineering principles, and takes account of the evolution of the HIV/AIDS epidemic in South Africa, changes in government, restructuring of the SA health care system, evolving relationships within the country (government and NGOs), and USAID priorities.

A. Consultation Process

The mission began planning the new program design a year prior to the final design with discussions with the SA Department of Health's HIV/AIDS/STD Directorate and other Departmental representatives, as well as with numerous NGOs and partners. Meetings were also held with various partners throughout early and mid-1997. During this period, the national DOH also was in the midst of planning for its future program and USAID agreed to work jointly to ensure maximum synergy. One example of USAID input occurred when the DOH had initially planned two separate reviews, one for HIV/AIDS and the other for STDs, and USAID suggested combining them. The Department took the advice, combined the reviews, and conducted it during July 1997. USAID was invited to participate in the National HIV/AIDS and STD Review by serving on the coordinating committee and providing 7 technical team members (1 USAID/SA, 2 USAID/W, 1 USAID/REDSO, 1 AIDSCAP, 2 CDC). The purpose of the national review was to review the implementation of the HIV/AIDS/STD program against the three principal objectives of the original NACOSA/National AIDS Plan, to assess the current situation in the country, and to mobilize new commitment against HIV/AIDS/STDs. USAID/SA had agreed to use the results of the comprehensive national review as the analytical base for its own program design. The national review also was led by the national DOH with strong participation by NGOs and CBOs, provincial governments, universities, donors, and other stakeholders, representing a highly participatory and transparent process.

The review was followed up by a national strategic planning meeting, sponsored by the DOH, during the first week of October, 1997. This meeting began to identify next steps for national and provincial action in response to the national review. Participants included representatives from provinces, NGOs, and donors, including USAID (4 persons). At the conclusion of this meeting, and resulting from it, Ms. Rose Smart, DOH HIV/AIDS Director, announced three preliminary directions for USAID assistance: capacity building (primarily at the provincial level), advocacy/leadership, and operations research. In addition, during this period of the last few months, USAID/SA staff have maintained close relations and discussions with a variety of partners, including NGOs, donors, and various levels of the SA government's health structure.

USAID conducted individual donor and NGO interviews in November 1997 to obtain key activity information. A one-day stakeholders meeting attended by 60 participants representing the DOH, provincial DOHs, the private sector, NGOs, and universities, explored in detail the programmatic direction for USAID's new HIV/AIDS program. This was followed up by a smaller meeting composed of nominated representatives of the initial stakeholder's meeting to review progress. The USAID/SA design team was also formulated to maximize coordination with the DOH, collaborating US Government agencies (HHS: CDC and NIH), as well as from USAID/Africa Bureau and from the USAID/REDSO office.

B. Bi-National Commission

The IR 5 results framework and package were developed in the context of the BNC priorities focused on in the July 1997 BNC meeting report. For HIV/AIDS, they included:

- Capacity building at a number of levels, including training of health workers in the public and private sectors.
- Facilitate the integration of TB and HIV/AIDS programmes
- Improve public and private sector management of major risk factors for HIV transmission such as STD treatment, partner notification, promotion of the use of barrier methods and counseling.
- Support for advocacy activities to promote a multisectoral response to the epidemic.
- Developing and piloting models of care along a continuum
- Establish a programme of community mobilization

Whereas these activity priorities were discussed as a basis for collaboration across the US Government and South African Government, the USAID program is solidly grounded in these priorities and addresses many of them.

C. Risks and Issues

The critical assumptions inherent in the Results Framework include the following:

- General political stability
- That key partners (DOH, NGOs, others) are willing to work collaboratively
- The economy remains stable, allowing for reasonable budget support to the health sector.
- Availability of drugs and commodities

Among the more specific issues relevant to this program, in view of both the programmatic links and the disease co-factors, is the continued support for an integrated primary health care approach encompassing HIV/AIDS, STDs, and TB. Overall threats to the implementation of an integrated health care system include such issues as the impact of the increased health care service volume arising from the free health care policy which could overburden the health facilities; increasing fiscal crises at the provincial level which may result in reduced support for health, retrenchment of personnel, and the lack of implementation or disruption in planned activities. Another threat to progress involves the potential conflict arising from the decentralization process whereby provincial, municipal, and in some cases regional redefinitions of boundaries and of roles and responsibilities leads to confusion and obstacles in implementation.

D. Re-evaluation of Development Hypotheses

USAID has recognized the very fluid nature of the health care system in South Africa. Although ongoing reforms are targeted at transforming the health care system to a more equitable and effective system, they also lead to delays and unexpected issues. In addition, the HIV/AIDS epidemic in South Africa is evolving. In recognition of these factors, the program has been structured in a way that recognizes that in three years time, the basic conditions governing the implementation of the program may change. Hence, the SO and management team (inclusive of the key stakeholders) for this program will revisit progress made and the underlying conditions every year with a major review in the third year of the program. As required, the expected results will be revised and programmatic directions changed as needed.

Throughout the life of this program, the management team will continuously assess progress and communicate with the stakeholders. The details of these processes are further defined under the implementation plan (section VII) and under the performance monitoring plan (section IX and Annex B).

IV. Summary of Expected Results and Illustrative Activities

A. Rationale and Results Framework

The expected results from this results package include a number of items. Of these, certain results were identified to be critical in the causality chain to a higher level intermediate result (IR), but do not involve USAID directly. These will be tracked by USAID and are represented by a dotted-line box in the results framework chart (Annex A). In addition, the results represent differential needs for investments to accomplish those results. For example, the capacity-building intermediate result will require the majority of available USAID resources within this program.

As indicated earlier, the major IR for this HIV/AIDS/STD activity is "the enhanced capacity to provide effective HIV/AIDS/STD and TB prevention, care and treatment." The three principal sub-IRs, along with the next lower level of results, are as follows (brackets indicate those results to which USAID will not directly contribute):

IR5.1 HIV/AIDS, STD, and TB program performance strengthened (primarily in selected provinces)

- IR5.1.1.** Provincial Department of Health management capacity increased
- IR5.1.2.** Broad-based implementation networks developed and implemented
- IR5.1.3.** Research outcomes used to strengthen service delivery
- [IR5.1.4.** NGO and local organization capacity and involvement strengthened]

The National Review findings and stakeholders have repeatedly pointed out the immediate need for HIV/AIDS related planning and management strengthening at the provincial and program levels. Such capacity building is critical to the South African government's and its partner's ability to respond effectively to the prevention and impact reduction of the pandemic. In order to achieve this result, the Provincial Department of Health must become an effective body concerning the oversight, planning, and implementation of HIV/AIDS and related activities. Given the numerous organizations and stakeholders in any one province, and limited USAID resources, the stakeholders recommended the formation of provincially-based partnerships and networks to increase coordination and collaboration. This method would also assist in maximizing USAID's impact and lead to greater sustainability. Critical to all decision making is the use of information (epidemiological, programmatic, and research findings). Hence, activities are recommended in this area. Finally, working through the networks, USAID will support management strengthening of NGOs and other partners. However, USAID will not develop a program of large scale individual NGO capacity building. Other organizations such as the EU, DOH, and DFID are funding programs to this end.

IR5.2 Multi-sectoral action for HIV/AIDS, STD, and TB policies, and programs improved

- [IR5.2.1.** Public awareness increased]
- IR5.2.2.** Commitment in support of HIV/AIDS, STD and TB prevention, care, and treatment programs increased
- IR5.2.3.** Sector specific HIV/AIDS programs developed

The National Review and stakeholders identified a number of key issues that preventing progress in combatting the HIV/AIDS epidemic in South Africa. These include large scale denial, fear, and inattention to the epidemic (resource wise). Specific sectors and audiences can play a role in HIV/AIDS prevention and care. In addition, resources (human and financial) are lacking at all levels. In order to help redress these obstacles, USAID will support advocacy training at the provincial level to enhance stakeholder's skills, as well as to provide technical assistance on certain key issues with an expected result of increasing commitment in support of HIV/AIDS programs. Sector-specific programs also need to be tailored to fit the individual sector. Finally, a change in the overall environment towards HIV/AIDS is based on a change in public awareness and acceptance. Given the heavy investment by the DOH and EU in the Beyond Awareness campaign, USAID will not be directly involved in this result area.

IR5.3 Selected strategies to reduce HIV/AIDS, STD, and TB transmission improved.

- IR5.3.1.** Newly implemented prevention care and treatment protocols improved
- IR5.3.2.** Case management strategy developed and improved
- [IR5.3.3.** Heterosexual maternal and infant transmission reduction strategies developed and evaluated.]

Increased effectiveness of the national response to HIV/AIDS is based not only on good program planning and management, commitment from all sectors in support of this program, but also on the availability of technically appropriate and up-to-date scientific and programmatic information. This information is used to develop strategies. In collaboration with the DOH, and being mindful of limited resources, USAID has identified key areas in which to support intervention-linked research to improve practices. These areas were selected based on the timeliness of the opportunity to make a difference, and on a prioritization of needs and awareness of other research activities being funded in South Africa. The illustrative activities include funding of a few modest research proposals, as well as providing technical assistance on research methodologies and design. Finally, other critical research areas are being supported by other donors and by other US Government agencies such as the National Institutes of Health and the Centers for Disease Control and Prevention (US Department of Health and Human Services).

The concept of linking HIV/AIDS, STD and TB reflects the comprehensive primary health care framework in the country by emphasizing integration among these three diseases.

The selection of these results is based on: input received from the DOH and from stakeholders, consideration of USAID's comparative advantages, available funding, BNC priorities, flexibility in programming to account for potential future changes in the South African health care system, and an emphasis on integration of HIV/AIDS with the other key co-factors (STDs and TB), as well as in the context of a comprehensive primary health care system.

B. Program Components

Guiding Principles. Based on the National Review, the national strategy workshop outcome, and extensive stakeholder input, guidance for USAID's HIV/AIDS/STD/TB assistance is clear. Capacity building, with a strong emphasis on the provincial level, has emerged as USAID's principal focus for assistance, in accordance with the following guiding principles:

- Assistance will emphasize involving South African organizations and individuals that are currently operational at the provincial level (eg DOH, NGOs).
- Assistance will focus on accelerating interventions to reduce HIV/AIDS/STD/TB prevalence and impact.
- Documenting and utilizing "lessons learned" throughout the comprehensive HIV/AIDS/STD/TB program currently underway in South Africa will provide guidance to all aspects of USAID assistance. "Better practices" based on lessons learned from one program experience will be further identified and analyzed, and adapted and expanded for use in other similar program settings.
- Assistance will focus on facilitating the building and strengthening of **networks and partnerships** among organizations working at the provincial level in order to maximize the prevention and reduction in impact of HIV/AIDS/STD/TB. A technical assistance team, likely led by an

institutional contractor but comprised principally of South African experts, will assist in the facilitation and phasing of the development of provincial networks, as well as coordinating all elements of program implementation.

The networks will be formed with the aim of bringing together actors to work on all relevant HIV/AIDS issues. The USAID assistance will be directed at a number of the overall assistance areas required. The goal is for the partnerships to remain viable and become an effective mechanism at the provincial level to support HIV/AIDS prevention and care programs and, thus, contribute to sustainability of efforts.

- **Four key components** will comprise assistance to provincial-level capacity building: 1) management and related support systems, 2) service delivery, 3) advocacy, and 4) use of quality data and findings/results from intervention-linked research.
- Activities will be phased and sequenced according to need.
- Capacity-building activities will be targeted to improve the effectiveness of HIV/AIDS/STDs and TB services.
- Selected capacity-building activities will focus on improving the continuum of care and increasing the distribution and use of condoms.
- All training will emphasize mentoring and follow-up.

In addition to capacity-building at the provincial level, there will be two additional illustrative activity components in this results package that will complement the provincial-level capacity-building: (1) specific, targeted national level activities in support of management and advocacy; and (2) specific, limited "intervention-linked research" activities.

Selected Provinces Approach. During the consultative process, stakeholders indicated their desire for USAID to support programming in the areas identified above in all nine provinces. However, the stakeholders also understood that in the best interests of maximizing results for the amount of financial resources available, a number of activities will be best implemented more fully in a few selected provinces rather than more superficially in many provinces. This will help to ensure both greater overall program impact and greater sustainability of the program interventions and systems introduced. In addition, there is a great need to learn about what works best and under what conditions and to be realistic about the time necessary to learn how to develop and implement the programs. Therefore, according to a set of selection criteria mutually agreed between the DOH and USAID, three provinces will be selected to implement capacity-building activities. These provinces are referred to as "selected provinces" and "early-implementation provinces" in this document. Lessons learned in the capacity-building effort will be documented and actively disseminated. For certain activities, all nine provinces will engage in activities supported through this results package. In addition, limited national-level capacity-building will be undertaken; illustrative activities for the national level are shown below. While USAID resources will only support comprehensive capacity-building in three provinces, an effort will be made to ensure that with adequate

planning and lead time, additional resources (through other donors, the national DOH, and perhaps the provinces themselves) will be identified and committed to ensure the rapid expansion of capacity-building activities to the other six provinces.

Illustrative activities. As indicated above, there are three interrelated areas of illustrative activities:

- (1) Capacity building at the provincial level;**
- (2) Selected national-level capacity building; and**
- (3) Intervention-linked research**

These components are described in the following subsections. The SO3 intermediate result(s) or sub-result(s) that each activity will help to achieve are noted in parentheses following the activity title.

1. Provincial capacity building

***Capacity Building Activity 1: Network Development* (IR 5.1.2)**

Recognizing the diversity among the nine provinces, formulation of networks and partnerships at the provincial level will differ. Some of the provinces will require little assistance in formalizing joint working relationships and plans, while others will require longer processes to develop operational networks. The Department of Health and the Provincial DOH HIV/AIDS Coordinator will serve as an integral part of each network. The technical assistance team will provide the following assistance to the early implementation provinces:

- 1) In partnership with the Department of Health in each province, conduct an inventory of the DOH and other organizations working in the HIV/AIDS/STD/TB sector and their capabilities. This inventory will supplement the existing South African AIDS Network directory, and will include an assessment of each organization's strategic involvement in the reduction of HIV/AIDS prevalence and its impact.
- 2) Prepare an analysis of the inventory of organizations with recommendations about the roles each could play in a provincial network.
- 3) In partnership with the provincial DOH, conduct an initial joint planning meeting to**** determine which organizations should cluster around the four key activity components (see previous page), which individuals or organizations have not been included and should be (including those in the private sector), and create follow-up fora, possibly in terms of "task forces" around each topic that will develop or refine workplans in support of the four capacity-building topic areas.
- 4) For a network to be effective, an entity within it should be established (possibly elected by the network), to ensure accountability. This entity

may exist in some provinces. This group could function in similar ways to a steering committee, until the network becomes better institutionalized.

- 5) Prepare a joint "phased" schedule for pursuing the development of workplans to develop models and mechanisms for capacity building in each of the four key activity components.

Capacity Building Activity 2: Management Support Systems: (IR 5.1)

The National Review identified several constraints in achieving the objectives of the National AIDS Plan, one of which was "lack of administrative capacity at provincial and local levels". Throughout the participatory/consultative process used to define appropriate activities for this results package, the need for capacity building in provincial level management was highlighted as critical to achieving impact in the national AIDS program. Once the provincial network is established and the "phased" schedule for capacity building formalized, the management "task force" with technical assistance and financial support from the umbrella program assistance group may consider these illustrative activities:

Activity 2A: Management Assessment: In order to improve the delivery of HIV/AIDS/STD/TB services, a "gap" analysis should be conducted to determine capacity weaknesses which prevent the efficient management of HIV/AIDS related services. Based on this analysis, management strengthening activities will be determined. This assessment will also guide the development of a skills training package.

Activity 2B: Management Training: In provinces where a management training system is in place, the analysis and training package will help to complement ongoing training activities (whether DOH or by other donors). In provinces without training system, a different model will be developed. At a minimum a training package will include:

- financial and resource allocation management
- human resource management,
- strategic and program planning,
- management information system development,
- project management,
- monitoring and evaluation.

Activity 2C: Performance Monitoring: Performance monitoring plans will be strengthened and tailored in accordance with the overall adjustments in the provincial management plan and in response to the training package. In some provinces there may be small adjustments, in others a more comprehensive alignment with the revised management plan will be necessary.

Activity 2D: Training of Management Trainers: The capability at the provincial level to provide on-going skills training is a critical element in capacity building. A strong focus will be placed on training of trainers within Capacity Building Activity One. The network together with the umbrella program assistance group will set objectives for TOT activities and will carefully monitor implementation. It is also expected that the TOT curriculum for management will become standardized to the extent possible in all of the implementing provinces. Linkages with the EQUITY project will provide access to

curriculums and materials already developed. Special emphasis on the DOH training unit designed to increase their capacity to provide the training on an ongoing fashion.

Activity 2E: Strategic and Programmatic Planning: As noted under Activity One B, this activity represents a major priority identified by the National Review and stakeholders. Approaches to these types of planning will be developed for use by the network and others. Emphasis will be placed on the implementation of plans and the feedback loop needed to link planning to implementation and evaluation.

Capacity Building Activity Three: Service Delivery (IR 5.1, IR 5.3.1, IR 5.3.2)

The National Review noted several weaknesses which relate to service delivery. Among those are: "lack of policies, guidelines, and management protocols for a comprehensive care and counselling strategy at both national and provincial levels" and "lack of adequate systems of referral and continuum of care encompassing prevention and treatment strategies". One of the recommendations in the National Review was to "set up mandatory training of doctors on the national guidelines for STD diagnosis and management". Considerable attention is now being paid to STD training and related diagnosis and treatment throughout the provinces, stemming from national attention and efforts.

This results package will support two targeted activities (described under A) and B) below) in the selected provinces, which will enhance the national plan and accelerate the appropriate response to the need for the continuum of care. A "service delivery task force" based in the network, at the provincial level, is envisaged as the accountable body for the two priority service delivery activities. The service delivery task forces from all of the early implementation provinces are expected to coordinate their content and implementation plans, and divide and share the development work related to these two activities.

Activity 3A: HIV Prevention Case Management (PCM): PCM provides intensive, individualized support and prevention counselling to assist persons to remain seronegative or to reduce the risk for HIV transmission to others by those who are seropositive. PCM is intended for persons who are having or who are likely to have difficulty initiating and sustaining safer behavior.

PCM involves the assessment of HIV risk behavior and the assessment of other psychosocial and health service needs in order to provide risk reduction counselling and to assure psychosocial and medical referrals (HIV/AIDS clinical management including TB screening and treatment, drug treatment, and other services). The referrals for care require providers to establish formal linkages in a **team approach**, so that the individual can be cared for in an environment of "shared confidentiality". In addition, assisting health care workers to manage PWA cases will be considered as part of this approach.

The service delivery task force together with technical assistance provided by the umbrella program assistance group will sensitize the medical community about this approach, adapt curriculum, and establish a training of trainers course to institutionalize PCM in the early implementation provinces. A performance monitoring plan will then be developed and implemented.

The introduction of PCM will account for the comprehensive primary health care approach used in South Africa and will assess the role of the health care worker and their availability.

Activity 3B: Overcoming Medical Barriers: The clinical provider's ability and desire to deliver quality integrated HIV/AIDS/STD/TB services is critical in the mitigation of the impact of AIDS. It is estimated that about 80% of clients seeking STD services are seen by private sector general practitioners. Nurse practitioners (and other public health workers) are also a key provider of related services. The service delivery task force with technical assistance and financial support will work together to develop advocacy and training strategies targeting this group of practitioners to incorporate PCM in their practices.

Special assessments to better understand the perspective of the health care worker and their attitudes will also be undertaken to help develop advocacy and training strategies targeting these workers.

Capacity Building Activity 4: Advocacy (IR5.2.2, IR 5.1, IR. 5.2.3)

A number of obstacles have been identified during the course of the National Review and consultations with stakeholders. Several key strategies have been identified at the national level to address these barriers and obstacles, to mobilize resources, and to create a supportive environment for HIV/AIDS activities. These strategies include:

- a) enhancing the ability of South Africans to advocate for resources, leadership and support, and to effect change in underlying factors preventing an effective response to the HIV/AIDS epidemic and its related conditions
- b) developing a coordinated approach to conducting advocacy for HIV/AIDS and related conditions in South Africa at the provincial and national levels
- c) focusing on influencing local leaders and developing their leadership potential regarding HIV/AIDS,
- d) supporting the inter-sectoral approach to preventing and mitigating HIV/AIDS/STD/TB (already underway through SAG)
- e) ensuring that advocacy efforts move along a continuum to policy change and formulation, action, and evaluation, and
- f) providing technical assistance on how to increase public support for policies and interventions conducive to successful HIV prevention efforts.

This results package will support activities, determined by the "advocacy task forces" within the networks formed in the early implementation provinces. Other advocacy activities will be supported at the national level and are described in the "National Level Activities section of this document".

To accelerate the implementation of the above recommended strategies at the provincial level the following activities will be supported by the umbrella program assistance group.

Activity 4A: Identification of Barriers: Advocacy task forces will need to determine the major constraints preventing full availability and access to the prevention of HIV/AIDS transmission and case managed care. Although overlap is expected in terms of

acceleration strategies among the provinces, specific barriers, often in terms of organizations and individuals will differ. Once a clear understanding is reached within a province about which barriers exist, and which strategies might be used to eliminate the barriers, a provincial advocacy plan and related activities can be developed.

Groups to consider include political candidates, religious groups, traditional leaders and the medical community, traditional healers and many others.

Activity 4B: Coordinated Planning for Advocacy. This illustrative activity is designed to assist provincial organizations, public and private, that are involved in advocacy for HIV/AIDS and related issues to increase their coordination in order to rationalize and increase their cumulative effect. Efforts can include the identification of key messages, audiences, strategies, and definition of a timetable, as well as deciding how to mobilize resources. Planning should be based on provincial level targets and locally identified provincial level barriers; identified in Activity Three A) above. It is anticipated that the coordinated training plan will require a multi-sectoral approach. In addition, an important component of this activity is to learn from the South African advocacy experiences to date, which represent an important potential resource that can be re-channelled.

Activity 4C: Materials Development and Improvement: Effective advocacy policy dialogue, and improvement of public awareness of HIV/AIDS relies on the availability and packaging of information. For example, target audiences which represents a barrier or constraint, need information which is designed to persuade them to improve their attitudes and perceptions about HIV/AIDS related issues. Information can be gathered and packaged for presentations to different audiences such as political decision makers, technical decision makers, business groups, and others. In addition, research findings from key studies should be translated into policy-relevant materials useful for advocacy.

A related illustrative activity includes the analysis and consensus on the use of models that project the impact of HIV/AIDS.

Activity 4D: Training of Trainers (TOT): Advocacy training has begun at the provincial level. Although designed to "train trainers", it is accepted that further efforts must be made to empower those trained, to train others. Currently, many of those trained have learned a great deal about how to implement advocacy, but require either follow-up technical assistance or additional training to be able to establish advocacy programs or to train others in advocacy skills. The advocacy task force with assistance from the umbrella program assistance group will evaluate TOT needs, plan training, improve (when necessary) curricula, and implement TOT training and follow-up activities. A related activity also requires that some assessment is made of past South African (especially NGO) advocacy efforts and to identify lessons learned. TOT and training approaches can then account for this basis and acknowledge what has worked.

Activity 4E: Denial Reduction/PWA Support Campaigns: There is clear recognition within the advocacy sector in South Africa that "denial" is a serious constraint in the prevention and care continuum. This includes denial by those who are HIV positive, those with AIDS, and those in the seronegative population who deny the risk of becoming HIV positive. A related aspect contributing to denial is the lack of a supportive environment for PWAs, which represents an important goal of advocacy. The provincial-level task forces will receive assistance from the umbrella program assistance group to learn more

about denial and the related PWA support strategies, prepare plans to address them, and conduct related campaigns and follow-up activities.

Capacity Building Activity 5: Use of Quality Data and Findings from Intervention Related Research. (IR 5.1.3, 5.2.2, 5.3)

It is widely recognized by the National Department of Health and many of the stakeholders that there are a number of lessons, throughout South Africa, that have been learned about "what works" programmatically in improving HIV/AIDS/STD/TB related services. However, it is also widely recognized that these lessons are not well understood or documented. To maximize the utility of lessons learned at the provincial level, **this results package will support the systematic assessment and documentation of lessons learned in all nine provinces.**

An inventory of lessons learned and documentation of better practices will be conducted. South African organizations, especially NGOs, often have initiated innovative approaches and programs which appear to be working on a small scale. To date, however, these activities have not been well-documented, evaluated, or shared with other NGOs or the Department of Health. An inventory of such programs and assessments and case studies of the most promising activities in the context of current HIV/AIDS/STDs/TB priorities would be an important step in reducing barriers to their adoption by others and expansion to the provincial or national level.

Criteria will need to be carefully selected and established in order to manage the examination of lessons learned in a cost-effective way. At a minimum the documentation of lessons learned should be conducted when the lesson:

- has been institutionalized or is likely to be
- can be cost-effectively replicated or adapted for expanded use elsewhere, and
- constitutes a "better practice" (an approach or strategy that "works")

Activity 5A: Selecting and Documenting Lessons Learned: This activity will begin ahead of a number of the others as an "early start" activity. Organizations and departments in all of the provinces will be canvassed to identify which lessons learned should be examined and documented using the agreed-upon criteria. As appropriate, site visits to the program or project will be made, interviews will be conducted, observations of the practices will be made, rapid assessments/case studies will be conducted to determine the results of the lesson or "better practice".

Activity 5B: Transfer of Capacity to Assess Lessons Learned: Provincial based operational staff will be targeted to work alongside those assessing and documenting lessons learned in a "mentoring" partnership to ensure the transfer of the skills necessary to provincial level staff. Decisions about which provincial-based individuals will receive mentoring will be made during the planning phase of this activity under A) above.

Activity 5C: Dissemination and Follow-Up: The findings from the documentation of lessons learned and better practices will be disseminated at the provincial and the national levels. Workshops and conferences will be planned for this dissemination, and follow-up

plans to monitor the expansion of the lessons learned will be prepared at the end of each of the meetings.

Activity 5D: Methodologies to Understand the Impact of HIV/AIDS: National Review results and stakeholder assessments indicate that there is a great lack of understanding of the impact, current and future, of HIV/AIDS on the health and other sectors. Development and application of methods to assess the impact on health care utilization and public expenditures will be developed.

Activity 5E: Capacity Development Process (CDP) for Intervention-Linked Research: The CDP for building and strengthening intervention-linked research in prevention and control programs is composed of the following three major activities or components:

Sub-Activity 5E(1): Development Workshop: Workshop for Utilizing and Developing Protocols for Intervention-linked Research Studies

The development, conduct, and evaluation of this workshop and capacity development process includes the following major activities: 1) developing the workshop materials, 2) developing and implementing an evaluation plan, 3) identifying trainers and expert lecturers, 4) identifying participants, 5) identifying the venue and conducting the workshop, 6) developing a technical assistance plan (TAP), 7) funding protocols, 8) implementing the technical assistance, 9) dissemination of results and lessons learned.

Sub-Activity 5E(2): Technical Assistance/Implementation and Evaluation:

Technical assistance represents a critical component of the "Capacity Development Process". The technical assistance will be tailored to the individual participant/province/district and is considered to be future oriented and dynamic. The technical assistance will be initially discussed during the workshop and then designed and developed with a partner mentor. The purposes of the technical assistance are (1) to build a stronger partnership among prevention partners, HIV prevention and tuberculosis control and prevention programs, and individual participants, (2) document future steps and assistance needed in carrying out the research protocol developed in the workshop, (3) document innovative practices and models that can be shared with other programs, and (4) enhance dissemination of findings from conduct of operations research and other lessons learned, (5) facilitate application/incorporation of research findings into program and policy.

The mentor will provide assistance through telephonic and written communications and will provide on-site consultation and assessment as needed. The technical assistance provided will be tailored to the needs of the individual and the province or district program.

Sub-Activity 5E(3): Workshop: Dissemination / Lessons Learned: Part of this Capacity Development Process includes the dissemination of results and lessons learned from the research conducted. It is expected that managers/researchers and mentors will share the lessons learned through meetings and publications. As part of facilitating the dissemination of results, a workshop will be planned to bring the researchers and their mentors together for this purpose. This sub-activity will be coordinated with the ongoing work of the Health Systems Trust.

The intervention-linked research utilization of research findings and protocol development workshop serves as the core for this capacity development process with the technical assistance plans and evaluation, and dissemination workshop serving as the essential follow-up components for mentoring, implementation, evaluation, and sustainability.

Activity 5F: Performance Monitoring Plan Indicator Baselines: For all performance results indicators found in the performance monitoring section of this results package, baselines will be established. A plan to systematically measure each indicator at appropriate intervals will be established as early on in the results package as possible.

2. Intervention-linked Research (ILR)

In recent years many institutional and community-based activities including various HIV/AIDS/STD/TB interventions have either been developed or are being planned that have a corresponding need for intervention-linked research. This research component is needed to improve the effectiveness, efficiency, cost-effectiveness, and quality of these interventions. In consultations with stakeholders regarding intervention-linked research, the following description of need was developed: The research should include documentation of better practices, scaling-up of successful interventions or pilot projects, improving the effectiveness and reducing the cost of existing interventions, documenting the cost effectiveness of linking prevention with care, and improving the criteria for focusing interventions.

Some of the following broad areas for intervention-linked research have been described as priorities by the DOH through consultative research committees: a) mass communication, b) management of STDs, c) barrier methods, d) care and support, e) workplace interventions, f) law reform, g) influential sectors, h) capacity building, and i) strategies for risk-reduction.

For this results package, the following activities were specifically discussed at stakeholder meetings, and determined to be priorities for consideration and further development.

- Alternative delivery systems for high-risk groups, including sex workers, truckers, migrants, military, and prisoners;
- Evaluation of newly implemented protocols, especially 1) barrier methods including both the male and female condom with special focus on youth; 2) vertical transmission - - breast-feeding, douching, short-course therapies, and 3) workplace guidelines.
- Operational strategies for focusing on the training of GPs, private nurse practitioners, and traditional healers in STD/HIV management and care.
- Developing models around the continuum of care for counselling, care and support strategies, and projecting future care and program needs.
- Development and evaluation of HIV/STD rapid testing methods and new technologies.

■ Capacity development in designing and implementing ILRA

High priority areas for intervention-linked research activities (ILRA) have been (detailed or delineated or discussed) or scrutinized with stake-holders, Department of Health, and USAID/South Africa. As a result of these discussions, intervention linked research activities will be assisted within this results package in three main areas. These are in addition to the lessons learned and better practices documentation described in section IV.B.1.

1. Alternative delivery systems for high-risk groups, including sex for survival, truckers, migrants, military, and prisoners;

The majority of South African high-risk groups seek medical attention outside the public sector or are underserved. The military, industrial workers (e.g. miners), and prisoners have separate health care systems. Most STD patients receive treatment from general practitioners in the private sector. Commercial sex workers (CSWs), immigrant populations, truckers, and rural populations receive intermittent care or none at all. Demonstration projects of innovative approaches or evaluations of current activities will remove barriers to the improvement and/or expansion of these services.

2. Evaluation of newly implemented protocols, especially 1) barrier methods including both the male and female condom with special focus on youth; 2) vertical transmission - - breast-feeding, douching, short-course therapies, and 3) workplace guidelines.

The Department of Health (DOH) has designed and is implementing guidelines and protocols for STD and TB treatment and HIV/AIDS prevention. Examples include acceptance and use of barrier contraceptives; short-course direct observational treatment systems (DOTS) for TB; and breast-feeding practices of HIV+ women. There is a need to evaluate the acceptability and effectiveness of these initiatives and, where necessary, to modify and improve them.

3. Development and/or evaluation of HIV/STD rapid testing methods, models and new technologies. Research advances are resulting in an array of new or improved diagnostic products for STDs, HIV/AIDS, TB, and other opportunistic infections. In addition, HIV/AIDS programs elsewhere in Africa are developing models for counselling, partner notification, referral, case management, and home care. Provision should be made to examine the suitability of these innovations for South Africa and the design of demonstration or pilot projects.

Research activities fall into categories for immediate implementation and for future implementation of follow-up or new projects. Two projects identified for early-start are A) Acceptance and use of condoms including female condoms by women and the male condom especially for male youth; and B) periodic presumptive treatment of STDs in high risk women: a community intervention.

Intervention-Linked Research Activity 1: Early Start Studies

Activity 1A: Female and Male Condom Acceptability, Use and Sustainability:

The European Union (EU) will provide large quantities of male and female condoms to the National HIV/AIDS and STD Program as part of the effort to promote protective behavior amongst youth and prevent sexually transmitted HIV. The EU plans an evaluation of condom distribution and use of male condoms, but, through an oversight, did not plan to monitor and evaluate the acceptability and use of female condoms. USAID's support office in Nairobi, REDSO/ESA, has received such a proposal from Family Health International. EU would welcome USAID funding of the proposal. This action would complement EU efforts and leverage project resources at modest cost.

Activity 1B: STD/HIV Prevention - - Free State - - Virginia: This proposal represents a continuation and expansion of a former AIDSCAP project involving Institute of Tropical Medicine/Antwerp, South African Institute for Medical Research, and Harmony Hospital from the Saaiplaas area. Initiated in September 1996, the demonstration project showed that presumptive treatment of female CSWs and syndromic management of male miners resulted in 1) an 80% reduction of STDs in women 2) a decrease of gonorrhea and chlamydia by 1/3, and 3) a reduction in genital ulcers by 2/3 in men. The pilot concentrated exclusively on STD reduction through treatment. It did not include either condom promotion or HIV diagnosis, counselling, and management. The study also found an unexpectedly high level of asymptomatic genitourinary infection (gonorrhea and chlamydia) in men. Before expansion and continuation, the pilot protocol should be revised to incorporate HIV/AIDS prevention and detection; barrier contraception promotion; validation of clinical and laboratory diagnostic criteria and procedures; and a rationalization of laboratory diagnostic test use as a cost reduction measure.

Intervention-Linked Research Activity 2: Developmental Projects

Activity 2A: Follow-up Projects: Follow-up projects/studies are follow-up projects expected to result from the current DoH solicitation for "Intervention-Linked Research and Pilot Projects in HIV/AIDS Care, Counselling, and Support". These one year studies will be funded in mid-December 1997. Follow-up proposals will be expected beginning in Year 2 of the project.

Activity 2B: New Projects/Studies: New projects are ideas, protocols, and demonstration or pilot projects stimulated by the HIV/AIDS and STD Program Review, USAID/Pretoria Share-Holders Sessions, and other sources. New projects will begin in year one of the project.

3. National-level Capacity Strengthening

At the national level, the Department of Health has provided leadership and support for HIV/AIDS activities. However, the Department lacks capacity in certain areas as well as sufficient staff to carry out their tasks. National NGOs involved with HIV/AIDS exist and have been historically active in HIV/AIDS and related work in South Africa (including NACOSA, NAPWA, AIDS Consortium, AIDS Law Project, PPSASA, SANTA, Red Cross, and others). Some of these organizations have changed their mission and all lack capacity in human resource terms as well as technical expertise in some areas.

An effective provincial response to HIV/AIDS and its related conditions is dependent on strong national public and private (NGO) sector bodies. For example, national DOH funding to the provinces requires a strong management capacity. Additional

responsibilities include regulatory, policy analysis, guidance and standard development, planning, evaluation, and multi-sectoral sector mobilization. Moreover, role clarification issues involving the provincial and national levels continues to be a problem, such as to what extent the national level can regulate provincial activities as opposed to simply funding them. National advocacy campaigns and efforts are also required to work with national political and public sector leadership, to influence national level policies and programs, as well as maximize effectiveness of various campaigns.

In order to strengthen the national level program management and advocacy efforts, the following strategies will be pursued:

- A. Selected programmatic management capacity building of the Department of Health.
- B. National organization advocacy assistance

Activity 1A: Selected programmatic management capacity of the DOH and of NGOs:

Assistance could be rendered in formulating packages directed at various sectors in support of an multi-sectoral/inter-departmental response to HIV/AIDS. This effort, for example, could include the development of sector specific AIDS responses, training for the non-health sectors, and development of organizational structures within the relevant department to address HIV/AIDS policy and programmatic issues.

Additional assistance could be provided on the National AIDS plan implementation processes and monitoring and evaluation. Assistance in development of impact assessment methodologies, data collection, and analysis to forecast the impact of HIV/AIDS on national public health expenditures and health care system utilization would help planning and advocacy efforts. Specialized areas of assistance could be rendered such as in monitoring and evaluation skills, integration of HIV and TB, intersectoral response development, as well as national NGO management, planning, and monitoring capacity. Additional support could be provided to the Deputy President's Inter-Ministerial Committee if requested.

Activity 1B: National organization advocacy assistance: Assisting in the development of a coordinated national advocacy planning process would help rationalize the various actors' contribution and their ongoing technical assistance needs. Specific technical assistance for how to advocate (including crafting and delivering messages, using data, etc) and on developing materials could be provided to a number of national organizations. Impact modeling, tried in several countries and proven to be effective, could be useful to influence decision makers about the severity of HIV/AIDS. In addition, assistance could be provided in how to formulate specialized campaigns targeted at specific audiences. These include the headquarters of national religious groups, business leaders, unions, media, political parties, political leaders, and other specialized groups that are best reached or can be most influential via national level efforts. A specific opportunity for political leadership and advocacy exists given the 1999 elections, and that many stakeholders believe HIV/AIDS should be a major campaign issue. Another specialized campaign, to be conducted in conjunction with provinces, involves changing behavior towards PWAs.

The introduction of a USAID developed method, the Private Sector AIDS Presentation (PSAP), could help mobilize the private sector.

V. Feasibility Analyses

Review of key findings from the National AIDS Review, the October 1997 Strategic Planning analysis, the November 12, 1997 Stakeholders meeting and follow-up meetings, a review of USAID capabilities, and any other documents.

Citation of data from Epidemiological Currents

Review of link of activities to the key findings described above.

VI. Customer Service

The participatory development of this results package has set the stage for future collaboration with our customers and obtaining and using their feedback. The Management Team, described in section VII B, provides the first opportunity for customer feedback. The team is composed of representatives of the national DOH, the focus province DOH, and of selected NGOs and key stakeholders from the networks. The role of the management team is to work collaboratively with USAID and project management to discuss issues and problems, resolve them, and to for the customers to provide guidance.

Customer needs will be assessed in several ways. In year one, a needs and gaps assessment will be conducted in the selected provinces providing the basis for project planning and for the design of training modules (Activity One A under section IV, Section 1). In addition, a national lessons learned/better practices review will take place that documents HIV intervention lessons learned across a wide array of organizations that will provide information on the broad base of customer needs.

The network structure, along with their component task forces, of the program has been designed so as to empower the customers to identify their prioritized needs that are to be met by the provided assistance. These needs may change over time and the program is designed to respond to these changes.

Additional sources of feedback information will include the update national reviews to the National AIDS Plan and the National Review conducted in July 1997.

Performance based monitoring for the networks as well as for USAID will provide ongoing information on the impact of the program. This will allow USAID to respond to positive or negative trends.

Specific surveys of various target customer audience needs, perceptions, and requests will be conducted as appropriate to the program and its components.

Feedback will be channeled through the networks to USAID, the management team, or the DOH and its communication to USAID, and/or directly to the USAID managers and program managers. The frequency of the opportunity to obtain the feedback is high. The management teams will meet once a month, surveys and other information collection (through a variety of mechanisms) will be ongoing, and USAID will practice an "open door" policy of receiving and listening to feedback.

VII. Implementation

A. Implementation Mechanisms

1. Obligation

Funds will be obligated through a bilateral Strategic Objective Agreement (SOAG) to be signed with the Department of Health and implemented in conjunction with the Department of Health. The Director General in the DOH will be the primary contact person for these activities, but it is expected that she will delegate specific authorities to other individuals in the DOH to facilitate implementation of the program.

2. Sub-Obligation

This results package is designed as a five-year Program which, after a significant consultative process (see section IV) and examination of all available avenues, four procurement mechanisms were identified. They include field support to a centrally funded Global Bureau contractor, as well as specific field support to another Global Bureau contractor and a grant to a South African institution for the conduct of two very specific intervention-linked research programs. In addition, agreements will be negotiated with other USG agencies such as the U.S. Department of Health and Human Services (which in turn represents access to its many component agencies) to provide specialized technical assistance over the course of the Program.

<u>ACTIVITY</u>	<u>A&A TYPE</u>	<u>INIT FY</u>	<u>FINAL FY</u>	<u>BUDGET (\$000)*</u>
1. Capacity Building	FS	96	00	9,000
2. Barrier Methods OR	FS	97	00	150
3. Early Start OR	G	97	00	225
4. TA	PASA	97	00	300

* Note that the budget allocations have not yet been finalized; thus the total does not add to \$10 million, the total amount of USAID funding.

Timing

The planned approach to the field support implementation activity is to obligate for the first three year period the amount necessary to implement the program and then to revisit the progress made and underlying conditions. This allows for any mid-course corrections to be made. Future field support would then be obligated.

Procurement Descriptions

The four procurements relate to the key intermediate result (IR 5) and its component results (5.1, 5.2, and 5.3). A brief description of each of the procurement mechanisms and the rationale for their choice follows.

a. Field support to the Policy Project to implement the majority of the results package (capacity building, advocacy, and interventions-linked research activities).

USAID/SA will use the Global Bureau field support mechanism to obtain the services of the centrally procured Policy Project (The Futures Group, Research Triangle Institute, CEDPA). The Policy Project has been working in close collaboration with the South African Department of Health for five months to facilitate the development of sound HIV/AIDS advocacy strategies. In this process, Policy has demonstrated the desire and ability to make maximum use of South African expertise, a key factor in the capacity building thrust of the results package. Having established productive working relationships with its South African partners, Policy is strategically positioned to more rapidly and effectively implement the results package. In addition, utilizing this centrally procured project will minimize the mission's management burden and will simplify the procurement process, facilitating a more timely implementation schedule.

In implementing the results package, Policy will make every effort to utilize local expertise. This is very important in the South African context, is appropriate, and is more cost-effective. With the exception of targeted Policy Project home office-provided technical expertise, South African persons and institutions should be used.

Policy will enlist a long term advisor for the first three years to manage the results package and provide technical assistance to build capacity in management. A second long term advisor will be employed for a two year period to support capacity building efforts across the result package activity areas. These advisors can be South African nationals.

The Policy Project will, in collaboration with South African partners, oversee and implement the majority of the results package. Initially, in a country wide effort, Policy will assess, document, and disseminate lessons learned and better practices. (Capacity Building Illustrative Activity Four.) Policy will also conduct research to identify alternative delivery systems for high-risk groups. (Interventions-linked Research Illustrative Activity One.) Additionally, Policy will refine the on-going training of trainers (TOT) in the advocacy program and provide advocacy training for provincial-level coordinators from all nine provinces. In a more focussed effort, Policy will collaborate with partners to establish provincial networks as the primary vehicle through which capacity building activities will be implemented. This effort will be undertaken in three selected provinces to be determined through a consultative process. Critical to more sustainable impact in the targeted locales will be intensive follow-up support in developing management, advocacy, and interventions-linked research capacity.

b. Field support to the FHI Family Planning and Contraceptive Technology Research Project to conduct early start interventions-linked research.

In conjunction with an EU funded study of condom use and distribution, FHI will evaluate the acceptability and use of male and female condoms. (Interventions-linked Activity Three: Study One.) This activity will be coordinated with the EU, as well as with the Medical Research Council and the DOH to avoid duplication (with their "fate of condoms" study)

- c. **Grant to conduct early start interventions-linked research (grantee organization not yet finalized).**

This grant will continue and expand on-going activities in the Harmony Mine Project. (Interventions-linked Research Activity 3: Study Two.)

- d. **Participating Agency Services Agreement (Interagency Agreement) with the U.S. Department of Health and Human Services (OS/OIRH)**

The PASA with the U.S. Department of Health and Human Services (Office of the Secretary, Office of International and Refugee Health) will provide short and medium term specialized technical assistance to be utilized in specific activities where the necessary expertise is not available locally. Consultants will work with local counterparts to develop capacity in the specified area of expertise. Expertise will be drawn from a variety of agencies composing the DHHS including, CDC, NIH, HRSA, and HCFA, as well as from available HHS grantees/contractors.

3. *Schedule for Implementation*

Implementation will begin in the 2nd Quarter, FY 1998. Field support transfer will occur on _____ to the Global Bureau Population, Health and Nutrition Center, Office of Population. [NOTE: check on Ob, de-ob issues regarding Equity funds and HIV/AIDS funds]

B. Personnel Requirements and Responsibilities

1. *USAID/SA Personnel*

Internal USAID/SA management and oversight of this program will be the responsibility of a professional FSN full-time manager who will report to the SO3 Team Leader, and will be assisted by an Administrative Assistant. The program manager will coordinate the providers of technical assistance and the overall activity management team.

2. *IR 5 Management Team*

The broad oversight and guidance for the program's activities will be provided by a management team composed (at a minimum) of representatives from the national DOH, focus province DOHs, and USAID/SA. NGOs and other representatives of the networks may also have a role in the management team. The team's deliberations will be advisory given US foreign assistance funding laws and regulations, but will function essentially as the EQUITY Project Strategic Management Team operates. The team will meet monthly and discuss operational and strategic issues. At a broader level, the team will annually consult with an expanded team of individuals who represent non-focus provinces and other civil society organizations.

The team will facilitate communication between contractor, USAID, and South African parties regarding the implementation of the program. The team will also assist in the selection of focus provinces and of providers of assistance via the review of proposals.

The USAID/SA and contractors will be expected to develop effective communication and partnership mechanisms within each of the focus provinces to maximize participation.

3. *Linkage with Other USAID/SA SOs*

The core USAID/SA staff responsible for the program will be responsible for linking with other USAID strategic objective teams to explore means to integrate HIV/AIDS programming information into their programs and to establish relationships among grantees, contractors, etc as the opportunities present themselves.

C. Selection Criteria for Focus Provinces

The National Review, the DOH Directorate for HIV/AIDS, and stakeholders identified the many needs present in South Africa regarding management capacity, program delivery, advocacy, and operations research skills. Assistance was requested to cover all provinces. In deliberating the program design and considering the level of resources, need for impact from the activities, and the need to learn from initial efforts in certain provinces, has led the mission to pursue a strategy of working primarily with selected provinces (three). The selection of these provinces will be discussed with the Department of Health and key stakeholders using from among the following criteria:

- Level of existing provincial capacity (if there is a minimum set of organizational preconditions)
 - A. Results of a "gaps" assessment
- Potential for province to serve as a model for others (replicability)
 - A. Prospect for learning and dissemination
- Access to HIV/AIDS/STD/TB/reproductive health donor funding
- Level of political commitment behind the DOH's HIV/AIDS program
- Prevalence rate of AIDS in the province
- Degree of migration across provincial borders
- Rural vs. urban based population
- Overall density of population
- Relationship to key constraints: which ones prevent any progress on a number of issues
- Prospect for intersectoral and intra-sectoral collaboration greatest

VIII. Financial Plan

Resource requirements for USAID

Counterpart funding

eg Provincial DOH/National providing space as in-kind

Tracking systems for USAID and counterpart funds

Obligation plan by fiscal year and mechanisms

Conditions precedent

Recurrent costs of those activities particularly related to sustainability requirements

USAID management costs

IX. Performance Monitoring Plan

The performance monitoring plan for this RP appears as Annex B. The indicators included in this plan are summarized below along with corresponding statements of each component of the RF. In addition to indicators of progress toward IR5 and the various lower-level results beneath it, indicators are included to complement those already tracked by USAID/South Africa at the mission goal level and the strategic objective level.

At the goal level, where USAID/South Africa has established "Improved Health Status" as a mission sub-goal, HIV prevalence figures among young women at antenatal clinics will be used as a general indicator of the course of the HIV/AIDS epidemic in South Africa. At the Strategic Objective level, trends in the use of condoms with "non-regular" partners will indicate the extent to which South Africans have begun to adopt safer sexual behavior, the most effective method to prevent HIV transmission. This indicator is intended to measure the overall level of success achieved by the South African health system, and South African society in general, in facilitating the behavioral changes necessary to reduce the impact of HIV/AIDS. It joins comparable indicators established at the SO level: the contraceptive prevalence rate to indicate use of family planning and immunization coverage rates to indicate use of child survival services.

The remaining indicators under IR5 comprise various measurements of essential intermediate results toward building South African capability to achieve this success, addressing necessary steps in capacity-building, policy development, and technical advancement that the mission's program will pursue.

Performance Monitoring Indicators related to SO3, IR5:

Sub-Goal: Political, Economic, and Social Empowerment (Improved Health Status)

- HIV Prevalence, pregnant women age 15-24, antenatal clinics nationwide

SO3: More equitable, unified and sustainable system delivering integrated PHC services to all South Africans

- Percent of men and women ages 15-49 who report the use of a condom during the most recent act of sexual intercourse with a non-regular partner.

IR5 Enhanced capacity to provide effective HIV/AIDS, STD, and TB prevention, care, and treatment

- Percent of individuals presenting with STDs in health facilities who are assessed and treated in an appropriate way (according to national standards)
- Number of service delivery points for HIV/STD, STD, and TB prevention, care, and treatment meeting basic minimum quality criteria (in selected provinces)

IR5.1: HIV/AIDS, STD, and TB program performance strengthened (primarily in selected provinces)

- Percent of provinces where integrated HIV/AIDS, STD, and TB services are routinely offered with PHC services

IR5.1.1: Provincial Department of Health management capacity improved

- Number of Provincial DOH's that are capable of designing, implementing, and evaluating HIV/AIDS, STD, and TB activities

IR5.1.2: Broad-based implementation networks developed and implemented

- Number of Provinces where HIV/AIDS Capacity-Building Networks have been established
- Number of Provinces where all three Task Forces have established Action Plans
- Number of Provinces where all three Task Forces have implemented Action Plans

IR5.1.3: Research outcomes used to strengthen service delivery

- Number of times research findings, evaluation results, or improved protocols adopted/applied in subsequent program design and implementation

IR5.1.4 NGO and local organization capacity and involvement strengthened (*mission not accountable*)

- Number of NGOs that are capable of designing, implementing, and evaluating HIV/AIDS, STD, and TB activities

IR5.2: Multi-sectoral action for HIV/AIDS, STD, and TB policies and programs improved

- AIDS Policy Environment Score (national)
- AIDS Policy Environment Score (by province)

IR5.2.1 Public awareness increased (*mission not accountable*)

- Percent of people aged 15-49 citing at least three acceptable ways of protection from HIV/STD infection

IR5.2.2 Commitment in support of HIV/AIDS, STD, and TB prevention, care, and treatment programs increased

- Percent of national health budget allocated to HIV/AIDS, STD, and TB programs
- Percent of local health budget allocated to HIV/AIDS, STD, and TB programs

IR5.2.3 Sector-specific HIV/AIDS programs developed

- Number of government ministries with appropriate HIV/AIDS policies
- Number of commercial firms with appropriate HIV/AIDS policies

IR5.3 Improved Strategies to reduce HIV/AIDS, STD, and TB transmission

- Number of reduction strategies evaluated
- Number of reduction strategies improved
- Number of new reduction strategies developed

IR5.3.1 Newly-implemented prevention, care, and treatment protocols improved

- Number of protocols evaluated
- Number of protocols improved

IR5.3.2 Case management strategy improved

- Strategy developed (yes/no)
- Strategy improved (yes/no)

IR5.3.3 Heterosexual, maternal, and infant transmission reduction strategies improved
(mission not accountable)

- Number of reduction strategies evaluated
- Number of reduction strategies improved
- Number of new reduction strategies developed

The above indicators are for purposes of program performance monitoring and are to be reported to in the annual Results Review to USAID/Washington. In addition, the following indicators are examples of other data to be monitored in conjunction with program activities and processes.

Lower-level process indicators to be monitored under HIV/AIDS RP:

Capacity-building activities (IR5.1):

Number of TOT workshops held

Number of trainers trained

Number of personnel trained by trained trainers

Advocacy for policy change (IR5.2):

Number of presentations (e.g. AIM, PSAP, etc.)

Number of workshops for advocates

Number of advocates trained

Number of advocacy strategies developed or improved

Intervention-linked research (IR5.3->IR5.1)

Dissemination of lessons learned and better practices

Number of USAID-supported research initiatives that receive follow-up funding from other sources

Data Collection

The indicators in the performance monitoring plan have been selected with data collection needs in mind. For the majority of the indicators, reporting will not require the creation of new data collection tools beyond those already in existence or those within the scope of routine activity reporting. Tables for each indicator in the Performance Monitoring Plan specify the source of data (see Annex B). Data collection instruments to be used include:

Demographic and Health Surveys (DHS): Two national, population-based surveys examining knowledge and behavior in the areas of health (including HIV/AIDS) and family planning are already scheduled for implementation during activities under this RP. These surveys will not require any additional funding under this RP. The 1998 DHS will coincide with the RP start-up of activities under the RP and establish timely baselines for two of the indicators in the PMP; a follow-up survey is scheduled for 2003, the year that activities under this RP are scheduled to be completed. Two of the 19 indicators included in the PMP will rely on the DHS.

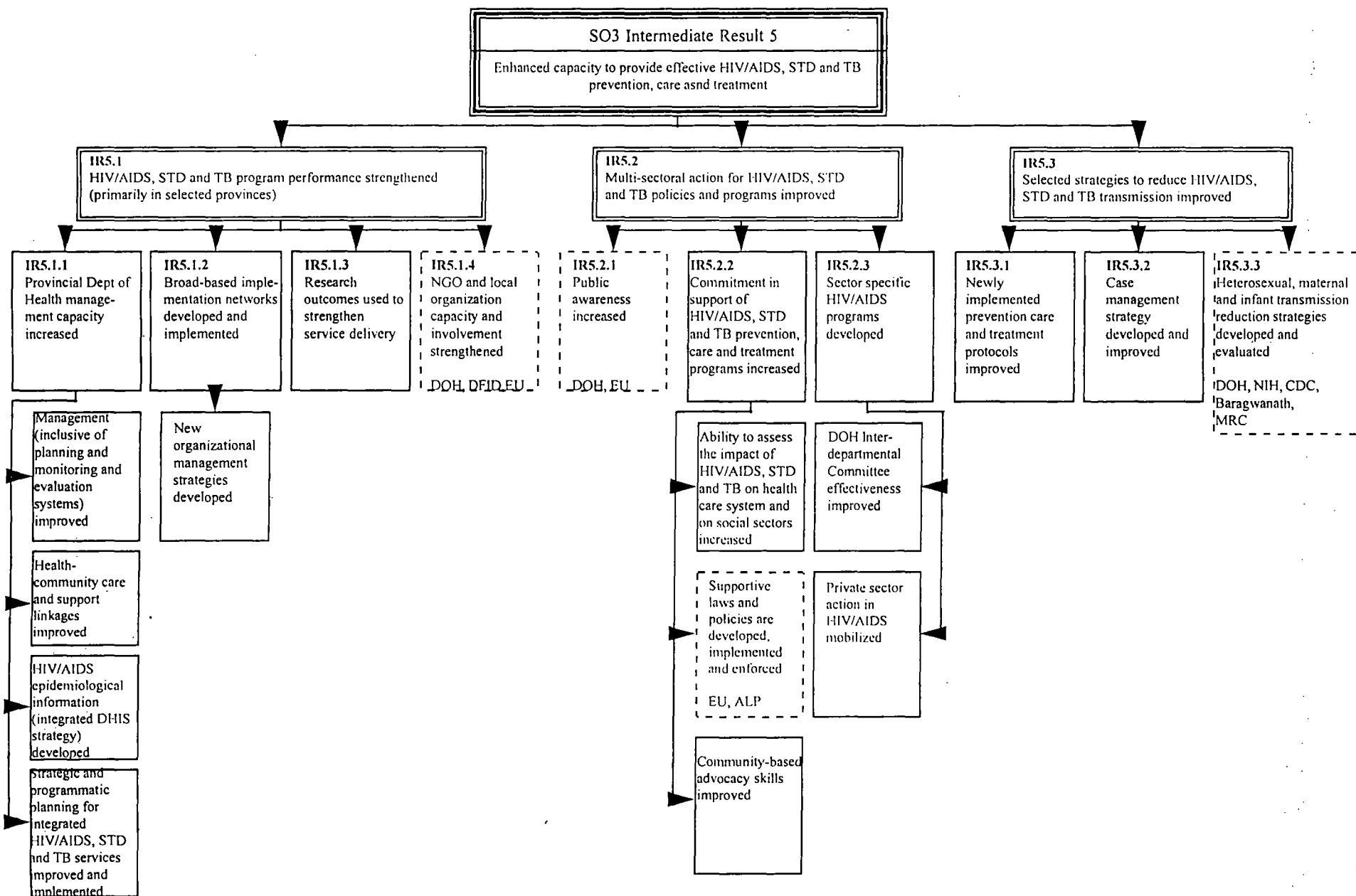
Routine Activity Reporting. Data for all of the indicators involving operations research (IR5) and all of the lower-level process indicators listed above will be the product of routine reporting by implementing organizations.

National and Local Government Data. Data for two indicators (HIV prevalence, % of health budget allocated to HIV/AIDS, STD, and TB programs) will be routinely available from the national Department of Health (DOH). Data to monitor the HIV/AIDS policies of various ministries will also be available from the DOH (Inter-Ministerial Committee on HIV/AIDS). Data on Provincial allocations for HIV/AIDS, STD, and TB programs will be obtained from Provincial DOH's in the focus provinces.

Health Facility Surveys, Organizational Assessments, Policy Assessments. Data on service quality, organizational capacity, and policy environment will require the implementation of health facility surveys and other assessments of organizational capacity and the policy environment. Wherever possible, relevant available data will be solicited from national and provincial governments as well as non-governmental organizations. Most importantly for the results being pursued under this RP, capacity-building for monitoring and evaluation at the provincial level will be designed to facilitate the collection of relevant data by provincial organizations, both for their own use and for USAID/South Africa's performance monitoring needs. Where local organizations are unable to produce data, the mission's implementing organization will be responsible data collection and reporting.

Where special survey tools are required, past experience of USAID/South Africa, USAID/Washington, and USAID's development partners in South Africa will ease the creation of such tools. USAID/South Africa is already engaged in monitoring organizational capacity in other sectors and can use this experience to great advantage for performance monitoring under this RP. The Mission is also supporting health facility surveys in Eastern Cape Province under the EQUITY Project. Tools to assess the HIV/AIDS policy environment have been created and put into operation elsewhere for USAID performance monitoring and are available from G/PHN/HIV-AIDS.

HIV/AIDS/STDs CAPACITY-BUILDING PROJECT RESULTS FRAMEWORK



ANNEX B

-Goal: Political, Economic and Social Development

Goal / Result: Improved Health Status

Indicator	Baseline Year & Value	1998	1999	2000	2001	2002
V prevalence, pregnant women 15-24, antenatal clinics nationwide	15.2% (1996)					
Data Unit:	percent					
Data Source:	DOH					
Frequency of Data Availability:	annual					
Responsible Officer:						

Comments:

This indicator is recommended by WHO (Prevention Indicator 9).

Baseline can be revised in 1998 to coincide with start of RP activities.

Data quality has been inconsistent from some provinces but is expected to improve.

Baseline calculated from DOH estimates for national population (*Epidemiological Comments* 23:2 (1997), p. 12, Table 3).

Strategic Objective 3: More equitable, unified and sustainable system delivering integrated PHC services to all South Africans

SO3: More equitable, unified and sustainable system delivering integrated PHC services to all South Africans

Indicators	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
of people ages 15-49 who report use of a condom during the most recent act of sexual intercourse with a non-regular partner - males - females - total	t.b.d. (1998)					t.b.d.
Data Unit:	percent	Numerator = men and women ages 15-49 who report use of condom in last act of sexual intercourse with a non-regular partner. Denominator = men and women ages 15-49 who report act of sexual intercourse with a non-regular partner in the last 12 months. For definition of "non-regular partner," see South Africa DHS 1998.				
Data Source:	DHS					
Frequency of Data Availability:	5 years					
Responsible Officer:						

Comments:

This is a USAID "Common Indicator."

Baseline and target can be established after results of 1998 DHS are available.

USAID-supported interventions will contribute to safer sexual behavior, and specifically increased use of condoms, among South Africans by improving access to effective HIV/AIDS prevention programs. Although not the only method of reducing the impact of HIV/AIDS, safer sexual behavior is currently the single most effective means of reducing HIV transmission.

5: Enhanced capacity to provide effective HIV/AIDS, STD, and TB prevention, care, and treatment

Indicator	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
of individuals presenting with Ds in health facilities who are assessed and treated in an appropriate way (according to national standards)	t.b.d.			t.b.d.		t.b.d.
Data Unit:	percent	Definition of appropriate is determined by national standards.				
Data Source:	health facility surveys					
Frequency of Data Availability:	every 2-3 yrs.					
Responsible Officer:						

Comments:
 EQUITY is establishing a baseline for Eastern Province focussing on syndromic management of STDs.
 Definition of agency-wide "Common Indicator" includes appropriate diagnosis only. Data for the common indicator will be available as a component of the above indicator ("assessed and treated in an appropriate way") and may be reported to G/PHN/HIV-IDS separately.

R5: Enhanced capacity to provide effective HIV/AIDS, STD, and TB prevention, care, and treatment

Indicator	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
of service delivery points for HIV/STD, STD, and TB prevention, care, and treatment meeting basic minimum quality criteria in selected provinces)	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	svc. delivery points	<i>service delivery points for:</i> - HIV/STD, STD, and TB prevention and case management - support for people living with AIDS, family members, and survivors <i>criteria:</i> to be determined through input from Provincial Networks and national coordinating body				
Data Source:	health facility survey / assessment					
Frequency of Data Availability:	annual					
Responsible Officer:						

Comments:
 USAID monitoring on this indicator will rely on the development of program monitoring capacity at the provincial level in focus provinces. Reporting from Provinces will come from the provincial DOH and/or the provincial capacity-building networks.

USAID/South Africa: Performance Monitoring Plan, SO3, HIV/AIDS Results Package (draft)

IR5.1: HIV/AIDS, STD, and TB program performance strengthened (primarily in selected provinces)						
Indicators	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
# of provinces where integrated HIV/AIDS, STD, and TB services are routinely offered with PHC services	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	province	Specific criteria for integration of services to be determined.				
Data Source:	USAID/DOH assessment					
Frequency of Data Availability:	annual					
Responsible Officer:						
Comments: USAID's impact on integration of services will occur both in focus provinces and on a national level. Monitoring on this indicator will therefore consider developments on the national level though the greatest impact will presumably occur in focus provinces.						

[R5.1.1: Provincial Department of Health management capacity improved]

Indicator	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
# of Provincial DOH's that are capable of designing, implementing, and evaluating HIV/AIDS, STD, and TB activities	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	Prov. DOH	Provincial DOH = Provincial Office of Department of Health Definition of "capable of designing, implementing, and evaluating HIV/AIDS, STD, and TB activities" to be determined through consensus among USAID, the Provincial Capacity-Building Networks, and the national coordinating body.				
Data Source:	organizational survey/assessment					
Frequency of Data Availability:	annual					
Responsible Officer:						

Comments:

- The following organizational assessment tools may be adapted to suit the mission's needs to assess institutional development of Provincial Departments of Health in the context of program performance monitoring:
 - PASCA model has been proposed by G/PHN/HIV-AIDS as an instrument for USAID units to assess management capacity for HIV/AIDS programs in particular (see G/PHN/HIV-AIDS PMP).
 - PACT model was prepared specifically to monitor organizational capacity in the NGO sector and is being considered as a model for measuring NGO capacity building results (see PACT Handbook).
 - "Organizational Capacity Guide" is a survey instrument designed by the Human Sciences Research Council to measure capacity and effectiveness of organizations assisted under USAID/South Africa's SO4, supporting economic growth (see HSRC, Organization Capacity Assessment Instrument).
- Because USAID's greatest impact will presumably occur in focus provinces, survey instruments will monitor developments in those provinces only. Reporting may be conducted on the national level only if sufficient data are readily available to assess capacity elsewhere.

R5.1.2: Broad-based implementation networks formed and improved

Indicators	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
# of Provinces where HIV/AIDS Capacity-Building Networks have been established # of Provinces where all three Task Forces have established Action Plans # of Provinces where all three Task Forces have implemented Action Plans	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	Prov. DOH					
Data Source:	assessment by USAID/South Africa					
Frequency of Data Availability:	annual					
Responsible Officer:						
Comments:						

R5.1.3: Research Outcomes Used to Strengthen Service Delivery						
Indicator	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
of times research findings, valuation results, or improved rotocols adopted or applied in bsequent program design and nplementation	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	adoption or application					
Data Source:	monitoring by USAID implementing partner					
Frequency of Data Availability:	annual					
Responsible Officer:						
Comments: Monitoring for progress under this IR will be conducted as follow-up to monitoring of intervention-linked research conducted under IR5.3.						

IR5.1.4: NGO and local organization capacity and involvement strengthened

Indicator	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
# of NGOs that are capable of designing, implementing, and evaluating HIV/AIDS, STD, and TB activities	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	NGOs					
Data Source:	see comment					
Frequency of Data Availability:	annual (see comment)					
Responsible Officer:						

Comments:

1. USAID will not be held accountable for this result but may track progress to check assumption that others are achieving the result. Monitoring responsibility may ultimately lie at provincial level and/or with the DOH, DFID, or EU implementing organizations.
2. Some options for monitoring methods are outlined under IR5.1.1.
3. G/PHN/HIV-AIDS has proposed to monitor a "Measure of HIV/AIDS Community Based Organization (CBO) Institutional Strength (number with minimum institutional strength composite indicator)" which may inform efforts to monitor this indicator.

IR5.2: Multi-sectoral action for HIV/AIDS, STD, and TB policies and programs improved						
Indicators	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
AIDS Policy Environment Score • national • by focus province	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	index score					
Data Source:	USAID implementing partner					
Frequency of Data Availability:	annual					
Responsible Officer:						
Comments: The AIDS Policy Environment Score is an agency-wide "Common Indicator." It is calculated through an index examining the degree to which the policy environment in a given country supports efforts to: (1) prevent the spread of HIV/STDs (2) provide quality care for people with AIDS (3) ensure the rights of people with AIDS (4) ameliorate the negative impact of AIDS on individuals, families, communities, and society						

IR5.2.1: Public awareness increased						
Indicators	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
% of people aged 15-49 citing at least three acceptable ways of protection from HIV/STD infection - males - females - total	t.b.d. (1998)					t.b.d.
Data Unit:	percent	Acceptable ways of protection include 1. Abstinence 2. Use of condom 3. Reduction of number of partners/mutual monogamy				
Data Source:	DHS					
Frequency of Data Availability:	5 years					
Responsible Officer:						
Comments: 1. USAID will not be accountable for progress toward this intermediate result but will monitor the indicator in order to check the assumption that awareness is increasing. Though the result implies an increase in general awareness of HIV/AIDS, STDs, and TB, the indicator focusses on personal awareness of methods to prevent HIV transmission, for which data will be readily available following the 1998 Demographic and Health Survey (DHS). Other interim survey data may be used if available before a second DHS (planned for 2003). 2. This indicator will be monitored globally by G/PHN/HIV-AIDS. A variation on this indicator is recommended by WHO (Prevention Indicator 1, specifying that only two methods need to be cited).						

IR5.2.2: Commitment in support of HIV/AIDS, STD, and TB prevention, care, and treatment programs increased

Indicators	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
% of government health budget allocated to HIV/AIDS, STD, and TB programs • national • by focus province	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	percent	Reporting to include both numerator and denominator as well as percentage. Numerators may also be reported adjusted for inflation to better indicate the real trend in spending in fixed-value currency.				
Data Source:	Budget reports by Govt. of RSA, Provinces					
Frequency of Data Availability:	annual					
Responsible Officer:						
Comments: Budget figures are a proxy for overall public sector commitment. The national figure is nearly identical to the agency-wide common indicator, which specifies spending allocated to HIV/AIDS programs only. If available, national budget data for HIV/AIDS programs only may be provided as well.						

IR5.2.3: Sector-specific HIV/AIDS programs developed						
Indicator	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
# of government ministries with appropriate HIV/AIDS policies	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	ministry	appropriate HIV/AIDS policies = establishment of HIV/AIDS program within sector, appropriate internal policies <i>(needs refining)</i>				
Data Source:	DOH					
Frequency of Data Availability:	annual					
Responsible Officer:						
Comments: 1. This indicator is intended to measure the effectiveness of advocacy efforts by the DOH Interdepartmental Committee on HIV/AIDS. 2. Scores from individual questions on the AIDS Policy Environment Index survey instrument may also inform reporting on this indicator.						

IR5.2.3: Sector-specific HIV/AIDS programs developed

Indicator	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
Number of commercial firms with appropriate HIV/AIDS policies	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	firms	appropriate HIV/AIDS policies = providing HIV/AIDS information and services to their employees, appropriate internal policies (employee regulations, insurance coverage, etc.) <i>(needs refining)</i>				
Data Source:	assessment by USAID implementing partner					
Frequency of Data Availability:	annual (?)					
Responsible Officer:						
Comments: 1. G/PHN/HIV-AIDS plans to monitor a similar indicator on a global level: <i>Number Commercial Firms Providing HIV/AIDS Information and Services to their Employees</i> . This may be calculated and reported separately. 2. Scores from individual questions on the AIDS Policy Environment Index survey instrument would also inform reporting on this indicator.						

IR5.3: Improved Strategies to reduce HIV/AIDS, STD, and TB transmission						
Indicators	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
# of reduction strategies evaluated # of reduction strategies improved # of new reduction strategies developed	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	strategy	"Reduction strategies" include means to interrupt heterosexual transmission and maternal-infant transmission of HIV as well as other methods of STD prevention and control				
Data Source:	USAID implementing partners					
Frequency of Data Availability:	annual					
Responsible Officer:						
Comments:						

USAID/South Africa: Performance Monitoring Plan, SO3. HIV/AIDS Results Package (draft)

IR5.3.1 Newly-implemented prevention, care, and treatment protocols improved						
Indicators	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
# of protocols evaluated # of protocols improved	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	protocol					
Data Source:	USAID implementing partners					
Frequency of Data Availability:	annual					
Responsible Officer:						
Comments:						

IR5.3: Improved Strategies to reduce HIV/AIDS, STD, and TB transmission						
Indicators	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
# of reduction strategies evaluated # of reduction strategies improved # of new reduction strategies developed	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	strategy	"Reduction strategies" include means to interrupt heterosexual transmission and maternal-infant transmission of HIV as well as other methods of STD prevention and control				
Data Source:	USAID implementing partners					
Frequency of Data Availability:	annual					
Responsible Officer:						
Comments:						

IR5.3.2: Case management strategy improved						
Indicators	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
Case management strategy developed Case management strategy improved	no (1998) no (1998)	t.b.d.	t.b.d.	t.b.d.	t.b.d.	yes yes.
Data Unit:	strategy	Define case management strategy here				
Data Source:	USAID implementing partners					
Frequency of Data Availability:	annual					
Responsible Officer:						
Comments:						

R5.3.3: Heterosexual, maternal, and infant transmission reduction strategies improved						
Indicators	Baseline	1999	2000	2001	2002	2003
	Year & Value	Target	Target	Target	Target	Target
of reduction strategies evaluated of reduction strategies improved of new reduction strategies eveloped	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.	t.b.d.
Data Unit:	strategy					
Data Source:	other donors, implementing partners					
Frequency of Data Availability:	annual					
Responsible Officer:						
Comments: USAID will not be accountable for progress toward this intermediate result but will monitor the indicator in order to check the assumption that strategies such as barrier methods are being evaluated and improved.						