World Vision

CONCEPT PAPER

Towards a Strategy for Addressing The HIV/AIDS Crisis in Africa

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Towards a Strategy for Addressing The HIV/AIDS Crisis in Africa

Submitted to:

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1. Background

In Africa, AIDS is a foremost cause of death. In 1998, more than 2 million people died of AIDS. This represents two thirds of all AIDS related deaths in the world, although Sub-Saharan Africa accounts for just 10% of world's population. At the end of 1998, some 22.5 million people, including 1 million children, were living with HIV/AIDS. In many African countries, the HIV virus continues to spread very fast. In 1998, approximately 4 million Africans became infected with about 10,500 new cases a day. In Botswana, Namibia, Zambia and Zimbabwe between 20 and 26% of the population ages 15 to 49 are infected. In twelve other Sub Saharan countries (including Ethiopia, Kenya, Mozambique, South Africa and Tanzania) 9 to 20% of adults are infected. Epidemiologists warn that what we are witnessing is the tip of an iceberg, as only 10% of the illness and deaths that this epidemic will bring have been seen. Millions of Africans are infected but have not yet started to fall ill. According to UNAIDS, 90% of those living with HIV do not even know it.

AIDS in Africa is more than an epidemic. It is a development catastrophe eroding many of the development gains made in previous decades. Unlike most diseases, AIDS targets people in the prime of their working lives and as parents. Generally most people who acquire HIV in Africa become infected before they are 25 years old, and are usually dead before their 35th birthday. This age factor makes AIDS uniquely threatening to families, communities and economies. Today, in many African countries, AIDS has already wiped out major gains in development registered in the past decade. Child vulnerability has increased as parents die off leaving children in the care of the sick, the elderly, or other children.

No sub-Saharan African country has escaped the virus. In the early 1990's, the epicenter for the epidemic was the Lake Victoria Basin countries of Uganda and Tanzania. Since then, the area of devastation has spread to cover the entire belt of countries from Ethiopia in East Africa to the countries of Central and Southern Africa, as well as the coastal countries of West Africa. HIV/AIDS is spreading especially fast in the Southern African countries of Botswana, Zimbabwe, Namibia, Zambia and South Africa. Demographers are attributing this faster spread to a late start (at the official level) in acknowledging the existence of the disease, against a background of significantly higher levels of internal and intra-regional migration

There is thus an urgent need to address the crisis of HIV/AIDS in Africa both on humanitarian as well as economic and security grounds. The two critical challenges that need to be tackled are:

- How can the HIV/AIDS infection rate be curtailed so that in time the numbers succumbing to it decline?
- How can societies best cope with the devastation to families and communities unleashed by AIDS?

2. Existing Best Practices for addressing HIV/AIDS.

A number of African countries have been planning and implementing HIV/AIDS programs since 1985. The first set of programs was designed by WHO and were monitored in-country by an AIDS Control Program Manager based within the Ministry of Health. As the epidemic

intensified, countries started developing strategies, with the help of UNAIDS, that identified priority areas and activities based on the determinants of the epidemic in-country. But, except for Uganda and Senegal, African leaders have not taken strong positions in support of these strategies. (Not a single African leader attended the last Global AIDS meeting held in Zambia.)

Available evidence from leading agencies working on HIV/AIDS and from countries where HIV/AIDS infection rates have been stabilized suggest a number of approaches for addressing the above challenges. All require a multi-sectoral approach within which issues of human sexuality are discussed openly with AIDS perceived like any other serious disease. Furthermore, communities must be empowered to play a leading role in addressing the challenges facing them. This requires commitment and leadership at all levels, starting with those in government, and including leadership in communities, business, labor unions, religious organizations, and NGOs. Experience has shown that only when there is this level of involvement can open and interactive discussion on issues of HIV/AIDS be possible. When such environment is fostered, it is possible to implement a coordinated package of initiatives that work synergistically to help people reduce the risk of HIV/AIDS infection and adjust to its aftermath. To date, specific approaches which have produced positive results in reducing the infection rate include:

- Increased faithfulness in marriage (or practicing 'zero grazing' as they say in East Africa)
- Delayed initiation of sexual activity (especially within the 15-24 age group)
- Discouraging un-protected sex among men with multiple partners
- Detection and early treatments of STDs in both males and females
- Maintaining safe blood transfusion supply
- Helping poor women who invariably depend on sex to have other ways of earning a livelihood
- Reducing vulnerability of women and girls in an adverse cultural environment
- Improving the well-being of people living with HIV/AIDS
- Making voluntary testing and counseling available and affordable
- Preventing transmission from mother to child
- Intense public education
- Easy access to condom distribution

In terms of coping with the aftermath, especially as it affects children, best practices thus far include:

- Youth related messages through music, video, radio and newspapers together with appropriate youth-friendly services
- Home based care of AIDS patients and increased access to HIV/AIDS related drugs
- Encouraging foster care for orphans
- Improved economic opportunities for households with orphans
- Reduced school fees so that children from poor families and AIDS orphans stay in school longer
- Educating children, especially girls, to enhance their abilities to avoid infection
- Establishing outreach programs for street children
- Social funds to help grassroots organizations cope

- Stimulating and strengthening community-based responses
- Ensuring that governments protect the most vulnerable children and provide essential services to them
- Building the capacity of children to support themselves
- Creating an enabling environment for affected children and families
- Improving economic opportunities, especially for women headed households
- Food programs for children and support for educational expenses
- Promotion of exclusive breastfeeding for 4-6 months, even in HIV positive mothers

The implication is that it requires the mobilization of ALL to ensure the well-being of ALL. This includes Government, whose role and commitment is key to creating the appropriate environment as well as ensuring that the necessary institutions are in place and functioning. It includes individuals, whose commitment to wellness is foundational to any initiative bearing results. It includes community organizations, NGOs and faith-based organizations to mobilize, inform and care for people at the grassroots level. Hence a multi-pronged approach targeting all the pathways through which HIV/AIDS spreads and exerts its impact is necessary.

Faith-based organizations are an essential part of this approach, given the high emphasis their teachings place on morality. Experience from Uganda, a country that has made the most dramatic turn around in the HIV/AIDS infection rate, suggests that through increased faithfulness in marriage and delayed onset of sexual involvement, especially among the 15 to 25 year olds, HIV/AIDS infection rate has significantly declined from 15% in 1992 to 9.5% in 1998. NGOs such as World Vision that operate broadly at the grassroots and have credibility with civil society also can play a key role in linking churches with communities.

3. WV's Experience Working with HIV/AIDS.

World Vision among the earliest NGOs to come up with a programmatic response once the devastating impact of HIV/AIDS became known. Its first significant response was made in 1990 in Uganda, where WV utilized funds from the Government of Uganda through a World Bank (IDA) credit to implement a program of assistance to orphans of HIV/AIDS and war in three districts. In the mid 1990's WV made an internal policy that required its Program Offices to add HIV/AIDS related activities within each of its existing health programs. To date a total of 65 projects in 11 countries have at least one goal that relates specifically to HIV/AIDS prevention. The bulk of these programs are in East Africa (24 in Uganda, 13 in Tanzania and 10 in Kenya). Zimbabwe and Mozambique have one project each. Malawi, South Africa and Zambia, have four such projects each.

In general WV's programs have been of varying magnitude and focus. The most notable one is WV's program of assistance to orphans of AIDS in the districts of Rakai and Masaka, in Uganda. This demonstrated the effectiveness of an approach that combines direct support to orphan children, coupled with initiatives geared to enhancing foster family productivity, and community recovery to create an environment where the needs of children could be catered for in a caring and sustainable manner.

World Vision, through its Child Survival Project in Kwazulu/Natal Province, South Africa, has actively targeted youth in schools to improve knowledge about the epidemic. Evaluation of those efforts prove they were effective in raising awareness regarding transmission and prevention of HIV. Also the program was successful in introducing teachers and parents to key concerns regarding reproductive health, sexual practices and communication in relationships. The project forged a strong collaboration with the Department of Education resulting in strengthening of training of teachers in both primary and secondary schools.

But further study is needed to determine how far educational efforts can impact on the behavior of adolescent school attendees over a longer period, especially those who are already sexually active at the time of the peer education encounter. One promising avenue may be through the churches as more than 75% of the youth reported regular church attendance, even those who were school leavers. As a follow-up to this initial work, the community is asking for AIDS education and assistance in caring for home cases. A new effort to combine micro-enterprise development with AIDS education for the community is now in the early stages of development.

Within WV, there has been limited replicability across countries or even within countries; the need for new programs remains great. Also, many of the major projects were of short duration and came to a premature close. Critical reasons for this state of affairs include the following:

- WV programs have been largely supported by government grants. Government grants have themselves been scarce, country specific, and of limited duration.
- The approach to HIV/AIDS has been project focused rather than setting out to address a problem programmatically. Hence projects have been started and phased out, while the problem has remained.
- We have only begun to capture the lessons learned; in so doing, our ability to be a significant influence in the evolution of HIV/AIDS related policies has been curtailed.
- Staff with the appropriate programming experience have not been able to stay with some of the strategic initiatives. This has tended to limit the ability of country programs to build credibility with the appropriate bilateral funding agencies.

4. The Challenge to World Vision

The key challenges for WV, an organization with major programs in Africa, are:

- To scale up activities relating to HIV/AIDS, Africa-wide to ensure that those who are not yet infected remain free of this virus. Currently, UNAIDS estimates that there are roughly 200 million adults in Africa who have not yet been infected by HIV/AIDS. In addition, the young, especially between the ages 5 through to 14 are free of HIV/AIDS. Hence a key challenge is to address the youth.

- To scale up within already devastated countries with programs that would enable communities to cope with the aftermath of HIV/AIDS, especially in those parts of Africa (such as the Southern African countries) which currently constitute the epicenter for this epidemic and where, for a variety of reasons, there has been less programmatic response.

- To design program responses that are realistic given the nature of the HIV/AIDS crisis. Knowledge is limited and the crisis will be long term. Hence how can programming be flexible enough to permit injection of learnings as they become available? How can funding be accessed?

- To disseminate learning on issues of HIV/AIDS related programming especially related to prevention and mitigation both within the organization and with other partners.

5. Suggested Steps Forward

- No single agency has sufficient reach to address all the problems of HIV/AIDS alone. In order to ensure effective results WV will actively seek to build alliances with others national, international and local levels.

- World Vision will enhance collaboration with faith-based organizations (church, mosque, and related NGOs). Faith-based organizations have a distinct comparative advantage in this respect because; they are present in communities, have grassroots credibility and understand grassroots language. They have the institutional infrastructure which is both extensive and self-sustaining. In addition, in many countries, the church supports up to 50% of health facilities. These agencies can be backstopped technically and given the resources they need, they can be extremely effective in advocacy for government official response and action; for broad education and behavior change initiatives, and for counseling and care. Currently, they are playing only a minimal role in combating this crisis.

- World Vision needs to survey existing funding opportunities in those countries where WV has an operational presence to establish what resources exist that could support significant bilateral programs in HIV/AIDS. The output of such work would help guide in-house teams as to where programming opportunities exist and where specific advocacy on behalf of neglected countries is needed.

- World Vision will promote in-country advocacy geared to creating a conducive national environment in which effective HIV/AIDS related programming can take place. Although many African countries are now more open to the issue of HIV/AIDS, there are still some where this is not yet the situation. WV national offices will the take lead in creating networks which are capable of mounting policy advocacy. They will work closely with faith-based organizations, who are at times better placed to influence their governments. The need for this in the heavily affected countries of Eastern and Southern Africa is urgent.

- Within the highly affected countries, WV will examine the potential of scaling up HIV/AIDS related interventions within its ADPs, to cover both prevention and mitigation and how to support this expansion. This task needs to be preceded by a clear understanding of the socio-economic situation which affected households find themselves in today, including the capacity of the current extended family to function as a safety-net for children. In particular,

there is need to evaluate how the extended family mechanism is operating in the urbanized societies of Zambia, and South Africa as well as the areas experiencing extreme land shortage such as Malawi. Equally significant, an assessment is needed as to whether child sponsorship could be expanded to include sponsorship of families. Experience gained from working with AIDS orphans in Uganda suggests that addressing the needs of children in a family setting (as opposed to an individual child) helps to minimize stigmatization, separation of siblings, as well as retaining harmony within the fostering family. This approach can help the orphan children to overcome the trauma of losing loved ones as well.

- World Vision should consider creation of an AIDS network (with a special internet forum) so that there is wider sharing of lessons learned and positive program outputs at the grassroots level in the prevention and mitigation of HIV/AIDS. This sharing must include both high level players and reach down to implementers of programs at the ADP level.

- Ideally, World Vision should also consider placing a Programming Specialist within both its EARO and SARO sub-regions to help guide other managers on integration of HIV/AIDS activities in both existing and emerging ADPs.

Established in 1950, World Vision is the largest privately funded Christian relief and development organization in the world. Each year, World Vision offers humanitarian assistance and hope to more than 60 million people in nearly 100 countries. Our mission is to help the poor and oppressed by providing holistic interventions that promote transformation, self-sufficiency, and dignity.

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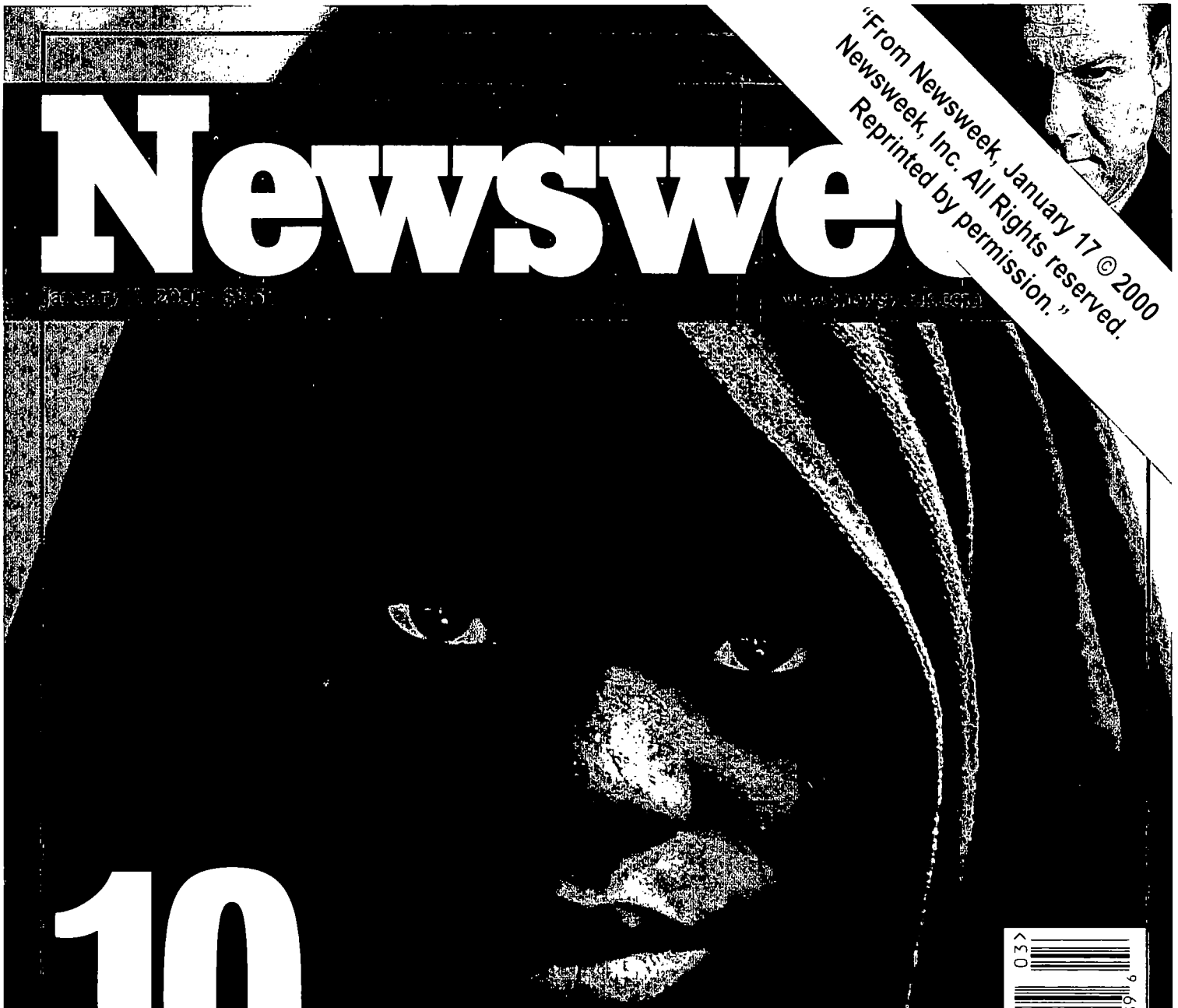
1950 — 2000
Our Family at Fifty
1999 Annual Report
World Vision

Newsweek



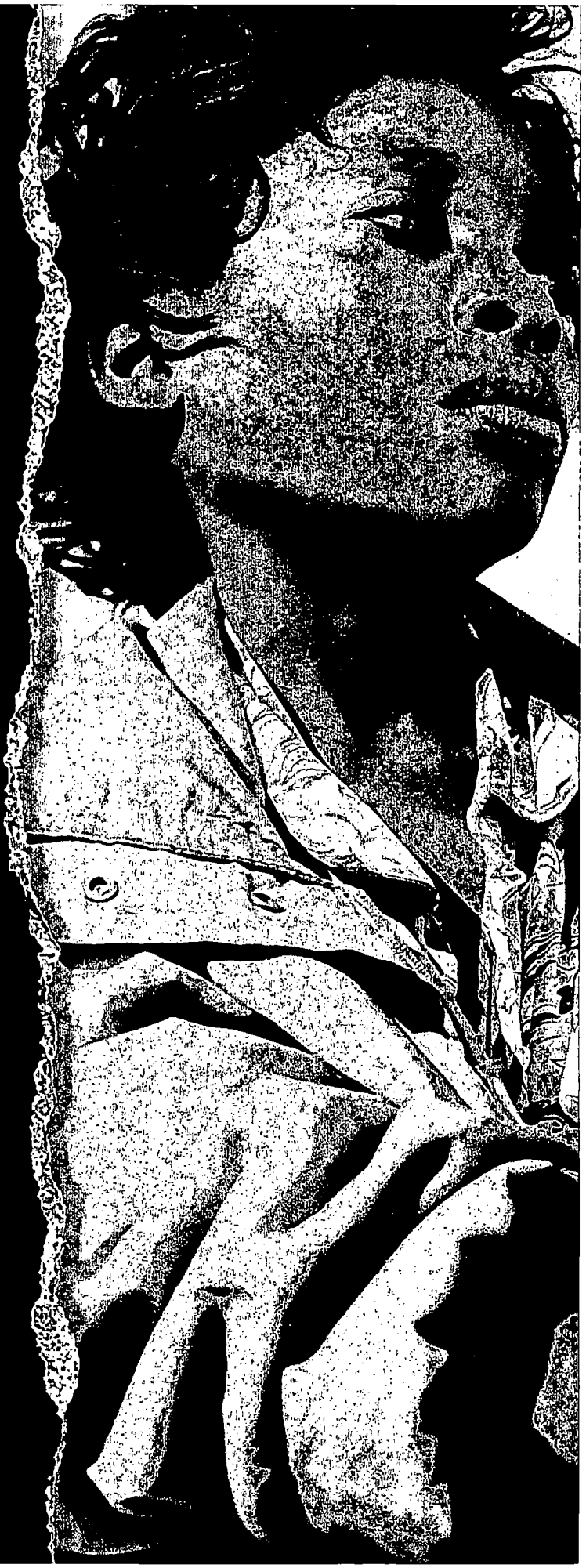
10 Million Orphans

The **AIDS epidemic** in Africa is leaving a generation of children without parents. Behind the plague–and what can be done.

A Zambian orphan whose parents died of AIDS

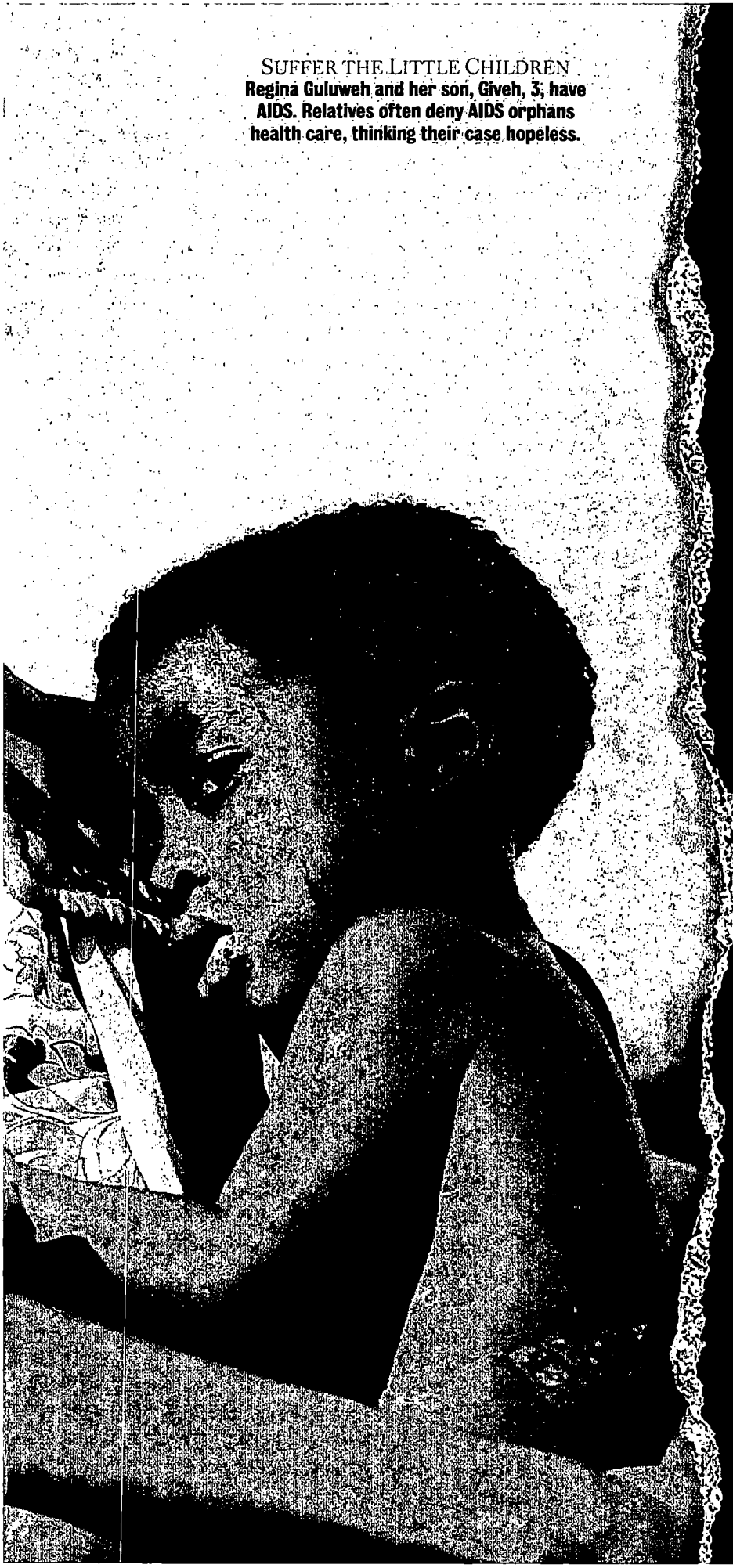
For the children who have lost their parents to AIDS, grief is only the beginning of their troubles. The disease's lasting victims. BY TOM MASLAND AND ROD NORDLAND

10 ORPHANS



EVEN ON THE MEAN STREETS OF HOMA BAY, a fishing center of 750,000 on Lake Victoria, the children stand out: Kenya has 350,000 AIDS orphans, and 35,000 of them live here. Many of those who have not been forcibly removed to the orphanage are street children pickpockets and beggars, prostitutes and thieves. To Hamis Otieno, 14, and his brother, Rashid Faraji, 10, the streets of Homa Bay were their last, best hope. Their father had died of AIDS in 1995; their mother turned to prostitution and abandoned them soon after. Relatives, unable to provide for the boys, cast them out. The brothers made their way by bus to Nairobi, 150 miles away, where they stole, begged and worked as drug couriers. But after a year, hungry and alone, the boys went home; hustling promised to be easier on the less competitive streets of Homa Bay. Soon after their arrival, however, they caught what in their world counts as a break: they were picked up and taken by force to an orphanage. There, every one of the children is an AIDS orphan. But then, that is hardly surprising: in Homa Bay, some 50 to 70 percent of the adults are HIV-positive. "So many have died," says Hamis, "so many."

In the nations south of the Sahara, almost two decades of AIDS deaths—2.2 million in 1998 alone, and a still untallied but certainly greater number in 1999—is leaving a sea of orphans in its wake. By the end of this year, 10.4 million of the children under 15 will have lost their mothers or both parents to AIDS. Before the current epidemic, the perennial



SUFFER THE LITTLE CHILDREN
Regina Guluweh and her son, Giveh, 3, have AIDS. Relatives often deny AIDS orphans health care, thinking their case hopeless.

cataclysms of war and famine orphaned 2 percent of the region's children; AIDS makes that figure look benign (graphic). A generation of orphans threatens to undermine economic development, for children without parents can seldom afford education. And many AIDS orphans end up "roaming the streets, prime targets for gangs [and] militia and creating more child armies like those that participated in massacres in West Africa," says Dr. Peter Piot, executive director of UNAIDS. But worse lies ahead. The number of AIDS orphans in the region is projected to double or triple by 2010.

It is not only the raw numbers that make this orphan crisis unlike any ever seen. The children, who have often watched their parents die alone and in pain, are left in a world where AIDS has unraveled such traditional safety nets as the extended family, and in households where not a single adult is able to earn a living. Josephine Ssenyonga, 69, lives on a small farm in the Rakai district of Uganda, where AIDS has been cutting through the population like a malevolent scythe for 14 years: 32 percent of the under-15 population, a total of 75,000 children, have been orphaned in Rakai. Of the four daughters and nine sons Ssenyonga raised, 11 are dead. Her son Joseph left her with eight children; Francis left four; Peter left three. "At first there were 22, living in that small hut over there," she says. "My children did not leave me any means to look after these young ones. All they had was sold to help treat them." Overwhelmed, she took the children to the hut one day. "I told them to shut the door so we could all starve to death inside and join the others," Ssenyonga says. She changed her mind when a daughter returned home to help, and World Vision provided a three-room house for them all.

Bernadette Nakayima, 70, lives in Uganda's Masaka district, where 110,000 of the 342,000 children are orphans. Nakayima lost every one of her 11 children to AIDS. "All these left me with 35 grandchildren to look after," she says. "I was a woman struck with sorrow beyond tears." But she is not alone: one out of every four families in Uganda is now caring for an AIDS orphan, says Pelucy Ntambirweki of the Ugandan Women's Effort to Save Orphans (UWESO).

When AIDS takes a parent, it usually takes a childhood, too, for if no other relative steps in, the oldest child becomes the head of a household. Yuda Sanyu Kitali-

was 10 in 1992 when his mother died of AIDS; the disease had killed his father in 1986. Sanyu had to drop out of school, of course, as did his younger brother, Emmanuel Kulabigwo, now 16, and sister, Margaret Nalubega, 15: when their parents died, so did any hope of affording academic fees. "No one came to claim us or toffer help," says Sanyu. A year after the children were orphaned, the grass-thatched house their father had built in the Rakai district collapsed in a heavy rain. "Since I was the oldest, I had to build another house," Sanyu says. He did his best with mud, poles, reeds and banana fiber. The children grew cassavas and greens on the land their parents left them, but they still went to sleep hungry many nights. As Sanyu tells his story Emmanuel nods silently. Margaret sits on a papyrus mat in the corner, staring at a wall and hiding a tear in her dirty brown dress.

Most orphans are taken in by their extended families, if they are taken in by anyone, but the sheer number of these lost children fills orphanages, too. Ethembeni House, run by the Salvation Army in downtown Johannesburg, has 38 children 5 or younger. All of them have tested HIV-positive. All were abandoned: a vagrant found the newborn Moses, now 3, in a dumpster; a woman handed days-old Simon, now 2, to a street vendor and never returned. The rooms in Ethembeni, lined with cribs, are clean and decorated with pictures of clowns and dolls. Other pictures, of children who died here, line the mantel. Moses points to one: "He's gone," he says. When a stranger enters the room, the children turn expectant faces to her: "Mama, mama," they cry.

In times past it was usually war or neglect or famine or poverty that brought abandoned or orphaned children to the Sanyu Babies Home in Kampala. Now the caseload of 26 is almost entirely AIDS orphans, many of whom have lost not only parents but all their other adult relatives, too. Patricia Namutebi, 3, was brought in as a 1-year-old by a thin, sickly man who said he was her neighbor and that her mother had died of AIDS. Patricia has been sick with one opportunistic infection after another; today she restlessly drags a chair to and fro and swings on the curtains, apart from the other children. Workers at the Babies Home suspect that the man was her father, but it hardly mattered. When they trace abandoned children back to their families, says Joyce Lolindya, administrator of the home, the survivors seem to feel that "it is hard to look after an AIDS victim, and then also the children of that victim, when you know they will all die." Especially when AIDS carries with it such a social stigma.

FULL ORPHANAGES

In Africa, war and famine made an orphan rate of 2 percent 'normal.' AIDS pushed that to 12 percent in some countries.

Unless abandoned AIDS orphans reach an institution like hers, they risk getting sucked into what Godfrey Sikipa of UNAIDS calls "a vicious circle." He adds: "In many cases the orphans, unless we prevent them from

LAST RITES
A 7-year-old boy, dead of AIDS, is buried in rural Zambia. Some 1 million children in Africa are HIV-positive.

going into deeper poverty, will become prostitutes." The fortunate ones become child brides, or the plaything of a sugar-daddy. They can only hope that the men will not be among the millions who believe that sex with a virgin cures AIDS.

When an extended family cannot afford to educate all the children in its care—virtually everywhere in Africa governments charge school fees—it is the orphan who is the likeliest dropout. In Zambia, a study cited by the UNAIDS report found, one third of urban children with parents enroll in school, but only one quarter of orphans do. "I wish I could go all the time," says Ben Sengazi, 13, one of Ssenyonga's grandsons. But when the family cannot scrape up the fees, the school turns him away.

Compared with children with parents, AIDS orphans are at far greater risk of malnutrition and of not receiving the health care they need. The little girl named Forget was 4 when her mother died of AIDS last November and she went to live with her grandmother in a village southeast of Harare. Her small body has recently developed ugly lesions, which she scratches constantly. Her grandmother says the causes of the plague are a mystery to her. Although she is doing what she can for Forget, the assumption by many caregivers is that the orphan, too, is infected with HIV, and that her illness is untreatable. Perhaps that explains one of the puzzles of the AIDS orphans. In 1995 Uganda had 1.2 million of them; based on the number of AIDS deaths and other factors, there should be 1.5 million now, but there are "only" 1.1 million. That is, Uganda is missing 400,000 AIDS orphans. "Either the babies were born [HIV-] positive, or they died from a lack of care," says UWESO's Ntambirweki.

Government and private programs do what they can for AIDS orphans. In Botswana, nongovernmental and community-based organizations provide services ranging from day care to food, clothing and bus fare to and from school. Villages in Malawi have organized communal gardens. Charity groups and orphanages teach the older children AIDS prevention, hoping that the cataclysm that befell the parents will not be visited on the children. World Vision built Sanyu's family a four-room house, paid for his sister and brother's schooling and trained Sanyu in bicycle repair. And after Harriett Namayanja, now 17, lost her parents to AIDS, a loan from a private agency saved her and her eight brothers and sisters. Harriett used the money for sisal grass, from which she weaves doormats. She sells them in Kampala, and with the money, she says, "I am able to look after my younger siblings" and even pay school fees for her brothers. But she and Sanyu are exceptions. Funding has not kept up with the needs of so many orphans, and institutions are stretched almost to the breaking point.

> The number of people who have gone into the coffin-making business—that is something you can see without being an epidemiologist.
>
> —G. SIKIPA, *UNAIDS*

Some 6,000 men and women in sub-Saharan Africa will die of AIDS today. Six thousand more will die tomorrow, and the next day. For the children they leave behind, the tragedy is only beginning.

With SIMON KAHERU *in Kampala,* LARA SANTORO *in Homa Bay,* VERA HALLER *in Johannesburg and* SHARON BEGLEY

World Vision

World Vision and AIDS

Fighting the world's deadliest disease on several fronts

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AIDS is the Third World is more than an epidemic. It is a catastrophe, eroding much of the progress made in previous decades to reduce poverty and children's deaths and improve living conditions in the world's poorest countries. And, according to a United Nations report released June 27, t he worst is yet to come, especially in Africa: More than one-third of today's 15-year-olds in the hardest-hit countries will die of AIDS.

For humanitarian agencies, the news was a double-edged sword: AIDS creates a need for new services, such as prevention education, patient care and support for survivors, at the same time it reverses hard-won health and economic gains for families, communities and entire countries.

World Vision, the largest privately funded Christian humanitarian organization in the world, started its first AIDS programs a decade ago, relatively early in the international response to the epidemic. The organization's first work included assistance for AIDS orphans and their foster families in Uganda, care for HIV-infected babies and children in Romania, and support for teens and young women escaping prostitution in Thailand.

Throughout Africa – and increasingly in Asia and other parts of the world – AIDS education is becoming as routine in community development work as interventions such as immunization and small business loans.

Here is a sampling of World Vision's AIDS work:

In **Uganda**, World Vision has been working in the Rakai District, ground zero for the AIDS epidemic, for the past 10 years, assisting children orphaned by AIDS and helping communities cope with the disease. In a project initiated with funding from the World Bank, World Vision has helped tens of thousands of AIDS orphans with education, health care, nutrition, shelter and other basic needs. Older orphans, most of them responsible for younger siblings, are given vocational and agricultural training. In addition, some 1,000 community health workers and counselors have been trained.

World Vision has been working with two high-risk groups in **Zambia**, truck drivers and prostitutes, to promote AIDS awareness and behavior change. A 1990 study in neighboring Tanzania found that truck drivers and their assistants had dozens of sexual partners per month; many of these truck drivers are from, or drive through, Zambia. Working with government and private agencies since 1996, World Vision has trained peer educators to promote AIDS prevention. These efforts are concentrated at five main

(more)

border-crossing areas – with the Democratic Republic of Congo, Malawi, Zimbabwe and Tanzania – where truckers have to wait two-to-four days for customs clearance. World Vision is lobbying customs officials to speed up the process, and also encouraging trucking firms to allow drivers to bring their wives on some long trips.

The Black Sea port of Constanta has the highest HIV infection rate in **Romania**. Because of unscreened blood transfusion and reuse of hypodermic needles, Romania has the highest child HIV-infection rate in Europe. World Vision has been providing medical supplies, staff and training to hospitals treating children with AIDS for the past decade. To prevent HIV-infected children from being unnecessarily institutionalized, World Vision supports social workers who provide food, clothing and other items needed by their families. World Vision also sponsors a Kids Club in Constanta; each week, some 230 HIV-infected children ages 9 to 14 attend parties and other events, or take field trips to the beach or a restaurant.

World Vision began its AIDS prevention and care program in **Cambodia** more than seven years ago, with a focus on AIDS education in the capital city, Phnom Penh. In 1997, the program opened the first HIV/AIDS counseling center in the country. Two years later, World Vision worked with the World Health Organization to improve community-based care for people living with HIV/AIDS. The Ponleu Chivit Club has been established as a support group so that people living with HIV/AIDS can assist one another to cope with the disease, both physically and psychologically.

END

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Name: Cheryl Bauerle,
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Fax: 456 2439
Phone: 456 2437
From: Serge Duss, Director, Public Policy & Govt Relations
Date: July 20, 2000
Subject: Appointment with Sandy Thurman
Pages: 2

Dear Cheryl,

Senior representatives of World Vision would like to meet with Sandy Thurman to discuss how we can contribute to US foreign policy to mitigate the HIV/AIDS pandemic in Africa and Asia.. World Vision president Richard Stearns, who is based in our US headquarters near Seattle, will be in Washington DC on Aug. 22. He will be joined by Bruce Wilkinson, senior vp for international programs, and myself.

World Vision is a 50-year old international Christian relief and development organization with more than 5,000 projects in almost 100 countries. In 1999, World Vision programs served 60 million people. World Vision is operational in 8 of the 12 African countries with the highest AIDS infected adult population. In Africa and Asia World Vision implements programs to prevent HIV transmission and care for AIDS victims, including orphans. As a faith-based organization, World Vision works with, and has the support of, churches and indigenous faith-based organizations. In Africa, the religious sector can do much more in AIDs prevention and care. World Vision is helping this community reach its outreach potential.

World Vision is also a partner with USAID and other USG bureaus, such as Population, Refugees and Migration. We have received grants from these two offices since the late 1970s.

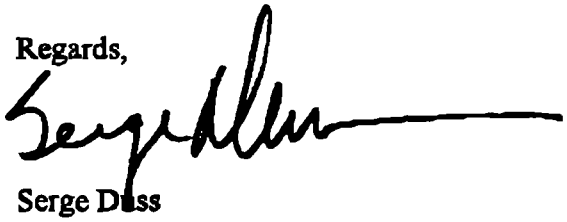
In a meeting with Ms. Thurman we'd like to offer ideas about partnerships with the US government that will help leverage resources from our large donor community in the US for programs in Africa and Asia. World Vision is also a member of an international partnership with offices in 18 industrial countries that support our global programs. Resources from these countries, such as Australia, Canada and German, can also be leveraged with US public and private resources in HIV/AIDS programs.

Mr. Wilkinson and I have already met with USAID administrator Brady Anderson and his AIDS program director, Dr. Paul DeLay. We have also met with Jim Babbitt in Leon Fuerth's office to discuss our ideas.

If Ms. Thurman is unavailable Aug. 22 for a meeting with Mr. Stearns, Mr. Wilkinson and I would still like to meet with her on a more convenient date in late August.

I leave for Asia on Monday. I would appreciate it if you would get back to me by Friday with even a tentative decision on a meeting with Mr. Stearns.

Regards,



Serge Dess
Director, Public Policy
& Government Relations

World Vision

CONCEPT PAPER

Towards a Strategy for Addressing The HIV/AIDS Crisis in Africa

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Towards a Strategy for Addressing The HIV/AIDS Crisis in Africa

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1. Background

In Africa, AIDS is a foremost cause of death. In 1998, more than 2 million people died of AIDS. This represents two thirds of all AIDS related deaths in the world, although Sub-Saharan Africa accounts for just 10% of world's population. At the end of 1998, some 22.5 million people, including 1 million children, were living with HIV/AIDS. In many African countries, the HIV virus continues to spread very fast. In 1998, approximately 4 million Africans became infected with about 10,500 new cases a day. In Botswana, Namibia, Zambia and Zimbabwe between 20 and 26% of the population ages 15 to 49 are infected. In twelve other Sub Saharan countries (including Ethiopia, Kenya, Mozambique, South Africa and Tanzania) 9 to 20% of adults are infected. Epidemiologists warn that what we are witnessing is the tip of an iceberg, as only 10% of the illness and deaths that this epidemic will bring have been seen. Millions of Africans are infected but have not yet started to fall ill. According to UNAIDS, 90% of those living with HIV do not even know it.

AIDS in Africa is more than an epidemic. It is a development catastrophe eroding many of the development gains made in previous decades. Unlike most diseases, AIDS targets people in the prime of their working lives and as parents. Generally most people who acquire HIV in Africa become infected before they are 25 years old, and are usually dead before their 35th birthday. This age factor makes AIDS uniquely threatening to families, communities and economies. Today, in many African countries, AIDS has already wiped out major gains in development registered in the past decade. Child vulnerability has increased as parents die off leaving children in the care of the sick, the elderly, or other children.

No sub-Saharan African country has escaped the virus. In the early 1990's, the epicenter for the epidemic was the Lake Victoria Basin countries of Uganda and Tanzania. Since then, the area of devastation has spread to cover the entire belt of countries from Ethiopia in East Africa to the countries of Central and Southern Africa, as well as the coastal countries of West Africa. HIV/AIDS is spreading especially fast in the Southern African countries of Botswana, Zimbabwe, Namibia, Zambia and South Africa. Demographers are attributing this faster spread to a late start (at the official level) in acknowledging the existence of the disease, against a background of significantly higher levels of internal and intra-regional migration

There is thus an urgent need to address the crisis of HIV/AIDS in Africa both on humanitarian as well as economic and security grounds. The two critical challenges that need to be tackled are:

- How can the HIV/AIDS infection rate be curtailed so that in time the numbers succumbing to it decline?
- How can societies best cope with the devastation to families and communities unleashed by AIDS?

2. Existing Best Practices for addressing HIV/AIDS.

A number of African countries have been planning and implementing HIV/AIDS programs since 1985. The first set of programs was designed by WHO and were monitored in-country by an AIDS Control Program Manager based within the Ministry of Health. As the epidemic

intensified, countries started developing strategies, with the help of UNAIDS, that identified priority areas and activities based on the determinants of the epidemic in-country. But, except for Uganda and Senegal, African leaders have not taken strong positions in support of these strategies. (Not a single African leader attended the last Global AIDS meeting held in Zambia.)

Available evidence from leading agencies working on HIV/AIDS and from countries where HIV/AIDS infection rates have been stabilized suggest a number of approaches for addressing the above challenges. All require a multi-sectoral approach within which issues of human sexuality are discussed openly with AIDS perceived like any other serious disease. Furthermore, communities must be empowered to play a leading role in addressing the challenges facing them. This requires commitment and leadership at all levels, starting with those in government, and including leadership in communities, business, labor unions, religious organizations, and NGOs. Experience has shown that only when there is this level of involvement can open and interactive discussion on issues of HIV/AIDS be possible. When such environment is fostered, it is possible to implement a coordinated package of initiatives that work synergistically to help people reduce the risk of HIV/AIDS infection and adjust to its aftermath. To date, specific approaches which have produced positive results in reducing the infection rate include:

- Increased faithfulness in marriage (or practicing 'zero grazing' as they say in East Africa)
- Delayed initiation of sexual activity (especially within the 15-24 age group)
- Discouraging un-protected sex among men with multiple partners
- Detection and early treatments of STDs in both males and females
- Maintaining safe blood transfusion supply
- Helping poor women who invariably depend on sex to have other ways of earning a livelihood
- Reducing vulnerability of women and girls in an adverse cultural environment
- Improving the well-being of people living with HIV/AIDS
- Making voluntary testing and counseling available and affordable
- Preventing transmission from mother to child
- Intense public education
- Easy access to condom distribution

In terms of coping with the aftermath, especially as it affects children, best practices thus far include:

- Youth related messages through music, video, radio and newspapers together with appropriate youth-friendly services
- Home based care of AIDS patients and increased access to HIV/AIDS related drugs
- Encouraging foster care for orphans
- Improved economic opportunities for households with orphans
- Reduced school fees so that children from poor families and AIDS orphans stay in school longer
- Educating children, especially girls, to enhance their abilities to avoid infection
- Establishing outreach programs for street children
- Social funds to help grassroots organizations cope

- Stimulating and strengthening community-based responses
- Ensuring that governments protect the most vulnerable children and provide essential services to them
- Building the capacity of children to support themselves
- Creating an enabling environment for affected children and families
- Improving economic opportunities, especially for women headed households
- Food programs for children and support for educational expenses
- Promotion of exclusive breastfeeding for 4-6 months, even in HIV positive mothers

The implication is that it requires the mobilization of ALL to ensure the well-being of ALL. This includes Government, whose role and commitment is key to creating the appropriate environment as well as ensuring that the necessary institutions are in place and functioning. It includes individuals, whose commitment to wellness is foundational to any initiative bearing results. It includes community organizations, NGOs and faith-based organizations to mobilize, inform and care for people at the grassroots level. Hence a multi-pronged approach targeting all the pathways through which HIV/AIDS spreads and exerts its impact is necessary.

Faith-based organizations are an essential part of this approach, given the high emphasis their teachings place on morality. Experience from Uganda, a country that has made the most dramatic turn around in the HIV/AIDS infection rate, suggests that through increased faithfulness in marriage and delayed onset of sexual involvement, especially among the 15 to 25 year olds, HIV/AIDS infection rate has significantly declined from 15% in 1992 to 9.5% in 1998. NGOs such as World Vision that operate broadly at the grassroots and have credibility with civil society also can play a key role in linking churches with communities.

3. WV's Experience Working with HIV/AIDS.

World Vision among the earliest NGOs to come up with a programmatic response once the devastating impact of HIV/AIDS became known. Its first significant response was made in 1990 in Uganda, where WV utilized funds from the Government of Uganda through a World Bank (IDA) credit to implement a program of assistance to orphans of HIV/AIDS and war in three districts. In the mid 1990's WV made an internal policy that required its Program Offices to add HIV/AIDS related activities within each of its existing health programs. To date a total of 65 projects in 11 countries have at least one goal that relates specifically to HIV/AIDS prevention. The bulk of these programs are in East Africa (24 in Uganda, 13 in Tanzania and 10 in Kenya). Zimbabwe and Mozambique have one project each. Malawi, South Africa and Zambia, have four such projects each.

In general WV's programs have been of varying magnitude and focus. The most notable one is WV's program of assistance to orphans of AIDS in the districts of Rakai and Masaka, in Uganda. This demonstrated the effectiveness of an approach that combines direct support to orphan children, coupled with initiatives geared to enhancing foster family productivity, and community recovery to create an environment where the needs of children could be catered for in a caring and sustainable manner.

World Vision, through its Child Survival Project in Kwazulu/Natal Province, South Africa, has actively targeted youth in schools to improve knowledge about the epidemic. Evaluation of those efforts prove they were effective in raising awareness regarding transmission and prevention of HIV. Also the program was successful in introducing teachers and parents to key concerns regarding reproductive health, sexual practices and communication in relationships. The project forged a strong collaboration with the Department of Education resulting in strengthening of training of teachers in both primary and secondary schools.

But further study is needed to determine how far educational efforts can impact on the behavior of adolescent school attendees over a longer period, especially those who are already sexually active at the time of the peer education encounter. One promising avenue may be through the churches as more than 75% of the youth reported regular church attendance, even those who were school leavers. As a follow-up to this initial work, the community is asking for AIDS education and assistance in caring for home cases. A new effort to combine micro-enterprise development with AIDS education for the community is now in the early stages of development.

Within WV, there has been limited replicability across countries or even within countries; the need for new programs remains great. Also, many of the major projects were of short duration and came to a premature close. Critical reasons for this state of affairs include the following:

- WV programs have been largely supported by government grants. Government grants have themselves been scarce, country specific, and of limited duration.
- The approach to HIV/AIDS has been project focused rather than setting out to address a problem programmatically. Hence projects have been started and phased out, while the problem has remained.
- We have only begun to capture the lessons learned; in so doing, our ability to be a significant influence in the evolution of HIV/AIDS related policies has been curtailed.
- Staff with the appropriate programming experience have not been able to stay with some of the strategic initiatives. This has tended to limit the ability of country programs to build credibility with the appropriate bilateral funding agencies.

4. The Challenge to World Vision

The key challenges for WV, an organization with major programs in Africa, are:

- To scale up activities relating to HIV/AIDS, Africa-wide to ensure that those who are not yet infected remain free of this virus. Currently, UNAIDS estimates that there are roughly 200 million adults in Africa who have not yet been infected by HIV/AIDS. In addition, the young, especially between the ages 5 through to 14 are free of HIV/AIDS. Hence a key challenge is to address the youth.

- To scale up within already devastated countries with programs that would enable communities to cope with the aftermath of HIV/AIDS, especially in those parts of Africa (such as the Southern African countries) which currently constitute the epicenter for this epidemic and where, for a variety of reasons, there has been less programmatic response.

- To design program responses that are realistic given the nature of the HIV/AIDS crisis. Knowledge is limited and the crisis will be long term. Hence how can programming be flexible enough to permit injection of learnings as they become available? How can funding be accessed?

- To disseminate learning on issues of HIV/AIDS related programming especially related to prevention and mitigation both within the organization and with other partners.

5. Suggested Steps Forward

- No single agency has sufficient reach to address all the problems of HIV/AIDS alone. In order to ensure effective results WV will actively seek to build alliances with others national, international and local levels.

- World Vision will enhance collaboration with faith-based organizations (church, mosque, and related NGOs). Faith-based organizations have a distinct comparative advantage in this respect because; they are present in communities, have grassroots credibility and understand grassroots language. They have the institutional infrastructure which is both extensive and self-sustaining. In addition, in many countries, the church supports up to 50% of health facilities. These agencies can be backstopped technically and given the resources they need, they can be extremely effective in advocacy for government official response and action; for broad education and behavior change initiatives, and for counseling and care. Currently, they are playing only a minimal role in combating this crisis.

- World Vision needs to survey existing funding opportunities in those countries where WV has an operational presence to establish what resources exist that could support significant bilateral programs in HIV/AIDS. The output of such work would help guide in-house teams as to where programming opportunities exist and where specific advocacy on behalf of neglected countries is needed.

- World Vision will promote in-country advocacy geared to creating a conducive national environment in which effective HIV/AIDS related programming can take place. Although many African countries are now more open to the issue of HIV/AIDS, there are still some where this is not yet the situation. WV national offices will the take lead in creating networks which are capable of mounting policy advocacy. They will work closely with faith-based organizations, who are at times better placed to influence their governments. The need for this in the heavily affected countries of Eastern and Southern Africa is urgent.

- Within the highly affected countries, WV will examine the potential of scaling up HIV/AIDS related interventions within its ADPs, to cover both prevention and mitigation and how to support this expansion. This task needs to be preceded by a clear understanding of the socio-economic situation which affected households find themselves in today, including the capacity of the current extended family to function as a safety-net for children. In particular,

there is need to evaluate how the extended family mechanism is operating in the urbanized societies of Zambia, and South Africa as well as the areas experiencing extreme land shortage such as Malawi. Equally significant, an assessment is needed as to whether child sponsorship could be expanded to include sponsorship of families. Experience gained from working with AIDS orphans in Uganda suggests that addressing the needs of children in a family setting (as opposed to an individual child) helps to minimize stigmatization, separation of siblings, as well as retaining harmony within the fostering family. This approach can help the orphan children to overcome the trauma of losing loved ones as well.

- World Vision should consider creation of an AIDS network (with a special internet forum) so that there is wider sharing of lessons learned and positive program outputs at the grassroots level in the prevention and mitigation of HIV/AIDS. This sharing must include both high level players and reach down to implementers of programs at the ADP level.

- Ideally, World Vision should also consider placing a Programming Specialist within both its EARO and SARO sub-regions to help guide other managers on integration of HIV/AIDS activities in both existing and emerging ADPs.

Established in 1950, World Vision is the largest privately funded Christian relief and development organization in the world. Each year, World Vision offers humanitarian assistance and hope to more than 60 million people in nearly 100 countries. Our mission is to help the poor and oppressed by providing holistic interventions that promote transformation, self-sufficiency, and dignity.

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1950 — 2000

Our Family at Fifty

1999 Annual Report

World Vision